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EURO HIV EDAT PROJECT

WP 9, Task 1

KAB/P study on the implementation of innovative HIV testing strategies: Main results of a study conducted among MSM and stakeholders

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ACRONYMS

CHAFEA - The Consumers, Health, Agriculture and Food Executive Agency

CBO – Community based organization

CBVCT – Community based voluntary counselling and testing

CESQ – Consumer's Experience of Stigma Questionnaire

CIBERESP - Consorcio de Investigación Biomédica en Red de Epidemiología y Salud Pública.

COBATEST – HIV community-based testing practices in Europe

DM/PHP – Decision makers/public health professionals

EMIS – European Men to Men Internet Survey

EU – European Union

EURO-HIV-EDAT - Operational knowledge to improve HIV early diagnosis and treatment among vulnerable groups in Europe

HIV – Human Immunodeficiency virus

IP – Internet Protocol

ISCIII – Instituto de Salud Carlos III

KAP/B ¬– Knowledge, attitudes, preferences and behaviours

LGTBI – Lesbians, gays, transgender, bisexuals and intersexual

MSM – Men who have sex with men

NGO – Nongovernmental organization

OptTEST - Optimizing testing and linkage to care for HIV across Europe

STI – Sexual transmitted infection

WP9 – Work package 9

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I. INTRODUCTION

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The purpose of the EURO-HIV-EDAT project is to generate operational knowledge to better understand the role and impact of Community Based Voluntary Counselling and Testing services (CBVCTs), to explore the use of innovative strategies based on new technologies and to increase early HIV/STI diagnosis and treatment in Europe among the most affected groups.

The work package number 9 includes two different tasks. This report refers only to task 1: KAP/B survey on innovative strategies

General objective and structure of the task 1

The final aim of this task is to evaluate the acceptability, feasibility, effectiveness and the foreseeable impact of some innovative strategies aimed at promoting early diagnosis of HIV based on the opinion of potential users and stakeholders.

The strategies considered are:

- self-sampling
- self-testing
- rapid testing in non-conventional settings

We also wanted to find out what testing patterns would be adopted by the different populations according to their needs and preferences and to come up with how the CBVCTs may help within this process.

The task includes two studies with a different methodological design:

- The potential users study: an online opinion survey among men who have sex with men potential users of these innovative strategies.
- The stakeholders study: an online survey among some of the key stakeholders, involved in the diagnostic process

II. THE POTENTIAL USERS STUDY

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1. SPECIFIC OBJECTIVES

- To estimate the percentage of MSM without an HIV test that would have been tested using a self-test kit, if available in their country.
- To analyse the potential that the approval of HIV self-testing kits would have to increase the percentage of MSM who meet the recommended testing frequency.
- To analyse whether the new strategies would be a predominant, complementary or a residual way of testing if they were to co-exist with already available strategies.
- To assess the preferences on models of accessibility, distribution and funding that would lead to a relevant impact by these new strategies.

2. PARTICIPATING COUNTRIES AND ASSOCIATED PARTNERS

The coordination tasks have been performed by professionals based in the Institute of Health Carlos III (ISCIII) and the Consortium for Biomedical Research in Epidemiology and Public Health (CIBERESP) from Spain.

The associated partners have been:

- Institute of Tropical Medicine (Belgium)
- AIDS Fondet (Denmark)
- AIDS-Hilfe NRW e.V. (Germany)
- Athens & Thessaloniki Checkpoints(Greece)
- GAT-Grupo Português de Activistas sobre Tratamentos de VIH/SIDA (Portugal)
- ARAS - Romanian Association Against AIDS (Romania)
- Legebitra (Slovenia)

3. METHODS

3.1. Study population. Inclusion and exclusion criteria

In order to be eligible, the participants had to meet all the following inclusion criteria:

- Being a man.
- Having had sex with other men.
- Declare to be old enough to legally have sexual relationships in his country, (all participants were, in fact, at least 18 years old).
- Living in one of the eight participant countries for most of the time during the last 12 months

In others words, people meeting any of the following exclusion criteria were not enrolled in the study:

- Being a woman.

- Being transgender.
- Never having had sex with other men.
- Not being old enough to legally have sex in his country.
- Living in a country not participating in the study.

3.2. Recruitment procedures

The aim was to capture a sample of MSM across Europe as heterogeneous and representative as possible, including MSM with and without previous HIV testing experience. To achieve this, the participants were recruited through two different convenience sampling methods:

- Via banners, newsletters, social media or mailing lists on commercial and non-commercial, national and transnational gay oriented websites.
- Via banners, social media or mailing lists of CBO/NGOs working with MSM.

A banner was designed in collaboration with CEEISCAT. A draft version of the banner was circulated among the associated partners and the final version was produced after receiving their comments. The definitive version included the message “And you, how do you like it?” The message was translated to all 8 languages and incorporated into the banner.

To promote the survey through newsletters and mailing lists, the work package leaders produced a standardized text in English to be used to invite potential participants. Nevertheless, partners were free to modify the content if they thought a different version could suit better the context

We carried out two recruitment campaigns one at the transnational level and another one at the national level:

a. Transnational websites

Based on the dating platforms used in the EMIS survey and on our own experience in a past online study carried out in Spain, we asked associated partners to choose which one of the following three platforms was more popular in their country: Planet Romeo, Manhunt and Gaydar. It was decided not to ask about Grindr because it was not affordable economically.

Based on the responses given by the associated partners and also due to its assumable cost, we chose Planet Romeo to conduct the transnational campaign. We agreed with the website managers to conduct two waves of recruitment. The first one would be carried out for free in all 8 countries. Based on the results of the first wave, we would design a second wave of recruitment focusing our resources on those countries where

Planet Romeo recruited a relevant number of participants during the first wave. Additionally to Planet Romeo a smaller size dating website (Bareback nation) as well as Aids Action Europe and the COBATEST network contributed to the transnational recruitment for free.

b. National websites

Given their better knowledge of the local community, each associated partner was asked to identify national level NGOs, gay media and gay dating websites that could be interested in participating in the process. We also asked them to include an estimated cost for promotion. Nevertheless, most of the websites contacted nationally agreed to participate for free or for a very reduced cost with the exception of a popular gay dating website who we worked with in Portugal.

The recruitment period started in April 2016 and finished in September 2016 in all countries with the exception of Portugal, where the recruitment had to be extended to December of 2016 due to bureaucracy hurdles related to the payment with the main recruitment website.

3.3. Sample size

Our commitment was to reach a minimum number of 100 individuals per country.

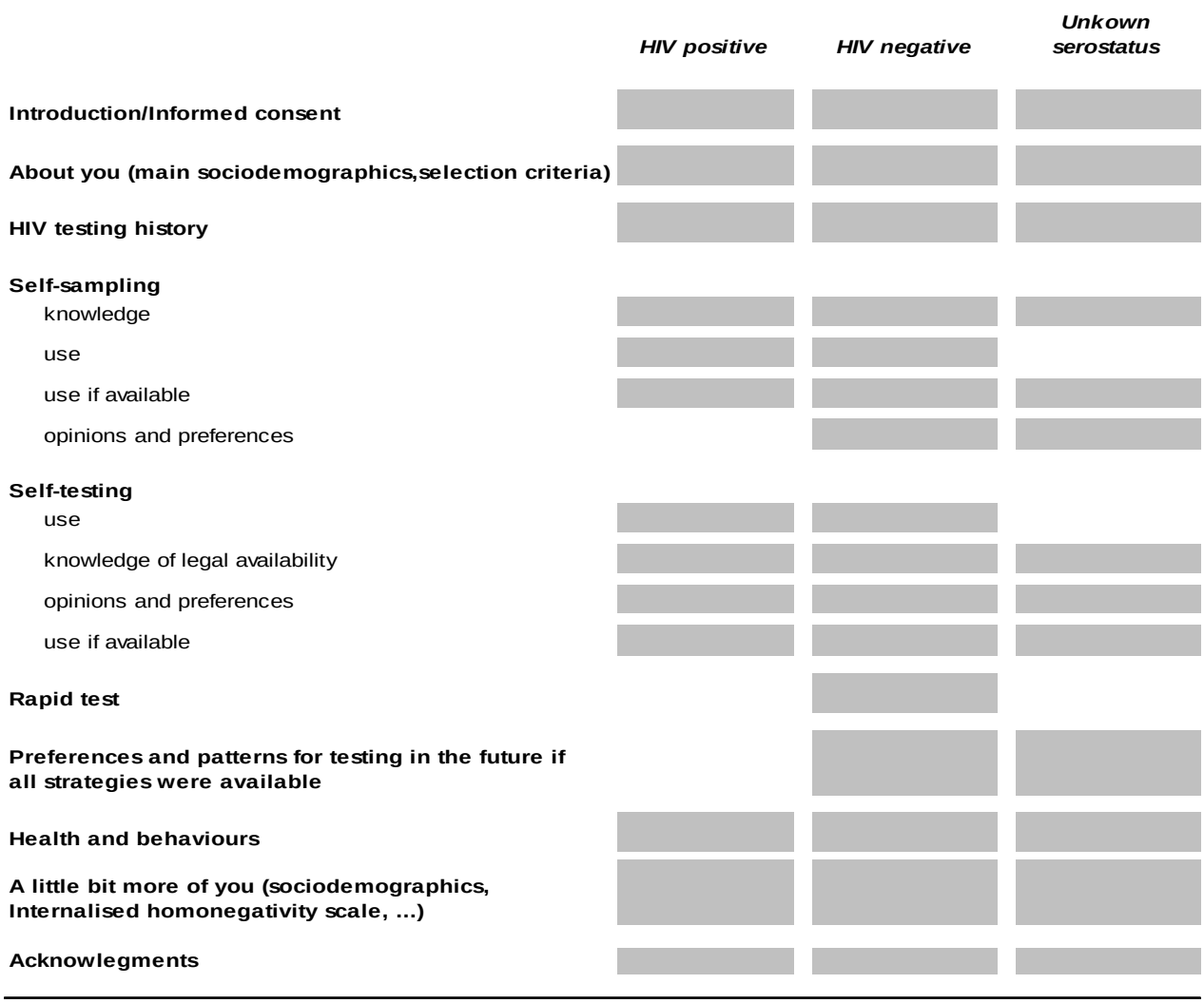
However, every associated partner was encouraged to increase the sample size in their country as much as possible to allow a better and meaningful analysis. A minimum of 250 participants per country was recommended.

3.4. The questionnaire. Contents

It was designed taking into consideration a Spanish-based study conducted previously by the WP leaders and the European MSM Internet Survey (EMIS). The Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) has repeatedly promoted the use of tools developed in the framework of previous financed European actions. Since EMIS was a multi-language, pan-European, cross-sectional survey, we have taken into account their experience when designing ours. Using as much as possible similar approaches and wording will allow better comparability of the results.

The core of the questionnaire is devoted to previous HIV testing history and future intentions with special focus on innovative strategies: self-sampling, self-testing, rapid HIV tests and preferences and patterns for testing in the future. The structure of the questionnaire can be seen in figure 1:

Figure 1. Structure of the questionnaire. Sections completed by participants according to HIV serostatus (in grey colour)



- *Introduction/informed consent:* participants were informed of the content and procedures and gave their explicit consent to participate in the survey.

- *About you:* This first set of questions was meant to collect some basic information on sociodemography, sexual behaviours and "outness". This information was also used to filter those whose answers were not going to be analysed due to the purpose of the study. Since the survey focused on MSM living in eight European countries, women, transgendered individuals, those who had never had sex, those who only had had sex with women and also those who did not live in one of the studied countries were informed that their responses would not be taken into account and they were given the chance of leaving the survey or keep on reading the questions.

- The next set of questions was on *HIV testing history and serostatus*. This divided the participants in three different groups:

1. Questions for those who had *never been tested*. People at risk of infection who have never undergone an HIV test is a priority group for public health policies and programmes aimed at promoting earlier diagnosis. The questionnaire tries to understand why they have never been tested; their knowledge and opinions on self-sampling and self-testing; and if the availability of some of these new strategies may help them to get tested.

2. Questions for those who knew that they were *HIV negative*. This population are people at risk of infection that have already been tested and, thus, know the advantages and disadvantages of testing process(es). They also know if they may benefit from the new strategies in terms of testing patterns and frequency. We inquired about their knowledge and use of self-sampling, self-testing and rapid tests, their opinions and intention to use. We also assessed which would be their testing preferences and patterns if these strategies were all available

3. Questions for those who already knew that they were *HIV positive*. Their opinion vital on the availability of different kinds of tests is of vital importance, since they have a unique point of view of the whole testing-diagnosing-linkage to care process. That is why we asked about their opinions on home self-sampling and self-testing and whether if they believed that they could have benefited from an earlier diagnosis if those strategies would have already been available.

- *New testing strategies section*. This section was divided in three sub-sections:

a. Self-sampling: The section investigated about knowledge and included several questions to assess past use. We also investigated about whether it would have been used had it already been available, preferred type of self-sample (blood/saliva), preferred result communication pathway and the impact that the approval of self-sampling would have if made available.

b. *Self-testing*: In this section, we also asked several questions to assess knowledge and past use of self-testing as well as the personal position towards this testing method. We included questions to estimate the price they would pay for a self-testing kit and to evaluate the place where they would like to acquire them. We also asked about whether it would have been used had it already been available and about the preferred confirmation site. Finally we also asked about the likeliness to self-test with casual/steady partners in a series of situations.

c. Rapid testing: We included a set of questions to assess past use of rapid testing and likeliness to use it in the future based on past experience.

- *Patterns and preferences among different testing options*: We included a set of questions to assess the preferred and least preferred testing options and the type of combined use that potential users would make if self-testing and self-sampling were available.

- *Health and behaviour*: Including questions on sex behaviours and drug use in the last 12 months as well as history of sexually transmitted infections.

- *A little more about you*: Where we included a few additional sociodemographic questions.

- HIV-related Stigma: using the Consumer's Experience of Stigma Questionnaire (CESQ).

- *Acknowledgement page*: Where we thanked for the participation and provided a link to the EURO HIV EDAT website for additional information.

Although the survey was comprised of more than 90 questions, normally participants did not have to answer all the questions. In fact, an important number of questions related to some new strategies had to be answered by a very low percentage of participants, for example, 2-3% for those referring to past use of self-testing.

3.5. *The questionnaire: piloting and administration*

A draft version of the survey was written in English and reviewed by the associated partners. Their feedback was discussed among all associated partners and the WP9 task 1 leaders and the agreed modifications incorporated into the final version. Once a definitive version was approved, the associated partners translated it into their language. The questionnaire was available in English and another eight languages:

1. Dutch
2. Danish
3. German
4. Greek
5. Portuguese
6. Romanian
7. Slovenian
8. Spanish

Since the questionnaire was self-administered and computer based, we first programmed the survey in Survey Monkey in English. Then, all the partners were given a link so they could navigate through the survey and were invited to send back opinions, comments and suggestions to check the duration, appearance, routing, mistakes in the programming process or other

features that could improve the administration process. Some of the persons involved in this process were Spanish potential participants in the study. The survey was programmed so that participants could go back to previously answered questions, in order to check and/or change them, before final submission. Each participant was able to choose their preferred language to answer independently of the country of residence.

Once, the programmed English version was considered satisfactory, the questionnaire was programmed in the eight languages. Each associated partner was responsible to check this version.

3.6. Information to participants. Informed consent

All the participants that decided to access the survey were redirected to the initial screen. Here, participants were informed about the rationale and purposes of the study. Participants were also informed that:

- It focused on men who have sex with men.
- It aimed to collect information on several innovative testing options to promote earlier HIV diagnosis.
- It was completely anonymous.
- No IP address we collected.
- Variables that could be used for personal identification purposes were asked on a way that would not identification. As an example, age instead of birth date, size of the city of residence instead of the name of city, etc.
- It was an EU funded project, and were redirected to the Euro HIV Edat Project website for additional information.

Before being able to answer the first question of the survey, those participants who decided to participate, were asked to give consent to participate by checking the "I have read and understood the above information, in the country I live in I am old enough to legally have sex and I want to participate" box before been redirected to the survey.

3.7. Ethical issue and institutional approval

The protocol of the study and the questionnaire were presented for approval to the Institutional Review Board of the Institute of Health Carlos III since it was the coordination centre. The most relevant characteristics were remarked:

- It was an anonymous study.
- No personal data were collected.
- Variables that could be used for personal identification purposes were asked on a way that would not allow identification.
- Only opinions and self-reported information were collected, without any biological sample.

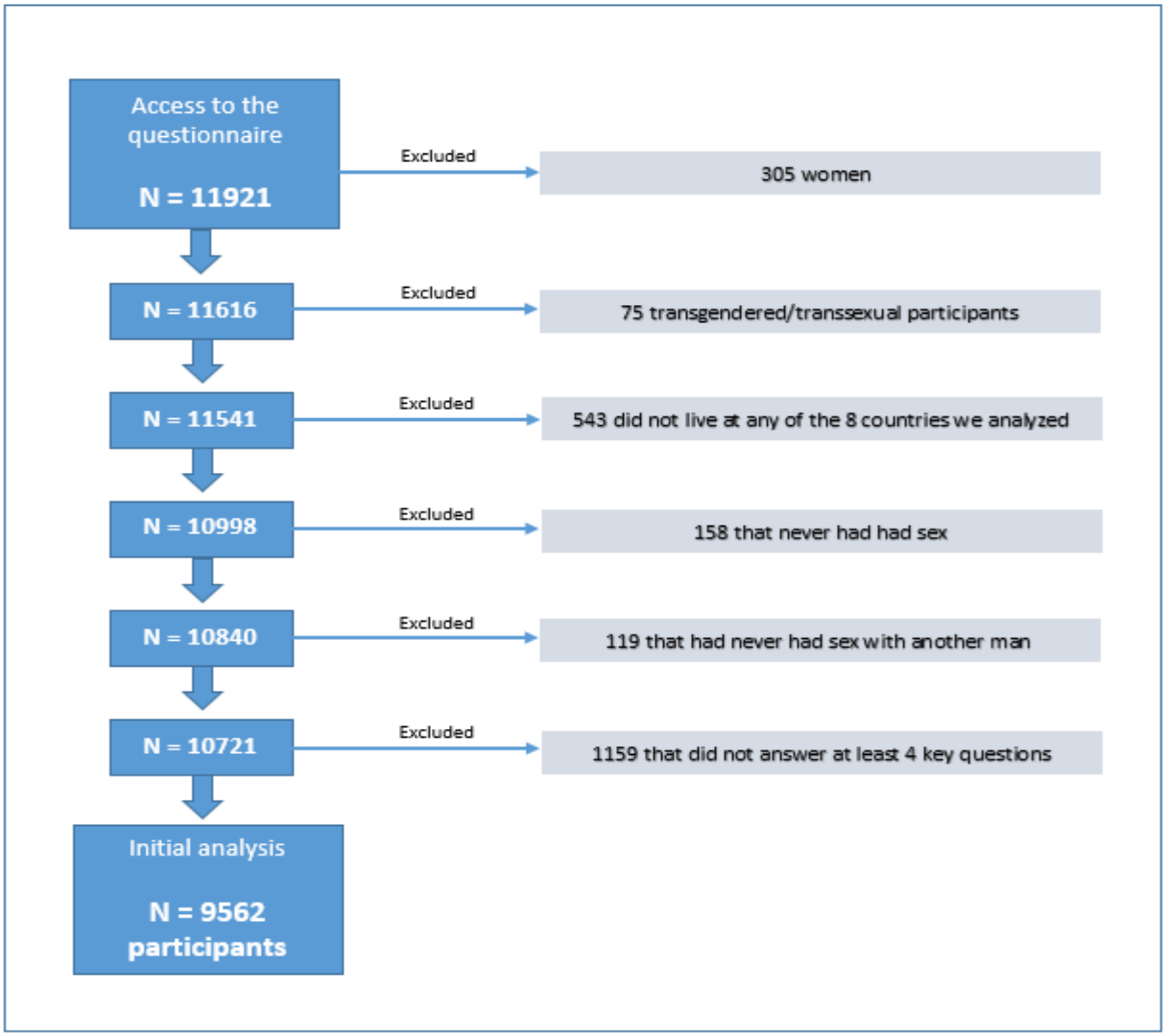
- No IP addresses were collected and no cookies were installed.
- The formal consent to participate no personal identification to avoid breach of anonymity.
- There was no personal risk for participants.

