NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE
PUBLIC HEALTH DRAFT GUIDANCE

Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England

Introduction

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE) to produce public health guidance on increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England.

The guidance is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, increasing the uptake of HIV testing among black African communities. This includes those working in: local authorities, and the wider public, private voluntary and community, sectors. It may also be of interest to members of the public, particularly black Africans living in England.

The guidance complements NICE guidance on increasing the uptake of HIV testing among men who have sex with men. The two pieces of guidance are separate referrals and are being produced independently. However, it is acknowledged that there is overlap in the populations. For further details see section 7.

The Public Health Interventions Advisory Committee (PHIAC) has considered the evidence reviews, cost effectiveness and expert testimony.
This document sets out the Committee's preliminary recommendations. It does not include all sections that will appear in the final guidance. NICE is now inviting comments from stakeholders (listed on our website at www.nice.org.uk).

Note that this document does not constitute NICE’s formal guidance on increasing the uptake of HIV testing among black Africans in England. The recommendations made in section 1 are provisional and may change after consultation with stakeholders and fieldwork.

The stages NICE will follow after consultation (including fieldwork) are summarised below.

- The Committee will meet again to consider the comments, reports and any additional evidence that has been submitted.
- After that meeting, the Committee will produce a second draft of the guidance.
- The draft guidance will be signed off by the NICE Guidance Executive.

For further details, see ‘The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)’ available from www.nice.org.uk/phprocess

**The key dates are:**

Closing date for comments: 22 November 2010.
Second Committee meeting: 10 December 2010.

Members of PHIAC are listed in appendix A and supporting documents used to prepare this document are listed in appendix E.

This guidance was developed using the NICE public health intervention process.
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1 Recommendations

When writing the recommendations, the Public Health Interventions Advisory Committee (PHIAC) (see appendix A) considered the evidence of effectiveness (including cost effectiveness), a qualitative review of barriers and facilitators to testing, and expert testimony. Note: this document does not constitute NICE’s formal guidance on this intervention. The recommendations are preliminary and may change after consultation.

The evidence statements underpinning the recommendations are listed in appendix C.

The evidence reviews and supporting evidence statements are available at www.nice.org.uk/guidance/insert url

PHIAC considers that the recommended measures are likely to be cost effective.

For the research recommendations and gaps in research, see section 5 and appendix D respectively.

Context

These recommendations focus on increasing the uptake of HIV testing and reducing late diagnosis in black African communities living in England. Black African communities encompass diverse population groups from a range of countries. Throughout this guidance the term ‘black African’ includes all people who identify themselves as black African, whether they are migrants from Africa, African descendants or African nationals. This includes people:

- from a range of cultural, ethnic and faith backgrounds
- who may be heterosexual, or behaviourally bisexual or gay
- who may be able bodied, or have physical or learning disabilities
- whose knowledge of English is limited.

Organisations and individuals wishing to implement these recommendations will need to take into account the characteristics of their client groups. They
should ensure that interventions are implemented with due concern for equity and access. Interventions should be suited to a person’s age, culture, gender and sexuality. They should take into account potential barriers to HIV testing, such as stigma or lack of access to services and be delivered in a non-judgemental way.

Although the immediate beneficiaries of these recommendations are people from black African communities, the health of the wider community may also benefit from reduced transmission of HIV as a result of testing and treatment.

This guidance assumes that HIV tests are delivered according to current best practice. They should be accompanied by pre- and post-test discussions according to locally agreed procedures. Further information can be found in the UK national guidelines for HIV testing (British HIV Association et al. 2008).

**Whose health will benefit?**

Black Africans who are living in England who are or have been sexually active.

**Recommendation 1: planning services**

**Who should take action?**

Directors of public health, public health specialists and commissioners with a remit for sexual health and local sexual health networks.

**What action should they take?**

- Ensure there is a local strategy for encouraging black African communities living in the local area to consider HIV testing. This strategy should be planned in partnership with relevant local voluntary organisations and user groups and in consultation with local black African communities.
Ensure the strategy is based on a needs assessment to inform service commissioning. This assessment should include:

- the collection and analysis of local data with which to estimate the prevalence and incidence of HIV among the local black African population
- information about the composition of local black African communities, including those who are less likely to access services
- ensuring there is an understanding of the particular needs of different African communities in the local area (this may help with understanding the patterns of undiagnosed HIV infection within different groups)
- information about current HIV-testing services including:
  - site (for example, genitourinary medicine clinic, GP surgery), access (for example, hours of access) and locality
  - types of test offered and speed of results (noting variations in factors such as waiting times and staff provision)
  - service users (identified gender, sexuality, age, ethnicity)
- an appraisal of local interventions that aim to increase HIV testing in black Africans (where they are delivered, by whom, when, and how often)
- the views of local black African communities on current local needs, interventions and services. (See recommendation 6 for more details on community engagement.)

Use information from the needs assessment to develop or revise a plan to tailor and target services that aim to increase HIV testing in black African communities. The plan should

- take into account the local needs of different groups
- pay particular attention to groups of black Africans who are less likely to use existing services
- be evaluated regularly (including user consultation).
Recommendation 2: HIV testing provision and referral pathways

Who should take action?

Directors of public health and commissioners of health services.

What action should they take?

- Ensure that local testing services are commissioned to meet the UK National Guidelines for HIV Testing (British HIV Association et al. 2008).

