



Findings from fieldwork on Draft NICE Intervention Guidance: Increasing the Uptake of HIV Testing Among Black Africans in England

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Abbreviations & Acronyms

A & E – Accident and Emergency Department	NAHIP – National African HIV Prevention Programme
BHIVA – British HIV Association	NHS – National Health Service
CBO – Community-Based Organisation	NICE – National Institute for Clinical Excellence
DH – Department of Health	OUK – Options UK, a subsidiary of Marie Stopes International
DPH – Director of Public Health	PCT – Primary Care Trust
FGD- Focus Group Discussion	PLHIV – People Living with HIV
GP – General Practitioner	POCT – Point of Care Testing
GU – Genito-Urinary Medicine	SHA – Strategic Health Authority
HIV – Human Immunodeficiency Virus	SHNA – Sexual Health Needs Assessment
HPA – Health Protection Agency	STI – Sexual Transmitted Infections
IDI – In-depth interview	SOPHID – Survey of Prevalent HIV Infections and Diagnoses
JSNA – Joint Strategic Needs Assessment	UCL – University College London
LARC – Long Acting Reversible Contraceptives	UK – United Kingdom
MESH – Migration Ethnicity and Sexual Health Programme	

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Executive Summary

The Centre for Public Health Excellence at the National Institute for Clinical Excellence developed draft guidance on *Increasing the Uptake of HIV Testing Among Black Africans in England*. The Centre for Sexual Health & HIV Research at University College London, in partnership with Options UK, were commissioned to test the usability and applicability of the draft guidance among those involved with HIV testing for Black Africans living in the UK.

Fieldwork Design

The fieldwork involved qualitative interviews and participative group discussions. The qualitative work took place in London, the West Midlands and the South Coast of England. The following took place:

- 30 telephone interviews
- 5 participative group discussions with a total of 39 respondents

The Recommendations

Recommendation 1 (Planning Services): Most respondents felt that this was a useful and useable recommendation, with a high feasibility of being implemented. Concerns raised about the feasibility of this recommendation included conducting a needs assessment if relevant public health staff were not available, and the relative prioritization of HIV among competing health issues. A needs assessment would be harder to conduct and justify in areas of smaller populations of Black Africans.

Recommendation 2 (HIV Testing Provision and Referral Pathways): Many respondents felt that this recommendation was feasible and practical, and could act as a driver for streamlining flow. Clear pathways were essential for gaining the confidence of providers to offer HIV testing. Some respondents felt that Recommendation supported a move towards 'normalization' of access to HIV testing. There was a lack of clarity over whether this recommendation fully endorsed HIV testing in community-based facilities or not.

Recommendation 3 (Promoting HIV testing and reducing Barriers): Many respondents welcomed the move towards opt out HIV testing as a way to 'move (HIV testing) forward'. However, some respondents said that specific training in cultural awareness was unfeasible. Many practitioners felt that the provision of anonymous testing was unfeasible and that the provision of rapid and/or less invasive tests had logistical and financial implications. There was strong support for the inclusion of health promotion, with some concerns that health promotion materials should not stigmatize Black Africans.

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Recommendation 4 (Providing HIV Testing outside of Sexual Health Settings): Overall, the recommendation aroused strong reactions from many respondents, who felt that some aspects of Recommendation 4 were discriminatory, and were based on racial, and not epidemiological assumptions. There was strong support for offering HIV testing to male partners of women attending ante-natal care, and varied support for other aspects of the recommendation (GPs routinely offering HIV testing, and all health practitioners taking bloods also testing for HIV).

Recommendation 5 (Training): Some respondents felt that this was an essential recommendation, and that the Guidance was only implementable with an investment in training. However, health practitioners noted the high training burden, and overall, felt that the training outlined risked being perceived to be unfeasible.

Recommendation 6 (Community Engagement): There was wide consensus that community approach was critical to the implementation of the Guidance, in order to address the risk that it would be seen as discriminatory.

Importance of the Recommendations

Many respondents felt that the recommendations came as an integrated package, and were difficult to rank. In those rankings that were conducted, Recommendations 1, 5 & 6 were prioritised. However, there were some strong divergences in the prioritization of the recommendations, with many health practitioners seeing Recommendation 4 as the most important. There was broad consensus that Recommendation Six on 'Community Engagement' was of pivotal importance and that implementation of the Guidance relied on the successful incorporation of this recommendation.

Barriers to Implementing the Guidance

- Provider attitudes (if HIV continued to be seen as a 'specialised' service and was not 'normalized')
- The state of change in the NHS
- The risk of stigmatization of Black Africans and reactions against the Guidance if it was seen as being stigmatizing
- The burden of implementation of the Guidance
- The financial implications of the Guidance

Suggestions for Improving the Guidance

- More integration of the 'community engagement' approach throughout the guidance
- Making the document more readable
- Better contextualisation of the guidance
- Better contextualisation of 'risk'

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- Better links to the evidence base
- Better links into existing initiatives
- Provision of toolkits
- Use of language
- Balancing the focus of the guidance

Conclusions

The respondents in the fieldwork recognized and welcomed the NICE Guidance on increasing the uptake of HIV testing. Some health practitioners and policy analysts recognised that this validated the BHIVA (2008) guidelines. For many, this represented a shift towards 'normalizing' access to HIV testing, which was what was needed to ultimately increase the uptake of HIV testing.

There was a strong divergence of views on whether the Guidance could and should adopt a 'targeting' approach to HIV testing among Black Africans, with some arguing that there was a deep public health need and others stating that this was discriminatory. There were strong advocates of both viewpoints across the range of occupational groups who engaged in the fieldwork.

1. 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.

This report presents the key findings related to the fieldwork to test the Draft Guidance (in terms of its usability and applicability) among key professional groups related to HIV.

2. Fieldwork Team

This report is a collaboration between University College London (UCL)'s Research Department of Infection and Population Health, and Options UK.

UCL has an international academic reputation. The Centre for Sexual Health and HIV Research within the Research Department of Infection and Population Health houses the Migration Ethnicity and Sexual Health (MESH) Programme which delivers high quality research on, and training in, sexual health associated with migrant and ethnic minority communities in the UK and Europe. Options UK is a leading provider of international technical assistance, consultancy and management services in the health and social care sectors. In 2007 Options UK (then known as 'Design Options') was commissioned by the Department of Health to produce *Sexual Health Needs Assessments (SHNA): A 'How To Guide'*. Options UK brings a solid understanding of the sexual health and HIV service environment, the specific needs of those accessing these services and the range of service models and approaches to HIV testing.

3. Fieldwork Aims and Objectives

The objectives of the fieldwork were:

1. To examine the relevance, usability, acceptability, and implementability of the NICE draft guidance, in particular the recommendations.
2. To consider the views of those working in the field in relation to the following:

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- a. The relevance and usefulness of the guidance/recommendations to current work and practice. Which of the recommendations are both feasible and likely to make a difference to practice?
- b. What are the potential consequences of the guidance/recommendations for improving health and tackling health inequalities?
- c. What is the potential impact of the guidance/recommendations on current policy, service provision or practice?
- d. What factors (e.g. time available, training) could impact - positively or negatively - on the implementation and delivery of the guidance/recommendations?
- e. What would be the relative priority of each of the recommendations?

4. Fieldwork Design

The methods employed were qualitative in nature. This approach was adopted to allow for individuals' views and experiences to be explored in detail. Qualitative methods neither seek, nor allow, data to be given on the numbers of people holding a particular view nor having a particular set of experiences. The aim of qualitative research is to define and describe the range of emergent issues and explore their linkages, rather than to measure their extent.

In order to gain the views and insights from those who would be implementing the Guidance in practice, the fieldwork used in-depth interviewing (IDI) and focus group discussions (FGD) to discuss the Guidance. Respondents were purposively sampled to reflect the range of professional groups working with Black Africans and efforts to tackle HIV in England. In-depth interviews were conducted on the phone, due to time and financial constraints.

4.1. *Specialist Interest FGD*

Two FGDs were planned for two groups of stakeholders with a specialist interest in HIV testing among African communities in England – with the National African HIV Prevention Programme (NAHIP) and Ffena.

NAHIP is a partnership of community-based organisations delivering sexual health and HIV prevention interventions across England. NAHIP is funded by the Department of Health (DH) and managed by the African HIV Policy Network (AHPN). In 2010, NAHIP

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organisations aimed to deliver a small and mass media HIV testing outreach campaign targeted at Africans living in England. Because of their unique and extensive experiences working directly with African communities a focus group discussion for NAHIP partners only was planned to take place in London.

Ffena is a scheme run by the African HIV Policy Network that enables views, voices and experiences of Africans in the UK living with and affected by HIV. The aim of the programme is to provide and contribute service users' perspectives on strategies, research and policy through service-user involvement activities. As with the NAHIP organisations, Ffena members' unique and exceptional insight into the feasibility and acceptability of the NICE guidance and recommendations was sought in a specialist FGD in London.

4.2. Recruitment of Participants

The fieldworkers aimed to recruit 20-30 participants for IDIs and 22-32 participants for the FGDs. The fieldworkers aimed to recruit 20-30 participants for IDIs, up to 32 participants for the four FGDs and a maximum of 50 participants for the two specialist FGD. To recruit, UCL/Options UK developed a sampling frame of key individuals across the South East of England, Greater London and North East of England (please see Appendix A for a full sample breakdown). This was done by contacting organisations for details of relevant personnel, and contacting those who were likely to be involved with, or working in the field of sexual health, HIV, and Black African communities. In addition, the African HIV Policy Network were asked to advertise and recruit individuals for the two specialist FGD.

The recruitment of participants was supervised by the Technical Lead from Options UK who has extensive experience working in the field of HIV and sexual health. A dedicated recruiter contacted potential participants. Each potential respondent (for FGDs, specialist FGD and IDIs) was emailed an invitation letter outlining details of the research (please see Appendix B), which was followed up with a telephone call from the Options UK recruiter, to set up an interview date. If agreeable the respondent, was emailed an introductory letter, and the Draft Guidance once this was available (it was published on the 27th September 2010).

4.3. Geographical Selection of Participants

Three geographical areas were purposively selected for the fieldwork focus group discussions. These were the Strategic Health Authorities (SHAs) of London (North and South), West Midlands and the South Coast of England. These areas were selected in order to provide geographical representation across England and in order to represent a range of high and low HIV prevalence areas and high and low prevalence areas of Black African residents.

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The prevalence of HIV in each Primary Care Trust (PCT) within the chosen SHAs was mapped using SOPHID data¹ from the Health Protection Agency. Within each FGD, where possible, participants were selected from PCTs with high prevalence (more than 2 people living with diagnosed HIV infection per 1000 population aged 15-59) and areas of low prevalence (less than 1 person living with diagnosed HIV infection per 1000 population). The geographical areas were selected to explore differences of views in high/low areas of prevalence, as well as in areas of high (London and West Midlands) and low (South East Coast) densities of Black African populations.

