



COBATEST data collection: report

Work Package 2: Monitoring

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28/02/2025



**Co-funded by
the European Union**

Co-funded by the European Union. Views and opinions expressed are however those of the author(s) only and do not necessarily reflect those of the European Union. Neither the European Union nor the granting authority can be held responsible for them.

Document Information	
Project Name	BOOST Project - BOOST access and quality of community-based communicable disease services for PWUD in the EU and neighbouring countries
Grant Agreement	101079910
Tasks	T 2.6, T 2.7, T 2.8
Deliverable	Deliverable 2.5 COBATEST Report
Contracted date of delivery	31.12.2024
Actual date of delivery	28.2.2025
Partner responsible	IGTP/ICO
Partners contributing	FRG/C-EHRN EHRA A-Clinic Foundation Free Clinic Podane ruce Villa Maraini EuroNPUD
Document status	Final
Total number of pages	37

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LIST OF ACRONYMS

HBV – Hepatitis B Virus

HCV – Hepatitis C Virus

HIV – Human Immunodeficiency Virus

MSM – Men Who Have Sex with Men

PrEP – Pre-exposure Prophylaxis

PWUD – People Who Use Drugs

PWID – People Who Inject Drugs

SW – Sex Worker

STI – Sexually Transmitted Infection

INTRODUCTION

Project BOOST is aimed at enhancing the implementation of high-quality, community-based communicable disease services as part of a comprehensive, people-centred, and integrated harm reduction approach.

To achieve its goals, BOOST implements a developed comprehensive approach in four key areas:

- **INFORM:** collection of information and data on community-based services for people who use drugs (PWUD).
- **IMPROVE:** organization of capacity building in the field of communicable disease.
- **SUPPORT:** enhancing scale-up of integrated community-based good practices.
- **CONNECT&ACT:** consolidating PWUD networks and fostering advocacy interventions.

The BOOST project involves three European harm reduction networks, supported by the European Network of People who Use Drugs, ensuring a wide range of experience and access to diverse risk populations across the EU and neighbouring regions. As part of the project, involved professionals are participating in data collection, knowledge sharing, capacity building, mutual coaching and learning, and the implementation of best practice models. Overall, BOOST aims to improve the availability and quality of communicable disease services for people who use drugs, enhance service providers capacities, and disseminate the results of the project to various stakeholders for advocacy purposes.

In the EU, harm reduction measures for HIV and viral hepatitis (VH) among PWUD are insufficient. Urgent scaling up of prevention and testing services, especially through community-based harm reduction organizations, is crucial. However, publicly available data tracking testing availability and linkage to care within such organizations is lacking.

The COBATEST network connects community-based organizations across Europe and Central Asia, providing voluntary counselling and HIV/VH/STI testing. It was developed in the context of the HIV-COBATEST project, and it's coordinated by the Centre for Epidemiological Studies on STI and AIDS in Catalonia (CEEISCAT) and Aids Action Europe. Currently, COBATEST network consists of 147 member CBVCTs from 28 European and 2 Central Asian countries. Full list of the network can be found [here](#).

The network uses standardized data collection instruments for monitoring and evaluating testing activities at the community level. The BOOST project, aimed at bolstering community-based organizations in providing communicable disease services, through its WP2, planned to adapt the COBATEST data collection tool to suit harm reduction services, enabling the collection of standardized data and reporting EU-wide indicators on testing activities for communicable infectious diseases.

During 2023, the COBATEST network data collection tools were adapted as necessary to the current needs of vulnerable population to HIV/STIs, following the Consensus Decision-Making Processes (please see annex 1) implemented with the BOOST expert team and the

expert group composed of members from the parallel Action Grant project [CORE \(Community Response to End Inequalities\)](#). All changes were approved by the COBATEST steering committee, which is made up of experts in the field and academia, in accordance with the network's internal procedures. Please see annex 2 for the list of all questions added or modified in the COBATEST data collection form.

This report presents a brief overview of the process of adapting the COBATEST data collection tools, the agreements reached pertaining to harm reduction, and the results of the data analysis collected by the COBATEST network in 2024 after the implementation of the changes.

METHODS

ADAPTATION OF THE TOOLS

An expert group from the BOOST consortium and Advisory Board discussed the adaptation of the COBATEST tool in two online meetings.

In preparation for the discussion on adapting the COBATEST tools in the expert online

meeting, a background document was developed and shared with all participants prior to the meeting. This document offered an overview of the COBATEST Network, outlined its data sharing methods and available tools, detailed current indicators, gender/key population variables while briefly explaining how these variables were derived. The document also included a set of questions designed to gather input, thoughts and ideas for improving and expanding these indicators and variables. Additionally, the document presented suggestions for new modules, questions and variables to be incorporated into the data collection form.

The proposals previously made by the expert groups were discussed in-depth together with all other details presented in the document as well as new points raised during the meetings. The Consent Decision Making process was employed to accept or reject the proposals and suggested changes. This decision-making mode is a process that allows groups to arrive at a mutually defined “acceptable and consensual” solution. Such viable solutions are about always being willing to compromise and accepting different perspectives.

At the same time, in the framework of the Action Grant CORE, a parallel process for the adaptation of the COBATEST data collection tools to the needs of key population groups took place. All proposals from the BOOST expert meetings were approved during the CORE expert meeting and the other way around.

All changes made were presented to the COBATEST network’s Steering Committee for approval as required by the COBATEST network’s internal regulations. The final version of the form is presented in this document together with all changes approved by CORE members, BOOST members, and the COBATEST network’s Steering Committee.

Detailed process of the adaptation of the tools, the proposals, and the agreements on all data collection questions are available in the CORE document Deliverable No: D5.1: Updated COBATEST tools.¹

¹ Fernández-López, L., Gogishvili, M., Alarcón, M., Vicente, M., Freitas, R., Gomes, F. (2023). *Updated COBATEST tools* (Deliverable No. D5.1). CORE - Community Response to End Inequalities (Project No. 101080079). IGTP-ICO (CEEISCAT) & GAT Portugal.

DATA COLLECTION

One of the yearly activities of the COBATEST network is collecting standardized data. There are three ways for members to submit data, specifically through: 1. COBATEST online data collection tool, 2. Disaggregated data through an excel file, 3. Aggregated data through pre-formatted excel file. This standardised data collection ensures data is comparable and can be analysed together. The data is submitted by 31st of March every year and is regulated by an agreement document that is signed between members and CEEISCAT at the time of their acceptance in the network. Description and instructions of all three methods of data submission is available [here](#).

Since COBATEST data for 2024 should be submitted by March 31st, 2025, the analysis provided in this report is based only on the data inputted by the COBATEST members into the COBATEST online data collection tool. This is because members input data throughout the year, not just at the end of the year.

To ensure uniformity in the data collected using the COBATEST data collection form, all COBATEST members were provided with the updated general [data collection form](#) (along with [PrEP and Chemsex updated data collection forms](#) and [other STIs form](#), in case they wish to collect data on them too), along with updated [instructions](#) on how to fill in the form with the definitions of the variables. An online training was also conducted in December 2023 to review all the changes and clarify the definitions of all variables, dedicating time at the end for Q&A to ensure everything was clear to everyone. The video was also recorded and shared with all members in case not everyone could attend the online meeting.

DEFINITIONS OF REFERRAL AND LINKAGE TO CARE

- Patient referred to healthcare system: whether the referral process has been started or in other words if a client with reactive HIV testing was referred/re-directed to the health care facility. This includes and is not limited to: flyer with the information, verbally explaining where to go, or calling and making an appointment.
- Patient linked to health care system: whether the client with reactive HIV test result attended first doctor's appointment at a health care facility after this diagnosis. This question can be filled in after your clients first visit with you - with a follow up call with the client, with a doctor, or with responsible person at a health care facility.

DATA ANALYSIS

As mentioned earlier, this report presents data only from member organisations using the COBATEST online data collection tool during 2024. Among these organisations, only three specifically target PWUD. Other member organisations working with PWUD share their data through other methods, so their data is not included in this analysis. We expect that, after further dissemination efforts, more harm reduction services and other organisations targeting PWUD will join COBATEST Network and begin using the online data collection tool.

All data were included in the analysis, regardless of the target population of the centre.

The data were analysed and presented in three parts: first, through a descriptive analysis of the main testing indicators disaggregated by gender, age groups, and key populations (men who have sex with men (MSM), PWUD, people who inject drugs (PWID), migrants, and sex workers (SW)); second, through a descriptive analysis of the new variables related to drug use; and finally, an analysis of the intersectionalities among the different key population groups, as well as integrated testing, with a focus on PWUD.

- *Testing indicators*

For this report the main testing indicators for HIV, HCV, HBV, and Syphilis were analysed, disaggregating them by gender, age groups, and key populations:

1. Number of tests performed
2. Number and percentage of reactive tests
3. Proportion of testing visits with previous tests.
4. Proportion of reactive cases referred and linked to care
5. Proportion of reactive cases with a confirmed diagnosis.

All indicators were reported **by gender (cisgender men, cisgender women, transgender men, transgender women), age (<16, 16-24, 25-45, 45-65, >65 years old) and key population at risk (MSM, SW, PWUD, PWID, Migrants).**

If a client is in two or more key populations, they were recorded as such (e.g. an PWUD SW would be recorded in two categories and then once in "All").

- *Descriptive Analysis of New Variables Related to Drug Use*

A descriptive analysis of following variables was conducted:

- Drug use
- Drug use route (injecting, sniffing/snorting, smoking, oral, other)
- Main drug used (cannabis, cocaine/crack cocaine, amphetamine/metamphetamine, MDMA, Heroin/other opioids, new psychoactive substances, other)
- Using material of injection that were already used by others in the last 12 months (syringes and/or needles, and spoons, filters, water.
- Using other material for non-injecting drug use that were already used by others in the last 12 months.
- Have you injected drugs in prison.
- Are you at opioid agonist treatment currently.
- Experience of homelessness

- *Integrating Testing*

For the analysis of integrated testing, Venn Diagrams were used for graphical representation of the combination of the number of tests performed (N, %) per testing visit with the different combinations of the 4 rapid tests (HIV, HCV, HVB, and Syphilis), for all the testing visits and for PWUD, and PWID. And the same for the reactive test results.

- *Intersectionalities*

For the analysis of intersectionalities among the different key population groups, Venn Diagrams were used for graphical representation of the Intersectionalities of key population groups (MSM, SW, PWUD, Migrants) among testing visits, and the same using PWID instead of PWUD. The same analysis was performed for reactive tests.