- Use the information from the needs assessment (see recommendation 1) to ensure that testing services:
  - are available in a range of healthcare settings¹ and other venues (for example Sure Start centres and where cultural events and prayer groups are hosted) that are accessible to the target population, in terms of both geographical setting and service design (for example appointment systems and opening hours).
  - have clear referral pathways for people with positive or negative test results. These should be in line with the ‘UK national guidelines for HIV testing’ (British HIV Association et al. 2008) and ensure:
    - a person with a positive result is seen by an HIV specialist at the earliest opportunity, preferably within 48 hours, certainly within 2 weeks of receiving the result (British HIV Association et al. 2008)
    - a person with a positive result is given information about their diagnosis and about local support groups for people living with HIV

¹ For example in genitourinary medicine clinics, sexual health clinics, antenatal services, termination of pregnancy services, drug dependency programmes and healthcare services for people diagnosed with relevant coexisting conditions (such as tuberculosis, hepatitis B or C and lymphoma).
a person with a positive or negative test result is offered further interventions such as safer sex advice, negotiating skills and getting condoms; interventions could be provided by statutory or voluntary sector organisations.

**Recommendation 3: promoting HIV testing and reducing barriers**

**Who should take action?**

- Public health, primary care (including GPs), local authority and voluntary sector staff with a remit for health promotion, education and advice for black Africans.

- Those who commission sexual health promotion services for black Africans.

- Providers of HIV testing services including, but not limited to, those in genitourinary medicine settings.

- Other organisations, locally and nationally, who produce or are responsible for providing information about HIV, HIV testing and treatment to black Africans.

**What action should they take?**

- Ensure that HIV testing services:
  - are confidential
  - are staffed by people who have been trained in and are aware of cultural and sensitive issues for black Africans (such as them being unfamiliar with preventive-health-seeking behaviour, and fear of isolation and social exclusion)
  - are sensitive to the needs of all genders
  - operate a policy of opt-out testing
  - either offer anonymous testing (for which an individual does not have to disclose their true identity) or direct people to anonymous testing services for those reluctant to take a
confidential HIV test (which would be attached to their medical record)
– can provide rapid tests (or if this is not possible, refer people to a service that can) for those reluctant to take a test that involves waiting for results
– can provide less invasive tests, such as a saliva test (or if this is not possible, refer people to a service that can) for those who are unwilling to have venepuncture.

• Promote HIV testing by:
  – tailoring health promotion material to the target group and addressing possible barriers to change; it should include information about:
    ◊ HIV infection and transmission
    ◊ the benefits of HIV testing, including the benefits of early diagnosis and treatment
    ◊ how and where to access HIV testing in the local area, including where rapid and anonymous testing is available
    ◊ myths and common misconceptions about HIV diagnosis and treatment
  – using venues that the local black African communities frequent
  – ensuring that HIV health promotion messages address non-English-speaking black African communities.

Recommendation 4: providing HIV testing outside sexual health settings

Who should take action?
Healthcare practitioners in non-sexual-health healthcare settings including, but not limited to, GP practices, accident and emergency departments, other acute settings and outpatient departments.
What action should they take?

- GPs should, when consulting with black Africans, routinely offer an HIV test to those who:
  - have not been tested before, or
  - have tested negative previously but may have been exposed to HIV and have been in the ‘window period’\(^2\) when tested, or
  - are at risk of exposure to the virus, for example as a result of a new sexual partner.

- All health practitioners should routinely provide an opt-out HIV test to any black African they are consulting with who is having blood taken for another reason.

- Midwives should, where possible, offer testing for HIV for black African men who attend with a woman for an antenatal appointment at which the woman is offered HIV testing. If this is not possible, midwives should direct partners to suitable HIV testing services.

**Recommendation 5: training**

Who should take action?

Those with a responsibility for training and continuing professional development of practitioners working with black African people. This includes employees whose role involves health promotion, HIV prevention or offering HIV testing; it also includes non-clinical staff such as reception staff.

What action should they take?

- Provide all staff involved in service delivery (for example reception staff) training in confidentiality, anti-discriminatory practices, cultural awareness and reducing stigma.

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\(^2\) The window period is the time between infection and when antibodies to the virus are detectable by a test. Depending on the type of test it can be up to 3 months.
• Provide staff offering and performing HIV testing training appropriate to their role on:
  
  – the issues surrounding HIV testing for different black African communities (for example, fear of social exclusion, access to treatment)
  – discussing and promoting the benefits of HIV testing and early diagnosis (for example, life expectancy on treatment) to enable people to provide informed consent for an HIV test.³

• In genitourinary medicine or sexual health centres:
  
  – Practitioners directly involved with testing for HIV and other sexually transmitted infections should be:
    ◦ trained in opt-out testing
    ◦ able to recommend HIV testing and discuss symptom awareness, the pros and cons of HIV testing and the implications of a positive or a negative test
    ◦ able to assess patients’ levels of knowledge about HIV and provide appropriate health promotion interventions or refer to a service where these can be provided.

• In primary care practitioners offering and performing HIV tests should have the skills and training set out for genitourinary medicine or sexual health centres above, and also:
  
  – be able to offer a quick and easy referral into specialist HIV services
  – undergo comprehensive training in suitable techniques for post-test discussions, including giving positive test results and post-test health promotion
  – provide appropriate information and interventions for people who test negative

³ For further details on pre-test discussion see section 5 of 'UK national guidelines for HIV testing' (British HIV Association et al. 2008).
– be trained to recognise illnesses that may signify primary HIV infection, and clinical indicator diseases that are often comorbid with HIV and that should prompt an offer of an HIV test.

**Recommendation 6: community engagement**

**Who should take action?**

Directors of public health and others with a remit for HIV prevention or responsibility for the health and wellbeing of black African communities.

**What action should they take?**

- In line with NICE guidance on community engagement (NICE public health guidance 9) plan, design and coordinate activities to promote the uptake of HIV testing in local black African communities. This should incorporate community involvement across all aspects of the plan. It should also take account of existing and past community activities among black African populations addressing HIV and wider sexual health.