In order to increase the coverage of the fieldwork and gather views from across England, participants for the in-depth interviews were selected from seven SHAs across England (see Table 1). In-depth interviews were used as a method in order to include the views of those who may be more difficult to recruit to participate in FGDs. As with the FGDs these areas were selected to explore views in areas with differing HIV prevalence and densities of black African communities.

Table 1. Targeted Participants for IDIs by SHA across England

Strategic Health Authority	Number of Target Participants
London	10
North East	4
North West	4
West Midlands	5
South East Coast	2
South West	2
East Midlands	3
Total	30

4.4. Conduct of the Interviews and Group Discussions

The FGD/IDI guide was developed by the research team, with input from the NICE research team (see Appendix D). The guide was slightly amended following the first FGD, which was observed by the NICE research team, to clarify certain topics.

¹ Survey of Prevalent HIV Infections Diagnosed (SOPHID) began in 1995 and is a cross-sectional survey of all individuals with diagnosed HIV infection who attend for HIV-related care within the NHS in England, Wales, and Northern Ireland (E, W & NI) within a calendar year.

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Trained qualitative researchers, experienced in conducting participatory research to explore experiences and views in-depth, conducted all interviews and FGDs. Focus group discussions were conducted with mixed groups of professionals, including sexual health service providers/commissioners, health staff from other professional groups (community-based pharmacists, midwives, health promotion staff, General Practitioners), members of health advocacy/support organisations, HIV policy and public health analysts and lay members. In all interviews and FGD, the purpose and process of the research was explained at the beginning of the interview. Participants were re-assured anonymity (verbatim quotes in this report will not use personal identifiers) to ensure full participation. It was understood that this topic was extremely sensitive, and that it was important for the validity of research findings that participants felt confident that anonymity would be assured. All participants gave consent for participation and recording of the interviews at the start.

Apart from one, all interviews were recorded and transcribed verbatim, and sent to respondents to check for accuracy. In the one case where consent was not given for recording, the interviewer took notes and sent these to the respondent to check for accuracy. All participatory FGDs were attended by a researcher and a note-taker to back-up the recordings and transcription in case of poor recording quality.

4.5. Numbers of Interviews and Groups

A total of 30 in-depth interviews were conducted. Four FGDs and one specialist FGD were conducted (three in London, one in the South-East, one in Birmingham). A total of 39 people attended FGD. Due to delays in issuing the Guidance, the NAHIP FGD did not take place as planned. Instead NAHIP delivery organisations were invited to participate in the other FGD that took place (see Appendix A for the sample breakdown).

4.6. The Analysis of Qualitative Material

This report is based on the themes and issues arising from the analysis of the qualitative data from the interviews and group discussions. Verbatim quotations are used throughout the report to illustrate points being made, and where relevant, attributed to those from a professional grouping.

Analysis of the qualitative material was done using thematic analysis. The lead researchers de-briefed after each workshop, to identify emerging themes, and areas that needed further exploration across professional groups included in the research. Debriefings were ongoing throughout the research.

At the end of the data collection, the research authors immersed themselves in the data, and themed the data. A sub-sample of interviews was shared across researchers from UCL and

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Options UK, to cross check and validate the themes. All of the transcripts were then coded, and blind coded by a separate researcher to check for consistency.

The analysis then explored the themes, seeking to establish patterns of agreement and congruence between different respondents, and ascertain the implications for views on the Guidance.

The report was written by a lead researcher from Options UK, and was reviewed and quality assured by researchers from UCL.

4.7. Report Outline

The results of the fieldwork are presented in relation to each Recommendation, considered in turn. Respondents' views on the whole Guidance is then considered from Section 7 onwards, finishing with Conclusions in Section 13. A summary box is included in each section to highlight the key messages for consideration.

5. Recommendations

5.1. Recommendation 1: Planning Services

Target Audience

In the FGDs, respondents felt that in the current flux of the NHS, there was a lack of clarity of whose (financial) responsibility it would be to lead on this recommendation. Many respondents felt that the local authority would have greater involvement in public health in the future and should be included in the target audience.

In some groups, there was agreement that action should be 'planned in partnership' and that local organisations/user groups should be involved but not lead the action. However, others (including respondents from community based organisation) wanted to see a clearer role for local organisations in the development of plans and strategies, through a 'dual ownership' model.

“There needs to be local ownership by the organisations. And I think later on I will indicate why so many initiatives which are promoting testing are failing. So yes, basically these are brilliant but it’s just that I think there needs to be African organisations taking a lead, ownership in what they are doing. And when we do that, issues like stigma actually starts to get addressed from the start.” *IDI, Community based organisation (CBO) representative, London*

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There was strong agreement that the Director of Public Health (DPH) should be included in the target audience. It was felt the DPH would be likely to be present in multi-stakeholder forums (such as local sexual health networks) to link planning in with wider agencies with a remit to work with local Black African communities. The anticipated link between the DPH and the local authority was seen as an opportunity by some respondents, and a risk by others. Some respondents underlined the need for a 'shared vision' of HIV testing in local areas, and that would need to bridge the (currently widening) gap between the local authority and public health on one side, and the NHS on the other.

There was a debate and a lack of consensus on whether the term 'commissioner' was sufficiently broad enough to encompass the range of commissioners that would need to be involved in implementing the Guidance (not just sexual health commissioners, but also Chief Executives in Acute Trusts, and other outpatient services would be argued to have a relevant role), but specific enough to become someone's responsibility.

Feasibility and Acceptability

Most respondents felt that this was a useful and useable recommendation, with a high feasibility of being implemented.

Some respondents felt that this recommendation supported a 'proper' commissioning cycle and appropriate commissioning standards, and would lead to a more strategic approach to HIV testing in local economies.

Provider respondents expressed a concern about the availability of staff to conduct the needs assessment, with the flux in the NHS, including the impending dissolution of PCTs. Some provider and commissioner respondents emphasized that the informational requirements of the needs assessment should be easy and quick to fulfil.

**"You should be able to find information, crudely put, in less than two hours",
Commissioner, FGD, London**

"I don't think that this should be somebody's job for the next 2 years. It should be quick and dirty", IDI, Health Practitioner, London

In one FGD, participants felt that the most relevant and insightful part of the needs assessment was the qualitative user engagement with communities, which allowed for effective targeting. Several respondents felt that this aspect of the needs assessment would also create links with CBOs and leaders, who could then become engaged in a dialogue about the need to promote HIV testing.

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It was noted that in some areas, demographic information would not adequately break down different African populations, thus information about their composition would be hard to obtain. This appeared to be the case in areas with smaller Black African populations, or in areas of greater population mobility (such as areas with a high concentration of service industries and short-term workers). Some respondents highlighted that this information would likely be gathered with involvement from local community groups.

A few respondents noted that there will be a differential pattern of HIV prevalence among different Black African communities as these vary enormously, but that collecting this information may be hard in some areas. Ethnicity may be recorded within a broad category ('Black Africans') and often does not disaggregate to specific country-specific or ethnic Black African populations (such as Somali Africans) in areas of low population densities. HIV prevalence may vary according to country of origin which may not be apparent through routinely collected data in an area.

Clarification was felt to be needed in one FGD about gathering information on 'those less likely to use services', which they said may be difficult to obtain.

"I'm not sure where you're going to get access to the information on the black African communities, who are those less likely to access services...it sounds, but I'm not quite sure how you're going to get that data, or what that really means in a practical point of view", Sexual Health Practitioner FGD, London

A few respondents noted the need for strategic engagement of other public health bodies, such as the Health Protection Agency (HPA), so that local data is available e.g. SOPHID²

Some respondents particularly felt that understanding the needs of specific social (and not ethnic/racial) groupings needed to be mentioned in Recommendation 1, especially those of asylum seekers, failed asylum seekers and refugees, who may be less likely to access health care services, due to fears about the repercussions and lack of knowledge about their entitlement to access services.

A few respondents also felt that the needs assessment needed to detail what support and treatment services were available, as a key part of a strategy to promote testing.

² The Survey of Prevalent HIV Infections Diagnosed (SOPHID) is conducted by the Health Protection Agency (HPA) and is a cross-sectional survey of all individuals with diagnosed HIV infection who attend for HIV-related care within the NHS in England, Wales, and Northern Ireland within a calendar year. It can give a more accurate picture of prevalence of people diagnosed and living with HIV in an area, as it counts those who access care 'out of area'. Complete data on prevalence would not be available from local testing services alone.

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Some respondents highlighted the lack of documentation on effective strategies to increase the uptake of testing that could be adapted to local areas. A few respondents commented on the paucity of evaluation of initiatives, and the need to encourage local stakeholders to pilot new approaches and develop the evidence-base on 'what worked'. This needed to be planned into local strategies.

A few respondents felt that the needs assessment could include an economic analysis of the financial implications of patterns of late diagnosis, and this would act as a catalyst and incentive for local commissioners to develop testing strategies.

“I think that there needs to be a cost argument as to why it makes sense to increase early diagnosis”, IDI, Policy/Public Health Analyst

There was a consistent concern throughout the Guidance over targeting of Black Africans, which was also apparent in discussions on Recommendation 1.

“So I'm not sure that it would be the best idea in every area to have a local strategy just focusing on Black African communities. I think there is probably should be... each area should have a local strategy for increasing HIV testing amongst those at high risk”, IDI, Commissioner, North-East SHA

“It could make them feel special or it could make them feel got at”, IDI, Sexual Health Practitioner, London

Some respondents, especially those in CBOs, felt that the recommendation did not recognize that local voluntary/community-based organisations would have more experience, local knowledge and information about local Black African communities, and thus would be more able to contribute to a needs assessment than a DPH.

A few respondents mentioned that the requirement for a needs assessment in the Guidance could introduce a risk that local health organisations would not initiate responses as they had not conducted a needs assessment:

“If you haven't got the resources to do a needs assessment that doesn't mean that you shouldn't offer HIV testing routinely in primary care, or whatever, so I think the main thing is about making sure the services are happening and joining up people with the services”, IDI, CBO Representative, North-East SHA

Factors Affecting Feasibility

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Two main issues were raised in relation to the feasibility of implementing the recommendation:

- Capacity to implement (workforce availability)
- Competing priorities for public health

The feasibility of the recommendation was mainly felt to hinge on the availability of a public health workforce, which many respondents felt was being rapidly undermined. The current confusion and lack of clarity about the future configuration on the NHS (and specifically public health) was felt by many to limit the feasibility of this recommendation.

Some highlighted the future emergence of GP consortia as commissioners as a risk for the implementation of the Guidance, and questioned whether GPs would view increasing testing for HIV as being a high priority among competing priorities:

“If there is going to be commissioning from groups of GPs then, who may not even know that there are HIV-positive patients in their cohort of patients or may not appreciate the level of HIV in any given community, or potential HIV, then I think taking this action would be more difficult”, IDI, Sexual Health Practitioner, London

Applicability

In areas of smaller populations of Black Africans, it was felt by some respondents that aspects of the needs assessment would be difficult to implement, “you are really looking at individual cases rather than prevalence and incidence. It’s a completely different concept”.