The protocol was approved by the Research Ethics Committee of the Institute of Health Carlos III" (CEI PI52_2015-v2).

3.8. Data analysis

Of the N=11921 (figure 2) individuals who accessed the questionnaire, we excluded 305 women, 75 transgendered/transsexual individuals, 543 that did not live at one of the 8 countries we analysed, 158 that never had had sex, 119 that had never had had sex with another man. Additionally, we excluded 1159 participants that did not answer at least 4 key questions: age, country of residence, born in current country of residence and testing history. Thus, our initial analysis includes n=9562 subjects.

Figure 2. From participants accessing the questionnaire to those finally included in the analysis.



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The number of expected participants in relation to the total male population between 18-64 years per country was not homogenous (see Table A). Assuming equal prevalence of men who have sex men in all the countries, we calculated and applied weighting coefficients to yield global estimates for the entire population of the eight participating countries. Only weighted percentages and no "N" are presented for the total male population.

We display a descriptive analysis of the main variables –with N and percentages- by country of residence with a column for the total male population. Only weighted percentages and no "N" are presented for the total population. For most of the variables some categories were aggregated. We do not present statistical significance or precision parameters. In the text we usually give the range naming the countries with the lowest and the highest percentage.

The first two tables refer to the overall population, but from table 3 onwards we excluded participants HIV positive individuals, focusing only on those without known HIV infection, which are the main target of the HIV innovative testing strategies.

Table A: Weighting coefficients per country

	Male population among 18-64 years	Number of participants	Rate of participants /100,000 males 18-64 years	Weighting coefficients
Belgium	3496486	155	4.433	3.62
Denmark	1748780	467	26.704	0.60
Germany	26143885	1964	7.512	2.14
Greece	3246801	950	29.260	0.55
Spain	14755298	4123	27.943	0.58
Portugal	3087887	861	27.883	0.58
Romania	6352515	769	12.105	1.33
Slovenia	679236	273	40.192	0.40
TOTAL	59510888	9562	16.068	

4. RESULTS

4.1. Participants´ main sociodemographic characteristics (Table 1)

Some 45.6% of the participants were >= 40 years of age (from 29.1% in Romania and 31.5% in Slovenia to 55.2% in Germany), 90.2% were born in their current country of residence (from 76.2% in Belgium to 97.9% in Romania), 45.9% had finished a university degree (from 33.6% in

Germany to 61.6% in Greece), 6.2% (from 3.3% in Germany or 3.7% in Belgium to 12.5% in Greece) were unemployed, and 70.2% (from 47% in Greece to 81.3% in Belgium) described their economic status as "comfortable". Virtually all were covered by a health insurance, except in Romania (8.0%).

4.2. Participants´ outness, sexual behaviours, history of sexually transmitted infections (STI) and HIV serostatus (Table 2)

A quarter of the participants lived their sex life with other men hidden or in total secrecy (from 9.9% in Denmark to 41.2% in Greece) and approximately 18% reported having had sex with men less or with the same frequency than with women (from 7.7% in Denmark to 27.6% in Romania).

In the 12 months preceding the survey, 64.4% had had at least one unprotected anal intercourse with another man (from 48.4% in Greece to 76.4% in Belgium), and 7.7% (from 4.7% in Slovenia to 12.8% in Belgium) and 6.3% (from 2.4% in Portugal to 17.3% in Belgium) had paid or received money for sex respectively.

Some 11.3% (from 8.3% in Romania to 17.8% in Belgium) had been diagnosed with an STI during this same period. Some 26% (from 8.7% in Belgium to 49.6% in Romania) self-reported not knowing their HIV serostatus and 11.6% (from 6.6% In Romania to 16.7% in Belgium) being HIV positive at the moment of the survey.

4.3. Perceived access to HIV testing and testing history among participants without known HIV infection (Table 3)

Among those who were not known to be HIV positive, 80.6% (from 61% in Romania to 94.6% in Slovenia) knew where to seek for an HIV test if necessary. Some 29.5% of this participants had never been tested for HIV (from 10.4% in Belgium to 53.1% in Romania) and across all countries. The main reason for not having been tested before was no risk perception (from 44.2% in Greece to 60.9% in Denmark). Primary care (33.9%) was the setting most frequently reported as the place of the last testing episode occurrence in all countries with the exception of Greece and Romania where private laboratory was reported by 28.8% and 42.7% of the participants respectively; and Slovenia where sexual health clinics were the most preferred site (39.9%).

Almost a half of the participants (49.0%; from 40.3% in Germany to 65.2% in Greece) tested at least every twelve months during last five years and 22.3% (from 11.5% in Slovenia to 39% in Portugal) underwent rapid testing in their last testing episode.

4.4. About self-sampling (Tables 4-5)

- *Knowledge, history of use and potential use* (Tables 4-5)

Knowledge about the existence of self-sampling kits was reported by 25.5% (from 18.8% in Spain to 47.2% in Belgium) and past use by 1.1% (n=69) (from 0.3% in Greece to 8.9% in Belgium). Among past users, six in ten reported having used it more than once and 44.9% reported having used a blood based kit in the last episode. Non-face-to-face was the most common result communication method (69.4%) in Belgium (all 11 past users), Romania (5 of 9), Slovenia (the only individual that reported past use) and Spain (8 of 13 past users).

Almost seven in ten (from 62.1% in Spain to 82.1% in Romania) reported that they would have used a self-sampling kit had it already been available, and 78.6% (from 59.8% in Belgium to 82.3% in Romania) would have used a blood based kit. Among potential users, 70.8% (from 59.1% in Greece to 79.9% in Portugal) reported that they would prefer to receive their result through a non-face-to-face method. Additionally, 71.8% reported preferring non-face-to-face methods even if the result was reactive.

4.5. About self-testing

- *Knowledge and history of use (Table 6)*

Knowledge about the existence of self-testing was reported by 21.1% of the respondents (from 11.1% in Romania to 30.6% in Belgium). The two most common ways of learning about its existence were general media (25.4%; from 15.3% in Denmark to 40.5% in Romania) and through a website specialized in HIV (23.7%; from 7.1% in Romania to 33.0% in Germany).

Past use was reported by 2.7% (from 0.1% in Romania to 4.5% in Germany) of the participants, among whom 74.7% had used it more than once (from 50.0% in Denmark to 100.0% in Romania and Belgium), 65.7% had purchased it in the internet (from 0.0% in Slovenia to 100% in Romania), and 85.9% reported that the last self-test used was a blood based kit (from 57.1% in Spain to 95.1% in Germany).

- *Opinions towards self-testing approval and reasons for (Table 7)*

Some 77.7% (from 69.8% in Germany to 88.3% in Portugal) reported being in favour of self-testing. The two main reasons for being in favour across all countries were “privacy” (33.2%) and that “it allows to test whenever they want” (27.3%). The only exception was observed, among Denmark-resident respondents who reported that “self-testing could save time, paperwork and queues” as their second most important reason (20.5%).

The proportion of participants reporting being against of self-testing was of 4.4% and the main reasons were related to the need of the presence of a professional either for counselling and result communication purposes (31.3%) or for obtaining the sample, performing the test and interpreting the result (31.0%). These were the two main reasons across all countries with the exception of Belgium and Slovenia where concerns about the validity of the results was the first and second most frequently reported reason respectively (44.0% and 23.1%) .

- *Price and preferred places to buy self-test (Table 8)*

Approximately sixty percent of the participants (60.3%) reported that they would be willing to pay 25-30 euros for a self-test. However, among respondents in Portugal and Romania this percentage was <50% (41.7% and 47.2% respectively). Some 71.2% reported that they would like to be able to acquire it in places other than pharmacies, mainly the internet (29.0%) and supermarkets or Para-pharmacies (22.8%).

Over 10% (from 6.7% in Greece to 16.3% in Romania) reported that they would never pay 25-30 euros for a self-test, and 29.6% (from 19.7% in Germany to 44.0% in Portugal) they would not pay this amount unless under great distress. The possibility of undergoing an HIV test for free in already existing services was the most commonly reported reasons for those unwilling to pay 25-30 euros (46.3%), with the exception of respondents from Belgium and Romania who reported that the "health system should cover the cost" as their main reason (38.1% and 35.5% respectively).

- *Potential use, reasons and preferred settings for confirmation (Table 9)*

The percentage of participants reporting that they would have used a self-test had it already been available was of 76.4% (from 70.3% in Belgium to 91.3% in Romania). The main reasons given by respondents were that it would allow to rapidly check ones serostatus (24.4%) and that it would provide autonomy (24.3%). Nevertheless, anonymity and discretion was very prevalent in Romania (23.9%) and "it allows to test more regularly" in Denmark (21.8%) and Portugal (21.2%).

When asked about their preferred setting to seek for a confirmation test, healthcare settings not specialized in HIV/STIs were reported by 31.1% of the respondents and was the preferred option in Greece (39.2%), Portugal (29.5%), Slovenia (48.5%) and Spain (39.9%). Primary care was chosen by 27.9% and was the preferred option in Belgium (47.3%), Denmark (41.6%) and Germany (39.7%). Sexual-health clinics were reported by 26.2% of the respondents and were the favourite site for confirmation in Romania (42.7%).

- *Likelihood to use in different scenarios*

In the context of a stable relationship, 65.0% said that it was likely that they would use a self-test with a stable partner to stop using condoms (from 56.2% in Germany to 75.2% in Spain) and 64.9% if they felt there was the possibility that their partner was having sex with other people (from 51.2% in Belgium to 72.8% in Greece). In the context of occasional sex partnerships, the majority (60.1%) reported that it was likely that they would offer a self-test before condomless sex although respondents form Greece and Belgium dropped below 50% (48.8% and 31.7%). Overall, participants were less likely to use a self-test to prove their current serostatus to a casual partner (48.2%) and even less when asked about the possibility of offering a self-test to a casual partner before first time sex (21.8%). In this two last scenarios, respondents from Romania were more likely than the rest of the countries (60.1%-43.5% respectively).

4.6. About rapid testing (table 11)

Having undergone a rapid test in the past was reported by 20.7% of the respondents, 58.1% of which were carried out in the last 12 months (21.4% in the last 3 months).

CBOs/NGOs were the most frequently reported site of last rapid testing episode occurrence across all countries (48.2%), with the exception of Belgium and Romania, where Sexual health clinics (52.6%) and Healthcare settings non-specialized in HIV/STIs (31.7%) respectively, were the most reported sites.

Primary care (24.5%) was identified as the preferred setting to seek for a rapid test by respondents from Belgium (37.8%) and Germany (32.7%); CBOs/NGOs (22.5%) was the preferred site for respondents from Denmark (33.3%), Portugal (38.2%) and Slovenia (37.8%); Sexual health clinics (19.3%) were the favourite setting for Greek (28.1%) and Spanish participants (28.8%); whereas the private laboratory was the preferred setting for participants living in Romania (25.3%).

Based on their experience, 57.9% of the participants (from 34.8% in Belgium to 78.9% in Greece) reported being more/much more likely to seek for a rapid test in the future based in their experience with this type of tests and 53.1% that it has made them more/much more likely to increase testing frequency (from 44.6% in Spain to 77.7% in Greece).

4.7. Patterns of use, least and most preferred testing options (tables 12-13)

If all testing options were available, 42.3% of the participants would mainly use one testing option and occasionally would choose a second one. This was the most common pattern of use of

testing options across all countries with the exception of Slovenia where 35.4% of the respondents would only use one testing option.

Self-testing (31.8%) was the preferred testing option across all countries with the exception of Greece and Romania, where conventional testing at a sexual health clinic was the preferred testing option (29.7% and 28.9% respectively).

Some 50.7% reported that they would never undergo a rapid test in a bar/pub, club or sauna. This was the least preferred testing option across all countries with the exception of Slovenia where rapid testing in pharmacies were the least favoured option (39.4% reported they would never use this option to test for HIV).

III. THE STAKEHOLDERS STUDY

1. SPECIFIC OBJECTIVES

Based on the opinion of the stakeholders we aim to:

- Know the opinion towards each of the new testing strategies analysed.
- Gain knowledge on the potential role to be played by the different stakeholders if the new strategies were to be introduced.
- Estimate the potential effect that the introduction of the innovative testing strategies would have in the testing frequency of a number of key population groups
- Assess if the introduction of the new strategies would change the current use of testing options, becoming a predominant ,complementary or a residual way of testing

2. PARTICIPATING COUNTRIES

The same 8 countries than in the potential users study.

3. METHODS

3.1. Study population

WP 9 task 1 leaders circulated a protocol describing the profiles of the stakeholders to be recruited with the associated partners. Eligible participants were defined as:

1. Professionals working in planning, implementing or/and developing public health or HIV programmes. From now on, we will refer to this profile as *"Decision makers, Public health professionals".*
2. Health care professionals whose activity is fully or partially related to the field of HIV prevention, diagnosis, treatment and care in the MSM population. From now on, we will refer to this profile as *"Health care professionals*".
3. People engaged professionally or as voluntaries in organizations working in the area(s) of LGTBI rights activism and/or HIV prevention, diagnosis and/or support programmes that target the MSM population or at least includes them. From now on, we will refer to this profile as *"CBO professionals".*

3.2. Recruitment procedures

The recruitment started in February and finished in May of 2017. WP9 task 1 leaders sent out an individualized link leading to the survey to each associated partner. Associated partners identified key stakeholders that pertained to the above mentioned professional profiles and

reached out to ask for their collaboration. Weekly follow up emails were sent by the WP9-task 1 leaders to all associated partners to inform about the number and profile of the stakeholders recruited. OptTEST project was also contacted to do a transnational recruitment through the partners working on that project.

Each profile was divided in specific subgroups and associated participants were asked to identify them.

3.3. The questionnaire. Contents

The data collection instrument was designed by the WP9 task 1 leaders.
The questionnaire had the following main sections:

- *Introduction/informed consent:* participants were informed about the objectives of the study and were required to give their consent to participate.

- *Sociodemographic and professional variables*: aimed to assess very basic sociodemographic information and the setting were they worked.

- *New testing strategies evaluation*: we included a section for each of the testing strategies investigated:

a) SELF-SAMPLING:

We used pre-coded questions to assess participants':

- Knowledge of the existence of home-sampling kits and personal opinion of this testing method
- Opinion about whether it would have been used by the population they serve had it already been available (potential use hereafter).
- Opinion about what would be the preferred way of receiving the results among the population they serve.
- Opinion about the impact on the testing frequency of several population groups and on the effect it would have on the current use of testing sites.
- Role played by the stakeholder in the promotion, distribution, consultations, result communication, confirmation and support if introduced.

Open ended questions were used to assess the reasons given by participants for their personal opinion on postal sampling and about the potential use it would have.

b) SELF-TESTING:

In the same way that we did for self-sampling, we used pre-coded questions to assess participants:

- Knowledge, personal opinion and potential use
- Reasons why they thought it would have been used/not used by the population they served
- Reasons why they thought people would be in favour/against self-testing
- Opinion about the willingness to pay 25-30 euros by the population they serve
- Opinion about the impact on the testing frequency of several population groups and on the effect it would have on the current use of testing sites.
- Role played by the stakeholder in the promotion, distribution, consultations, result communication, confirmation and support if introduced.

Multiple choice questions were used to assess participants:

- Opinions about where individuals from their target population would prefer to purchase a self-test and what would be the preferred setting for confirmation testing
- Opinion about why individuals from the population they serve, would have used/would have not used self-testing kits if available.

Open ended questions were used to assess the reasons given by participants for their personal opinion on self-testing and about the perceptions regarding the approval of self-testing in their countries.

c) RAPID TESTING:

Two precoded questions to asses if past experience with rapid testing has made people more prone to use it more frequently.

Figure 3. Structure of the questionnaire. Sections completed by participants according to their professional profile.

	Decision makers/ Public Health Professionals	*Health care professionals*	*CBO members*
Introduction/informed consent	■	■	■
About you (main sociodemographics,selection criteria)	■	■	■
job level	■		
region of work	■		
profession		■	
work setting		■	
focus on HIV and/or other STIs			■
target population			■
Self-sampling			
knowledge and personal opinion	■	■	■
use if it had already been available	■	■	■
non face-to-face results communication	■	■	■
impact and pattern of use if approved	■	■	■
roles to be played	■	■	■
Self-testing			
knowledge and personal opinion	■	■	■
use if it had already been available	■	■	■
users' reasons to be in favour/against	■	■	■
willingness to pay 25-30 euros	■	■	■
impact and pattern of use if approved	■	■	■
roles to be played	■	■	■
Rapid test	■	■	■

3.4. The questionnaire. Piloting

The instrument was reviewed by all the associated partners and some stakeholders in Spain. Their feedback was incorporated to improve the content and the design. With the exception of Spain, it was decided not to translate the instrument to the different languages unless considered necessary by the partners.

The two versions of the survey (English and Spanish) were programmed in Survey Monkey and piloted.

3.5. Information to participants. Informed consent

When clicking on the link, all participants accessed an initial screen where they were informed about:

- *Aim and content:* several innovative testing options to promote earlier HIV diagnosis.
- *Anonymity and confidentiality*: The study was completely anonymous and confidential. No IPs or cookies were collected. Variables that could be used for personal identification purposes were asked on a way that did not allow this to occur. For example, we asked about the setting where the respondent carried out his/her job but did not ask to provide the name of their workplace.

Before being able to answer the first question, participants were required to give their informed consent by explicitly ticking a box.

3.6. Data analysis

In total 823 stakeholders accessed the data collection instrument. We excluded 25 who did not answer the question that assessed the country where they currently worked in and 6 that reported working in countries other than the ones considered in this study. We also excluded n=39 that did not report their area of work and n=16 that could not be categorized in one of the three areas of work of interest in this study. Thus, we included 737 stakeholders in the analysis.

To analyse the open ended questions, we created a list of categories to classify the themes emerging from the free text. In order to be able to compare potential users and stakeholders views, when possible we also had in mind pre-coded options for similar questions in the potential uses study. For each open question, an individualized data extraction sheet was designed. Open ended questions were then reviewed and coded. When more than one opinion was given by the respondent, the main reason was extracted.

The main results are presented by a four category country- European region variable: North EU (Belgium, Denmark and Germany), South EU (Greece and Portugal), Central EU (Romania and Slovenia) and Spain. We decided not to include Spain in the South EU region to avoid its larger sample size to mask the results of the rest of the South EU countries.

We display a descriptive analysis of the main variables –with N and percentages- by country of residence without a column for the total population, taking into account the heterogeneity of the sample size by country and stakeholder profile. For most of the variables some categories were aggregated. We do not present statistical of significance or precision parameters.

4. RESULTS

4.1. Main characteristics of participants (Table 14)

A large majority of Decision makers/public health professionals (DM/PHP) from North EU, Central EU and Spain, were 40 years of age or more (from 85.4% in Spain to 100% in North and Central EU). The percentage was of 25% in the case of South EU countries. Almost all had at least a university degree (from 85.7% in Central EU to 100% in South EU) and most of them worked as HIV/and or public health technicians (from 50.0% in Central EU to 76.9% in Spain). With the exception of Spain (10.3%), most carried out their work at a country level (from 58.8% in North EU to 71.4% in Central EU).

The majority of Healthcare professionals were 40 or older (from 54.1% in South EU to 91.3% in Central EU) and virtually all had completed at least a university degree (from 84.2% in North EU to 100.0% in Spain, South EU and Central EU). Most of the participants were medical doctors (from 50.0% in South EU to 90.0% in Central EU), with the exception of North EU countries where nurses (45.5%) were more prevalent. In North EU, South EU and Central EU countries the most common work setting was an HIV/STI specific setting (from 45.8% in South EU to 68.4% in North EU), while in Spain it was primary care (76.7%).

Approximately half of the CBO professionals from North EU countries (56.1%) and Spain (48.0%), were 40 years old or over. This percentage was of 20.9% in South EU and 38.5% in Central EU countries. Almost all had at least finished a university degree (from 75.4% in Spain to 92.7% in North EU). The percentage of CBO professionals that worked at a CBO exclusively focused on HIV/STIS was of 42.5% in North EU, 53.7% in South EU, 33.3% in Central EU and 41.5% in Spain. LGTB+ was the most frequently reported target population in North EU and South EU countries (56.4% and 44.7% respectively), while Central EU stakeholders reported not serving a specific population (50.0%) and those answering from Spain, other key populations (37.3%).

