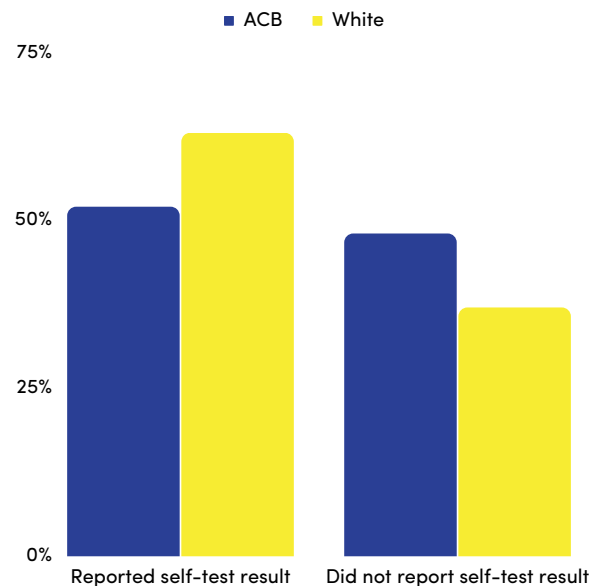


## HIV self-testing enabled access to testing for Black persons.

In Ontario, new cases of HIV affect gay, bisexual, and other men who have sex with men (gbMSM) and persons of African, Caribbean, or Black (ACB) ethnicities more than others. Because of this, easily accessible HIV testing is important for these groups. GetaKit aimed to target promotion of HIV self-test distribution towards these communities through social media, connecting with partner agencies, and creating specific GetaKit subsites.

Over the first 10 months of GetaKit (April 1 2021 – January 31 2022), of the 1551 kits distributed, over a quarter of these people were ACB, and 40% were white.

More white than ACB participants reported being tested for HIV in the past. Of the 62% of participants who received kits, the figure to the right shows that more white than ABC people reported their results on GetaKit.ca



### What does this tell us?

Through the GetaKit self-assessment, we found that ACB people were less likely to meet the criteria for starting HIV pre-exposure prophylaxis (PrEP) medication, which prevents people who are HIV negative from being infected with HIV if they are exposed to the virus.

HIV self-testing through GetaKit resulted in more testing among ACB populations, despite lower rates of reporting results. We need to do more work to increase HIV testing among ACB populations. This includes figuring out new strategies for providing HIV care.

We also now know that we need to develop better clinical indicators for identifying ACB people who are good candidates for PrEP, as current guidelines may not be adequate.

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### HIV self-testing enabled access to testing for Black persons: The GetaKit study

O'Byrne, Patrick; Musten, Alexandra; McCready, Lance; Robinson, Robin; Durrant, Garfield; Tigert, Jason; Orser, Lauren

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## RESEARCH ARTICLE

# HIV self-testing enabled access to testing for Black persons: The GetaKit study

Patrick O'Byrne<sup>1</sup>  | Alexandra Musten<sup>1</sup> | Lance McCready<sup>2</sup> | Robin Robinson<sup>3</sup> | Garfield Durrant<sup>3</sup> | Jason Tigert<sup>2</sup> | Lauren Orser<sup>1</sup>

<sup>1</sup>School of Nursing, University of Ottawa, Ontario, Ottawa, Canada

<sup>2</sup>University of Toronto, Ontario, Toronto, Canada

<sup>3</sup>Black Coalition for AIDS Prevention, Ontario, Toronto, Canada

## Correspondence

Patrick O'Byrne, School of Nursing, University of Ottawa, School of Nursing, 451 Smyth Rd, Ottawa, Ontario K1H 8M5, Canada.

