HIV testing: increasing uptake among people who may have undiagnosed HIV

NICE guideline

Draft for consultation, May 2016

This guideline covers how to increase the uptake of HIV testing to reduce undiagnosed HIV in people who may have been exposed to it. The guideline focuses on people who live in areas or communities with a high prevalence of HIV, whose lifestyle or sexual behaviour puts them at risk, or who have an illness that may indicate HIV infection.

Who is it for?

- Local authority and NHS commissioners of HIV testing services
- Providers of HIV testing services
- Practitioners working in services that offer HIV testing

It may also be relevant for:

- Royal colleges, clinical institutions and related professional bodies
- People who want to use self-testing or self-sampling kits to test for HIV
- People who are considering using HIV testing services, their families and carers, and the general public

This guideline will update and replace NICE guidelines PH33 and PH34 (both published March 2011). We have updated or added new recommendations on raising awareness about, and improving uptake of, HIV testing among people who may have undiagnosed HIV.

New recommendations are marked as **[new 2016]** which means that the evidence has been reviewed and the recommendation has been added.

We have not updated recommendations shaded completely in grey and marked **[2011]**. In recommendations marked **[2011, amended 2016]** we have made amendments to clarify the language or action and to show where the population groups covered by PH33 and PH34 recommendations have been broadened. These changes are marked with yellow shading, and explanations of the reasons for the changes are given in update information.

This guideline contains the draft recommendations, information about implementing the guideline, context, the guideline committee's discussions and recommendations for research. Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest.

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Contents

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Offering and recommending HIV testing in different settings

Specialist sexual health services (including genitourinary medicine)

The following recommendations are for healthcare professionals in specialist sexual health services.

1.1.1 Offer and recommend an HIV test to everyone who attends for screening or treatment. **[PH34 2011, amended 2016]**

1.1.2 Ensure both fourth generation serological testing and point-of-care testing (POCT) are available. **[PH34 2011, amended 2016]**

Secondary and emergency care

The following recommendations are for healthcare professionals in secondary and emergency care.

1.1.3 Routinely offer and recommend an HIV test to everyone attending their first appointment (followed by repeat testing in line with recommendation 1.2.8) in:

- drug dependency programmes
- hepatitis B services
- hepatitis C services

- lymphoma services
- termination of pregnancy services
- tuberculosis services.

[PH33 2011, amended 2016]

1.1.4 Offer and recommend HIV testing on admission to hospital, including emergency departments, to everyone who has not previously been diagnosed with HIV and who:

- lives in an area of high prevalence of HIV and is undergoing blood tests for another reason
- has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator conditions)
- is known to be from a country or community with a high prevalence of HIV
- if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous year
- reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence
- discloses that they have changed sexual partner or discloses high-risk sexual practices
- is diagnosed with, or requests screening for, a sexually transmitted infection
- discloses that they are the sexual partner of a man or woman known to be HIV positive
- reports a history of injecting drug use. **[PH33, PH34 2011, amended 2016]**

GP surgeries

The following recommendations are for healthcare professionals in GP surgeries.

1.1.5 Offer and recommend HIV testing promptly to everyone who has not previously been diagnosed with HIV and who:

- has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator conditions)
- registers with a practice in an area with a high HIV prevalence
- is known to be from a country or community of high HIV prevalence
- if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous year
- reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence
- discloses that they have changed sexual partner or discloses high-risk sexual practices
- is diagnosed with, or requests screening for, a sexually transmitted infection
- lives in an area of high prevalence of HIV and is undergoing blood tests for another reason
- discloses that they are the sexual partner of a man or woman known to be HIV positive
- reports a history of injecting drug use. **[PH33, PH34 2011, amended 2016]**

1.1.6 Offer and recommend repeat testing to these people in line with recommendation 1.2.8 **[new 2016]**

1.1.7 If a venous blood sample is not already being taken for another reason, or is refused, offer a less invasive form of specimen collection, such as a mouth swab or finger-prick. **[PH33, PH34 2011, amended 2016]**

Community settings

The following recommendations are for community and voluntary sector organisations who offer HIV testing, and for outreach and detached services offering HIV testing in community settings.

1.1.8 Set up community testing services in venues or areas where there is high-risk sexual behaviour or a high prevalence of HIV. This could include:

- community or voluntary sector premises

- public sex environments
- venues where people at high risk may gather. **[PH34 2011, amended 2016]**

1.1.9 Recognise that not all community settings are appropriate for providing testing services, for example because tests should be undertaken in a secluded or private area (in line with British HIV Association guidelines). **[PH34 2011, amended 2016]**

1.1.10 Ensure that people who decline or are unable to consent to a test (for example, they are under the influence of alcohol or drugs, they fear community stigma or because of their age) are given information about other local testing services, including self-sampling. See making decisions using NICE guidelines for more information about consent. **[PH34 2011, amended 2016]**

1.1.11 Ensure that lay testers delivering tests are competent to do so and have access to clinical advice and supervision. **[PH34 2011, amended 2016]**

1.2 Increasing opportunities for HIV testing

The following recommendations are for organisations and practitioners who offer HIV testing.

Point-of-care testing

1.2.1 Offer POCT in situations where follow-up may be difficult so that people do not need to return to get their results. **[new 2016]**

1.2.2 Practitioners delivering POCT should explain to people at the time of their test about the relatively poor specificity and sensitivity of POCT and the need for confirmatory serological testing. **[PH34 2011, amended 2016]**

Self-sampling

1.2.3 Consider providing self-sampling kits, in a sensitive manner, to groups and communities with a high prevalence of HIV. **[new 2016]**

1.2.4 Recognise that not all community settings are appropriate for providing access to self-sampling kits. For example, people may fear stigma if they are seen asking for a self-sampling kit in a public place. Choose an area that provides privacy and signpost to it clearly within the venue (see also recommendation 1.1.9). **[new 2016]**

1.2.5 Consult stakeholders when setting up self-sampling services (see NICE's guideline on community engagement). **[new 2016]**

1.2.6 Ensure that people know how to get their own self-sampling kits, for example, by providing details of websites to order them from. **[new 2016]**

Repeat testing

1.2.7 When giving results to people who have tested negative but who may have been exposed to HIV, recommend that they have another test once they are past the 'window period'. **[PH34 2011, amended 2016]**

1.2.8 Recommend annual testing to people in groups or communities with a high prevalence of HIV, and more frequent testing for those who have a high risk of exposure, for example through multiple sexual partners or unsafe sexual practices. **[PH34 2011, amended 2016]**

1.2.9 Consider providing the following interventions to promote repeat testing:

- Call-recall methods using letters or other media, such as text messages or email, to remind people to return for annual testing.
- Electronic reminders in health records systems to prompt healthcare professionals to identify the need for testing during appointments and offer it if needed. **[new 2016]**

People who decline a test

1.2.10 If people choose not to take up the immediate offer of a test, tell them about nearby testing services and how to get self-sampling kits. **[PH33 2011, amended 2016]**

1.3 Promoting awareness and uptake of HIV testing

The following recommendations are for statutory and voluntary sector organisations who offer or promote HIV testing.

Content

1.3.1 Design materials and interventions for promoting awareness and increasing the uptake of HIV testing in line with NICE's guidelines on behaviour change: general approaches and behaviour change: individual approaches. **[new 2016]**

1.3.2 Produce promotional material tailored to the needs of local communities. It should:

- provide information about HIV infection and transmission, the benefits of HIV testing and the availability of treatment
- emphasise that early diagnosis is not only a route into treatment and a way to avoid complications and reduce serious illness in the future, but also reduces the chances of onward transmission
- detail how and where to access local HIV testing services, including services offering POCT and self-sampling, and sexual health clinics (where people do not have to give their real name)
- dispel common misconceptions about HIV diagnosis and treatment
- present testing as a responsible act by focusing on trigger points, such as the beginning of a new relationship or change of sexual partner, or on the benefits of knowing one's HIV status
- address the needs of non-English-speaking communities, for example, through translated information. **[PH33, PH34 2011, amended 2016]**

1.3.3 Ensure interventions to increase the uptake of HIV testing are hosted by, or advertised at, venues that encourage or facilitate sex (such as some saunas, websites, or geospatial apps that allow people to find sexual partners in their proximity). This should be in addition to general community-based HIV health promotion. **[PH34 2011, amended 2016]**

1.3.4 Promote HIV testing when delivering sexual health promotion and HIV prevention interventions. This can be carried out in person (using printed publications such as leaflets, booklets and posters) or through electronic media. **[PH34 2011]**

1.3.5 Ensure health promotion material aims to reduce the stigma associated with HIV testing and living with HIV, both among communities and among healthcare professionals. **[PH34 2011, amended 2016]**

1.3.6 Ensure health promotion material provides up-to-date information on modern HIV tests, in particular, the availability of POCT. In addition, it should highlight the significantly reduced window period resulting from the introduction of newer tests such as fourth generation serological testing. **[PH34 2011]**

Methods of raising awareness

1.3.7 Use or modify existing resources, for example TV screens in GP surgeries, to help raise awareness that HIV testing is available locally (for content see recommendations 1.3.1 and 1.3.2). **[new 2016]**

1.3.8 Consider using a range of approaches to promote HIV testing, including:

- local media campaigns
- digital media, such as educational videos
- social media, such as online social networking, dating and geospatial apps
- printed materials, such as information leaflets. **[new 2016]**

1.4 Reducing barriers to HIV testing

The following recommendations are for statutory and voluntary sector organisations who offer HIV testing.

1.4.1 Advertise HIV testing in settings that offer it (for example, using posters in GP surgeries) and make people aware that healthcare professionals welcome the opportunity to discuss HIV testing. **[new 2016]**

1.4.2 Staff offering HIV tests should:

- Emphasise that the tests are confidential. If people remain concerned about confidentiality, refer them to a sexual health clinic, where they do not have to give their real name.
- Be able to discuss HIV symptoms and the implications of a positive or a negative test.
- Be familiar with existing referral pathways so that people who test positive receive prompt and appropriate support.
- Provide appropriate information if someone tests negative, including details of where to get free condoms and how to access local behavioural and preventive interventions.
- Recognise and be sensitive to the cultural issues facing different groups (for example, black Africans may be less used to preventive health services and advice, or may fear isolation and social exclusion if they test positive for HIV).
- Be able to challenge stigmas and dispel misconceptions surrounding HIV and HIV testing and be sensitive to people's needs.
- Be able to recognise the symptoms that may signify primary HIV infection or illnesses that often coexist with HIV. In such cases, they should be able to offer and recommend an HIV test. **[PH33 2011, amended 2016]**

1.4.3 Ensure practitioners delivering HIV tests (including those delivering outreach POCT) have clear referral pathways available for people with both positive and negative test results, including to sexual health services and confirmatory serological testing. These pathways should ensure the following:

- People who test positive are seen by an HIV specialist preferably within 48 hours, certainly within 2 weeks of receiving the result (in line with UK national guidelines for HIV testing 2008 British HIV Association). They should also be given information about their diagnosis and local support groups.