In areas with smaller populations of Black Africans and/or lower prevalence of HIV, it was felt that HIV testing among Black Africans would compete for attention and risk not being prioritized. Third sector/ community representatives may be more available in higher prevalence (most often urban) areas, and conversely less available in lower prevalence (most often rural) areas.

In areas of high HIV prevalence, local commissioners have developed strategies in response to late diagnosis. For example, the London Sexual Health Programme in collaboration with the Health Protection Agency have developed a late diagnosis target for London PCTs.³ A few respondents said this may not be the case in other areas and that consequently, the strength of motivation to address this issue may be less.

³ www.londonsexualhealth.org/documents-resources

Summary of Recommendation 1

- Most respondents felt that this was a useful and useable recommendation, with a high feasibility of being implemented.
- Concerns raised about the feasibility of this recommendation included conducting a needs assessment if relevant public health staff were not available, and the relative prioritization of HIV among competing health issues. A needs assessment would be harder to conduct and justify in areas of smaller populations of Black Africans.

Suggestions for Improving the Usability of Recommendation 1

- Many respondents felt that the target audience needed to be expanded to include local authorities. Some respondents advocated the strategic involvement of providers, not in conducting the needs assessment but in the development of a local testing strategy. This was particularly relevant to GP consortia, which some respondents felt would not view themselves as 'having a remit for sexual health', but whose involvement was crucial.
- A few respondents felt that the needs assessment would be more useful if it provided information on social networks and channels of communication that can be used to effectively engage and target Black Africans in a local area, "I just think that there are some things that we're missing, tricks that we are missing, that we really need to look at; how information is passed through the African communities".
- Several respondents said that estimating uptake of testing (especially in 'opt-out' settings) and testing patterns (disaggregated by age/sex among different groups and site of testing) among Black African populations (available from local laboratory data) would give useful, relevant information on the pattern of late diagnosis. Information on new diagnoses of HIV would be easier to obtain than estimations of incidence (number of new infections).
- In several FGDs, respondents felt that a toolkit, linking to sources of data (such as the health observatories, and the HPA), would be useful and necessary, targeted at a wide audience.

5.2. Recommendation 2: HIV Testing Provision and Referral Pathways

Target Audience

There was consensus across respondents that the DPH and 'commissioners' were the correct people to take action. As with Recommendation 1, there was a concern that the target audience did not reflect the range of providers and commissioners who would be needed to

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respond to the Guidance, particularly provider groups, such as primary care and acute settings.

In some FGDs, there was a concern that the target audience did not adequately reflect the drive to push testing into a wider range of settings, including community-based initiatives. There was agreement that other agencies, such as the local authority, needed to be mentioned. A few respondents felt that the voluntary and third sector could play a greater role, especially for 'hard to reach' groups such as asylum seekers/refugees.

As for Recommendation 1, 'community engagement' was seen as crucial and CBOs advocated that they should be included in the target audience.

Feasibility and Acceptability

Feasibility of implementing the recommendation was felt to be medium to high.

Many respondents felt that the recommendation was a useable and highly feasible one. In areas where patient pathways were unclear, the recommendation could act as a driver for streamlining patient flow.

Clear referral pathways into specialist HIV services and social support were felt by many to increase provider acceptability and thus increase access to HIV testing. Many respondents remarked that this was a recommendation that was already being acted on (especially in higher prevalence areas) and was regarded as general good practice for all groups accessing HIV testing.

A few respondents felt that the recognition of the BHIVA Guidelines (2008) in the recommendation was immensely important for the shift towards 'normalizing' access to HIV testing:

"It's the first endorsement effectively of the BHIVA testing guidelines from a statutory health body, NICE, and so I think it's immensely important and valuable."

IDI, Policy/Public Health Analyst, London

In terms of the action outlined, the mention of increasing accessibility to testing services was welcomed as useful by respondents.

There was an apparent lack of clarity about whether Recommendation 2 fully endorsed testing in community-based sites or not. Some respondents felt that availability in 'other venues' did represent an endorsement, but others felt that this was not clear enough, and

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needed more emphasis. Several respondents noted that testing sites focused primarily on NHS settings.

In one FGD and several in-depth interviews, respondents felt that referral pathways from community-settings into specialized services were more liable to be unclear, and that thus the recommendation should address this issue, "because they're not bits of the NHS, so we really need to make sure we get them right". A few respondents felt that there was a prevailing perception that community-based testing provision was not feasible, but that the success of the drive to make HIV testing more accessible needed to address this issue, and endorse a move into the community.

There was a debate in several FGDs about the importance of applying and enacting quality standards in community-based settings, principally with regards to maintaining confidentiality. Specific examples cited included rapid point of care (POC) testing for HIV in public areas, where a negative result would become quickly apparent. In these discussions, CBO respondents clearly viewed these initiatives as being valuable, especially in reaching 'hard-to-reach' groups who may not be in contact with the health services (such as Black African men or failed asylum seekers). However, they felt that these concerns should be addressed in the Guidance.

Many respondents felt that this recommendation implied a level of training and regular updating of a wide range of staff, which may be limited by the availability of resources, especially pushing for HIV testing to be made 'available in a range of settings' (see Recommendation 4 for further details on this theme).

A few respondents with experience of trialling community-based testing initiatives felt that integrating testing into a wider range of health screening packages had been found to be a more effective approach, and strongly advocated that testing should not be only be available but also integrated. Some clinicians and CBO respondents, for instance, pointed out the strategic advantage of integrating HIV testing into ante-natal screening:

"People who are going for antenatal services, and then when they go there and they offer them an HIV test as well, when they come out, people will not think that [they have been tested for] HIV, because that's an antenatal clinic, and [there are] other services as well, so when it's integrated, it's part and parcel of some of the routine services", Health Practitioner, FGD, London

Many respondents felt that referral of a person with a positive result was feasible within 48 hours. Some provider/commissioner respondents also felt that a maximum of two weeks for referrals was too long for client to have not accessed HIV specialist services, and that referral

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to health support staff (such as health advisers) would be feasible within a much shorter time span.

Many respondents, especially those in CBOs, were highly supportive of having post-test interventions, especially around safer sex advice, and viewed this as an important time for risk reduction interventions. However, a few respondents also felt that this put an additional burden on health staff time, and that post-test interventions for those with a negative test result went beyond what was required by the BHIVA (2008) guidelines.

Sexual health clinicians often supported the view that a more effective approach would be to increase access to testing, rather than burdening clinicians' time with requirements for post-test interventions. In GU settings, current practice is moving away from a personal-contact results system to more technologically advanced methods (for instance, through texting results). It would be difficult to reconcile such methods with the need to give post-test interventions. Some also questioned the effectiveness of this approach:

"So, two minutes spent with someone after their HIV test and always use a condom, and I might as well talk to a parking attendant, so I think it's highly unnecessary. The key thing to find is the testing", *Sexual Health Practitioner, FGD, London*

In one FGD, respondents also specified that this was less applicable in settings where pressures on clinical time were greater, such as acute and A&E settings:

"If you raise the bar for testing so high, [there is a risk] that people say they can't do it", *Sexual Health Practitioner FGD, London*

"I think obviously if it's got a positive result then obviously you do offer more intervention. But if it's got a negative test result, I think to offer that intervention would take up an awful, once again, a lot of time. With every consultation we talk about using condoms, but it's nothing extra if you know what I mean? I don't know if you're saying, everybody should see a health advisor, for instance, there, and I think that would be impractical", *IDI, Sexual Health Practitioner, West Midlands SHA*

Conversely, CBO respondents were more likely to support the view that post-test interventions were needed for those with a negative test result, as a valuable opportunity for post-test interventions.

A few respondents also felt that the referral pathways should specifically mention:

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- referral pathways that could link people into full sexually transmitted infection (STI) screens, and
- partner notification - an important intervention for reducing onward transmission.

In several FGDs and some in-depth interviews, it was strongly felt that clarification on referral pathways for those who had difficulties with immigration status was needed. A few respondents felt it was unethical to offer testing pathways without specifying whether treatment would be available:

**"It takes me back to the old time in Africa, where you were tested and told, that's it",
CBO Representative, FGD, London**

These respondents questioned whether people would be motivated to test by knowing their status alone without the certainty of access to treatment, and that this approach was unlikely to be successful.

In one FGD, it was noted that social support groups for people living with HIV (PLHIV) are currently being cut back, and that these may not always be available. One FGD respondent talked about initiatives to train mainstream service providers (such as social workers and home carers) on social support for PLHIV, and that 'social support' may not come from groups, but from mainstream services.

Several respondents noted that, due to high levels of stigma in Black African communities, PLHIV sometimes opted for one-to-one rather than group support.

One GP respondent felt that there was a mixed message for GPs in the Guidance, specifically in that they were asked to refer those with a positive result on to specialist HIV services within 48 hours:

This was felt to run counter to the prevailing push for GPs to assume greater responsibility for routine management of HIV. Guidance on referral pathways needed to emphasize the message to (primary care) providers that the management of HIV was 'normal' chronic disease management:

**"What message is that giving GPs about their involvement in HIV care?" IDI, GP,
London**

"From a GP's point of view is that (referral timelines for those with a positive result are) wildly different from any of the other urgent and non-urgent systems that are in place, and it's a bit stupid. We need to be normalizing HIV", IDI, GP, London

Factors Affecting Feasibility

Factors affecting the feasibility of implementing the recommendation included:

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- The need for training and skilling up staff in wider settings
- Post-test interventions for negative test results were felt by some to imply a substantial burden on staff time, or the need to resource more staff posts (for instance, for health advisors), and thus made the recommendation less feasible. However, CBO respondents strongly supported focusing on post-test interventions.

Applicability

In areas of less ethnic mix, or with smaller populations of Black Africans it was felt that community-based testing initiatives would be less feasible, as community venues specifically for use by Black Africans might not be available, and could re-enforce stigma. Additionally, support groups would be less available in more rural areas, but more widely, resources for social support are being cut back and becoming less available.

Summary of Recommendation 2

- Many respondents felt that this recommendation was feasible and practical, and could act as a driver for streamlining flow.
- Clear pathways were essential for gaining the confidence of providers to offer HIV testing.
- Some respondents felt that Recommendation supported a move towards 'normalization' of access to HIV testing.
- There was a lack of clarity over whether this recommendation fully endorsed HIV testing in community-based facilities or not.

Suggestions for Improving the Usability of Recommendation 2

- Some respondents felt that case studies of referral pathways that can be adapted to the local context would be useful.
- Case studies of 'what works' in terms of HIV testing provision, linked to a clear evidence-base (especially regarding community-based testing initiatives).
- Clarification on community-based testing and how to apply standards to those (including on maintaining confidentiality and clinical governance).