For the data analysis statistical software STATA® 15.0 and R version 4.4.1 were used. For the Venn diagrams the ggVennDiagram package² was used.

² Gao C, Dusa A (2024). `_ggVennDiagram`: A 'ggplot2' Implement of Venn Diagram. R package version 1.5.2, <<https://CRAN.R-project.org/package=ggVennDiagram>>.

RESULTS

CHANGES RELATED TO HARM REDUCTION SERVICES AND PWUD

New questions relevant to harm reduction services and PWUD needs were agreed upon for inclusion in the adapted data collection tool, covering various aspects of drug use and other needs of the PWUD population, such as:

- the main routes and frequencies of drug use
- main drugs used
- sharing materials for injection and non-injecting drug use
- injection in prison
- opioid agonist treatment
- experience of homelessness
- HBV testing in addition to HIV, HCV, and syphilis.

It was discussed whether to include the new questions related to drug use in a specific module for harm reduction services, but it was ultimately decided to include them in the general module. This way, all members of the COBATEST network can report on these questions related to drug use, even if their target population is not specifically PWUD.

These modifications aim to collect comprehensive data, potentially contributing significantly to service and policy planning.

RESULTS OF THE COBATEST DATA ANALYSIS

In 2024, 73 COBATEST members from 10 European countries submitted disaggregated data through the COBATEST online tool.

A total of 22,994 testing visits were reported during the year.

Table 1 presents the breakdown of the testing visits by gender, age groups, and key populations.

- **By gender**, most tests were conducted on cisgender men (65.62%), followed by cisgender women (30.39%). Transgender individuals accounted for 1.85% of all testing visits (0.52% trans men; 1.33% trans women), while non-binary people represented 1.63%.
- **By age**, the largest group tested was 25–45 years old (52.82%), followed by individuals aged 16–25 years.
- **By key population**, the most tested group was MSM (42.91%), followed by migrants (26.77%), PWUD (16.90%), and SW (7.58%). PWID accounted for only 0.74% of all testing visits.

Table 1. Characteristics of the testing visits performed.

	Testing visits	
	Number of testing visits	%
TOTAL	22994	
Gender		
<i>Cis men</i>	15089	65,62%
<i>Cis women</i>	6989	30,39%
<i>Trans men</i>	119	0,52%
<i>Trans women</i>	306	1,33%
<i>Non-binary</i>	375	1,63%
<i>Other</i>	25	0,11%
<i>Missing</i>	91	0,40%
Age groups		
<16	22	0,10%
>=16-25	7173	31,20%
>=25-45	12145	52,82%
>=45-65	2709	11,78%
>65	205	0,89%
<i>Missing</i>	740	3,22%
Key population		
<i>MSM</i>	9867	42,91%
<i>SW</i>	1742	7,58%
<i>PWID</i>	171	0,74%
<i>PWUD</i>	3886	16,90%
<i>Migrants</i>	6156	26,77%

- *Testing indicators*

- HIV TESTS

In 2024, a total of 21,751 HIV tests were recorded in the COBATEST online tool. Of these, 38.28% were first-time testers, and 154 individuals (0.67%) had a previous HIV diagnosis.

Figure 1 illustrates the testing cascade, from HIV tests performed to confirmed HIV-positive cases. Among all tests, 231 (1.06%) were reactive, but 42 cases corresponded to individuals already diagnosed with HIV. This means 189 (0.87%) were newly reactive. Of these, 111 (77.78%) were referred to care, 113 (56.08%) linked to care, and 106 cases were confirmed as new HIV-positive cases.

Figure 1. HIV Testing Cascade: From Screening to Linkage to Care

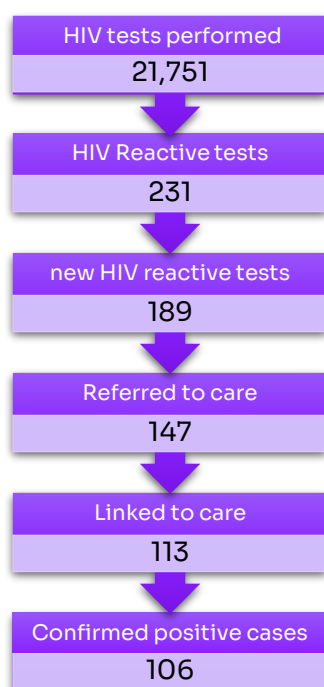


Table 2 presents the number of HIV tests performed, the number of reactive cases, and the reactivity rate, disaggregated by gender, age group, and key population.

- **By gender**, most tests were conducted on cisgender men (66.61%), while transgender women had the highest reactivity rate (7.39%).
- **By age**, the most tested groups were 25-45 years (52.95%) and 16-25 years (31.58%), with the highest reactivity rate observed in the 45-65 age group (1.47%).
- **By key population**, MSM accounted for 43.49% of tests, migrants for 26.89%, PWUD for 17.10%, and SW for 7.65%. Though PWID represented only 0.74% of tests, they had the highest reactivity rate (4.38%), followed by SW (2.52%).

Table 2. HIV Testing descriptive

	HIV				
	Number of tests	%	Number of reactives	%	Reactivity rate
TOTAL	21751		231		1.06%
Gender					
<i>Cis men</i>	14271	65.61%	176	76.19%	1.23%
<i>Cis women</i>	6648	30.56%	28	12.12%	0.42%
<i>Trans men</i>	111	0.51%	2	0.87%	1.80%
<i>Trans women</i>	284	1.31%	21	9.09%	7.39%
<i>Non-binary</i>	358	1.65%	3	1.30%	0.84%
<i>Other</i>	23	0.11%	0	0.00%	0.00%
<i>Missing</i>	56	0.26%	1	0.43%	1.79%
Age groups					
<16	22	0.10%	0	0.00%	0.00%
>=6-25	6869	31.58%	45	19.48%	0.66%
>25-45	11518	52.95%	139	60.17%	1.21%
>45-65	2512	11.55%	37	16.02%	1.47%
>65	196	0.90%	1	0.43%	0.51%
<i>Missing</i>	634	2.91%	9	3.90%	1.42%
Key population *					
<i>MSM</i>	9460	43.49%	153	66.23%	1.62%
<i>SW</i>	1665	7.65%	42	18.18%	2.52%
<i>PWID</i>	160	0.74%	7	3.03%	4.38%
<i>PWUD</i>	3720	17.10%	66	28.57%	1.77%
<i>Migrants</i>	5849	26.89%	114	49.35%	1.95%

*Key population groups are not mutually exclusive, so if a client is in two or more key population groups, they were recorded as such.

Disaggregating the SW group by gender (Table 3), transgender sex workers had a particularly high reactivity rate (9.58%), with 13.33% for trans men and 9.20% for trans women. Non-binary SW also had a high rate (7.69%), followed by male SW (3.5%).

Analysis of PWUD and PWID by gender (Table 4) shows transgender women had the highest reactivity rate (33.33%).

Table 3. HIV Testing for SW disaggregated by gender.

	HIV		
	Number of tests	Number of reactives	Reactivity rate
SW gender			
<i>MSW</i>	428	15	3.50%
<i>FSW</i>	1012	7	0.69%
<i>Trans men SW</i>	15	2	13.33%
<i>Trans women</i>	174	16	9.20%
<i>Non-binary SW</i>	26	2	7.69%
<i>Other SW</i>	4	0	0.00%
<i>Missing</i>	6	0	0.00%

Table 4. HIV Testing for PWUD and PWID disaggregated by gender.

	HIV		
	Number of tests	Number of reactives	Reactivity rate
PWUD gender			
<i>Cis men</i>	2460	46	1.87%
<i>Cis women</i>	1004	8	0.80%
<i>Trans men</i>	21	1	4.76%
<i>Trans women</i>	112	9	8.04%
<i>Non-binary</i>	113	2	1.77%
<i>Other</i>	4	0	000%
<i>Missing</i>	6	0	0.00%
PWID gender			
<i>Cis men</i>	113	4	3.54%
<i>Cis women</i>	41	2	4.88%
<i>Trans men</i>	2	0	0.00%
<i>Trans women</i>	3	1	33.33%
<i>Non-binary</i>	1	0	0.00%
<i>Other</i>	0	0	0.00%
<i>Missing</i>	0	0	0.00%

○ HCV TESTS

In 2024, 12,092 HCV tests were reported in the COBATEST online tool. Only 6.9% of individuals had been tested previously, and 109 (0.47%) had a prior HCV diagnosis.

Figure 2 outlines the testing cascade, from tests conducted to confirmed HCV cases. A total of 124 tests (1.03%) were reactive. Among them, 58 cases (47.77%) were referred to care, 28 (22.58%) were linked to care, and 9 were confirmed as active HCV cases.

Figure 2. HCV Testing Cascade: From Screening to Linkage to Care

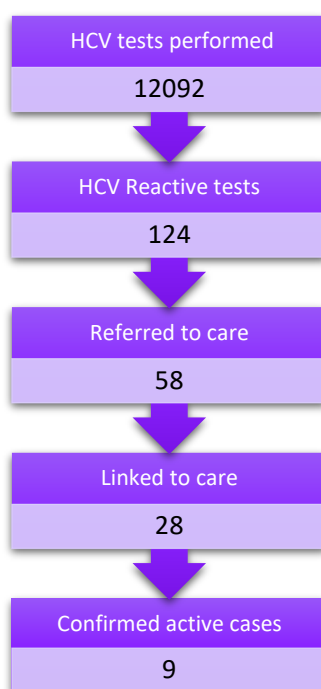


Table 5 details the number of HCV tests performed, the number of reactive cases, and the reactivity rate by gender, age group, and key population.

- **By gender**, most tests were conducted on cisgender men (69.59%), while transgender women had the highest reactivity rate (1.55%).
- **By age**, the most tested groups were 25-45 years (52.75%) and 16-25 years (32.65%), with the highest reactivity rate in the 45-65 age group (2.32%).
- **By key population**, MSM accounted for 49.65% of tests, migrants for 24.83%, PWUD for 17.91%, and SW for 0.87%. Though PWID represented only 1.06% of tests, they had the highest reactivity rate (42.47%), followed by SW (23.81%).

