Self-collection of samples as an additional approach to deliver testing services for sexually transmitted infections: a systematic review and meta-analysis

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ABSTRACT

Background Self-collection of samples for diagnostic testing offers the advantages of patient autonomy, confidentiality and convenience. Despite data showing their feasibility and accuracy, there is a need to better understand how to implement such interventions for sexually transmitted infections (STIs). To support WHO guidelines on self-care interventions, we conducted a systematic review to investigate whether self-collection of samples should be made available as an additional approach to deliver STI testing services.

Methods Peer-reviewed studies were included if they compared individuals who self-collected samples for chlamydia, gonorrhoea, syphilis and/or trichomonas testing to individuals who had samples collected by clinicians on the following outcomes: uptake/frequency of STI testing, social harms/adverse events, positive yield (case finding), linkage to clinical assessment/treatment and reported sexual risk behaviour. We searched PubMed, CINAHL, LILACS and EMBASE for articles published through July 2018. Risk of bias was assessed using the Cochrane tool for randomised controlled trials (RCTs) and the Evidence Project tool for non-RCTs. Meta-analysis was conducted using random effects models to generate pooled estimates of relative risk (RR).

Results Eleven studies, including five RCTs and six observational studies with a total of 202,745 participants, met inclusion criteria. Studies were conducted in Australia, Denmark and the USA. Meta-analysis found that programmes offering self-collection of samples increased overall uptake of STI testing services (RR: 2.94, 95% CI 1.18 to 7.28) and case finding (RR: 2.17, 95% CI 1.19 to 3.98). No studies reported measuring STI testing frequency, social harms/adverse events, linkage to care or sexual risk behaviour.

Discussion While greater diversity in study designs, outcomes and settings would strengthen the evidence base, findings from this review suggest that self-collection of STI samples could be an effective additional strategy to increase STI testing uptake.

Prospero registration number PROSPERO CRD42018114866.

Key questions

What is already known?

► Self-collected samples for sexually transmitted infection (STI) testing are as accurate as clinician-collected methods and are feasible and acceptable in a variety of populations.

What are the new findings?

► A systematic review identified 11 studies from three high-income countries (Australia, Denmark and the USA), conducted in a variety of populations.

► Meta-analysis showed that, compared with clinician-collection, self-collection of samples increased uptake of STI testing services.

► In meta-analysis, the intervention group (people who were offered STI services with self-collection of samples) had a higher yield of positive diagnoses (ie, case finding) compared with the group offered only clinician-collected STI tests; however, when analyses were limited to those who accepted STI testing services (rather than all offered services), self-collection was associated with lower positive yield.

What do the new findings imply?

► Self-collection methods can offer an alternative approach for STI testing, with implications for universal health coverage and the achievement of the UN Sustainable Development Goals.

INTRODUCTION

Worldwide each year, there are an estimated 357 million new infections of one of the four curable sexually transmitted infections (STIs): chlamydia, gonorrhoea, syphilis and trichomoniasis.1 2 Aetiological diagnosis via STI testing is the best way to ascertain infection status and promote appropriate treatment.3 4 While STI diagnostic tests are available and used in many high-income countries, diagnostic tests in low-income and middle-income...
country (LMIC) settings are largely unavailable. Syndromic management has been the primary approach for STI treatment in LMICs, which has significant limitations despite its practicality; experts doubt it will impact STI disease burden. Globally, social stigma and a lack of effective policies also affect STI testing uptake and treatment-seeking behaviour. Low STI testing coverage and high transmission rates are common among at-risk vulnerable adolescents and key populations including men who have sex with men (MSM), migrants, sex workers, Indigenous and minority populations and those affected by humanitarian emergencies. Left undiagnosed and untreated, curable STIs can cause acute and chronic illness, infertility, ectopic pregnancy, long-term disability, neurological and cardiovascular disease and death. Serious diseases in their own right, STIs also increase the risk of contracting or transmitting HIV infection. Consequently, greater efforts are needed to expand STI testing globally to reduce this heavy burden of disease.

Self-collection of samples is one way to facilitate the expansion of STI testing services. Self-collection of samples occurs when individuals take a sample themselves, either at the clinic or elsewhere, and send it to a laboratory for testing. Follow-up in the case of positive test results requires a linkage with the health system. Research in high-income countries, where organised lab facilities and healthcare are available, shows that self-collected STI samples are as diagnostically accurate as clinician-collected samples and that self-collection interventions are feasible and acceptable in a variety of populations. Self-collection approaches also have the potential to address some common barriers to clinician-dependent and/or clinic-based diagnosis, such as concerns around autonomy, inconvenience, stigma and lack of privacy. Systematic reviews have been conducted to compare STI testing programmes (some including self-collection methods) in home or non-clinic settings to those in clinic settings. However, no review to date has systematically compared self-collection of samples to clinician-collected methods for STI testing on programmatic outcomes. In order to develop WHO guidance on self-care interventions for sexual and reproductive health and rights, we conducted a systematic review to investigate whether STI self-sampling should be made available as an additional approach to deliver STI testing services, whether incorporated into routine STI services or as an alternative model with linkage to care.

**METHODS**

**Definition**

We assessed self-collection of samples for Chlamydia trachomatis (CT), Neisseria gonorrhoeae (NG), Treponema pallidum (syphilis) and Trichomonas vaginalis (TV). This is in line with ongoing multicountry evaluations of promising point-of-care testing (POCT) interventions to detect these four curable STIs as well as the goal of the WHO STI POCT initiative to achieve universal access to reliable and affordable STI testing. There are numerous types of self-collected samples for different STIs, including: urine (mainly among men, but also women and youth) for NG, CT and TV; vulvovaginal swabs for NG, CT and TV; and pharyngeal and anorectal swabs for NG and CT. Rapid dual tests for HIV/syphilis have been developed and evaluated, but only one so far has been prequalified by the WHO, though others are in the process.

**Research question and inclusion criteria**

The review addressed the following research question: should self-collection of samples be offered as an additional approach to deliver STI testing services?

**Population**

Individuals using STI testing services.

**Intervention**

STI testing services that incorporate self-collection of samples.

**Comparison**

STI testing services that do not incorporate self-collection of samples (ie, clinician-collection) or no STI testing services (ie, syndromic management alone or no lab-based intervention).

**Outcomes**

Primary:

1. Uptake of STI testing services (eg, the proportion who accepted and completed the test).
2. Frequency of STI testing.
3. Social harms or adverse events (eg, device-related issues, coercion, violence, psychosocial harm, self-harm, suicide, stigma, discrimination and frequency of HIV testing) and whether these harms were corrected or had redress available.

Secondary:

1. Proportion of people who tested positive for an STI (case finding).
2. Linkage to clinical assessment or STI treatment following a positive test result.
3. Reported sexual risk behaviour (eg, condom use, condomless sex, unprotected sex, number of sexual partners).

To be included in the review, an article had to meet the following criteria:

1. Study design comparing people who self-collected samples to people who had samples collected by a clinician for STI testing or to those who received no STI testing services.
2. Evaluated one or more of the outcomes listed above.
3. Published in a peer-reviewed journal.

Because this study was designed to inform WHO guidelines on the viability of self-sampling as an additional means to increase testing, articles that compared self-collection of samples by the location of intervention delivery (ie, self-collection at home vs self-collection at the clinic) are included.
Figure 1 PRISMA flowchart of the study selection process.