Email: [pjobyrne@uottawa.ca](mailto:pjobyrne@uottawa.ca)

## Funding information

Ontario HIV Treatment Network

## Abstract

In Ontario, new HIV diagnoses continue to affect gay, bisexual, and other men who have sex with men (gbMSM) and persons of African, Caribbean, or Black (ACB) ethnicities. Because treatment and suppressed viral loads flow from diagnosis, testing is key. We sought to determine the outcomes of online ordering and mail-out of free at-home HIV self-testing in Ontario, Canada. We implemented the GetaKit study to offer such free HIV self-testing using the INSTI<sup>®</sup> test and offered it via a website (GetaKit.ca) to eligible persons in Ontario. From April 1, 2021 to January 31, 2022, we distributed kits to 1551 persons; 40% were white and 26% were ACB. We found that ACB participants were less likely to fulfill established criteria for HIV PrEP, such as previous sexually transmitted infections diagnoses and drug use, despite having a similar test positivity rate. We also found that ACB women, who may represent a larger number of new infections than previously thought, did not have a higher rate of first-time testing. Our results suggest that HIV self-testing can enable testing, but that work is required to increase uptake among ACB persons and women. Overall, HIV self-testing thus corresponded with increased testing among persons who were Black, yet lower rates of results reporting. Patient or Public Contributions: Community members from the AIDS Committee of Ottawa, Max Ottawa, and Black Cap, and nurses from Ottawa Public Health were involved in the design, promotion, and implementation of this study.

## KEYWORDS

ethnicity, gender, HIV, race, self-testing

## 1 | INTRODUCTION

HIV disproportionately affects specific groups, namely gay, bisexual, and other men who have sex with men (gbMSM), and persons of African, Caribbean, or Black (ACB) ethnicities.

In Ontario in 2019 (last year of published data), based on exposure category, gbMSM accounted for 59% of new HIV diagnoses; based on ethnicity, ACB persons accounted for 26% of new HIV diagnoses while accounting for only 3.5% of the Ontario population (Ontario HIV Epidemiology and Surveillance Initiative

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[OHESI], 2021). Notably, 59% of new HIV diagnoses among ACB persons were in women (OHESI, 2021), signaling an unequal burden among this subgroup.

Importantly, testing is one strategy to address ongoing inequitable HIV transmission among gbMSM and ACB populations. By identifying persons as HIV-negative or HIV-positive, tailored risk reduction counseling can occur, including the benefits of HIV preexposure prophylaxis (PrEP) and of suppressed viral loads from treatment. Research shows that, when an HIV-positive person takes antiretroviral therapy and achieves an undetectable viral load—that is, when the virus becomes undetectable in blood—HIV transmission no longer occurs (i.e., *undetectable = untransmittable*) (Eisinger et al., 2019). Likewise, when an HIV-negative person takes a low dose of antiretroviral medication before a potential HIV exposure, their risk of HIV acquisition is reduced by over 99% (CDC, 2021a, 2021b; Tan et al., 2017). While these prevention outcomes are remarkable, both require that persons undergo HIV testing—making testing one key entry point to prevention.

In Canada, the newest strategy to help people know their HIV-status is self-testing, which international research suggests corresponds with increased testing frequencies, more uptake among first-time testers, and higher user satisfaction, compared to traditional testing approaches (Eshun-Wilson et al., 2021; Jamil et al., 2021; Ontario HIV Treatment Network, 2019; Witzel et al., 2020). Other research shows that members of ACB communities may prefer self-testing compared to serology, particularly if they have experienced stigmatization by healthcare providers or in healthcare settings (Hawk et al., 2020; Mathews et al., 2020).

To capitalize on the potential benefits of self-testing, we launched GetaKit, which was a research study for persons in Ontario to order free HIV self-tests via the Internet (GetaKit.ca). While any HIV-negative Ontario resident who was 16 years of age or older could enroll in GetaKit, this study focused on the groups most affected by HIV, including gbMSM and ACB persons. While we have published the pilot study, screening system, and preliminary results for GetaKit (O'Byrne, Musten, Orser, Buckingham, et al., 2021; O'Byrne, Musten, Orser, Inamdar, et al., 2021; O'Byrne, Musten, Vandyk, et al., 2021), herein we report on the ethnicity data we obtained to see if we could identify elements that were unique to our ACB participants compared to White participants. In other words, the overarching purpose of GetaKit was to offer free HIV self-tests to persons in Ontario to observe uptake and results, whereas our purpose in the analysis presented below was to see if and how ACB participants were dis/similar from other GetaKit participants. The main questions we had were thus, “do ACB persons, as a group that is disproportionately affected by HIV, actually use GetaKit, and, if so, what are their characteristics and testing outcomes?” We then discuss implications of our findings in relationship to the use of GetaKit among ACB persons.

