PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	ANRS–COM'TEST: Description of a community-based HIV testing intervention in non-medical settings for men who have sex with men
AUTHORS	Karen Champenois, Jean-Marie Le Gall, Cédric Jacquemin, Sophie Jean, Cyril Martin, Laura Rios, Olivier Benoit, Stéphanie Vermoesen, France Lert, Bruno Spire and Yazdan Yazdanpanah

VERSION 1 - REVIEW

REVIEWER	Juan E. Losa, PhD, MD. Chief, Division of Infectious Diseases. Professor of Medicine. Hospital Universitario Fundación Alcorcón Rey Juan Carlos University Madrid, Spain
REVIEW RETURNED	28/12/2011

RESULTS & CONCLUSIONS	I recommend to the change table 2
GENERAL COMMENTS	**Abstract** The authors consider "*the population reached*" an outcome, but in the results they don't say how many people were the intervention addressed to (see my comments about results). In view of the data presented I'd recommend to change the expression "*a substantial proportion had **never** been tested before*" by "a substantial proportion had not been tested lately". **Methods** Intervention Did the investigators do an estimation of the population to whom the study was addressed? **Results** Sixty-six participants were excluded: 25 because of sex exclusively with women, 14 were women and 10 because of the amount of time. What about the 17 remaning up to 66. Because of redundancy related to table 1, I'd delete or resume the next pararagrah: *Median age was 31 years (IQR, 25-38; Table 1). Most men were single (69%), educated (71% above high school level), and employed (64%). Although 432 participants (82%) defined themselves as homosexual and 66 (12%) as bisexual, 128 of these (25%) stated that their sexual identity was not known to their family, and 64 (13%) said that they had not revealed it to anyone.* I don't understand the foot of the table 1: *There were 527-532 respondents to each question, except for questions regarding acceptance of homosexuality and bisexuality, to which 497-510 participants responded.* What does "527-532" mean and what does "497-510" mean?

	About table 2: I think it's feasible to transform it in a table with 3 columns like that No test in the previous two years At least one test in the previous two years History of HIV testing - Months since… - Number… Casual male partners and…. History of STIs…. "The use of recreational drugs" could be take out from the table 2 to complet the text at the end of the paragraph. The text "*152 (35%) reported having unprotected anal intercourse with risky casual partners (HIV-infected or HIV-serostatus unknown)"* must precede the text *"The median number of casual partners within the last six months was 12 (IQR, 6-25)"*, as it appears in the abstract. **Discussion** There are three results that, in my opinion, should be more stressed/dealed with in the discussion: 1.- *MSM who returned did not differ demographically from those who came only once, but a larger proportion of returners had tested for HIV within the previous two years (94% vs. 68%; p<0.0001).* 2.- *Among the 15 men with positive results, eight (57%) had not been tested for HIV in the previous two years (vs. 30% among HIV-negative men; p=0.03).* 3.- *The main reasons for which some patients were not "very satisfied" (43; 8%) were the amount of time spent at the testing facility (median, two hours, including a 45-minute explanation of the study and questionnaires completion) and the hours during which testing was available.*

REVIEWER	Alexandra CALMY Geneva University Hospital (HUG) Geneva Switzerland I have no competing interes
REVIEW RETURNED	04/01/2012

RESULTS & CONCLUSIONS	There is no clear research question nor research hypothesis. Results report on descriptive data and the non-comparative design of the study does not allow conclude that community-based VCT performed better or not as compared to standard VCT.
GENERAL COMMENTS	The authors describe a community-based HIV testing program performed by non healthcare workers in 4 French cities. They aim at reaching high risk MSM and describe the characteristics of this population, the quality of VCT as well as the satisfaction of the participating clients. General comment: strategies to access difficult to reach population are very welcome and decentralisation/demedicalisation of VCT is certainly a key element in order to reach this objective. Rapid tests however have been used since years in other countries and international experiences could have been described with more details. In Switzerland for instance, Checkpoint Geneva opened in 2004, and do use Abbott 4th generation rapid tests since three years already; a large amount of data regarding the patient's