4.2. About self-sampling (Table 15-20)

Knowledge about the existence of self-sampling was reported by more than 60% of all stakeholders, with the exception of healthcare professionals from countries from South EU (52.2%), Spain (33.9%) and stakeholders working in CBOs in South EU countries (54.3%). (Table 15)

The majority of DM/PHP from North EU (71.4%) and central EU (66.7%), healthcare professionals from north EU (63.9%) and Spain (54.2%) as well as CBO professionals from North EU (75.7%) and Central EU (50%) reported a favorable personal position towards self-sampling. DM/PHP from South EU (50%) and Spain (53.8%), healthcare professionals from South EU (63.6%) and central EU (57.1%) as well as CBO professionals from Spain (56.9%), reported “not being sure” about their personal position. (Table 15)

The main reason given by stakeholders in most countries to be in favour of self-sampling was that it could constitute an additional testing option that could help to uncover undiagnosed individuals (from 30% in health care professionals from Spain or CBO members from South EU countries, to 68.8% of health care professionals from North EU or 100% DM/PHP from South EU). The exception was observed among South EU Health care professionals who understood that the main reason was that it would allow testing privately, confidentially and anonymously (40.0%). (Table 16)

Regarding reasons to be against self-sampling, stakeholders across all regions felt that the presence of a professional to provide counselling and give the result was the most important reason be against self-sampling kits (between 28.6% or 32.8% among North EU or Spanish healthcare professionals to 66.7% of North EU DM/PHP or CBO professionals from North EU). (Table 16)

Except DM/PHP and CBO professionals from South EU countries, the majority of all other stakeholders thought that the population they serve would have used self-testing if already available (from 51.5% in Spanish CBO members to 80.0% in North EU DM/PHP). (Table 15)

DM/PHP from North EU (100%) and Spain (30.8%) as well as healthcare professionals from South EU (50%) and Spain (22.7%) and CBO members also from Spain (39.1%) thought that self-sampling would have been used by their target population mainly because it is an anonymous and discreet method. Healthcare (36.4%) and CBO professionals (30.0%) from North EU countries thought that the main reason was that it is a practical and convenient method. South EU DM/PHP thought that the main reason for it to be used was that it would help to overcome barriers derived from face-to-face encounters (50%) whereas healthcare and CBO professionals from central EU thought that the main reasons would have been that it helps to overcome barriers of already existing services (33.3%) and that it provides autonomy (50%). (Table 17)

The majority of all stakeholders - from 55.3% in Spanish CBO members to 87.5% in Central EU CBO members- considered that individuals from their target population would prefer a non-face-to-face method to receive a negative test result. If the test was to come back positive, stakeholders thought that people would prefer a face-to-face method (from 50.0% in North European DM/PHP to 87.5% in South European DM/PHP). (Table 15)

Regarding the stakeholders' own opinions to be in favour of non-face-to-face methods for the result communication, the majority of DM/PHP from North EU (33.3%) as well as healthcare (50.0%) and CBO (40.0%) professionals from south EU countries said that as long as it was safe, they would support non-face-to-face methods to give results. DM/PHP from South EU (100%) and Spain (42.1%) as well as CBO professionals from north EU (33.3%) and healthcare professionals from Spain (38.2%) were in favour of giving results through non-face-to-face methods as long as they were not positive. North EU health care professionals (71.4%) and CBO professionals from Spain (42.9%) said that if it is a method demanded by the public there would be no reason not to use it. (Table 18)

Regarding their opinions against, the main reason not to support non-face-to-face methods for result communication purposes among most stakeholders, was that it was not the optimal way of giving a positive result –proportions ranged from 41.5% of healthcare professionals from Spain to 100% of DM/PHP of South EU or healthcare professionals from South EU countries-. However for North EU (100%) and Central EU DM/PHP (100%) as well as healthcare professionals (80%) and CBO professionals (100%) from Central EU and CBO professionals from Spain (39.3%) the main reason to be against non-face-to-face communication of results was that it is not the optimal way of providing preventive counselling. (Table 18)

The majority of all stakeholders –from 50.0% in South EU DM/PHP and Central EU CBO members to 83.3% in Central EU DM/PHP and South EU health care professionals- considered that the approval of self-sampling would lead to a slight-moderate increase of testing frequency among MSM. (Table 19)

The majority of all stakeholders –proportions ranged from 50.0% in Central EU DM/PHP to 84.2% in Central EU health care professionals- considered that the approval of self-sampling would lead to a marginal-moderate variation of the current use that MSM make of already existing testing sites. The only exception was observed in South EU DM/PHP among whom the majority (50.0%) thought that it would lead to a substantial variation. (Table 19)

Among DM/PHP, those answering from South EU countries and Spain thought they would play a major role in all but two of the tasks assessed more frequently than their counterparts from North and Central EU countries, with the exceptions of the mail distribution of self-sampling kits and result communication where those answering from South EU countries were still the ones that most frequently reported that they would be playing a major role (10.0% and 20.0%) but it was North EU countries that followed in the first case (8.3%) and North EU as well as Central EU countries in the second (16.7% each). (Table 20)

Among healthcare professionals, those answering from South EU countries and Spain also thought that they would play a major more frequently than professionals from North and central EU countries, with three exceptions: Promotion of self-sampling and being a reference center for confirmation purposes, where healthcare professionals working in Spain where still the ones more

frequently answering that they would be playing a major role (46.1% and 64.5% respectively), but they were followed by central EU countries (29.4% and 52.6% respectively). The third exception was seen when we assessed the possibility of being the support services for positive results. Here, 66.7% of the central EU health care professionals said they would play a major role and those working in Spain 56.0%. (Table 20)

At least six in ten of the CBO professionals of all regions, thought that they would play a major role regarding consultations on sexual health, risk reduction etc. (from 59.1% in South EU to 81.8% in Central EU), and in the possibility of being a confirmation center (from 63.6% in Central EU to 83.0% in Spain); >=50% regarding the provision of information on where to obtain a self-sampling kit (from 57.1% in South EU to 66.0% in Spain), and on the consultations about the limitations of this testing method (from 54.5% in South EU to 81.8% in Central EU). Forty percent and over regarding the promotion of self-sampling (from 43.4% in Spain to 59.4% in North EU) and on tasks related with the communication of the result (from 40.6% in North EU to 64.2% in Spain) and the provision of support service in positive results (from 36.4% in Central EU to 52.8% in Spain). The percentage of CBO professionals reporting that they would play a major role in the mail distribution of self-sampling kits was >30% (from 31.3% in North EU to 45.5% in Central EU) with the exception of those working in South EU (14.3%). The percentage of CBO professionals that reported that they would play a major role in over the counter distribution of self-sampling was of 58.5% and 45.5% in Spain and Central EU respectively and 29.0% and 19.0% in North EU and South EU. (Table 20)

4.3. About self-testing (Tables 21-26)

The knowledge about the existence of self-testing kits was well above 60% mark (from 66.7% in Central EU DM/PHP to 100% in South EU DM/PHP) among all the stakeholders surveyed, with the exception of healthcare professionals from countries from South EU (42.9%) and Spain (32.2%), and stakeholders working in CBOs in South EU (45.5%). (Table 21)

A favorable position towards self-testing was reported by the majority DM/PHP in North EU countries (46.2%) and Spain (55.2%); Health care professionals in North EU (60.0%) and Spain (67.5%) and CBO professionals from North EU (59.4%) and Central EU (54.5%). Among the rest the most common position was “not being sure”. (Table 21)

The most common reason that most stakeholders thought that people have to be in favour of self-testing was that it helps to maintain their privacy (percentages ranged from 26.7% in North EU CBO members to 56.3% in Central EU health care professionals). The exceptions were found among North EU DM/PHP who thought that people favour self-testing because it helps to avoid intimate questions and/or counselling (38.5%), North EU healthcare professionals and South EU CBO professionals, who thought that peoples main reason to be in favour was that it helps to test

whenever they want (34.5% and 45.0% respectively) and among CBO professionals in Central EU who reported that self-responsibilization of ones health is the main reason (36.4%). (Table 21)

Regarding reasons that stakeholders thought that people could have against self-testing, the most frequent reason among all stakeholders was that the presence of an expert to provide counselling and inform about the results was essential (percentages ranged from 27.3% in Central EU CBO members to 73.3% South EU health care professionals).(Table 21)

Regarding their own reasons to be against, stakeholders across all countries reported that the presence of a professional to provide counselling and give the result is essential (ranging from 25.0% among Central EU CBO professionals to 100% of South EU or Central EU DM/PHP). The only exception was seen among healthcare professionals from Central EU countries who reported concerns about the validity of results as their main reason (66.7%). (Table 22)

All stakeholders thought that the population they work with would not be willing to pay 25-30 euros for a self-test, with the exception of DM/PHP from countries in central EU (50%), health care professionals from North EU countries (62.1%) and CBO professionals also from North EU (50%). (Table 21)

With the exception of DM/PHP from South EU (countries), the majority of all other stakeholders thought that the population they serve would have used self-testing if already available (from 54.5% in Central EU CBO members to 89.7% in North EU health care professionals). (Table 23)

Sexual health clinics were thought to be the site that their target populations would prefer in case of having to confirm a reactive self-test by healthcare professionals from North EU countries (53.6%), Central EU (53.3%) and CBO workers from Central EU (54.5%). Health care settings not specialized in HIV/STI were considered the preferred option by DM/PHP in Central EU (75.0%) and Spain (37.9%) and healthcare professionals in South EU (38.5%). CBOs were thought to be the preferred option by DM/PHP in North EU (45.5%) and CBO professionals in Spain (39.1%) and Primary care identified as the preferred option by Spanish healthcare professionals (55.3%). (Table 23)

Across all regions, the majority of DM/PHP, healthcare and CBO professionals considered that, if available, self-testing would lead to a slight/moderate increase of the testing frequency among MSM (proportions ranged from 43.8% in Central EU health care professionals to 83.3% in Central EU DM/PHP). The exception to this rule was observed among DM/PHP and CBO workers from South EU countries who thought that it could lead to a substantial variation (88.9% and 60% respectively). (Table 24)

The majority of all stakeholders –proportions ranged from 54.5% in Central EU CBO members to 100.0% in North EU DM/PHP- considered that the approval of self-testing would lead

to a marginal-moderate variation of the current use that MSM make of already existing testing sites. The only exception was observed in South EU DM/PHP among whom the majority (66.7%) thought that it would lead to a substantial variation. (Table 24)

Among DM/PHP, those answering from South EU countries and Spain thought they would play a major role in all the tasks assessed more frequently than their North EU and Central EU counterparts with two exceptions: the highest percentage of stakeholders reporting they would be playing a major role in the mail distribution of self-testing was observed among those from central EU countries (16.7%) (followed by south EU countries (11.1%)), and the highest percentage of stakeholders reporting they would be playing a major role in being a confirmation center was reported by South EU countries (44.4%) but followed by North EU (27.3%). (Table 25)

The same pattern was observed among healthcare professionals, with the exception of tasks related with the provision of support services and being a confirmation center. In these two cases it was Spanish healthcare professionals who reported that they would play a major role more frequently, but it was healthcare professionals from Central EU countries who followed. (Table 25)

Among CBO professionals of all regions, over 60% answered that they expected to play a major role regarding the provision of consultations about the limitations of self-testing (proportions ranged from 63.6% in Central EU to 75.0% in Spain) and consultations on sexual health, risk reduction etc. (from 60.0% in Central EU to 78.0% in Spain). Over 60% also said that they would play a major role in providing support for those obtaining a reactive result (from 65.4% in North EU to 80.5% in Spain), with the exception of those from Central EU (36.4%). Over 50% of reported that they would be playing a major role in providing information on where to obtain self-testing kits (from 54.5% in Central EU to 68.4% in South EU) and over 30% in promoting self-testing (from 31.6% in South EU to 46.3% in Spain). A percentage of over 30% also reported that they would be playing a major role when we assessed "over-the-counter distribution of self-testing" (from 34.6% in North EU to 54.5% in Central EU) -with the exception of those working in South EU countries (15.8%); and when we assessed the possibility of being a confirmation center (from 31.6 in South EU to 56.1% in Spain) - with the exception of Central EU (27.3%). Regarding the mail distribution of self-testing, 54.5% of Central EU CBO professionals said that they would play a major role vs. 25.6% in Spain and approximately fifteen percent among those from North EU and South EU countries. (Table 25)

Regarding the stakeholders' perceptions about the approval of self-testing, DM/PHP from all regions reported that it was a discussion that was open in their countries (ranging from 50% in Spain to 100% in North an Central EU). Similar to DM/PHP, Healthcare (44.4%) and CBO professionals (72.7%) from North EU also thought that the discussion was open. On the other hand, the majority of healthcare professionals from South EU (40.0%), Central EU (66.7%) and Spain (74.2%) reported not knowing if this discussion was on the table, whereas the majority of South EU and Central EU CBO professionals (40% and 50% respectively) thought it was something that was not on the political agenda. (Table 26)

Across all Stakeholders' the general opinion was that self-testing was going to be approved in the future (ranging from 40% among South EU DM/PHP to 100% among DM/PHP of North EU and Central EU, healthcare professionals from Central EU or CBO members from North EU and Central EU); with the exception of healthcare and CBO professionals from Spain who reported not knowing what was going to happen (52.3% and 47.4% respectively) (Table 26)

4.4. About rapid testing (Table 27)

According to a proportion of between 60% and 100% of all stakeholders, having used a rapid test in the past has made people more or much more likely to use it again in the future. The majority (between 50% and 100%) also reported that past use of a rapid test has made people more or much more likely to increase their testing frequency.

Almost all stakeholders identified CBOs/NGOs as the site that their target population would choose to undergo a rapid test (percentages ranged from 36.4% to 71.4%), with the exception of DM/PHP from Central EU who identified Sexual health clinics and healthcare settings not-specialized in HIV/STIs (40% each), healthcare professionals from North EU who identified Sexual health clinics (55.6%) and Spanish healthcare professionals who identified primary care as the favourite setting to seek for an HIV test (41.3%).

IV. FINAL RECOMMENDATIONS

The present recommendations are based on the results of the two studies conducted by the team of WP9-task 1. The potential users study was conducted among men who have sex with men (MSM) from Belgium, Denmark, Germany, Greece, Portugal, Romania, Slovenia and Spain. The stakeholder's survey was conducted among Decision makers /Public health professionals (DM/PHP), Healthcare professionals (HP) and professionals working at Community Based Organizations (CBO) and non-governmental Organizations (NGO) in the same 8 countries.

We first present the three primary recommendations (one per strategy) followed by a number of secondary recommendations for each one of the strategies evaluated.

PRIMARY RECOMMENDATIONS

1. Given the favorable position towards self-testing expressed by MSM, its high potential use in this group and that the price does not seem to be a determinant barrier, we recommend that national guidelines and regulations should urgently incorporate this methodology as a diagnostic option to reduce the number of individuals who remain undiagnosed. This is reinforced by the fact that, if available, self-testing would be the preferred testing option for MSM

2. Self-sampling has a high potential use since the majority of MSM from all 8 countries reported that they would have used it if already available. However, they do not consider it would occupy a central role in their testing habits if made available. Thus, we recommend its consideration as a future testing option that could probably complement already existing strategies.

3. The high prevalence of untested MSM residing in Romania and the low proportion that reported having ever undergone rapid testing suggests the need to develop MSM specific rapid testing programmes in the community and other settings to increase testing rates in this country.

SECONDARY RECOMMENDATIONS

Self Testing

1. Opinions towards self-testing are much more favorable among MSM than among stakeholders. Efforts to understand this gap should be made especially among decision makers in South and Central EU countries and CBO organizations in Spain.

2. Based on the opinion of MSM, and on the views expressed by CBO professionals, CBO/NGOS should constitute a key setting to provide information about of self-testing.

3. Primary care and other healthcare settings not specialized in HIV/STIs were pointed out by MSM as their preferred places to attend to confirm a reactive self-test and should be considered as locations that could play a major role in the confirmation process. Thus, there should be a preparatory work to inform staff about the existence of self-testing, about the limitations of the test and to establish clear and seamless pathways for effective confirmation and linkage to care.

4. Based on the preferences of MSM, we recommend to make self-testing widely available in settings other than pharmacies in order to increase access. The internet and supermarkets/parapharmacies should be especially considered.

5. Based on the preferences expressed by MSM and better performance in real life scenario (shorter window period and lower rates of false positives), we recommend the use of blood based self-testing kits as the primary option.

Self Sampling

1. Non-face-to-face methods should be considered as the main option for result communication since they were the preferred method for MSM. Based on their opinion, the possibility of also communicating reactive results through non-face-to-face methods should also be well thought-out.
2. A joint effort between public health professionals, decision makers and professionals directly involved in the diagnostic process should be made in order to develop clear materials to minimize the potential drawbacks of non-face result communication methods which is the main concern raised both by MSM and stakeholders. This is especially important when considering a reactive result.
3. Based on the preferences expressed by MSM we recommend the use of blood based self-sampling kits. However, we also recommend assessing that the use of blood based kits (vs. oral based) does not result in a lower return rate.

Rapid Testing

1. Although half of all rapid testing episodes have occurred in CBO/NGOs and that satisfaction appears to be high, there is a demand of rapid testing in other contexts, especially in primary care were very few rapid tests are carried out.

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V. ANNEX 1: TABLES

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1. THE POTENTIAL USERS STUDY

Table 1.Sociodemographic profile by country of residence

	Belgium (N=155)		Denmark (N=467)		Germany (N=1964)		Greece (N=950)		Portugal (N=861)		Romania (N=769)		Slovenia (N=273)		Spain (N=4123)		TOTAL (weighted) (N=9562)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Age																	
< 25	9	5.8	58	12.4	141	7.2	144	15.2	120	13.9	148	19.2	40	14.7	665	16.1	**11.6**
25-29	17	11.0	69	14.8	192	9.8	131	13.8	115	13.4	142	18.5	46	16.8	664	16.1	**13.0**
30-34	21	13.5	59	12.6	270	13.7	159	16.7	133	15.4	148	19.2	51	18.7	624	15.1	**14.9**
35-39	32	20.6	64	13.7	277	14.1	192	20.2	137	15.9	107	13.9	50	18.3	579	14.0	**14.9**
40-49	37	23.9	130	27.8	573	29.2	207	21.8	211	24.5	154	20.0	62	22.7	993	24.1	**25.9**
>50	39	25.2	87	18.6	511	26.0	117	12.3	145	16.8	70	9.1	24	8.8	598	14.5	**19.7**
Place of birth																	
In country of current residence	115	76.2	405	87.1	1775	91.1	887	96.9	753	88.1	750	97.9	253	92.7	3589	87.9	**90.2**
Europe (west,central and east)	29	19.2	35	7.5	115	5.9	20	2.2	31	3.6	13	1.7	19	7.0	152	3.7	**5.4**
Latinomerica	4	2.6	6	1.3	18	.9	3	.3	50	5.8	0	.0	0	.0	313	7.7	**2.8**
Others	3	2.0	19	4.1	41	2.1	5	.5	21	2.5	3	.4	1	.4	31	.8	**1.6**
Number of inhabitants in place of residence																	
>=1.000.000	17	11.0	158	33.9	465	23.7	479	50.8	159	18.6	181	23.6	4	1.5	1368	33.3	**26.6**
500.000-999.000	26	16.8	75	16.1	248	12.7	50	5.3	124	14.5	62	8.1	4	1.5	438	10.7	**11.6**
100.000-499.999	22	14.2	77	16.5	386	19.7	127	13.5	140	16.4	247	32.2	119	43.6	1008	24.5	**21.6**
50.000-99.999	27	17.4	40	8.6	207	10.6	88	9.3	98	11.5	64	8.4	24	8.8	376	9.1	**10.3**
10.000-49.999	49	31.6	53	11.4	338	17.3	122	12.9	189	22.1	101	13.2	62	22.7	541	13.2	**16.6**
<10.000	14	9.0	63	13.5	314	16.0	77	8.2	144	16.9	111	14.5	60	22.0	380	9.2	**13.4**
Education																	
Up to upper secondary education	49	31.6	216	46.4	839	43.1	195	20.6	323	37.6	263	34.5	69	25.4	1250	30.4	**36.7**
Post secondary Non-tertiary education	14	9.0	19	4.1	455	23.4	168	17.8	54	6.3	105	13.8	39	14.3	588	14.3	**17.4**
University education	92	59.4	231	49.6	654	33.6	582	61.6	481	56.1	394	51.7	164	60.3	2273	55.3	**45.9**
Source of income																	
Employed (full or part time)*	67	62.0	230	67.3	864	71.5	297	53.9	388	67.6	282	68.6	115	61.5	1698	60.0	**66.2**
Freelance	20	18.5	27	7.9	132	10.9	81	14.7	48	8.4	42	10.2	15	8.0	307	10.8	**11.2**
Unemployed	4	3.7	23	6.7	40	3.3	69	12.5	46	8.0	18	4.4	16	8.6	288	10.2	**6.2**
Student	9	8.3	45	13.2	81	6.7	85	15.4	68	11.8	46	11.2	36	19.3	443	15.6	**10.7**
Retired-long term leave	8	7.4	17	5.0	92	7.6	19	3.4	24	4.2	23	5.6	5	2.7	96	3.4	**5.7**
Economic status																	
Comfortable	87	81.3	266	77.8	934	77.5	258	47.0	339	59.4	318	77.6	134	72.0	1671	59.1	**70.2**
Tight	17	15.9	63	18.4	201	16.7	200	36.4	153	26.8	60	14.6	38	20.4	774	27.4	**21.0**
Make ends meet with difficulty/have to go into debt	3	2.8	13	3.8	70	5.8	91	16.6	79	13.8	32	7.8	14	7.5	384	13.6	**8.8**
Insurance status																	
Social security	90	84.1	319	93.3	935	77.8	492	89.9	478	84.0	292	71.2	171	91.9	2480	87.8	**81.9**
State based mutuality (for civil servants, armed forces etc.)	4	3.7	14	4.1	2	.2	0	.0	114	20.0	31	7.6	0	.0	250	8.8	**4.6**
Private insurance	42	39.3	72	21.1	271	22.5	75	13.7	149	26.2	117	28.5	158	84.9	626	22.2	**24.5**
Other situation	0	.0	31	9.1	17	1.4	36	6.6	1	.2	4	1.0	3	1.6	23	.8	**1.6**
I do not have a health insurance	1.0	.9	1	.3	8	.7	0	.0	8	1.4	33	8.0	4	2.2	57	2.0	**1.7**

*Includes participants that are employed full or part time or that are self employed

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Table 2. Outness, sexual behaviors, history of sexually transmitted infections (STI) and HIV serostatus by country of residence.