Table 5. HCV Testing descriptive

	HCV				
	Number of tests	%	Number of reactivities	%	Reactivity rate
TOTAL	12092		124		1,03%
Gender					
<i>Cis men</i>	8415	69,59%	89	71,77%	1,06%
<i>Cis women</i>	3222	26,65%	32	25,81%	0,99%
<i>Trans men</i>	46	0,38%	0	0,00%	0,00%
<i>Trans women</i>	193	1,60%	3	2,42%	1,55%
<i>Non-binary</i>	196	1,62%	0	0,00%	0,00%
<i>Other</i>	6	0,05%	0	0,00%	0,00%
<i>Missing</i>	14	0,12%	0	0,00%	0,00%
Age groups					
<16	8	0,07%	0	0,00%	0,00%
>16-25	3948	32,65%	22	17,74%	0,56%
>25-45	6379	52,75%	62	50,00%	0,97%
>45-65	1465	12,12%	34	27,42%	2,32%
>65	98	0,81%	1	0,81%	1,02%
<i>Missing</i>	194	1,60%	5	4,03%	2,58%
Key population *					
<i>MSM</i>	6004	49,65%	23	18,55%	0,38%
<i>SW</i>	105	0,87%	25	20,16%	23,81%
<i>PWID</i>	128	1,06%	55	44,35%	42,97%
<i>PWUD</i>	2166	17,91%	70	56,45%	3,23%
<i>Migrants</i>	3003	24,83%	27	21,77%	0,90%

*Key population groups are not mutually exclusive, so if a client is in two or more key population groups, they were recorded as such.

Breaking down the SW group by gender (Table 6), female SW and transgender women SW had the highest reactivity rates (2.94% and 2.27%, respectively).

Analysis of PWUD and PWID by gender (Table 7) shows transgender women had the highest reactivity rate (100%), followed by cisgender women (58.82%) and cisgender men (36.67%).

Table 6. HCV Testing for SW disaggregated by gender.

	HCV		
	Number of tests	Number of reactivities	Reactivity rate
SW gender			
<i>MSW</i>	239	4	1.67%
<i>FSW</i>	613	18	2.94%
<i>Trans men SW</i>	7	0	0.00%
<i>Trans women SW</i>	132	3	2.27%
<i>Non-binary SW</i>	13	0	0.00%
<i>Other SW</i>	1	0	0.00%
<i>Missing</i>	0	0	0.00%

Table 7. HCV Testing for PWUD and PWID disaggregated by gender.

	HCV		
	Number of tests	Number of reactives	Reactivity rate
PWUD gender			
<i>Cis men</i>	1527	44	2.88%
<i>Cis women</i>	487	23	4.72%
<i>Trans men</i>	10	0	0.00%
<i>Trans women</i>	80	3	3.75%
<i>Non-binary</i>	60	0	0.00%
<i>Other</i>	1	0	0.00%
<i>Missing</i>	1	0	0.00%
PWID gender			
<i>Cis men</i>	90	33	36.67%
<i>Cis women</i>	34	20	58.82%
<i>Trans men</i>	1	0	0.00%
<i>Trans women</i>	2	2	100.00%
<i>Non-binary</i>	1	0	0.00%
<i>Other</i>	0	0	0.00%
<i>Missing</i>	0	0	0.00%

○ HBV TESTS

In 2024, 4,987 HBV tests were recorded in the COBATEST online tool. Only 18.31% of individuals had been tested previously, and 68 (0.30%) had a prior HBV diagnosis.

Figure 3 illustrates the testing cascade, from tests performed to confirmed HBV cases. A total of 29 tests (0.58%) were reactive. Of these, 24 cases (82.76%) were referred to care, 9 (31.03%) were linked to care, and 7 received an HBV diagnosis.

Figure 3. HBV Testing Cascade: From Screening to Linkage to Care

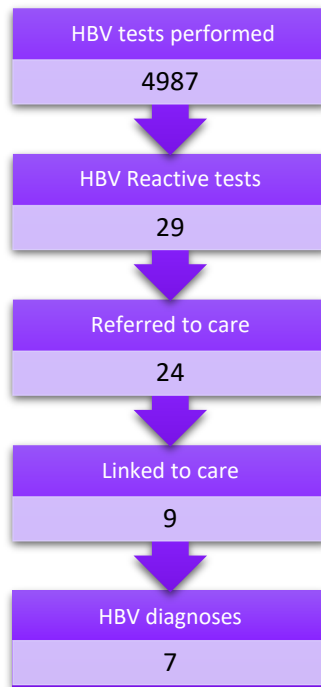


Table 8 provides details on HBV testing, reactivity rates, and breakdowns by gender, age, and key population.

- **By gender**, most tests were performed on cisgender men (78.84%), while transgender women had the highest reactivity rate (1.28%).
- **By age**, the majority tested were aged 25-45 (68.97%), with the highest reactivity rate in the 45-65 group (0.99%).
- **By key population**, MSM represented 68.94% of tests, migrants 23.60%, PWUD 20.87%, and SW 8.30%. PWID accounted for only 0.98% but had the highest reactivity rate (4.08%), followed by migrants (1.02%).

Table 8. HBV Testing descriptive

	HBV				
	Number of tests	%	Number of reactives	%	Reactivity rate
TOTAL	4987		29		0.58%
Gender					
<i>Cis men</i>	3932	78.84%	24	82.76%	0.61%
<i>Cis women</i>	849	17.02%	4	13.79%	0.47%
<i>Trans men</i>	23	0.46%	0	0.00%	0.00%
<i>Trans women</i>	78	1.56%	1	3.45%	1.28%
<i>Non-binary</i>	102	2.05%	0	0.00%	0.00%
<i>Other</i>	1	0.02%	0	0.00%	0.00%
<i>Missing</i>	2	0.04%	0	0.00%	0.00%
Age groups					
<16	5	0.10%	0	0.00%	0.00%
>16-25	1944	38.98%	3	10.34%	0.15%
>25-45	2462	49.37%	20	68.97%	0.81%
>45-65	506	10.15%	5	17.24%	0.99%
>65	37	0.74%	0	0.00%	0.00%
<i>Missing</i>	33	0.66%	1	3.45%	3.03%
Key population *					
<i>MSM</i>	3438	68.94%	10	34.48%	0.29%
<i>SW</i>	414	8.30%	3	10.34%	0.72%
<i>PWID</i>	49	0.98%	2	6.90%	4.08%
<i>PWUD</i>	1041	20.87%	3	10.34%	0.29%
<i>Migrants</i>	1177	23.60%	12	41.38%	1.02%

*Key population groups are not mutually exclusive, so if a client is in two or more key population groups, they were recorded as such.

Disaggregating SW by gender (Table 9), transgender women SW had the highest reactivity rate (2.56%).

The analysis of PWUD and PWID by gender (Table 10) shows us that the higher reactivity rate is for Trans Women with a 100%.

Table 9. HBV Testing for SW disaggregated by gender.

	HBV		
	Number of tests	Number of reactives	Reactivity rate
SW gender			
<i>MSW</i>	109	1	0.92%
<i>FSW</i>	260	1	0.38%
<i>Trans men SW</i>	2	0	0.00%
<i>Trans women SW</i>	39	1	2.56%
<i>Non-binary SW</i>	4	0	0.00%
<i>Other SW</i>	0	0	0.00%
<i>Missing</i>	0	0	0.00%

Table 10. HBV Testing for PWUD and PWID disaggregated by gender.

	HBV		
	Number of tests	Number of reactives	Reactivity rate
PWUD gender			
<i>Cis men</i>	827	2	0.24%
<i>Cis women</i>	143	0	0.00%
<i>Trans men</i>	2	0	0.00%
<i>Trans women</i>	28	1	3.57%
<i>Non-binary</i>	41	0	0.00%
<i>Other</i>	0	0	0.00%
<i>Missing</i>	0	0	0.00%
PWID gender			
<i>Cis men</i>	44	1	2.27%
<i>Cis women</i>	3	0	0.00%
<i>Trans men</i>	0	0	0.00%
<i>Trans women</i>	1	1	100.00%
<i>Non-binary</i>	1	0	0.00%
<i>Other</i>	0	0	0.00%
<i>Missing</i>	0	0	0.00%

○ SYPHILIS TESTS

In 2024, 17,066 syphilis tests were reported in the COBATEST online tool. Only 8% had been tested previously, and 1,076 (12.51%) had a prior syphilis diagnosis.

Figure 4 illustrates the testing cascade, from tests performed to confirmed active syphilis cases. A total of 549 tests (3.22%) were reactive. Among them, 359 cases (65.39%) were referred to care, 223 (40.62%) were linked to care, and 182 were confirmed as active cases.

Figure 4. Syphilis Testing Cascade: From Screening to Linkage to Care

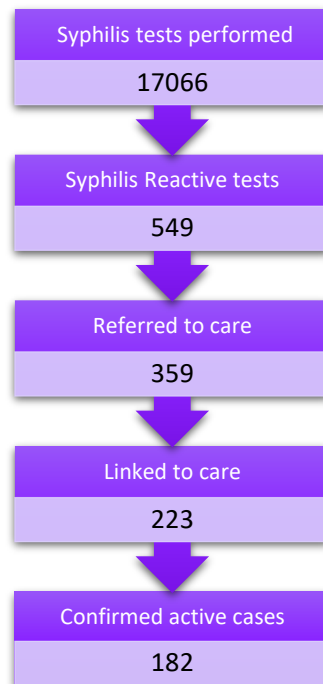


Table 11 presents the number of syphilis tests, reactive cases, and reactivity rates by gender, age, and key population.

- **By gender**, most tests were performed on cisgender men (67.62%), while transgender women had the highest reactivity rate (11.21%).
- **By age**, the largest groups tested were 25-45 years (53.40%) and 16-25 years (31.29%), with the highest reactivity rate in those over 60 years (5.26%), followed by the 45-65 group (4.52%).
- **By key population**, MSM accounted for 48.69% of tests, migrants 25.01%, PWUD 16.25%, and SW 7.94%. Though PWID represented only 0.67%, they had the highest reactivity rate (11.30%), followed by SW (5.46%) and MSM (5.45%).