5.3. Recommendation 3: Promoting HIV Testing and Reducing Barriers

Target Audience

Most respondents felt that this was the correct target audience, and welcomed the wide range of stakeholders who were mentioned.

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A few respondents felt that the term 'primary care' should specify that it applied to GPs and community pharmacies, as the latter was currently playing a wider role in testing initiatives, and was an first point of contact for those who were not in contact with other health services.

Some respondents noted that providers were included, and that this meant that they would be responsible to initiating implementation of the Guidance, without necessarily having a drive to do so from commissioners. A few respondents felt that African communities themselves should be mentioned, rather than 'those responsible' for them.

Feasibility and Acceptability

This Recommendation encompasses two distinct themes: i) Ensuring Testing Services, and; ii) Promotion of HIV Services. This section will consider the feasibility and acceptability of these in turn. The feasibility of implementing the recommendation was overall felt to be medium to high.

i) Ensuring HIV Testing Services

There were debates in several FGDs and in-depth interviews about the requirement for training and awareness of "cultural and sensitive issues" for Black African communities. Some providers and commissioners felt that this recommendation was unrealistic, and that staff should have a broad, general awareness of culture and diversity for different ethnic groups, rather than specific awareness of issues for a single group (see Recommendation 5).

Respondents working in settings where there were pressures on their time (such as primary care, or A&E) felt that providers would be even less likely to be able to have the time to access this kind of training, and that this presented a risk that HIV testing would not be initiated.

"[If] you are saying people need to be trained, and it will stop in its tracks. Absolute tracks, you won't get it done", *Sexual Health Practitioner, FGD, London*

Many respondents welcomed the inclusion of an 'opt-out' policy, and there was general agreement that it is 'the way to go' and would result in better uptake. However, some GU respondents felt that it was not always clear to staff in other healthcare settings what 'opt-out' testing was, and how it could be practically applied to their work setting.

"That's very important. The people... from whatever profession they're from, whatever profession they're from, however experienced they are, however high up, the two questions they always ask me is, 'what do I say and what do I do?...' They don't know what to say, and those methods are really important, the script, just one line. People don't understand the concept of opt-out testing, and don't blame them", *Sexual Health Practitioner, FGD, London*

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Some respondents also felt that 'opt-out' testing was difficult to apply in some settings, including GP practices and acute settings. Concerns were raised in several FGDs and some IDIs that 'opt-out' policies in pressurized settings (such as A&E) may result in less informed consent (see discussion of Recommendation 4).

There was clear divergence in opinions about the inclusion of rapid and less invasive forms of testing. Some respondents from CBOs noted that these were clearly preferred and demanded by patients. Several commissioners also felt that there was a need to provide these to clients who would not routinely access other forms of testing.

However, some clinician respondents felt that rapid tests were not appropriate to all settings, For instance, in one group respondents felt that rapid tests were highly appropriate to provision of testing in pharmacies, but inappropriate to primary care. and that rapid testing could affect the client's ability to absorb post-test information. A few respondents called for more evidence and clarity from the Guidance regarding which settings were most appropriate for rapid testing:

“Rapid testing may not be available in a lot of places, but I think the [DH] pilot could use that just to see what the evidence is behind that and whether that can again put more flesh on the bones regarding that and what kind of settings that’s acceptable and provides the best results really”, IDI, Policy/Public Health Analyst

In GU settings, some practitioners felt that less invasive and rapid tests were less practical, due to their high unit cost and relative inaccuracy (compared to serum tests). In practice, many GU departments had chosen not to provide these tests. Some GU and other practitioners also felt that demand for less invasive tests would be low, thus that there were implications on maintaining stock and that this would increase the overall unit price.

Some practitioners across a range of practitioner groups wanted the recommendation to be site-specific on the range of tests offered – for example, in lower prevalence areas where demand for testing is low, serum tests should be recommended. This was a reflection that lower prevalence areas may face logistical challenges (maintaining stock of rapid/less invasive tests), or of maintaining practitioner skills, "you certainly don't want to be using an unreliable test in a low prevalence area by people who are minimally trained". Conversely in high prevalence areas (or where demand was high), POC testing would be more appropriate, including settings such as community pharmacies.

There were substantial debates about anonymous testing in most of the FGDs. There was confusion over what was meant by the term 'anonymous testing', with some believing that this entailed testing without results being communicated (for surveillance purposes).

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Some CBOs and some respondents recognized the need for anonymous testing services, especially for those groups who were less likely to test, or who were not linked with formal health services (such as undocumented migrants). Providing anonymous testing would increase opportunities to test but could impact negatively on prevention due to the risk of lack of follow up of those who tested positive.

It was commonly perceived that GU offered 'anonymous' testing, and for instance, that GPs could refer clients there if they had concerns over confidentiality. However, GU practitioners clarified that they offered 'confidential' testing. In practice, patient details were not followed up, but GU practitioners (and some commissioners) did not condone anonymous testing. GU practitioners felt that this reinforced a negative and stigmatizing attitude towards HIV, rather than 'normalizing' it.

"I think that we need to bring out the stigma, and talk to them about being HIV positive. In other words, testing is a good thing because it will prolong your life...you can live longer, you can plan for your family, and it's important...So I think we shouldn't promote [anonymous testing]", CBO Representative, FGD, London

Overall, some provider and commissioner respondents felt that the recommendation should focus on providing the test, rather than specifying the range of testing.

"Yes, I would say keep it simple, just do the blood test", IDI, GP, West Midlands SHA

A few respondents wanted the Guidance to include emphasis on sensitivity to the needs of African MSM, and not just to 'all genders'.

ii) Promoting HIV Testing

Overall, the section of the recommendation on health promotion was felt to be feasible and was commonly accepted as 'good practice'. Some felt that messages around HIV and promotion of testing could be consistently applied across different settings, with slight modifications to content (such as sites providing HIV testing). A few respondents called for more thought on what was universally applicable and what needed to be tailored, so that different areas could use common resources, and not have to replicate materials in each location.

Some respondents felt that the recommendation implied print-based materials (delivered by health staff to their clients in NHS health care settings), and that there was a need to expand it to other forms of community-based health promotion (one-to-one interventions and others), especially among groups where uptake of HIV testing is low. Some respondents

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highlighted that health promotion was 'sensitive' and may imply a blame on Black African groups for 'spreading HIV':

"The minute you narrow in on the African communities, you don't get maximum mileage out of that", *Health Practitioner, FGD, London*

"When we tailor it strictly to the target group, this is where the stigma comes", *IDI, Sexual Health Practitioner, West Midlands SHA*

Several respondents said that there was a need to integrate messaging into other health messages/targeting other groups. A few respondents felt that a health campaign that focused on a single BME group was not feasible in terms of staff capacity.

Applicability

In some settings health promotion targeted at one ethnic group might be sensitive, for instance, in new dispersal areas for refugees and asylum seekers. Some respondents felt that this could undermine the feasibility of the Guidance in this setting. Health promotion initiatives would be harder to implement in settings with a small or scattered population of Black Africans.

Summary of Recommendation 3

- Many respondents welcomed the move towards opt out HIV testing as a way to 'move (HIV testing) forward'. However, some respondents said that specific training in cultural awareness was unfeasible.
- Many practitioners felt that the provision of anonymous testing was unfeasible and that the provision of rapid and/or less invasive tests had logistical and financial implications.
- There was strong support for the inclusion of health promotion, with some concerns that health promotion materials should not stigmatize Black Africans.

Suggestions for Improving the Usability of Recommendation 3

- There was a wide consensus among provider respondents to remove mention of 'anonymous' testing, though some commissioners/CBOs advocated for its inclusion.
- Some advocated the inclusion of faith groups under 'Health promotion', who could more effectively mobilize the community to access testing.
- Some respondents felt that the Guidance should specify that health promotion efforts should be broadened across groups in the community, and that Black African people/communities could be targeted within that initiative, to avoid stigmatizing them.

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- Clarification was felt to be needed by several respondents on the frequency of testing, which is not specified. A few respondents felt that clarification was also needed on what is meant by 'confidential' and maybe materials to address (service users') misconceptions around this needed to be developed, as this acted as a strong barrier to accessing HIV testing services.
- Many respondents wanted clear links to centrally-produced health promotion materials that can be used – for example, the materials published by the National African HIV Prevention Programme (NAHIP).

5.4. Recommendation 4: Providing HIV Testing Outside of Sexual Health Settings

Target Audience

Some respondents noted that it was helpful to list providers offering and performing HIV testing services, as they could thus act on this regardless of the involvement of the DPH. Some felt that others could be included among providers, such as community pharmacy and contraception services.

Feasibility and Acceptability

Discussion of this recommendation focused on different providers in turn (GPs/primary care, all healthcare practitioners, and midwives), as it became apparent that there were different views on the feasibility of implementation in each setting.

Overall, the recommendation aroused strong reactions from many respondents, who felt that some aspects of Recommendation 4 were discriminatory, and were based on racial, and not epidemiological assumptions.

"Race has nothing to do with risk", IDI, Commissioner, London

Some respondents also felt that identification of Black Africans presented an innate difficulty, as some may identify as 'Black British'. In one FGD, there was confusion about whether the Guidance applied to those of Black-Caribbean descent.

Community-based venues are not listed and a few respondents felt that the recommendation needed to focus more widely than just healthcare settings, and that Recommendation 4 was thus inconsistent with Recommendation 3. Given that there were a number of differing types of healthcare practitioner identified within this Recommendation, the issues raised for each area of practice are addressed separately.

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i) Primary Care

Many respondents were strong advocates for the shift of HIV testing into primary care, and envisaged that it would begin an attitudinal shift in GPs.

"I think that this is a cultural shift for many GPs, I think that this is a challenging but a very good recommendation", IDI, Commissioner, West Midlands SHA

Some respondents noted that GPs could have a significant impact on reducing late diagnosis, as one of the main points of contact for undiagnosed Black Africans.

There was a clear and strong support for initiatives to 'normalize' access to HIV testing through primary care, which is already supported in the BHIVA guidelines. In some areas, this was already being enacted, and HIV testing was being routinely offered to high risk patients, in areas of high prevalence (greater than 2 diagnosed HIV positive people per 1000 of population).

Many respondents felt that as this recommendation stands, it is unfeasible and likely to result in a strong stigmatization of Black Africans, which carried a risk of dissuading them from accessing primary care, if Black African patients were visibly being offered an HIV test that non-Black Africans were not.

For many respondents (including GPs), one of the main difficulties of implementation was how the issue of HIV testing could be raised in a routine consultation. Notably, GP respondents with a special interest in sexual health (and who had been trained) foresaw this as being less of a difficulty.