	Belgium (N=155)		Denmark (N=467)		Germany (N=1964)		Greece (N=950)		Portugal (N=861)		Romania (N=769)		Slovenia (N=273)		Spain (N=4123)		TOTAL (weighted) (N=9562)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Lives sex life with men...																	
Openly	75	48.4	339	72.6	902	46.1	167	17.6	153	17.8	89	11.6	79	29.0	1719	41.7	**39.0**
Discreetly	59	38.1	82	17.6	545	27.8	392	41.3	454	52.7	378	49.2	136	50.0	1674	40.6	**35.9**
Hidden/In total secrecy	21	13.5	46	9.9	511	26.1	391	41.2	254	29.5	302	39.3	57	21.0	727	17.6	**25.1**
Sex of sex partners (ever)																	
Mainly women/men and women equally	14	9.0	36	7.7	374	19.0	187	19.7	174	20.2	212	27.6	41	15.0	575	13.9	**17.8**
Mainly men	58	37.4	157	33.6	650	33.1	278	29.3	258	30.0	243	31.6	79	28.9	1078	26.1	**31.1**
Only men	83	53.5	274	58.7	940	47.9	485	51.1	429	49.8	314	40.8	153	56.0	2470	59.9	**51.1**
Number of unprotected anal intercourses (last 12 moths)																	
None	26	23.6	88	25.6	435	35.3	297	51.6	205	35.2	127	30.2	65	33.9	1131	39.2	**35.6**
1	40	36.4	84	24.4	324	26.3	167	29.0	175	30.1	144	34.3	80	41.7	879	30.4	**29.2**
2-4	24	21.8	89	25.9	254	20.6	68	11.8	142	24.4	100	23.8	34	17.7	540	18.7	**20.4**
>=5	20	18.2	83	24.1	220	17.8	44	7.6	60	10.3	49	11.7	13	6.8	338	11.7	**14.8**
Has payed or given any kind of goods in exchage for sex (last 12 moths)	14	12.8	27	7.8	82	6.6	60	10.4	29	5.0	37	8.8	9	4.7	232	8.0	**7.7**
Has received money or other goods in exchange for sex (last 12 moths)	19	17.3	20	5.8	71	5.8	18	3.1	14	2.4	23	5.5	8	4.2	179	6.2	**6.3**
History of STIs																	
STI diagnosis in the last 12 months	19	17.8	47	13.7	128	10.6	67	11.9	75	13.1	34	8.3	25	13.3	312	10.9	**11.3**
STI diagnosis > 12 months ago	40	37.4	137	39.9	377	31.1	143	25.5	156	27.3	72	17.5	37	19.7	822	28.8	**29.3**
No STI diagnosis	48	44.9	159	46.4	707	58.3	351	62.6	341	59.6	306	74.3	126	67.0	1716	60.2	**59.4**
HIV Serostatus																	
Unknown	13	8.7	70	15.2	447	23.7	250	27.8	184	22.2	373	49.6	59	22.3	1031	25.9	**26.0**
Last HIV test negative	112	74.7	327	71.1	1191	63.1	545	60.6	571	68.8	329	43.8	183	69.3	2541	63.9	**62.4**
HIV positive	25	16.7	63	13.7	250	13.2	104	11.6	75	9.0	50	6.6	22	8.3	402	10.1	**11.6**

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Table 3. Perceived access to HIV testing and testing history by country of residence.

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Would know where to seek for an HIV test	107	85.6	356	89.9	1388	84.8	640	80.5	571	75.7	428	61.0	229	94.6	2871	80.5	**80.6**
Number of HIV tests (ever)																	
Never tested	13	10.4	70	17.6	447	27.3	250	31.4	184	24.4	373	53.1	59	24.4	1031	28.9	**29.5**
1	14	11.2	43	10.8	234	14.3	108	13.6	104	13.8	91	13.0	41	16.9	513	14.4	**13.8**
2-5	44	35.2	126	31.7	590	36.0	255	32.1	265	35.1	166	23.6	90	37.2	1203	33.7	**33.6**
6-9	18	14.4	65	16.4	169	10.3	76	9.6	93	12.3	34	4.8	27	11.2	397	11.1	**10.4**
>=10	36	28.8	93	23.4	198	12.1	106	13.3	109	14.4	38	5.4	25	10.3	428	12.0	**12.7**
Testing history																	
Never tested	13	10.4	70	17.7	447	27.4	250	31.5	184	24.4	373	53.1	59	24.4	1031	28.9	**29.5**
>=12 months ago	32	25.6	111	28.0	526	32.2	148	18.7	192	25.5	128	18.2	62	25.6	930	26.1	**27.4**
<12 months ago	80	64.0	215	54.3	660	40.4	395	49.8	377	50.1	201	28.6	121	50.0	1604	45.0	**43.1**
Reasons for never having undergone an HIV test																	
Reasons related to risk perception*	6	46.2	42	60.9	236	55.9	107	44.2	86	48.6	185	51.8	32	57.1	463	46.3	**51.6**
Reasons related to the lack of anonimity	3	23.1	12	17.4	55	13.0	40	16.5	44	24.9	65	18.2	6	10.7	206	20.6	**17.0**
Fear of the consequences of a positive result**	1	7.7	3	4.3	48	11.4	28	11.6	11	6.2	43	12.0	3	5.4	99	9.9	**10.7**
Fear of stigma/discrimination or of having to outing regarding my sex life with men	3	23.1	4	5.8	20	4.7	21	8.7	16	9.0	28	7.8	5	8.9	39	3.9	**6.0**
I am a blood donor	0	.0	3	4.3	29	6.9	25	10.3	8	4.5	8	2.2	3	5.4	112	11.2	**6.9**
Convenience related reasons***	0	.0	4	5.8	18	4.3	16	6.6	11	6.2	21	5.9	6	10.7	42	4.2	**4.8**
Others	0	.0	1	1.4	16	3.8	5	2.1	1	.6	7	2.0	1	1.8	40	4.0	**3.1**
Setting of last HIV test																	
Primary care	64	57.1	128	39.1	451	38.0	2	.4	162	28.5	10	3.0	2	1.1	982	38.7	**33.9**
Sexual health clinic	20	17.9	87	26.6	224	18.9	138	25.3	95	16.7	55	16.8	73	39.9	527	20.8	**19.9**
Healthcare setting non specialized in HIV/STI****	11	9.8	30	9.2	213	17.9	91	16.7	83	14.6	86	26.2	41	22.4	356	14.0	**16.5**
CBO/NGO (office, outreach activities)	5	4.5	64	19.6	119	10.0	110	20.2	103	18.1	8	2.4	57	31.1	257	10.1	**10.7**
Private laboratory	1	.9	5	1.5	24	2.0	157	28.8	96	16.9	140	42.7	3	1.6	196	7.7	**8.7**
Through a blood donation	0	.0	1	.3	42	3.5	18	3.3	12	2.1	19	5.8	2	1.1	88	3.5	**3.2**
Used a self sampling/ self testing kit	8	7.1	8	2.4	33	2.8	5	.9	4	.7	5	1.5	2	1.1	22	.9	**2.3**
Other settings	3	2.7	4	1.2	81	6.8	24	4.4	14	2.5	5	1.5	3	1.6	107	4.2	**4.8**
Underwent rapid testing in last testing episode	22	19.6	97	29.8	206	17.3	198	36.4	222	39.0	46	14.0	21	11.5	692	27.3	**22.3**
Tested at least every12 months (during last 5 years)	63	64.3	136	48.9	370	40.3	279	65.2	264	57.3	130	57.0	68	49.6	1025	51.5	**49.0**

* Reasons related to risk perception include: "I felt very healthy"; "With my behaviours, I cannot be infected"; **Includes: "I am afraid of the consequence for my health"; "I am afraid I might loose my job or not find another"; "I do not have a work permit and I think that I might have problems to obtain one if positive"; *** Includes: "Having to wait several days to know the result stresses me out";"I never happen to find the time"; "I want to go to a private centre but cannot afford it"

****Includes: "Hospital or clinic", "Office of medical specialist", "Emergency room"

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Table 4. Knowledge and history of use of self-sampling kits by country of residence.

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Knows about the existence of self-sampling	58	47.2	91	23.2	434	27.4	179	23.2	169	23.0	166	24.6	70	29.7	657	18.8	**25.5**
Has used a self-sampling kit in the past	11	8.9	2	.5	11	.7	2	.3	10	1.3	9	1.3	1	.4	15	.4	**1.1**
Number of times used																	
One	5	45.5	2	100.0	3	27.3	1	50.0	2	22.2	4	44.4	0	.0	7	46.7	**40.0**
>1	6	54.5	0	.0	8	72.7	1	50.0	7	77.8	5	55.6	1	100.0	8	53.3	**60.0**
Self-sampling technique used (last episode)																	
Blood based	0	.0	1	50.0	8	72.7	2	100.0	7	77.8	9	100.0	1	100.0	10	71.4	**44.9**
Oral based	11	100.0	1	50.0	3	27.3	0	.0	2	22.2	0	.0	0	.0	4	28.6	**55.1**
Test communication pathway																	
Non-face-to-face	11	100.0	1	50.0	4	36.4	1	50.0	3	33.3	5	55.6	1	100.0	8	61.5	**69.4**
Face-to-face	0	.0	0	.0	7	63.6	1	50.0	6	66.7	3	33.3	0	.0	0	.0	**25.3**
Others	0	.0	1	50.0	0	.0	0	.0	0	.0	1	11.1	0	.0	5	38.5	**5.3**

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Table 5. Potential use of self-sampling kits if already available, and preferences regarding reception for results by country of residence.

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Would have used a self-sampling kit if already available																	
Yes/probably yes	77	68.1	267	68.8	996	63.6	498	65.4	548	76.5	533	82.1	172	73.8	2139	62.1	**66.6**
Not Sure	21	18.6	60	15.5	306	19.5	154	20.2	86	12.0	65	10.0	40	17.2	572	16.6	**17.2**
No/probably not	15	13.3	61	15.7	264	16.9	110	14.4	82	11.5	51	7.9	21	9.0	732	21.3	**16.2**
Would use a blood-based self-sampling kit																	
Yes	64	59.8	261	79.8	976	79.0	497	79.4	510	81.9	488	82.3	161	77.0	2111	79.7	**78.6**
Would prefer an oral based kit	40	37.4	50	15.3	239	19.4	120	19.2	107	17.2	94	15.9	46	22.0	507	19.1	**19.7**
Would never use this testing method	3	2.8	16	4.9	20	1.6	9	1.4	6	1.0	11	1.9	2	1.0	32	1.2	**1.7**
Preferred option for result reception																	
NON-FACE-TO-FACE	82	79.6	229	74.4	809	66.5	361	59.1	489	79.9	400	69.9	162	79.4	1990	76.2	**70.8**
Email	33	32.0	61	19.8	311	25.6	137	22.4	245	40.0	159	27.8	53	26.0	959	36.7	**29.4**
Secure website	22	21.4	56	18.2	291	23.9	41	6.7	115	18.8	72	12.6	52	25.5	495	18.9	**19.8**
SMS	19	18.4	64	20.8	127	10.4	97	15.9	112	18.3	120	21.0	43	21.1	386	14.8	**14.5**
Phone call	8	7.8	48	15.6	80	6.6	86	14.1	17	2.8	49	8.6	14	6.9	150	5.7	**7.2**
FACE-TO-FACE	19	18.4	76	24.7	367	30.2	243	39.8	120	19.6	160	28.0	39	19.1	580	22.2	**26.9**
Medical office	17	16.5	51	16.6	285	23.4	164	26.8	74	12.1	144	25.2	25	12.3	519	19.9	**21.5**
At a CBO/NGO	2	1.9	25	8.1	82	6.7	79	12.9	46	7.5	16	2.8	14	6.9	61	2.3	**5.3**
OTHERS	2	1.9	3	1.0	40	3.3	7	1.1	3	.5	12	2.1	3	1.5	43	1.6	**2.3**
Would still prefer non-face-to-face methods when receiving a reactive result*	58	69.9	177	78.3	590	74.1	238	66.1	350	72.3	300	75.4	114	70.4	1334	67.4	**71.8**

*Denominator: Participants answering a non-face-to-face option as preferred way of receiving their test results (SMS,Phone call, email, secure website)

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Table 6. Knowledge and history of use of self-testing kits by country of residence.

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Knows about the existence of self-testing	37	30.6	59	15.4	409	28.1	113	15.9	111	16.0	69	11.1	53	23.6	478	14.4	**21.1**
How did you learn about the existence of self-testing																	
Through general media	13	35.1	9	15.3	78	19.4	25	22.9	27	25.0	17	40.5	19	38.0	178	37.6	**25.4**
Through a website specialized in HIV	5	13.5	8	13.6	133	33.0	12	11.0	27	25.0	3	7.1	4	8.0	37	7.8	**23.7**
Through gay oriented media	4	10.8	8	13.6	53	13.2	8	7.3	7	6.5	3	7.1	6	12.0	46	9.7	**11.6**
Through a CBO/NGO	7	18.9	14	23.7	34	8.4	15	13.8	18	16.7	5	11.9	6	12.0	45	9.5	**10.7**
Through friends or sex partner	3	8.1	8	13.6	40	9.9	12	11.0	6	5.6	4	9.5	3	6.0	46	9.7	**9.6**
Through a search engine (google etc)	1	2.7	7	11.9	26	6.5	33	30.3	8	7.4	5	11.9	6	12.0	77	16.2	**9.3**
Add in a gay dating website	3	8.1	1	1.7	20	5.0	3	2.8	4	3.7	2	4.8	3	6.0	18	3.8	**4.8**
Others	1	2.7	4	6.8	19	4.7	1	.9	11	10.2	3	7.1	3	6.0	27	5.7	**4.9**
Has used a self-testing kit in the past	3	2.5	6	1.5	69	4.5	12	1.6	9	1.3	1	.1	6	2.6	50	1.5	**2.7**
Lifetime use of self-testing																	
Once	0	.0	3	50.0	16	24.6	2	18.2	1	11.1	0	.0	3	42.9	20	40.0	**25.3**
> than once	3	100.0	3	50.0	49	75.4	9	81.8	8	88.9	2	100.0	4	57.1	30	60.0	**74.7**
Time since last self-test																	
In the last 12 months	1	33.3	1	16.7	33	51.6	7	63.6	8	88.9	1	50.0	6	85.7	25	50.0	**51.5**
> 12 months ago	2	66.7	5	83.3	31	48.4	4	36.4	1	11.1	1	50.0	1	14.3	25	50.0	**48.5**
Place of purchase of last self-test																	
Through the internet	1	33.3	5	83.3	48	78.7	3	27.3	3	33.3	1	100.0	0	.0	16	33.3	**65.7**
Someone gave me a rapid test	1	33.3	0	.0	8	13.1	1	9.1	3	33.3	0	.0	3	50.0	8	16.7	**15.4**
Bought in a country where it is legally sold (online or otherwise)	0	.0	1	16.7	1	1.6	3	27.3	2	22.2	0	.0	2	33.3	15	31.3	**8.0**
Others	1	33.3	0	.0	4	6.6	4	36.4	1	11.1	0	.0	1	16.7	9	18.8	**10.9**
Self-test type																	
Blood-based	2	66.7	4	66.7	58	95.1	7	63.6	8	88.9	1	100.0	5	83.3	28	57.1	**85.9**
Oral-based	1	33.3	2	33.3	2	3.3	4	36.4	1	11.1	0	.0	1	16.7	20	40.8	**12.6**
Others	0	.0	0	.0	1	1.6	0	.0	0	.0	0	.0	0	.0	1	2.0	**1.4**
Was accompanied during last self testing episode	1	33.3	0	.0	7	11.5	5	45.5	2	22.2	0	.0	3	42.9	16	32.7	**17.5**

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Table 7. Opinion towards self-testing and main reasons to be in favour and against this testing option by country of residence

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Position towards self-testing																	
In favour	94	79.0	300	78.9	987	69.8	493	71.0	605	88.3	507	82.2	192	86.5	2857	86.8	**77.7**
Not sure	17	14.3	62	16.3	326	23.0	184	26.5	68	9.9	99	16.0	29	13.1	380	11.6	**17.9**
Against	8	6.7	18	4.7	102	7.2	17	2.4	12	1.8	11	1.8	1	.5	53	1.6	**4.4**
Main reason to be in favor of self-testing*																	
It gives privacy	23	20.9	65	18.5	529	42.4	182	28.4	159	24.0	222	38.9	67	31.3	790	24.8	**33.2**
You can test whenever you want	33	30.0	112	31.8	332	26.6	209	32.7	221	33.4	142	24.9	84	39.3	801	25.2	**27.3**
It saves time, paperwork, queues	14	12.7	72	20.5	108	8.7	106	16.6	78	11.8	48	8.4	21	9.8	712	22.4	**13.6**
It contributes to self-responsabilization of ones health	22	20.0	52	14.8	138	11.1	89	13.9	115	17.4	56	9.8	26	12.1	505	15.9	**13.4**
It avoids counselling and answering to intimate questions	10	9.1	20	5.7	70	5.6	16	2.5	47	7.1	46	8.1	9	4.2	217	6.8	**6.3**
It saves from jdgmental attitudes	5	4.5	13	3.7	52	4.2	22	3.4	30	4.5	49	8.6	6	2.8	89	2.8	**4.3**
Others	3	2.7	18	5.1	18	1.4	16	2.5	12	1.8	7	1.2	1	.5	68	2.1	**1.9**
Main reason to be against self-testing**																	
The presence of a professional to provide counselling and give the result is essential	8	32.0	25	34.2	124	31.1	65	34.8	26	34.7	19	19.0	5	19.2	152	36.3	**31.3**
Obtaining the sample, performing the test and interpreting the results should be done by a professional	3	12.0	25	34.2	123	30.8	59	31.6	24	32.0	44	44.0	12	46.2	125	29.8	**31.0**
Concerns about the validity of the results	11	44.0	14	19.2	101	25.3	42	22.5	7	9.3	15	15.0	6	23.1	67	16.0	**23.2**
It maintains HIV as a matter of taboo/shame	1	4.0	4	5.5	20	5.0	12	6.4	6	8.0	11	11.0	2	7.7	32	7.6	**6.1**
It increases the risk of coercitive testing	2	8.0	0	.0	20	5.0	3	1.6	9	12.0	9	9.0	0	.0	16	3.8	**5.1**
Others	0	.0	5	6.8	11	2.8	6	3.2	3	4.0	2	2.0	1	3.8	27	6.4	**3.3**