- Use existing community activities to:
  - promote HIV testing and the benefits of early diagnosis and treatment
  - raise awareness of HIV testing in the local area, including how to access services
  - address misconceptions about HIV testing and treatment, for example life expectancy following a positive diagnosis and HIV treatment costs
  - reduce stigma (real and perceived) associated with HIV testing and living with HIV, both among health professionals and black Africans.

- Recruit, train and encourage members of the local black African community to act as:
  - ‘health champions’ to be involved in planning activities to address any unmet HIV testing needs of the local population
- role models to help encourage the local community to take tests
- a link to specific communities who are less likely to use standard services.
2 Public health need and practice

In mid 2008, an estimated 33 million people worldwide were living with HIV – around 2.7 million were newly infected. The previous year, 2 million people died from AIDS-related illnesses (UNAIDS 2009).

HIV among black Africans in England

During 2009 there were 1842 new diagnoses of HIV infection among black Africans, representing 30% of all new diagnoses in the UK (Health Protection Agency 2009a). Most (87%) had acquired their infection heterosexually and in Africa (Health Protection Agency 2009b). In 2008, of the 22,282 black African HIV-infected people seen for care in the UK, 91.5% reported having acquired the infection through heterosexual intercourse. Black Africans are disproportionately infected with HIV in England, accounting for approximately 1% of the UK population yet nearly a third of new HIV diagnoses (Health Protection Agency 2008a). The prevalence of diagnosed HIV infection in black African communities in England is estimated to be 3.7%, compared with 0.09% among the white population (Health Protection Agency 2008a).

Late HIV diagnosis is a particular problem among black Africans (Burns et al. 2001). Late diagnosis is defined as taking place after antiretroviral treatment would typically have begun, or when the person has an AIDS-defining illness. In 2007 more than 40% of new diagnoses among black Africans were classified as late (Health Protection Agency 2008a). It is estimated that approximately 30% of HIV-positive sub-Saharan Africans leave genitourinary clinics without a diagnosis (Health Protection Agency 2008b). Lack of a diagnosis – or late diagnosis – can deprive people (including the partners of those infected) of treatment and support. It can also increase the potential for onward transmission of HIV. There might be several reasons for late diagnosis, including fear of the stigma surrounding HIV/AIDS, and general misinformation about the infection (Sigma Research 2008). Late HIV diagnosis is one of the most important factors associated with HIV-related disease and death in the UK.
Sexual behaviour
The main risk for HIV transmission is serodiscordant unprotected intercourse; that is, one HIV-positive and one HIV-negative person having unprotected sex (anal or vaginal). Results from the Bass Line survey (a community-based research project involving 2580 African people living in England) provide an insight into the sexual behaviour of black Africans in England. More than 75% of the sample reported having been sexually active in the previous year, with more than half having a regular sexual partner. Of those with a regular partner, 25% reported having had other sexual relationships outside the regular relationship. Of those who reported having had sex in the previous year, 10% reported definitely or probably having had sexual intercourse without a condom with someone of a different HIV status from theirs; that is, serodiscordant unprotected intercourse. The risk of serodiscordant unprotected intercourse increased with the number of sexual partners: 25% of respondents who had sex in the past year did not use a condom in that time. Among those who had used condoms, one third reported that they had experienced condom failure in the past year (Sigma Research 2008).

The role of testing and treatment in prevention
HIV testing and treatment can help reduce transmission of the virus. People who find out they have HIV infection may change their sexual behaviour as a result of the diagnosis. For example, they may start using condoms with partners who are not HIV positive or whose HIV status is unknown (Coates et al. 2000; Marks et al. 2005; Weinhardt et al 1999). Testing also provides an opportunity to address ‘unmet HIV prevention needs’ (for example, sexual negotiation skills and access to condoms) (National African HIV Prevention Programme, 2008). In addition, people with an HIV diagnosis may choose to receive antiretroviral therapy, which suppresses the virus and can reduce further transmission. A negative HIV test provides an opportunity to offer preventive education and advice and may also lead to changes in behaviour. Increasing the frequency of testing may result in earlier detection of HIV, thereby providing greater opportunity to reduce transmission.
It is estimated that someone aged 35 who is living with HIV in a developed country is likely to live for a further 37 years with treatment. On that basis, it is estimated that it would cost an average £5485 a year to treat them in the UK. At 2009 prices, this amounts to between £200,000 and £360,000 over their lifetime (Devine A: personal communication 2010).

The introduction of antiretroviral therapies in the mid 1990s made HIV a manageable medical condition and meant that people could remain fit and well on treatment. As a result, perceptions among experts and professionals of the importance of HIV testing changed substantially, with the benefits of having a diagnosis outweighing the risks.

**Testing policy and guidelines**

In 2001 the government Strategy for HIV and Sexual Health (DH 2001) set a 10-year target to reduce the levels of undiagnosed HIV infection. Sullivan et al. (2005) found a significant number of missed opportunities for earlier diagnosis of HIV infection, with a high proportion of people with symptoms (17%) who sought medical care in the preceding 12 months but remained undiagnosed. In 2008 there was a review of the strategy by the Medical Foundation for Aids and Sexual Health (Medical Foundation for Aids and Sexual Health 2008). Audits of late presentation and death undertaken by specialist providers of HIV services prompted the development of a set of guidelines for increasing provider-initiated HIV testing by the British HIV Association, the British Association for Sexual Health and HIV and the British Infection Society (British HIV Association et al. 2008).