- People who regularly engage in high-risk sexual behaviour or inject drugs (whatever their test result) are offered behavioural or health promotion interventions (for example, advice on safer sex or injecting, training in negotiating skills and providing condoms).
- Practitioners in the voluntary or statutory sector can refer people from HIV prevention and health promotion services for HIV testing and vice versa. **[PH33, PH34 2011, amended 2016]**

Putting this guideline into practice

NICE has produced tools and resources [link to tools and resources tab] to help you put this guideline into practice.

Some issues were highlighted that might need specific thought when implementing the recommendations. These were raised during the development of this guideline and are:

- The need to address misconceptions about HIV testing and treatment, for example:
  - the cost of HIV treatment
  - life expectancy following a positive diagnosis (particular emphasis is needed on the benefits of early diagnosis for outcomes including life expectancy).
- The need to reduce the stigma (real or perceived) associated with HIV testing and living with HIV, both among communities with a high prevalence of HIV and among healthcare professionals.
- The need to take local patterns of HIV into account when planning how to deliver services. Services should match the needs of the population, for example by using POCT in high-prevalence populations where its lack of specificity is less of a barrier.

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

Context

In 2014, an estimated 103,700 people (69,200 men and 34,400 women) in the UK were living with HIV. The overall HIV prevalence was 1.9 per 1,000 people aged 15 and over (HIV in the UK Public Health England).

Although there are significant pockets of HIV in other populations and communities, the most significant burden of HIV continues to be borne by men who have sex with men and by black Africans. An estimated 45,000 men living with HIV in the UK in 2014 had acquired their infection through sex with other men, an increase from 43,000 in 2013. One in 20 men aged 15–44 who have sex with men is estimated to be living with HIV.

A recent increase in HIV testing coverage among men attending sexual health clinics is likely to be the reason for an increase in new diagnoses and a decline in undiagnosed infections: about 6,500 men who have sex with men were unaware of their infection in 2014, compared with 8,500 in 2010 (HIV in the UK Public Health England).

Almost 1 in 1,000 heterosexual people aged 15–44 in the UK is estimated to be living with HIV. Prevalence is higher in black African heterosexual men (1 in 56) and women (1 in 22), who form the second largest group affected by HIV. Late diagnosis remains a significant problem in heterosexual people: in 2014, 55% were newly

diagnosed at a late stage of infection (just over half of whom were black African) (HIV in the UK Public Health England).

Overall, a quarter (24%) of people estimated to have HIV are unaware they are infected and so are at risk of passing it on. More people living outside London are unaware of their HIV infection (24%) compared with those in London (12%) (HIV in the UK Public Health England).

In 2013, in response to the international AIDS epidemic, UNAIDS launched a new target known as '90-90-90' (90-90-90: An ambitious treatment target to help end the AIDS epidemic UNAIDS). By 2020:

- 90% of all people living with HIV will know their HIV status
- 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy
- 90% of all people receiving antiretroviral therapy will have viral suppression.

In 2011, NICE published guidelines PH33 and PH34, which aimed to increase the uptake of HIV testing in black Africans living in the UK and in men who have sex with men. In 2014, experts reviewed the evidence and agreed that the guidelines should be updated to reflect changes in the way HIV testing is delivered (following the legalisation of self-sampling and self-testing kits) and to reflect the normalisation of HIV testing across health services.

More information

To find out what NICE has said on topics related to this guideline, see our web page on HIV and AIDS.

The committee's discussion

Background

The committee discussed the recommendations and considerations in the 2 guidelines being updated (NICE guidelines PH33 and PH34), and considered the view of the experts in the review decision. The committee agreed that the previous

recommendations and considerations are still pertinent to current practice, although they needed some updating to better reflect the current situation.

The committee discussed the distinction between testing and screening. It was reminded that recommending screening programmes is outside NICE's role. It also discussed the differences between opt-in and opt-out approaches to testing, that is whether people are asked if they want an HIV test or they are told they will be tested for HIV unless they specifically ask not to be. It agreed that it was important to make sure people understand that HIV testing is voluntary and to give everyone the opportunity to opt out of a test.

The committee discussed and agreed that it would be useful for other NICE guidelines to recommend offering HIV testing, especially when diagnosing or treating conditions that may indicate HIV infection.

When considering the recommendations from the previous guidelines, the committee discussed whether it would be appropriate to broaden the recommendations from men who have sex with men, or black Africans to any population at high risk of HIV. For further information on the relevance of this guideline for other groups, see the equality impact assessment.

The committee agreed that the British HIV Association guidelines referred to in the recommendations were the most up to date available in the UK and should remain in the recommendations. The only exception relates to indicator conditions where more up-to-date guidance is available from HIV in Europe (see below).

The committee did not make recommendations for all of the evidence statements. This was mainly because it did not believe, based on the evidence, that an intervention was effective; or it agreed that the intervention would not be applicable in the UK. For details of the evidence statements not used to make recommendations, see the evidence reviews section.

Sections 1.1 and 1.2

The discussion below explains how we made recommendations in:

- Section 1.1 Offering and recommending HIV testing in different settings

- Section 1.2 Increasing opportunities for HIV testing

Current practice

The committee agreed that, although there are pockets of high prevalence of HIV in other communities, the main at-risk groups for HIV are men who have sex with men, and black Africans.

The committee noted the pressures on healthcare professionals' time during short appointments and that some kinds of tests might not always be appropriate due to time restrictions. For example, a GP would not be able to perform point-of-care testing (POCT) during a 10-minute appointment in addition to the main consultation.

The committee discussed the meaning of 'high prevalence'. NICE guidelines PH33 and PH34 used the definition given by Public Health England of 2 in 1,000 people. However, as more people are being diagnosed with HIV and treated, and because they are living longer, the background prevalence of HIV is rising and the overall UK prevalence is 1.9 per 1,000. Experts told the committee that a more realistic value to use would be an undiagnosed prevalence of 1 in 1,000. However, the committee noted the difficulties that local areas would have in estimating their undiagnosed prevalence. The committee agreed that a useful value to define high prevalence for the purposes of this guideline was 4 diagnosed cases in 1,000.

Evidence for effectiveness

The committee discussed the distinction between self-sampling and self-testing (see recommendations 1.1.10, 1.2.3, 1.2.4, 1.2.5,1.2.6 1.2.10). No evidence was found on self-testing and therefore it didn't include this in the recommendations.

The committee noted that the uptake of HIV testing was generally high when testing was offered but that staff are often reluctant to offer and recommend a test. The committee felt it was particularly important that practitioners who are reluctant to offer tests more widely should know about this.

The committee discussed the effectiveness of offering testing to people who present to health services with conditions that might indicate HIV. The effectiveness of this depends to some extent on the accuracy of the list of indicator conditions used. The committee agreed that defining a list of indicator conditions was outside the scope of

this guideline; however, it agreed that HIV in indicator conditions from HIV in Europe was sufficiently evidence-based to inform recommendations 1.1.4 and 1.1.5 and a useful supplement to the guideline.

The committee discussed the frequency of HIV testing and agreed that repeat testing should be promoted to people in higher-risk groups. It discussed evidence for the effectiveness of different systems to promote repeat testing, such as call-recall methods and electronic reminders. The committee agreed that systems like these should be implemented wherever possible.

When discussing electronic reminders for practitioners (see recommendation 1.2.9), the committee discussed how the evidence showed that electronic reminders that could be clicked and dismissed were less effective than reminders that required filling in before they could be dismissed.

Resource impact and implementation issues

When discussing testing in GP surgeries and emergency departments (see section 1.1), the committee considered the resource impact of the recommendations. It was felt that routine testing in either GP or emergency settings would have a substantial resource impact and would not be implementable. However, it was agreed that opportunistic routine testing for everyone having a blood test in these settings in high prevalence areas was a good idea. They also considered the potential resource impact of self-sampling (and a resource impact report was produced). It was felt that self-sampling was likely to be less costly than traditional testing approaches involving healthcare professionals. It may also be an effective approach in harder to reach sub-groups at risk, and have potential to reduce late diagnosis in these groups. This could reduce the health and social care costs associated with late diagnosis.

Sections 1.3 and 1.4

The discussion below explains how we made recommendations in:

- Section 1.3 Promoting awareness and uptake of HIV testing
- Section 1.4 Reducing barriers to HIV testing

Current practice

The committee discussed interventions that raise awareness of HIV testing and their impact on behaviour change. After considering the evidence, it was agreed that the guideline should refer to existing NICE guidance on behaviour change (see recommendation 1.3.1).

Evidence for effectiveness

There was some evidence of effectiveness for media campaigns, educational videos, online social networking and information leaflets in raising awareness of HIV testing. The committee agreed that different methods of awareness-raising are effective for different groups and that a range of methods should be recommended.

The committee discussed the evidence from 1 study on the effectiveness of motivational interviewing for increasing uptake of HIV testing. The committee felt that there wasn't enough evidence from the study to recommend this as an intervention but that referring to NICE's guidelines on behaviour change would cover this type of approach.

The committee noted that evidence showed computerised interviews and risk assessments were not effective at increasing uptake of HIV testing in people who may have undiagnosed HIV so it did not make a recommendation about them.

There was evidence suggesting that financial incentives are effective at increasing uptake of HIV testing. However, the committee noted a lack of applicability of the evidence to UK healthcare settings. Without stronger evidence of effectiveness in the UK, the potentially significant resource impact of the intervention could not be justified.

Evidence reviews

Details of the evidence discussed are in evidence reviews, reports and papers from experts in the area.

The evidence statements are short summaries of evidence. Each statement has a short code indicating which document the evidence has come from.

