

HIV TESTING AMONG AFRICAN PEOPLE IN ENGLAND

The knowledge, the will and the power (KWP) is the National African HIV Prevention (NAHIP) Programme's strategic plan to prevent sexual HIV transmissions among African people in England. One of the aims of the plan is to reduce the length of time between HIV infection and diagnosis among African people in England.

This briefing reviews the rationale for and implementation of policies to increase HIV testing uptake among African people, and summarises *Bass Line 2008-09* findings related to HIV testing history, motivation and HIV testing need. The information contained in this briefing is intended to support provision of integrated, client-led interventions that go beyond simply directing African people to get HIV tested.

A voluntary HIV test offers those who have been at risk of acquiring HIV a means of taking control over their own health and well-being, as well as that of their sexual partners (and any children they may conceive). Those who receive an HIV negative result can gain resources to better enable them to manage sexual health risk, and to know when to consider testing again in future. Those who receive an HIV positive diagnosis can immediately benefit from high quality social and medical care, and treatment advances that mean they can lead a long and productive life. While it remains the case that free access to HIV treatment within England is sometimes restricted only to those with recourse to public funds (thereby excluding irregular migrants), decisions on such matters can differ between local service providers.

As documented by the Health Protection Agency, many people in the UK are infected with HIV for considerable periods of time before being diagnosed. In such cases, diagnosis may only occur once AIDS-defining illnesses have set in, often making it more difficult for anti-retroviral medicines to work. This problem is particularly pronounced among African people (and for African men especially). Reducing the amount of time between infection and diagnosis requires that a number of HIV prevention needs are met (see kwp.org.uk). Getting an HIV test requires that an African person knows how screening may be beneficial for them personally, that they are motivated to test by recognising that the benefits can outweigh the perceived costs of testing, and that they have the power to attend clinical services without substantial negative consequences.

EXPANDED ACCESS TO HIV TESTING

An array of structural interventions have been undertaken in order to improve access to HIV testing among those most likely to benefit. THT's fasTest community-based HIV testing service, was evaluated and was found to be acceptable to those accessing the service. More recently, a

BENEFITS OF TIMELY DIAGNOSIS

Improving health and longevity. An HIV diagnosis should enable access to high quality treatment. Those who can maintain and tolerate a stable treatment regime are now predicted to have a full life-span.

Reducing the chances of passing on HIV. Being diagnosed with HIV prompts most people to take action (such as changing the sex they have, reducing partner numbers, and using male or female condoms) to reduce the chance of transmission. In addition to these behavioural changes, people who maintain their treatment regime will have a lower and sometimes undetectable viral load (in blood plasma and/or genital fluids and mucous). This is a key element in the move towards considering 'treatment as prevention'. It is argued that among people with HIV whose viral load is undetectable, are otherwise healthy and have no other sexually transmitted infections, their risk of passing on HIV infection is greatly reduced or eliminated (see aidsmap.com). Pregnant women with diagnosed HIV can get help to reduce the chances of transmission to their child to below 1% (see aidsmap.com).

Department of Health trial of expanded healthcare and community HIV testing in hospitals, primary care and community settings demonstrated that increasing the routine offer of HIV testing in these settings is both feasible and acceptable with community settings faring the best of these three in terms of positive diagnoses – although few sites showed capacity to decrease undiagnosed HIV at a population level. The British HIV Association (BHIVA) issued guidance on expanding HIV testing in 2008, and the National Institutes for Health and Clinical Excellence (NICE) has also recently released guidance on this topic.

The Medical Foundation for AIDS & Sexual Health has undertaken a number of activities, including development of

NICE HIV TESTING RECOMMENDATIONS

The National Institutes for Health and Clinical Excellence (NICE) consulted widely during its development of 2011 guidance for the NHS on *Increasing the uptake of HIV testing among black Africans in England*. The recommendations include:

- Assessments of local need and mapping of local services.
- Development of local strategies to meet locally identified needs.
- Tailoring and targeting of interventions.
- Reducing structural barriers to HIV testing.
- Routine offer of HIV testing by all health professionals to (among others): those from a country of high HIV prevalence, those with an STI, men who have sex with men, partners of people with HIV, and those in areas where HIV prevalence is greater than 2 in 1000 people.
- Ensuring appropriate community involvement, including local African HIV testing champions.
- Ensuring clear and timely referral pathways (preferably within 48 hours of a positive result).