	satisfaction, the clients' characteristics etc have been collected and are available on the website (direct access: http://ge.ch/dares/SilverpeasWebFileServer/evaluation_activites_sidavih_rds165_fr.pdf?ComponentId=kmelia1026&SourceFile=1294734730360.pdf&MimeType=application/pdf&Directory=Attachment/Images/). Moreover, checkpoint has now the possibility to function without direct medical supervision (peer counselors). In resource limited setting also, VCT is mainly performed by lay counselors with no direct medical supervision – a model that could have been cited. The manuscript has a very clear message: VCT can be performed outside of the standard medical structures – and HIV/AIDS associations have a major role in the roll out of this message. This deserves to be said and published. However, as the study design is weak (descriptive data, no study hypothesis), the number of clients included low (only about 590 clients in 18 months study duration) and I would favor a short report/concise communication rather than a full original paper. Detailed review: - Introduction: description of alternative VCT strategies in Europe and elsewhere would have been appreciated (see above comment). - Study hypothesis? Not described. - Method: 1. Description of the intervention: any previous experience in similar centers with health care workers? What was the expected attendance? Were the study sites advertized? If yes: how? 2. Description of the intervention: ANRS-COM TEST exclusively targeted MSM and men reporting exclusively sex with female were not included in the study – how then can we conclude that the intervention is well targeted? 3. Quality of the procedure: I find it difficult to assess quality as a study endpoint – no (historical or current) comparison with a standard procedure has been mentioned. 4. Intervention: the 2-hours time to access and HIV test is neither convenient nor attractive – - Results: (page 10, line 41) "difficulties in handling tests were rarely reported" – rarely is vague…as well as "most often" (line 47). - Discussion: ANRS COM TEST reports on a program description– with a clear message that alternative VCT options should be offered to high risk population – together with community stakeholders. A deeper description of previous experiences (in Europe, in RLS) would have been welcome. Several elements have not been discussed: the low number of clients visiting the centers (Checkpoint has more than 600 clients per year in only one Swiss city), the "plus value" of having peer educator rather than health care workers (stigma?), the other VCT strategies (auto test, tests available in pharmacies as in the UK) etc.

VERSION 1 – AUTHOR RESPONSE

Reviewer: Juan E. Losa, PhD, MD.
Chief, Division of Infectious Diseases.
Professor of Medicine.
Hospital Universitario Fundación Alcorcón
Rey Juan Carlos University

Madrid, Spain

Description of a community-based HIV testing intervention in non-medical settings for men who have sex with men

Abstract
The authors consider “the population reached” an outcome, but in the results they don’t say how many people were the intervention addressed to (see my comments about results).

R: The number of people to whom we wanted to address the intervention was defined hypothesizing that 30% of MSM who will be enrolled will not be tested at all or regularly tested for HIV and requiring a 4% precision around this estimate (see below, reviewer 1 comment about Methods). The number of people to whom the intervention was addressed was 598 of whom 66 were excluded (see below, reviewer 1 comment about Results). These points are clarified below.

In view of the data presented I’d recommend to change the expression “a substantial proportion had never been tested before” by “a substantial proportion had not been tested lately”.

R: We agree with the reviewer and changed this as requested.

Methods
Intervention
Did the investigators do an estimation of the population to whom the study was addressed?

R: We added the following sentences in the Methods / Study population part (page 7) to clarify this point:

“One of the most important goals of the intervention evaluated in this study was to target MSM who are not regularly tested for HIV (or never tested). In the French 2004 Gay Press survey -a survey investigating lifestyle and sexual behaviors in MSM who read the gay press- 17% of MSM stated that they have never been tested for HIV in their life. Among those with at least a history of one HIV test, 27% stated that they were not tested in the previous two years. Based on these results we therefore anticipated that 30% of MSM enrolled in our study would not have a history of HIV testing in the previous two years. We calculated the number of patients to be enrolled in this study to have a precision of 4% around this estimated point. The calculated sample size was 504 MSM; given the highest number of participants that could be tested by session in each center, the enrollment time was estimated at approximately one year.”

Results

Sixty-six participants were excluded: 25 because of sex exclusively with women, 14 were women and 10 because of the amount of time. What about the 17 remaining up to 66.

R: We thank the reviewer for pointing out this. Actually, these were the first three main reasons for participants to not be enrolled in the study and other reasons were not stated to not overload the manuscript.
Following the reviewer comment, we however changed the sentences as follow (page 10):

“The three main reasons to not be included were: 1) they reported sex exclusively with women (n=25), 2) were women (n=14), or and 3) refused to participate due to the amount of time they should have spent for testing and research procedures (around two hours, n=10). Among the 17 remaining men not enrolled in the study, 10 refused for different reasons (afraid of lack of confidentiality, no need to

be tested for HIV, need time to think about a possible participation), the seven other were excluded because of age <18 years, a risk exposure <48 hours, or they did not understand French speaking."