The Health Protection Agency recommended in its most recent annual HIV report (Health Protection Agency 2009b) that initiatives to expand HIV testing in clinical and community settings should be promoted to reduce late diagnosis and undiagnosed HIV infections. The report also highlighted the need to reinforce prevention messages and promote regular HIV testing within black African communities.

The US Centers for Disease Control and Prevention (Branson et al. 2006) and the World Health Organisation (WHO, UNAIDS 2007) have recommended the
scaling up of HIV testing and the introduction of opt-out testing systems in healthcare settings.

The current UK strategy for HIV and sexual health ends in 2011 and consultation is underway to set future priorities.

Strategies aimed specifically at HIV in African communities include the ‘HIV and AIDS in African communities framework for prevention and care’ (DH 2005). This strategy describes some of the differences between African communities and the general population in terms of HIV services. It sets out actions to improve the effectiveness of HIV prevention and health promotion, and treatment and care services for African communities affected by or at risk of HIV. In 2008 the National African HIV prevention programme released a statement that detailed its plans to prevent HIV transmission among the diverse population of Africans living in England (National African HIV Prevention Programme et al. 2008).

Current UK guidelines for HIV testing (British HIV Association et al. 2008) recommend universal HIV testing in genitourinary medicine and sexual health clinics, antenatal services, termination of pregnancy services, drug dependency programmes and in healthcare services for those diagnosed with tuberculosis, hepatitis B and C and lymphoma. The guidelines also recommend that HIV testing should be considered for everyone registering with a GP and for general medical admissions if diagnosed HIV prevalence exceeds two in 1000 in the local population (defined as the population living in the primary care trust or local authority). The testing guidelines also state the situations in which HIV tests should be routinely offered, including to all men and women known to be from a country of high HIV prevalence (more than 1%) and all men and women who report sexual contact abroad or in the UK with people from countries of high HIV prevalence.
3  Considerations

The Public Health Interventions Advisory Committee (PHIAC) took account of a number of factors and issues when developing the recommendations.

Context

3.1  PHIAC noted that HIV testing was one part of a strategy for HIV prevention. The strategy should also include appropriate follow-up and support to encourage and enable black Africans to change any risky sexual behaviour, whether or not they have a positive test result. Although the focus of this guidance is on increasing testing, it does not imply that other HIV prevention strategies are ineffective or less effective.

3.2  The committee recognised that black Africans are not a homogenous group; the term describes diverse populations with a range of social and cultural beliefs and norms. It also recognised that this diversity manifests in sexual behaviours and therefore risk of HIV transmission.

3.3  ‘Black African communities’, like any other population group in England, encompasses people across the inequality spectrum. For example, some may have a high socioeconomic status and others may be seeking asylum.

3.4  UK surveillance data indicate that a high proportion of HIV infections diagnosed among black Africans in England are thought to have been acquired abroad. Experts suggested that more recently there has been an increase in within-England transmission among black Africans.

3.5  There are differences in the rate of disease by age and gender among black Africans living in England. Black African women have a higher diagnosed incidence than men; the committee was aware
that this may be related to greater opportunity for testing among women through antenatal services.

3.6 PHIAC acknowledged that initiatives aimed at increasing HIV testing generally among the whole population may also lead to an increase in HIV testing among black African communities. It also identified that HIV testing provides an opportunity to address any other unmet HIV prevention needs that a person may have.

3.7 PHIAC recognised that there are points in a person’s life that are useful trigger points for HIV testing, for example, pregnancy or having a new sexual partner.

3.8 PHIAC acknowledged that for some people there may be no perceived incentive to test for HIV. For some people there may be other areas of their lives that are more pressing than knowing if they are HIV positive, for example, housing, employment or immigration.

3.9 PHIAC recognised that most people who take an HIV test will test negative, and that it is important that care pathways are in place to help such people stay HIV negative; for example, interventions to promote safe sex negotiation.

3.10 Historically, HIV testing has been associated with genitourinary medicine and sexual health settings; the committee recognised the need for non-sexual health settings (such as primary and secondary care) to be involved to help normalise HIV testing.

Evidence

3.11 PHIAC drew on the content of the British HIV Association guidelines on HIV testing (2008) when formulating the recommendations.

3.12 There is a general lack of effectiveness and cost-effectiveness evidence specifically focused on increasing the uptake of HIV
testing among black Africans, particularly in England. Much of the evidence is US-based. However, PHIAC considered that it was sufficiently applicable to the UK context to inform the recommendations.

3.13 PHIAC was aware that a series of pilot projects funded by DH was underway to test various strategies to improve the uptake of HIV testing in black Africans. However, these pilots did not report in time for the evidence to be included in the draft guidance, although they may report in time for the final guidance.

3.14 PHIAC acknowledged that many of the interventions detailed in the evidence were already underway in England to varying degrees.

3.15 Home testing – that is tests sold remotely to people to take at home – was excluded from the literature searches because the sale of such tests is illegal. However, that does not mean that tests performed at home or outreach HIV testing using point-of-care tests would not be acceptable to black African communities.

3.16 There is a lack of evidence that provides detail on the effectiveness of interventions to increase the uptake of HIV testing among HIV-positive people; that is, studies tended not to report how many of those who did test tested positive.

3.17 PHIAC considered that any intervention to increase HIV testing would also incur the additional costs of treating people who are HIV positive. These costs were considered justifiable both from a moral perspective and from the perspective of reducing transmission of the virus. The high cost of treating AIDS and AIDS-related illness and providing end-of-life care was also noted.

3.18 PHIAC noted that there was a marked lack of robust data about sexual behaviour, infectivity and disease progression. All of these factors affect the rate of transmission of HIV. Sexual behaviour change after a positive HIV diagnosis is fundamental in reducing
the transmission of HIV. The lack of data meant that assumptions had to be made about sexual behaviour, infectivity and disease progression to develop an economic model. The estimates obtained from the model are therefore subject to considerable uncertainty.