Table 11. Syphilis Testing descriptive

	Syphilis				
	Number of tests	%	Number of reactivities	%	Reactivity rate
TOTAL	17066		549		3.22%
Gender					
<i>Cis men</i>	11540	67.62%	473	86.16%	4.10%
<i>Cis women</i>	4900	28.71%	42	7.65%	0.86%
<i>Trans men</i>	71	0.42%	4	0.73%	5.63%
<i>Trans women</i>	214	1.25%	24	4.37%	11.21%
<i>Non-binary</i>	282	1.65%	6	1.09%	2.13%
<i>Other</i>	15	0.09%	0	0.00%	0.00%
<i>Missing</i>	44	0.26%	0	0.00%	0.00%
Age groups					
<16	16	0.09%	0	0.00%	0.00%
>16-25	5340	31.29%	147	26.78%	2.75%
>25-45	9114	53.40%	296	53.92%	3.25%
>45-65	1971	11.55%	89	16.21%	4.52%
>65	152	0.89%	8	1.46%	5.26%
<i>Missing</i>	473	2.77%	9	1.64%	1.90%
Key population *					
<i>MSM</i>	8310	48.69%	453	82.51%	5.45%
<i>SW</i>	1355	7.94%	74	13.48%	5.46%
<i>PWID</i>	115	0.67%	13	2.37%	11.30%
<i>PWUD</i>	2773	16.25%	137	24.95%	4.94%
<i>Migrants</i>	4269	25.01%	154	28.05%	3.61%

*Key population groups are not mutually exclusive, so if a client is in two or more key population groups, they were recorded as such.

Breaking down the SW group by gender (Table 12), transgender men and women had the highest reactivity rates (30% and 13.18%, respectively), followed by male SW (8.73%).

Analysis of PWUD and PWID by gender (Table 13) reveals that transgender men and women had the highest reactivity rates among PWUD (7.14% and 6.90%, respectively), while cisgender men had a 6.39% rate. Among PWID, transgender women had the highest rate (33.33%), followed by cisgender men (14.47%).

Table 12. Syphilis Testing for SW disaggregated by gender.

		Syphilis		
		Number of tests	Number of reactives	Reactivity rate
SW gender				
	<i>MSW</i>	332	29	8.73%
	<i>FSW</i>	856	25	2.92%
	<i>Trans men SW</i>	10	3	30.00%
	<i>Trans women SW</i>	129	17	13.18%
	<i>Non-binary SW</i>	23	0	0.00%
	<i>Other SW</i>	3	0	0.00%
	<i>Missing</i>	2	0	0.00%

Table 13. Syphilis Testing for PWUD and PWID disaggregated by gender.

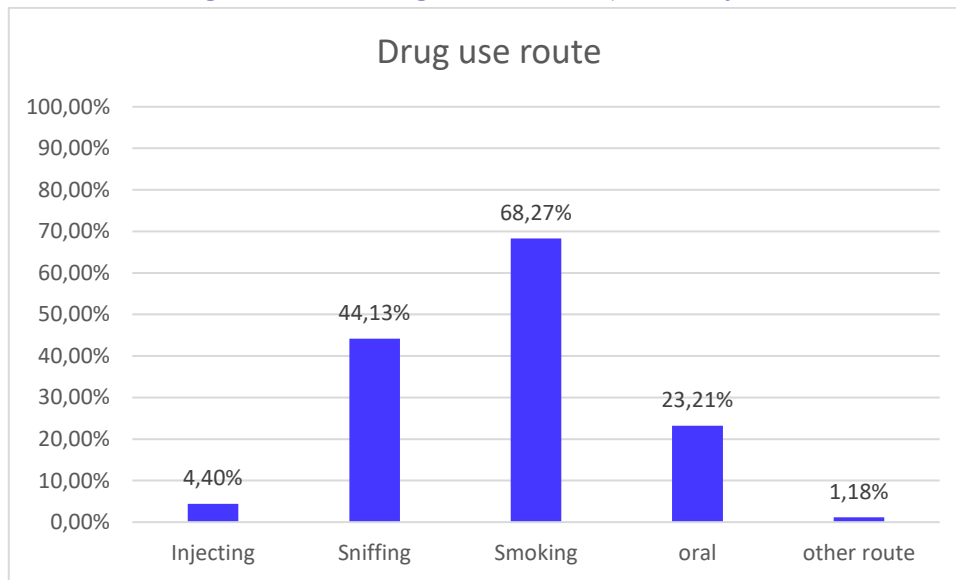
		Syphilis		
		Number of tests	Number of reactives	Reactivity rate
PWUD gender				
	<i>Cis men</i>	1847	118	6.39%
	<i>Cis women</i>	730	11	1.51%
	<i>Trans men</i>	14	1	7.14%
	<i>Trans women</i>	87	6	6.90%
	<i>Non-binary</i>	90	1	1.11%
	<i>Other</i>	2	0	0.00%
	<i>Missing</i>	3	0	0.00%
PWID gender				
	<i>Cis men</i>	76	11	14.47%
	<i>Cis women</i>	33	1	3.03%
	<i>Trans men</i>	2	0	0.00%
	<i>Trans women</i>	3	1	33.33%
	<i>Non-binary</i>	1	0	0.00%
	<i>Other</i>	0	0	0.00%
	<i>Missing</i>	0	0	0.00%

- *New variables related to drug use*
- **Main routes and frequencies of drug use**

A total of 3,886 people (16.90%) reported some form of drug use. The primary routes of drug use (Figure 5) were smoking (68.27% of the total who reported some drug use), sniffing (44.13%), oral consumption (23.21%), and injection (0.74%). An alternative route was reported in 1.18% of cases.

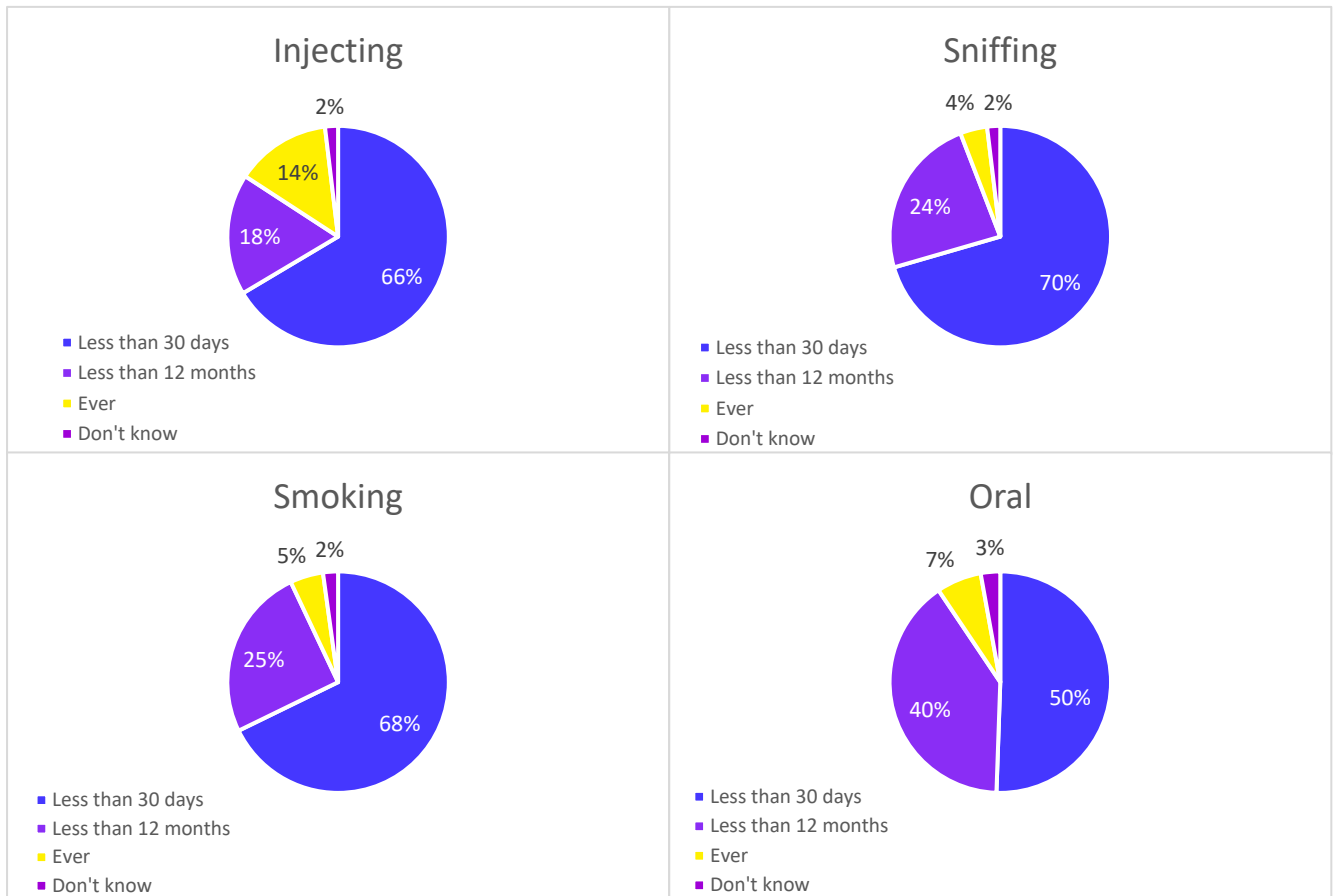
Among those who reported some route of drug use, 66.96% used only one route, 22.82% reported using 2 routes, and 10.23% used 3 or more routes.

Figure 5. Main drug use routes reported by PWUD



Regarding the frequency of use by route (Figure 6), 66% of drug users who reported injection stated that their last use was within the past 30 days. For sniffing, 70% reported use within the past 30 days, compared to 68% for smoking and 50% for the oral route.

Figure 6. Frequency of injection of the main drug use routes reported by PWUD

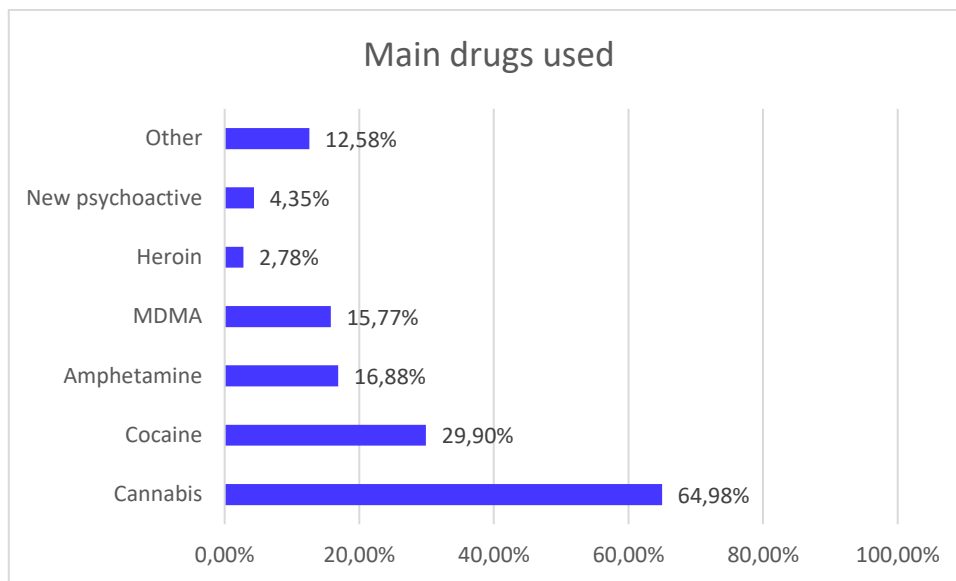


- **Main drugs used**

The most commonly reported drug (Figure 7) was cannabis (65.98%), followed by cocaine (29.90%), amphetamines (16.88%), and MDMA (15.77%). New psychoactive drugs and heroine were reported in the 4.35% and 2.78% of cases, respectively.