Because of redundancy related to table 1, I'd delete or resume the next paragraph:
Median age was 31 years (IQR, 25-38; Table 1). Most men were single (69%), educated (71% above high school level), and employed (64%). Although 432 participants (82%) defined themselves as homosexual and 66 (12%) as bisexual, 128 of these (25%) stated that their sexual identity was not known to their family, and 64 (13%) said that they had not revealed it to anyone.

R: As requested by the reviewer, we replaced this paragraph by the following (page 10):

"Sociodemographic characteristics of participating men were shown in Table 1. Although 94% of men defined themselves as MSM, 128 (25%) stated that their sexual identity was unknown to their family, and 64 (13%) that they had not revealed it to anyone."

I don't understand the foot of the table 1:

There were 527-532 respondents to each question, except for questions regarding acceptance of homosexuality and bisexuality, to which 497-510 participants responded.
What does "527-532" mean and what does "497-510" mean?

R: These numbers are the number of patients who responded to each question / variable investigated. However, we agree with the reviewer that the way this is stated is not clear. We therefore rephrased this note (page 19):

a The study enrolled 532 men who have sex with men (MSM). Percentages are calculated based on the number of respondents to each question. For each question, there were less than 5 missing data points (<1%); for questions regarding acceptance of homosexuality and bisexuality, there were between 22 (4%) and 35 (7%) missing data points according to the question.

About table 2: I think it's feasible to transform it in a table with 3 columns like that
No test in the previous two years At least one test in the previous two years
History of HIV testing
- Months since…
- Number…
Casual male partners and….
History of STIs….
"The use of recreational drugs" could be take out from the table 2 to complete the text at the end of the paragraph.

R: We transformed the Table 2 according to your advice (see page 20) and added in the text the following paragraph regarding recreational drugs (page 11):

"The recreational drugs the most used here were alcohol (336; 65%), poppers (236; 46%) and cannabis (140; 27%)."

The text "152 (35%) reported having unprotected anal intercourse with risky casual partners (HIV-infected or HIV-serostatus unknown)" must precede the text "The median number of casual partners within the last six months was 12 (IQR, 6-25)", as it appears in the abstract.

R: We thank the reviewer for pointing this out and this was done as suggested (page 11)

Discussion

There are three results that, in my opinion, should be more stressed/dealed with in the discussion:

1.- MSM who returned did not differ demographically from those who came only once, but a larger proportion of returners had tested for HIV within the previous two years (94% vs. 68%; p<0.0001).

R: We added the following sentences at the end of the second paragraph of the Discussion (page 14) to stress that the program is suitable for regularly HIV tested men.

“The MSM who returned for testing in the COM’TEST program were also tested significantly more often for HIV than men who came once. Increased availability and selection of HIV testing services may therefore encourage even those who already test regularly in traditional programs to test more often, thereby moving HIV diagnoses to earlier in infection.”

2.- Among the 15 men with positive results, eight (57%) had not been tested for HIV in the previous two years (vs. 30% among HIV-negative men; p=0.03).

R: We added the following sentences at the end of the fourth paragraph of the Discussion (page 16)

“MSM with an HIV positive test have been tested less often in the previous two years than men with a negative test; this result suggests also this program could reach MSM at high-risk who were not tested recently in other testing services.”

3.- The main reasons for which some patients were not “very satisfied” (43; 8%) were the amount of time spent at the testing facility (median, two hours, including a 45-minute explanation of the study and questionnaires completion) and the hours during which testing was available.

R: We added the following sentences at the end of the third paragraph of the Discussion (page 15).

“Reasons for not being satisfied of the program were linked to the study part that was too long and imposed tight opening sessions. The study part may curb some men to come for testing; attendance may be higher in the real life.”

Reviewer: Alexandra CALMY
Geneva University Hospital (HUG)
Geneva
Switzerland

I have no competing interest

There is no clear research question nor research hypothesis.
Results report on descriptive data and the non-comparative design of the study does not allow conclude that community-based VCT performed better or not as compared to standard VCT.

R: The reviewer is right. This study was not designed to compare community-based testing with other testing strategies but to illustrate that it is possible. The idea is not to claim that community-based VCT is better than standard VCT but that it is possible and should be therefore considered as a testing strategy in addition to the others.