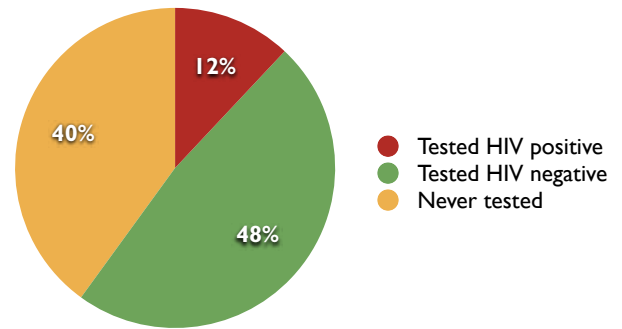
the Tackling HIV Testing toolkit, to increase the extent to which non-HIV specialist healthcare providers in general practice and aligned disciplines recognise clinical indications of risk and HIV infection, and feel confident to offer an HIV test. A coalition of stakeholders (including the African Health Policy Network) have also recently launched the Halve It campaign, setting out a five-year plan to halve the number of people diagnosed at the point when they should have already started HIV treatment, and to halve the current proportion of people with HIV who are unaware of their infection. Innovative clinic to community HIV testing programmes using rapid point-of-care tests and/or direct referral mechanisms are currently provided by a range of organisations. Beyond making HIV testing more accessible, successful interventions to increase HIV testing uptake (in clinical and community settings) will need to address a range of HIV testing needs which are discussed in the following section.

WHAT HAVE WE LEARNED FROM BASS LINE 2008-09 ABOUT...

HIV testing history

All Bass Line respondents were asked if and when a health professional had given them an HIV test result. Just under half (48%) had tested HIV negative at some time in the past. Half (51%) of those who had tested negative had done so in the previous year, including 1-in-8 (12%) who had tested negative in the previous month. Among the remainder who had tested negative, most (38%) reported having done so in the last 2-5 years.

HIV testing history in Bass Line 2008-09



About 1-in-8 (12%) of all Bass Line respondents had diagnosed HIV infection. The Health Protection Agency (HPA) has estimated a 4% prevalence of diagnosed HIV infection among Black African adults in England, therefore the proportion in our survey is about three times greater than official estimates for this population. Bass Line did not seek to establish HIV prevalence in the population, which is the role of the HPA. The high proportion of Bass Line respondents with diagnosed HIV arises because the survey over-represents African people who come into contact with NAHIP agencies and other providers of HIV prevention, treatment and care services.

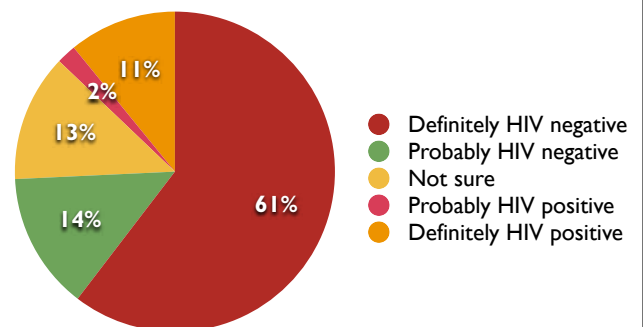
Among those completing Bass Line, two fifths (40%) had never tested for HIV. Given that the sample is mainly drawn from those within the reach of HIV prevention agencies, we can presume that this figure would be higher among those outside of their reach.

HIV status belief

Prior to the questions in the Bass Line survey on HIV testing, all respondents were asked: *What do you think your current HIV status is (whether or not you've ever tested)?* and offered the following five options: definitely negative (I don't have HIV); probably negative; not sure / don't know; probably positive; definitely positive (I do have HIV).