3.19 The economic modelling incorporated the cost of treatment into some of the ICERs, which means that they are high compared with the usual NICE threshold. However, these ICERs will be lower if the assumptions include the likely effects of more recent treatment regimens. If treatment costs are excluded, all of the interventions are cost effective compared with a £20,000 per QALY threshold. PHIAC determined that excluding HIV treatment costs is appropriate because NICE was asked only to consider the cost effectiveness of interventions to increase the uptake of HIV testing.

**Barriers to testing**

3.20 PHIAC recognised that there are many barriers to testing for black African communities, for example:

- Perceived stigma surrounding HIV, such as fear of isolation and social exclusion after a positive diagnosis and fear of racism and prejudice from outside the community, may result in a reluctance to test.

- Perceptions among black Africans that they are at low risk of having or acquiring HIV.

- The lack of clarity around treatment costs and immigration status for some black Africans in England.

- The criminalisation of HIV: that is, the fear of possible legal action against individuals aware of their positive status who did not share this information with a partner who subsequently contracts the infection.
- A lack of knowledge about HIV in general and the benefits of HIV testing.

3.21 PHIAC was aware of the possibility that focusing HIV testing on black Africans could increase stigmatisation by supporting the message that ‘AIDS is an African disease’. However, it felt that because black Africans are disproportionately infected with HIV in England, the guidance was justified in addressing their needs.
4 Implementation

NICE guidance can help:

- NHS organisations, social care and children's services meet the requirements of the DH's 'Operating framework for 2008/09' and 'Operational plans 2008/09–2010/11'.

- NHS organisations, social care and children's services meet the requirements of the Department of Communities and Local Governments' 'The new performance framework for local authorities and local authority partnerships'.

- National and local organisations within the public sector meet government indicators and targets to improve health and reduce health inequalities.

- Local authorities fulfil their remit to promote the economic, social and environmental wellbeing of communities.

- Local NHS organisations, local authorities and other local public sector partners benefit from any identified cost savings, disinvestment opportunities or opportunities for redirecting resources.

- Provide a focus for multi-sector partnerships for health, such as local strategic partnerships.

NICE will develop tools to help organisations put this guidance into practice. Details will be available on our website after the guidance has been issued (www.nice.org.uk/guidance/PHxx).

5 Recommendations for research

This section will be completed in the final document.

More detail on the gaps in the evidence identified during development of this guidance is provided in appendix D.
6 Updating the recommendations

This section will be completed in the final document.

7 Related NICE guidance

Published


Under development

Increasing the uptake of HIV testing among men who have sex with men. NICE public health guidance. Publication expected March 2011.

8 References


Department of Health (2001) Better prevention, better services, better sexual health. The national strategy for sexual health and HIV. London: Department of Health


Health Protection Agency (2009b) HIV in the United Kingdom, 2009 report. London: Health Protection Agency


National African HIV Prevention Programme et al (2008) The knowledge, the will and the power: a plan of action to meet the HIV prevention needs of


Appendix A Membership of the Public Health Interventions Advisory Committee (PHIAC), the NICE project team and external contractors

Public Health Interventions Advisory Committee

NICE has set up a standing committee, the Public Health Interventions Advisory Committee (PHIAC), which reviews the evidence and develops recommendations on public health interventions. Membership of PHIAC is multidisciplinary, comprising public health practitioners, clinicians, local authority officers, teachers, social care professionals, representatives of the public, academics and technical experts as follows.

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**External contractors**

**Evidence reviews**

Review 1: ‘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’ was carried out by University College London. The principal authors were: Ibidun Faykoya, Alison Evans, Gianluca Baio, Fiona Burns, Stephen Morris and Graham Hart.
Review 2: ‘Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England – barriers to HIV testing’ was carried out by University College London. The principal authors were: Ibidun Fakoya, Audrey Prost, Fiona Burns and Graham Hart.

**Cost effectiveness**

The economic modelling 'Economic analysis to inform the development of NICE public health intervention guidance on preventing and reducing transmission of HIV among Black Africans in England' was carried out by Matrix Evidence. The principal authors were: Kevin Marsh, Jennie Lewsey, Meena Venkatachalam, Leeza Osipenko.
Appendix B Summary of the methods used to develop this guidance

Introduction

The reviews and economic modelling report include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the Public Health Interventions Advisory Committee (PHIAC) meetings provide further detail about the Committee’s interpretation of the evidence and development of the recommendations.

All supporting documents are listed in appendix E and are available at www.nice.org.uk/guidance/insert specific url
**Guidance development**

The stages involved in developing public health intervention guidance are outlined in the box below.

1. Draft scope released for consultation
2. Stakeholder meeting about the draft scope
3. Stakeholder comments used to revise the scope
4. Final scope and responses to comments published on website
5. Evidence reviews and economic modelling undertaken and submitted to PHIAC
6. PHIAC produces draft recommendations
7. Draft guidance (and evidence) released for consultation and for field testing
8. PHIAC amends recommendations
9. Final guidance published on website
10. Responses to comments published on website

**Key questions**

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by PHIAC to help develop the recommendations. The questions were:

1. What are the most effective and cost-effective ways of increasing the uptake of HIV testing to reduce undiagnosed infection among black Africans living in England?
2. What factors help or hinder the uptake of HIV testing by black African communities living in England and how can the barriers be overcome?

These questions were made more specific for each review(s) (see review/s for further details).
**Reviewing the evidence**

Two reviews were conducted: one review of effectiveness and cost effectiveness, and one review of barriers and facilitators to HIV testing.