The authors describe a community-based HIV testing program performed by non healthcare workers in 4 French cities. They aim at reaching high risk MSM and describe the characteristics of this population, the quality of VCT as well as the satisfaction of the participating clients.

General comment: strategies to access difficult to reach population are very welcome and decentralisation/demedicalisation of VCT is certainly a key element in order to reach this objective. Rapid tests however have been used since years in other countries and international experiences could have been described with more details. In Switzerland for instance, Checkpoint Geneva opened in 2004, and do use Abbott 4th generation rapid tests since three years already; a large amount of data regarding the patient's satisfaction, the clients' characteristics etc have been collected and are available on the website (direct access: http://ge.ch/dares/SilverpeasWebFileServer/evaluation_activites_sidavih_rds165_fr.pdf?ComponentId=kmelia1026&SourceFile=1294734730360.pdf&MimeType=application/pdf&Directory=Attachment/Images/). Moreover, checkpoint has now the possibility to function without direct medical supervision (peer counselors).
In resource limited setting also, VCT is mainly performed by lay counselors with no direct medical supervision – a model that could have been cited.

R: Community-based VCT using HIV rapid test in Europe including Checkpoint Geneva were cited in the introduction. In addition, in the discussion section, we compared our results to results of studies conducted in Europe when they were available. However, in the new version of the manuscript as recommended by the reviewer we now cite other community-based VCT programs in Europe. We did not address voluntary of VCT in resource limiting settings because we considered that it is a totally different context. However, again in the new version of the manuscript this is stated (Page 5).

"In recent years, several European countries [14-18] have begun implementing community-based HIV testing using rapid tests. They propose rapid testing in CBOs in large urban areas. The principle behind this strategy is the same than the one applied in developing countries where testing is conducted by lay counselors from the community to facilitate access to testing to vulnerable populations [20]. However, most of the reported programs in developed countries involve medical staff, and although welcoming and support are conducted by community peers, HIV tests are performed by healthcare workers. To our knowledge in Europe, the only ongoing community-based HIV testing programs that do not involve medical staff is Checkpoint in Barcelona, Spain [19] and LASS in Leicester, England (http://www.lass.org.uk). However, data on these programs (evaluation of an existing program or set up into a study) have not yet been published.

The manuscript has a very clear message: VCT can be performed outside of the standard medical structures – and HIV/AIDS associations have a major role in the roll out of this message. This deserves to be said and published.

Detailed review:
- Introduction: description of alternative VCT strategies in Europe and elsewhere would have been appreciated (see above comment).
- Study hypothesis? Not described.

R: The research was based on the observations that some MSM were not tested for HIV, or not as much as they would like, because they did not find an HIV testing suitable with their sexual lifestyle. The reasons reported by these MSM were: difficulties to talk about their sexuality, but also difficulties for healthcare providers to hear about their sexuality, moralistic attitudes towards their sexual behavior and the repeated use of HIV testing. The research hypothesis was that a community–based HIV testing offer would facilitate the access to testing for MSM who were not tested for HIV and MSM who use HIV testing regularly, because sexuality is addressed openly with peers and a non-medical

setting supposed to be more comfortable with more confidentiality. These points were addressed at the end of the first paragraph and in the second paragraph of the introduction.
Furthermore, the idea is not to claim that community-based VCT is better than standard VCT but that it is feasible and should be therefore considered as a testing strategy in addition to other strategies.

To clarify this as requested by the reviewer, we added the following sentences at the end of the objective paragraph to better highlight the research hypothesis (page 5).

“The hypothesis was that a community based HIV testing intervention may reach high-risk MSM, a high proportion of whom have not been tested lately; consequently in addition to other existing HIV testing services, it may increase access to HIV testing in high-risk groups.”

- Method:
1. Description of the intervention: any previous experience in similar centers with health care workers?

R: There was no previous similar experience with healthcare workers in France. The intervention study was initiated before HIV rapid test use was allowed in other situations than predefined emergency cases (like occupational exposition to HIV or delivery if the mother had an unknown HIV status).

What was the expected attendance?