Three quarters of the entire Bass Line sample believed themselves to be HIV negative, including almost two-thirds (61%) who felt they were definitely negative. There was a small group who believed they were HIV positive but had

HIV status belief in Bass Line 2008-09



not been diagnosed (2% of those who had never tested and 2% of people whose last test was negative). Of similar interest are the 13% of all respondents who were unsure or did not know what their status was.

People in the two latter groups (those who believed they were positive, but had not been diagnosed, and those who were unsure of their status) will have a range of unmet HIV testing needs. However, it is unclear whether they are more or less likely to have undiagnosed HIV infection than those who are confident they are negative. In the THT community HIV testing evaluation, testers were poor at predicting the outcome of the test they were about to undertake with most of those expecting to be positive receiving a negative result, and most of those who were diagnosed positive, not expecting to be so. This finding reaffirms the value of pre-and post-test counselling to help service users prepare for and adjust to news of their result.

One of the goals of HIV prevention is to increase the extent to which people are realistically aware of the chance that they might have HIV. While many people who have never (or not recently) had an HIV test and who believe themselves to be HIV negative will be making a correct judgement about their status, those involved in sex that carries a risk of transmission need that certainty of their negative status challenged through one-to-one information and advice interventions in order to prompt them to have an HIV test.

When considering the Bass Line sample as a whole, the majority of respondents fell into two categories: those who had never tested and thought they were negative (29%) and those who had previously tested negative and who thought they were still negative (45%). It is this strong tendency to believe yourself to be HIV negative (despite not having the certainty of a recent test result) that requires challenging among many African people in England.

High levels of prevention need among those who have never tested

When comparing testing history across other HIV prevention needs within the Bass Line sample, findings demonstrate that those who had never had an HIV test had the greatest needs. Those who had never tested were least motivated, empowered, resourced, socially confident and knowledgeable about HIV. This suggests interventions intended to increase motivation, knowledge, access to resources and social confidence should disproportionately benefit those who have never tested. Men were significantly more likely than women to have never tested for HIV, and to report wanting a test but not knowing where to get one, meaning that men are in disproportionate need of interventions that support testing decision-making and increase knowledge of testing locations.

Among all those who had never tested, by far the most common reason given for not testing was *I've no reason to think I have HIV* (echoing the findings described above on HIV status belief). More than half (53%) of all people that

had never tested gave this as the main reason. The reasons given for not testing were broadly similar for men and for women (although women were more likely to report never having had sex as a reason for not testing). It was more common for homosexually active men and women to say they did not trust the places they knew where they could test, as compared to those who were exclusively heterosexual, suggesting that perceived racism or homophobia may be barriers to testing for those in this group. Fear of a positive result was highest among exclusively homosexually active African men when compared to other groups of men (which may ultimately be a realistic concern given that anal intercourse between men carries a disproportionate risk of HIV transmission).

When making comparisons by age, never having tested was most common among those under 20, and not knowing where to test for HIV was most common among the youngest age group and declined with age (each of these findings is unsurprising given that sexual and service use experience naturally increases with age). Most of the reasons given for not testing did not vary across the age range. However, fear of a positive test result prevented people in their 30s from testing much more often than other age groups, and perhaps not unrelated, this group were also most likely to say testing may cause problems in their relationship. Knowledge about HIV is lowest among the under 20s who are also most likely to be unsure about their motivation to avoid HIV and most likely to feel powerless to do so. Those who deliver HIV prevention interventions targeting young people should seek to increase their HIV knowledge and awareness of HIV testing locations.