Among those reporting main drugs used, 55.88% used only one drug, 21.27% used two, 8.46% used three, 3.10% used four, and 1.28% reported using five or more drugs.

Figure 7. Main drugs reported by PWUD



- **Sharing of injection and non-injection drug use materials**

Among those who reported injection drug use (171 individuals), 36.26% (62 people) reported sharing syringes and/or needles in the past 12 months, while 32.75% (56 people) reported sharing other injection-related materials such as spoons, filters, or water.

Among all PWUD (3,886), 17.50% (680 people) reported sharing materials used for non-injection drug use.

- **Injection in prison**

Among those who reported injection drug use (171 individuals), 11.70% reported injecting drugs while in prison.

- **opioid agonist treatment**

Among those reporting drug use (3,886) 73 individuals (1.88%) reported being on opioid agonist treatment at the time of the testing visit.

- **Experience of homelessness**

Among all testing visits, 3.26% reported to experiencing homelessness in the past 12 months, while 2.24% (515 people) were homeless at the time of the visit.

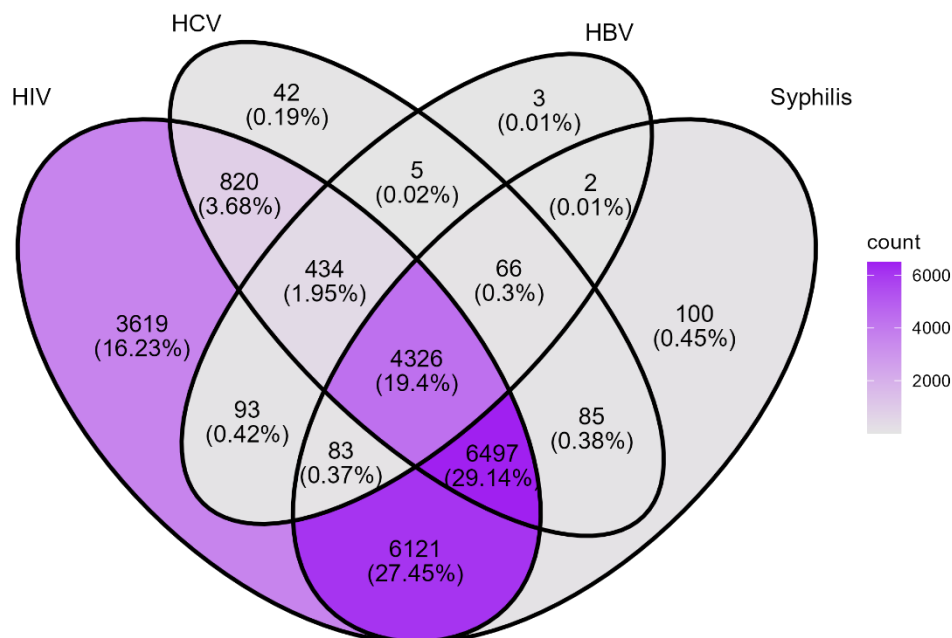
Among those who reported drug use, 6.51% had experienced homelessness in the past 12 months, while 3.91% (152 people) were homeless at the time of the visit.

- *Integrated testing*

Most of the community-based testing services perform integrated testing based on risk criteria for multiple infections. The majority conduct rapid test for HIV and syphilis, some also include HCV, and incorporates HVB as well.

Figure 8 illustrates the combination of different rapid tests performed during each testing visit. The full panel of four rapid test was conducted in 19.4% of all testing visits. In the 29.14% of visits, HIV, Syphilis and HCV rapid test were performed, while in 27.45% of visits, only HIV and syphilis tests were conducted. In 16.3% of visits, only an HIV tests was performed.

Figure 8. Combination of tests performed per testing visit.



Focusing on PWUD (Figure 9), the distribution varies slightly, with the most frequent combinations being all four 4 tests and the combination of HIV, Syphilis, and HCV, each occurring in 23.56% of visits.

Figure 10 presents the test combination for PWID, where the most frequent combination was HIV, Syphilis, and HCV (34.55% of visits), followed by the full panel of four tests (24.85% of visits).

Figure 9. Combination of tests performed per testing visit for PWUD

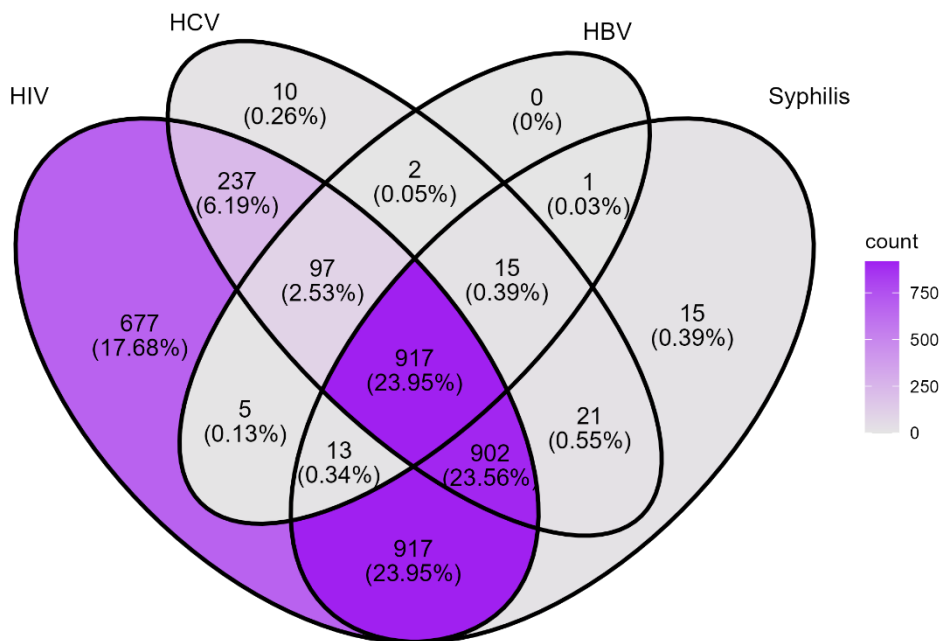
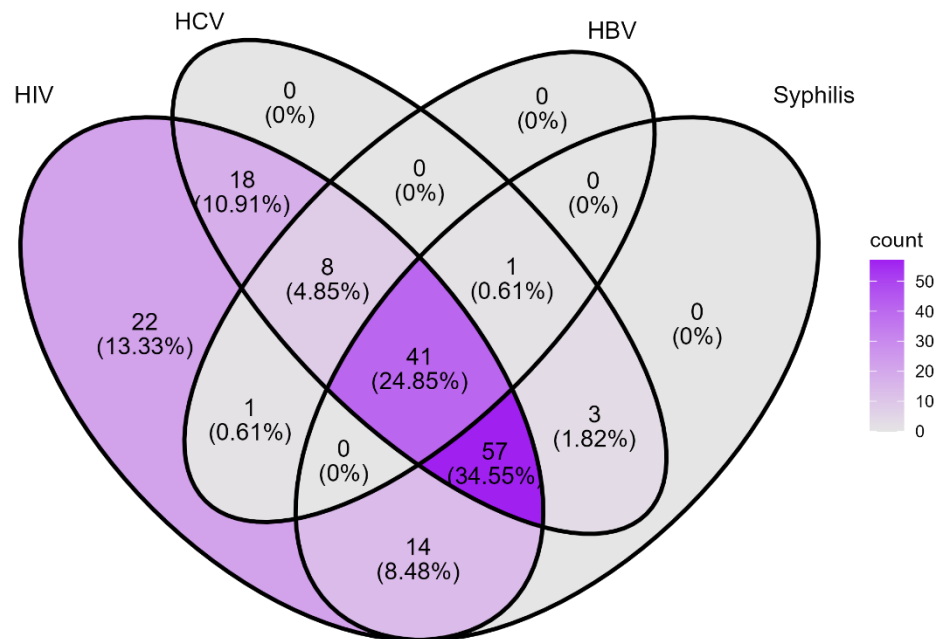
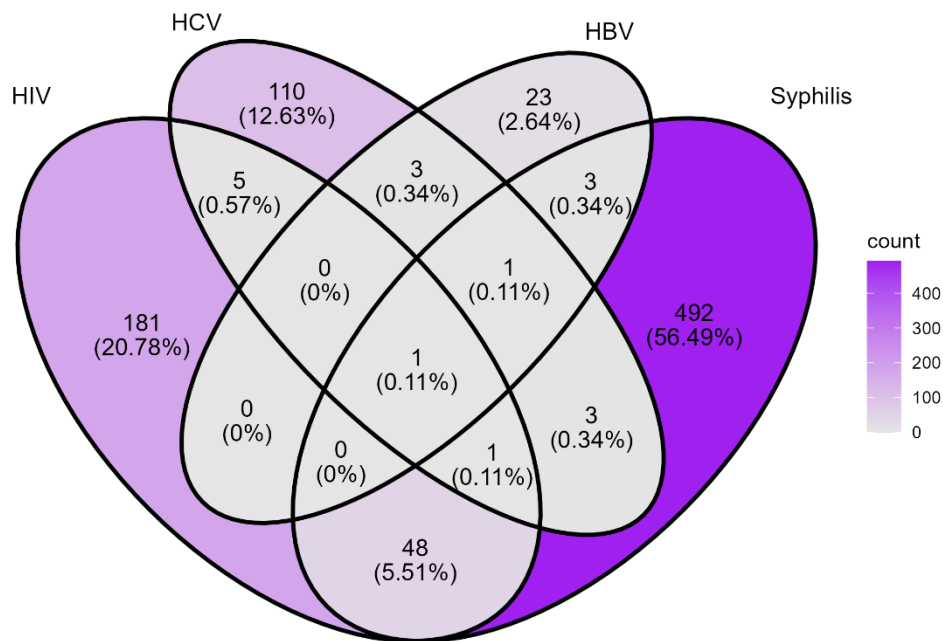


Figure 10. Combination of tests performed per testing visit for PWID



Regarding reactive test results, in one case (0.11% of all visits with at least one reactive test result), the test was reactive for all four infections. Another case (0.11%) was reactive for HIV, HCV, and Syphilis, while a third case (0.11%) showed reactivity for HCV, HBV, and syphilis. Additionally, 48 cases (5.51%) were reactive for both HIV and Syphilis, 5 cases (0.57%) for HIV and HCV; 3 cases (0.34%) for HCV and HBV, another 3 cases (0.34%) for HCV and syphilis, and 3 more cases (0.34%) for HBV and syphilis.

