HIV COMMISSION

HOW ENGLAND WILL END NEW CASES OF HIV

THE HIV COMMISSION'S RECOMMENDATIONS ON NORMALISING HIV TESTING

ABOUT THE HIV COMMISSION

An innovative approach

The HIV Commission is an ambitious, independent process to find the path to ending new HIV transmissions and HIV attributed deaths in England by 2030. This Commission – our founding partners and the Department for Health – believes this is an achievable goal which requires energy and commitment.

The HIV Commission consisted of twelve Commissioners, all leaders in their fields beyond the HIV sector, who committed to working together to explore the issues and find solutions. They brought fresh eyes and leadership to old and new challenges. The HIV Commission launched a call for evidence open from November 2019 – January 2020 (targeted at organisations) and opened the 'Have Your Say' portal (targeted at individuals) from February to May 2020. We received ninety-seven written contributions of evidence across these two consultations. In February and March 2020, HIV Commissioners also held five public meetings across England, to talk to local stakeholders and community members, to understand the different regional responses to the epidemic.

On visits to Manchester, Birmingham, London, Brighton and Hove and Bristol, HIV Commissioners attended local HIV clinics, sexual health services and support services, and all included open public meetings in which Commissioners discussed the local landscape, problems and solutions with attendees. Alongside written and oral evidence from the public, an expert Advisory Group authored twenty-seven evidence papers, to brief HIV Commissioners on key topics related to HIV transmission in England. The writing of these papers represented an unprecedented level of cross-sector collaboration. This formed the evidence base for our recommendations and this report.

As the evidence-collection process was coming to an end, the COVID-19 crisis changed every aspect of life in England and across the world. The pandemic has held a mirror up to our society, drawing attention to long existing inequalities and costing lives. No report on solutions for the next ten years can ignore this change. The Commission has worked with a wide range of stakeholders to understand the impact of COVID-19 on prevention and care in England, reflecting this learning throughout this report.

> *'The message from the HIV Commission is 'test, test, test'. To find the estimated 5,900 undiagnosed people living with HIV in England, HIV testing must be normalised throughout the health service. Everyone should know their HIV status.'*
>
> **Dame Inga Beale, Chair HIV Commission**

Why a commission?

As a tried and tested model for influencing change, a commission brings a level of independence from government, statutory bodies and service providers in order to constructively challenge preconceptions and the status quo.

Who established it?

The HIV Commission was an independent process supported and funded by National AIDS Trust, Terrence Higgins Trust, and Elton John AIDS Foundation. The organisations used their convening power to combine the expertise and resources of new and existing cross sector partners to end new HIV transmission in England, through collecting evidence and developing recommendations.

OUR COMMISSIONERS

The HIV Commission has drawn on the ideas and experience of people living with HIV, businesses, the voluntary sector and the public.

Dame Inga Beale (Chair)
British businesswoman and the former CEO of Lloyd's of London

Dr Rob Berkeley
Founder and Managing Editor at BlkOutUK.com

Steve Brine MP
MP for Winchester and Chandler's Ford. Former Parliamentary Under Secretary of State for Public Health and Primary Care

Rev Steve Chalke
British Baptist minister, Founder of the Oasis Charitable Trust

Joshua Graff
UK Country Manager & Vice President EMEA & LATAM at LinkedIn

Dr Richard Horton
Editor-In-Chief of The Lancet

Mercy Shibemba
HIV campaigner and winner of the inaugural Diana Award

Wes Streeting MP
Member of Parliament for Ilford North

Dame Alison Saunders
Dispute Resolution Partner at Linklaters. Former Director of Public Prosecutions and Head of the Crown Prosecution Service

Mehmuda Mian
Associate Director of the Lokahi Foundation

Gareth Thomas
HIV advocate and former Welsh rugby captain

ADVISORY GROUP

An expert Advisory Group, of over 40 topic experts representing different sectors in HIV treatment and prevention provided invaluable support to the HIV Commission throughout the process. This group included representatives from academia, community members, community-based organisations, government and statutory bodies, medical practitioners and clinicians. The full list of experts can be found online: **www.hivcommission.org.uk/advisory-group/**.