Evidence statement number **E1.1** indicates that the linked statement is numbered 1.1 in review 1 for PH33, 'Review of effectiveness and cost effectiveness: increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England'. **Q1** indicates that the linked statement is numbered 1 in review 2 for PH33, 'Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England – barriers to HIV testing'. **ES1** indicates that the linked statement is numbered 1 in the review for PH34 'Preventing and reducing HIV transmission among men who have sex with men'. **ES1a.1** indicates that the linked statement is numbered 1 in review 1a for this guideline. **ES1b.1** indicates that the linked statement is numbered 1 in review 1b for this guideline. **ES1c.1** indicates that the linked statement is numbered 1 in review 1c for this guideline. **ES2.1** indicates that the linked statement is numbered 1 in review 2 for this guideline. **EP1** indicates that expert paper 'Targeted testing based on indicator conditions' is linked to a recommendation. **EP2** indicates that expert paper 'HIV testing in the UK and summary of current UK practice' is linked to a recommendation.

The expert report 'Time to test for HIV: expanded healthcare and community HIV testing in England. Interim report' was also used to inform the original recommendations in PH33 and PH34.

If a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by **IDE** (inference derived from the evidence).

Recommendation 1.1.1: E3.5b, ES4, ES1b.14, ES2.3

Recommendation 1.1.2: E3.5c, ES1b.12; ES1c.1, ES1c.3 IDE

Recommendation 1.1.3: E3.5b, ES4, ES1b.14, ES1c.8, ES2.1

Recommendation 1.1.4: ES4, Q6.1, ES1c.5, ES1c.6; IDE

Recommendation 1.1.5: Q6.2, Q6.3, ES4, ES1c.6, ES2.1; IDE

Recommendation 1.1.6: ES4; IDE

Recommendation 1.1.7: ES15, ES1b.15; IDE

Recommendation 1.1.8: Q6.2, ES1, ES14, ES15, ES2.3; IDE

Recommendation 1.1.9: ES14, ES15; IDE

Recommendation 1.1.10: Q1.3, ES18, ES2.2; EP2

Recommendation 1.1.11: IDE

Recommendation 1.2.1: E3.5c, Q6.3, ES1b.16, ES1c.1, ES1c.3; IDE

Recommendation 1.2.2: IDE

Recommendation 1.2.3: Q5.3, ES1, ES1b.17, ES2.4; EP2; IDE

Recommendation 1.2.4: Q1.3, Q5.3, Q6.2, ES18, ES1b.17, ES2.2, ES2.4; IDE

Recommendation 1.2.5: IDE

Recommendation 1.2.6: ES1a.7, ES1a.9; EP2; IDE

Recommendation 1.2.7: E3.5b, ES4, ES16, ES7; IDE

Recommendation 1.2.8: ES4; IDE

Recommendation 1.2.9: ES1b.18, ES1c.7; IDE

Recommendation 1.2.10: EP2; IDE

Recommendation 1.3.1: ES13; IDE

Recommendation 1.3.2: E3.3, E3.4, Q1.2, Q1.3, Q4.2, Q4.3, Q5.1, ES3, ES13; IDE

Recommendation 1.3.3: ES3, ES13; IDE

Recommendation 1.3.4: ES13, ES1a.6; IDE

Recommendation 1.3.5: Q.3, ES10, ES13, ES18, ES2.2; IDE

Recommendation 1.3.6: ES10, ES13; IDE

Recommendation 1.3.7: E3.2, ES3, ES13, ES1a.1, ES1a.2, ES1a.6, ES1a.7, ES1a.8, ES1a.9, ES1a.10

Recommendation 1.4.1: ES1a.6; IDE

Recommendation 1.4.2: E3.5c, E3.6, E3.7a, E3.7b, Q1.3, Q5.4, Q7.4, ES18, ES1b.20, ES2.2

Recommendation 1.4.3: Q5.1; IDE

The following new 2016 evidence statements were not used to make recommendations: ES1a.3, ES1a.4, ES1a.5, ES1b.13, ES1b.19, ES1b.20, ES1b.21, ES1b.22, ES1c.2, ES1c.4.

Gaps in the evidence

The committee's assessment of the evidence on HIV testing identified a number of gaps. These gaps are set out below.

1. Interventions to increase awareness of the benefits of HIV testing and details of local testing services among people who have not been diagnosed with HIV, particularly:

- one-to-one and group-based information provision
- opportunistic information provision
- use of social media
- mass media campaigns.

(Source ER1)

2. Interventions to increase awareness of the indicators for, and the benefits of, HIV testing among practitioners who should offer testing or refer people for testing.

(Source ER1)

3. Increasing the number of settings where tests can be carried out, particularly in community and outreach settings.

(Source ER1)

4. Changes in service delivery to increase the uptake of HIV testing, for example, increasing the number of tests offered; changing opening times and appointment systems; and changing confidentiality policies.

(Source ER1)

5. The impact of lay testers recommending or offering an HIV test.

(Source ER1)

6. The effectiveness of self-testing for HIV and self-sampling for an HIV test.

(Source ER1)

7. Interventions to assess whether indicator condition-targeted testing is effective compared with routine testing.

(Source ER1)

8. Interventions to increase uptake of HIV testing among people who have an illness that may indicate HIV infection.

(Source ER1)

9. Attitudes towards HIV testing among people who may have undiagnosed HIV, and service providers (that is, whether or not there is any stigma associated with HIV tests).

(Source ER2)

10. Barriers to HIV testing for people who may have undiagnosed HIV (for example, people who do not speak English as a first language) and service providers.

(Source ER2)

11. Appropriate settings for delivering HIV testing, for example custodial settings or faith settings.

(Source ER1)

12. Appropriate definition of ‘high prevalence’ in the UK context, especially in terms of cost effectiveness.

(Source committee discussion)

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Community and outreach interventions to improve the acceptability and uptake of HIV testing

What interventions would be effective and cost effective in community and outreach settings in the UK to improve attitudes towards and increase uptake of HIV testing among people who may have undiagnosed HIV?

Why this is important

Improving the acceptability of HIV testing and increasing the uptake of HIV testing will reduce the pool of undiagnosed infection, improve outcomes for those affected and reduce onward transmission. Evidence suggests that there are substantial barriers to HIV testing related to beliefs, attitudes and stigma, particularly in some high-risk populations.

2 Supporting healthcare professionals to offer HIV tests

What interventions are effective and cost effective locally, and could be used in different areas in the UK, to support healthcare professionals in offering and recommending an HIV test?

Why this is important

Evidence suggests that the uptake of HIV testing is high among people who are offered and recommended a test. However, healthcare professionals often do not offer or recommend HIV tests in situations where guidelines suggest it would be appropriate to do so. Research exploring interventions to promote the offer of HIV testing among a variety of test providers would inform future iterations of the guideline.

Most of the evidence on increasing the uptake of HIV testing came from the USA, often from settings that do not exist in the UK, for example veterans' health clinics. Given the lack of UK-based evidence, it is also important to ascertain how applicable this research is to cultural and healthcare contexts in the UK.

3 Cost utility

What is the cost utility of increasing the offer or uptake of HIV testing in different settings, for different types of tests, using different strategies, for example opt-in or opt-out approaches, and in areas with different background prevalence?

Why this is important

There is no UK evidence to enable commissioners and service providers to plan the most cost-effective services for their local communities.

4 Self-sampling and self-testing

How effective are self-sampling and self-testing in terms of accuracy of sampling, ability to reach different groups, test completion, receipt of results and subsequent help-seeking behaviour?

Why this is important

Self-sampling and self-testing are relatively new modalities in the UK and limited evidence exists about their effectiveness and cost effectiveness.

5 Indicator conditions

How effective are interventions using indicator condition-targeted testing compared with routine testing in terms of ability to reach different groups, test completion, receipt of results and subsequent help-seeking behaviour? In addition:

- what interventions and tools are most effective in delivering this type of testing?
- what are the barriers to this type of testing and how can they be overcome?

Why this is important

There is a lack of evidence on the effectiveness of using indicator conditions to target HIV testing, an approach that may improve detection rates. Also, because it is

targeted, there may be economies of scale, for example, HIV testing could be commissioned in clinics that treat people with indicator conditions.

Update information

This guideline is an update of NICE guidelines PH33 and PH34 (published March 2011) and will replace them.

See the original NICE guideline and supporting documents.

Recommendations that have been deleted or changed

Recommendations to be deleted

Recommendations from 2011 guidelines	Comment
Recommendations from PH33	
Community engagement and involvement • Plan, design and coordinate activities to promote the uptake of HIV testing among local black African communities, in line with NICE guidance on community engagement[2]. Seek to develop trust and relationships between organisations, communities and people. Communities should be involved in all aspects of the plan, which should take account of existing and past activities to address HIV and general sexual health issues among these communities. • Work in partnership with those running existing community activities to promote HIV testing and the benefits of early diagnosis and treatment, and to raise awareness of local services and how to access them. This includes addressing any misconceptions about HIV testing and treatment (for example, in relation to life expectancy following a positive diagnosis – or related to HIV treatment costs). It also includes reducing the stigma (real or perceived) associated with HIV testing and living with HIV, both among black Africans and health professionals. • Recruit, train and encourage members of local black African communities to act as champions and role models to help encourage their peers to take an HIV test. This includes helping to plan awareness-raising activities or acting as a link to specific	This recommendation has been deleted because the principles underpinning it are now part of the implementation section or are covered elsewhere in the guideline.

communities that are less likely to use existing services. (**recommendation 1**)	
Planning services – assessing local need • Collect and analyse local data to estimate the prevalence and incidence of HIV among black African communities. • Collect information about the composition of local black African communities, including groups that are less likely to use services. Ensure there is an understanding of the particular needs of different groups. • Gather the views and experiences of local black African communities to understand their specific concerns and needs in relation to HIV testing. (See recommendation 1 for more details on community engagement.) • Collect information about HIV-testing services. This includes data on where they are offered (for example, in genitourinary medicine clinics and GP surgeries), access times and general accessibility. In addition, determine the types of test offered and how frequently, the take-up rates and how quickly results are given. Note variations in factors such as waiting times and staff provision. Also gather information on service users (identified by gender, sexuality, age, ethnicity and date of last HIV test). • Collect information about current HIV diagnoses, including the proportion of people being diagnosed late (that is, after treatment should have begun), broken down by gender, age and country of origin. Take note of the CD4 count on diagnosis, the settings where people are being diagnosed and the suspected	This recommendation has been deleted because NICE public health guidelines no longer make recommendations about planning services as the principles underpinning it are now part of the implementation section (unless it is explicitly stated in the scope that the guideline will cover service delivery).