Online database searching retrieved 1207 records and secondary searching 4 records; there were 681 unique citations after removing duplicates (figure 1). After initial screening of titles and abstracts, 286 citations remained for double-screening and 184 underwent full-text review. Total 173 articles were excluded after full-text review, 14 of which were excluded because they compared self-sampling delivery approaches (ie, self-sampling at home vs self-sampling in the clinic) rather than self-sampling vs a non-self-collected sampling approach. A total of 11 studies reported in 11 articles met the criteria for inclusion in the review, 44–51 10 of which were included in meta-analyses. 44–46 48–51

RESULTS

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Study characteristics

All included studies—with 202 745 participants total—were conducted in high-income countries, with six in the USA, 44–46 51 three in Denmark, 48–50 and two in Australia. 44 47 Years of publication ranged from 1998 to 2018.

Search strategy and screening process

We searched PubMed, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Latin American and Caribbean Health Sciences Literature (LILACS) and Embase through the search date of 18 July 2018, with no limits on publication year, study location or language. We also conducted secondary reference searching on all studies included in the review and three relevant systematic reviews. 19 28 31 Selected experts in the field were contacted to identify additional articles not identified through other search methods. We searched for ongoing randomised controlled trials (RCTs) on clinicaltrials.gov, the WHO International Clinical Trials Registry Platform, Pan African Clinical Trial Registry and the Australian New Zealand Clinical Trials Registry. Search terms were developed for STIs and self-sampling; the full search strategy for is available in online supplementary file 1.

After initial screening of titles, abstracts, citation information and descriptor terms, records were screened independently and in duplicate by two reviewers, with differences resolved through consensus. Full-text articles were obtained of all selected records. Three reviewers independently assessed all full-text articles for eligibility to determine final study selection. Differences were resolved through consensus.

Data extraction and management

For each study, the following information was compiled via independent double-data extraction: study citation, objectives, location, population characteristics, description of the type of STI sampling, description of any additional intervention components, sample size, follow-up periods and loss to follow-up, analytic approach, reported numerical outcomes, results and limitations.

Methodological components of the studies were assessed and classified as high or low risk of bias. For RCTs, risk of bias was assessed using the Cochrane Collaboration’s tool for assessing risk of bias. 38 For comparative studies that were not RCTs, study rigour was assessed using the Evidence Project risk of bias tool for intervention evaluations. 29

Data analysis

Data were analysed according to coding categories and outcomes. Where multiple studies reported the same outcome, we conducted meta-analysis using random effects models to generate pooled estimates of relative risk (RR) using the programme Comprehensive Meta-Analysis. 40 Heterogeneity was assessed using both Q and I-squared statistics. Data from RCTs and observational studies were analysed separately. For the case finding outcome for the RCTs, we ran sensitivity analyses to explore differential effects between self-collection and clinician-collection by using as a denominator (1) all study participants enrolled and randomised to study arms regardless of testing uptake (true intention-to-treat) and (2) only participants who collected samples for STI testing services (subgroup of respondents only).

Patient and public involvement

Patients and the public are currently involved in a global survey of values and preferences and in focus group discussions with vulnerable communities conducted to inform the WHO self-care guidelines and thus play a significant role in the overall recommendation outcome from this review.
to 2018. Three studies focused on NG and CT, and five studies on CT exclusively. One study did not report which specific bacterial STIs were covered. No studies compared findings for syphilis. Studies varied in location of self-collection (ie, clinic-based vs home-based), as well as target population (ie, general population, MSM, people living with HIV, adolescents and young people, detainees, people who inject drugs, sex workers and partners of CT-positive patients). Sample self-collection methods included first-void urine, vaginal flush using saline and pharyngeal, rectal and vaginal swabs. The observational studies showed similar findings. Meta-analysis of two observational studies testing for multiple STIs (CT and NG) found a RR of 2.990, but this was not statistically significant (95% CI 0.426 to 20.978, I squared: 95.333). When examining the uptake of CT testing specifically, one study found a positive association with self-collection (RR: 2.351, 95% CI 1.597 to 3.462). A third observational study could not be combined in meta-analysis but found that after implementing an express clinic with self-collection of genital and rectal samples within a large sexual health clinic, 5335 patients were seen (combining both the express and main clinics) compared with 4804 patients seen through the prior routine STI triage and testing services.

Case finding

Four RCTs and five observational studies reported comparisons of STI test positivity rate comparing participants who self-collected samples to those whose samples were collected by a clinician. Meta-analysis of RCTs for case finding found effects in opposite directions, depending on which sensitivity analysis was used (figure 4). When the denominator was all study participants who were enrolled and randomly allocated to self-collection or clinician-collection (intention-to-treat), meta-analysis of the four RCTs measuring the proportion of people who tested positive for any STI found double the likelihood of receiving a positive test result among those who self-collected samples for STI testing, with significant heterogeneity (RR: 2.166, 95% CI 1.043 to 4.498, I squared: 84.387). However, when comparing self-collection to clinician-collection among only those who ultimately provided samples for STI testing, the association between proportion of positive tests and self-collection went in the opposite direction (RR: 0.718, 95% CI 0.585 to 0.882, I-squared: 0.000). These four RCTs measured CT only.

The observational studies generally showed no difference in case finding between self-collection and clinician-collection groups, whether meta-analyses were performed using a denominator of the entire study population or a subgroup of only those who took up STI testing services, and regardless of which specific STI or combination of STIs were getting tested.
Table 1 Description of included studies