R: As stated above one of the most important goals of the intervention evaluated in this study was to target first, MSM at high risk of HIV infection and second, those who were not tested at all or regularly tested for HIV. We added the following sentences about the estimation of sample size in the Methods / Study population part (page 7)
“One of the most important goals of the intervention evaluated in this study was to target MSM who are not regularly tested for HIV (or never tested). In the French 2004 Gay Press survey -a survey investigating lifestyle and sexual behaviors in MSM who read the gay press- 17% of MSM stated that they have never been tested for HIV in their life. Among those with at least a history of one HIV test, 27% stated that they were not tested in the previous two years. Based on these results we therefore anticipated that 30% of MSM enrolled in our study would not have a history of HIV testing in the previous two years. We calculated the number of patients to be enrolled in this study to have a precision of 4% around this estimated point. The calculated sample size was 504 MSM; given the highest number of participants that could be tested by session in each center, the enrollment time was estimated at approximately one year.”

Were the study sites advertized? If yes: how?

R: People, and specifically MSM, were informed about the intervention (what, who, where and when) through different channels. We added some precisions about this in the Methods section page 7:

“We informed the MSM community about the intervention through communication campaigns (posters, flyers, web banners and ads) at commercial and non-commercial gay venues, as well as in gay websites, magazines and organizations. The study sites were the settings of the AIDES CBO. The possibility of performing an HIV test was however not advertized outside the setting to preserve confidentiality.”

2. Description of the intervention: ANRS-COM TEST exclusively targeted MSM and men reporting exclusively sex with female were not included in the study – how then can we conclude that the intervention is well targeted?

R: As stated above (point 1 of Methods), one of the most important goals of the intervention evaluated in this study was to first target MSM at high risk of HIV-infection (in particular unprotected anal intercourse with casual partner with different or unknown HIV status) and second those who were not tested at all or regularly tested for HIV. Given the results of the study we therefore consider that it was well targeted.

3. Quality of the procedure: I find it difficult to assess quality as a study endpoint – no (historical or current) comparison with a standard procedure has been mentioned.

R: We agree with the reviewer comment. We deleted “quality of the procedure” from the main outcomes of the study, but however described the procedure of testing and counseling as part of the satisfaction assessment (see page 8 for the Methods part and 12 for the Results part).

4. Intervention: the 2-hours time to access and HIV test is neither convenient nor attractive –

R: We of course completely agree with the reviewer. The 2-hour time was first related to the study part with some paperwork regarding participants’ enrollment (including informed consent) and participants were also asked to complete two questionnaires. Moreover, for testing at the time the study was designed, we decided to use the Vikia HIV rapid test that gives result in 30 minutes. This test was chosen for its sensibility and specificity in population with a low HIV prevalence but also for its simplicity to use by non healthcare workers.
In real life, outside a study, using more recent HIV rapid test with more rapid results, testing time may be subsequently reduced.

- Results: (page 10, line 41) “difficulties in handling tests were rarely reported” – rarely is vague…as well as “most often” (line 47).

R: This was clarified (page 12):
“Difficulties in handling tests were rarely reported (<2%) by testers, except concerning self-drawn blood samples (19%), and blood collection by testers (14%).”
“A second test had to be performed for eight of the 592 tests (1.5%), because an insufficient amount of blood had been collected.”

- Discussion: ANRS COM TEST reports on a program description– with a clear message that alternative VCT options should be offered to high risk population – together with community stakeholders. A deeper description of previous experiences (in Europe, in RLS) would have been welcome.

R: We added this in the introduction part as stated above.

Several elements have not been discussed: the low number of clients visiting the centers (Checkpoint has more than 600 clients per year in only one Swiss city),

R: We had no evidence to say attendance was high or low. First, the COM’TEST study was within the regulatory framework of a biomedical research with obligation of complete information, writing consent, and deep evaluation. It might be an obstacle to the attractiveness of the VCT. Second, only MSM were enrolled.
311 MSM were tested in one year in Paris (opening 6 hours a week). Comparing with attendance in Geneva Checkpoint, the attendance in Paris was higher than overall attendance in Geneva until 2007 (389 MM tested of 574 people in 2009). Attendance in other cities was lower, mainly because these were smaller cities with smaller pools of MSM than in Paris. We discussed this point in the limitations

paragraph (page 16).

“First, ANRS-COM’TEST was conducted in four French cities, but more than half of the participants enrolled in Paris. Community-based HIV testing programs may be attractive and efficient in large urban areas, but perhaps less so in smaller cities, where an outreach approach may work better.”

… the “plus value” of having peer educator rather than health care workers (stigma?),

R: To complete this point, we added some results (page 12) and a sentence in the Discussion part (page 15):

“More than 98% of participants attested they could address sexuality openly with peers and no one reported feeling judged.”
“Overall, participants reported feeling more comfortable with testing and counseling with peers.”

… the other VCT strategies (auto test, tests available in pharmacies as in the UK) etc.

R: These alternative HIV testing strategies may be interesting for high risk population such as MSM who don’t want counseling, which is on the contrary of the objectives of the community-based VCT. However, we added the following to the Discussion section (page 14):

“In addition to community-based HIV testing, other HIV testing strategies such as home tests or tests available in pharmacies, may also be interesting to supplements pre-existing HIV testing services and increases access to HIV testing in high-risk groups. However, additional data are needed on benefits and harms of these strategies.”

VERSION 2 – REVIEW

REVIEWER	Juan E. Losa Chief of Infectious Diseases Department Professor of Medicine Hospital Universitario Fundación Alcorcón Universidad Rey Juan Carlos
REVIEW RETURNED	16/02/2012

THE STUDY	In my modest opinion, I think this issued shuold be revised.
RESULTS & CONCLUSIONS	1) In table 2 (page 23), the sum of 50 plus 100 establishes 150 participants with unprotected anal intercourse with partners who were HIV-, BUT in the text (page 13) they refer 152. 2) I suppose that none of the differences between the two groups in the variables shown in table 2 are statistically significant. 3) I think table 3 is expendable, because identical results are expressed in a paragraph in page 14 4) In the Discussion, the authors do a repetition. In page 16 the affirm "The MSM who returned for testing in the COM’TEST program were also tested significantly more often for HIV than men who came once." and in page 18 they say "MSM with an HIV positive test have been tested less often in the previous two years than men with a negative test; this result suggests also this program could reach

	MSM at high-risk who were not tested recently in other testing services."

VERSION 2 – AUTHOR RESPONSE

Reviewer: Juan E. Losa
Chief of Infectious Diseases Department
Professor of Medicine
Hospital Universitario Fundación Alcorcón
Universidad Rey Juan Carlos

Spain

In my modest opinion, I think this issued should be revised [standard of written English].

1) In table 2 (page 23), the sum of 50 plus 100 establishes 150 participants with unprotected anal intercourse with partners who were HIV-, BUT in the text (page 13) they refer 152.

R: Results in Table 2 are presented according to having or not a history of HIV test in the previous two years. The information about “a history of HIV test in the previous two years” is missing for five participants (cf. footnotes a) including two men who stated having unprotected anal intercourse with partners with HIV serostatus unknown or positive.
We agree with the reviewer that it is not clear and we added this precision in the Table 2 footnotes: “Overall, 152 men reported having unprotected anal intercourse with partners with HIV serostatus unknown or positive, but for two of them, the information about the last test was missing.”

2) I suppose that none of the differences between the two groups in the variables shown in table 2 are statistically significant.

R: The reviewer is right; in Table 2, the differences between the two groups (i.e. those with and those without a history of HIV test in the previous two years) were not statistically significant except for having a history of STI $p<0.05$.
We added this precision in the Table 2 footnotes:
“With the exception of the history of STIs in the previous two years, the differences between MSM tested or not tested for HIV in the previous two years were not statistically significant ($p>0.05$).”

3) I think table 3 is expendable, because identical results are expressed in a paragraph in page 14

R: We agree with the reviewer. However, we think these results are important and should be presented clearly in a table.

4) In the Discussion, the authors do a repetition. In page 16 the affirm "The MSM who returned for testing in the COM’TEST program were also tested significantly more often for HIV than men who came once." and in page 18 they say "MSM with an HIV positive test have been tested less often in the previous two years than men with a negative test; this result suggests also this program could reach MSM at high-risk who were not tested recently in other testing services."

R: We think the two ideas are important. The first sentence ("The MSM who returned for testing in the COM’TEST program were also tested significantly more often for HIV than men who came once.") refers to MSM who have been tested twice or more in the program, all except one were tested HIV-negative. This sentence suggests the HIV testing proposed is convenient for repeated testing.
The second sentence ("MSM with an HIV positive test have been tested less often in the previous two

years than men with a negative test; this result suggests also this program could reach MSM at high-risk who were not tested recently in other testing services.") refers to MSM who were tested HIV-positive in the COM'TEST intervention and suggests the HIV testing proposed is convenient for MSM who have not been tested for HIV (never or not lately).