transmission route. (This includes detail on whether or not the infection probably occurred abroad or in the UK.) • Carry out an appraisal of local interventions that aim to increase the number of black Africans who choose to take an HIV test. Information should be gathered on where, when and how often HIV testing is promoted to these communities and by whom. (**recommendation 2**)	
Planning services – developing a strategy and commissioning services in areas of identified need In areas where there is an identified need (see recommendation 2): • Ensure there is a local strategy to increase the uptake of HIV testing among local black Africans. It should encourage them to undergo HIV testing. It should also encourage professionals to offer and recommend HIV testing to them, where appropriate. • Ensure the strategy is planned in partnership with relevant local voluntary and community organisations and user groups, and in consultation with local black African communities (see recommendation 1). • Ensure the strategy takes into account the needs of people from different black African communities. In particular, it should pay attention to groups that are less likely to use existing services. • Ensure the strategy is regularly monitored and evaluated. • Ensure HIV testing is available in a range of healthcare and community settings (for example, GP surgeries and community centres) based on the outcomes of a needs assessment. These should be accessible and acceptable to the target population, in terms of both geographical setting and service	This recommendation has been deleted because NICE public health guidelines no longer make recommendations about planning services as the principles underpinning it are now part of the implementation section (unless it is explicitly included in the scope as part of service delivery).

design (for example, in terms of appointment systems, opening hours and cultural sensitivity). (**recommendation 3**)	
Promoting HIV testing for black African communities In areas where there is an identified need (see recommendation 2): • Produce promotional material tailored to the needs of local black African communities. It should: – provide information about HIV infection and transmission, the benefits of HIV testing and the availability of treatment – emphasise that early diagnosis is a route into treatment and a way to avoid complications and serious illness in the future – detail how and where to access local HIV testing services, including services offering rapid testing and genitourinary medicine clinics (where people do not have to give their real name) – dispel myths and common misconceptions about HIV diagnosis and treatment – present testing as a responsible act by focusing on trigger points, such as the beginning of a new relationship or change of sexual partner, or on the benefits of knowing one's HIV status – address the needs of non-English-speaking black African communities, for example through translated information. • Work with black African community organisations to promote HIV testing (see recommendation 1). • Use venues that local black African communities frequent (for example, prayer groups or cultural events). (**recommendation 4**)	Replaced by: 1.3.2 Produce promotional material tailored to the needs of local communities. It should: • provide information about HIV infection and transmission, the benefits of HIV testing and the availability of treatment • emphasise that early diagnosis is not only a route into treatment and a way to avoid complications and reduce serious illness in the future, but also reduces the chances of onward transmission • detail how and where to access local HIV testing services, including services offering POCT and self-sampling, and sexual health clinics (where people do not have to give their real name) • dispel common misconceptions about HIV diagnosis and treatment • present testing as a responsible act by focusing on trigger points, such as the beginning of a new relationship or change of sexual partner, or on the benefits of knowing one's HIV status • address the needs of non-English-speaking communities, for example, through translated information.
Reducing barriers to HIV testing for black African communities • Ensure staff offering HIV tests emphasise that the tests are	Replaced by: 1.4.2 Staff offering HIV tests should: • Emphasise that the tests are

confidential. They should be able to direct those who are concerned about confidentiality to a genitourinary medicine clinic, where people do not have to give their real name. • Ensure staff are able to recommend HIV testing and have the ability to discuss HIV symptoms and the implications of a positive or a negative test. • Ensure staff are familiar with existing referral pathways so that people who test positive receive prompt and appropriate support (see recommendation 7). • Ensure staff can provide appropriate information, including details of where to get free condoms or training in negotiation skills, if someone tests negative. • Ensure primary care staff can recognise the symptoms that may signify primary HIV infection or illnesses that often co-exist with HIV. In such cases, they should be able to offer and recommend an HIV test. • Ensure HIV testing services are staffed by people who are aware of and sensitive to, the cultural issues facing black Africans. (For example, black Africans may be less used to preventive health services and advice or may fear isolation and social exclusion should they test positive for HIV.) Staff should also be able to challenge the stigma of, and dispel any myths surrounding, HIV and HIV testing and be sensitive to the individual needs of people. • Ensure HIV testing services can offer rapid tests to people who are reluctant to wait for results (or can refer people to a service that provides rapid tests). If people are unwilling to have a blood test, they should be offered less invasive options (such as a saliva test), or should be referred elsewhere for such a test.	confidential. If people remain concerned about confidentiality, refer them to a sexual health clinic, where they do not have to give their real name. • Be able to discuss HIV symptoms and the implications of a positive or a negative test. • Be familiar with existing referral pathways so that people who test positive receive prompt and appropriate support. • Provide appropriate information if someone tests negative, including details of where to get free condoms and how to access local behavioural and preventive interventions. • Recognise and be sensitive to the cultural issues facing different groups (for example, black Africans may be less used to preventive health services and advice, or may fear isolation and social exclusion if they test positive for HIV). • Be able to challenge stigmas and dispel misconceptions surrounding HIV and HIV testing and be sensitive to people's needs. • Be able to recognise the symptoms that may signify primary HIV infection or illnesses that often coexist with HIV. In such cases, they should be able to offer and recommend an HIV test. 1.2.1 Offer POCT in situations where follow-up may be difficult, so that people do not need to return to get their results. 1.1.7 If a venous blood sample is not already being taken for another reason, or is refused, offer a less invasive form of specimen collection, such as a mouth swab or finger-prick.

(recommendation 5)	
Healthcare settings: offering and recommending an HIV test • In line with British HIV Association (BHIVA) guidelines[1], all health professionals should routinely offer and recommend an HIV test to: – men and women known to be from a country of high HIV prevalence[3] – men and women who report sexual contact abroad or in the UK with someone from a country of high HIV prevalence – patients who have symptoms that may indicate HIV or where HIV is part of the differential diagnosis (see the BHIVA guidelines for a list of indicator diseases) – patients diagnosed with a sexually transmitted infection – the sexual partners of men and women known to be HIV positive – men who have disclosed that they have sexual contact with other men – the female sexual contacts of men who have sex with men – patients reporting a history of injecting drug use. • In addition, health professionals should (regardless of local HIV prevalence), routinely offer and recommend an HIV test to all those who may be at risk of exposure to the virus. For example, this may be as a result of having a new sexual partner or may be because they have previously tested negative during the 'window period'[4]. • In line with BHIVA guidelines[1], all health professionals should routinely offer and recommend an HIV test to all patients attending: – genitourinary medicine or sexual health clinics – antenatal services – termination of pregnancy services	Replaced by: 1.1.3 Routinely offer and recommend an HIV test to everyone attending their first appointment (followed by repeat testing in line with recommendation 1.2.8) in: • drug dependency programmes • hepatitis B services • hepatitis C services • lymphoma services • termination of pregnancy services • tuberculosis services. 1.1.4 Offer and recommend HIV testing on admission to hospital, including emergency departments, to everyone who has not previously been diagnosed with HIV and who: • lives in an area of high prevalence of HIV and is undergoing blood tests for another reason • has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator conditions) • is known to be from a country or community with a high prevalence of HIV • if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous year • reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence • discloses that they have changed sexual partner or discloses high-risk sexual practices • is diagnosed with, or requests screening for, a sexually transmitted infection • discloses that they are the sexual partner of a man or woman known to be HIV positive • reports a history of injecting drug use. 1.1.5 Offer and recommend HIV testing promptly to everyone who has not

– drug dependency programmes – tuberculosis, hepatitis B, hepatitis C and lymphoma services. • In areas where more than 2 in 1000 population have been diagnosed with HIV: – primary care and general medical admissions professionals should consider offering and recommending an HIV test when registering and admitting new patients (this is in line with BHIVA guidelines)[1] – all health practitioners should offer and recommend an HIV test to anyone who has a blood test (regardless of the reason). **(recommendation 6)**	previously been diagnosed with HIV and who: • has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator conditions) • registers with a practice in an area with a high HIV prevalence • is known to be from a country or community of high HIV prevalence • if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous year • reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence • discloses that they have changed sexual partner or discloses high-risk sexual practices • is diagnosed with, or requests screening for, a sexually transmitted infection • lives in an area of high prevalence of HIV and is undergoing blood tests for another reason • discloses that they are the sexual partner of a man or woman known to be HIV positive • reports a history of injecting drug use.
HIV referral pathways • Ensure there are clear referral pathways for people with positive and negative HIV test results. • Ensure people who test positive are seen by an HIV specialist at the earliest opportunity, preferably within 48 hours, certainly within 2 weeks of receiving the result (in line with British HIV Association guidelines). They should also be given information about the diagnosis and about local support groups. • For people with positive and negative HIV test results, if appropriate, offer or provide information about further behavioural or health promotion interventions available from both voluntary and statutory services	Replaced by: 1.4.3 Ensure practitioners delivering HIV tests (including those delivering outreach POCT) have clear referral pathways available for people with both positive and negative test results, including to sexual health services and confirmatory serological testing. These pathways should ensure the following: • People who test positive are seen by an HIV specialist preferably within 48 hours, certainly within 2 weeks of receiving the result (in line with UK national guidelines for HIV testing 2008 British HIV Association). They should also be given information about the diagnosis and local support groups. • People who regularly engage in high-risk sexual behaviour or