Motivation, desire and access to HIV testing

About one-in-six (16%) of all Bass Line respondents did not know that there are HIV-medicines that help people with HIV to stay healthy, and more than one-in-three (38%) did not know that these treatments work better the earlier they are taken. Although it was a smaller proportion, about one-in-ten (11%) were unaware that people can have HIV without knowing it. These issues directly connect to HIV testing needs, given that awareness of the health benefits of testing (even in the absence of symptoms) contributes directly to the motivation to test. Furthermore, when asked if they knew that Africans are NOT deported from the UK solely because they have HIV, more than one third of Bass Line respondents (38%) did not know this to be the case. It is therefore important for people with uncertain or irregular immigration status to know that an HIV positive test result does not mean that they will be reported to the UK Border Agency or any other immigration authority. These knowledge indicators tell us that interventions aiming to increase testing uptake among black African people should certainly feature information about the relationship between immigration and HIV, as well as treatment effectiveness.

Bass Line respondents who had not tested HIV positive were asked *Would you like to take an HIV test (or another test*

if you have tested before?). The most common response was that individuals did not want to take a test (41%). More than one third (38%) said they did want to take an HIV test (or another one), while one fifth (21%) were not sure.

A desire to test was associated with people's previous experience of testing. Half of those who had already tested negative in the past (50%) were more likely to want to test again than those who had never had a test (24%). The recency of a prior test also had an effect on willingness to test again, as those who had tested negative for HIV more than five years ago were less likely to want to test again when compared to those tested within the last year. The uncertainty of the HIV testing setting and the outcomes can make a person's first HIV test the most daunting.

Encouraging regular or routine testing for those at risk requires helping people to overcome the barriers to their first test and then on a routine basis. The recent NICE guidance suggests that African people consider having an HIV test prior to intercourse with a new sexual partner.

All Bass Line respondents who were not already diagnosed with HIV, and who said they either wanted to take a test, or were unsure about it, were asked *If you wanted an HIV test, would you know where to get one?* One quarter (25%) of all these respondents said they did not know where to get an HIV test. When we place these figures into the context of the sample as a whole, a total of 12% of all respondents (approximately one-in-eight) wanted to take an HIV test (or were not sure if they wanted to) but did not know how to access one, with this need being most common among men, younger people, those with lower educational levels, those that had been living in the UK for less than one year, and among members of African traditional religions.

OVERVIEW

Access to timely, regular HIV testing and counselling provided in a range of settings is a priority for black African people in the UK. Reducing HIV prevention testing need in this population requires enabling those at greatest risk of HIV acquisition to **recognise their risk** and ensuring they have the **capacity** and **desire** to get tested. This means

enabling people to increase their knowledge, will and power.

Knowledge: about the efficacy of medicines used to treat HIV, the importance of starting medication before becoming ill, where to get a test, what will happen in a testing centre, and what further support will be available (whatever the outcome).

Will: to realistically recognise the possibility that they have been at risk, and where there is risk, to take action by having an HIV test after each potential exposure, and to believe that the benefits of knowing one's HIV status (no matter what the result) will outweigh the costs of not knowing.

Power: to possess the time and freedom of movement to attend for an HIV test, be able to access a local HIV testing service in a place and at a time that is suitable and acceptable, and to trust that accessing such a service will not result in discrimination of any sort (including racism, homophobia, or HIV-related stigma).

The principles articulated in KWP do not assert that *all* African people who have never had an HIV test should do so, or that *all* African people in England should be having an HIV test more often. The findings summarised above mean that we should be undertaking prevention interventions that address the particular HIV testing needs of individuals and groups at greatest risk of acquiring HIV. Simply telling all African people to get an HIV test is insufficient to contribute to the KWP goal of reducing the length of time between HIV infection and diagnosis among African people in England.

EXAMPLES OF INTERVENTIONS

Time2Know (T2K) is an Embrace UK integrated clinic and community HIV testing intervention. Staff work with service users to assess risk, and then assist in making fast-tracked referrals to their local hospital for HIV testing.

Staff and volunteers at Leicestershire AIDS Support (LASS) have recently produced a rapid HIV testing promotional video. The advert promotes HIV testing, without many words but with a high visual impact. The message is: *It is better to know my HIV status – now I can move on.*

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