## 2 | METHODS

### 2.1 | Project overview

GetaKit is a web-based platform (GetaKit.ca), which allowed eligible Ontario residents to obtain free HIV self-tests. The study emerged in response to the licensure of the INSTI<sup>®</sup> HIV self-test in Canada and its sale price of \$54CAD, including taxes and shipping costs (BioLytical, 2022). Because this cost was prohibitive for many of the persons most affected by HIV—which would likely negate the potential benefits of self-testing—we implemented GetaKit to evaluate the outcomes associated with distributing free HIV self-tests to persons with risk factors in a nonclinical setting. The pilot operated in Ottawa from July 20, 2020 to March 31, 2021. The full project, with Ontario-wide distribution, started April 1, 2021. The Ontario HIV Treatment Network funded this study (EFP-2020-DC1) and research ethics approval was obtained from the University of Ottawa (H-12-20-6450).

To obtain a free HIV self-test, all potential participants had to review and digitally accept a research consent form, register on the website, complete the online HIV risk self-assessment, and, if eligible, order the self-test for home delivery or curbside pick-up. In other words, to obtain an HIV self-test, when completing their risk assessment on GetaKit.ca, persons needed to report injection drug use or sexual practices that can transmit HIV (i.e., condomless vaginal and/or anal sex). This HIV risk assessment was based on the CDC and Public Health Agency of Canada guidelines for clinical practice (CDC, 2021a, 2021b; Public Health Agency of Canada PHAC, 2022).

Regarding test results, study participants were asked to report their self-test results after testing and were reminded of this twice (at day 10 and 17 from ordering); result reporting, which included the options of positive, negative, invalid, and prefer not to report, was also required when participants reordered self-tests. Participants who reported test results were given status specific information: those who reported positive results were linked to confirmatory HIV testing and care; those who reported invalid results were instructed to reorder a test and given supplemental information about performing the self-test; those who reported negative results were given details about HIV window periods and retesting, with those belonging to the groups most affected by HIV (e.g., gbMSM and ACB) also being given information about HIV PrEP and postexposure prophylaxis (PEP), and how/where to obtain these interventions. Of note, in Ontario, where this study occurred, confirmatory HIV testing and HIV care was provided without charge to all residents.

### 2.2 | Sample

Inclusion criteria for the study were as follows: living in Ontario, being HIV-negative or of unknown HIV status, and being 16 years of age and older. Exclusion criteria included being HIV-positive or in an HIV vaccine trial, taking PrEP and doing HIV testing per guidelines, or having a bleeding disorder.

## 2.3 | Recruitment

While anyone who was eligible based on these criteria could obtain a self-test, targeted promotion was geared at gbMSM and ACB populations through social media (via Facebook, Instagram, and Twitter) and through partner agencies who work with these populations. We also created specific GetaKit subsites (e.g., GetaKit.ca/BlackCap and GetaKit.ca/Max), which were dedicated to recruiting these participants. These subsites were all components of the GetaKit study (with centralized consent, assessment, and data collection), but had different images and resources to tailor them to specific populations.

## 2.4 | Measures and data collection

The GetaKit registration form inquired about age, ethnicity, and country of birth. The risk self-assessment asked questions about sex, gender, sexual orientation, sex and drug use practices, condom use, history of sex work, and testing histories for, and prior diagnoses of, sexually transmitted infections and HIV. Data collection occurred through the website and captured the following: registration, risk assessment, ordering, and results reporting information. The study period for this paper was April 1, 2021 to January 31, 2022, thus constituting a 10-month data collection period starting with the Ontario-wide scale up.

## 2.5 | Data analysis

We exported anonymized data from the website into an MS Excel file for analysis.  $\chi^2$  analyses were performed using an a priori determined  $p$  value of 0.05 to determine significance. For analyses involving sex, we classified persons based on their self-identification as male or female, whereby, for example, trans-females and cis-females were both considered to have identified as female. This approach both respected participants self-determined gender and enhanced privacy by eliminating small cell sizes during data analysis. No preliminary or pilot data were included in this analysis.

## 3 | RESULTS

During the study period, 2121 persons registered on GetaKit.ca, of whom 73% ( $n = 1551$ ) were eligible (see Table 1.) Eligible participants were on average 32 years old, 40% ( $n = 626/1551$ ) White and 26% ( $n = 399/1551$ ) ACB. Regarding gender, 21% ( $n = 325/1551$ ) were cis-female, 65% ( $n = 1015/1551$ ) cis-male, 1% ( $n = 15/1551$ ) trans-female, 2% ( $n = 25/1551$ ) trans-male, and 7% ( $n = 109/1551$ ) gender nonconforming. Regarding sexual orientation, 53% ( $n = 823/1551$ ) identified as gbMSM, 10% ( $n = 153/1551$ ) as lesbian, bisexual, or other women who have sex with women, 25% ( $n = 394/1551$ ) as heterosexual, and 1% ( $n = 20/1551$ ) as asexual. Lastly, 60% ( $n = 937$ )

**TABLE 1** Comparing ACB and White Participants

Characteristics	ACB		White		Bivariate	
	N	%	N	%	$\chi^2$	$p$
Sex						
Male	251	66	445	64	0.4817	NS
Female	129	34	251	36		
Males						
gbMSM	189	80	386	89	1.3456	NS
Heterosexual	46	20	47	11		
Country of birth						
Canada	134	34	553	88	327.6126	<0.001
Outside of Canada	261	66	72	12		
Risk practices—drug use						
Drug use	16	4	70	11	16.0239	<0.001
No drug use	379	96	555	89		
Risk practices—sex work						
Sex work	33	8	61	10	0.5216	NS
No sex work	358	92	562	90		
History of STI diagnosis						
Prior STI diagnosis	63	16	166	27	16.1647	<0.001
No prior STI diagnosis	336	84	460	73		
Last HIV test						
<12 months ago	140	60	189	47	8.8264	0.002
>12 months ago	95	40	210	53		
Prior HIV testing—total						
Prior HIV testing	252	70	467	79	8.9703	0.002
No prior HIV testing	108	30	127	21		
Prior HIV testing—gbMSM						
Prior HIV testing	11652	69	301	80	8.1949	0.004
No prior HIV testing		31	74	20		
Prior HIV testing—females						
Prior HIV testing	87	72	108	71	0.5885	NS
No prior HIV testing	34	28	34	22		
HIV results reported						
Reported	209	52	397	63	12.2838	<0.001
Not reported	190	48	229	37		

Abbreviations: ACB, African, Caribbean, or Black; gbMSM, gay, bisexual, and other men who have sex with men; STI, sexually transmitted infections.

reported that they were employed, 21% ( $n = 319$ ) were students, and 1% ( $n = 16/1551$ ) were retired.

Among participants who identified as ACB or White, there were no differences in the proportion who identified as male or female ( $\chi^2 = 0.48$ ,  $p = 0.48$ ). There were also no differences in the proportion

of males who identified as gbMSM or heterosexual in ACB versus White participants ( $\chi^2 = 135$ ,  $p = 0.24$ ), nor in the distribution of females who denied prior HIV testing for ACB and White participants ( $\chi^2 = 0.59$ ,  $p = 0.44$ ). There were no differences in the proportion of all participants who reported a history of sex work in ACB versus White ( $\chi^2 = 0.52$ ,  $p = 0.47$ ), nor among female participants only ( $\chi^2 < 0.001$ ,  $p = 0.98$ ).