"That means that somebody comes with ear wax and you've got to talk to them about their sex life. The reality of that is quite tricky", IDI, GP, West Midlands SHA

Some respondents noted that there had been a low level of response from GPs to provide a Level 1 sexual health service. Provision of HIV testing was felt by some unlikely to be uniform, and performed only by GPs who had a 'special interest' in sexual health.

Some respondents felt that the algorithm outlined in the recommendation for screening Black African patients was useful, but notably this did not lessen the perception that the recommendation was discriminatory. In one group, some respondents felt that the algorithm could effectively be applied to any Black African attending a GP surgery at every appointment they attended. This was seen as problematic for both service users and practitioners.

There was a strong consensus that it would be more useful to include routine testing in new registrations for all patients, as part of routine screening. A few respondents pointed out that

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this was already required in the BHIVA guidelines in areas of high prevalence and that the NICE Guidance should endorse this.

"To me the easiest point at which to do it would be when patients register. We offer everybody a new patient health screen so we could include it in there", IDI, GP, West Midlands SHA

Many respondents also felt that there had to be a clearer link with clinical indicator illnesses.

"If someone is presenting with an infection I would feel quite relaxed about the fact that this person is probably statistically at risk of being HIV positive and I need to know whether he is being checked", IDI, GP, London

Some respondents also felt that GPs would need to be incentivised in order for them to respond to the NICE Guidance. One respondent suggested that commissioning should encourage case finding versus increasing testing across the board.

A few GP respondents thought the Guidance unnecessarily fragmented GP-led action, and that the focus of the Guidance (by group and by health issue) was too narrow. GPs would be responding to a number of targets around sexual health (including those on Long Acting Reversible Contraceptives) and that the strategic advantage of primary care was its integration of all aspects of care.

ii) All health care practitioners

There was an evident polarizing of opinion in response to this component of the recommendation. Many respondents again saw this as opening up the opportunities to offer screening to Black African patients, and to 'normalize' access to HIV testing. Equally, many respondents felt that it was an unworkable recommendation in practice, with a high risk of stigmatizing all Black Africans.

iii) Accident & Emergency Departments

Many of the discussions focused specifically on A&E departments, where it was acknowledged that high risk groups and those less likely to access care would be attending (such as failed asylum seekers). Many provider and CBO respondents felt that offering HIV tests in acute settings would effectively reach 'high risk' groups.

"The big wins, the big hit is acute emergency hospital admissions. That's your big hit", Health Practitioner, FGD, London

"I just imagine that it is really the way to move things forward, because you're saying it needs to be done, and also it gives you, if you look at the acute psychosis

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patients coming in high prevalence, they're with A&E, there is such high risk. They've got high risk written all over them, and that's going to be helpful", *Sexual Health Practitioner, FGD, West Midlands SHA*

In one FGD, there were strong advocates of this approach, who expected that the recommendation would lead to a strong reaction from both providers and others.

"A lot of people are going to see it, and a lot of people are going to hate it", *Health Practitioner, FGD, London*

One A&E practitioner said that offering HIV tests without 'proper justification' would not be permitted. There had to be the presence of a clinical indicator to testing to be offered.

"If you told the doctor just to take an HIV test of any Black person that comes in just because they have a blood sample, nobody would do it [...] they're not supposed to do that, unless you're assessing the patient and we can't figure out what's wrong, and this might be a link and this is the reason why it might be possible to have HIV test. But that's the only way we're allowed to do an HIV test on people and linked into their symptoms, not just to take blood", *Health Practitioner, FGD, West Midlands SHA*

Some of the main concerns about offering HIV tests in A&E were that:

- It would be difficult to maintain confidentiality and get proper informed consent with opt-out testing in such a pressurized environment.
- Black African patients in such a public environment would notice that they were being offered HIV tests, whereas other non-Black Africans were not.
- It would be difficult to follow-up patients once they were diagnosed.

iv) Midwives

Offering HIV tests through ante-natal screening to male partners was overall felt to be the most feasible of the three components of Recommendation 4, but with some financial and logistical barriers to implementation.

Many respondents felt that this action would have a low uptake of testing, as men infrequently accessed the service with their partners. It would thus have a low impact on increasing rates of diagnoses of HIV.

Opt-out HIV testing is already being provided to women attending ante-natal care, and many respondents felt that establishing this had been a struggle, but that it was now working well, and presented a good opportunity to extend testing to male (Black African) partners. Some respondents supported this component as they felt that there was a strong moral imperative for both partners to test and prevent mother to child transmission.

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Some respondents were concerned about the logistical problems of implementing the recommendation. Key points raised included:

- Commissioning arrangements, as midwifery services were focused exclusively on women and children.
- Some respondents felt that new male partners would have to be registered, and that in some settings, this would create a burden on midwives.

There was a contradiction in terms of what different respondents felt would be an acceptable recommendation for midwives - some felt that midwives would be more accepting of the recommendation if they could signpost male partners to testing sites, whereas others pointed out that this would be unlikely to result in a high uptake of testing - HIV testing had to be offered on site to be effective.

Some respondents felt that offering HIV tests to male partners should be offered subject to consent from the woman. Several respondents pointed out the strong impact that a positive diagnosis would have on a couple's relationship, and that testing male partners could have a negative repercussion on the woman. A few respondents felt that the Guidance made an assumption that couples were Black African, and did not address mixed race couples.

v) Community Pharmacy Settings

A few respondents also felt that community pharmacies should be specifically mentioned.

"Lots of people aren't registered with GPs, but they do use a community pharmacy, and a lot of them are African", Health Practitioner, FGD, West Midlands SHA

Factors Affecting Feasibility

It was evident that many respondents saw the potential in Recommendation 4 to normalize access to testing.

"So wherever they go, someone will be talking about HIV testing, so it becomes a routine test", IDI, Sexual Health Practitioner, West Midlands SHA

Others clearly felt that the targeting of Black Africans - testing on the basis of racial groupings and not through a risk assessment - was felt to be strongly stigmatizing. This strongly undermined service provider acceptability and consequently the usability of this recommendation.

"I'm not saying that we shouldn't be doing it. I'm saying you have to do it in the context of all high risk groups, otherwise you are stigmatizing one group," Health Practitioner, FGD, London

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A few respondents felt that the targeting approach would be unfeasible under policies of 'Equality and Diversity', as it may result in the marginalization of other groups who would have less access to testing.

Several practitioners highlighted that there was a risk of backlash against targeting HIV testing at Black Africans, which would adversely affect previous efforts of CBOs to encourage access to HIV testing.

Some respondents noted that there was an implied training and/or educational burden across a wide range of health practitioners, including GPs. This will be explored under Recommendation 5.

Applicability

Many respondents felt that this recommendation was applicable in all settings, and that even in areas of small Black African populations, it should be enacted.

Summary of Recommendation 4

- Overall, the recommendation aroused strong reactions from many respondents, who felt that some aspects of Recommendation 4 were discriminatory, and were based on racial, and not epidemiological assumptions.
- There was strong support for offering HIV testing to male partners of women attending ante-natal care, and varied support for other aspects of the recommendation (GPs routinely offering HIV testing, and all health practitioners taking bloods also testing for HIV).

Suggestions for Improving the Usability of Recommendation 4

- Many respondents felt that the wording of this recommendation needed to be re-phrased.
- There was a need to qualify the recommendation by levels of prevalence, and including a sexual risk assessment. There was a perceived need for a universal approach around 'risk'. This included targeting Black Africans on the basis of being a 'high risk' group, among other groups, which would improve provider acceptability and engagement.
- Several respondents said that the guidance should specify offering HIV tests in family planning/contraception services.
- Several respondents felt that there was a need to recommend non-didactic and interactive forms of training, using role-plays where GPs can practise how to raise the issue of HIV testing during a routine consultation.

- A few respondents felt that the recommendation was too broad, and needed to state which settings should be prioritized for HIV testing.
- Some respondents wanted to see clearer linkages between testing and clinical indicator conditions, especially in acute settings and general practice.

5.5. Recommendation 5: Training

Target Audience

There was a clear consensus that this is the correct audience. Some respondents wanted to include the voluntary sector, who would have more directly relevant experience of working on cultural issues with Black African communities.

Feasibility and Acceptability

The general structure of Recommendation 5, which outlined different levels of training, was welcomed by some respondents. The discussion on Recommendation 5 often revolved around several key issues, with often divergent opinions among different respondents:

- Learning needs - whether there was a need to 'exceptionalise' HIV and consequently the training needs around such 'exceptionalisation'.
- The levers of change - what would motivate practitioners to offer and promote HIV testing (confidence in technical competence - in which case training is needed - or attitudinal shift - in which case awareness raising is needed).
- The feasibility of delivering different components of the training.

Many respondents acknowledged the importance of training, but were also concerned about the practicalities of delivering the training package to all of the health staff implicated in the Guidance.

Many respondents felt that the level of training outlined in the Guidance was substantial, and carried a risk that HIV testing would not be provided outside of GU/Sexual Health settings.

"I know you're right and it has to be included, I think the term ('training') is dangerous, because that's like, oh, that's like the cost, the logistics, I think that's where it gets very, very problematic, and that's a huge barrier," *Sexual Health Practitioner, FGD, London*

Some respondents said that a complicated training package would give the message that offering HIV testing was itself a complicated process (entailing lots of counselling, and the

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training required to deliver it) rather than a simple, opt-out procedure. This ran counter to efforts to 'normalize' access to HIV testing.

There was a strong divergence in opinions between occupational groups and their support for training. Some clinical staff (across all groups) and some HIV/AIDS policy analysts felt that adoption of opt-out testing policies (and the endorsement of the BHIVA (2008) guidelines) entailed a more streamlined training package, especially for primary care practitioners.

A few clinical respondents emphasized that what was required from medical staff was 'an awareness of' key issues, rather than a 'formal' package of training, which was more amenable to 'on the job' training.

"If I do training on the A&E nurses, I don't need to give them all of this. I don't need to take them out for the day. It is an awareness rather than anything else. I can do that in twenty minutes on a powerpoint presentation," *Health Practitioner, FGD, London*

CBO HIV/AIDS advocates however, were more likely to emphasize the usefulness of some aspects of the training package, such as cultural awareness of Black African communities.

Many respondents viewed this recommendation as being a critical part of ensuring the HIV testing was delivered in a non-discriminatory way and addressed concerns about the discriminatory targeting in Recommendation 4.

There was some agreement that training of reception staff was needed, especially in primary care, but respondents raised concerns about the training burden if this were to apply to all relevant reception staff in the guidance (such as those in acute and other health care settings). Some respondents also felt that all staff, including reception staff, are contractually bound to follow policies around confidentiality in an NHS setting, and that training around this issue was thus less of an imperative.

In several FGDs, respondents questioned the need for staff offering and performing HIV tests to have specific 'cultural awareness' of Black African communities. This was principally because:

- 'Cultural awareness' and 'anti-discrimination' was already covered for all ethnic groups through equality and diversity training.
- In areas of greater cultural diversity, focusing exclusively on one group for one health condition was felt to be harder to justify. The need to 'exceptionalise' cultural issues around Black Africans and HIV was seen to be a reflection of high levels of stigma around this issue, rather than an actual 'training need'.