**Identifying the evidence**

The following databases were searched for both reviews in January 2010:

- AEGIS (AIDSLine and International AIDS Society abstract archives)
- Allied and Complementary Medicine
- Cochrane Library databases
- Cumulative Index to Nursing & Allied Health Literature
- Current Contents
- Database of Abstracts of Reviews of Effects
- EMBASE
- EPPI Centre
- Eric (Education Resources Information Centre)
- Health Management Information Consortium
- Health Technology Assessment
- International Bibliography of the Social Sciences
- ISI Web of Science (Social Science Citation Index)
- Medline (Ovid) Includes Medline In-Process & Other Non-Indexed Citations
- NHS Evidence (National Library for Public Health and National Library for Ethnicity and Health)
- Popline
- PsychINFO
- Social Policy and Practice
- UK Clinical Research Network Portfolio Database.

The following websites of African-led community-based organisations and other key websites were also searched:

- African HIV Research Forum [www.ahrf.org.uk](http://www.ahrf.org.uk)
- Avert [www.avert.org](http://www.avert.org)
Selection criteria

Studies were included in the effectiveness review if:

- the population included black African men and women or other black, Asian and minority ethnic groups or migrant populations in high income countries

- they were conducted in an Organisation for Economic Cooperation and Development (OECD) country

- they took place after the introduction of highly active antiretroviral therapy

- they looked at interventions that aimed to increase awareness or uptake of HIV testing.

Studies were excluded if:

- the interventions focused on HIV home testing

- they measured the validity or diagnostic effectiveness of different types of HIV test

- they examined testing following exposure to HIV in the workplace.

Studies were included in the barriers and facilitators review if:

- the population was black African men and women living in England; black, Asian and minority ethnic groups living in England; or sexual health and HIV prevention, treatment and care providers working with black, Asian and minority ethnic groups in England
they examined or described awareness of how black African communities in the UK view HIV testing and how they think the barriers to testing can be overcome

they examined or described attitudes towards HIV testing among population groups and service providers in UK

they described or examined the environmental, social, cultural and personal barriers to HIV testing among population groups

they were published in 1996 or later

the methods used were document analysis; observation and participant observation; focus group discussion; or in-depth interview.

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual ‘Methods for the development of NICE public health guidance’ (see appendix E). Each study was graded (++, +, –) to reflect the risk of potential bias arising from its design and execution.

Study quality

++ All or most of the checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are very unlikely to alter.

+ Some of the checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are unlikely to alter the conclusions.

– Few or no checklist criteria have been fulfilled. The conclusions of the study are likely or very likely to alter.

The evidence was also assessed for its applicability to the areas (populations, settings, interventions) covered by the scope of the guidance. Each evidence statement concludes with a statement of applicability (directly applicable, partially applicable, not applicable).
Summarising the evidence and making evidence statements

The review data were summarised in evidence tables (see full reviews).

The findings from the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the external contractors (see appendix A). The statements reflect their judgement of the strength (quality, quantity and consistency) of evidence and its applicability to the populations and settings in the scope.

Cost effectiveness

There was a review of economic evaluations as part of the effectiveness review (see above) and an economic modelling exercise.

Economic modelling

An economic model was constructed to incorporate data from the reviews of effectiveness and cost effectiveness. The results are reported in: ‘Economic analysis to inform the development of NICE public health intervention guidance on increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black Africans in England’.

Fieldwork

This section will be completed in the final document.

How PHIAC formulated the recommendations

At its meetings in June and July 2010, PHIAC considered the expert testimony, evidence, and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement
- where relevant, whether (on balance) the evidence shows that the intervention or programme/activity can be effective or is inconclusive
- where relevant, the typical size of effect
- whether the evidence is applicable to the target groups and context covered by the guidance.
PHIAC developed draft recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of the evidence.
- The applicability of the evidence to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population’s health.
- Impact on inequalities in health between different groups of the population.
- Equality and diversity legislation.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of harms and benefits.
- Ease of implementation and any anticipated changes in practice.

Where possible, recommendations were linked to an evidence statement(s) (see appendix C for details). Where a recommendation was inferred from the evidence, this was indicated by the reference ‘IDE’ (inference derived from the evidence).
Appendix C The evidence

This appendix lists the evidence statements from two reviews provided by external contractors (see appendix A) and links them to the relevant recommendations. (See appendix B for the key to quality assessments.) The evidence statements are presented here without references – these can be found in the full review (see appendix E for details).

Evidence statement E3 indicates that the linked statement is numbered 3 in the effectiveness and cost effectiveness review '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'

Evidence statement Q4 indicates that the linked statement is numbered 4 in the qualitative review 'Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England – barriers to HIV testing'

The reviews and economic analysis are available at [insert full url]. Where 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: IDE

Recommendation 2: evidence statements E3.5a, E3.5b, IDE

Recommendation 3: evidence statements E3.5c, E3.7a, E3.7b, Q4.2, Q6.3, IDE

Recommendation 4: evidence statements E3.5b, Q5.3, Q5.4, Q6.1, Q6.2

Recommendation 5: IDE

Recommendation 6: evidence statements Q1.2, Q1.3, Q1.4, Q4.3, Q 7.1, Q7.2, Q7.3, Q7.4, IDE
**Recommendation 7:** evidence statements Q2.3, Q5.1, IDE

**Evidence statements**

Please note that the wording of some evidence statements has been altered slightly from those in the evidence review(s) to make them more consistent with each other and NICE’s standard house style.

**Evidence statement E3.5a**

There is moderate evidence from one before-and-after study (++) to suggest that the uptake of HIV testing in genitourinary medicine clinics can be increased by implementing a bookable appointment system. The study found that the proportion of HIV tests taken by new patients increased after the intervention (37.3% compared with 31.0%, p = 0.04).