(for example, advice on safer sex, training in negotiating skills and providing condoms). • Encourage repeat testing after a negative result for those who are at risk of infection (for example, for those who have new or multiple partners). • Ensure people who choose not to take up the immediate offer of a test know how to access testing services. **(recommendation 7)**	inject drugs (whatever their test result) are offered behavioural or health promotion interventions (for example, advice on safer sex or injecting, training in negotiating skills and providing condoms). • Practitioners in the voluntary or statutory sector can refer people from HIV prevention and health promotion services for HIV testing and vice versa. 1.2.10 If people choose not to take up the immediate offer of a test, tell them about nearby testing services and how to get self-sampling kits.
Recommendations from PH34	
Planning services – assessing local need and developing a strategy • Ensure there is a local strategy to increase the uptake of HIV testing among men who have sex with men. The strategy should encourage these men to undergo HIV testing. It should also encourage professionals to offer and recommend HIV testing to them. • Ensure the strategy is planned in partnership with relevant local voluntary and community organisations and user groups and in consultation with men who have sex with men. • Ensure the strategy is developed with representation from: – genitourinary medicine clinics, GPs, secondary and emergency care, the police and other voluntary and statutory bodies whose remit includes promoting the health of men who have sex with men – owners and managers of commercial gay venues, including venues that may not be associated with gay people, but where men congregate to have opportunistic sex with other men (for example, some saunas and gyms) – those with a responsibility for local	This recommendation has been deleted because NICE public health guidelines no longer make recommendations about planning services as the principles underpinning it are now part of the implementation section (unless it is explicitly included in the scope as part of service delivery).

sites used as public sex environments (for example, the local authority or organisations that own land used for these purposes). • Ensure the strategy is informed by existing strategic frameworks such as the 'Making it count' strategy[3]. It should also be developed in accordance with UK national guidelines for HIV testing[1]. It should take into account the local needs of different groups and pay particular attention to groups of men who are less likely to use existing services. • Ensure the strategy is regularly monitored and evaluated (including via consultation with men who have sex with men). • Collect and analyse local data to estimate the prevalence and incidence of HIV among men who have sex with men. This includes information (for example, from the annual 'Gay men's sex survey'[4]) about the composition of local groups and about commercial gay venues, public sex environments and other locations where men have sex with men. • Collect information about HIV-testing services. This includes data on where they are offered (for example, in genitourinary medicine clinics and GP surgeries), access times and general accessibility (especially if rural). In addition, determine the types of test offered and how frequently, the take-up rates and how quickly results are given. Note variations in factors such as waiting times and staff provision. Also gather information on service users (self-identified sexuality, age, ethnicity, sexual behaviour and date of last HIV test). • Carry out an appraisal of local interventions that aim to increase the number of men in this group who take an HIV test. (Information	

should be gathered on where, when and how often HIV testing is promoted to this group and by whom.) • Gather the views of local men who have sex with men and their representatives to understand their specific issues and concerns in relation to HIV testing. **(recommendation 1)**	
Promoting HIV testing among men who have sex with men • Ensure interventions to increase the uptake of HIV testing are hosted by, or advertised at, venues that encourage or facilitate sex between men (such as some saunas or websites). This is in addition to general, community-based HIV health promotion (for example, at GP surgeries and in other locations such as bars). • Promote HIV testing when delivering sexual health promotion and HIV prevention interventions to men who have sex with men. This can be carried out in person (using printed publications such as leaflets, booklets and posters) or via electronic media. • Ensure that health promotion material about HIV testing encourages all sexually active men who have sex with men to test for HIV at least annually[1]. Testing should be presented as an empowering and responsible act. Promotional material could focus on getting tested at key life stages, such as at the beginning of a new relationship or when changing sexual partner. • Ensure health promotion material presents a positive test result as a route into treatment and a way to avoid complications and serious illness in the future. In addition, it should aim to reduce the stigma associated with HIV testing and living with HIV, both among men who have sex with men and	Replaced by: 1.3.2 Produce promotional material tailored to the needs of local communities. It should: • provide information about HIV infection and transmission, the benefits of HIV testing and the availability of treatment • emphasise that early diagnosis is not only a route into treatment and a way to avoid complications and reduce serious illness in the future, but also reduces the chances of onward transmission • detail how and where to access local HIV testing services, including services offering POCT and self-sampling and sexual health clinics (where people do not have to give their real name) • dispel common misconceptions about HIV diagnosis and treatment • present testing as a responsible act by focusing on trigger points, such as the beginning of a new relationship or change of sexual partner, or on the benefits of knowing one's HIV status • address the needs of non-English-speaking communities, for example through translated information. 1.3.3 Ensure interventions to increase the uptake of HIV testing are hosted by, or advertised at, venues that encourage or facilitate sex (such as some saunas or websites or geospatial apps that allow people to find sexual partners in their proximity). This should be in addition to general, community-based HIV health

among health professionals. It should also dispel any myths about the need to disclose HIV status for insurance or legal purposes. • Ensure health promotion material includes information on how and where to access HIV testing locally. It should also provide up-to-date information on modern HIV tests, in particular, the availability of POCT. In addition, it should highlight the significantly reduced 'window period'[5] resulting from the introduction of newer tests such as 'fourth generation' p24 antigen testing (if these tests are available). **(recommendation 2)**	promotion. 1.3.4 Promote HIV testing when delivering sexual health promotion and HIV prevention interventions. This can be carried out in person (using printed publications such as leaflets, booklets and posters) or through electronic media. 1.3.5 Ensure health promotion material aims to reduce the stigma associated with HIV testing and living with HIV, both among communities and among healthcare professionals. 1.3.6 Ensure health promotion material provides up-to-date information on modern HIV tests, in particular, the availability of POCT. In addition, it should highlight the significantly reduced window period resulting from the introduction of newer tests such as fourth generation serological testing. 1.2.8 Recommend annual testing to people in groups or communities with a high prevalence of HIV, and more frequent testing for those who have a high risk of exposure, for example, through multiple sexual partners or unsafe sexual practices. 1.2.9 Consider providing the following interventions to promote repeat testing: • call-recall methods using letters or other media such as text messages or email to remind people to return for annual testing. • electronic reminders in health record systems to prompt healthcare professionals to identify the need for testing during appointments and offer it if needed.
Specialist sexual health services: offering and recommending an HIV test • Ensure all men who attend a specialist sexual health service for screening or treatment are offered and recommended an HIV test[6]. This includes those who have previously tested negative for HIV or have never been tested. This should happen	Replaced by: 1.1.1 Offer and recommended an HIV test to everyone who attends for screening or treatment. 1.1.2 Ensure both fourth generation serological testing and point-of-care testing (POCT) are available.

whether or not they disclose that they have sex with men. • Ideally, offer both fourth generation serological testing and POCT. • Ensure practitioners directly involved with testing for HIV and other sexually transmitted infections are trained to routinely offer and recommend an HIV test. They should be able to: – provide information on HIV testing and discuss why it is recommended (including to those who indicate that they may wish to decline the test) – conduct post-test discussions, this includes giving positive test results and delivering post-test and general health promotion interventions – recognise illnesses that may signify primary HIV infection and clinical indicator diseases that often coexist with HIV – assess the man's level of knowledge about HIV and refer him to a service where health promotion interventions can be provided, if necessary. **(recommendation 3)**	
Primary and secondary care: offering and recommending an HIV test • Primary care providers should offer and recommend HIV testing to all men who have not previously been diagnosed HIV positive and who: – register with a practice in an area with a large community of men who have sex with men, or – register with a practice in an area with a high HIV prevalence (high prevalence means more than two diagnosed cases per 1000 people), or – disclose that they have sex with other men, or – are known to have sex with men and have not had a HIV test in the	Replaced by: 1.1.5 Offer and recommend HIV testing promptly to everyone who has not previously been diagnosed with HIV and who: • has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator conditions) • registers with a practice in an area with a high HIV prevalence • is known to be from a country or community of high HIV prevalence • if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous

previous year, or – are known to have sex with men and disclose that they have changed sexual partner or disclose high risk sexual practices, or – have symptoms that may indicate HIV or HIV is part of the differential diagnosis (see national guidelines[1] for HIV indicator diseases), or – are diagnosed with, or request screening for, a sexually transmitted infection, or – live in a high prevalence area and are undergoing blood tests for another reason. • Primary care providers should ensure annual HIV testing is part of the integrated healthcare offered to men who are known to have sex with men. • Secondary and emergency care providers should offer and recommend HIV testing to all men admitted to hospital who have previously tested negative for HIV, or have never been tested, and who: – are admitted in areas with a high prevalence of HIV (more than two diagnosed cases per 1000 people), or – disclose that they have sex with other men, or – have symptoms that may indicate HIV or HIV is part of the differential diagnosis (see British HIV Association guidelines for HIV indicator diseases[1]). • Ideally, test providers should offer both fourth generation serological testing and POCT. • Ensure practitioners directly involved with testing for HIV and other sexually transmitted infections are trained to routinely offer and recommend an HIV test. They should be able to: – provide information on HIV testing and discuss why it is recommended (including to those	year • reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence • discloses that they have changed sexual partner or discloses high-risk sexual practices • is diagnosed with, or requests screening for, a sexually transmitted infection • lives in a high prevalence area and is undergoing blood tests for another reason • discloses that they are the sexual partner of a man or woman known to be HIV positive • reports a history of injecting drug use. 1.1.6 Offer and recommend repeat testing to these people in line with recommendation 1.2.8 1.2.8 Recommend annual testing to people in groups or communities with a high prevalence of HIV, and more frequent testing for those who have a high risk of exposure, for example, through multiple sexual partners or unsafe sexual practices. 1.2.9 Consider providing the following interventions to promote repeat testing: • Call-recall methods using letters or other media, such as text messages or email, to remind people to return for annual testing. • Electronic reminders in health records systems to prompt healthcare professionals to identify the need for testing during appointments and offer it if needed. 1.1.3 Routinely offer and recommend an HIV test to everyone attending their first appointment (followed by repeat testing in line with recommendation 1.2.8) in: • drug dependency programmes • hepatitis B services • hepatitis C services • lymphoma services • termination of pregnancy services

who indicate that they may wish to decline the test) – conduct post-test discussions, including giving positive test results and delivering post-test and general health promotion interventions – recognise illnesses that may signify primary HIV infection and clinical indicator diseases that often coexist with HIV – assess the man's level of knowledge about HIV and refer him to a service where health promotion interventions can be provided, if necessary. (**recommendation 4**)	• tuberculosis services. 1.1.4 Offer and recommend HIV testing on admission to hospital, including emergency departments, to everyone who has not previously been diagnosed with HIV and who: • lives in an area of high prevalence of HIV and is undergoing blood tests for another reason • has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator conditions) • is known to be from a country or community with a high prevalence of HIV • if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous year • reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence • discloses that they have changed sexual partner or discloses high-risk sexual practices • is diagnosed with, or requests screening for, a sexually transmitted infection • discloses that they are the sexual partner of a man or woman known to be HIV positive • reports a history of injecting drug use
Outreach: providing rapid point-of-care tests • Set up outreach services in a sensitive manner in consultation with men who have sex with men. (For example, be aware that not all community settings are appropriate for POCT.) • Offer tests via outreach in venues where there is high-risk sexual behaviour or in venues sited in areas where there is high local prevalence of HIV. This could include community or voluntary sector premises, public sex	Replaced by: 1.1.8 Set up community testing services in venues or areas where there is high-risk sexual behaviour or a high prevalence of HIV. This could include: • community or voluntary sector premises • public sex environments • venues where people at high risk may gather. 1.1.9 Recognise that not all community settings are appropriate for providing testing services, for example because tests should be undertaken in a secluded