Figure 11. Combination of reactive tests per testing visit.



Figures 12 and 13 presents the same analysis but for PWUD and PWID, respectively.

Figure 12. Combination of reactive tests per testing visit for PWUD.

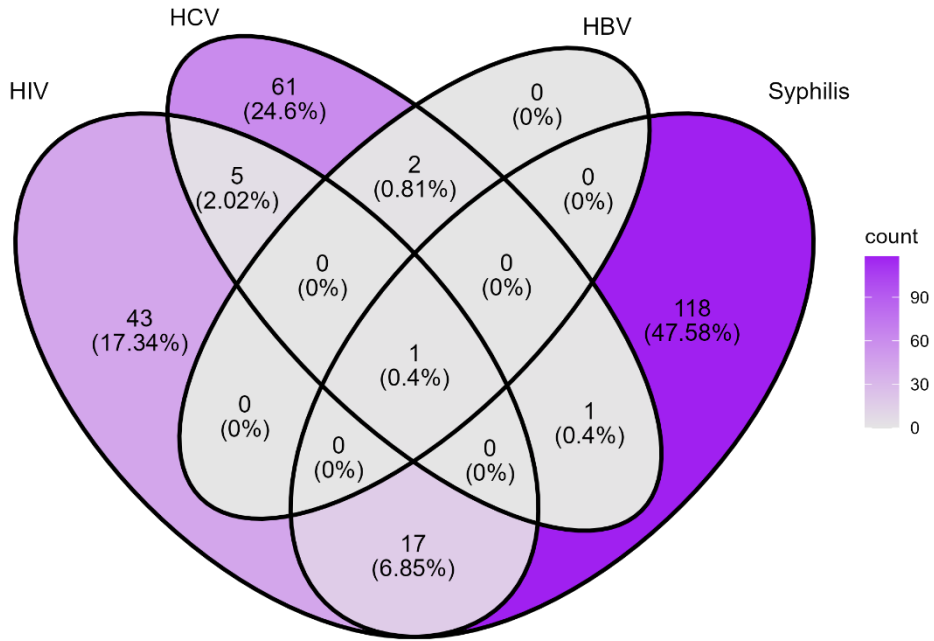
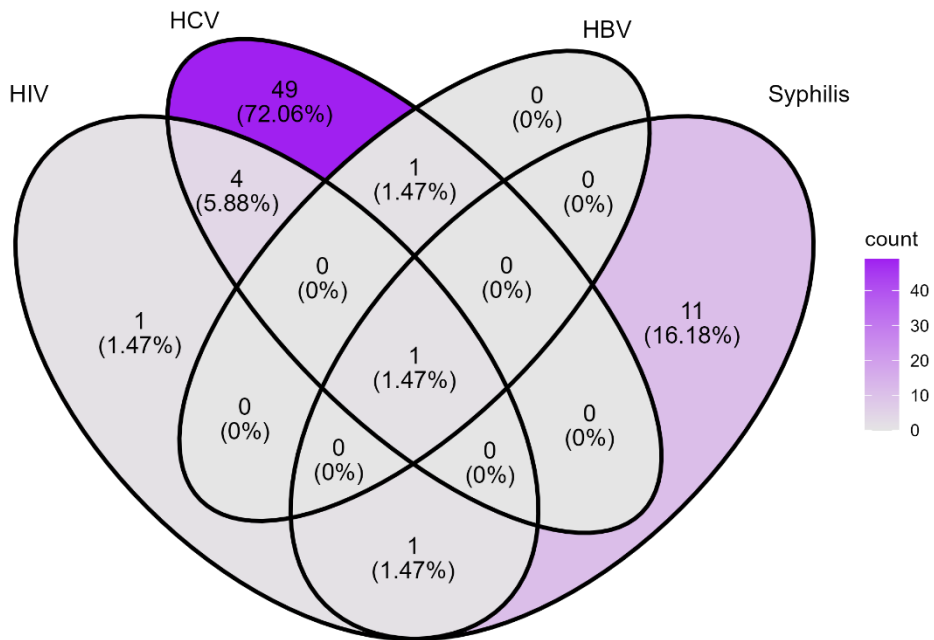


Figure 13. Combination of reactive tests per testing visit for PWID.



- *Intersectionalities*

People attending community-based testing services may face multiple vulnerabilities and belong to more than one key population group.

We analysed intersectionalities among different key population groups using Venn diagrams for visualisation.

Figure 14 illustrates the overlap between key population groups (MSM, SW, PWUD, and Migrants) across all testing visits. The most frequent category was MSM only (41.24%), followed by migrants only (13.2%), and MSM who were also migrants (10.55%). In 92 cases (0.59%), individuals belonged to all four key population groups.

Figure 15 presents the same data but replaces PWUD with PWID as a key population group.

Figure 14. Intersectionalities of key population groups (MSM, SW, PWUD, Migrants) among testing visits

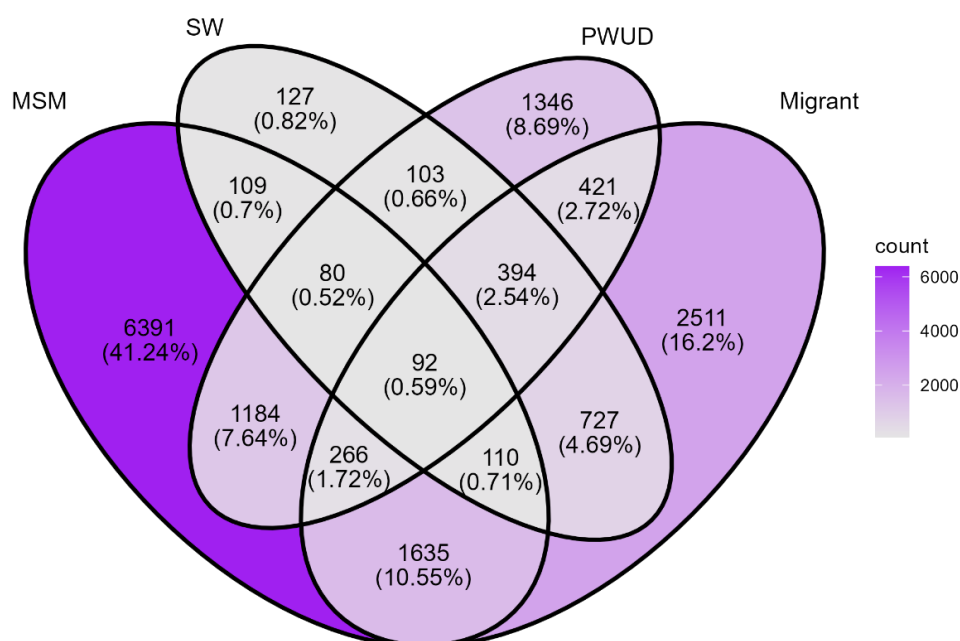


Figure 15. Intersectionalities of key population groups (MSM, SW, PWID, Migrants) among testing visits

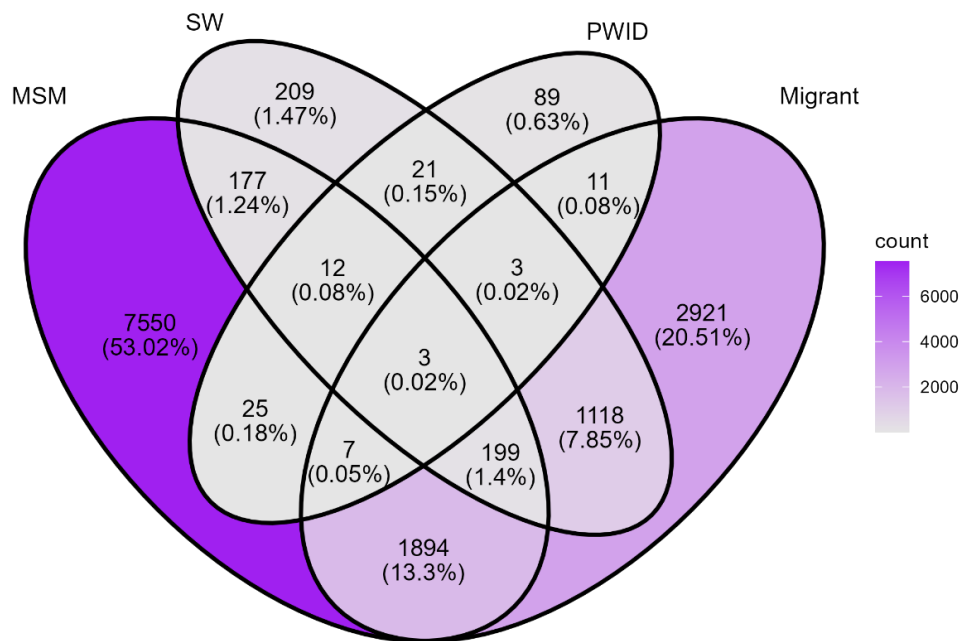


Figure 16 shows the distribution of key population groups (MSM, SW, PWUD, and Migrants) among individuals with reactive test results for HIV, HCV, HBV, and syphilis.

For HIV, the group with the highest number of reactive cases was MSM (67 cases; 31.02%), followed by MSM who were also migrants (43 cases; 19.91%). Seven cases (3.24%) were reactive among individuals belonging to all four key population groups.

For HCV, the group with the highest number of reactive cases was PWUD (40 cases; 39.22%), followed by PWUD who were also SW (17 cases; 16.67%).

For HBV, the groups with the highest number of reactive cases were MSM and Migrants, with 8 cases (33.33%) each one.