In contrast, more White than ACB participants reported prior HIV testing, whether as serology, point-of-care testing, or self-testing ( $\chi^2 = 8.97$ ,  $p = 0.002$ ), although more White than ACB participants reported that their last HIV test was more than 12 months ago ( $\chi^2 = 8.83$ ,  $p = 0.002$ ). For gbMSM participants, more White compared to ACB gbMSM similarly reported prior HIV testing ( $\chi^2 = 8.19$ ,  $p = 0.004$ ). Drug use and previous sexually transmitted infections (STI) diagnoses were also more frequently reported by White compared to ACB participants ( $\chi^2 = 16.02$ ,  $p < 0.001$  for both). Similarly, among the 62% ( $n = 962/1551$ ) of participants who reported their HIV self-test results, more White than ACB participants reported their results ( $\chi^2 = 12.28$ ,  $p < 0.001$ ). Lastly, there were five positive HIV self-test results reported, split evenly among ACB and White participants.

## 4 | DISCUSSION

In this paper, we reported on ethnicity data—specifically focusing on ACB participants—for the first 10 months of the Ontario-wide GetaKit study, which allowed persons at-risk for HIV to order free HIV INSTI<sup>®</sup> self-tests for home delivery or curbside pickup. Herein, we focused on differences by ethnicity among GetaKit participants, comparing those who identified as ACB or White, and male or female. Among the 1551 eligible participants, 26% identified as ACB and 40% as White, and 22% as female. In comparing ACB and White participants, there were no differences in the distributions of gender/sex or sexual orientation between the two groups. More White compared to ACB participants however reported prior HIV testing both overall and among gbMSM, although there was no difference in first-time testing among female participants. We also identified more drug use and prior STI diagnoses among White participants. Lastly, fewer ACB participants reported their HIV self-test results, although the number of reported positive results were similar between groups. These findings raise some points for discussion regarding the benefits of HIV self-testing for members of ACB communities.

First, our findings identifying ACB characteristics in relation to use of GetaKit suggest that targeted HIV self-testing through GetaKit enabled access to HIV testing for ACB persons. Whereas 26% of GetaKit participants identified as ACB, in 2019 members of ACB communities accounted for only 4.6% of HIV blood tests done in Ontario (OHESI, 2019). As well, in GetaKit, more ACB (30%) compared to White (21%) participants were first-time testers. These results correspond with the extant literature, which suggests that HIV self-testing is accepted, and in some cases preferred, over traditional

testing strategies across many populations (Frye et al., 2021; Hawk et al., 2020; Mathews et al., 2020). A recent literature review further suggested that, “in North America, Asia, and the Pacific regions, web-based distribution ranked highest” (Eshun-Wilson et al., 2021). Lastly, a meta-analysis of randomized controlled trials (13 of 14 being from sub-Saharan Africa) identified that HIV self-testing “increased testing uptake overall” (Jamil et al., 2021).

Despite these successes with uptake, our results highlight the need to increase access for ACB women who have not previously undergone HIV testing. As of 2019 in Ontario, ACB women accounted for 59% of new diagnoses among females (OHESI, 2019), yet we identified no significant differences in the rate of uptake among ACB women compared to White women in our study. While previous syntheses of the literature suggest that web-based ordering is preferred in North American contexts (Eshun-Wilson et al., 2021), research is required to determine why the proportion of first-time female testers was not higher among ACB participants in GetaKit, despite increased uptake among first-time testers overall and a specific focus on members of ACB communities. In other words, despite ACB populations having been targeted for recruitment in GetaKit, the proportion of first-time testers was not significantly different between female White and ACB participants. Researchers need to determine if this finding relates to the online interface used for GetaKit, concerns about privacy or confidentiality, or other factor(s). In-depth qualitative research that unpacks sexuality and relationships among ACB men and women are required (Husbands et al., 2019). To the best of our knowledge, there is also a paucity of information about ACB women and HIV self-testing that needs further development.

Second, our identification of ACB GetaKit user characteristics contribute to a growing body of literature which suggests that the clinical indications listed in current PrEP guidelines, such as a diagnosis of rectal gonorrhoea, may not be adequate for identifying ACB persons who are good candidates for PrEP (Auerbach et al., 2015; Lelutiu-Weinberger & Golub, 2017; Nelson et al., 2019). Current guidelines from Canada and the United States emphasize offering PrEP after diagnoses of STIs and to persons who use drugs. However, compared to White participants in this study, ACB participants had lower rates of both STIs and drug use and no difference in HIV positivity despite lower rates of results reporting (Centers for Disease Control, 2021; Tan et al., 2017). Identifying clinical indicators for PrEP for ACB populations is essential, considering that this group accounts for an inequitable number of new HIV diagnoses. The lower rate of results reporting in GetaKit also highlights that our strategy to offer information about PEP and PrEP after a reported result meant that a relatively smaller number of ACB participants obtained information about and referrals for PrEP, compared to White participants. This signals that alternate strategies are required and more sensitive clinical indicators—whatever these are determined to be—are needed to help members of ACB populations be identified for and obtain PrEP.

## 5 | LIMITATIONS

Our results must be interpreted considering certain limitations. For one, this study targeted ACB and gbMSM populations, yielding higher proportions of these individuals than would likely occur by chance. Such targeting may have had more influence over early adopters, signaling that these results are influenced by those who were most willing to use self-testing. The COVID-19 pandemic also likely influenced results, as lockdowns restricted healthcare access, and potentially increased uptake of GetaKit above what would have occurred otherwise. Lastly, our data were based on self-report, with about 38% of results not having been reported. Variations in the positivity rates between groups may have emerged with more data reporting. Self-report may also have influenced these results, with some participants being more/less likely to report socially stigmatized practices (e.g., condomless anal sex, injection drug use, and sex work). How this might have influenced the results, however, is unknown—and should be the basis of future research.

## 6 | CONCLUSIONS

In this paper, we overviewed the first 10-months of the Ontario-wide GetaKit study, which provided free HIV self-tests to individuals with risk factors for HIV acquisition. Our findings suggest that self-testing enabled access to HIV testing among our ACB participants, who had a higher proportion of first-time testers compared to others in the study, and who had lower reported rates of prior drug use or STI diagnosis. Because HIV testing can identify undiagnosed infections, which can correspond with treatment initiation, improved quality of life, and decreased onward transmission, and it can identify persons who warrant PrEP, increasing access to testing is a key HIV prevention strategy overall. We did identify, however, lower rates for reporting self-test results among our ACB, compared to White, participants, signaling the need to determine if new strategies are required for linkage to care and PrEP referral. Additional qualitative research (interviews and/or focus groups) is needed to learn why some ACB participants did not report their self-test results. Trust in the healthcare system could be a concern, as could fear of being criminalized. The voices of ACB participants are thus needed to explain the lower rates of self-reporting and subsequently to develop strategies for improvement, as well as a possible rationale for not relying on clinical data for access to PrEP. Increasing access among first-time testing among ACB women was also identified as a need. Taken together, these results highlight that research focusing on sex and race/ethnicity identifies important findings about who uses self-testing, and that self-testing is an important component of the HIV prevention armamentarium—just one that requires further research to determine how to maximize its uptake among, and benefits for, ACB populations and women.

## AUTHOR CONTRIBUTIONS

Patrick O'Byrne designed and oversaw the study, undertook data collection and analysis, and led this manuscript. Alexandra Musten is the coinvestigator on GetaKit; she helped design the study, and was involved in data collection and analysis and manuscript development. Lance McCready is a coinvestigator on GetaKit, and helped with data analysis and manuscript preparation. Robin Robinson contributed to recruitment and final paper review and approval. Garfield Durrant contributed to recruitment and final paper review and approval. Jason Tigert is a research assistant who contributed to data analysis and paper development and drafting. Lauren Orser is a research assistant who contributed to recruitment, data analysis and write up, and paper drafting, editing, and final approval.

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## CONFLICT OF INTEREST

The authors declare no conflict of interest.

## DATA AVAILABILITY STATEMENT

The data are upon request.

## ETHICS STATEMENT

The University of Ottawa Research Ethics Board approved this project (H-12-20-6450). All participants provided informed consent to participate.

## ORCID

Patrick O'Byrne  <http://orcid.org/0000-0002-0587-1409>

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