environments (such as saunas or cruising areas) or other venues identified during the planning exercise (see recommendation 1). Tests should be undertaken in a secluded or private area, in line with British HIV Association guidelines[1]. • In appropriate settings, offer rapid POCT to men who have previously tested negative for HIV, or who have never been tested. Use a less invasive form of the test such as a mouth swab or finger-prick. CE-marked[7] POCT kits should be used. • Provide men who refuse, or who may not be able to consent to, a test with information about other local testing services. (Inability to consent may be due to alcohol or drugs, for example. A refusal might be because of the setting or concerns about privacy.) • Ensure non-clinical practitioners delivering POCT are trained to collect blood spots and mouth swabs, handle test material and administer the test. Training should be supervised and signed off by an appropriate clinician. It should be updated annually. Staff should also have access to clinical advice and supervision. • Ensure non-clinical practitioners delivering POCT are aware of local referral systems and services for people who test positive. They should be trained to provide appropriate information and support, including information about the relatively poor specificity and sensitivity of POCT. In addition, they should be able to assess the client's level of knowledge about HIV and provide appropriate health promotion interventions (or refer them to a service that can). (**recommendation 5**)	or private area (in line with British HIV Association guidelines). 1.1.7 If a venous blood sample is not already being taken for another reason, or is refused, offer a less invasive form of specimen collection, such as a mouth swab or finger-prick. 1.1.10 Ensure that people who decline or are unable to consent to a test (for example, they are under the influence of alcohol or drugs, they fear community stigma or because of their age) are given information about other local testing services, including self-sampling. See making decisions using NICE guidelines for more information about consent. 1.1.11 Ensure lay testers delivering tests are competent to do so and have access to clinical advice and supervision. 1.2.2 Practitioners delivering POCT should explain to people at the time of their test about the relatively poor specificity and sensitivity of POCT and the need for confirmatory serological testing.
Repeat testing • Recommend that all men who have tested negative but who	Replaced by: 1.2.7 When giving results to people who have tested negative but who may have

may have been exposed to HIV have another test, once they are past the 'window period'[4]. • Recommend annual testing to all men who have sex with men, and more frequent testing for those who have a high risk of exposure to the virus, for example, through multiple sexual partners or unsafe sexual practices. **(recommendation 6)**	been exposed to HIV, recommend that they have another test once they are past the window period. 1.2.8 Recommend annual testing to people in groups or communities with a high prevalence of HIV, and more frequent testing for those who have a high risk of exposure, for example, through multiple sexual partners or unsafe sexual practices. 1.2.9 Consider providing the following interventions to promote repeat testing: • Call-recall methods using letters or other media, such as text messages or email, to remind people to return for annual testing. • Electronic reminders in health records systems to prompt healthcare professionals to identify the need for testing during appointments and offer it if needed.
HIV referral pathways • Ensure there are clear referral pathways for practitioners delivering HIV tests (including those delivering outreach, rapid POCT), for both positive and negative test results. They should be able to refer clients quickly and easily to suitable sexual health services, confirmatory HIV testing, and post-test care and treatment services. These pathways should include ensuring the following: – Men who test positive are seen by an HIV specialist at the earliest opportunity, preferably within 48 hours, certainly within 2 weeks of receiving the result[1]. They should also be given information about the diagnosis and about local support groups. – Men who regularly engage in high-risk sexual behaviour (whatever their test result) are offered behavioural or health promotion interventions (for example, advice on safer sex, training in negotiating skills and	Replaced by: 1.4.3 Ensure practitioners delivering HIV tests (including those delivering outreach POCT) have clear referral pathways available for people with both positive and negative test results, including to sexual health services and confirmatory serological testing. These pathways should ensure the following: • People who test positive are seen by an HIV specialist preferably within 48 hours, certainly within 2 weeks of receiving the result (in line with UK national guidelines for HIV testing 2008 British HIV Association). They should also be given information about their diagnosis and local support groups. • People who regularly engage in high-risk sexual behaviour or inject drugs (whatever their test result) are offered behavioural or health promotion interventions (for example, advice on safer sex or injecting, training in negotiating skills and providing condoms). • Practitioners in the voluntary or statutory sector can refer people

providing condoms). Some men (including under-16s) may need additional psychological support and should be referred to counselling services that are totally accepting of their sexuality. – Repeat testing is encouraged after a negative result (see recommendation 6). – Practitioners in the voluntary or statutory sector are able to refer men from HIV prevention and health promotion services for HIV testing and vice versa. – People who choose not to take up the immediate offer of a test know how to access testing services. (**recommendation 7**)	from HIV prevention and health promotion services for HIV testing and vice versa. 1.2.10 If people choose not to take up the immediate offer of a test, tell them about nearby testing services and how to get self-sampling kits.

Amended recommendation wording

Recommendations are labelled **[2011, amended 2016]** if the evidence has not been reviewed but either:

- changes have been made to the recommendation wording that change the meaning **or**
- NICE has made editorial changes to the original wording to clarify the action to be taken.

1

Recommendation in 2011 guidelines	Recommendation in current guideline	Reason for change
Recommendations from PH33		
Promoting HIV testing for black African communities In areas where there is an identified need (see recommendation 2): • Produce promotional material tailored to the needs of local black African communities. It should: – provide information about HIV infection and transmission, the benefits of HIV testing and the availability of treatment – emphasise that early diagnosis is a route into treatment and a way to avoid complications and serious illness in the future – detail how and where to access local HIV testing services, including services offering rapid testing and genitourinary medicine clinics (where people do not have to give their real name) – dispel myths and common misconceptions about HIV diagnosis and treatment – present testing as a responsible act by focusing on trigger	1.3.2 Produce promotional material tailored to the needs of local communities. It should: • provide information about HIV infection and transmission, the benefits of HIV testing and the availability of treatment • emphasise that early diagnosis is not only a route into treatment and a way to avoid complications and reduce serious illness in the future, but also reduces the chances of onward transmission • detail how and where to access local HIV testing services, including services offering POCT and self-sampling, and sexual health clinics (where people do not have to give their real name) • dispel common misconceptions about HIV diagnosis and treatment • present testing as a responsible act by focusing on trigger points, such as the beginning of a new relationship or change of sexual	Wording to describe population has been changed as the updated guideline has a broader population. Self-sampling has been added to the updated guideline. Wording clarifications have been made in line with NICE editorial style.

points, such as the beginning of a new relationship or change of sexual partner, or on the benefits of knowing one's HIV status – address the needs of non-English-speaking black African communities, for example through translated information. • Work with black African community organisations to promote HIV testing (see recommendation 1). • Use venues that local black African communities frequent (for example, prayer groups or cultural events). (**recommendation 4**)	partner, or on the benefits of knowing one's HIV status • address the needs of non-English-speaking communities, for example through translated information.	
Reducing barriers to HIV testing for black African communities • Ensure staff offering HIV tests emphasise that the tests are confidential. They should be able to direct those who are concerned about confidentiality to a genitourinary medicine clinic, where people do not have to give their real name. • Ensure staff are able to recommend HIV testing and have the ability to discuss HIV symptoms and the	1.4.2 Staff offering HIV tests should: • Emphasise that the tests are confidential. If people remain concerned about confidentiality, refer them to a sexual health clinic, where they do not have to give their real name. • Be able to discuss HIV symptoms and the implications of a positive or a negative test. • Be familiar with existing referral pathways so that people who test	Wording to describe population has been changed as the updated guideline has a broader population. Wording about confidentiality has been changed to improve clarity. Bullet point 7 from this PH33 recommendation has been changed into 2 standalone recommendations (1.2.1 and 1.1.7) for clarity and emphasis. 'Training in negotiation skills' in bullet 4 has been broadened to say 'how to access local behavioural and preventive interventions'.

implications of a positive or a negative test. • Ensure staff are familiar with existing referral pathways so that people who test positive receive prompt and appropriate support (see recommendation 7). • Ensure staff can provide appropriate information, including details of where to get free condoms or training in negotiation skills, if someone tests negative. • Ensure primary care staff can recognise the symptoms that may signify primary HIV infection or illnesses that often co-exist with HIV. In such cases, they should be able to offer and recommend an HIV test. • Ensure HIV testing services are staffed by people who are aware of and sensitive to, the cultural issues facing black Africans. (For example, black Africans may be less used to preventive health services and advice or may fear isolation and social exclusion should they test positive	positive receive prompt and appropriate support. • Provide appropriate information if someone tests negative, including details of where to get free condoms and how to access local behavioural and preventive interventions,. • Recognise and be sensitive to the cultural issues facing different groups (for example, black Africans may be less used to preventive health services and advice, or may fear isolation and social exclusion if they test positive for HIV). • Be able to challenge stigmas and dispel misconceptions surrounding HIV and HIV testing and be sensitive to people's needs. • Be able to recognise the symptoms that may signify primary HIV infection or illnesses that often coexist with HIV. In such cases, they should be able to offer and recommend an HIV test. 1.1.7 If a venous blood sample is not already being taken for another reason, or is refused, offer	