For Syphilis, the group with more reactive cases was MSM (256 cases; 49.52%), followed by MSM who were also PWUD (79 cases; 15.28%), and MSM who were also migrants (70 cases; 13.54%).

Figure 17 presents the same analysis but replaced PWUD with PWID as one of the key population groups.

Figure 16. Intersectionalities of key population groups (MSM, SW, PWUD, Migrants) among reactive tests

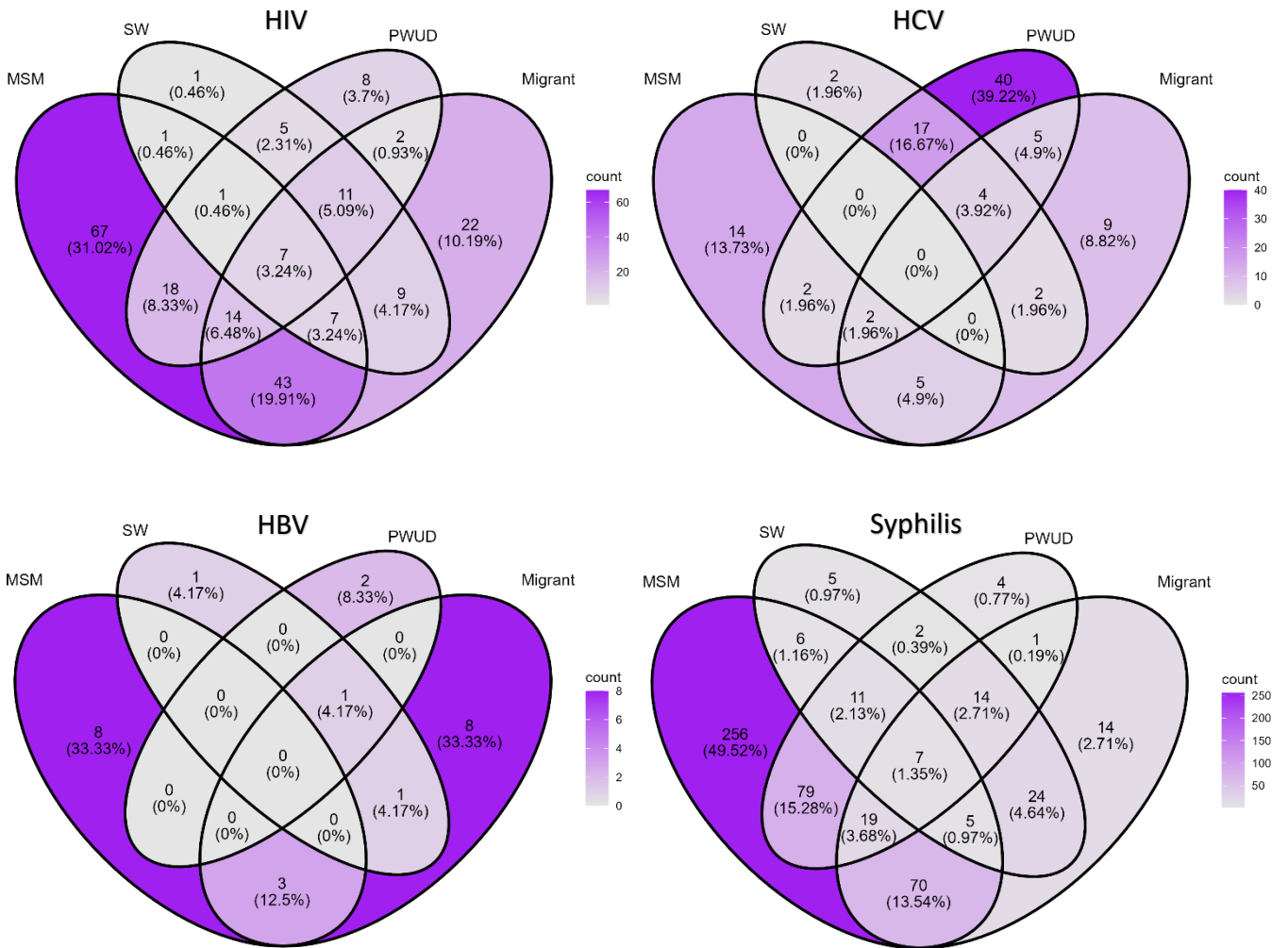
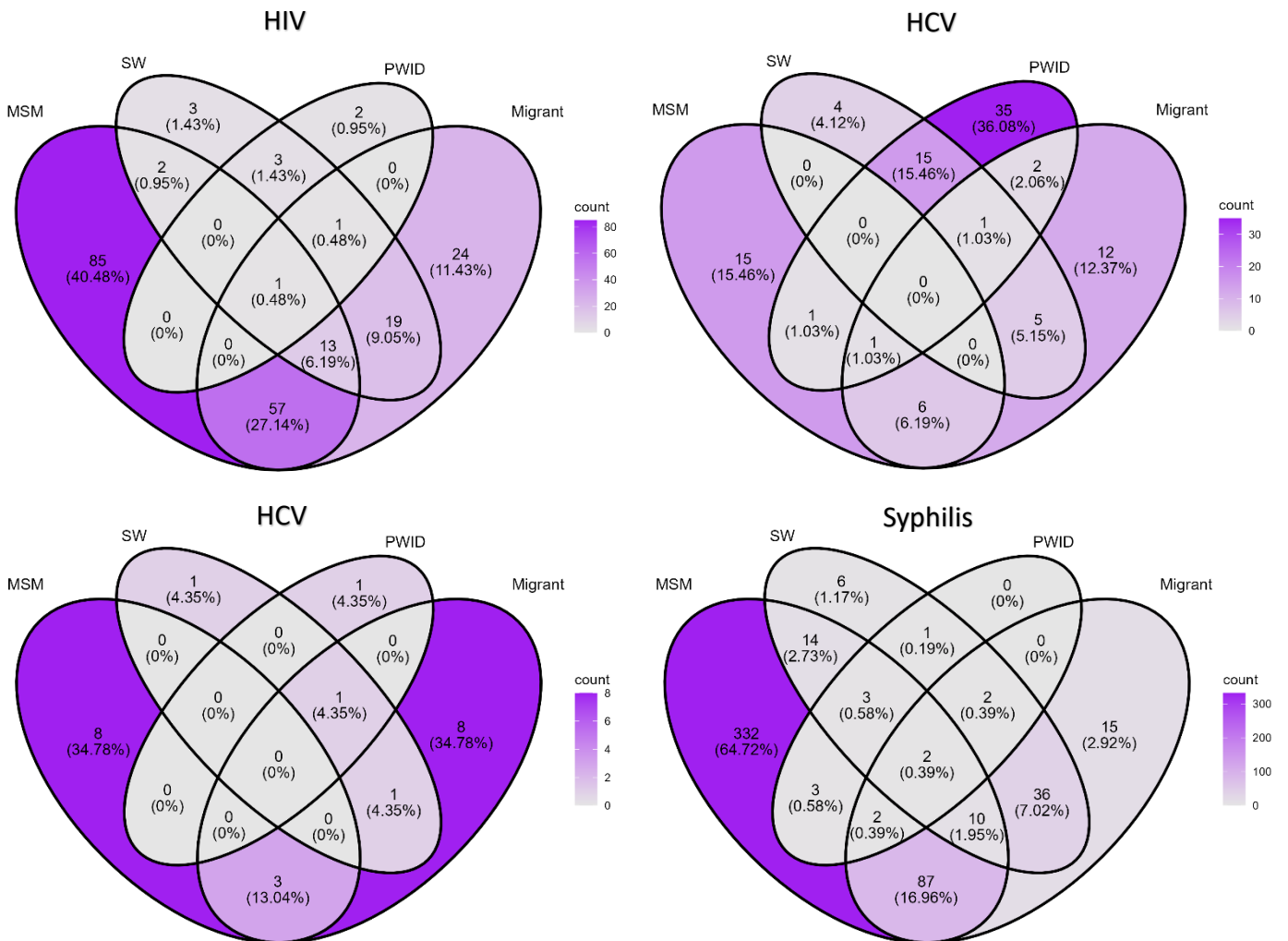


Figure 17 Intersectionalities of key population groups (MSM, SW, PWID, Migrants) among reactive tests



HIGHLIGHTS AND RECOMMENDATIONS

- The adaptation of the COBATEST data collection tools successfully integrated new variables related to harm reduction services and the needs of PWUD, such as drug use patterns, material sharing, opioid agonist treatment, and homelessness.
- The COBATEST network expanded its monitoring capabilities by incorporating hepatitis B testing alongside HIV, HCV, and syphilis. A specific module for other STIs, such as chlamydia and gonorrhoea, has also been added for centres that conduct screening for these infections.
- Data analysis from 2024 showed that the majority of testing visits were conducted for MSM, migrants, and PWUD, highlighting the importance of targeted interventions.
- Reactive test results for HIV, HCV, HBV, and syphilis revealed disparities among key populations, with PWID and transgender women showing particularly high reactivity rates.
- Integrated testing for multiple infections remains crucial. A significant proportion of visits included HIV, HCV, HBV, and syphilis testing, but efforts should be made to increase comprehensive screening across all community-based services.
- The intersectionality of key populations emphasizes the need for multi-faceted approaches to testing and linkage to care. Individuals belonging to more than one key population group often face higher risks and barriers to healthcare.
- To enhance linkage to care, referral mechanisms and follow-up strategies must be strengthened, particularly for PWUD and PWID, who show lower linkage rates despite high reactivity rates.
- Further dissemination and training are needed to encourage more harm reduction services to adopt the COBATEST online data collection tool and report standardized data.

CONCLUSIONS

The adaptation of the COBATEST data collection tools under the BOOST project has been a significant step toward improving the monitoring and evaluation of communicable disease services for PWUD. The inclusion of key variables related to drug use and social vulnerabilities provides a more comprehensive picture of the needs of at-risk populations.

The 2024 data highlights the importance of community-based voluntary counselling and testing services in reaching key populations, especially MSM, migrants, and PWUD. However, the high reactivity rates among certain subgroups, such as PWID and transgender women, call for enhanced prevention and care strategies.

Despite improvements in integrated testing, gaps remain in ensuring linkage to care. Strengthening referral pathways and collaboration between community organizations and healthcare systems is essential for improving health outcomes.