| Study | Location, population and STI(s) tested | Intervention | Study methods |
|-------|----------------------------------------|--------------|---------------|
| Anderson et al, 1998[^48] | Location: Aarhus, Denmark  
Population: Index patient CT-positive women attending general practice clinic; their male sexual partners received the intervention  
STI(s) tested: CT | Intervention: Index patients completed a questionnaire about numbers of sexual partners and contacted their partners to collect a first-void urine sample at home for CT testing. Then they returned the sample to laboratory in a prepaid envelope.  
Control: Index patients were given an envelope containing a contact slip and a request for their partner to visit his doctor for a urethral swab sample for CT testing (not reported if index patients completed the questionnaire about number of sexual partners). The doctor returned the sample to study laboratory in a prepaid envelope. | Study design: Randomised controlled trial  
Sample size: Total n=133  
Intervention n=65  
Control n=68 |
| Barbee et al, 2016[^41] | Location: Seattle, Washington, USA  
Population: MSM attending HIV care clinic who were asymptomatic for STIs  
STI(s) tested: CT, NG | Intervention: A new programme included clinic-based, unsupervised, self-initiated self-collection of pharyngeal, rectal and urethral samples by swab for CT and NG testing.  
Comparison: Provider or triage nurse would ensure patient was asymptomatic for STIs (and thus eligible for screening); clinician-collected pharyngeal and rectal swabs for CT and NG testing | Study design: Serial cross-sectional  
Sample size: Total n=3030  
Intervention n=1520  
Comparison n=1510 |
| Bradshaw et al, 2005[^42] | Location: Melbourne central business district, Australia  
Population: People who inject drugs, ages 17–45 years, attending a weekly outreach service of The Melbourne Sexual Health Centre who had not been recently screened for STIs  
STI(s) tested: CT, NG, TV | Intervention: Participants were approached on foot by research staff in known injecting and dealing locations and encouraged to accompany staff back to nearby clinic for STI testing. Participants self-collected vaginal swab (tampon) samples for CT, NG and TV (for women) or urine samples for CT and NG (for men or women who declined the swab method).  
Comparison: In the pilot programme, participants provided clinician-collected endocervical and vaginal samples for CT, NG and TV for women and clinician-collected urethral samples for CT and NG for men. | Study design: Serial cross-sectional  
Sample size: Total n=314  
Intervention n=258  
Comparison n=56 |
| Cook et al, 2007[^43]  
Study name: Detection Acceptability Intervention for STDs in Youth (DAISY) study | Location: Western Pennsylvania, USA  
Population: Sexually active young women, ages 15–24 years, including: (1) women recently diagnosed with CT, NG or TV, recruited from clinic and (2) women from same communities as clinics with less frequent use of health services, meeting at least three of the following five criteria: young age, black race, monthly douching, >1 sexual partner in the past year or living in a high-risk neighbourhood  
STI(s) tested: CT, NG | Intervention: Participants received a vaginal swab self-collection kit for CT and NG testing at home at 6, 12 and 18 months after enrolment (either mailed to address or picked up at clinic), which included a cover letter, instruction sheet, questionnaire, Dacron-tipped swab, prelabelled swab container and postage-paid mailing carton.  
Control: Participants received an invitation to attend an assigned clinic for a free, routine test for CT and NG via clinician-collected vaginal and cervical swabs. | Study design: Randomised controlled trial  
Sample size: Total n=420  
Intervention n=211  
Control n=209 |
| Study          | Location, population and STI(s) tested                                                                                                                                                                                                 | Intervention                                                                                                                                                                                                                                                                                                                                 | Study methods                  |
|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| Gaydos et al., 2011 | Location: Baltimore City and the State of Maryland, USA  
Population: Females, ages 14+ years, median age: 23 (range: 14–63)  
STI(s) tested: CT | Intervention: An internet-based website (advertised on radio and free community magazines) was designed to promote CT home self-sampling (vaginal swab) among young women. For the first 2 years of the programme, participants were able to obtain self-sampling kits via community pickup locations as well as by mail; in the last 3 years of the programme, kits were mailed only.  
Comparison: Participants underwent CT screening in National Infertility Prevention Project family planning clinic, with clinician-collected cervical swab specimens. | Study design: Cross-sectional  
Sample size: Total n=169,531  
Intervention n=1171  
Comparison n=168,360 |
| Habel et al., 2018 | Location: Pennsylvania State University, University Park campus (State College), Pennsylvania, USA  
Population: Males and female students, ages 18+ years, attending Pennsylvania State University and using University Health Services  
STI(s) tested: CT, NG | Intervention: Participants used a CT and NG self-testing walk-in clinic service with self-collected vaginal swabs (for women) or urine samples (for men), which eliminated scheduling barriers and allowed for STI testing without seeing a clinician (but could consult a clinician if the student wanted).  
Comparison: Participants scheduled an STI testing appointment with a clinician. Clinician collected cervical specimens during the examination (for women); men were examined by a clinician and provided urine specimens for lab testing (urethral swabs not offered). | Study design: Serial cross-sectional  
Sample size: Total n=8110  
Intervention n=4385  
Comparison n=3725 |
| Holland-Hall et al., 2002 | Location: Juvenile correctional facility, Allegheny County, Pennsylvania, USA  
Population: New female detainees, ages 12–17 years  
STI(s) tested: CT, NG, TV (TV-related outcome data not reported) | Intervention: Newly admitted girls to the juvenile detention centre were invited to self-collect samples and were provided with a self-sampling kit (containing a Dacron-tipped swab, POR transport tube, cotton-tipped swab, empty sterile test tube and instructions for vaginal swab collection) to test for CT, NG and TV.  
Comparison: As standard of care for new detainees, physicians performed a pelvic examination and endocervical swab sampling for CT and NG testing and vaginal swab sampling for TV testing. (These participants also provided self-collected samples for the intervention group.) | Study design: Cross-sectional  
Sample size: Total n=133  
Intervention n=133  
Comparison n=25 |
| Knight et al., 2013 | Study name: Xpress  
Location: Sydney, Australia  
Population: Patients attending Sydney Sexual Health who were asymptomatic for STIs and from a priority population (MSM, Aboriginal people, sex workers, people who use drugs, HIV-positive people and youth younger than 25 years).  
STI(s) tested: not specified, but bacterial STIs (likely CT, NG, TV) | Intervention: A fast-track STI testing service (Xpress) for drop-in clients was implemented in a large sexual health clinic, which included a computer-assisted self-interview for sexual history and risk assessment followed by a 15 min consultation with an enrolled nurse and self-collected genital and rectal swabs for STI testing (STIs not specified).  
Comparison: Participants underwent the routine triage system by an experienced sexual health registered nurse at the sexual health clinic and, if they met inclusion criteria, were allocated a 30 min consultation with a registered nurse which included a pen-and-paper sexual history and risk assessment, genital examination and clinician-collected genital and rectal specimens for STI testing. | Study design: Serial cross-sectional  
Sample size: Total n=10,139  
Intervention n=5,335  
Comparison n=4,804 |

**Table 1 Continued**
### Table 1 Continued

| Study | Location, population and STI(s) tested | Intervention | Study methods |
|-------|---------------------------------------|--------------|--------------|
| **Ostergaard et al, 1998**<sup>50</sup> | **Location:** Aarhus, Denmark  
**Population:** Male and female high school students, mean age: 18 (female), 18.2 (male)  
**STI(s) tested:** CT | **Intervention:** Students completed a questionnaire and received information regarding CT infection. Female students were asked to collect two urine samples and one vaginal flush sample using saline and males were asked to collect one first-void urine sample. Participants mailed samples from home to the laboratory.  
**Control:** Students completed a questionnaire and received information regarding CT infection; they were offered free STI testing from their doctor or at the local clinic. | **Study design:** Randomised controlled trial  
**Sample size:**  
Total n=8909  
Intervention n=4336  
Control n=4573 |
| **Ostergaard et al, 2003**<sup>49</sup> | **Location:** Four counties in Denmark  
**Population:** Male and female index patients identified as CT-positive in routine lab testing at General Practitioner offices; sexual partners received intervention, mean age: 23.7 (control, female), 22.7 (intervention, female); 25.1 (control, male), 25.6 (intervention, male)  
**STI(s) tested:** CT | **Intervention:** Index patients gave or mailed a package of five specimen collection kits to their partners to be used over the next 12 months. The partners mailed the self-collected samples (first-void urine for male partners; vaginal pipette flush for female partners) to the laboratory for CT testing in postage-paid, preaddressed envelopes.  
**Control:** Partners of index patients needed to go to a medical office to obtain a sample for CT testing, using the provided specimen collection kit. | **Study design:** Randomised controlled trial  
**Sample size:**  
Total N=734  
Intervention n=398  
Control n=336 |
| **Xu et al, 2011**<sup>51</sup> | **Location:** New Orleans, Louisiana; St Louis, Missouri and Jackson, Mississippi, USA  
**Population:** CT-positive women at STI or family planning clinics, ages 16+years, mean age: 22.4 (STI clinic, control), 22.5 (STI clinic, intervention), 21.8 (family planning clinic, control), 21.4 (family planning clinic, intervention)  
**STI(s) tested:** CT | **Intervention:** Participants were mailed (or could pick up from the clinic) a self-collection vaginal swab kit for CT testing; after self-collecting at home, they returned the sample in postage-paid, preaddressed envelopes.  
**Control:** Participants were given an appointment to return to STI or family planning clinics for rescreening for CT infection. | **Study design:** Randomised controlled trial  
**Sample size:**  
Total n=1292  
Intervention n=639  
Control n=653 |