This evidence is only partially applicable to black Africans in England. This is because the study was conducted before the introduction of universal opt-out HIV testing in sexual health clinics in England. Under this system patients are tested for HIV unless they specifically reject the test. Additionally, the study took place in a large clinic located in an ethnically mixed, socially deprived district in London. The evidence may not be applicable in smaller clinics or clinics in areas with a less ethnically diverse population.

**Evidence statement E 3.5b**

There is moderate evidence from one interrupted time series study (++) and one before-and-after study (+) to suggest that encouraging the routine offer of an HIV test may increase the uptake of HIV testing among migrant and minority ethnic inpatients, outpatients and those attending genitourinary medicine clinics. The interrupted time series study found that removing the need for separate signed consent documentation increased HIV testing among various ethnic and linguistic groups. Mean increase (95% confidence interval [95% CI] shown in brackets): Asian 2.80 (1.37–4.23); black 5.58 (2.11–9.04); Hispanic −1.56 (−0.49–3.61); white 5.58 (2.95–8.21); English-speaking 5.04 (2.40–7.69); Spanish-speaking −0.95 (−3.31–1.40); other primary language 2.69 (1.16–4.22). Findings from the before-and-after study showed routine offers of HIV testing to all new patients at a sexual health
clinic increased rates of HIV testing among people from sub-Saharan Africa (odds ratio 8.0, 95% CI 6.5–9.8).

This evidence is only partially applicable to black Africans in England. This is because separate signed consent is not required for HIV testing in England. Also, most sexual health clinics in England use a universal opt-out testing and the uptake among black Africans is more than 85%.

**Evidence statement E3.5c**

There is moderate evidence from one randomised controlled trial (+) that suggests that rapid HIV testing in clinical settings is acceptable to all ethnic minority groups but standard HIV testing is not. The study showed that the acceptance rate of standard testing differed across ethnic groups (black or white Hispanic 18.2% compared with black non-Hispanic 59%, p = 0.04).

This evidence is partially applicable to black Africans in England. The study was conducted in the USA using ethnic groupings not widely used in England. And, unlike in the UK, the US healthcare system is not free at the point of care. It is therefore difficult to assess whether the conclusions reached would be applicable to black and minority ethnic groups in England.

**Evidence statement E3.7a**

There is moderate evidence from one study to suggest that people who test anonymously test earlier in the course of their HIV. One retrospective cohort study (+) showed that anonymous testers received their HIV diagnosis on average 529 days earlier than those tested confidentially (p ≤ 0.001).

This evidence is partially applicable to black Africans in the UK. The study was conducted in the USA where both anonymous and confidential testing are widely available. In England anonymous HIV testing is informally available in sexual health clinics but not in hospitals or GP surgeries. It is unclear whether this context substantially mirrors the formal provision of anonymous testing available in the USA.
Evidence statement E3.7b

There is weak evidence from one study to suggest that anonymous testing is more acceptable in minority ethnic communities than named testing. One before-and-after study (−) found HIV testing rates increased from 1.6 tests per week to 11.4 tests per week when anonymous tests were offered. This increase was not shown to be statistically significant.

This evidence is not applicable to black Africans in England. The study was conducted in Australia by an Aboriginal-controlled health service providing health services to remote communities occupying ancestral homelands. This setting and political context differs considerably from the situation in England.

Evidence statement Q1.2

Two studies (both ++), one with people newly diagnosed with HIV and another with people from African communities in England, report that low visibility of HIV and lack of positive imagery increase HIV related stigma within African communities.

This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

Evidence statement Q1.3

Reluctance to undergo HIV testing because fear of racism and prejudice from outside African communities is found in three studies (two ++, one −) with key stakeholders working in sexual health and HIV research.

This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

Evidence statement Q1.4

Four studies (one ++, two +, one −) reported fear of isolation and social exclusion following HIV diagnosis as a barrier to HIV testing. Another study of patients attending a GP surgery found lack of psychosocial support as a potential disadvantage to rapid testing in primary care.
This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

**Evidence statement Q2.3**

Participants in three studies (one ++, one +, one −) with people living with HIV attending HIV clinics or HIV support groups (two with African men and women and one with African men who have sex with men) had perceived themselves to be at risk of HIV only after becoming seriously ill.

This evidence is directly applicable to black African communities in England. All studies were conducted in England with black African people.

**Evidence statement Q4.2**

Preventive, health-seeking behaviour (that is, accessing HIV testing when well) was seen an unfamiliar concept to Africans in one study (++) with key stakeholders working in sexual health and HIV among African communities in England.

This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

**Evidence statement Q4.3**

One study (++) with newly diagnosed African men and women recruited in an HIV clinic reported that the reliance on oral traditions in African societies made it difficult for migrant Africans in England to obtain appropriate information about HIV testing.

This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

**Evidence statement Q5.1**

Six studies (three ++, one +, two −) conducted with African men and women living with HIV or key stakeholders working with these communities reported that complicated pathways to genitourinary medicine clinics, for example multiple referrals from GPs, delayed HIV testing and resulted in late diagnosis.
This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

**Evidence statement Q5.3**

Four studies (three ++, one +) reported that HIV testing in sexual health clinics was seen as stigmatising, complicated and time consuming. These studies were conducted with African men and women living with newly diagnosed HIV and attending HIV clinics. Participants were recruited as part of a study examining the feasibility and acceptability of HIV testing as part of a new GP health check and with key stakeholders working in sexual health and HIV with African communities.

This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

**Evidence statement Q5.4**

Four studies (two ++, one +, one −) conducted with African men and women living with HIV attending HIV support groups or HIV clinics and key stakeholders working in sexual health and HIV found that fears of breaches in confidentiality in clinical or community-based HIV testing services deterred people from accessing these services.