for HIV.) Staff should also be able to challenge the stigma of, and dispel any myths surrounding, HIV and HIV testing and be sensitive to the individual needs of people. • Ensure HIV testing services can offer rapid tests to people who are reluctant to wait for results (or can refer people to a service that provides rapid tests). If people are unwilling to have a blood test, they should be offered less invasive options (such as a saliva test), or should be referred elsewhere for such a test. **(recommendation 5)**	a less invasive form of specimen collection, such as a mouth swab or finger-prick.	
Healthcare settings: offering and recommending an HIV test • In line with British HIV Association (BHIVA) guidelines[1], all health professionals should routinely offer and recommend an HIV test to: – men and women known to be from a country of high HIV prevalence[3] – men and women who report sexual contact abroad or in the UK with someone from a country of high HIV	1.1.3 Routinely offer and recommend an HIV test to everyone attending their first appointment (followed by repeat testing in line with recommendation 1.2.8) in: • drug dependency programmes • hepatitis B services • hepatitis C services • lymphoma services • termination of pregnancy services • tuberculosis services. 1.1.4 Offer and recommend HIV testing on admission to hospital, including emergency departments, to everyone who has not previously been diagnosed with HIV	Recommendation 6 from PH33 and recommendation 4 from PH34 have been merged. Wording has been clarified in the stems of recommendations 1.1.4 and 1.1.5 to make the timing of when to offer testing clearer. Additionally, more up-to-date information about indicator conditions is available, thus the link from BHIVA from the original guideline (2011) has been replaced. The committee clarified that testing people who were diagnosed with an STI should include all people who ask for STI tests since this indicates

prevalence – patients who have symptoms that may indicate HIV or where HIV is part of the differential diagnosis (see the BHIVA guidelines for a list of indicator diseases) – patients diagnosed with a sexually transmitted infection – the sexual partners of men and women known to be HIV positive – men who have disclosed that they have sexual contact with other men – the female sexual contacts of men who have sex with men – patients reporting a history of injecting drug use. • In addition, health professionals should (regardless of local HIV prevalence), routinely offer and recommend an HIV test to all those who may be at risk of exposure to the virus. For example, this may be as a result of having a new sexual partner or may be because they have previously tested negative during the 'window period'[4]. • In line with BHIVA guidelines[1], all health professionals should routinely	and who: • lives in an area of high prevalence of HIV and is undergoing blood tests for another reason • has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator conditions) • is known to be from a country or community of high HIV prevalence • if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous year • reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence • discloses that they have changed sexual partner or discloses high-risk sexual practices • is diagnosed with, or requests screening for, a sexually transmitted infection • discloses that they are the sexual partner of a man or woman known to be HIV positive • reports a history of injecting drug use. 1.1.5 Offer and recommend HIV testing	that they see themselves as having been at risk. Timing of offering and recommending HIV testing has been added to recommendations for clarity.

offer and recommend an HIV test to all patients attending: – genitourinary medicine or sexual health clinics – antenatal services – termination of pregnancy services – drug dependency programmes – tuberculosis, hepatitis B, hepatitis C and lymphoma services. • In areas where more than 2 in 1000 population have been diagnosed with HIV: – primary care and general medical admissions professionals should consider offering and recommending an HIV test when registering and admitting new patients (this is in line with BHIVA guidelines)[1] – all health practitioners should offer and recommend an HIV test to anyone who has a blood test (regardless of the reason). **(recommendation 6)**	promptly to everyone who has not previously been diagnosed HIV positive and who: • has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator conditions) • registers with a practice in an area with a high HIV prevalence • is known to be from a country or community of high HIV prevalence • if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous year • reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence • discloses that they have changed sexual partner or discloses high-risk sexual practices • is diagnosed with, or requests screening for, a sexually transmitted infection • lives in an area of high prevalence of HIV and is undergoing blood tests for another reason • discloses that they are the sexual	

	partner of a man or woman known to be HIV positive • reports a history of injecting drug use.	
HIV referral pathways • Ensure there are clear referral pathways for people with positive and negative HIV test results. • Ensure people who test positive are seen by an HIV specialist at the earliest opportunity, preferably within 48 hours, certainly within 2 weeks of receiving the result (in line with British HIV Association guidelines). They should also be given information about the diagnosis and about local support groups. • For people with positive and negative HIV test results, if appropriate, offer or provide information about further behavioural or health promotion interventions available from both voluntary and statutory services (for example, advice on safer sex, training in negotiating skills and providing condoms). • Encourage repeat testing after a negative result for those who are at	1.4.3 Ensure practitioners delivering HIV tests (including those delivering outreach POCT) have clear referral pathways available for people with both positive and negative test results, including to sexual health services and confirmatory serological testing. These pathways should ensure the following: • People who test positive are seen by an HIV specialist preferably within 48 hours, certainly within 2 weeks of receiving the result (in line with UK national guidelines for HIV testing 2008 British HIV Association). They should also be given information about the diagnosis and local support groups. • People who regularly engage in high-risk sexual behaviour or inject drugs (whatever their test result) are offered behavioural or health promotion interventions (for example, advice on safer sex or injecting, training in negotiating skills and providing condoms). • Practitioners in the voluntary or	Wording changes have been made for clarification. Wording merged with that of recommendation 7 in PH34. Wording to describe population has been changed as the updated guideline has a broader population Self-sampling has been added to the updated guideline.

risk of infection (for example, for those who have new or multiple partners). • Ensure people who choose not to take up the immediate offer of a test know how to access testing services. **(recommendation 7)**	statutory sector can refer people from HIV prevention and health promotion services for HIV testing and vice versa. 1.2.10 If people choose not to take up the immediate offer of a test, tell them about nearby testing services and how to get self-sampling kits	
Promoting HIV testing among men who have sex with men • Ensure interventions to increase the uptake of HIV testing are hosted by, or advertised at, venues that encourage or facilitate sex between men (such as some saunas or websites). This is in addition to general, community-based HIV health promotion (for example, at GP surgeries and in other locations such as bars). • Promote HIV testing when delivering sexual health promotion and HIV prevention interventions to men who have sex with men. This can be carried out in person (using printed publications such as leaflets, booklets and posters) or via electronic media. • Ensure that health promotion material	1.3.2 Produce promotional material tailored to the needs of local communities. It should: • provide information about HIV infection and transmission, the benefits of HIV testing and the availability of treatment • emphasise that early diagnosis is not only a route into treatment and a way to avoid complications and reduce serious illness in the future, but also reduces the chances of onward transmission • detail how and where to access local HIV testing services, including services offering POCT and self-sampling and sexual health clinics (where people do not have to give their real name) • dispel common misconceptions about HIV diagnosis and treatment	Wording to describe population has been changed as the updated guideline has a broader population. Wording merged with that of recommendation 4 in PH33. Wording clarifications have been made in line with NICE editorial style. Genitourinary medicine clinics changed to sexual health clinics for consistency throughout. Clarifications and additions added to the recommendations on repeat testing. Additional examples added to recommendation 1.3.3.

about HIV testing encourages all sexually active men who have sex with men to test for HIV at least annually[1]. Testing should be presented as an empowering and responsible act. Promotional material could focus on getting tested at key life stages, such as at the beginning of a new relationship or when changing sexual partner. • Ensure health promotion material presents a positive test result as a route into treatment and a way to avoid complications and serious illness in the future. In addition, it should aim to reduce the stigma associated with HIV testing and living with HIV, both among men who have sex with men and among health professionals. It should also dispel any myths about the need to disclose HIV status for insurance or legal purposes. • Ensure health promotion material includes information on how and where to access HIV testing locally. It should also provide up-to-date information on modern HIV tests,	• present testing as a responsible act by focusing on trigger points, such as the beginning of a new relationship or change of sexual partner, or on the benefits of knowing one's HIV status • address the needs of non-English-speaking communities, for example through translated information. 1.3.3 Ensure interventions to increase the uptake of HIV testing are hosted by, or advertised at, venues that encourage or facilitate sex (such as some saunas or websites or geospatial apps that allow people to find sexual partners in their proximity). This should be in addition to general, community-based HIV health promotion. 1.3.4 Promote HIV testing when delivering sexual health promotion and HIV prevention interventions. This can be carried out in person (using printed publications such as leaflets, booklets and posters) or through electronic media. 1.3.5 Ensure health promotion material aims to reduce the stigma associated with HIV testing and living with HIV, both among communities and among healthcare professionals. 1.3.6 Ensure health promotion material provides up-to-date information on modern HIV tests, in particular, the	

in particular, the availability of POCT. In addition, it should highlight the significantly reduced 'window period'[5] resulting from the introduction of newer tests such as 'fourth generation' p24 antigen testing (if these tests are available). **(recommendation 2)**	availability of POCT. In addition, it should highlight the significantly reduced window period resulting from the introduction of newer tests such as fourth generation serological testing. 1.2.8 Recommend annual testing to people in groups or communities with a high prevalence of HIV, and more frequent testing for those who have a high risk of exposure, for example, through multiple sexual partners or unsafe sexual practices.	
Specialist sexual health services: offering and recommending an HIV test • Ensure all men who attend a specialist sexual health service for screening or treatment are offered and recommended an HIV test[6]. This includes those who have previously tested negative for HIV or have never been tested. This should happen whether or not they disclose that they have sex with men. • Ideally, offer both fourth generation serological testing and POCT. • Ensure practitioners directly involved with testing for HIV and other sexually transmitted infections are trained to routinely	Replaced by: 1.1.1 Offer and recommend an HIV test to everyone who attends for screening or treatment. 1.1.2 Ensure both fourth generation serological testing and point-of-care testing (POCT) are available.	Wording to describe population has been changed as the updated guideline has a broader population. Wording in rec 1.1.2 updated to current NICE style. Reference to training has been removed; NICE no longer makes recommendations about training in public health guidelines.