CT, *Chlamydia trachomatis*; MSM, men who have sex with men; NG, *Neisseria gonorrhoeae*; STI, sexually transmitted infection; TV, *Trichomonas vaginalis.*
| Study                          | Outcome: Uptake of STI testing services                                                                 | Outcome: Case finding                                                                 |
|-------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| **Anderson et al, 1998**     | ► The proportion of males who accepted and completed the at-home test was 68% (44/65), a higher proportion compared with males who visited their doctor with a proportion of 28% (19/68), (RR: 2.42, 95% CI 1.60 to 3.68). | ► The proportion of males diagnosed positive for CT was 27% (12/44) for those who self-tested and 37% (7/19) for those who physician-tested (RR: 0.740). |
| **Barbee et al, 2016**       | ► Any site NG/CT: 670/1520 at baseline, 770/1510 during intervention; 15.0% increase (p<0.001).               | ► Detected NG infections overall: 98/1794 at baseline, 147/2706 during intervention; 50% increase. |
|                               | ► Pharyngeal NG/CT: 444/1520 at baseline, 586/1510 during intervention; 32.0% increase (p<0.001).                | ► Detected CT infections overall: 96/1794 at baseline, 141/2706 during intervention; 47% increase. |
|                               | ► Rectal NG/CT: 390/1520 at baseline, 520/1510 during intervention; 33.3% increase (p<0.001).                   | ► Test positivity for pharyngeal NG increased by 22% from 6.4% to 7.8% (p=0.292) and for pharyngeal CT by 21% from 1.4% to 1.7% (p=0.639). |
|                               | ► Urethral NG/CT: 510/1520 at baseline, 697/1510 during intervention; 36.7% increase (p<0.001).               | ► Test positivity for rectal infections declined by 4% (p=0.836) for NG and 16% (p=0.239) for CT. |
|                               | ► All three sites (pharyngeal, rectal, urethral) NG/CT: 243/1520 at baseline, 466/1510 during intervention; 91.8% increase (p<0.001). | ► Urethral chlamydia test positivity increased by 33% (p=0.076).                          |
|                               | ► Absolute testing coverage: 39% tested at the pharynx, 34% at the rectum and 46% at the urethra.            |                                                                                       |
|                               | ► Complete testing (testing at all three sites) completed by 31% of participants                           |                                                                                       |
| **Bradshaw et al, 2005**     | ► Acceptance of genital examination and practitioner-collected sampling for NG/TV in the pilot study was low (5/56, 9%, 95% CI 3 to 19). If these individuals were then offered screening for CT only by urine collection, substantially more accepted testing (18/56, 32%; 95% CI 21 to 45; p<0.01). | ► The overall prevalence of STIs in those who consented to screening for CT, NG and TV was 8% (95% CI 5 to 13). |
|                               | ► STI screening by self-collected sampling had a substantially greater level of acceptance among participants (195/258, 76%; 95% CI 70 to 81; p<0.001) compared with practitioner sampling. | ► All STIs detected were from self-collected samples.                                    |
|                               |                                                                                                         | – CT prevalence: self: 12/195 (6%); practitioner: 0/18.                                |
|                               |                                                                                                         | – TV prevalence: self: 3/195 (2%); practitioner: 0.5.                                  |
|                               |                                                                                                         | – NG prevalence: self: 1/195 (1%); practitioner: 0/5.                                  |

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Ogale, Y., et al. BMJ Glob Health 2019;4:e001349. doi:10.1136/bmjgh-2018-001349

| Study                    | Outcome: Uptake of STI testing services                                                                 | Outcome: Case finding                                                                 |
|-------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| Cook *et al.*, 2007[^43] | ▶ The proportion of women who completed at least one asymptomatic (screening) STI test during the 2 years of follow-up was significantly greater among women in the intervention group (162/197 (82.2%) vs 117/191 (61.3%), p<0.001).<br>▶ The proportion of women who completed >2 asymptomatic STI tests was significantly greater among women in the intervention group (55.9% vs 37.2%, p<0.001).<br>▶ The number of CT and NG tests completed per year was significantly greater in women in the intervention group for all tests (1.94 vs 1.41 tests per woman-year, p<0.001; RR: 1.38 (95% CI 1.23 to 1.55)) and for asymptomatic tests (1.18 vs 0.75 tests per woman-year, p<0.001; RR: 1.57 (95% CI 1.34 to 1.83)).<br>▶ Women in the intervention group were over two times as likely to complete an STI test when asymptomatic or otherwise (RR: 2.12 (95% CI 1.70 to 2.66) vs RR: 1.18 (95% CI 1.03 to 1.35)). | ▶ No significant difference in the rate of incidence of STIs detected during follow-up in the intervention group compared with the control group (20.4 vs 24.1 infections per 100 woman-years, p=0.28). The results were similar when restricted to chlamydia only (17.6 vs 18.9 infections per 100 woman-years) or when restricted to gonorhrea only (4.9 vs 7.9 infections per 100 woman-years). |
| Gaydos *et al.*, 2011[^44] | Not reported                                                                                           | ▶ CT positivity was 10.3% (121/1156) for females mailing swabs obtained online; prevalence ranged from 3.3% to 5.5% (total 6947/168308) in testing performed at family planning clinics.<br>▶ CT positivity for internet age groups was much higher than those for family planning age groups: CT positivity for internet participants ranged from a low of 4.4% in Baltimore in 2005 to a high of 15.2% in Baltimore in 2007. CT positivity in family planning clinics in Baltimore and Maryland ranged from a low of 3.3% in Baltimore in 2006 to a high of 5.5% in Baltimore in 2008. Compared with age-specific positivity proportions obtained for women attending family planning clinics for the City of Baltimore and the State of Maryland for 2004–2008, CT positivity was higher among internet female participants for all age categories; statistically significant differences between programmes for age groups younger than 25 years for Baltimore and <30 years for Maryland.<br>▶ Although trends were similar for earlier years, in 2007, differences in prevalence in Baltimore for internet-recruited samples for age 20–24 years, was 23.5%, compared with 5.4% in family planning, (p<0.001). |