This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

**Evidence statement Q6.1**

Two studies (one ++, one +) described how participants (African men and women living with HIV, attending HIV clinics or HIV support groups) had viewed opportunistic offers of HIV testing in hospital as beneficial or routine.

This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

**Evidence statement Q6.2**

HIV testing outside of genitourinary medicine clinics (for example in GP surgeries, community- or faith-based venues) was found to be acceptable in
five studies (two ++, one +, two −) conducted with people living with HIV recruited in HIV clinics and HIV support groups, key stakeholders working in sexual health and HIV, and people recruited as part of a study examining the feasibility and acceptability of HIV testing in GP surgeries as part of a new patient health check. Two studies with African men and women living with HIV and attending HIV support groups and with key stakeholders working with these communities reported joint testing in antenatal clinics as beneficial to women who may test positive but fear disclosing their HIV-positive status to their male partners.

This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

**Evidence statement Q6.3**

Three studies (one ++, one +, one −) with key stakeholders working in sexual health and HIV, and patients offered an HIV test as part of a new patient health check in a GP surgery found that rapid testing and quick access to HIV test results is seen as advantageous and accessible.

This evidence is directly applicable to black African communities in England. All studies were conducted in England and included black African people.

**Evidence statement Q7.1**

Mobilising community members to advocate about HIV testing through outreach and education programmes was identified as a potential factor in the success of HIV testing in three studies (two +, one −) with key stakeholders working in sexual health and HIV and one study with African men and women newly diagnosed with HIV and recruited from an HIV clinic.

This evidence is directly applicable to black African communities in England. All studies were conducted in England with black African people.

**Evidence statement Q7.2**

Four studies (two ++, one +, one −) (three with key stakeholders working in sexual health and HIV and one African men and women living with HIV
recruited in an HIV clinic) described HIV prevention and testing messages that target African people only as problematic and stigmatising.

This evidence is directly applicable to black African communities in England. All studies were conducted in England with black African people.

**Evidence statement Q7.3**

Two studies (one ++, one −) (one with key stakeholders working in sexual health and HIV, one with African men and women living with HIV recruited in an HIV clinic) found that there are few highly visible HIV-positive role models in England, which are needed to help breakdown the stigma associated with HIV.

This evidence is directly applicable to black African communities in England. All studies were conducted in England with black African people.

**Evidence statement Q7.4**

Two studies (one ++, one −) (one with key stakeholders working in sexual health and HIV, one with African men and women living with HIV recruited in an HIV clinic) reported that increasing the awareness of the benefits of earlier diagnosis and access to HIV medication might increase HIV testing.

This evidence is directly applicable to black African communities in England. All studies were conducted in England with black African people.

**Cost-effectiveness evidence**

Cost effectiveness is difficult to determine for interventions to prevent an infectious disease, because preventing any one case of the disease will on average prevent further transmission in the future. The estimated cost per QALY gained for finding, testing and treating someone with HIV (without including the transmission of the disease to others) is at the top end of the conventional NICE threshold. This ignores the contributions of reducing future costs of treating others to whom the disease has been passed, and also ignores the future QALYs that are gained by these people by not contracting the disease. Taking these things into account is problematic, because the
QALY gain to society is continued into the distant future, and because the far future is very uncertain. It is therefore in society’s interests to find and treat people who are currently HIV positive as rapidly as possible, to prevent disease transmission, even if the apparent short-term cost is high. To that extent, the cost per QALY of finding and treating an HIV-positive person may be estimated, but it is not of much relevance to do so.

For this guidance, the most pertinent cost per QALY is the additional cost of finding the person with HIV as soon as possible. This has been estimated to be between £300 and £1300 for different interventions.
Appendix D Gaps in the evidence

The Public Health Interventions Advisory Committee (PHIAC) identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence. These gaps are set out below.

1. High-quality studies that evaluate the effectiveness and cost effectiveness of interventions to increase the uptake of HIV testing among black African communities living in England. Of particular relevance to this guidance are:
   a) interventions that look at ways of addressing stigma associated with HIV and HIV testing among black Africans in England
   b) interventions that involve black African communities in the design and implementation
   c) assessment of ways of increasing uptake among specific black African groups for example different cultural, ethnic or faith groups or for different ages or genders.

2. Evaluation of attitudes of black African communities to opt-out testing for HIV.

3. Evidence to inform assumptions and parameterisation of economic evaluations of interventions to increase the uptake of HIV testing including:
   a) sexual behaviour of black Africans living in England before and after a positive test result
   b) indicators of transmissibility of infection based on biological markers
   c) disease progression among black Africans living in England.
4. Research examining the implementation of interventions to increase the uptake of HIV testing in black Africans in a full range of healthcare services; social care; institutional settings such as prisons and other Home Office facilities, and recreational settings.

5. Research targeting black Africans leaving sexual health services (or presenting with sexual health-related matters to other healthcare or advisory services) without HIV testing. This includes epidemiological assessment of the proportion of black Africans leaving a service without testing as well as qualitative research into reasons for declining a test and factors facilitating or acting as barriers to uptake of HIV testing.

6. Research into the effectiveness, cost effectiveness and acceptability of ‘home’ HIV testing.

7. Factors that affect the effectiveness of behavioural interventions that target individuals based on their ethnicity.
Appendix E Supporting documents

Supporting documents are available at www.nice.org.uk/guidance/insertspecificurl. These include the following.

- Evidence reviews:
  - 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’ and
  - ‘Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England - barriers to HIV testing’.

For information on how NICE public health guidance is developed, see:
