Community based syphilis screening: feasibility, acceptability, and effectiveness in case finding


Objectives: To investigate the feasibility and acceptability of implementing community based syphilis screening using different sample collection techniques, and its effectiveness in screening at-risk populations and identifying new syphilis cases.

Methods: Two phases of syphilis screening were conducted in venues frequented by men who have sex with men (MSM). Phase 1 used venepuncture and phase 2 a validated saliva test. Evaluation used quantitative data from testers, venues and the local genitourinary medicine (GUM) clinic, and qualitative data from venue and programme staff.

Results: 1090 MSM were tested over 7 weeks. 62% of testers had not attended a GUM clinic in the past year. 64% of testers reported ≥2 sexual contacts in the past 90 days and 11% reported ≥10. Similar diagnosis rates were recorded for phase 1 (1.4%) and phase 2 (1.8%). There was greater uptake of testing with the saliva test in saunas during phase 2.

Conclusions: Syphilis screening in gay venues is feasible and acceptable to at-risk MSM, and reaches a group not routinely accessing GUM services. The low case detection for syphilis suggests this approach, while unlikely to contain outbreaks, may be more useful if combined with screening for other sexually transmitted infections and effective health promotion strategies.

METHODS

The screening programme was undertaken in two phases and involved a collaboration between a community based organisation (CBO), the local genitourinary medicine (GUM) clinic, the primary care trust (PCT), and research partners. Our overall approach was similar to screening programmes in Dublin and Manchester. During each session, one to four CBO workers circulated venues explaining the testing procedure. GUM clinic staff (one or two) collected a specimen from customers in a designated area of the venue and collected basic clinical and evaluative data. Staff also recorded the type of venue, estimated population, and numbers testing during each session. Those testing positive were contacted within 15 days and invited to attend the GUM clinic for confirmatory testing, treatment, and contact tracing.

Phase 1 “Only a little prick”
Phase 1 ran for 4 weeks in autumn 2002 and used conventional venepuncture. All local gay venues were invited to participate to provide as comprehensive a service as possible, and to identify any associations between type of venue and infection rates. Venues were excluded only where managers/owners declined.

Phase 2 “Suck it and see”
The second phase of the screening programme ran for 3 weeks during summer 2003. The shorter recruitment period was in response to customer saturation observed during the last stage of the first programme. The selection of venues in phase 2 was service driven rather than answering a specific research question. Screening was concentrated in a smaller number of venues where data from phase 1 demonstrated that men screened reported more casual and anonymous sexual partners and were therefore potentially at greater risk of syphilis. Testing in phase 2 involved a newly validated saliva assay rather than venepuncture.

The salivary test was devised and validated as part of a separate study organised by the Health Protection Agency (report in preparation). Tests on 167 subjects with serological evidence of infectious syphilis showed an overall sensitivity of 86%, comprising 71% for primary, 93% for secondary, and 90% for early latent syphilis. Tests on 139 controls revealed two reproducible false positives. All cases identified during the screening phases were confirmed using standard serological testing.

Evaluation design
Our evaluation incorporated four key outcomes: acceptability and feasibility to customers and venues, effectiveness in identifying new syphilis cases.

Abbreviations: CBO, community based organisation; GUM, genitourinary medicine; MSM, men who have sex with men; PCT, primary care trust; STI, sexually transmitted infections
testing at-risk populations, effectiveness in identifying new syphilis cases, and the comparative acceptability and feasibility of using saliva samples versus conventional venepuncture. “At-risk” populations were defined as MSM similar to known syphilis cases in age and number of sexual partners, or MSM with no recent history of GUM attendance, despite multiple sexual partners. Qualitative interviews and focus groups were conducted with programme staff and venue managers and analysed to identify factors that impeded or facilitated “feasibility, acceptability, and effectiveness in screening at-risk populations”.