OUR RECOMMENDATIONS

'Ending HIV transmissions in England by 2030' is not just a government target but has the potential to change lives for many. At the moment nearly 3,000 people a year are newly diagnosed. Achieving this goal will prevent tens of thousands of new infections and all the complications that can follow – mental health challenges, medical complications, living with stigma and discrimination. This is such a worthwhile aspiration, it requires urgent government action.

To meet the ambition to end new HIV transmissions in England by 2030, the government should reaffirm this target, but also adopt the new interim milestone recommended by this commission to see an 80% reduction by 2025. This will ensure we are on track. We should seek to build on positive progress made to date and ensure that the government commit to England being the first country to achieve a goal that will change so many lives.

> *"The government should reaffirm [its 2030] target, adopt the new interim milestone recommended by this commission to see an 80% reduction by 2025 ... and ensure that the government commit to England being the first country to achieve a goal that will change so many lives."*

The worryingly high number of late HIV diagnoses is bad for patients, results in more progressed disease, leads to new preventable transmissions and impacts public finances. Every late diagnosis must be viewed as a serious incident requiring investigation, lessons being learned and a report produced to drive change in local health systems.

From the evidence received by this commission, it is clear that the single most important intervention to meet the 2025 and 2030 goals is widespread HIV testing, made routine across the NHS and delivered as opt-out – not opt-in – provision. The fragmentation of the system makes this more challenging, but no less important.

The health system must, over the next decade, make every contact count. Every blood test undertaken that is not also used as a chance to test for undiagnosed HIV, is an opportunity missed. No longer should people leave a sexual health clinic without being offered an HIV test. But to achieve this ambitious goal our attention must be wider, with a whole health system approach to testing. People presenting at A&E, registering for a GP and accessing other health services should be tested for HIV, with the default approach being an opt-out – not opt-in – for an HIV test. The success of this approach in maternity services shows us what is possible and how impactful it can be. Changes in HIV testing are urgent and national funding to enable this is key.

Finally, in a system so fragmented, leadership is necessary and accountability crucial. This is a role only national government can take on – the more it does the more our success is assured.

1. England should take the necessary steps to be the first country to end new HIV transmissions, by 2030, with an 80% reduction by 2025. Jointly the Department of Health and Social Care and the Cabinet Office should report to parliament on an annual basis the progress toward these three goals.
2. National government must drive and be accountable for reaching this goal through publishing a comprehensive national HIV action plan in 2021.
3. HIV testing must become routine – opt-out, not opt-in, across the health service.

The success in ending HIV transmissions lies in tackling HIV-related stigma and health inequalities. The building blocks of this report – and any future HIV Action Plan – are service transformation, equity for HIV affected communities, increased resources, bold leadership and effective partnerships. The report addresses each of these and sets out actions and calls for change.

Address stigma and health inequalities

Transformation	Equity	Resources	Leadership	Partnerships
Build a health and care system which can take advantage of innovation.	Address social and structural barriers to HIV testing and treatment access.	Ensure there are the right resources to meet the 2025 and 2030 goals.	Make HIV a national and local priority, and set a desire for England to be the first country to end new transmissions.	Strengthen alliances within and beyond the HIV community.

HIV TESTING

Free and confidential HIV testing is available for everyone, regardless of immigration or residency status, through open access sexual health services (SHS). Guidance also recommends free testing in a variety of other settings including, primary care, secondary care, prisons, community settings and online. In reality, however, implementation of guidance is patchy and testing is not routine or universally accessible to all. There are some paid for testing services, online or through pharmacies (such as HIV self-tests), but these are restricted to those who know about and can afford them. HIV testing informs people of their HIV status – enabling people living with HIV access to treatment and stopping onward transmission.

Accountability for delivery of HIV testing, and who pays for it, is another victim of the fragmented healthcare system in England and the split between primary care and public health commissioning. Solving this problem is a priority so we can find everyone living with HIV, ensure they have access to the lifesaving care they need and deserve, and end new transmissions by 2030. It is the single most important change needed to meet this goal.

Everyone should know their HIV status. This will require a significant upscale in HIV testing opportunities across online, community and healthcare settings. It must become a routine and expected part of every person's interaction with the healthcare system, with inclusion of HIV in blood screens being normalised. The increased opportunities for testing for other blood borne viruses (BBVs) would be an additional benefit of this change.