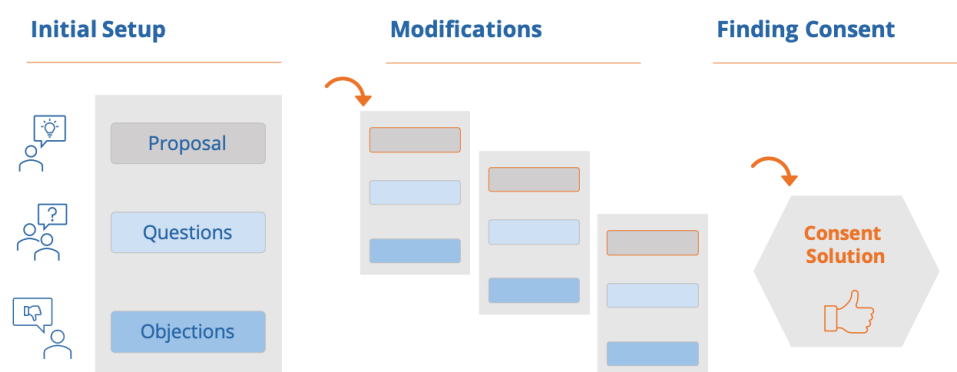
Future efforts should focus on increasing the adoption of standardized data collection tools among harm reduction services, refining strategies to address intersectional vulnerabilities, and scaling up integrated testing initiatives. By continuing to enhance data-driven interventions, the COBATEST network and the BOOST project can contribute to more effective, equitable, and comprehensive harm reduction and communicable disease services across Europe.

Annex 1

Consent Decision Making Process

For the process of adaptation of the COBATEST data collection tools, the Consent Decision Making process will be used.

The Consent Decision Making Method is a decision-making process for groups to arrive at a mutually defined “acceptable and consensual” solution. Such viable solutions are about always being willing to compromise and accepting different perspectives.³



After taking 3 steps demonstrated in the graph above, if an objection has been made by a participant during the final step, he/she/they should provide an argumentation and possible adjustment to the topic objected to. After the explanation of the objection and proposal of an adjustment, the topic will again go through the above shown 3 steps. This process can be repeated several times before reaching a solution that is “acceptable and consensual” for everyone. At the time of the objection, the moderator will check if the point made is crucial to solve, thus requires adjustment and compromise, or it can be overlooked.

³Consent Decision Making - ConWISE [Internet]. [cited 2023 Aug 1]. Available from: <https://www.conwise.de/en/knowledge-base/strategy/consent-decision-making/>

Annex 2

List of all questions added or modified in the COBATEST data collection form

- **Improvement to the Client's characteristics section of the data collection form**

1. To add a section on who provides the testing in the first section of the data collection form:
 - ✓ *Who provides the testing? Health professional / Lay worker (no peer) / Peer / Other*
2. To include the 'Other' answer option to the Gender question:
 - ✓ *Cis men / Cis women / Trans women / Trans men / Non-binary / Other (which other)*

For analysis purposes 'Other' will be included under 'Non-binary'
3. To add a question about homelessness / housing status:
 - ✓ *Have you been homeless during past 12 months? (living on the street, in a shelter in a car...) Yes, currently / Yes, but not currently / No / Don't know / Refuse to answer*

- **Improvement to the Reasons for HIV testing section**

4. To add PrEP as one of the reasons to test. The following option was added to the 'For control/screening' options:
 - ✓ *I want to start PrEP / Monitoring PrEP*

- **Improvement to the Risk behaviour/factors section**

5. To change the title of the section 'Risk behaviour/factors' to eliminate the word risk. The title was changed to 'Behavioural factors'.
6. To modify the question on sex in the last 12 months to a multi-answer question to include all the possible answer options:
 - ✓ *Sex in the last 12 months with (multianswer): Men (cis), Women (cis), Trans men, Trans women, Non-binary, I haven't has sex, Don't know*
7. To delete the question "Condom less penetration in last 12 months"
8. Favoured wording change – "share of materials of injection" to "using other materials for drug use that were already used by others". The 2 questions using this expression were reworded:
 - ✓ *Using materials of injection that were already used by others*

- ✓ *Using other materials for drug use that were already used by others*
9. New options to answer the 'Last time (of use)' question were added:
 - ✓ *30 days / less than 12 months / more than 12 months / don't know.*
 10. It was proposed to start with the question 'Drug use', followed by 'Drug use route' with answer options of different drug consumption routes. The 'Last time' question should also appear for each drug use route. A new question on main drugs use was approved and added, with the list of different drugs. Add question on injection in prison and question on current treatment. The section on drugs use was modified accordingly:
 - ✓ *Drug use (non-prescribed)? Yes / No / Don't know*
 - ✓ *If yes, Drug use route? (multi-answer) Injecting / Sniffing / Smoking / Oral / Other*
 - ✓ *For each option: Last time: Less than 30 days / Less than 12 months / Ever / Don't know*
 - ✓ *Main drugs used: Cannabis / Cocaine/Crack cocaine / Amphetamine/Methamphetamine / MDMA / Heroin/other opioids / New psychoactive substances / Other*
 - ✓ *Have you injected drugs in prison? Yes / No / Never in prison / Don't know*
 - ✓ *Are you currently at opioid agonist treatment? Yes / No / Don't know*

1. Improvement to the Risk behaviour/factors section

11. To add a question on Mpox vaccination
 - ✓ *Vaccination for Mpox (with all required doses): yes, no, don't know*
12. To delete the question on 'Other vaccinations'
13. The section has been moved at the end of the general section, after the behavioural factors section.

• Improvement to the HIV screening test section

14. To delete questions on 'Previous HIV tests' (in the general section) and incorporate them in the 'HIV screening test' section with the purpose of having a general section and then specific questions per HIV/STI testing.
15. To delete question on 'Previous HIV test in the same CBVCT last 12 months'.
16. To delete question on 'Did the client receive the HIV screening test result'.
17. To delete the questions related to pre-test and post-test counselling.
18. To add a question on referral and leave the question on linkage to healthcare. Both questions should be repeated for other STIs.
 - ✓ *Patient referred to healthcare system? Yes / No / Don't know.*

The definitions agreed for referral and linkage to care concepts are as follows:

- Referral: to start the process of getting an appointment to healthcare facilities.
- Linkage to care: first visit with the HIV specialist attended.

19. To add a question on treatment for those with a previous HIV diagnosis.

- ✓ *Are you on treatment? Yes / No / Don't know*

- **Improvement to the Module B, Syphilis section**

20. To delete the detail 'Date of specimen collection' from the questions 'Syphilis Test performed' and 'Diagnosis test performed'.

21. To add questions on referral and linkage to care to the 'Syphilis test' section:

- ✓ *Patient referred to healthcare system? Yes / No / Don't know*
- ✓ *Patient linked to healthcare system? Yes / No / Don't know*

22. To add a question on the last syphilis diagnosis.

- ✓ *Year of last syphilis diagnosis?*

- **Improvement to the Module B, HCV section**

23. To delete the detail 'Date of specimen collection' from the questions 'HCV test performed' and 'Diagnosis test performed'.

24. To add both questions on referral and linkage to care to the 'HCV test' section:

- ✓ *Patient referred to healthcare system? Yes / No / Don't know*
- ✓ *Patient linked to healthcare system? Yes / No / Don't know*

25. To add a question on the last HCV diagnosis.

- ✓ *Year of last HCV diagnosis?*

26. For those patients with previous HCV diagnosis add questions on the year of last HCV diagnosis, and on treatment:

- ✓ *Year of last HCV diagnosis*
- ✓ *Have you received treatment? Yes, no, don't know*
- ✓ *If yes, Which treatment? Interferon (treatment completed, stopped treatment, don't know); New DAA (Treatment completed, on treatment, stopped treatment, don't know); don't know*

- **Improvement to the Module B, add HBV section**

27. To include the 'HBV test section' to the Testing section of the general module.

28. To delete the detail 'Date of specimen collection' from the questions 'HBV test performed' and 'Diagnosis test performed'.
29. To delete the word 'last' from 'Date of last HBV diagnosis'. The question has been reworded as following:
- ✓ *Year of HBV diagnosis*
30. To add both questions on referral and linkage to care to the 'HBV test' section:
- ✓ *Patient referred to healthcare system? Yes / No / Don't know*
 - ✓ *Patient linked to healthcare system? Yes / No / Don't know*
31. To change the answer options of 'HBV diagnosis' to only 'positive / negative / unknown, and if yes, give all the possible options:
- ✓ *HBV diagnosis? Positive / Negative / Unknown*
 - ✓ *If positive, 'Diagnosed as: Acute infection / Healthy carrier / Chronic infection / Past cured infection / Don't know'*
- **Improvement to the optional Module Other STIs (for Chlamydia and Gonorrhea testing)**
32. To restructure the sections and put together all rapid tests: HIV/syphilis/HCV/HBV. The HBV test section, previously in the 'Other STIs' section has been moved to the 'Testing' section of the general module.
33. To change 'given' with 'provided' in the question: 'Has treatment been given?':
- ✓ *Has treatment been provided*
34. If 'yes' to any previous STI, to add: 'Have you received treatment?'
- ✓ *Have you received treatment? Yes / No / Don't know*
35. To add 'Inconclusive' to test result options for Gonorrhea and Chlamydia.
- 36.
37. If 'Inconclusive', to add the question 'Was the test repeated?' and if 'yes', to add the test result.
38. If test result 'positive', add the question 'has treatment been received'.
39. The 'Inconclusive' option has been included as an answer option for 'Test results'. The question 'Was the test repeated' has been added for the 'Inconclusive' answer option.
40. The question 'Has treatment been received: Yes / No / Don't know' has been added.

- Improvement to the Chemsex/PrEP module

41. To add a question on the monitoring of PrEP If the answer to the question 'Have you ever taken PrEP?' is 'Yes':
 - ✓ *Was the PrEP been prescribed? Yes/No/Don't know*
 - ✓ *Was the PrEP been monitored? Yes/No/Don't know*
42. To add a question on PrEP referral. if the answer to the question 'Are you interested in using PrEP' is 'Yes':
 - ✓ *Has the client been referred to PrEP services? Yes / No / Don't know*
 - ✓ *If 'Yes', Where? To hospital / To a community service*
43. To improve the question on chemsex use 'Have you used drugs before/during group sex in the last 12 months':
 - ✓ *Have you used drugs for the purpose of enhancing sex?'*
44. If 'Yes', to add the question 'When was the last time?'
 - ✓ *When was the last time? Last 30 days / Last 12 months / More than 12 months / Don't know*