[^43]: Cook et al., 2007[^43]<br>[^44]: Gaydos et al., 2011[^44]
### Table 2: Study of Uptake of STI testing services

| Study                        | Outcome: Uptake of STI testing services                                                                 | Outcome: Case finding                                                                 |
|------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Habel et al, 2018\(^45\)    | ▶ In 2013 55 male and 2711 female students used clinician testing for CT and NG. In 2015, after adding a self-testing option (and retaining clinician testing), 1303 male (28.5% increase) and 3082 female (13.7% increase) students tested for CT and NG. 18.9% of testers in 2015 opted for self-testing.  
▶ 18.9% of testers opted for self-testing in 2015: 31.0% of male students and 13.6% of female students.  
▶ Clinician testing from 2013 to 2015 declined by 11.3% for male students and declined by 1.8% for female students. | ▶ In 2013, 9.7% (98/1007) of male students and 5.0% (135/2700) of female students tested positive for CT/NG via clinician testing. Combined positive diagnoses over total tested before intervention: 103/823.  
▶ In 2015, 1% (111/895) of male students and 4.8% (129/2656) of female students tested positive for CT/NG via clinician testing and 12.9% (52/402) of male students and 12.4% (51/412) of female students tested positive via self-testing. Combined positive diagnoses over total tested after intervention: 240/3562  
▶ In 2015, female students were more likely to test positive when electing to test via self-test vs a clinician test ($\chi^2(1, N=3068)=36.54$, $p<0.01$). No such significant difference in testing type was observed for male students ($\chi^2 = \chi^2(1, N=1297)=0.072$, $p=0.79$). |
| Holl-Willard et al, 2002\(^46\) | Not reported                                                                                             | ▶ The prevalence of any STI (NG, CT, TV) was not significantly higher among those who had pelvic exams (5/25) than among those who underwent self-testing only (21/133) ($p=0.173$).  
- NG: self: 8/94; clinician: 2/25  
- CT: self: 15/133; clinician: 4/25  
- TV (cultured): self: 12/133; clinician: 2/25  
- TV (PCR): self: 11/94; clinician: 2/25  
▶ Only 30% of subjects with infections had pelvic examinations; therefore, 70% of girls with infections would have been missed in the absence of the self-testing option. |
| Knight et al, 2013\(^47\) | ▶ After implementing Xpress clinic (with self-collection of samples for STI testing), 5335 patients were seen (705 in Xpress clinic) compared with 4804 before.  
▶ The ratio of total patients seen to clinical staff hours rostered after implementing Xpress was 1.49 (1.7 in the Xpress clinic and 1.4 in other clinics) compared with 1.52 before. (OR: 1.02; 95% CI 0.96 to 1.09; $p<0.44$)  
▶ Total clinic capacity with Xpress was 8007 patients, compared with 6301 before.  
▶ Utilisation rates were lower after implementing Xpress (67%), compared with 76% before ($p<0.01$). | Not reported. |
### Other outcomes

No studies compared the impact of self-collection of samples to clinician-collection of samples on the following outcomes: frequency of STI testing, social harms or adverse events, linkage to clinical assessment or STI treatment following a positive test result and reported sexual behaviour.

### DISCUSSION

Despite a limited evidence base and considerable heterogeneity in meta-analyses, the existing literature suggests that using self-collection of samples for STI testing increases uptake of STI testing services, whether for testing of any STI, a combination of multiple STIs or CT alone. Meta-analysis also showed that self-collection...
### Table 3: Quality assessment of included studies

#### Cochrane Risk of Bias Tool (for randomised controlled trials (RCTs))

| Study                          | Random sequence generation (selection bias) | Allocation concealment (selection bias) | Blinding of participants and personnel (performance bias) | Blinding of outcome assessment (detection bias) | Incomplete outcome data addressed (attrition bias) | Selective reporting (reporting bias) | Other bias |
|-------------------------------|---------------------------------------------|------------------------------------------|--------------------------------------------------------|------------------------------------------------|--------------------------------------------|-----------------------------------|------------|
| Andersen et al, 1998          | High                                        | Unclear†                                  | High                                                   | Unclear§                                       | High¶                                      | Unclear**                       | High††     |
| Cook et al, 2007              | Low                                         | Low                                      | High                                                   | Low                                            | Unclear††                                  | Low                              | Unclear** |
| Ostergaard et al, 1998        | Unclear§§                                  | Unclear†                                  | High                                                   | Unclear§                                       | High¶                                      | Unclear**                       | Low        |
| Ostergaard et al, 2003        | Unclear§§                                  | Low                                      | High                                                   | Unclear§                                       | High¶                                      | Unclear**                       | High††     |
| Xu et al, 2011                | Low                                         | Low                                      | High                                                   | Unclear§                                       | Low                                        | Unclear**                       | Unclear** |

#### Evidence Project Risk of Bias Tool (for non-RCTs)

| Study                          | Study design includes preintervention and postintervention data | Study design includes control or comparison group | Study design includes cohort | Comparison groups equivalent at baseline on sociodemographics | Comparison groups equivalent at baseline on outcome measures | Random assignment (group or individual level) to the intervention | Participants randomly selected for assessment | Control for potential confounders | Follow-up rate >80% |
|-------------------------------|----------------------------------------------------------------|--------------------------------------------------|-----------------------------|---------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------|--------------------------------------|----------------------------------|-------------------|
| Barbee et al, 2016            | Yes                                                            | No                                               | No                          | Not applicable                                                | Not applicable                                             | Not applicable                                 | No                                   | Unclear***                      | Not applicable   |
| Bradshaw et al, 2005          | Yes                                                            | No                                               | No                          | Not applicable                                                | Not applicable                                             | Not applicable                                 | No                                   | Unclear***                      | Not applicable   |
| Gaydos et al, 2011            | No                                                             | Yes                                              | No                          | Not applicable                                                | Not applicable                                             | Not applicable                                 | No                                   | Unclear***                      | Not applicable   |
| Habel et al, 2018             | Yes                                                            | No                                               | No                          | Not applicable                                                | Not applicable                                             | Not applicable                                 | No                                   | Unclear***                      | Not applicable   |
| Holland-Hall et al, 2002      | No                                                             | Yes                                              | No                          | Not applicable                                                | Not applicable                                             | Not applicable                                 | No                                   | Unclear §§§                     | Not applicable   |
| Knight et al, 2013            | Yes                                                            | No                                               | No                          | Not applicable                                                | Not applicable                                             | Not applicable                                 | No                                   | Unclear §§§§                  | Not applicable   |

*Participants randomly divided into intervention and control ‘according to date of birth’.
†No details on allocation concealment reported.
‡No blinded, and the outcomes are likely to be influenced by lack of blinding.
§No blinding, but no subjective outcomes were reported, and unknown if laboratory personnel or testing assessors were blinded.
¶Over 20% of participants were not tested, and the missing data were not balanced in the intervention and control groups.
**Study protocol not available from trial registries.
††Participants were sexual partners of CT-positive patients.
‡‡Number of completed tests at 6, 12 and 18 months not clearly reported: 58% and 56% missing data from the intervention and control group, respectively.
§§Details on random sequence generation method not reported.
|||TI management strategy included reminders; study aim was to evaluate retesting of CT-positive patients.
***Confounders not mentioned.
††‡‡STI testing uptake history at baseline (at preintervention time point or in comparison group) not reported.
§§§Stratified analysis by gender only, other confounders not mentioned.
¶¶¶Stratified analysis by clinic type only, other confounders not mentioned.
**: Both intervention and the control groups had access to usual care if symptomatic.
Table 4  Summary of effect sizes and meta-analyses

| Outcome of STI testing services | Study type | Number of effect sizes | RR\(^1\) | 95% CI | P value for RR | Q value | P value for Q statistic | i\(^2\) |
|--------------------------------|------------|------------------------|---------|--------|----------------|---------|------------------------|-------|
| Any STI                        | RCT        | 5                      | 2.941   | 1.188 to 7.281 | 0.020 | 378.005 | 0.000 | 98.942 |
| Multiple STIs (CT and NG)      | RCT        | 1                      | 1.370   | 1.190 to 1.580 | –     | –       | –     | –     |
| CT only                        | RCT        | 4                      | 3.567   | 1.096 to 11.608 | 0.035 | 294.647 | 0.000 | 98.982 |
| Any STI—females only           | RCT        | 4                      | 3.292   | 1.072 to 10.115 | 0.037 | 284.542 | 0.000 | 98.946 |
| Any STI—males only             | RCT        | 3                      | 6.900   | 1.721 to 27.656 | 0.006 | 62.182  | 0.000 | 96.784 |
| CT only—males only             | RCT        | 3                      | 6.900   | 1.721 to 27.656 | 0.006 | 62.182  | 0.000 | 96.784 |
| Multiple STIs (CT and NG; NG and TV) | Obs    | 2                      | 2.990   | 0.426 to 20.978 | 0.271 | 21.427  | 0.000 | 95.333 |
| CT only                        | Obs        | 1                      | 2.351   | 1.597 to 3.462 | –     | –       | –     | –     |