RESULTS
Feasibility and acceptability to customers and venues
In phase 1, all 30 local gay venues were invited to participate and 23 (77%) agreed. In phase 2’s more focused screening, 16 venues, including 13 from the previous phase and three newly opened ones, were approached and all agreed to participate. In total, 588 MSM were tested during phase 1 and 502 during phase 2. The proportion of the venue population tested varied between sessions, between venue types, and between phases of the screening programme. Lowest uptake rates were in cruising grounds and the highest in saunas (table 1).

Qualitative data identified the following facilitators of acceptability: the strong relation between the CBO and local venues, provision of a separate testing area, and involving venue staff in promoting the programme (wearing campaign T-shirts and testing themselves). Barriers to acceptability included testing during “happy hours” and sessions provided by all female clinic staff.

Effectiveness in testing at-risk populations
Overall, 62% (672/1090) of testers had not been to a GUM by all female clinic staff. Testing during “happy hours” and sessions provided included testing during “happy hours” and sessions provided. Barriers to acceptability: the strong relation between the CBO and local grounds and the highest in saunas (table 1).

Effectiveness in identifying new index cases of syphilis
From 1090 tests a total of 17 cases of previously undiagnosed syphilis were detected, giving an overall new diagnosis rate of 1.6%. Of these 17 cases, six were confirmed as early syphilis. The remaining 11 had either not attended GUM services in the past year, or had not previously syphilis serology and were therefore classified as late latent syphilis. Case identification rates were similar in phase 1 (1.4%) and phase 2 (1.8%) (table 1). In the GUM clinic during phase 1 and phase 2, nine and seven early infectious syphilis cases were diagnosed, respectively, giving a diagnosis rate of 4% (16/397) in the clinical setting.

Acceptability and feasibility of saliva samples versus venepuncture
Testing uptake was higher in phase 2 in saunas, but did not differ between phases with any of the other venue types (table 1). The lower specificity of the saliva test resulted in a higher rate of false positives than occurred in phase 1. Qualitatively, saliva testing was more acceptable and easier to administer, although outreach workers reported customer tool, raising awareness and encouraging some groups—for example, some sauna users who did not access other areas of the gay scene, to attend GUM services. Of those who had not recently attended GUM services, 65% (434/672) reported ≥2 sexual partners in the past 90 days. In both phases testers were similar to early syphilis cases already diagnosed in the GUM clinic with respect to age and number of partners in the past 90 days (table 1). Comparison of testers recruited from different venue types showed that in both phases, public sex site testers were significantly older (p<0.001), and reported significantly more partners in the past 90 days (p<0.001).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Feasibility and acceptability based on venue and tester uptake in phases 1 and 2 of community syphilis screening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feasibility</strong></td>
<td><strong>Phase 1</strong></td>
</tr>
<tr>
<td>% of venues agreeing to participate</td>
<td>77% (23/30)</td>
</tr>
<tr>
<td>Number of venue sessions</td>
<td>70</td>
</tr>
<tr>
<td><strong>Acceptability</strong></td>
<td></td>
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<tr>
<td>Total number of men testing</td>
<td>588</td>
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<tr>
<td>Overall % of venue populations who tested</td>
<td>9.8%</td>
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<tr>
<td>% of non-public sex site bar/club populations testing</td>
<td>9.0%</td>
</tr>
<tr>
<td>% of sauna populations testing</td>
<td>23.1%</td>
</tr>
<tr>
<td>% of cruising ground populations testing</td>
<td>11.7%</td>
</tr>
<tr>
<td>% of sex on premises club populations testing</td>
<td>12.0%</td>
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Effectiveness in testing at-risk populations

| **Phase 1** | **Phase 2** |
| % of sex on premises club populations testing | 12.0% | 19.5% |
| No of previously undiagnosed syphilis cases that were early syphilis | 4 | 2 |
| No of EIA positive results | 29 | 43 |
| No of previously undiagnosed syphilis cases | 8 | 9 |
| Difference between community testers and known syphilis cases: | | |
| Phase 1 | Phase 2 |
| No of sexual contacts in last 90 days (median) | 33 | 33 |
| Age (median) | 33 | 36 |
| Number of sexual contacts in last 90 days (median) | 3 | 7 |
| Co-infection | 1× HIV+ (already diagnosed) | 1× HIV+ (already diagnosed) |
| Known cases | 93 | 156 |
| Phase 1 | Phase 2 |
| 1× rectal gonorrhoea (co-diagnosed) | 4 | 2 |
| 1× chlamydia (co-diagnosed) | 4 | 2 |

*p values for categorical variables from the χ² test, p values for continuous variables from the Mann-Whitney test.
Angeles’ gay venues in 1999 (0.48%). By contrast, the venues in 2000–1 (1.4%), and somewhat higher than in Los Angeles’ gay venues in 1999 (0.48%). By contrast, the diagnosis rate in Dublin gay venues in 2000–1 was considerably higher (7.5%). The number of uncontrolled variables in a programme evaluation compared to an experimental study makes these differences hard to interpret and anonymous prevalence surveys may be the most useful way to investigate such variation.

Saliva testing was easier to administer, and demanded fewer clinical staff and health and safety requirements than venepuncture. Because the test does not differentiate between old and new infection, we would advise avoiding testing those with a previous history of syphilis. However, it does allow teams to go into a venue, screen large numbers, identify the small proportion of positive individuals, and fast track them for a clinic appointment and full laboratory investigation for all infections. Overall, saliva testing did not increase testing uptake, although it did increase uptake in saunas. It is also possible that saliva testing led to increased overall uptake among MSM at lower risk of syphilis, based on the higher proportion of testers in phase 2 that reported GUM attendance in the previous year compared to phase 1.

The value of undertaking a community based syphilis screening in outbreak management depends on the populations, the testing venues, and the rationale for its implementation. Our findings concur with reports from other community based screening programmes that this approach results in low case detection rates. It is unlikely therefore that such interventions will have a significant impact on outbreak evolution. In comparison, testing for other STIs in community settings, particularly male only saunas, has proved more fruitful with prevalence rates of 10.7% for chlamydia and/or gonorrhoea, and 11.5% for gonorrhoea alone. As we have shown, focusing testing on such venues may identify individuals with higher numbers of partners, and therefore greater overall risk for STI acquisition.

In summary, we have shown it is possible to identify a large population of MSM, at risk of STIs, who are not routinely accessing GUM services, but who are willing to test in a community environment. We believe that such programmes in future should not restrict themselves to syphilis identification, but rather should be used to screen for multiple STIs and encourage further effective health promotion.

**ACKNOWLEDGEMENTS**

The authors wish to thank those who tested and who made their venues available to the project, the Department of Health for providing funding, and the staff of the Claude Nicol Centre and the Lawson Unit, Royal Sussex Country Hospital, Brighton, for their patience, commitment, and support of this study.

**CONTRIBUTORS**

NL managed the screening programme and data collection and wrote the first draft of the paper; NL and JI designed the evaluation and data collection tools; CM, NL, and JI guided and performed the quantitative analysis; NL, JI, and RW performed qualitative data collection and analysis; AP and RW supervised the day to day running of the programme and staffing; RW coordinated community support and participation for the Brighton Syphilis Outbreak Project; JF led the saliva test validation and supervised laboratory testing of them; AI and NP provided programme advice; MF and GD were the principal investigators on the Brighton Syphilis Outbreak Project and contributed to all stages of the project and paper writing; all of the authors contributed to the design and development of the programme, paper review and comments on successive drafts.

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Funding: UK Department of Health.

Conflict of interest: none.

Ethical approval: Ethical approval for the Brighton Syphilis Outbreak Project, including this evaluation, was obtained from the Brighton and Mid-Sussex Local Research Ethics Committee.

**REFERENCES**


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