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- This would require contracting an external organisation to provide such a specialized form of cultural training. In in-depth interviews, some respondents felt that these organisations would not be available in areas where less African-specific CBOs were present.

Several clinical respondents had participated in training around sexual health in primary care (a consistently highlighted case study was the Sexual Health in Practice [SHIP] project) and emphasized that non-didactic, interactive and participatory forms of training worked best, where primary care physicians could role-play raising the issue of HIV testing with potential clients.

Many respondents felt that GPs and others offering HIV tests needed to build their confidence to be able to have a conversation around HIV with patients, specifically about how to raise the topic of HIV testing, rather than to increase their capacity to give comprehensive information around HIV.

A few respondents felt that training for GPs on giving post-test information was too burdensome. They also noted that giving post-test information to those with a negative test result was not required in the BHIVA guidance (see Recommendation 2).

Some respondents felt that there was a need for a national programme that could train and engage GPs in promoting the uptake of HIV testing through primary care. There was a strong perception among respondents that this would require significant resources and incentives built into commissioning arrangements.

A few respondents felt that these training packages should be integrated into routine professional development as much as possible. An E-learning training package ('e-GP') has been developed for GPs which includes sexual health modules (by the Royal College for General Practitioners) which could contribute towards professional development of those in practice.

Some respondents, some of whom were strong advocates of expanding HIV testing into primary care, felt that primary care practitioners were already trained to be able to offer and perform an HIV test. Some highlighted that what was needed was engagement and mobilization around the public health need to increase uptake of HIV testing in Black Africans, to convince health practitioners of their role in this, and basic competence around HIV testing.

A few respondents felt that practitioners needed ongoing support, and that local sexual health networks should be mentioned as a potential source of that support.

"It would be possible for NICE to make a recommendation on training, but I just think [this] is unrealistic, undoable and not connected with the learning needs in General Practice, and actually sets us back", *IDI, GP, London*

"I think that the training needs to be neat and focused on practical skills", *IDI, GP, West Midlands SHA*

"I was really impressed with this recommendation. It sort of allayed my fears from the last one", *IDI, CBO Representative, West Midlands SHA*

"GPs are health professionals. They are already well trained", *IDI, Commissioner, London*

Factors Affecting Feasibility

This recommendation was felt to be unfeasible without significant resourcing, especially for 'labour intensive' training, such as that for primary care. It was suggested by one respondent that the roll-out affected feasibility - starting with GPs who have a special interest and then moving on to other competent staff within GP surgeries, such as practice nurses.

Applicability

In its current form, some respondents felt that the recommendation was more applicable to settings with higher numbers of Black Africans, as it implied a level of investment that was not justifiable in areas with a small population. Some respondents raised concerns about the availability of training, such as Equality and Diversity training, which may be less available outside of London.

In settings with low density of Black African populations, it was felt that specific cultural awareness training would be unavailable and inaccessible.

Summary of Recommendation 5

- Some respondents felt that this was an essential recommendation, and that the Guidance was only implementable with an investment in training. However, health practitioners noted the high training burden, and overall, felt that the training outlined risked being perceived to be unfeasible.

Suggestions for Improving the Usability of Recommendation 5

- Some respondents wanted to have links to creative forms of training, such as E-

learning packages, that could be more accessible to practitioners.

- There was a strong divergence of opinion between respondents on the scale and depth of training needed, with some supporting specialized training and others envisioning a streamlined package that could easily be rolled out.
- Some respondents said that different levels of training for GPs may be more applicable, with a basic level of training for all GPs and further training for those with a 'special interest'.

5.6. Recommendation 6: Community Engagement

Target Audience

Many respondents felt that faith groups and leaders needed to be included in the target audience, as they could potentially play a pivotal role in mobilizing engagement among communities. A few respondents also suggested that local authorities and voluntary sector agencies should be included in the target audience. Many respondents commented on the need to include faith groups as 'health champions' and 'role models', particularly to address issues of stigma. A few respondents felt that churches may be engaging in practices that feed stigma, and thus their involvement was crucial to counter this.

In one FGD and several IDIs, respondents objected to the phrasing - specifically those with a 'responsibility for the health and wellbeing of Black African communities'. It was felt that this implied a lack of responsibility on the part of communities themselves.

“It’s the black African communities themselves that have got responsibility for their own health, yes. I think we need to hammer this point at every contact that we have with communities. The responsibility to health is on you and the onus on your health is not the [responsibility of] the director of public health”, CBO Representative, FGD, West Midlands SHA

Feasibility and Acceptability

In many areas, respondents felt that implementation of the recommendation was highly feasible, and that this was being implemented already. There was strong support for the inclusion of a community engagement approach which many respondents saw as crucial in order to address the risk of viewing the implementation of the Guidance as being discriminatory, and to increase demand for HIV testing services.

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Some respondents wanted to see clearer integration of community engagement throughout the recommendations, and not just within Recommendation 6. Some respondents from CBOs wanted to see greater involvement of PLHIV in the community engagement.

Respondents across all groups noted that implementation of this recommendation necessitated an investment in training and staff. Respondents felt it might be more feasible to 'encourage' communities, than to 'train and recruit' them.

Several respondents also advocated that community engagement should happen within a wider health inequalities framework, which would also support 'normalizing' HIV.

While there was strong agreement in the approach and content of the recommendation, some respondents felt that the implementation would be challenging, given prevailing high levels of stigma in many communities, and the possible difficulties of recruiting lay health advocates.

“Just because recruiting, training and encouraging members of the local black African community to act as, it's a fantastic phrase but actually particularly in previously, in areas where there's not a very big community it's going to be quite difficult to attract people from those communities and they may not want to be talking about sexual health or HIV. I think to actually get local communities to act in this way can be very difficult”, IDI, Sexual Health Practitioner, London

A few respondents felt that implementation of the recommendation would be stronger with clear links between commissioners, providers and community groups. In some areas, 'HIV health forums' had facilitated identifying community members with an interest in HIV who could lead engagement activities.

A few respondents noted the positive tone of the recommendation's phrasing, in 'encouraging' community action.

Factors Affecting Feasibility

As with other recommendations, some respondents noted that this recommendation would be less likely to be actionable without some investment.

Applicability

In areas of low numbers of Black African populations, some respondents noted that 'community engagement' would be likely to entail engagement with individuals and not with clearly delineated community groups. Mechanisms to engage with them (through third sector organisations or local faith groups) may not be readily available.

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However, a few respondents also felt that community engagement may be more important in settings with low cultural diversity where stigmatization of one community might be more likely to happen.

Summary of Recommendation 6

- There was wide consensus that community approach was critical to the implementation of the Guidance, in order to address the risk that it would be seen as discriminatory.

Suggestions for Improving the Usability of Recommendation 6

- The inclusion of faith groups, and community leaders in the target audience.
- Some respondents wanted to see greater integration of the community engagement aspect throughout the recommendations, to emphasize that the initiative was based on 'dual ownership' between providers/commissioners and communities, and to reduce the risk of tokenistic engagement.
- Several respondents wanted the recommendation to reflect that integrated messaging could be more effective than focusing on the sole issue of HIV.

5.7. Relative Importance of Each Recommendation

Many respondents felt that the recommendations fitted together as a package, and that each was needed for effective promotion of HIV testing. Approximately a third (9/30) of respondents in the IDIs agreed to conduct the ranking according to recommendation importance. Ranking was not performed consistently across all FGDs as a result of time limitations. Where ranking was done, this is summarised in Table 2. However, it was felt that overall the recommendations were difficult to prioritize, and the results of the ranking do conflict with the qualitative data on the relative importance and prioritization of the recommendations.

Table 2. Results of the Ranking of the Recommendations

Recommendation	Ranking (1 - most important, 6 - least important)
Recommendation 1 – Planning Services	1
Recommendation 2 – HIV Testing Provision and Referral Pathways	4
Recommendation 3 – Promoting HIV testing provision and reducing Barriers	5

Recommendation 4 – Providing HIV testing outside sexual health settings	6
Recommendation 5 - Training	2
Recommendation 6 - Community Engagement	3

There was broad consensus that Recommendation 6 on ‘Community Engagement’ was of pivotal importance and that implementation of the Guidance relied on the successful incorporation of this recommendation.

"It's imperative, it's not just important. We cannot do that [without] community involvement and it's so important", *Sexual Health Practitioner, FGD, London*

Recommendation 4 was seen as being of crucial importance by many health practitioners, who felt that this recommendation would have the highest impact on current service provision, and ultimately would lead to increased testing. Overall, however, Recommendation 4 is lowest in the rankings.

Lastly, many respondents prioritized Recommendation 5 ('Training'), however, many health practitioner respondents argued that too much of an emphasis on training could make implementation of the Guidance unfeasible.

6. Other Sections of the Guidance

Not all participants reviewed the whole of the NICE Guidance; some only focused on the Recommendations sections. Apart from the Recommendations, the main section reviewed was the ‘Considerations’ section. Of those who had reviewed the Considerations, most found it insightful and useful, especially in terms of understanding the rationale for the issuance of the NICE Guidance.

"I think it makes the document more practical, so if you're the head of an organisation and you wanted to read through this, it justifies what's being done and what's being said, and why NICE have concentrated on this, and it gives people a little bit of background knowledge as to why it's still important", *IDI, Sexual Health Practitioner, London*

A few respondents felt that the issue of targeting versus universalist approaches needed to be reviewed in the ‘Considerations’ section, and a clear justification made for adopting a targeting approach. One respondent pointed out that universal screening (promoting the uptake of HIV testing among all people attending primary care, for instance) had been

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adopted in other international settings, and that NICE needed to demonstrate whether they had considered taking this approach or not.

A few respondents felt that there was a conflict between statement 3.2 (Considerations Section), which recognised the different levels of risk among different Black African communities, and the whole approach to targeting ‘any Black African’ in the document.

“There is a difference within the Black African community, in terms of culture and risk - so why are they offering it to everybody?” *IDI, Commissioner, London*

A few respondents felt that the gender-based differences in attitudes towards and uptake of testing needed to be further explored, especially as it related to offering testing to male partners of pregnant women.

“I think that's got huge cultural implications that should be taken into account”, *IDI, CBO Representative, London*

Several respondents felt that the sections on economic modelling were not understandable (Section 3.19). A few respondents felt that this section had not sufficiently detailed the impact that immigration status may have on accessing health services more generally, and HIV testing and treatment in particular. Many respondents felt that they were a key risk group and that this needed to be considered throughout the Guidance (see Section 11).