Case finding (proportion of positive test results)

Sensitivity analysis: denominator: those randomised/enrolled (intention to-treat)

| CT only                        | RCT        | 4                      | 2.166   | 1.043 to 4.498 | 0.038 | 19.214  | 0.000 | 84.387 |
| Any STIs (CT, NG and TV)       | Obs        | 1                      | 1.122   | 0.449 to 2.802 | –     | –       | –     | –     |
| CT only                        | Obs        | 2                      | 1.396   | 0.372 to 5.237 | 0.621 | 1.237   | 0.266 | 19.168 |
| NG only                        | Obs        | 2                      | 0.978   | 0.249 to 3.835 | 0.974 | 0.071   | 0.789 | 0.000 |
| TV (PCR) only                  | Obs        | 2                      | 1.590   | 0.43 to 5.878  | 0.487 | 0.001   | 0.981 | 0.000 |
| TV (culture) only              | Obs        | 1                      | 1.469   | 0.338 to 6.38  | –     | –       | –     | –     |

Sensitivity analysis: denominator: those who collected samples for STI testing (subgroup)

| CT only                        | RCT        | 4                      | 0.718   | 0.585 to 0.882 | 0.002 | 1.343   | 0.719 | 0.000 |
| Multiple STIs (CT and NG; NG and TV) | Obs    | 2                      | 1.378   | 0.582 to 3.264 | 0.466 | 3.886   | 0.049 | 74.269 |
| CT only                        | Obs        | 4                      | 1.354   | 0.622 to 2.947 | 0.445 | 41.531  | 0.000 | 92.776 |
| NG only                        | Obs        | 3                      | 0.939   | 0.558 to 1.577 | 0.811 | 2.272   | 0.321 | 11.956 |
| TV (PCR) only                  | Obs        | 2                      | 0.791   | 0.208 to 3.004 | 0.730 | 1.041   | 0.308 | 3.926 |
| TV (culture) only              | Obs        | 1                      | 1.463   | 0.346 to 6.178 | –     | –       | –     | –     |

CT, Chlamydia trachomatis; NG, Neisseria gonorrhoeae; RR, risk ratio (pooled risk ratio if number of effect sizes>1); STI, sexually transmitted infection; TV, Trichomonas vaginalis.

Figure 2  Meta-analysis of RCTs: uptake of STI testing services for any STI. RCTs, randomised controlled trials; STI, sexually transmitted infection.
A. Among males only

| Study name          | Risk ratio | Lower limit | Upper limit | Z-Value | p-Value |
|---------------------|------------|-------------|-------------|---------|---------|
| Anderson 1998       | 2.423      | 1.597       | 3.767       | 4.159   | 0.000   |
| Ostergaard 1998     | 10.771     | 35.233      | 278.784     | 9.282   | 0.000   |
| Ostergaard 2003     | 1.873      | 1.538       | 2.290       | 2.358   | 0.000   |
| Xu 2011             | 6.900      | 1.721       | 27.696      | 7.277   | 0.006   |

B. Among females only

| Study name          | Risk ratio | Lower limit | Upper limit | Z-Value | p-Value |
|---------------------|------------|-------------|-------------|---------|---------|
| Cook 2007           | 1.371      | 1.191       | 1.580       | 4.382   | 0.000   |
| Ostergaard 2003     | 15.248     | 11.872      | 19.052      | 21.342  | 0.000   |
| Ostergaard 2003     | 3.544      | 1.917       | 6.551       | 4.035   | 0.000   |
| Xu 2011             | 1.610      | 1.316       | 1.986       | 4.638   | 0.000   |
|                     | 3.292      | 1.072       | 10.115      | 2.061   | 0.037   |

**Figure 3** Meta-analysis of RCTs: uptake of STI testing services for any STI, stratified by gender. RCTs, randomised controlled trials; STI, sexually transmitted infection.

which we could draw conclusions. Included studies presented comparative data for CT, NG, and TV, but not for syphilis. This is not surprising, given the early stage of developing rapid tests for syphilis and the difficulty of collecting whole blood. The number and type of outcomes were also limited; no studies compared the effect of self-collection of samples to clinician-collection on frequency of STI testing, adverse events, linkage to care or sexual risk behaviour. The included studies varied in their target populations, delivery strategies and STIs of interest, making cross-study comparisons difficult. Finally, no studies were conducted in LMICs. STIs are a global epidemic, and more data are needed on self-collection of samples for STI testing in resource-limited settings.

Strengths of this review include the inclusion of both randomised and non-randomised studies and inclusion of studies in any location or language. While we searched multiple online databases and used several additional approaches to identify relevant articles, it is always possible that our search strategy missed some articles. We also relied on peer-reviewed journal articles, which while ensuring a minimal level of quality, may also be subject to publication bias.

This review expands on previous reviews, which have assessed accuracy, feasibility and acceptability of self-collection of samples for STI testing and have compared sample (self-) collection in clinical and non-clinical settings. Our findings that self-collection of samples is associated with increased uptake of testing are comparable with other reviews, which found that home-based sampling is associated with greater uptake compared with clinic-based sampling. Together, these reviews and ours generally support the idea of self-collection as an approach to facilitate STI testing uptake among diverse populations.

Similar to a Cochrane review of home-based versus clinic-based sample collection for chlamydia and gonorrhoea testing, we found that, among participants who collected samples for STI testing, self-collection of samples was associated with a lower proportion of positive results, though when we expanded the denominator to all enrolled and randomised study participants, case finding increased among self-collectors. It is possible that people who perceived themselves as having lower risk of STIs were more willing to test for STIs when given the option to self-collect samples than if they were asked to come to a clinic for a provider to collect samples for STI testing. Conversely, individuals experiencing symptoms or who believed themselves at higher risk of STIs might have had additional motivation to use clinic-based STI testing services, possibly due to the care and support offered by a conventional STI clinic or the perceived accuracy and trust of a clinician-performed exam. A systematic review of patients' values and preferences around sample self-collection suggests that accuracy and trust in test results is a concern in some populations. Thus, for programmatic purposes, self-collection of samples may both increase STI testing uptake and the number of positive diagnoses, though the proportion of case finding among those who actually self-collected samples for STI testing may be comparatively less than those who had samples collected by a clinician.

