

HEPscreen Toolkit Case Study:

a hybrid model in Barcelona using active community outreach and opportunistic testing in primary care

Who are you?

My name is Manuel Fernandez and I am a medical doctor specialising in public health and epidemiology. I work at the Public Health Agency of Barcelona (ASPB) and I coordinated the HEPscreen pilot along with my colleagues in epidemiology, community health and primary care. The Unit for Prevention and Control of Tuberculosis, the Unit of Tropical Medicine, the International Health Centre in Drassanes (UMTSID), and the Raval Sud Primary Care Centre were also closely involved in the project.



Where are you based?

ASPB covers the city of Barcelona in Catalonia, Spain. This project was focused in Ciutat Vella, an inner city neighbourhood of 100,000 people close to the port. In this neighbourhood, over 40% of people are migrants, mostly from Latin America, Central/Eastern Europe, North Africa, and South and East Asia. Migration is a relatively recent phenomenon in Spain, following a dramatic increase after the turn of the 21st century.

Which population did you hope to reach? Why was this group targeted?

The target populations were migrants from Latin America and Central/Eastern Europe. Latin American migrants were identified because they are the largest migrant community both in Spain and in the city of Barcelona. The relatively large Central/Eastern Europe migrant population, mainly from Romania, was selected also because of size but also because of the medium to high viral hepatitis prevalence in these countries.

What did you do?

There were two approaches – active outreach via community health workers (CHW) and opportunistic testing in an international health centre. In the outreach strategy, CHWs held education and awareness sessions in social and cultural locations that are easy to access

and well-known to the target population. Information leaflets were also provided to supplement the face-to-face education session. At the end of the education sessions, people were referred to the GP to complete a health questionnaire and were then offered an appointment for testing. At the point of testing, a follow up appointment for the results was then made. In the opportunistic testing strategy, people who met eligibility criteria (country of birth) who visited the health centre for another issue were then offered an appointment for viral hepatitis testing. Information about viral hepatitis was provided face-to-face by the nurse offering testing. All of those testing positive were referred to a specialist for further examination and possible treatment. HBV vaccination was offered to susceptible people.



Did you provide language support to people offered testing? Either translated materials or interpreters?

Being native Spanish speakers, most migrants from Latin America didn't need language support. For the Central/Eastern European migrants, language was an issue. The educational and awareness sessions were delivered in languages spoken by migrants from these countries including Russian.

What training did you offer to workers involved in raising awareness or offering testing?

Nurses and GPs who collaborated in the project have extensive experience in communicable diseases and work regularly with migrant populations. CHW are experienced in education outreach and health promotion. Specific training about viral hepatitis was provided to CHW prior the implementation of the educational sessions.

When did this intervention take place?

From October 2012 to July 2014

What was the uptake? How many people benefited from the intervention?

In the outreach strategy, 45 education sessions were held with a total of 337 people, of which 316 provided consent for further contact and testing. Of these, 210 (67%) were seen by the GP for the health questionnaire. Of the 210, 16 participants were excluded by clinical criteria (recent screening test or prior HBV vaccination). Of these 210, 194 were referred to be tested and 171 of whom were actually tested hepatitis B and C. Three cases of chronic hepatitis B and six cases of chronic hepatitis C were identified. The opportunistic testing strategy reached 247 people of whom 234 were tested for hepatitis B and C. Three cases of chronic hepatitis

B and four cases of chronic hepatitis C were identified. We found a low prevalence of both chronic HBV (0.6%) and HCV (0.3%) in migrants from Latin America. We found a medium prevalence of chronic HBV (4.8%) and high prevalence of chronic hepatitis C (11.1%) among migrants from Central/Eastern Europe.

What are the key lessons learnt? If another service were to replicate your model, what advice would you give? What would you do differently if you were to repeat the intervention? What would you repeat?

Both strategies are effective and we would repeat them, but with certain considerations and modifications. In the case of the outreach strategy, on-site screening after the educational session could increase the numbers actually screened and limit the drop out we experienced at the different stages. This strategy also reached people in socio-economically vulnerable circumstances, such as insecure housing or employment conditions and limited access to the health care system. It is important and recognise and try to overcome these barriers; for us, the mediation role of CHW was invaluable and did improve adherence, solve problems and prevent the loss of these participants. To expand opportunistic testing, clear clinical guidelines for GPs that explain who should be offered testing, why and how are much needed. This would help to ensure screening is systematically offered in an effective and sensitive way to risk groups. It would also help to reduce professional uncertainty about screening for viral hepatitis.