*Asked to participants who answered: "In favour" or "Not sure" to the question assesing the position towards self-testing

**Asked to participants who answered: "Against" or "Not sure" to the question assesing the position towards self-testing

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Table 8. Price and prefer places to buy self-testing kits by country of residence

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Would pay 25-30 euros for a self-test																	
Yes	64	59.3	212	60.1	912	72.7	417	64.0	277	41.7	269	47.2	145	67.4	1615	50.7	**60.3**
No, unless under great distress	31	28.7	85	24.1	247	19.7	191	29.3	292	44.0	208	36.5	53	24.7	1254	39.3	**29.6**
Never	13	12.0	56	15.9	96	7.6	44	6.7	95	14.3	93	16.3	17	7.9	318	10.0	**10.1**
Reasons for not wanting to pay 25-30 euros																	
Can undergo testing for free	13	31.0	88	62.9	144	42.6	137	58.3	212	55.2	74	24.7	42	60.0	869	55.5	**46.3**
Cannot afford to pay it	9	21.4	17	12.1	58	17.2	44	18.7	67	17.4	106	35.5	6	8.6	257	16.4	**19.8**
The health system should cover the costs	16	38.1	28	20.0	105	31.1	42	17.9	81	21.1	106	35.5	15	21.4	358	22.9	**27.4**
Other reasons	4	9.5	7	5.0	31	9.2	12	5.1	24	6.3	13	4.3	7	10.0	81	5.2	**6.5**
Preferred places to purchase self-testing kits apart from pharmacies																	
They only should be sold in pharmacies	18	25.4	55	24.3	272	28.6	202	43.9	65	19.2	27	7.6	42	28.4	710	38.2	**28.8**
Internet	26	36.6	93	41.2	314	33.1	91	19.8	89	26.3	73	20.4	49	33.1	448	24.1	**29.0**
Supermarkets/parapharmacies	12	16.9	33	14.6	171	18.0	67	14.6	115	33.9	195	54.6	28	18.9	382	20.6	**22.8**
CBO/NGO	6	8.5	31	13.7	123	12.9	12	2.6	16	4.7	35	9.8	12	8.1	82	4.4	**9.3**
Vending machines	8	11.3	6	2.7	54	5.7	56	12.2	43	12.7	17	4.8	16	10.8	195	10.5	**7.7**
Phone ordering	0	.0	2	.9	3	.3	31	6.7	7	2.1	6	1.7	1	.7	13	.7	**1.0**
Other places	1	1.4	6	2.7	13	1.4	1	.2	4	1.2	4	1.1	0	.0	27	1.5	**1.3**
Total	71	100.0	226	100.0	950	100.0	460	100.0	339	100.0	357	100.0	148	100.0	1857	100.0	**100.0**
Importance of receiving information about self-testing from CBOs																	
Important/Very important	90	87.4	305	88.4	1098	90.5	556	87.1	624	96.7	498	93.8	192	90.6	2717	87.0	**89.8**
Irrelevant/Not important	13	12.6	40	11.6	115	9.5	82	12.9	21	3.3	33	6.2	20	9.4	407	13.0	**10.2**

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Table 9. Potential use of self-testing kits if approved, reasons why it would and would not be used and preferred settings for result confirmation

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Would have used a self-test if already available																	
Yes/probably yes	78	70.3	274	75.3	957	72.6	517	78.9	568	85.9	493	91.3	177	83.1	2382	75.0	**76.4**
Not Sure	17	15.3	49	13.5	182	13.8	88	13.4	52	7.9	25	4.6	24	11.3	407	12.8	**12.3**
No/probably not	16	14.4	41	11.3	180	13.6	50	7.6	41	6.2	22	4.1	12	5.6	386	12.2	**11.4**
Times that it would have been used																	
Once	3	3.9	30	11.4	90	9.8	51	10.3	63	11.4	114	24.2	15	8.7	362	15.6	**13.0**
2-3	33	42.9	101	38.3	375	40.9	215	43.4	286	51.8	153	32.4	86	49.7	993	42.7	**41.3**
4-5	10	13.0	43	16.3	155	16.9	65	13.1	68	12.3	47	10.0	16	9.2	324	13.9	**14.4**
>5	31	40.3	90	34.1	296	32.3	164	33.1	135	24.5	158	33.5	56	32.4	644	27.7	**31.3**
Why yes (main reason)*																	
It allows to rapidly check serostatus	15	16.5	55	20.0	271	26.3	87	17.6	77	13.1	146	31.5	49	27.5	612	24.5	**24.4**
It provides autonomy	30	33.0	86	31.3	221	21.5	117	23.6	131	22.4	73	15.7	42	23.6	754	30.1	**24.3**
It is anonimous and discreet	12	13.2	21	7.6	152	14.8	61	12.3	112	19.1	111	23.9	33	18.5	325	13.0	**15.2**
It allows to test more regularly	14	15.4	60	21.8	155	15.0	86	17.4	124	21.2	46	9.9	19	10.7	291	11.6	**14.2**
It allows to ask sex partners to self-test	4	4.4	14	5.1	92	8.9	61	12.3	47	8.0	50	10.8	13	7.3	236	9.4	**9.0**
It is a practical method	13	14.3	32	11.6	94	9.1	57	11.5	72	12.3	8	1.7	14	7.9	207	8.3	**8.8**
It is a less stressing method	2	2.2	6	2.2	39	3.8	23	4.6	21	3.6	28	6.0	7	3.9	63	2.5	**3.6**
Why no (main reason)**																	
Already tests with regularity in existing services	10	33.3	22	28.2	85	27.3	33	28.2	36	45.0	12	30.0	14	41.2	218	31.5	**29.9**
Does not want to learn about the result alone	6	20.0	27	34.6	69	22.2	21	17.9	7	8.8	2	5.0	2	5.9	86	12.4	**18.2**
Does not need to test	2	6.7	13	16.7	46	14.8	12	10.3	11	13.8	9	22.5	2	5.9	164	23.7	**16.7**
Concerns about the reliability of the method	5	16.7	1	1.3	62	19.9	19	16.2	1	1.3	9	22.5	7	20.6	47	6.8	**14.6**
Fear of not using it correctly	5	16.7	9	11.5	36	11.6	28	23.9	16	20.0	4	10.0	5	14.7	99	14.3	**13.6**
Others	2	6.7	6	7.7	13	4.2	4	3.4	9	11.3	4	10.0	4	11.8	77	11.1	**7.0**
Preferred setting to confirm a reactive self-test																	
Healthcare setting non specialized in HIV/STIs***	12	12.9	59	19.0	293	27.4	218	39.2	174	29.5	148	31.4	95	48.5	1063	39.9	**31.1**
Primary care	44	47.3	129	41.6	425	39.7	6	1.1	122	20.7	15	3.2	24	12.2	590	22.1	**27.9**
Sexual health clinic	29	31.2	74	23.9	205	19.1	211	37.9	132	22.4	201	42.7	39	19.9	743	27.9	**26.2**
CBO/NGO (office or outreach activities)	2	2.2	45	14.5	97	9.1	60	10.8	126	21.4	19	4.0	30	15.3	195	7.3	**8.7**
Private laboratory	4	4.3	2	.6	18	1.7	53	9.5	26	4.4	83	17.6	3	1.5	41	1.5	**4.1**
Other	2	2.2	1	.3	33	3.1	8	1.4	10	1.7	5	1.1	5	2.6	33	1.2	**2.0**

*Asked to participants who answered: "Yes/Probably yes" or "Not sure" to the question assesing use of self testing if already available.

**Asked to participants who answered: "No/Probably not " or "Not sure" to the question assesing use of self testing if already available.

***Includes: "Hospital or clinic", "Office of medical specialist", "Emergency room"

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Table 10. Likelihood to use self-testing in several scenarios by country of residence

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
With a steady partner to stop using condoms																	
Not likely	25	29.4	51	17.8	294	30.6	108	21.3	95	18.2	114	28.5	29	16.0	403	16.3	**24.5**
Somewhat likely	5	5.9	29	10.1	127	13.2	33	6.5	56	10.7	41	10.3	22	12.2	208	8.4	**10.5**
Likely	55	64.7	206	72.0	540	56.2	366	72.2	371	71.1	245	61.3	130	71.8	1856	75.2	**65.0**
With a steady partner if there is the possibility he has had sex with another person																	
Not likely	26	31.7	83	29.2	225	23.7	94	18.7	96	18.4	93	24.0	32	17.7	421	17.2	**21.9**
Somewhat likely	14	17.1	52	18.3	135	14.2	43	8.5	66	12.6	43	11.1	22	12.2	293	12.0	**13.2**
Likely	42	51.2	149	52.5	588	62.0	366	72.8	360	69.0	251	64.9	127	70.2	1732	70.8	**64.9**
With a casual partner before condomless sex																	
Not likely	32	38.1	100	35.2	264	28.1	292	58.2	155	29.4	108	26.7	28	15.4	694	28.2	**30.4**
Somewhat likely	11	13.1	24	8.5	94	10.0	51	10.2	46	8.7	35	8.7	15	8.2	217	8.8	**9.6**
Likely	41	48.8	160	56.3	581	61.9	159	31.7	327	61.9	261	64.6	139	76.4	1549	63.0	**60.1**
With a casual partner to prove current serostatus																	
Not likely	33	40.2	124	44.0	372	39.7	189	38.0	163	31.4	108	27.6	54	30.0	820	33.6	**36.2**
Somewhat likely	22	26.8	36	12.8	143	15.2	65	13.1	73	14.1	48	12.3	30	16.7	390	16.0	**15.6**
Likely	27	32.9	122	43.3	423	45.1	244	49.0	283	54.5	235	60.1	96	53.3	1232	50.5	**48.2**

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Table 11. Rapid testing: experience and future preferences

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL weighted (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Has undergone rapid testing (ever)	24	22.6	125	35.3	231	16.9	184	27.1	220	33.6	45	7.4	31	14.3	859	27.0	**20.7**
Last rapid-test																	
<3 months	5	20.8	21	17.2	45	20.2	73	40.6	50	22.9	8	20.0	5	17.2	161	19.4	**21.4**
3-12months	6	25.0	50	41.0	86	38.6	77	42.8	88	40.4	11	27.5	7	24.1	293	35.3	**36.7**
>12 months ago	13	54.2	51	41.8	92	41.3	30	16.7	80	36.7	21	52.5	17	58.6	376	45.3	**41.9**
Setting of last rapid test																	
CBO/NGO (office, outreach activities)	6	31.6	93	80.2	75	39.5	117	70.1	125	59.5	7	17.1	23	85.2	375	49.1	**48.2**
Sexual health clinic	10	52.6	17	14.7	72	37.9	39	23.4	60	28.6	12	29.3	1	3.7	211	27.6	**31.2**
Healthcare setting non specialized in HIV/STI*	3	15.8	4	3.4	25	13.2	9	5.4	17	8.1	13	31.7	3	11.1	54	7.1	**10.4**
Primary care	0	.0	1	.9	16	8.4	0	.0	3	1.4	1	2.4	0	.0	40	5.2	**4.8**
Pharmacies	0	.0	1	.9	0	.0	0	.0	2	1.0	1	2.4	0	.0	66	8.6	**3.3**
Private laboratory	0	.0	0	.0	2	1.1	2	1.2	3	1.4	7	17.1	0	.0	18	2.4	**2.1**
Likeliness of use of rapid testing based on past experience with rapid tests																	
Much more/more likely	8	34.8	74	64.3	125	59.2	138	78.9	129	60.8	29	70.7	12	42.9	424	53.4	**57.9**
The same	14	60.9	31	27.0	72	34.1	27	15.4	73	34.4	2	4.9	10	35.7	310	39.0	**34.6**
Much less/less likely	1	4.3	10	8.7	14	6.6	10	5.7	10	4.7	10	24.4	6	21.4	60	7.6	**7.5**
Likeliness to increase HIV testing rates based on past experience with rapid tests																	
Much more/more likely	11	50.0	65	57.5	110	52.9	136	77.7	119	56.9	28	71.8	19	67.9	353	44.6	**53.1**
The same	10	45.5	39	34.5	92	44.2	33	18.9	83	39.7	6	15.4	5	17.9	390	49.2	**41.9**
Less likely/Much less	1	4.5	9	8.0	6	2.9	6	3.4	7	3.3	5	12.8	4	14.3	49	6.2	**4.9**
Preferred setting to seek for a rapid test																	
Primary care	34	37.8	75	28.1	285	32.7	1	.2	57	12.9	9	3.9	8	5.4	425	20.8	**24.5**
CBO/NGO (office, outreach activities)	11	12.2	89	33.3	210	24.1	107	26.4	169	38.2	25	10.9	56	37.8	394	19.3	**22.5**
Sexual health clinic	24	26.7	49	18.4	92	10.6	114	28.1	83	18.8	53	23.1	30	20.3	589	28.8	**19.3**
Healthcare setting non specialized in HIV/STI*	8	8.9	28	10.5	126	14.5	102	25.1	75	17.0	55	24.0	34	23.0	309	15.1	**15.5**
Private laboratory	3	3.3	3	1.1	16	1.8	54	13.3	30	6.8	58	25.3	7	4.7	104	5.1	**5.3**
Pharmacies	3	3.3	6	2.2	43	4.9	12	3.0	13	2.9	3	1.3	2	1.4	167	8.2	**5.1**
Others	7	7.8	17	6.4	99	11.4	16	3.9	15	3.4	26	11.4	11	7.4	57	2.8	**7.7**

*Includes: "At a hospital or clinic", "Office of medical specialist", "Emergency room"

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Table 12. Pattern of use of self-testing options and preferred testing option

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Pattern of use of testing options (if all available)																	
Would only use one testing option	11	11.7	43	14.2	257	24.3	66	13.0	75	13.8	107	26.8	63	35.4	375	14.3	**19.6**
Mainly one, ocasionally would use a second one	35	37.2	114	37.7	487	46.0	257	50.6	181	33.2	110	27.5	53	29.8	1174	44.6	**42.3**
Would use one more frequently, but would also use two others quite regularly	24	25.5	57	18.9	131	12.4	89	17.5	176	32.3	67	16.8	25	14.0	580	22.0	**17.9**
Would use two options equally	10	10.6	32	10.6	89	8.4	31	6.1	55	10.1	53	13.3	17	9.6	218	8.3	**9.0**
Woud use more than 3 options	14	14.9	56	18.5	94	8.9	65	12.8	58	10.6	63	15.8	20	11.2	284	10.8	**11.1**
Preferred testing option (if all available)																	
Conventional test at sexual health clinic	19	20.4	38	13.0	180	17.6	147	29.7	57	10.7	112	28.9	34	20.0	477	18.6	**19.2**
Conventional test at primary care	7	7.5	57	19.5	92	9.0	16	3.2	45	8.5	9	2.3	6	3.5	258	10.1	**8.5**
Conventional test at private laboratory	7	7.5	5	1.7	23	2.2	51	10.3	36	6.8	53	13.7	4	2.4	71	2.8	**4.5**
Rapid test at primary care or at the emergency department	3	3.2	10	3.4	59	5.8	8	1.6	29	5.5	2	.5	5	2.9	236	9.2	**5.7**
Rapid test at sexual health clinic	8	8.6	9	3.1	57	5.6	50	10.1	28	5.3	20	5.2	7	4.1	207	8.1	**6.5**
Rapid test at a pharmacy	1	1.1	2	.7	29	2.8	7	1.4	13	2.4	13	3.4	2	1.2	100	3.9	**2.9**
Rapid test performed at the community	6	6.5	41	14.0	77	7.5	48	9.7	74	13.9	9	2.3	18	10.6	172	6.7	**7.5**
Self-sampling	8	8.6	20	6.8	30	2.9	13	2.6	20	3.8	26	6.7	9	5.3	101	3.9	**4.1**
Self-testing	24	25.8	79	27.0	388	37.9	124	25.1	174	32.8	90	23.3	68	40.0	725	28.3	**31.8**
Two options with similar frequency	10	10.8	32	10.9	89	8.7	31	6.3	55	10.4	53	13.7	17	10.0	218	8.5	**9.3**

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Table 13. Least preferred testing options by country of residence

	Belgium (N=125)		Denmark (N=397)		Germany (N=1638)		Greece (N=795)		Portugal (N=755)		Romania (N=702)		Slovenia (N=242)		Spain (N=3572)		TOTAL (weighted) (N=8226)
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Would never use this testing option																	
A rapid test in a Sexual health clinic	11	11.8	18	5.8	75	7.0	43	8.5	55	10.2	32	7.8	14	8.0	224	8.5	**8.0**
A conventional test in a Sexual health clinic	12	12.9	34	11.0	82	7.6	69	13.6	75	14.0	81	19.8	20	11.4	320	12.2	**11.2**
A self-testing kit	11	11.8	37	12.0	138	12.8	60	11.8	46	8.6	38	9.3	13	7.4	276	10.5	**11.4**
A rapid test in primary care	17	18.3	32	10.4	114	10.6	183	36.1	109	20.3	76	18.6	55	31.4	432	16.4	**15.5**
A rapid test in CBO/NGO	16	17.2	20	6.5	158	14.7	101	19.9	87	16.2	82	20.0	19	10.9	437	16.6	**15.9**
A conventional test in a private laboratory	26	28.0	59	19.2	131	12.2	91	17.9	82	15.3	47	11.5	22	12.6	663	25.2	**17.3**
A conventional test in primary care	12	12.9	48	15.6	108	10.0	176	34.7	140	26.1	151	36.9	56	32.0	519	19.7	**18.1**
A self-sampling kit	14	15.1	56	18.2	207	19.2	103	20.3	106	19.7	49	12.0	23	13.1	634	24.1	**19.6**
A rapid test (performed by a pharmacist) in a pharmacy	32	34.4	121	39.3	325	30.2	229	45.2	216	40.2	121	29.6	69	39.4	824	31.3	**32.4**
A rapid test at a bar/pub, club or sauna	40	43.0	148	48.1	528	49.0	286	56.4	270	50.3	183	44.7	60	34.3	1507	57.3	**50.7**

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2. THE STAKEHOLDERS STUDY

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Table 14. Main characteristics of stakeholders by area of work and region.

	Decision makers/Public health professionals								Health care professionals								CBO members							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=38)		South EU (N=24)		Central EU (N=23)		Spain (N=399)		North EU (N=41)		South EU (N=43)		Central EU (N=13)		Spain (N=74)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Age																								
<29	0	0.0	5	31.3	0	0.0	1	2.4	3	7.9	3	12.5	0	0.0	48	12.1	7	17.1	8	18.6	1	7.7	14	19.2
30-39	0	0.0	7	43.8	0	0.0	5	12.2	6	15.8	8	33.3	2	8.7	69	17.3	11	26.8	26	60.5	7	53.8	24	32.9
40-49	5	29.4	0	0.0	5	71.4	12	29.3	14	36.8	5	20.8	7	30.4	103	25.9	10	24.4	5	11.6	3	23.1	21	28.8
>=50	12	70.6	4	25.0	2	28.6	23	56.1	15	39.5	8	33.3	14	60.9	178	44.7	13	31.7	4	9.3	2	15.4	14	19.2
Study level																								
< higher education	2	11.8	0	0.0	1	14.3	1	2.4	6	15.8	0	0.0	0	0.0	0	0.0	3	7.3	10	23.3	2	15.4	18	24.7
University degree	8	47.1	13	81.3	4	57.1	30	73.2	19	50.0	19	82.6	4	17.4	306	76.7	34	82.9	33	76.7	10	76.9	51	69.9
Post graduate	7	41.2	3	18.8	2	28.6	10	24.4	13	34.2	4	17.4	19	82.6	93	23.3	4	9.8	0	0.0	1	7.7	4	5.5
Job level																								
High senior official	6	35.3	2	13.3	1	16.7	2	5.1																
HIV and/or public health technician	9	52.9	11	73.3	3	50.0	30	76.9																
Other	2	11.8	2	13.3	2	33.3	7	17.9																
Region of Work																								
Country level	10	58.8	9	64.3	5	71.4	4	10.3																
Regional level	3	17.6	4	28.6	2	28.6	26	66.7																
City/local level	4	23.5	1	7.1	0	0.0	9	23.1																
Profession (medical)																								
Medical doctor									13	39.4	9	50.0	18	90.0	314	83.1								
Nurse									15	45.5	6	33.3	1	5.0	56	14.8								
Other									5	15.2	3	16.7	1	5.0	8	2.1								
Work setting																								
HIV specific setting									26	68.4	11	45.8	13	56.5	46	11.5								
Primary care									5	13.2	6	25.0	3	13.0	306	76.7								
Secondary care setting									4	10.5	1	4.2	3	13.0	18	4.5								
Other									1	2.6	2	8.3	4	17.4	15	3.8								
Focus on HIV and/or other STIs																								
Exclusively focused on HIV/STIs																	17	42.5	22	53.7	4	33.3	27	41.5
Not exclusively but includes HIV/STIs																	23	57.5	18	43.9	8	66.7	38	58.5
Nothing to do with HIV/STIs																	0	0.0	1	2.4	0	0.0	0	0.0
Target population																								
Mainly LGTB+ population																	22	56.4	17	44.7	5	41.7	23	34.3
Mainly other key populations																	5	12.8	9	23.7	1	8.3	25	37.3
Does not serve a specific group																	11	28.2	10	26.3	6	50.0	19	28.4
Others																	1	2.6	2	5.3	0	0.0	0	0.0
The CBO has a HIV testing counselling service																	32	84.2	22	62.9	6	50.0	60	95.2
Stakeholder directly involved with HIV testing counselling service																	31	91.2	19	79.2	6	85.7	50	73.5

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Table 15. Personal knowledge and position towards self-sampling; potential use of self-sampling if available and opinion of the preferred options by their target population to receive the results by area of work and region.