7. Barriers to Implementing the Guidance

In considering the recommendations, respondents were asked about what factors they felt would impact on their implementation. The key findings are listed below:

Provider Attitudes

Several medically trained respondents felt that HIV testing and care was widely perceived by the medical community to need to be delivered by a specialized service, and that this acted as barrier for providers in non-sexual health care settings. Many felt that this had allowed HIV to remain as a stigmatized service, and that the NICE Guidance should primarily aim to ‘normalize’ access to HIV testing, both for service providers and service users. Related to this was the need for providers to see HIV as part of chronic disease management. A few respondents drew analogies with other initiatives to mainstream HIV testing into screening programmes:

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"Ante-natal testing prove[s] it. It took ten years, and the midwives only did it because they were told to. They didn't do it because they wanted it, but we know we can normalize it", Commissioner, FGD, London

Some respondents also felt that 'opt-out' testing policies should be the main means for normalizing access to HIV.

Assumptions by medical staff that extensive pre- and post-test counselling would be needed were seen by some to act as a barrier. This included, for instance, the extensive training requirements, and post-test interventions for those with a negative HIV test results.

NHS is in a state of flux

The current changes underway in the NHS recurred frequently as a theme by service providers. It was felt that the impact of this on the Guidance was unpredictable in the short-term, and with specific associated risks. The key factors associated with this were:

- The increasing pressures on staff capacity (including primary care) as services have been cut back.
- The loss of certain 'specialist' posts, including health promotion staff, public health analysts, and HIV/sexual health commissioners, among others, to lead and push the HIV testing agenda forward.
- The uncertainty around the position of public health. This was seen by some as an opportunity to link in with local authority-based agencies who may have a wider agenda with Black African communities (and thus could integrate HIV into other areas), but also as a risk, since it implied a separation from the NHS, and a greater need for improved partnership working for effective implementation. It was also unclear to what extent roles such as 'Director of Public Health' would be able to dictate and influence others, such as GP consortia.
- The shift towards GP-led commissioning. Many respondents from non-primary care settings viewed this as a risk:

"I think certainly public health needs to have a key role in this, and I would worry if the responsibility is handed over to GPs", IDI, Commissioner, West Midlands SHA

- Flux in general - some respondents felt that over the next few years, the scale of re-organisation would present an opportunity for providers to selectively choose which areas to specialize in, and thus to avoid 'complicated' areas such as HIV.

Stigma and Stigmatization

It was evident that even among strong advocates of efforts to increase HIV testing among Black Africans, there was a deep disquiet and anxiety about targeting Black Africans,

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through the Guidance itself, and in specific recommendations, such as Recommendation Four. Among many respondents there was fear of a backlash from Black African communities once they realized that they were being 'targeted', and a consequent low uptake on HIV testing.

“Yes, because I’ve seen a lot of people not going for tests because of that, they think okay, because people think we are black, they think we like sex, they think we are all these...beliefs that it’s because I’m black, that’s why people treat me this way, but otherwise I really do agree with that”, CBO Representative, FGD, West Midlands SHA

“I think a negative thing which needs to be really managed carefully, obviously there will be an outcry from the black African community that okay, this is as it stands to label them, because they’ve got other, bigger problems besides HIV”, IDI, CBO Representative, London

“Scotland Yard started what was called the stop and search among black Africans, because of the high usage of drugs among that community. Statistics pointed them to stop and search every black person in that big time, and I really feel that if we are not careful and proceed just by use of statistics, it can cause an adverse effect”, CBO Representative, FGD, West Midlands SHA

Many of the arguments around stigma often seemed circular (“HIV is stigmatizing because it is stigmatized”). There was nonetheless a widely held view that implementation of aspects of the Guidance would lead to HIV being “a pointed finger of blame”, which could adversely affect Black African communities. The perception was that service providers would also morally object to, and thus be less likely to implement, the Guidance, although suggestions to resolve this issue were not forthcoming. Practitioners offering HIV tests for the first time may face an adverse reaction if the person felt that they were being targeted, and that without adequate training and/or support, this might quickly dissuade health staff from offering HIV tests again.

Targeted Versus a Universalist Approach

A few respondents pointed out that the NICE Guidance also goes beyond the current BHIVA Guidelines (2008), which talk about 'at risk groups'. However, there were also some very strong advocates of the approach of targeting Black Africans, including those among CBOs and health advocates, who recognized the public health need. A few felt confident that there will be recognition among the public of the need for testing:

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"I doubt that there will be a problem with public perception of this, I think that actually, that it's an area where we are probably falling behind what the public expects us to be doing", IDI, Sexual Health Practitioner, London

These respondents supported increasing all available opportunities to offering HIV testing to people from Black African communities.

CBO advocates acknowledged that current levels of stigma around HIV are very high among both service providers and service users, but that this should not detract from the need for targeted work:

"We do universal as well as targeted work and [do] not shy away from the targeted work because it might be discriminatory, it's going to be targeting, it's going to be stigmatizing", IDI, CBO Representative, London

Those from CBOs, with experience of developing community-based testing initiatives (in the UK and in Africa), also contended that there may be several phases of implementation, and that until HIV testing became 'normalized', adverse reactions because of targeting would have to be accepted.

There were also many respondents who advocated a '*universalist*' approach, making HIV testing routinely offered to a wider population.

"It would be good to reduce the stigma across the board, for HIV testing, rather than just specifically saying; these people definitely need to come", IDI, GP, London

There was significant support for screening at certain points for all groups, such as during new patient registrations, and for male partners of women attending ante-natal screenings.

Related to this was a strong support for integrating HIV into wider mandates (such as health inequalities) and thus into other non-stigmatized screening programmes. Several respondents had offered HIV screenings within a package of interventions, and reported higher rates of uptake of testing. These respondents felt that attempting to mobilize interest in a single health issue in the context of other health concerns was unlikely to be successful.

The Burden of Implementing the Guidance

The detail and burden of the Guidance itself was seen as a potential risk by some respondents, often those working in clinical settings, especially the focus on training and cultural awareness. There were some strong advocates for making the Guidance more realistic and easier to implement.

Cost and Financial Implications

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A few respondents felt that there needed to be a means of making the economic case for implementing the Guidance to commissioners, as "in the short term it's going to cost more" (IDI, Sexual Health Practitioner, London). Economic models to demonstrate the long-term economic benefits of investing in HIV testing were felt to be needed by some.

A few respondents also felt that it should be made clear that the opt-out policy would not result in a greater financial burden for providers:

"The most important financial restriction is the provider time, so if we make it absolutely clear that opt-out testing is okay, which reduces provider time", *Sexual Health Practitioner, FGD, London*

Summary of Barriers to Implementing the Guidance

- Provider attitudes (if HIV continued to be seen as a 'specialised' service and was not 'normalized')
- The state of change in the NHS
- The risk of stigmatization of Black Africans and reactions against the Guidance if it was seen as being stigmatizing
- The burden of implementation of the Guidance
- The financial implications of the Guidance

8. Suggestions for Improving the Guidance

In terms of addressing the barriers to implementation, the following suggestions were made in order to improve the document and aid successful implementation.

More Integration of the 'Community Engagement' Approach Throughout the Guidance

Some respondents felt that the 'community engagement' aspect needed to be more integrated into the Guidance, for instance, given greater prominence in the 'Intended Audience'. Some advocated that the concept of 'dual ownership' should be integrated into the Guidance, or that a 'partnership' approach should be explicitly named.

Some respondents, especially those in CBOs advocating on HIV, were concerned that 'community engagement' should not come at the end of the process of developing a local testing strategy.

Making the Document More Readable

A few respondents wanted to make the document more accessible by including an Executive Summary.

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Better Contextualisation of the Guidance

Some respondents felt that the Guidance needed to 'make the case for' NICE's approach to targeting Black Africans for HIV testing, through contextualizing the public health need at the beginning of the document. While the respondents in the fieldwork were, for the most part, very aware of the epidemiology of HIV in the UK and the rationale for targeting efforts to increase HIV testing, this was often misunderstood or re-interpreted as targeting on the basis of race.

Some respondents also felt that the main conceptual thrust of the Guidance should be around 'normalizing' HIV testing (in tune with the BHIVA Guidelines), and that explicit reference should be made to this at the beginning of the Guidance.

Better Contextualisation of 'Risk'

In a point related to point (c), many respondents wanted the action laid out in the Guidance to be better contextualized around an approach that looked at 'risk', and not 'race'. As discussed above, this especially had an impact on the wording around Recommendation Four.

A few respondents emphasized that the NICE Guidance would be used in practice as a tool to advocate with communities about the need to engage with HIV testing, and that as such it was the "minute qualifications that makes it easier to implement".

Better Links to the Evidence Base

Some respondents felt that there needed to be a better link into the evidence-base, with clearer case studies on what strategies had been found to be effective. Some respondents remarked that the action in the Guidance seemed to 'make sense', but did not feel confident that it was based on a robust evidence-base. A few respondents also felt that they would have preferred to have the results from the Department of Health's pilot studies integrated into the Guidance.

Better Links into Existing Initiatives

In areas of smaller Black African populations, a few respondents felt that the actions laid out in the Guidance would have to be integrated into other existing initiatives, especially around activities such as needs assessments, Joint Strategic Needs Assessments (JSNA), and local sexual health strategies:

"I would like to see a bit more... linking to things that relate to this that are already in place, so for example where it talks about as a local strategy, what local strategies

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are already in place and how this would fit in with stuff that's already in place, because that's not really covered", CBO Representative, FGD, South Coast

Provision of Toolkits

Throughout the discussion of the individual recommendations, respondents made suggestions of toolkits or links to existing resources that could facilitate implementation.

This included:

- a) a toolkit on conducting an HIV Needs Assessment (and links to relevant repositories of data);
- b) health promotion materials that could be adapted to the local context (and links to existing materials, such as those produced by NAHIP);
- c) case studies of local strategies and initiatives which have been found to be effective in increasing the uptake of testing;
- d) referral pathways that could be adapted to the local context;
- e) Links to existing resources that could be flexible and accessible to health practitioners (for instance, E-learning); and
- f) clarifications on community-based testing (application of national standards and guidelines for clinical governance).

Use of Language

There was wide consensus that the language used in the Guidance was clear and accessible. None of the respondents reported any difficulties in understanding the Guidance as it was laid out.

"I really like simple language when I'm reading these sorts of guidelines, and I actually understood them, so I think that means that the language is very good", IDI, Sexual Health Practitioner, West Midlands

In two of the FGDs, respondents (including those from CBOs) objected to the use of language, specifically of the term 'Black African', which they would prefer to replace with 'African'. This was contradicted in one in-depth interview, where a respondent felt that epidemiologically the burden of HIV was found among Black Africans in contrast to other African ethnicities.

Some respondents felt that the understandings of the complexities of the Black African communities outlined in the 'Considerations' section was not adequately reflected throughout the document.

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Some respondents welcomed the reference to ‘communities’ and not to a single, homogenous ‘community’, reflecting that in many areas, Black Africans were living in diverse communities. However, in areas with smaller populations, a few respondents felt that the terms in the Guidance did not reflect that Black Africans in these areas would be a collection of households and individuals, rather than a ‘community’.