The STI burden in many countries has not been adequately addressed, particularly in the face of institutional and funding capacities focused on prevention and treatment of HIV. Self-collection of samples for STI testing—already the standard in most high-income settings and well-accepted by a variety of end-users and providers—has the potential to increase uptake of testing services, thus reaching individuals at higher risk of STIs, in particular, those who may be unwilling to provide samples in the traditional manner by healthcare providers. If both uptake and case finding increase, expansion of STI services through sample self-collection may be cost-effective, though more research on this is warranted. Several studies have suggested that...
internet-based screening or other models using self-collection of samples for STI testing may be cost-effective compared with clinician-collected samples.\(^{27,54}\) Self-collection as an additional approach to STI testing and diagnosis supports the WHO global health sector strategy on STIs, which emphasizes the need for identifying targeted accessible interventions, which ensure that people use the quality health services they need without suffering financial hardship or stigmatization.\(^{55}\) Promoting self-collection of samples as an additional approach for STI testing service delivery could contribute to the achievement of the United Nations Sustainable Development Goals, including universal health coverage and integrated services for sexual and reproductive health, which requires achieving early diagnosis of STIs and linkage to effective treatment.\(^{55}\)

Acknowledgements We thank Laura Ferguson, Gina Ogilvie and Nandi Siegfried for their thoughtful comments on the systematic review protocol. We also thank Poonam Gupta and Eric Rodriguez for their assistance in extracting data.

Contributors MN conceptualised the study, CEK and PTY designed the protocol. CEK conducted the search. YPO and PTY conducted screening, data extraction and assessment of bias and quality of reporting. YPO and PTY drafted the manuscript. YPO, PTY, CEK, IT and MN reviewed the draft, provided critical review and read and approved the final manuscript. The corresponding author, as guarantor, accepts full responsibility for the finished article, has access to any data and controlled the decision to publish. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

Funding We gratefully acknowledge financial support of the UNDP-UNFPA-UNICEF-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) and the Children’s Investment Fund Foundation (CIFF). HRP was involved in the study design.

Disclaimer The funders played no part in the decision to publish the article for publication nor in the collection, analysis and interpretation of data. All authors had full access to all of the data (including statistical reports and tables) in the study and can take responsibility for the integrity of the data and the accuracy of the data analysis.

Competing interests All authors have completed the ICMJE universal disclosure form at www.icmje.org/col1_disclosure.pdf and declare: no support from any organization for the submitted work; no financial relationships with any organizations that might have an interest in the submitted work in the previous three years; no other relationships or activities that could appear to have influenced the submitted work.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement Extracted data are available on request to the corresponding author.

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REFERENCES
1. Newman L, Rowley J, Vender Hoorn S, et al. Global estimates of the prevalence and incidence of four curable sexually transmitted infections in 2012 based on Systematic review and global reporting. \(\text{PLoS One}\) 2015;10:e0143304.
2. World Health Organization. Sexually transmitted infections (STIs) fact sheet. Geneva, Switzerland: World Health organization; 2016. Available: http://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis)
3. Toskini I, Peeling RW, Mabey D, et al. Point-of-care tests for STIs: the way forward. \(\text{Sex Transm Infect}\) 2017;93:51–52.
4. UNDP/UNFPA/WHO/World Bank Special Programme of Research and Development and Research Training in Human Reproduction. Sexually transmitted infections (STIs): the importance of a renewed commitment and to STIs has STI syndromic management and control in achieving global sexual and reproductive health. Geneva, Switzerland: World Health Organization; 2012. Available: http://www.who.int/iris/handle/10665/75838
5. Cristillo AD, Bristow CC, Peeling R, et al. Point-of-care sexually transmitted infection diagnostics: proceedings of the STAR sexually transmitted Infection-Clinical Trial Group programmatic meeting. \(\text{Sex Transm Dis}\) 2017;44:211–8.
6. Tucker JD, Bien CH, Peeling RW. Point-of-care testing for sexually transmitted infections: recent advances and implications for disease control. \(\text{Curr Opin Infect Dis}\) 2013;26:73–9.
7. Toskini I, Blondeel K, Peeling RW, et al. Advancing point of care diagnostics for the control and prevention of STIs: the way forward. \(\text{Sex Transm Infect}\) 2017;93:581–588.
8. Garrett NJ, Osman F, Maharaj B, et al. Beyond syndromic management: opportunities for diagnosis-based treatment of sexually transmitted infections in low- and middle-income countries. \(\text{PLoS One}\) 2018;13.
9. World Bank. Sexually transmitted infections in developing countries: current concepts and strategies on improving STI prevention, treatment, and control. Washington, D.C.: world bank; 2008. Available: http://documents.worldbank.org/curated/en/867421468313772326/Sexually-transmitted-infections-in-developing-countries-current-concepts-and-strategies-on-improving-STI-prevention-treatment-and-control
10. Garrett NJ, McGrath N, Mindel A. Advancing STI care in low/middle-income countries: the success of syndromic management reached its use-by date? \(\text{Sex Transm Infect}\) 2017:93–4–9.
11. Holmes KT, Sparling PF, Stamm WE, et al. Sexually transmitted diseases. 4th ed. New York: McGraw-Hill, 2008.
12. Harding-Esch EM, Hollis E, Mohammed H, et al. Self-sampling and self-testing for STIs and HIV: the case for consistent nomenclature. \(\text{Sex Transm Infect}\) 2017:93:445–8.
13. Lunny C, Taylor D, Hoang L, et al. Self-collected versus clinician-collected sampling for Chlamydia and gonorrhoea screening: a systematic review and meta-analysis. \(\text{PLoS One}\) 2015;10:e0132776.
14. Geisler WM. Diagnosis and Management of Uncomplicated Chlamydia trachomatis Infections in Adolescents and Adults: Summary of Evidence Reviewed for the 2015 Centers for Disease Control and Prevention Sexually transmitted Diseases Treatment Guidelines. \(\text{Clin Infect Dis}\) 2015;61(Suppl 8):S774–S784.
15. Jamil MS, Hocking JS, Bauer HM, et al. Home-based Chlamydia and gonorrhoea screening: a systematic review of strategies and outcomes. \(\text{BMJ Public Health}\) 2013:13.
16. Kohl KS, Markowitz LE, Kourmans EH. Developments in the screening for Chlamydia trachomatis: a review. \(\text{Obstet Gynecol Clin North Am}\) 2003;30:637–58.
17. Long L, Abraham C, Paquette R, et al. Brief interventions to prevent sexually transmitted infections suitable for in-service use: a systematic review. \(\text{Prev Med}\) 2016:91:364–82.
18. Marrazzo JM, Scholes D. Acceptability of urine-based screening for Chlamydia trachomatis in asymptomatic young men: a systematic review. \(\text{Sex Transm Dis}\) 2008;35(11 Suppl):S28–S33.
19. Odesanmi TY, Waisi SP, Odesanmi OS, et al. Comparative effectiveness and acceptability of home-based and clinic-based sampling methods for sexually transmissible infections screening in females aged 14–50 years: a systematic review and meta-analysis. \(\text{Sex Health}\) 2015:12:165–173.
20. Ong JJ, Fu H, Smith MK, et al. Expanding syphilis testing: a scoping review of syphilis testing interventions among key populations. \(\text{Expert Rev Anti Infect Ther}\) 2018;16:423–32.
21. Paudyal P, Llewellyn C, Lau J, et al. Obtaining Self-Samples to Diagnose Curable Sexually Transmitted Infections: A Systematic Review of Patients’ Experiences. \(\text{PLoS One}\) 2015;10:e0124310-e.
22. Pavlin NL, Gunn JM, Parker R, et al. Implementing Chlamydia screening: what do women think? A systematic review of the literature. \(\text{BMJ Public Health}\) 2006;6.
23. Yared N, Horvath K, Fanan Q, et al. Optimizing screening for sexually transmitted infections in men using self-collected swabs: a systematic review. \(\text{Sex Transm Dis}\) 2018;45:294–300.
24. Garland SM, Tabrizi SN. Diagnosis of sexually transmitted infections (STI) using self-collected non-invasive specimens. \(\text{Sex Health}\) 2004;1:121–6.
25. Potter Y. Self-screening for sexually transmitted infections. \(\text{Nurs Stand}\) 2014;28:37–43.
28. BMJ Global Health: first published as 10.1136/bmjgh-2018-001349 on 22 April 2019. Downloaded from http://gh.bmj.com/ on November 23, 2023 by guest. Protected by copyright.