	Decision makers/Public health professionals								Health care professionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=38)		South EU (N=24)		Central EU (N=23)		Spain (N=399)		North EU (N=41)		South EU (N=43)		Central EU (N=13)		Spain (N=74)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Knows about the existence of self-sampling	16	94.1	9	75.0	5	83.3	28	68.3	33	86.8	12	52.2	18	81.8	129	33.9	35	89.7	19	54.3	9	69.2	48	71.6
PERSONAL opinion on self-sampling																								
In favour	10	71.4	4	33.3	4	66.7	15	38.5	23	63.9	5	22.7	7	33.3	199	54.2	28	75.7	16	48.5	6	50.0	15	23.1
Against	1	7.1	2	16.7	1	16.7	3	7.7	4	11.1	3	13.6	2	9.5	23	6.3	2	5.4	1	3.0	2	16.7	13	20.0
Not sure	3	21.4	6	50.0	1	16.7	21	53.8	9	25.0	14	63.6	12	57.1	145	39.5	7	18.9	16	48.5	4	33.3	37	56.9
The population you serve would have used self-sampling if already available																								
Yes/Probably yes	12	80.0	4	36.4	4	66.7	22	57.9	25	69.4	11	57.9	15	71.4	212	58.9	27	73.0	13	41.9	7	58.3	34	51.5
Not sure	2	13.3	5	45.5	1	16.7	13	34.2	6	16.7	4	21.1	2	9.5	81	22.5	5	13.5	9	29.0	1	8.3	15	22.7
No/Probably no	1	6.7	2	18.2	1	16.7	3	7.9	5	13.9	4	21.1	4	19.0	67	18.6	5	13.5	9	29.0	4	33.3	17	25.8
Preferred way to receive a NEGATIVE result by the population you serve																								
NON FACE TO FACE	9	75.0	5	62.5	3	60.0	24	68.6	27	87.1	9	60.0	12	75.0	178	63.1	24	85.7	16	72.7	7	87.5	26	55.3
SMS	4	33.3	2	25.0	2	40.0	6	17.1	8	25.8	6	40.0	3	18.8	69	24.5	9	32.1	7	31.8	3	37.5	11	23.4
Phone call	2	16.7	2	25.0	0	0.0	4	11.4	5	16.1	0	0.0	2	12.5	41	14.5	4	14.3	6	27.3	0	0.0	7	14.9
Email	3	25.0	0	0.0	0	0.0	9	25.7	6	19.4	1	6.7	2	12.5	36	12.8	4	14.3	2	9.1	1	12.5	1	2.1
Secure website	0	0.0	1	12.5	1	20.0	5	14.3	8	25.8	2	13.3	5	31.3	32	11.3	7	25.0	1	4.5	3	37.5	7	14.9
FACE TO FACE	1	8.3	3	37.5	1	20.0	7	20.0	2	6.5	6	40.0	4	25.0	87	30.9	4	14.3	6	27.3	1	12.5	19	40.4
At a medical office	0	0.0	1	12.5	0	0.0	3	8.6	2	6.5	2	13.3	3	18.8	82	29.1	1	3.6	0	0.0	0	0.0	4	8.5
At a CBO/NGO	1	8.3	2	25.0	1	20.0	4	11.4	0	0.0	4	26.7	1	6.3	5	1.8	3	10.7	6	27.3	1	12.5	15	31.9
OTHERS	2	16.7	0	0.0	1	20.0	4	11.4	2	6.5	0	0.0	0	0.0	17	6.0	0	0.0	0	0.0	0	0.0	2	4.3
Preferred way to receive a POSITIVE result by the population you serve																								
NON FACE TO FACE	6	50.0	0	0.0	1	20.0	4	11.8	13	41.9	2	13.3	5	31.3	68	24.2	13	48.1	7	33.3	3	37.5	7	14.9
SMS	0	0.0	0	0.0	0	0.0	1	2.9	2	6.5	1	6.7	0	0.0	9	3.2	1	3.7	1	4.8	0	0.0	0	0.0
Phone call	4	33.3	0	0.0	1	20.0	3	8.8	4	12.9	0	0.0	0	0.0	24	8.5	9	33.3	5	23.8	0	0.0	3	6.4
Email	1	8.3	0	0.0	0	0.0	0	0.0	3	9.7	0	0.0	1	6.3	13	4.6	1	3.7	1	4.8	1	12.5	0	0.0
Secure website	1	8.3	0	0.0	0	0.0	0	0.0	4	12.9	1	6.7	4	25.0	22	7.8	2	7.4	0	0.0	2	25.0	4	8.5
FACE TO FACE	6	50.0	7	87.5	4	80.0	25	73.5	16	51.6	13	86.7	10	62.5	202	71.9	14	51.9	14	66.7	5	62.5	37	78.7
At a medical office	3	25.0	5	62.5	4	80.0	18	52.9	14	45.2	10	66.7	9	56.3	188	66.9	5	18.5	2	9.5	2	25.0	14	29.8
At a CBO/NGO	3	25.0	2	25.0	0	0.0	7	20.6	2	6.5	3	20.0	1	6.3	14	5.0	9	33.3	12	57.1	3	37.5	23	48.9
OTHERS	0	0.0	1	12.5	0	0.0	5	14.7	2	6.5	0	0.0	1	6.3	11	3.9	0	0.0	0	0.0	0	0.0	3	6.4

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Table 16. Reasons given by stakeholders to be in favour and against self-sampling by area of work region (open ended question)

	Decission makers/Public health profesionals								Health care professionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=38)		South EU (N=24)		Central EU (N=23)		Spain (N=399)		North EU (N=41)		South EU (N=43)		Central EU (N=13)		Spain (N=74)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Stakeholders' reasons to be In favour of self-sampling*	**(N=14)**		**(N=10)**		**(N=5)**		**(N=36)**		**(N=32)**		**(N=19)**		**(N=19)**		**(N=344)**		**(N=35)**		**(N=32)**		**(N=10)**		**(N=52)**	
It allows to test privately, confidentially and anonymously	1	25.0	0	.0	0	.0	3	20.0	0	.0	2	40.0	0	.0	46	25.6	0	.0	2	20.0	1	20.0	2	9.1
It allows to test whenever and wherever	0	.0	0	.0	1	50.0	0	.0	1	6.3	0	.0	0	.0	13	7.2	3	15.0	1	10.0	0	.0	0	.0
It saves time, paperwork, queues	0	.0	0	.0	0	.0	1	6.7	1	6.3	0	.0	1	25.0	15	8.3	0	.0	0	.0	0	.0	0	.0
It contributes to self-responsabilization of ones health	0	.0	0	.0	0	.0	1	6.7	1	6.3	0	.0	0	.0	3	1.7	1	5.0	2	20.0	0	.0	4	18.2
It saves from judgamental attitudes	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	19	10.6	2	10.0	0	.0	0	.0	1	4.5
Avoids counselling	0	.0	0	.0	0	.0	0	.0	1	6.3	0	.0	0	.0	0	.0	1	5.0	0	.0	0	.0	0	.0
Avoids having to answer questions	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	1	.6	0	.0	0	.0	0	.0	0	.0
It is an addtional method that could lead to uncovering new diagnoses	2	50.0	2	100.0	1	50.0	7	46.7	11	68.8	1	20.0	1	25.0	54	30.0	12	60.0	3	30.0	3	60.0	9	40.9
Effective and reliable method	0	.0	0	.0	0	.0	0	.0	1	6.3	0	.0	0	.0	2	1.1	0	.0	0	.0	0	.0	0	.0
Others	0	.0	0	.0	0	.0	1	6.7	0	.0	1	20.0	1	25.0	6	3.3	1	5.0	1	10.0	0	.0	1	4.5
Does not know	1	25.0	0	.0	0	.0	2	13.3	0	.0	1	20.0	1	25.0	21	11.7	0	.0	1	10.0	1	20.0	5	22.7
Stkeholders' reasons to be against self-sampling**	**(N=4)**		**(N=8)**		**(N=2)**		**(N=24)**		**(N=13)**		**(N=17)**		**(N=14)**		**(N=168)**		**(N=9)**		**(N=17)**		**(N=6)**		**(N=50)**	
Obtaining the sample, performing the test and interpreting the results should be done by a professional	0	.0	0	.0	0	.0	1	6.3	2	28.6	1	16.7	1	14.3	6	5.0	0	.0	0	.0	0	.0	1	2.3
The presence of a professional to provide counselling and give the result is essential	2	66.7	3	60.0	0	.0	9	56.3	2	28.6	3	50.0	4	57.1	39	32.8	4	66.7	2	40.0	1	33.3	26	60.5
Concerns about the validity of the results	0	.0	0	.0	0	.0	1	6.3	0	.0	0	.0	0	.0	2	1.7	0	.0	1	20.0	1	33.3	2	4.7
It maintains HIV as a matter of taboo/shame	0	.0	2	40.0	0	.0	0	.0	0	.0	0	.0	0	.0	1	.8	0	.0	0	.0	0	.0	0	.0
It increases the risk of coercitive testing	0	.0	0	.0	0	.0	0	.0	1	14.3	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0
Problems related to confidenciality and anonymity breach	0	.0	0	.0	0	.0	1	6.3	0	.0	0	.0	0	.0	10	8.4	0	.0	0	.0	0	.0	0	.0
Problems related to sending the sample via post mail	0	.0	0	.0	0	.0	0	.0	1	14.3	0	.0	0	.0	12	10.1	0	.0	0	.0	0	.0	2	4.7
Difficulties related to follow-up and linkage to care	0	.0	0	.0	0	.0	0	.0	0	.0	1	16.7	0	.0	8	6.7	2	33.3	1	20.0	0	.0	4	9.3
Delays when obtaining the result	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	1	2.3
Others	0	.0	0	.0	0	.0	2	12.5	1	14.3	0	.0	1	14.3	21	17.6	0	.0	0	.0	0	.0	2	4.7
Does not know	1	33.3	0	.0	0	.0	2	12.5	0	.0	1	16.7	1	14.3	20	16.8	0	.0	1	20.0	1	33.3	5	11.6

*Denominator: Those who reported being "in favour" of self sampling or not being sure about their personal position regarding this method
**Denominator: Those who reported being "against" of self sampling or not being sure about their personal position regarding this method

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Table 17. Reasons why the populations they serve would have and would have not used a sampling kit in the past if already available by area of work and region (open ended question)

	Decission makers/Public health professionals								Health care professionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=38)		South EU (N=24)		Central EU (N=23)		Spain (N=399)		North EU (N=41)		South EU (N=43)		Central EU (N=13)		Spain (N=74)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
If available, the population they serve would have used self-sampling in the past because:*	(N=14)		(N=9)		(N=5)		(N=35)		(N=31)		(N=15)		(N=17)		(N=293)		(N=32)		(N=22)		(N=80)		(N=49)	
They can obtain a result quickly	0	0.0	0	0.0	0	0.0	0	0.0	1	9.1	0	0.0	0	0.0	3	2.7	0	0.0	0	0.0	0	0.0	1	4.3
It gives them autonomy	0	0.0	0	0.0	0	0.0	1	7.7	0	0.0	0	0.0	0	0.0	12	10.9	1	10.0	0	0.0	1	50.0	2	8.7
It is anonymous and discreet	1	100.0	0	0.0	0	0.0	4	30.8	0	0.0	1	50.0	1	16.7	25	22.7	1	10.0	0	0.0	0	0.0	9	39.1
It is practical and convenient: they can test at home	0	0.0	0	0.0	0	0.0	1	7.7	4	36.4	0	0.0	0	0.0	15	13.6	3	30.0	1	25.0	0	0.0	4	17.4
It allows to increase testing frequency	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	3	2.7	0	0.0	0	0.0	0	0.0	0	0.0
It would help to overcome barriers of already existing services	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	33.3	1	0.9	0	0.0	1	25.0	0	0.0	0	0.0
It would help to overcome barriers derived from face to face encounters	0	0.0	1	50	0	0.0	2	15.4	0	0.0	1	50.0	1	16.7	17	15.5	1	10.0	1	25.0	1	50.0	2	8.7
It increases accessibility	0	0.0	0	0.0	0	0.0	1	7.7	2	18.2	0	0.0	1	16.7	8	7.3	0	0.0	1	25.0	0	0.0	2	8.7
Others	0	0.0	1	50.0	0	0.0	4	30.8	4	36.4	0	0.0	1	16.7	26	23.6	4	40.0	0	0.0	0	0.0	3	13.0
If available, the population they serve would have not used self-sampling in the past because:**	(N=3)		(N=7)		(N=2)		(N=16)		(N=11)		(N=8)		(N=6)		(N=148)		(N=10)		(=18)		(N=5)		(N=32)	
People that do not feel the need to be tested will not change their opinion	0	0.0	0	0.0	0	0.0	1	20.0	0	0.0	0	0.0	0	0.0	2	2.9	0	0.0	0	0.0	0	0.0	1	8.3
People will keep using already existing services to test for HIV	0	0.0	0	0.0	0	0.0	1	20.0	3	100.0	1	50.0	0	0.0	20	29.4	1	20.0	1	12.5	1	100.0	1	8.3
Lack of trust in the reliability of the method	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4	5.9	0	0.0	1	12.5	0	0.0	0	0.0
Fear of not using the method properly	0	0.0	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	5	7.4	0	0.0	1	12.5	0	0.0	0	0.0
Fear of knowing the result alone at home	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	1.5	0	0.0	0	0.0	0	0.0	0	0.0
Because of lack of face-to-face assistance during the process	0	0.0	1	33.3	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0	1	1.5	0	0.0	0	0.0	0	0.0	2	16.7
Fear of confidenciality breach during the process	0	0.0	0	0.0	0	0.0	1	20.0	0	0.0	0	0.0	0	0.0	4	5.9	0	0.0	0	0.0	0	0.0	0	0.0
Reasons related to the price	0	0.0	1	33.3	0	0.0	1	20.0	0	0.0	0	0.0	0	0.0	3	4.4	0	0.0	1	12.5	0	0.0	1	8.3
For reasons associated with the population they work with	0	0.0	1	33.3	0	0.0	0	0.0	0	0.0	1	50.0	0	0.0	17	25.0	1	20.0	3	37.5	0	0.0	3	25.0
Others	0	0.0	0	0.0	0	0.0	1	20.0	0	0.0	0	0.0	0	0.0	4	5.9	2	40.0	0	0.0	0	0.0	2	16.7
Would not know about its existence	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	7	10.3	1	20.0	1	12.5	0	0.0	2	16.7

*Denominator: Those answering that self-sampling whould have been used in the past or not being sure

**Denominator: Those answering that self-sampling whould have not been used in the past or not being sure

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Table 18. Reasons reported by stakeholders to be in favour and against non-face-to-face result communication methods by area of work and region (open ended question)

	Decision makers/Public health professionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=38)		South EU (N=24)		Central EU (N=23)		Spain (N=399)		North EU (N=41)		South EU (N=43)		Central EU (N=13)		Spain (N=74)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Reasons to be in favour of non-face-to-face result communication																								
They are already used in other clinical analyses	1	16.7	0	0.0	0	0.0	0	0.0	1	14.3	0	0.0	0	0.0	2	1.8	1	16.7	0	0.0	1	33.3	0	0.0
They avoid potential problems derived from a face to face contact	0	0.0	0	0.0	1	100	1	5.3	0	0.0	1	25.0	1	50.0	3	2.7	1	16.7	1	20.0	0	0.0	0	0.0
If its demanded by the public there no reason not to use it	1	16.7	0	0.0	0	0.0	3	15.8	5	71.4	0	0.0	0	0.0	16	14.5	1	16.7	1	20.0	1	33.3	6	42.9
As long as it is safe	2	33.3	0	0.0	0	0.0	2	10.5	0	0.0	2	50.0	0	0.0	4	3.6	1	16.7	2	40.0	1	33.3	2	14.3
As long as the result is negative	1	16.7	1	100	0	0.0	8	42.1	1	14.3	1	25.0	1	50.0	42	38.2	2	33.3	1	20.0	0	0.0	2	14.3
Others	1	16.7	0	0.0	0	0.0	5	26.3	0	0.0	0	0.0	0	0.0	43	39.1	0	0.0	0	0.0	0	0.0	4	28.6
Reasons against non-face-to-face consultations																								
It is cold and impersonal	0	0.0	0	0.0	0	0.0	4	23.5	0	0.0	0	0.0	0	0.0	12	8.2	0	0.0	1	20.0	0	0.0	9	32.1
It is not the optimal way of carrying out preventive counselling	1	100	0	0.0	1	100	3	17.6	2	22.2	0	0.0	4	80.0	46	31.3	4	44.4	1	20.0	1	100	11	39.3
It makes linkage to care difficult	0	0.0	0	0.0	0	0.0	0	0.0	1	11.1	0	0.0	0	0.0	1	.7	1	11.1	1	20.0	0	0.0	1	3.6
Not the optimal way of giving a positive result	0	0.0	3	100	0	0.0	9	52.9	5	55.6	1	100	1	20.0	61	41.5	4	44.4	2	40.0	0	0.0	5	17.9
Others	0	0.0	0	0.0	0	0.0	1	5.9	1	11.1	0	0.0	0	0.0	27	18.4	0	0.0	0	0.0	0	0.0	2	7.1

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Table 19. Impact of self-sampling if approved on testing frequency and on the patterns of use of existing testing options of several population groups by area of work- region