Opt-out HIV testing in antenatal services

There is one real success story in NHS HIV testing. Maternity services have mainstreamed HIV testing and deliver the service in a non-judgemental environment with remarkable results. Opt-out testing for HIV is routine for pregnant women and there is now a 99% testing coverage. This has been an incredibly effective way of diagnosing women living with HIV of reproductive age who may not otherwise have tested. Women who are diagnosed during pregnancy can start treatment, improving their health outcomes and preventing vertical transmission (the rate is now less than 0.5% in the UK). However, antenatal testing alone does not reach all women and other initiatives have so far been woefully inadequate at reaching women.

Despite various initiatives, elsewhere the picture is not one of routine or mainstream testing.

HIV testing in sexual health services (SHS)

In 2019, overall HIV testing coverage was only 65% in specialist sexual health services, which are the foundation of any HIV testing strategy. While this represents a continued increase in HIV testing in this environment, this has been largely driven by increased testing of gay and bisexual men. We can and must do much better.

Of the 549,849 people not tested for HIV in a specialist sexual health service last year, 46% were not offered a test and the remainder declined testing. This means over a quarter of a million people who accessed a sexual health service, were not even offered a test. These were overwhelmingly women, and disproportionately women of colour. This is also reflected in those who declined a test. Heterosexual women were more likely than heterosexual men to decline a test (25% vs 13%) and, according to Public Health England, "few GBM declined testing

(4%), in contrast to 20% of Black African heterosexual women and 9% of Black African heterosexual men."[1]

In 2008, the British Association for Sexual Health and HIV (BASHH), British HIV Association (BHIVA) and the British Infection Association (BIA) developed national testing guidelines that recommend universal HIV testing in sexual health services and promote the normalisation of routine HIV testing. It is the view of this commission that the BASHH, BHIVA and BIA guidance must be implemented with haste. No one should leave a sexual health clinic without being offered an HIV test and up-take should be dramatically increased so that refusal is an exceptional event.

HIV testing in other healthcare settings

National Institute for Health and Care Excellence (NICE) guidance on increasing testing uptake (2016), recommends testing in a broad range of settings. In areas of high or extremely high local HIV prevalence (more than 2 per 1000 in the population and 5 per 1000 respectively), NICE calls for testing on registration in primary care and in secondary and emergency care (hospitals and A&E) to everyone who is undergoing blood tests for another reason. BASHH, BHIVA and BIA guidelines further support this, recommending that testing is opt-out and routine in many parts of the NHS.

> *"Providing HIV testing to all patients attending the emergency department, regardless of social group (gender identity, ethnicity, religion or sexuality) in areas of high prevalence has a significant role in reducing the stigma associated with testing and the potential diagnosis of HIV."*
>
> **Guys and St Thomas' NHS Foundation Trust**

At evidence hearings across the country, we were told time and time again by stakeholders that the NICE guidelines for testing provided a good framework for testing strategies but were not being followed. Urgent implementation of these guidelines, not just in hospitals, A&E departments but also GP surgeries, is needed.

As we heard in our evidence sessions, one of the major barriers is funding, both in terms of clarifying responsibility and accountability, and in terms of making the necessary investment available.

Who pays? The clinical or public health commissioners? This confusion has gone on too long and has led to a hotchpotch of initiatives and models in different areas with mixed success and poor coordination and integration across services.

As well as the pressure on the limited public health grant, economies of scale don't support localised routine testing. As we make progress towards our goal of ending HIV transmissions the

---

[1] Public Health England, Trends in HIV testing, new diagnoses and people receiving HIV-related care in the United Kingdom: data to the end of December 2019. October 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/931964/hpr2020_hiv19.pdf

number of people we need to test compared to the diagnoses made will inevitably increase. If we are doing our job right, the positivity rate of testing will decrease, along with overall incidence of HIV. This is not a reason to slow testing down, as returns on investment appear smaller, but to double-down efforts. The upscale in testing that is needed cannot be simply absorbed to local-level responsibilities and budgets. Only action from the Department of Health and Social Care can solve this problem.

PHE data indicated that local initiatives have led to an increase in testing in some A&E departments. As a result of this increase in testing volume, the positivity rate decreased from 1.3% to 0.6%.[2] But positivity rates are still higher in A&E than in most settings. A&E HIV testing has again been boosted by the fact many trusts included HIV testing in their A&E COVID-19 testing protocols – a welcome development. However, there is a real concern that without further incentive and national policy direction, this will not be sustained.

It is the view of this commission that it will need more than clarity about commissioning responsibilities, there needs to be new funding made available both for existing bodies involved in testing, as well as a national HIV testing programme that will drive this agenda forward and coordinate implementation with those involved in delivery of testing locally and nationally.

Improving access to testing: evidence from Lambeth, Southwark and Lewisham

The Elton John AIDS Foundation's Social Impact Bond (SIB) funds HIV testing in the London boroughs of Lambeth, Southwark and Lewisham, with opt-out testing in A&Es, regular testing in GPs practices, and targeted testing by community groups. The three-year programme takes an outcomes-based approach and aims to increase HIV diagnoses and engagement into care. This is done in partnership with local NHS bodies and the three councils with some of the highest UK HIV incidences. The whole project is supported by funding from The National Lottery Community Fund and the London Borough of Lambeth.

In 2018 there were an estimated 1,000 people unaware they had HIV in Lambeth, Southwark and Lewisham.[3] Over 140,000 HIV tests have been delivered on an opt out basis in A&E departments through the SIB, changing the conversation from 'do you want a HIV test' to 'we routinely test unless you ask us not to' and thus vastly increasing the acceptability of HIV testing to patients . Consequently, from October 2018 to September 2020, 130 people were newly diagnosed with HIV and started treatment. A further 107 returned to HIV care after a substantial break in treatment – an important outcome helping this group reduce their viral load so they 'can't pass it on' and have improved health personally.

The SIB's activities highlights the importance and effectiveness of: one, opt-out HIV testing in emergency departments; two, regular testing by GP practices offered whenever blood is taken or at new registration; three, community organisations acting as a bridge to engage vulnerable people in HIV testing; and, four, dedicated audit and recall systems to re-engage people disconnected from HIV care.

These interventions improve the health of people living with HIV, reduce future HIV transmission, and generate cost savings for the public purse. Finally, initial modelling on the SIB programme

---

[2] PHE 'HIV in the United Kingdom: Towards Zero HIV transmissions by 2030' (2019)

[3] Lambeth Southwark and Lewisham (LSL) sexual reproductive health and HIV 2019-24 Strategy, March 2019: https://www.lambeth.gov.uk/adult-social-care-and-health/your-health/sexual-health-and-hiv/sexual-and-reproductive-health

shows that these testing and engagement interventions create significant savings to the NHS from two sources – reduction in lifetime costs of care for people living with HIV through earlier engagement in treatment, and avoidance of future transmission and the lifetime care costs that each new patient incurs.

The Elton John AIDS Foundation conducted an analysis of healthcare costs avoided through the SIB in November 2020, using lifetime costs of treatment for people with HIV, likelihood of HIV transmission, and likely number of sexual partners each year. They estimated that over £220,000 in future healthcare costs is saved per person who was diagnosed and linked into the right treatment care. That's because it saves the cost of intensive inpatient medical care associated with very late HIV diagnosis and limits the possibility of further transmissions. This suggests that, by linking 256 people into care between November 2018 to November 2020, future healthcare costs of £56,800,000 have been avoided. Implementation costs to the SIB providers have been approx. £1,500,000 over that period, which implies a net 'healthcare costs avoided' total of over £55,000,000.

Expanding the scope of routine HIV testing

The evidence from the SIB underpins why HIV testing must be increased in A&Es and primary care across all areas with high or extremely high incidence of HIV as soon as possible. But this will not be enough to end new transmissions completely and we need also to look beyond areas of high and extremely high prevalence to reach everyone. Cost savings will be less in areas of lower incidence due to the higher level and costs of testing required to reach each undiagnosed person living with HIV. Again, this is not a reason not to do it. A national approach to investment and coordination could support routine HIV testing at this scale and expand it beyond (but including) areas with the highest prevalence.

A national testing programme should also prioritise the exploring and enabling of testing in non-mainstream services that are more likely to be accessed by those who face broader inequalities and marginalisation. This should include termination clinics, as per NICE guidelines 2016, while doing cervical screening and at gender clinics.

Pharmacies are an ideal intermediate location, especially in towns and rural areas, where other services are not nearby or home sampling/testing is not desirable. There is currently no charge backs agreed for pharmacies when doing HIV testing[RA2], and this needs to change.

All of these services are potential opportunities to make PrEP available to those less likely to have access to sexual health services or unaware of PrEP availability and its benefits. To be able to provide PrEP, HIV testing needs to be available in all these settings.

The Testing Traffic Light

Below are examples of some healthcare services where the HIV Commission believes HIV testing should be provided. Green indicates that normalised HIV testing is policy and practice, currently in antenatal screening; amber indicates where there is direction to test but application is not thorough nor routine; red indicates areas for HIV testing to take place to meet the 2025 target for 80% reduction in new transmissions, the 2030 goal to end HIV transmissions and the aim for England to be the first country to eliminate HIV transmissions by 2030. This improved testing situation would be necessary to make PrEP available to all groups.

Service	Current policy and guidance	Responsibility	Implementation	To reach 2030 goal
Maternity services / antenatal screening	Offered to all women on opt-out basis as part of the Infectious diseases in pregnancy screening (IDPS) programme.	Funded nationally by NHS England through Section 7A agreement.	99% testing coverage. Transformative results, almost eliminating vertical transmission and dramatically increasing the proportion of women diagnosed.	Continue current practice. Identify factors in success and learning for increasing uptake elsewhere.
Sexual health services (SHS)	NICE 2016 guidance- all should be offered on attendance. BASHH, BHIVA and BIA guidelines 2020 – universal testing on an opt-out basis.	Local authorities through devolved public health grant.	In 2019, only 65% testing coverage across SHS attendees. Almost half (43%) of those not tested were not offered a test.	Implementation of opt-out HIV testing to all SHS attendees.
Prisons	NICE guidance on HIV testing and physical health of people in prison, both 2016 – all people should be offered an HIV test on an opt-out basis.	Joint commitment by NHS England, NOMS and PHE through their Partnership Agreement on healthcare in prisons.	Mixed implementation. In 2018 77% were offered a test with only 44% uptake. Testing practice is unlikely to be truly opt-out when it is in place. Test positivity rates are higher than other settings (1.2%).	Renewed efforts to implement true opt-out testing for people entering prison in England.

A&Es in areas of high or extremely high local HIV prevalence	NICE Guidance 2016 – all should be offered on admission and in routine blood tests. BASHH, BHIVA and BIA 2020 guidance – all patients accessing should be offered a test and recommends an opt-out approach. BASHH, BHIVA and BIA 2020 guidance – testing should be done in secondary care when clinically indicated.	Unclear responsibility with some local authorities funding through the public health grant. Some STPs/ ICSs have implemented across admissions during COVID-19. CCG funded when clinically indicated.	Not routinely implemented across the country. Difficult to collect data on testing in this setting due to differential data collection/reporting mechanisms. Challenges around both funding and implementation at a local level.	Implement opt-out HIV testing for all emergency and secondary care admissions and/or when bloods taken, starting in high and extremely high prevalence areas. All people presenting with HIV indicator conditions should be offered an HIV test.
Hospitals in areas of high or extremely high local HIV prevalence				

GP surgeries in areas of high or extremely high local HIV prevalence	2016 NICE guidelines – all should be offered a test on admission. BASHH, BHIVA and BIA 2020 guidance – all patients accessing should be offered a test and recommends an opt-out approach. BASHH, BHIVA and BIA 2020 guidance – testing should be done when clinically indicated.	Unclear responsibility – Some local initiatives funded through the local authority public health grant. Funded by Social Impact Bond in Lambeth, Southwark and Lewisham. CCG funded when clinically indicated.	Poor implementation though has been done on an ad hoc basis. Difficult to collect data on testing in this setting due to differential data collection/reporting mechanisms. Key to increasing testing to those less likely to access an STI clinic – women, Black communities and other ethnic minorities and those living outside cities and big towns. Challenges around funding responsibility and nervousness amongst GPs around offering HIV tests have been barriers.	Implement opt-out testing for all new registrants at GP surgeries. All people presenting with HIV indicator conditions should be offered an HIV test.
During cervical screening			No current guidance but is an opportunity to reach women living with HIV who have not been pregnant or acquired HIV post-pregnancy.	Offered to women and people with a cervix as part of the service.
A&E in areas of low or medium local HIV prevalence	NICE guidance 2016 – recommends testing on admission for key populations, those reporting possible risk or when clinically indicated.	Unclear responsibility. CCG funded when clinically indicated.	Not routine. High levels of late diagnosis (common in lower prevalence areas) and look back data indicate that people are also being missed who present with indicator conditions. Difficult to collect data on testing in this setting due to differential data collection/reporting mechanisms.	HIV testing should be routine on an opt-out basis for anyone receiving a blood test and on admission. All people presenting with HIV indicator conditions should be offered an HIV test.
Hospitals in areas of low or medium local HIV prevalence				

Pharmacies	NICE guidance 2016 – recommends community testing in pharmacies in areas of high or extremely high prevalence. No system of charge back for the pharmacist to undertake this work.		Sometimes available to purchase in pharmacies. An intermediate location for those, especially in towns and rural areas, where other services are not near or taking a home sample/test alone is not desirable. Would help make pharmacies a place to access PrEP.	Free HIV tests should be accessible through pharmacies and POCT should be offered where practicable.
Termination clinics	NICE guidelines 2016 recommend testing on first attendance and repeat testing. BASHH, BHIVA and BIA guidance 2020- all patients accessing should be offered a test and recommends an opt-out approach.	Unclear responsibility.	Not routinely implemented. This will also be necessary for this setting to become a place to access PrEP.	Opt-out HIV testing should be routine.
Addiction and substance misuse services	NICE guidance 2016 – routine HIV testing in 'drug dependency services'. BASHH, BHIVA and BIA guidance 2020- all should be offered a test and recommends an opt-out approach.	Local authorities through the public health grant.	Unclear but commissioning framework doesn't support routine testing in these settings. Some done as part of broader BBV testing initiatives. PHE reports high level of missed opportunities to diagnose people living with HIV who inject drugs.	HIV testing (as part of BBV testing) should be routinely provided on an opt-out basis for those accessing addiction and substance misuse services.

Testing outside traditional healthcare settings

Most of the above has been focused on increasing and normalising testing opportunities in healthcare settings. This is however, only one piece of the puzzle. Online and community testing play a vital role. In 2019, PHE reported that 25,514 self-sampling test kits were returned via the national HIV self-sampling scheme alone [7[RA3]]. Community HIV testing describes testing which is generally led by voluntary and community sector organisations and that is delivered by and for communities it targets. PHE has in recent years tried to capture data on community testing to demonstrate the contribution and impact. 35,095 tests were reported through PHE's 'Survey of HIV Testing in Community Settings' in 2019 [xiv] [8[RA4]].

Test reactivity in self sampling and community tests was 0.5% in both services. This compares with 0.2% in specialist sexual health services, 0.6% in A&E departments, 0.3% in GPs in extremely high prevalence areas and 0.7% in prisons. Community testing services are a proven tool in reaching people who are not accessing traditional health services.[4] Well designed, community-led and culturally competent testing can overcome some of the barriers to testing we see such as concerns around stigma, lack of trust in services, or low perception of personal risk. It also provides opportunities to open up conversations about HIV and sexual health, providing a gateway to broader services.

At a local level, funding of community testing is highly inconsistent. Targeted peer-led design and delivery is critical but it can be difficult to achieve economies of scale and this does not fit easily with the direction of travel towards larger scale integrated sexual health service contracts. Community testing is often de-prioritised or traded-off against online testing- but these are not an either/or but rather are services often meeting different needs that are both critical components to a whole-systems approach to testing.

National AIDS Trust's Community Testing Toolkits, developed with experienced providers across England, are an invaluable resource for community organisations and funders to design and evaluate good HIV testing interventions. Local commissioners need to be supported through a national HIV testing programme to appropriately invest in them to the necessary extent to drive innovation in this area.

Optimising online and community testing

Availability of online testing is dependent on local authority buy-in to the variety of services available (including the National Home Sampling Service and the London Sexual Health Programme). Terrence Higgins Trust runs HIV Prevention England (the national HIV prevention programme) and coordinates National HIV Testing Week – the only time that online testing is available for free across the country apart from for a limited time during the COVID-19 pandemic. It has significantly increased traffic to online self-sampling services. COVID-19 showed how critical online options are when there are limitations on face-to-face services (which are experienced by some people all the time). It should not take a pandemic to make online HIV Testing an accessible option, available to all.

HIV Prevention England has similarly supported greater engagement with community testing at a local level. Local commissioners and community organisations have been able to leverage

---

[4] Croxford S et al., 2019, Community-based HIV testing in Europe: a systematic review (Poster), HepHIV
2019 Conference, 28-30 January
2019, Bucharest, Romania [https://www.eurotest.org/Portals/0/PS4_04.pdf]

the national resources and momentum generated through HPE and testing week to increase engagement with their services. This is an example of how a national programme can support local amplification of HIV testing interventions. It was shown to be successful at reaching key populations, gay and bisexual men, Black African communities and first time testers. This impact could be increased with greater investment to extend reach.

> *"I live in an area where STI testing is otherwise only available from a clinic that's open for 3 hours once a month. I'm physically disabled and can't get there easily. Being able to get tested at home is so much less taxing on my health, and I appreciate it being an option."*
>
> **SH:24**

In addition, Terrence Higgins Trust has been running an online self-testing service for HIV since 2016, supplying more than 43,000 tests since launch. It has demonstrated clear demand and acceptability for self-testing among its target audience. 12% of orders have been from Black African people. Unlike self-sampling, users read their own result at home and are prompted to report their test results, with more than 60% doing so.

Since 2018, Terrence Higgins Trust's self-testing service has also offered a free Click and Collect option, with 4,000 collection points across the UK. This has been used by nearly 10% of those ordering, including 13% of Black African people and 13% of BAME men who have sex with men (MSM). It is clear, both self-testing and Click and Collect options for broader postal testing have a role to play in improving access.

HIV testing beyond key populations

Increasing the visibility of HIV testing to a wider audience is also critical and should be a core component of national investment. According to PHE, "While Black Africans remain one of the main groups likely to be diagnosed with HIV amongst heterosexuals, they only constitute about 40% of heterosexuals diagnosed with HIV in 2018. There isn't a clear strategy or plans to effectively target the other communities from which the 60% of new diagnoses amongst heterosexuals came from in 2018." Again, the necessary effort and investment to meet this challenge cannot be achieved by simply carrying on as we are. Local areas are not equipped with the necessary resources or tools to reach the testing capacity that this challenge demands.

Opportunities to identify undiagnosed HIV are hugely limited by the current system and its approach to testing. We must find those who are not yet diagnosed to reach our goal and this will take a radical upscale in HIV testing. HIV testing must become standard in healthcare, with increased opportunities for screening programmes, such as in emergency departments. Not being offered or turning down an HIV test should be an exceptional event. This requires a significant shift in emphasis to opt-out rather than opt-in testing. Structural problems within the NHS that prevent this from being funded must be resolved through national support. This will reduce the number of late HIV diagnoses and prevent onward transmission, while also supporting re-engagement into care for those who need it. COVID-19 and the 'test and trace' moment has demonstrated the importance of numbers when it comes to testing and this is now something that resonates with the public. Now, more than ever, it is vital that upscaling testing efforts is at the core of our HIV response.

> *"A number of people did not want to self-test and would strongly prefer to go to a service where they could also have a conversation about their sexual health."*
>
> **LGBT Foundation**

We are recommending that testing become routine and an opt-out approach is adopted because a single approach to upscaling testing efforts will not address the inequalities in our testing systems.

Health Equity Considerations

- The implementation of testing guidelines remains patchy which results in regional inequalities.
- Late HIV diagnosis remains unacceptably high with 48% of those diagnosed for first time 2019. Levels are higher amongst heterosexuals as compared to gay and bisexual men with Black African men affected acutely. Encouraging regular testing among heterosexuals remains a challenge.

Stigma Considerations

- In specialist sexual health services in 2019, 35% of people eligible for an HIV test were not tested. Half of those eligible were not offered a test, with the other half declining a test. We know that stigma significantly limits the uptake of HIV testing services. This is well documented particularly for Black African communities.[5]

ACTION

Opt-out rather than opt-in HIV testing must become routine across healthcare settings, starting with areas of high prevalence.

---

[5] National Institute for Health and Care Excellence (NICE). *HIV testing: encouraging uptake.* https://www.nice.org.uk/guidance/ng60/evidence/barriers-to-hiv-testing-final-full-report-ph33-pdf-2727985357

HIV COMMISSION

hivcommission.org.uk

NATIONAL AIDS TRUST
Securing rights
Stopping HIV

Terrence Higgins Trust

ELTON JOHN
AIDS FOUNDATION