offer and recommend an HIV test. They should be able to: – provide information on HIV testing and discuss why it is recommended (including to those who indicate that they may wish to decline the test) – conduct post-test discussions, this includes giving positive test results and delivering post-test and general health promotion interventions – recognise illnesses that may signify primary HIV infection and clinical indicator diseases that often coexist with HIV – assess the man's level of knowledge about HIV and refer him to a service where health promotion interventions can be provided, if necessary. **(recommendation 3)**		
Primary and secondary care: offering and recommending an HIV test • Primary care providers should offer and recommend HIV testing to all men who have not previously been diagnosed HIV positive and who: – register with a	1.1.5 Offer and recommend HIV testing promptly to everyone who has not previously been diagnosed with HIV and who: • has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator	Recommendation 6 from PH33 and recommendation 4 from PH34 have been merged. Additionally, more up-to-date information about indicator conditions is available, thus the link from BHIVA from the original guideline (2011) has been replaced. Clarifications and additions have been

practice in an area with a large community of men who have sex with men, or – register with a practice in an area with a high HIV prevalence (high prevalence means more than two diagnosed cases per 1000 people), or – disclose that they have sex with other men, or – are known to have sex with men and have not had a HIV test in the previous year, or – are known to have sex with men and disclose that they have changed sexual partner or disclose high risk sexual practices, or – have symptoms that may indicate HIV or HIV is part of the differential diagnosis (see national guidelines[1] for HIV indicator diseases), or – are diagnosed with, or request screening for, a sexually transmitted infection, or – live in a high prevalence area and are undergoing blood tests for another reason. • Primary care providers should ensure annual HIV testing is part of the integrated	conditions) • registers with a practice in an area with a high HIV prevalence • is known to be from a country or community of high HIV prevalence • if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous year • reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence • discloses that they have changed sexual partner or discloses high-risk sexual practices • is diagnosed with, or requests screening for, a sexually transmitted infection • lives in a high prevalence area and is undergoing blood tests for another reason • discloses that they are the sexual partner of a man or woman known to be HIV positive • reports a history of injecting drug use. 1.2.8 Recommend annual testing to people in groups or communities with a high prevalence of HIV, and more frequent testing for those who have a high risk of exposure, for example, through multiple sexual	added to the recommendations on repeat testing. Wording has been clarified in the stems of recommendations 1.1.4 and 1.1.5 to make the timing of when to offer testing clearer.

healthcare offered to men who are known to have sex with men. • Secondary and emergency care providers should offer and recommend HIV testing to all men admitted to hospital who have previously tested negative for HIV, or have never been tested, and who: – are admitted in areas with a high prevalence of HIV (more than two diagnosed cases per 1000 people), or – disclose that they have sex with other men, or – have symptoms that may indicate HIV or HIV is part of the differential diagnosis (see British HIV Association guidelines for HIV indicator diseases[1]). • Ideally, test providers should offer both fourth generation serological testing and POCT. • Ensure practitioners directly involved with testing for HIV and other sexually transmitted infections are trained to routinely offer and recommend an HIV test. They should	partners or unsafe sexual practices.. 1.1.4 Offer and recommend HIV testing on admission to hospital, including emergency departments, to everyone who has not previously been diagnosed with HIV and who: • lives in an area of high prevalence of HIV and is undergoing blood tests for another reason • has symptoms that may indicate HIV or HIV is part of the differential diagnosis (in line with HIV in Europe's HIV in indicator conditions) • is known to be from a country or community with a high prevalence of HIV • if male, discloses that they have sex with men, or is known to have sex with men and has not had a HIV test in the previous year • reports sexual contact abroad or in the UK with someone from a country of high HIV prevalence • discloses that they have changed sexual partner or discloses high-risk sexual practices • is diagnosed with, or requests screening for, a sexually transmitted	

be able to: – provide information on HIV testing and discuss why it is recommended (including to those who indicate that they may wish to decline the test) – conduct post-test discussions, including giving positive test results and delivering post-test and general health promotion interventions – recognise illnesses that may signify primary HIV infection and clinical indicator diseases that often coexist with HIV – assess the man's level of knowledge about HIV and refer him to a service where health promotion interventions can be provided, if necessary. (**recommendation 4**)	infection • discloses that they are the sexual partner of a man or woman known to be HIV positive • reports a history of injecting drug use.	
Outreach: providing rapid point-of-care tests • Set up outreach services in a sensitive manner in consultation with men who have sex with men. (For example, be aware that not all community settings are appropriate for POCT.) • Offer tests via outreach in venues where there is high-risk sexual	1.1.8 Set up community testing services in venues or areas where there is high-risk sexual behaviour or a high prevalence of HIV. This could include: • community or voluntary sector premises • public sex environments • venues where people at high risk may gather. 1.1.9 Recognise that not all community settings are appropriate for providing	Wording to describe population has been changed as the updated guideline has a broader population. Wording changes have been made to improve clarity. Self-sampling added to recommendations in updated guideline. In recommendation 1.1.7, 'venous' added to differentiate blood sample from finger-prick test. In recommendation

behaviour or in venues sited in areas where there is high local prevalence of HIV. This could include community or voluntary sector premises, public sex environments (such as saunas or cruising areas) or other venues identified during the planning exercise (see recommendation 1). Tests should be undertaken in a secluded or private area, in line with British HIV Association guidelines[1]. • In appropriate settings, offer rapid POCT to men who have previously tested negative for HIV, or who have never been tested. Use a less invasive form of the test such as a mouth swab or finger-prick. CE-marked[7] POCT kits should be used. • Provide men who refuse, or who may not be able to consent to, a test with information about other local testing services. (Inability to consent may be due to alcohol or drugs, for example. A refusal might be because of the setting or concerns about privacy.) • Ensure non-clinical	testing services, for example because tests should be undertaken in a secluded or private area (in line with British HIV Association guidelines). 1.1.7 If a venous blood sample is not already being taken for another reason, or is refused, offer a less invasive form of specimen collection, such as a mouth swab or finger-prick. 1.1.10 Ensure that people who decline or are unable to consent to a test (for example, they are under the influence of alcohol or drugs, they fear community stigma or because of their age) are given information about other local testing services, including self-sampling. See making decisions using NICE guidelines for more information about consent. 1.1.11 Ensure lay testers delivering tests are competent to do so and have access to clinical advice and supervision. 1.2.2 Practitioners delivering POCT should explain to people at the time of their test about the relatively poor specificity and sensitivity of POCT and the need for confirmatory serological testing.	1.1.11, 'lay testers' replaces non-clinical practitioners as this term is now in common usage. Minor wording changes have also been added to the recommendation to improve clarity. Timing and wording clarification added to recommendation 1.2.2.

practitioners delivering POCT are trained to collect blood spots and mouth swabs, handle test material and administer the test. Training should be supervised and signed off by an appropriate clinician. It should be updated annually. Staff should also have access to clinical advice and supervision. • Ensure non-clinical practitioners delivering POCT are aware of local referral systems and services for people who test positive. They should be trained to provide appropriate information and support, including information about the relatively poor specificity and sensitivity of POCT. In addition, they should be able to assess the client's level of knowledge about HIV and provide appropriate health promotion interventions (or refer them to a service that can). (**recommendation 5**)		
Repeat testing • Recommend that all men who have tested negative but who may have been exposed to HIV have another	1.2.7 When giving results to people who have tested negative but who may have been exposed to HIV, recommend that they have another test once they are past the window period. 1.2.8 Recommend annual	Wording to describe population has been changed as the updated guideline has a broader population. Clarifications and additions added to the recommendations on

test, once they are past the 'window period'[4]. • Recommend annual testing to all men who have sex with men, and more frequent testing for those who have a high risk of exposure to the virus, for example, through multiple sexual partners or unsafe sexual practices. **(recommendation 6)**	testing to people in groups or communities with a high prevalence of HIV, and more frequent testing for those who have a high risk of exposure, for example, through multiple sexual partners or unsafe sexual practices..	repeat testing. Timing added to recommendation 1.2.7 for clarity.
HIV referral pathways • Ensure there are clear referral pathways for practitioners delivering HIV tests (including those delivering outreach, rapid POCT), for both positive and negative test results. They should be able to refer clients quickly and easily to suitable sexual health services, confirmatory HIV testing, and post-test care and treatment services. These pathways should include ensuring the following: – Men who test positive are seen by an HIV specialist at the earliest opportunity, preferably within 48 hours, certainly within 2 weeks of receiving the result[1]. They should also be	1.4.3 Ensure practitioners delivering HIV tests (including those delivering outreach POCT) have clear referral pathways available for people with both positive and negative test results, including to sexual health services and confirmatory serological testing. These pathways should ensure the following: • People who test positive are seen by an HIV specialist preferably within 48 hours, certainly within 2 weeks of receiving the result (in line with UK national guidelines for HIV testing 2008 British HIV Association). They should also be given information about the diagnosis and local support groups. • People who regularly engage in high-risk sexual behaviour or inject drugs (whatever their test result) are	Wording to describe population has been changed as the updated guideline has a broader population. Clarifications and additions added to the recommendations on repeat testing. Self-sampling added to recommendation 1.2.10 in updated guideline and wording changes added for editorial style and clarity.

given information about the diagnosis and about local support groups. – Men who regularly engage in high-risk sexual behaviour (whatever their test result) are offered behavioural or health promotion interventions (for example, advice on safer sex, training in negotiating skills and providing condoms). Some men (including under-16s) may need additional psychological support and should be referred to counselling services that are totally accepting of their sexuality. – Repeat testing is encouraged after a negative result (see recommendation 6). – Practitioners in the voluntary or statutory sector are able to refer men from HIV prevention and health promotion services for HIV testing and vice versa. – People who choose not to take up the immediate offer of a test know how to access testing services. (**recommendation 7**)	offered behavioural or health promotion interventions (for example, advice on safer sex or injecting, training in negotiating skills and providing condoms). • Practitioners in the voluntary or statutory sector can refer people from HIV prevention and health promotion services for HIV testing and vice versa. 1.2.10 If people choose not to take up the immediate offer of a test, tell them about nearby testing services and how to get self-sampling kits.	

Glossary

Fourth generation serological testing

Fourth generation tests look for HIV antibodies and p24 antigen simultaneously. This means they have the advantage of reducing the time between infection and testing HIV positive to about 1 month.

High prevalence

A high prevalence (for the purposes of universal testing) means more than 4 diagnosed cases per 1,000 people.

Lay tester

A non-clinical practitioner who has been trained to carry out HIV tests.

Point-of-care testing

Point-of-care tests (POCT) or 'rapid' tests are a common way to test for HIV. They are easy to use when venepuncture is not possible, for example outside conventional healthcare settings and where it's important to avoid a delay in obtaining a result. However, they have reduced specificity and sensitivity compared with fourth generation laboratory tests. This means there will be false positives, particularly in areas with lower HIV prevalence, and all positive results need to be confirmed by serological tests.

Public sex environments

Public sex environments are public areas where people go to engage in consensual sexual contact (both same sex and opposite sex).

Self-sampling

Self-sampling HIV kits allow people to collect their own sample of blood or saliva and send it by post for testing. They usually receive their results by text message.

Self-testing

Self-testing kits allow people to perform their own HIV test in private and get an immediate result (typically within 15–20 minutes).

Window period

The window period is the time between potential exposure to HIV infection and when a test will give an accurate result. The window period is 1 month for a fourth generation test and 3 months for older tests and most POCT.

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