	Decision makers/Public health professionals								CBO professionals			
	North EU (N=18)	South EU (N=16)	Central EU (N=7)	Spain (N=41)	North EU (N=38)	South EU (N=24)	Central EU (N=23)	Spain (N=399)	North EU (N=41)	South EU (N=43)	Central EU (N=13)	Spain (N=74)
	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %
If available self-sampling would lead to an increase in the testing frequency among:												
Men who have sex with men												
No	0 0.0	0 0.0	0 0.0	5 13.9	3 9.1	1 5.6	1 5.3	18 5.5	1 3.1	0 0.0	2 20.0	7 12.3
Yes, slight/moderate	10 71.4	5 50.0	5 83.3	24 66.7	20 60.6	15 83.3	12 63.2	203 61.5	20 62.5	16 61.5	5 50.0	37 64.9
Yes, substantial	4 28.6	5 50.0	1 16.7	7 19.4	10 30.3	2 11.1	6 31.6	109 33.0	11 34.4	10 38.5	3 30.0	13 22.8
Male sex workers												
No	2 14.3	1 10.0	0 0.0	7 20.0	6 18.2	0 0.0	1 5.6	30 9.1	3 9.4	1 3.7	3 30.0	12 21.1
Yes, slight/moderate	9 64.3	6 60.0	5 83.3	25 71.4	22 66.7	14 82.4	11 61.1	205 62.3	23 71.9	21 77.8	3 30.0	36 63.2
Yes, substantial	3 21.4	3 30.0	1 16.7	3 8.6	5 15.2	3 17.6	6 33.3	94 28.6	6 18.8	5 18.5	4 40.0	9 15.8
Transgender/transsexual population												
No	1 7.1	1 10.0	1 16.7	9 26.5	3 9.1	1 6.3	3 15.8	53 16.3	3 9.7	2 7.7	2 22.2	16 28.6
Yes, slight/moderate	12 85.7	6 60.0	4 66.7	22 64.7	27 81.8	13 81.3	14 73.7	212 65.2	24 77.4	20 76.9	4 44.4	30 53.6
Yes, substantial	1 7.1	3 30.0	1 16.7	3 8.8	3 9.1	2 12.5	2 10.5	60 18.5	4 12.9	4 15.4	3 33.3	10 17.9
Transgender/transsexual sex workers												
No	0 0.0	1 10.0	1 16.7	8 22.2	2 6.3	0 0.0	2 11.1	28 8.5	5 15.6	2 7.4	2 22.2	15 26.3
Yes, slight/moderate	12 85.7	5 50.0	4 66.7	23 63.9	25 78.1	13 76.5	12 66.7	201 61.3	21 65.6	19 70.4	4 44.4	33 57.9
Yes, substantial	2 14.3	4 40.0	1 16.7	5 13.9	5 15.6	4 23.5	4 22.2	99 30.2	6 18.8	6 22.2	3 33.3	9 15.8
Variation of current use of existing sites if self-sampling was approved among:												
Men who have sex with men												
No variation	1 8.3	1 10.0	0 0.0	6 17.1	4 13.3	2 12.5	0 0.0	18 5.9	3 9.1	0 0.0	2 20.0	9 16.1
Marginal/Moderate variation	10 83.3	4 40.0	3 50.0	24 68.6	22 73.3	13 81.3	16 84.2	203 66.8	26 78.8	17 77.3	7 70.0	43 76.8
Substantial variation	1 8.3	5 50.0	3 50.0	5 14.3	4 13.3	1 6.3	3 15.8	83 27.3	4 12.1	5 22.7	1 10.0	4 7.1
Male sex workers												
No variation	5 41.7	1 10.0	0 0.0	8 22.9	4 13.3	2 12.5	1 5.6	27 8.9	9 28.1	1 4.3	3 30.0	14 25.9
Marginal/Moderate variation	7 58.3	6 60.0	4 66.7	22 62.9	25 83.3	14 87.5	15 83.3	206 68.0	18 56.3	19 82.6	5 50.0	38 70.4
Substantial variation	0 0.0	3 30.0	2 33.3	5 14.3	1 3.3	0 0.0	2 11.1	70 23.1	5 15.6	3 13.0	2 20.0	2 3.7
Transgender/transsexual population												
No variation	4 36.4	1 10.0	1 16.7	6 17.6	4 13.8	2 12.5	1 5.6	40 13.2	7 21.9	1 4.3	2 25.0	16 29.6
Marginal/Moderate variation	6 54.5	9 90.0	4 66.7	26 76.5	25 86.2	12 75.0	16 88.9	208 68.6	23 71.9	19 82.6	5 62.5	34 63.0
Substantial variation	1 9.1	0 0.0	1 16.7	2 5.9	0 0.0	2 12.5	1 5.6	55 18.2	2 6.3	3 13.0	1 12.5	4 7.4
Transgender/transsexual sex workers												
No variation	2 16.7	1 10.0	0 0.0	10 28.6	3 10.0	2 12.5	1 5.6	22 7.3	7 21.9	1 4.8	3 33.3	13 23.2
Marginal/Moderate variation	9 75.0	5 50.0	5 83.3	22 62.9	26 86.7	12 75.0	15 83.3	211 69.6	20 62.5	17 81.0	4 44.4	40 71.4
Substantial variation	1 8.3	4 40.0	1 16.7	3 8.6	1 3.3	2 12.5	2 11.1	70 23.1	5 15.6	3 14.3	2 22.2	3 5.4

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Table 20. Opinion on the roles to be played if self-sampling was to be approved.

	Decission makers/Public health professionals								Health care professionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=38)		South EU (N=24)		Central EU (N=23)		Spain (N=399)		North EU (N=41)		South EU (N=43)		Central EU (N=13)		Spain (N=74)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Would carry out this role:																								
Active promotion of self-sampling																								
Major role	3	25.0	4	40.0	0	0.0	14	45.2	3	10.0	4	26.7	5	29.4	135	46.1	19	59.4	11	52.4	6	54.5	23	43.4
Minor role	7	58.3	4	40.0	4	66.7	9	29.0	15	50.0	9	60.0	6	35.3	111	37.9	8	25.0	5	23.8	3	27.3	18	34.0
No role	2	16.7	2	20.0	2	33.3	8	25.8	12	40.0	2	13.3	6	35.3	47	16.0	5	15.6	5	23.8	2	18.2	12	22.6
Over-the-counter distribution of self-sampling																								
Major role	1	8.3	1	10.0	0	0.0	5	16.1	3	10.0	4	26.7	2	11.8	104	35.5	9	29.0	4	19.0	5	45.5	31	58.5
Minor role	0	0.0	6	60.0	2	33.3	12	38.7	6	20.0	4	26.7	7	41.2	106	36.2	14	45.2	10	47.6	3	27.3	13	24.5
No role	11	91.7	3	30.0	4	66.7	14	45.2	21	70.0	7	46.7	8	47.1	83	28.3	8	25.8	7	33.3	3	27.3	9	17.0
Mail distribution of self-sampling																								
Major role	1	8.3	1	10.0	0	0.0	2	6.5	1	3.3	2	13.3	1	5.6	46	15.7	10	31.3	3	14.3	5	45.5	18	34.0
Minor role	1	8.3	6	60.0	1	16.7	9	29.0	4	13.3	3	20.0	8	44.4	73	24.9	9	28.1	6	28.6	2	18.2	12	22.6
No role	10	83.3	3	30.0	5	83.3	20	64.5	25	83.3	10	66.7	9	50.0	174	59.4	13	40.6	12	57.1	4	36.4	23	43.4
Provision of information about where to obtain a self-sampling kit																								
Major role	1	8.3	4	40.0	1	16.7	14	45.2	4	13.8	6	40.0	5	27.8	174	59.4	21	65.6	12	57.1	7	63.6	35	66.0
Minor role	8	66.7	6	60.0	2	33.3	11	35.5	17	58.6	7	46.7	10	55.6	94	32.1	10	31.3	9	42.9	3	27.3	14	26.4
No role	3	25.0	0	0.0	3	50.0	6	19.4	8	27.6	2	13.3	3	16.7	25	8.5	1	3.1	0	0.0	1	9.1	4	7.5
Consultations about limitations of self-sampling																								
Major role	2	16.7	5	50.0	1	16.7	11	35.5	8	26.7	9	60.0	9	50.0	203	69.3	25	78.1	12	54.5	9	81.8	39	72.2
Minor role	5	41.7	5	50.0	2	33.3	16	51.6	15	50.0	3	20.0	7	38.9	66	22.5	6	18.8	7	31.8	2	18.2	12	22.2
No role	5	41.7	0	0.0	3	50.0	4	12.9	7	23.3	3	20.0	2	11.1	24	8.2	1	3.1	3	13.6	0	0.0	3	5.6
Consultations on sexual health, risk reduction strategies, etc																								
Major role	2	16.7	5	50.0	2	33.3	11	35.5	9	30.0	8	53.3	9	50.0	211	72.0	24	75.0	13	59.1	9	81.8	41	77.4
Minor role	3	25.0	5	50.0	1	16.7	14	45.2	15	50.0	4	26.7	6	33.3	59	20.1	5	15.6	4	18.2	2	18.2	11	20.8
No role	7	58.3	0	0.0	3	50.0	6	19.4	6	20.0	3	20.0	3	16.7	23	7.8	3	9.4	5	22.7	0	0.0	1	1.9
Communication of the result																								
Major role	2	16.7	2	20.0	1	16.7	3	9.7	3	10.0	8	53.3	9	50.0	163	55.8	13	40.6	10	45.5	5	45.5	34	64.2
Minor role	0	0.0	4	40.0	2	33.3	11	35.5	9	30.0	3	20.0	6	33.3	78	26.7	14	43.8	3	13.6	4	36.4	12	22.6
No role	10	83.3	4	40.0	3	50.0	17	54.8	18	60.0	4	26.7	3	16.7	51	17.5	5	15.6	9	40.9	2	18.2	7	13.2
Support services for those obtaining a positive result																								
Major role	2	16.7	4	40.0	1	16.7	6	19.4	7	23.3	8	53.3	12	66.7	164	56.0	16	50.0	10	45.5	4	36.4	28	52.8
Minor role	3	25.0	4	40.0	2	33.3	8	25.8	11	36.7	2	13.3	5	27.8	70	23.9	11	34.4	3	13.6	5	45.5	16	30.2
No role	7	58.3	2	20.0	3	50.0	17	54.8	12	40.0	5	33.3	1	5.6	59	20.1	5	15.6	9	40.9	2	18.2	9	17.0
Reference center for confirmation purposes																								
Major role	2	16.7	4	40.0	0	0.0	8	25.8	11	36.7	5	33.3	10	52.6	189	64.5	21	65.6	17	77.3	7	63.6	44	83.0
Minor role	2	16.7	6	60.0	4	66.7	9	29.0	11	36.7	8	53.3	4	21.1	70	23.9	9	28.1	2	9.1	3	27.3	6	11.3
No role	8	66.7	0	0.0	2	33.3	14	45.2	8	26.7	2	13.3	5	26.3	34	11.6	2	6.3	3	13.6	1	9.1	3	5.7

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Table 21: Personal knowledge and position towards self-testing, reasons to be in favour/against and willingness to pay 25-30 euros for a self test by the population they work with by area of work and region

	Decision makers/Public health professionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=38)		South EU (N=24)		Central EU (N=23)		Spain (N=399)		North EU (N=41)		South EU (N=43)		Central EU (N=13)		Spain (N=74)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Knows about the existence of self-testing	12	92.3	10	100	4	66.7	21	67.7	27	90.0	6	42.9	16	84.2	93	32.2	32	97.0	10	45.5	10	90.9	38	71.7
PERSONAL Position towards self-testing																								
In favour	6	46.2	2	20.0	2	33.3	16	55.2	18	60.0	6	40.0	8	44.4	189	67.5	19	59.4	9	40.9	6	54.5	18	35.3
Against	2	15.4	4	40.0	2	33.3	1	3.4	4	13.3	1	6.7	2	11.1	14	5.0	2	6.3	2	9.1	1	9.1	10	19.6
Not sure	5	38.5	4	40.0	2	33.3	12	41.4	8	26.7	8	53.3	8	44.4	77	27.5	11	34.4	11	50.0	4	36.4	23	45.1
Reasons to be in favour of self-testing of THE POPULATION THEY SERVE																								
It helps to keep their privacy	2	15.4	5	50.0	3	50.0	12	41.4	5	17.2	7	46.7	9	56.3	90	33.5	8	26.7	7	35.0	2	18.2	16	32.7
It saves them judgemental attitudes	0	0.0	2	20.0	0	0.0	2	6.9	5	17.2	2	13.3	1	6.3	71	26.4	4	13.3	3	15.0	2	18.2	11	22.4
It helps to avoid intimate questions and/or counselling	5	38.5	0	0.0	1	16.7	4	13.8	3	10.3	1	6.7	1	6.3	18	6.7	4	13.3	0	0.0	0	0.0	7	14.3
It helps to test whenever they can/want	4	30.8	0	0.0	1	16.7	5	17.2	10	34.5	4	26.7	4	25.0	54	20.1	7	23.3	9	45.0	1	9.1	7	14.3
It saves time, paperwork, queues, waiting time	2	15.4	2	20.0	1	16.7	1	3.4	1	3.4	1	6.7	0	0.0	9	3.3	1	3.3	0	0.0	2	18.2	4	8.2
It contributes to take responsibility for their own health	0	0.0	1	10.0	0	0.0	3	10.3	4	13.8	0	0.0	1	6.3	23	8.6	3	10.0	1	5.0	4	36.4	3	6.1
Other	0	0.0	0	0.0	0	0.0	2	6.9	1	3.4	0	0.0	0	0.0	4	1.5	3	10.0	0	0.0	0	0.0	1	2.0
Reasons to be against self-testing THE POPULATION THEY SERVE																								
The presence of an expert to provide counselling and inform about the result is essential	5	38.5	5	50.0	4	66.7	19	63.3	14	48.3	11	73.3	6	37.5	103	38.1	16	53.3	10	50.0	3	27.3	23	50.0
Performing the test and interpreting the results should be done by a professional	3	23.1	1	10.0	1	16.7	5	16.7	5	17.2	1	6.7	4	25.0	61	22.6	7	23.3	2	10.0	2	18.2	11	23.9
Concernes about the quality of the test and the validity of the results	1	7.7	1	10.0	1	16.7	3	10.0	6	20.7	2	13.3	5	31.3	52	19.3	2	6.7	5	25.0	3	27.3	2	4.3
Self-testing may help to maintain HIV as a matter of taboo/shame	2	15.4	2	20.0	0	0.0	2	6.7	2	6.9	0	0.0	0	0.0	25	9.3	0	0.0	1	5.0	0	0.0	4	8.7
People could be forced to self-test in front of their partner	1	7.7	1	10.0	0	0.0	0	0.0	0	0.0	0	0.0	1	6.3	15	5.6	2	6.7	2	10.0	3	27.3	3	6.5
Other	1	7.7	0	0.0	0	0.0	1	3.3	2	6.9	1	6.7	0	0.0	14	5.2	3	10.0	0	0.0	0	0.0	3	6.5
The population they serve would pay 25-30 euros																								
Never	0	0.0	5	50.0	0	0.0	2	6.3	2	6.9	1	6.7	2	11.8	16	5.9	1	3.3	4	20.0	3	27.3	15	29.4
No unless in great distress	7	53.8	4	40.0	3	50.0	18	56.3	9	31.0	10	66.7	9	52.9	176	64.7	14	46.7	12	60.0	5	45.5	27	52.9
Yes	6	46.2	1	10.0	3	50.0	12	37.5	18	62.1	4	26.7	6	35.3	80	29.4	15	50.0	4	20.0	3	27.3	9	17.6

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Table 22. Reasons given by stakeholders to be in favour/against self-testing by area of work region (open ended question)

	Decision makers/Public health professionals								Healthcare professionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Main reason to be in favour of self-testing																								
It gives privacy	0	.0	0	.0	0	.0	2	13.3	0	.0	1	50.0	0	.0	29	20.4	0	.0	0	.0	0	.0	5	26.3
It allows to test whenever/wherever	1	25.0	0	.0	0	.0	3	20.0	2	18.2	0	.0	0	.0	16	11.3	1	6.7	0	.0	0	.0	3	15.8
It saves time, paperwork, queues	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	1	.7	0	.0	0	.0	0	.0	0	.0
It contributes to self-responsabilization of ones health	0	.0	0	.0	0	.0	2	13.3	0	.0	1	50.0	0	.0	8	5.6	0	.0	1	33.3	0	.0	1	5.3
It avoids counselling and answering to intimate questions	0	.0	0	.0	0	.0	0	.0	1	9.1	0	.0	0	.0	7	4.9	0	.0	0	.0	0	.0	2	10.5
It saves from judgmental attitudes	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0
Would contribute to reduce the undiagnosed fraction of the epidemic	1	25.0	1	50.0	0	.0	4	26.7	1	9.1	0	.0	0	.0	31	21.8	4	26.7	0	.0	0	.0	4	21.1
Diversification of testing options	1	25.0	0	.0	0	.0	1	6.7	1	9.1	0	.0	0	.0	11	7.7	7	46.7	0	.0	1	33.3	2	10.5
Would be an option for those that do not want/can acess already existing services	1	25.0	1	50.0	0	.0	2	13.3	2	18.2	0	.0	0	.0	9	6.3	1	6.7	0	.0	0	.0	0	.0
Others	0	.0	0	.0	0	.0	1	6.7	3	27.3	0	.0	1	100.0	26	18.3	2	13.3	2	66.7	1	33.3	1	5.3
I don´t know	0	.0	0	.0	0	.0	0	.0	1	9.1	0	.0	0	.0	4	2.8	0	.0	0	.0	1	33.3	1	5.3
Main reason to be against self-testing																								
The presence of a professional to provide counselling and give the result is essential	2	50.0	4	100.0	2	100.0	7	70.0	4	66.7	2	66.7	1	33.3	22	36.7	3	33.3	1	33.3	1	25.0	16	72.7
Obtaining the sample, performing the test and interpreting the results should be done by a professional	0	.0	0	.0	0	.0	0	.0	2	33.3	0	.0	0	.0	10	16.7	3	33.3	0	.0	0	.0	1	4.5
Concerns about the validity of the results	1	25.0	0	.0	0	.0	1	10.0	0	.0	0	.0	2	66.7	7	11.7	0	.0	1	33.3	1	25.0	0	.0
It maintains HIV as a matter of taboo/shame	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	1	1.7	1	11.1	0	.0	0	.0	0	.0
Concerns regarding the result confirmation and linkage to care	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	2	3.3	1	11.1	0	.0	0	.0	1	4.5
Concerns about the reaction to a reactive self-test	1	25.0	0	.0	0	.0	1	10.0	0	.0	1	33.3	0	.0	3	5.0	0	.0	0	.0	1	25.0	2	9.1
Concerns related to the window period	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	0	.0	3	5.0	0	.0	1	33.3	0	.0	1	4.5
Others	0	0.0	0	0.0	0	0.0	1	10.0	0	0.0	0	0.0	0	0.0	12	20.0	1	11.1	0	0.0	1	25.0	1	4.5

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Table 23. Potential use of self-testing if already available and preferences regarding the result confirmation by the population they serve by area of work and region

	Decission makers/Public health proffesionals								CBO professionals			
	North EU (N=18)	South EU (N=16)	Central EU (N=7)	Spain (N=41)	North EU (N=38)	South EU (N=24)	Central EU (N=23)	Spain (N=399)	North EU (N=41)	South EU (N=43)	Central EU (N=13)	Spain (N=74)
	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %
The population you serve would have used self-testing if already available												
Yes/Probably yes	10 76.9	3 30.0	4 66.7	25 80.6	26 89.7	10 66.7	12 75.0	198 73.3	23 79.3	11 55.0	6 54.5	31 60.8
Not sure	1 7.7	3 30.0	1 16.7	4 12.9	2 6.9	4 26.7	1 6.3	38 14.1	3 10.3	5 25.0	3 27.3	13 25.5
No/Probably no	2 15.4	4 40.0	1 16.7	2 6.5	1 3.4	1 6.7	3 18.8	34 12.6	3 10.3	4 20.0	2 18.2	7 13.7
Why yes												
It is anonymous and discreet	5 45.5	2 50.0	4 80.0	14 51.9	9 33.3	6 46.2	6 50.0	100 44.2	14 53.8	3 20.0	2 25.0	16 41.0
They can obtain a result quickly	0 0.0	0 0.0	0 0.0	7 25.9	8 29.6	1 7.7	2 16.7	58 25.7	3 11.5	0 0.0	2 25.0	8 20.5
It gives them autonomy	0 0.0	0 0.0	0 0.0	1 3.7	4 14.8	3 23.1	1 8.3	31 13.7	2 7.7	3 20.0	0 0.0	8 20.5
They offer an HIV test to their sexual partners	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	1 7.7	0 0.0	5 2.2	1 3.8	0 0.0	0 0.0	0 0.0
It is practical and convenient	3 27.3	0 0.0	0 0.0	4 14.8	5 18.5	0 0.0	2 16.7	16 7.1	6 23.1	3 20.0	1 12.5	2 5.1
It allows them to test more regularly	2 18.2	2 50.0	1 20.0	1 3.7	0 0.0	0 0.0	1 8.3	12 5.3	0 0.0	5 33.3	2 25.0	1 2.6
It is less stressful	1 9.1	0 0.0	0 0.0	0 0.0	1 3.7	2 15.4	0 0.0	3 1.3	0 0.0	1 6.7	0 0.0	3 7.7
Other	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	1 0.4	0 0.0	0 0.0	1 12.5	1 2.6
Why no												
Fear of not using it properly	1 33.3	0 0.0	1 50.0	1 20.0	1 33.3	0 0.0	2 50.0	4 5.9	1 16.7	2 22.2	0 0.0	5 29.4
Fear of receiving a test result alone at home	0 0.0	2 40.0	0 0.0	1 20.0	2 66.7	2 50.0	0 0.0	10 14.7	0 0.0	0 0.0	1 20.0	5 29.4
People that do not feel they are in need of testing, will not change their opinion	0 0.0	1 20.0	0 0.0	2 40.0	0 0.0	1 25.0	2 50.0	28 41.2	3 50.0	3 33.3	3 60.0	3 17.6
People will keep on going to their usual testing sites	0 0.0	1 20.0	1 50.0	0 0.0	0 0.0	1 25.0	0 0.0	15 22.1	0 0.0	1 11.1	0 0.0	3 17.6
Self-testing is not reliable	1 33.3	0 0.0	0 0.0	1 20.0	0 0.0	0 0.0	0 0.0	6 8.8	0 0.0	0 0.0	0 0.0	0 0.0
Other	1 33.3	1 20.0	0 0.0	0 0.0	0 0.0	0 0.0	0 0.0	5 7.4	2 33.3	3 33.3	1 20.0	1 5.9
Preferred setting for confirmation of the population they serve												
CBO/NGO (office, outreach activities)	5 45.5	0 0.0	0 0.0	2 6.9	2 7.1	0 0.0	1 6.7	5 2.0	7 25.9	7 38.9	2 18.2	18 39.1
Sexual health clinic	3 27.3	3 42.9	1 25.0	7 24.1	15 53.6	4 30.8	8 53.3	40 15.7	8 29.6	4 22.2	6 54.5	15 32.6
Healthcare setting non specialized in HIV/STI*	3 27.3	3 42.9	3 75.0	11 37.9	6 21.4	5 38.5	4 26.7	63 24.7	8 29.6	7 38.9	1 9.1	12 26.1
Primary care	0 0.0	0 0.0	0 0.0	8 27.6	5 17.9	3 23.1	0 0.0	141 55.3	4 14.8	0 0.0	0 0.0	1 2.2
Private laboratory	0 0.0	1 14.3	0 0.0	0 0.0	0 0.0	1 7.7	2 13.3	4 1.6	0 0.0	0 0.0	2 18.2	0 0.0
Other	0 0.0	0 0.0	0 0.0	1 3.4	0 0.0	0 0.0	0 0.0	2 0.8	0 0.0	0 0.0	0 0.0	0 0.0

*Includes: "Hospital or clinic", "Office of medical specialist", "Emergency room"

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Table 24. Impact of self-testing if approved in testing frequency of several population groups by area of work and region

	Decission makers/Public health proffesionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=38)		South EU (N=24)		Central EU (N=23)		Spain (N=399)		North EU (N=41)		South EU (N=43)		Central EU (N=13)		Spain (N=74)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
If available, self-testing would have led to an increase in the testing frequency among:																								
Men who have sex with men																								
No	0	0.0	0	0.0	0	0.0	1	3.6	2	6.9	0	0.0	3	18.8	5	1.9	0	0.0	0	0.0	1	9.1	2	4.4
Yes, slightly/moderately	9	81.8	1	11.1	5	83.3	18	64.3	17	58.6	9	64.3	7	43.8	146	56.4	19	67.9	8	40.0	7	63.6	31	68.9
Yes, substantially	2	18.2	8	88.9	1	16.7	9	32.1	10	34.5	5	35.7	6	37.5	108	41.7	9	32.1	12	60.0	3	27.3	12	26.7
Male sex workers																								
No	3	27.3	0	0.0	0	0.0	1	3.6	2	6.9	0	0.0	3	20.0	11	4.3	3	11.1	1	5.0	1	9.1	8	18.2
Yes, slightly/moderately	7	63.6	6	66.7	5	83.3	23	82.1	22	75.9	7	53.8	8	53.3	157	60.9	19	70.4	11	55.0	8	72.7	29	65.9
Yes, substantially	1	9.1	3	33.3	1	16.7	4	14.3	5	17.2	6	46.2	4	26.7	90	34.9	5	18.5	8	40.0	2	18.2	7	15.9
Transgender/transsexual population																								
No	1	9.1	0	0.0	0	0.0	2	7.1	3	10.3	0	0.0	3	20.0	22	8.5	2	7.7	1	5.3	2	22.2	10	23.8
Yes, slightly/moderately	10	90.9	7	77.8	5	83.3	22	78.6	24	82.8	6	46.2	10	66.7	176	68.2	21	80.8	12	63.2	5	55.6	26	61.9
Yes, substantially	0	0.0	2	22.2	1	16.7	4	14.3	2	6.9	7	53.8	2	13.3	60	23.3	3	11.5	6	31.6	2	22.2	6	14.3
Transgender/transsexual sex workers																								
No	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	3	20.0	10	3.9	0	0.0	1	5.3	1	11.1	9	20.9
Yes, slightly/moderately	9	81.8	4	44.4	5	83.3	23	82.1	24	82.8	7	53.8	8	53.3	158	61.0	21	77.8	12	63.2	6	66.7	25	58.1
Yes, substantially	1	9.1	5	55.6	1	16.7	5	17.9	5	17.2	6	46.2	4	26.7	91	35.1	6	22.2	6	31.6	2	22.2	9	20.9
Variation of current use of existing sites if self-testing was approved:																								
Men who have sex with men																								
No variation	0	0.0	0	0.0	0	0.0	3	10.3	1	3.4	1	7.1	1	6.3	9	3.6	2	7.1	0	0.0	2	18.2	3	6.8
Marginal/Moderate variation	10	100	3	33.3	6	100	20	69.0	23	79.3	9	64.3	13	81.3	170	67.7	21	75.0	12	63.2	6	54.5	34	77.3
Substantial variation	0	0.0	6	66.7	0	0.0	6	20.7	5	17.2	4	28.6	2	12.5	72	28.7	5	17.9	7	36.8	3	27.3	7	15.9
Male sex workers																								
No variation	4	40.0	0	0.0	0	0.0	4	14.3	2	6.9	0	0.0	2	13.3	15	6.0	5	18.5	2	10.5	2	20.0	7	16.7
Marginal/Moderate variation	6	60.0	7	77.8	6	100	19	67.9	23	79.3	8	61.5	12	80.0	172	68.5	18	66.7	12	63.2	6	60.0	30	71.4
Substantial variation	0	0.0	2	22.2	0	0.0	5	17.9	4	13.8	5	38.5	1	6.7	64	25.5	4	14.8	5	26.3	2	20.0	5	11.9
Transgender/transsexual population																								
No variation	1	10.0	0	0.0	1	16.7	8	27.6	3	10.3	0	0.0	2	13.3	23	9.2	1	3.7	1	5.6	3	33.3	10	23.8
Marginal/Moderate variation	9	90.0	7	77.8	5	83.3	18	62.1	25	86.2	8	61.5	12	80.0	181	72.4	24	88.9	15	83.3	5	55.6	28	66.7
Substantial variation	0	0.0	2	22.2	0	0.0	3	10.3	1	3.4	5	38.5	1	6.7	46	18.4	2	7.4	2	11.1	1	11.1	4	9.5
Transgender/transsexual sex workers																								
No variation	0	0.0	0	0.0	0	0.0	3	10.3	1	3.4	0	0.0	2	13.3	15	6.0	3	11.1	0	0.0	2	22.2	8	18.6
Marginal/Moderate variation	10	100	7	77.8	6	100	22	75.9	24	82.8	9	69.2	12	80.0	170	67.7	20	74.1	14	77.8	5	55.6	29	67.4
Substantial variation	0	0.0	2	22.2	0	0.0	4	13.8	4	13.8	4	30.8	1	6.7	66	26.3	4	14.8	4	22.2	2	22.2	6	14.0

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Table 25. Opinion on the roles to be played if self-testing was to be approved.

	Decision makers/Public health professionals								CBO professionals			
	North EU (N=18)	South EU (N=16)	Central EU (N=7)	Spain (N=41)	North EU (N=38)	South EU (N=24)	Central EU (N=23)	Spain (N=399)	North EU (N=41)	South EU (N=43)	Central EU (N=13)	Spain (N=74)
	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %
Would carry out this role:												
Active promotion of self-testing												
Major role	4 40.0	4 44.4	1 16.7	13 44.8	1 3.4	3 23.1	3 21.4	126 50.8	11 42.3	6 31.6	5 45.5	19 46.3
Minor role	3 30.0	3 33.3	2 33.3	13 44.8	17 58.6	9 69.2	6 42.9	83 33.5	10 38.5	7 36.8	5 45.5	14 34.1
No role	3 30.0	2 22.2	3 50.0	3 10.3	11 37.9	1 7.7	5 35.7	39 15.7	5 19.2	6 31.6	1 9.1	8 19.5
Over-the-counter distribution of self-testing												
Major role	1 10.0	3 33.3	1 16.7	8 28.6	1 3.4	1 7.7	1 7.1	86 34.7	9 34.6	3 15.8	6 54.5	19 46.3
Minor role	1 10.0	2 22.2	1 16.7	7 25.0	7 24.1	7 53.8	5 35.7	82 33.1	9 34.6	5 26.3	1 9.1	11 26.8
No role	8 80.0	4 44.4	4 66.7	13 46.4	21 72.4	5 38.5	8 57.1	80 32.3	8 30.8	11 57.9	4 36.4	11 26.8
Mail distribution of self-testing												
Major role	1 10.0	1 11.1	1 16.7	1 3.6	0 0.0	0 0.0	0 0.0	33 13.4	4 15.4	3 15.8	6 54.5	11 25.6
Minor role	0 0.0	5 55.6	0 0.0	10 35.7	5 17.2	4 30.8	4 28.6	62 25.2	10 38.5	6 31.6	1 9.1	11 25.6
No role	9 90.0	3 33.3	5 83.3	17 60.7	24 82.8	9 69.2	10 71.4	151 61.4	12 46.2	10 52.6	4 36.4	21 48.8
Provision of information about where to obtain a self-testing kit												
Major role	1 10.0	6 66.7	1 16.7	14 50.0	2 6.9	4 30.8	2 14.3	141 57.1	15 57.7	13 68.4	6 54.5	25 59.5
Minor role	5 50.0	3 33.3	4 66.7	7 25.0	17 58.6	7 53.8	8 57.1	83 33.6	9 34.6	6 31.6	4 36.4	13 31.0
No role	4 40.0	0 0.0	1 16.7	7 25.0	10 34.5	2 15.4	4 28.6	23 9.3	2 7.7	0 0.0	1 9.1	4 9.5
Consultations about the limitations of self-testing												
Major role	2 18.2	6 66.7	1 16.7	13 46.4	6 20.7	10 76.9	6 42.9	176 71.5	18 69.2	13 65.0	7 63.6	30 75.0
Minor role	5 45.5	3 33.3	3 50.0	7 25.0	17 58.6	2 15.4	6 42.9	49 19.9	5 19.2	5 25.0	4 36.4	8 20.0
No role	4 36.4	0 0.0	2 33.3	8 28.6	6 20.7	1 7.7	2 14.3	21 8.5	3 11.5	2 10.0	0 0.0	2 5.0
Consultations on sexual health, risk reduction strategies, etc												
Major role	2 18.2	4 44.4	2 33.3	11 37.9	9 31.0	10 76.9	7 46.7	183 73.8	16 61.5	13 68.4	6 60.0	32 78.0
Minor role	5 45.5	4 44.4	1 16.7	9 31.0	15 51.7	2 15.4	6 40.0	42 16.9	8 30.8	3 15.8	3 30.0	9 22.0
No role	4 36.4	1 11.1	3 50.0	9 31.0	5 17.2	1 7.7	2 13.3	23 9.3	2 7.7	3 15.8	1 10.0	0 0.0
Support services for those obtaining a reactive result												
Major role	2 18.2	6 75.0	0 0.0	8 28.6	11 37.9	6 46.2	7 46.7	167 67.9	17 65.4	15 78.9	4 36.4	33 80.5
Minor role	2 18.2	1 12.5	3 50.0	9 32.1	12 41.4	6 46.2	5 33.3	50 20.3	5 19.2	2 10.5	4 36.4	4 9.8
No role	7 63.6	1 12.5	3 50.0	11 39.3	6 20.7	1 7.7	3 20.0	29 11.8	4 15.4	2 10.5	3 27.3	4 9.8
Reference center for confirmation purposes												
Major role	3 27.3	4 44.4	1 16.7	4 14.3	11 37.9	6 46.2	8 57.1	148 59.9	13 50.0	6 31.6	3 27.3	23 56.1
Minor role	1 9.1	3 33.3	1 16.7	8 28.6	9 31.0	3 23.1	5 35.7	56 22.7	5 19.2	4 21.1	5 45.5	12 29.3
No role	7 63.6	2 22.2	4 66.7	16 57.1	9 31.0	4 30.8	1 7.1	43 17.4	8 30.8	9 47.4	3 27.3	6 14.6

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Table 26. Perception about the approval of self-testing by area of work and region (open ended question)

	Decisionmakers/Public health professionals								Health care professionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
STATE OF THE DISCUSSION REGARDING THE APPROVAL OF SELF-TESTING																								
The discussion is open	2	100.0	3	60.0	1	100.0	9	50.0	4	44.4	1	20.0	1	33.3	9	7.3	8	72.7	3	30.0	2	33.3	8	38.1
The discussion is not open/ It is not on the political agenda	0	0.0	2	40.0	0	0.0	4	22.2	2	22.2	2	40.0	0	0.0	23	18.5	1	9.1	4	40.0	3	50.0	4	19.0
Does not know	0	0.0	0	0.0	0	0.0	5	27.8	3	33.3	2	40.0	2	66.7	92	74.2	2	18.2	3	30.0	1	16.7	9	42.9
PERSONAL OPINION ON FUTURE APPROVAL																								
It will be approved	7	100.0	2	40.0	3	100.0	15	71.4	5	71.4	3	60.0	1	100.0	58	38.4	12	100.0	4	80.0	3	100.0	7	36.8
Will not be approved/Has serious doubts it will be approved	0	0.0	1	20.0	0	0.0	1	4.8	1	14.3	1	20.0	0	0.0	14	9.3	0	0.0	1	20.0	0	0.0	3	15.8
Does not know	0	0.0	2	40.0	0	0.0	5	23.8	1	14.3	1	20.0	0	0.0	79	52.3	0	0.0	0	0.0	0	0.0	9	47.4
GENERAL ATTITUDE TOWARDS SELF-TESTING																								
There is an open/positive attitude towards self-testing	2	66.7	1	100.0	0	0.0	8	44.4	1	9.1	2	50.0	0	0.0	38	23.6	5	35.7	1	50.0	1	33.3	4	16.7
There is an attittude of rejection towards self-testing	0	0.0	0	0.0	0	0.0	2	11.1	0	0.0	0	0.0	0	0.0	9	5.6	2	14.3	0	0.0	0	0.0	3	12.5
There are doubts, concerns about its implementation	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4	2.5	1	7.1	0	0.0	0	0.0	3	12.5
Its implementation will depend on its price	0	0.0	0	0.0	0	0.0	1	5.6	0	0.0	0	0.0	0	0.0	11	6.8	0	0.0	0	0.0	0	0.0	3	12.5
It will not be in demand	0	0.0	0	0.0	0	0.0	0	0.0	2	18.2	0	0.0	0	0.0	4	2.5	1	7.1	1	50.0	1	33.3	1	4.2
Attitude will be favourable among potential users, not so much among professionals	1	33.3	0	0.0	0	0.0	1	5.6	0	0.0	1	25.0	0	0.0	3	1.9	1	7.1	0	0.0	0	0.0	0	0.0
Does not know	0	0.0	0	0.0	0	0.0	5	27.8	0	0.0	1	25.0	1	20.0	78	48.4	0	0.0	0	0.0	0	0.0	9	37.5
Others	0	0.0	0	0.0	1	100.0	1	5.6	8	72.7	0	0.0	4	80.0	14	8.7	4	28.6	0	0.0	1	33.3	1	4.2

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Table 27. Effect of past use of rapid test on likeliness to use it in the future, on testing frequency and preferred option to seek for a rapid test according to the opinion of stakeholders' area of work and region

	Decission makers/Public health proffesionals								Health care professionals								CBO professionals							
	North EU (N=18)		South EU (N=16)		Central EU (N=7)		Spain (N=41)		North EU (N=38)		South EU (N=24)		Central EU (N=23)		Spain (N=399)		North EU (N=41)		South EU (N=43)		Central EU (N=13)		Spain (N=74)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Likeliness to have another rapid test in the furture based on peoples past experience with this testing method																								
Much less likely	1	9.1	0	0.0	0	0.0	1	3.7	0	0.0	2	18.2	1	8.3	8	3.4	2	7.7	0	0.0	1	10.0	2	4.7
Less likely	1	9.1	0	0.0	0	0.0	2	7.4	0	0.0	0	0.0	0	0.0	5	2.1	0	0.0	1	5.0	0	0.0	4	9.3
Same as before	2	18.2	0	0.0	1	16.7	4	14.8	3	10.7	1	9.1	3	25.0	38	16.0	3	11.5	1	5.0	2	20.0	4	9.3
More likely	5	45.5	4	44.4	4	66.7	19	70.4	19	67.9	5	45.5	6	50.0	140	59.1	12	46.2	8	40.0	3	30.0	17	39.5
Much more likely	2	18.2	5	55.6	1	16.7	1	3.7	6	21.4	3	27.3	2	16.7	46	19.4	9	34.6	10	50.0	4	40.0	16	37.2
Likeliness to increase testing frequency based on peoples past experience with rapid testing																								
Much less likely	1	9.1	0	0.0	0	0.0	0	0.0	0	0.0	1	9.1	1	7.7	8	3.4	2	7.7	0	0.0	1	10.0	2	4.5
Less likely	0	0.0	0	0.0	0	0.0	2	7.4	0	0.0	0	0.0	0	0.0	8	3.4	0	0.0	2	10.0	0	0.0	4	9.1
Same as before	2	18.2	0	0.0	3	50.0	9	33.3	4	14.3	1	9.1	3	23.1	48	20.4	2	7.7	0	0.0	2	20.0	9	20.5
More likely	7	63.6	6	66.7	2	33.3	16	59.3	21	75.0	6	54.5	8	61.5	139	59.1	16	61.5	12	60.0	3	30.0	21	47.7
Much more likely	1	9.1	3	33.3	1	16.7	0	0.0	3	10.7	3	27.3	1	7.7	32	13.6	6	23.1	6	30.0	4	40.0	8	18.2
Stakeholders' target population preferred option to be tested for HIV using rapid test																								
CBO/NGO (office, outreach activities)	5	50.0	5	71.4	1	20.0	12	42.9	8	29.6	5	50.0	6	54.5	18	8.0	13	54.2	14	70.0	4	36.4	26	66.7
Sexual health clinic	4	40.0	1	14.3	2	40.0	4	14.3	15	55.6	2	20.0	2	18.2	38	16.9	6	25.0	5	25.0	2	18.2	9	23.1
Healthcare setting not specialized in HIV/STI*	1	10.0	0	0.0	2	40.0	4	14.3	2	7.4	1	10.0	2	18.2	30	13.3	4	16.7	0	0.0	3	27.3	2	5.1
General practitioner/family doctor	0	0.0	0	0.0	0	0.0	4	14.3	1	3.7	2	20.0	0	0.0	93	41.3	0	0.0	0	0.0	0	0.0	0	0.0
Private laboratory	0	0.0	1	14.3	0	0.0	0	0.0	0	0.0	0	0.0	1	9.1	3	1.3	0	0.0	0	0.0	1	9.1	1	2.6
At a pharmacy	0	0.0	0	0.0	0	0.0	4	14.3	0	0.0	0	0.0	0	0.0	15	6.7	0	0.0	0	0.0	0	0.0	1	2.6
Home	0	0.0	0	0.0	0	0.0	0	0.0	1	3.7	0	0.0	0	0.0	26	11.6	0	0.0	1	5.0	0	0.0	0	0.0
Elsewhere	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	.9	1	4.2	0	0.0	1	9.1	0	0.0

*Includes: "Hospital or clinic", "Office of medical specialist", "Emergency room"

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