26. Bernstein KT, Chow JM, Pathela P, et al. Bacterial sexually transmitted disease screening outside the clinic—implications for the modern sexually transmitted disease program. Sex Transm Dis 2016;43(2 Suppl 1):S42–S52.

27. Blay PJ, Sperling M, Luvey V, et al. Could home sexually transmitted infection specimen collection with e-prescription be a cost-effective strategy for clinical trials and clinical care? Sex Transm Infect 2015;42:13–19.

28. Fajardo-Bernal L, Aponte-Gonzalez J, Vigil P, et al. Home-based versus clinic-based specimen collection in the management of Chlamydia trachomatis and Neisseria gonorrhoeae infections. Cochrane Database Syst Rev 2015;9:CD011317.

29. Ford CA, Viadro CI, Miller WC. Testing for chlamydia and gonorrhoeal infections outside of clinic settings: a summary of the literature. Sex Transm Infect 2018;94:312–58.

30. Graseck AS, Shih SL, Peipert JF. Home versus clinic-based specimen collection for Chlamydia trachomatis and Neisseria gonorrhoeae. Expert Rev Anti Infect Ther 2019;17:183–94.

31. Shih SL, Graseck AS, Secura GM, et al. Screening for sexually transmitted infections at home or in the clinic? Curr Opin Infect Dis 2011;24:78–84.

32. World Health Organization. Point-of-care diagnostic tests (POCTs) for sexually transmitted infections (STIs), Geneva, Switzerland: World Health organization; 2014. Available: http://www.who.int/reproductivehealth/topics/rtis/pocts/en/

33. Gaydos CA, Klausner JD, Pai NP, et al. Rapid and point-of-care tests for the diagnosis of Trichomonas vaginalis in women and men. Sex Transm Infect 2017;93:S31–S35.

34. Gaydos CA, Klausner JD, Pai NP, et al. Performance and operational characteristics of point-of-care tests for the diagnosis of urogenital gonococcal infections. Sex Transm Infect 2017;93:S16–S21.

35. Kelly H, Coitart CEM, Pant Pai N, et al. Systematic reviews of point-of-care tests for the diagnosis of urogenital Chlamydia trachomatis infections. Sex Transm Infect 2017;93:S22–S30.

36. Gliddon HD, Peeling RW, Kamb ML, et al. A systematic review and meta-analysis of studies evaluating the performance and operational characteristics of dual point-of-care tests for HIV and syphilis. Sex Transm Infect 2017;93:851.

37. Taylor MM, Peeling RW, Toskin I, et al. Role of dual HIV/syphilis test kits in expanding syphilis screening. Sex Transm Infect 2017;93:458–9.

38. Higgins JPT, Green S. Chapter 8.5 The Cochrane Collaboration’s tool for assessing risk of bias. In: Higgins JPT, Altman DG, Sterne JAC, et al. eds. Cochrane Handbook for Systematic Reviews of Interventions, Version 5-1-0 [updated March 2011], London, England: The Cochrane Collaboration, 2011.

39. Kennedy CE, Forner VA, Armstrong KA, et al. The evidence project risk of bias tool: assessing study rigor for both randomized and non-randomized intervention studies. Syst Rev 2019;8.

40. Borenstein M, Hedges L, Higgins JPT. Comprehensive meta-analysis version 3. Biostat, Englewood, NJ: 2013, 2013. Available: https://www.meta-analysis.com/

41. Barbee LA, Tat S, Dhanireddy S, et al. Effectiveness and patient acceptability of a sexually transmitted infection self-testing program in an HIV care setting. J Acquir Immune Defic Syndr 2016;72:e26–31.

42. Bradshaw CS, Pierce Li, Tabrizi SN, et al. Screening injecting drug users for sexually transmitted infections and blood borne viruses using street outreach and self collected sampling. Sex Transm Infect 2005;81:53–8.

43. Cook RL, Østergaard L, Hillier SL, et al. Home screening for sexually transmitted diseases in high-risk young women: randomised controlled trial. Sex Transm Infect 2007;83:286–91.

44. Gaydos CA, Barnes M, Aumakhb B, et al. Chlamydia trachomatis age-specific prevalence in women who used an Internet-based self-screening program compared to women who were screened in family planning clinics. Sex Transm Dis 2011;38:74–8.

45. Habel MA, Brookmeyer KA, Oliver-Vereini R, et al. Creating innovative point-of-care testing options for university students: the impact of an STI self-testing program. Sex Transm Infect 2018;45:272–7.

46. Holland-Hall CM, Wiesenberg HC, Murray PJ. Self-collected vaginal swabs for the detection of multiple sexually transmitted infections in adolescent girls. J Pediat Adolesc Gynecol 2002;15:307–13.

47. Knight V, Ryder N, Guy R, et al. New Xpress sexually transmissible infection screening clinic improves patient journey and clinic capacity at a large sexual health clinic. Sex Transm Dis 2013;40:75–80.

48. Andersen B, Østergaard L, Møller JK, et al. Home sampling versus conventional contact tracing for detecting Chlamydia trachomatis infection in male partners of infected women: randomised study. BMJ 1998;316:350–1.

49. Østergaard L, Andersen B, Møller JK, et al. Managing partners of people diagnosed with Chlamydia trachomatis: a comparison of two partner testing methods. Sex Transm Infect 2003;79:358–61.

50. Østergaard L, Andersen B, Olesen F, et al. Efficacy of home sampling for screening of Chlamydia trachomatis: randomised study. BMJ 1998;317:26–7.

51. Xu F, Stoner BP, Taylor SN, et al. Use of home-obtained vaginal swabs to facilitate rescreening for Chlamydia trachomatis infections: two randomized controlled trials. Obstet Gynecol 2011;118:231–9.

52. Russell D. The epidemiology of STIs in the HIV and AIDS era (conference presentation). 9th IAS Conference on HIV Science, Paris, France, 2017.

53. World Health Organization. Global health sector strategy on sexually transmitted infections 2016–2021: towards ending STIs, Geneva, Switzerland: World Health organization; 2016, 2016. Available: https://www.who.int/reproductivehealth/publications/rtis/gnss-stis/en/

54. Huang W, Gaydos CA, Barnes MR, et al. Cost-effectiveness analysis of Chlamydia trachomatis screening via Internet-based self-collected swabs compared with clinic-based sample collection. Sex Transm Dis 2011;38:815–20.

55. Bekker L-G, Alleyne G, Baral S, et al. Advancing global health and strengthening the HIV response in the era of the sustainable development goals: the International AIDS Society-Lancet Commission. Lancet 2018;392:312–58.