“I know why it’s been addressed in this way, but if it goes out in this form it will only be read and used by people who deliver services in predominantly black African communities. That would be a very bad things because we want a lot of this good practice to be applied to dealing with black Africans in any situation by a sexual health person, GUM staff member and so on, but it has to be written for both audiences”, IDI, Commissioner, West Midlands SHA

Some respondents found the repetition of ‘any Black African’ (particularly in Recommendation Four) as stigmatizing. However, sensitivity around the language was difficult to separate from that around the issue of targeting ‘Black Africans’ in general (see Section 11 for a fuller discussion) in the Guidance.

Consider Sequencing

There was broad agreement across the FGDs and IDIs that the sequencing of the Guidance could be re-ordered to give more prominence to Recommendations 5 and 6. Many respondents felt that the current position of Recommendation 6 emphasized that community engagement was done as an additional and possibly tokenistic activity, and that it needed to be given greater prominence. It was felt that Recommendation 5 needed to come earlier in the Guidance, as it was needed in order to facilitate implementation.

Balance the Focus of the Guidance

Some respondents felt that the Guidance was too broad, and needed to have qualifications based on health care settings and/or HIV prevalence. For instance, several respondents felt that the situation in London was qualitatively different than other, lower prevalence settings. The greater availability of community-based organisations conducting health promotion activities in London was felt to facilitate the increase in testing, and communities had a high level of awareness of the need for it. However, a few respondents wanted to have greater clarity about different screening approaches according to levels of HIV prevalence, and more guidance on the phasing of implementation, and which settings were most appropriate at which stages. Others, however, felt that this might lead to smaller populations of Black Africans being ignored: *“Already we are using a different approach which is making our work even more difficult because then we are creating room for people to come up with excuses to say, oh, we’ve only got 200 Africans”*.

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On the other hand, a few respondents, who were often GPs, felt that the focus of the Guidance (on one ethnic group, with one condition) was too narrow.

"It's just very difficult and counterintuitive for a GP to look at something like this and feel comfortable with the super-specialization", *IDI, GP, London*

GPs also highlighted that the guidance would be competing with other targets/priorities, and sits alongside rather than being integrated into a cohesive vision for sexual health in primary care.

Levers of Change

Many respondents felt that the Guidance implied a regional or national investment programme, or additional means of prompting implementation of the Guidance. Some respondents drew analogies with other national screening programmes (national Chlamydia screening programme, ante-natal HIV screening programme), where performance management, targets and a national investment programme pushed the agenda forward.

Community Engagement Approach

There was wide consensus on the need for community engagement (Recommendation Six) both to increase the effectiveness of implementation of the Guidance and to mitigate the potential negative reaction to targeting from communities. It was felt that the implementation of the Guidance will succeed or fail based on the ways in which it is communicated, and the strength of the community engagement activities supporting it.

There was a concern among some respondents about the potential impact of the Guidance on CBOs who have been working with Black African communities to increase the uptake of HIV testing specifically, or to raise issues to do with HIV more broadly. It was felt that there was a risk that a stigmatizing approach could undo the gains to date in community engagement.

"I would be really anxious that this could damage some very good work that's gone on in African communities", *Sexual Health Practitioner, FGD, London*

Improving Health and Tackling Health Inequalities

Overall, respondents felt that the Guidance could improve health and tackle health inequalities, and that ultimately it would lead to an increase in HIV testing,

"I think definitely the recommendations could lead to more people being tested", *IDI, Sexual Health Practitioner, London*

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Along with this support was a strong anxiety about the potential backlash from targeting a single group.

Some respondents felt that the Guidance validated current approaches to increasing uptake of HIV testing, particularly outside of sexual health settings, *"it's probably an area of [for tackling] HIV that has not been exploited"* (IDI, Policy/Public Health Analyst, London).

The key findings about what respondents felt would be the mechanisms for improving health and tackling health inequalities are listed below:

- Respondents from CBOs, and some commissioners, saw the principal value of the Guidance in acting as a tool for local community-based advocates to demand implementation, hold public health directors to account, and support local initiatives to increase rates of testing. Some respondents reported that they have previously struggled to get engagement from local health agencies, and that the NICE Guidance would greatly facilitate doing this.
- Allowing those with a 'special interest' in HIV to take testing forward, including those working in primary care. Respondents were not confident that all of the health care staff implicated in the Guidance would do so without substantial investment in training.
- Raising awareness among public health practitioners of the public health need to increase testing among Black Africans,

"It does raise the profile of the issue and a few, very salient facts. Like this figure of a third of all HIV in this country now presenting in the Black African population, for me as a GP that being hammered in will make me think, gosh, when I see somebody who has come from Africa I need to offer them HIV testing", IDI, GP, West Midlands SHA

- Health promotion and generally making people more aware where HIV testing services were available from.
- 'Normalizing' HIV testing, which some respondents felt could impact on all people at risk of HIV, as more people began to be tested and encourage others to do so as well.

Some respondents felt that the Guidance would have a neutral effect on improving health and addressing health inequalities. This was mainly due to;

- Existing initiatives had been ongoing in some areas, but uptake of HIV testing remained low. A few respondents felt that the current Guidance did not 'add anything new', and that it was unlikely to be more successful than previous efforts.
- Some respondents felt that health inequalities were currently widening, and that the Guidance would do little to reverse that trend.

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- Many respondents felt that the Guidance did not go far enough, and that other groups were not included. As the Guidance focused on one group exclusively, there was a risk that other groups would be ignored, and consequently have less opportunities to test for HIV.
- Many respondents felt that the Guidance did not address the challenges of HIV testing among undocumented migrants in sufficient detail, and that these were a substantial risk group. In addition to this, a few felt that there was a lack of a clear link between testing and treatment for this group. While respondents recognized that this was an issue for national policy, a few also felt that it was unethical to push for HIV testing without having clear resolution.

Summary of Suggestions for Improving the Guidance

- More integration of the 'community engagement' approach throughout the guidance
- Making the document more readable
- Better contextualisation of the guidance
- Better contextualisation of 'risk'
- Better links to the evidence base
- Better links into existing initiatives
- Provision of toolkits
- Use of language
- Balancing the focus of the guidance
- Community engagement approach

9. Limitations of the Fieldwork

Recruitment Challenges

Recruiting health professionals who have not traditionally been involved in HIV testing, such as A&E staff, proved challenging. On contacting certain services, the fieldwork recruiter was often rapidly transferred to the local GUM service at the mention of HIV testing. There was a sense that some practitioner groups had 'nothing to say' or didn't feel qualified to comment on the Guidance as they had never been involved in HIV testing before. This in itself suggests something about the challenges of engaging non-traditional services that will need to be addressed as the Guidance is widely implemented.

The Ffena/NAHIP workshop did not gather the kind of interest the researchers anticipated. This is in part due to change in personnel at African HIV Policy Network, who were participating in the fieldwork on a voluntary basis. Additionally such low response is not unusual when working with community groups who often have human resource limitations

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and time constraints. Due to the delay of the release of the guidance NAHIP partners and Ffena members were given 2 weeks to select individuals to attend the specialist FGD. Many NAHIP partner organisations were unable to release people from their planned work to participate in the workshop, without financial compensation and on such short notice.

Sensitivity

It was clear from analysis of the transcripts that the very high sensitivity of the issue being discussed had an impact on the clarity of responses during discussions. Some respondents felt that the Guidance was targeting Black Africans for HIV testing on the basis of race, despite often being very cognizant of the epidemiology of HIV in the UK, and recognizing that interventions to increase the uptake of HIV testing were a needed. There was strong divergence among respondents on key issues, with some feeling that their views on the Guidance were unresolved, and notably often adopted seemingly contradictory views within themselves.

It is suggested that in the future, NICE assess the sensitivity of the topic for fieldwork, and include a longer time between reading the Guidance and the interview, so that respondents can have an adequate time to review the draft Guidance.

Guaranteeing Anonymity

As a matter of course, Options UK assures anonymity to those it who participate in qualitative research. Members of the NICE team did attend one FGD, which may have introduced a bias into the research. However, it was felt that this was necessary in order for NICE contract managers to input into the research process, which the research team found useful for conducting the rest of the fieldwork.

Timescale

The timelines for the fieldwork were set at the beginning of the project. It was originally envisaged that the NICE Guidance would be available at an earlier date. Recruitment for the FGDs started before the NICE Guidance was issued, in order to ensure that the report could be completed on time. However, there was a delay to issuing the Draft NICE Guidance and consequently, one FGD with NAHIP partner representatives did not go ahead. Efforts were made by the research team to incorporate the views of this group into other FGD; however, the benefits of having a group solely comprised of community-based service providers were missed.

Understanding of Key Terms within the Guidance

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The research interviewers often found that understanding the implications and practicalities of the NICE Guidance depended on participants' own grasp of the workings of the NHS. Some respondents did not understand the process of 'commissioning' and its role in performance management of providers, for instance. In some instances, this may have led to a lack of understanding of recommendations around planning of services (Recommendations 1 and 2).

Methodological Approach

The qualitative nature of the fieldwork, and the range of issues in the Topic Guide, meant that interviews and focus groups took a substantial amount of time, and there was a high volume of data that was collected. Some of the questions covered (such as ranking feasibility of implementation, or the relative importance of the Recommendations) would have been better suited to a quantitative approach, with further probing on key issues using qualitative methods.

10. Conclusions

This fieldwork used qualitative methods to examine the relevance, usability, acceptability, and implementability of the NICE draft guidance. Using focus group discussions and in-depth interviews the authors were able to consider the views of those working in a wide range of health and social care organisations in relation to the following:

- a) The relevance and usefulness of the guidance/recommendations to current work and practice? Which of the recommendations are both feasible and likely to make a difference to practice?
- b) What are the potential consequences of the guidance/recommendations for improving health and tackling health inequalities?
- c) What is the potential impact of the guidance/recommendations on current policy, service provision or practice?
- d) What factors (e.g. time available, training) could impact - positively or negatively on the implementation and delivery of the guidance/recommendations?
- e) What would be the relative priority of each of the recommendations?

The respondents in this research recognized and welcomed the NICE Guidance on increasing the uptake of HIV testing. Some health practitioners and policy analysts recognised that this validated the BHIVA (2008) guidelines. For many, this represented a

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shift towards 'normalizing' access to HIV testing, which was what was needed to ultimately increase the uptake of HIV testing.

Some respondents felt that the NICE Guidance only partially embraced this approach, as it did not specify that this was its aim, and the action outlined was argued to necessitate substantial investment in time and resources. Many health practitioners (especially those from sexual health settings) felt that the Guidance should re-enforce messages to providers that opt-out HIV testing was highly implementable within their settings.

This often seemed to contrast with some CBO and other health practitioners, who felt a lack of confidence that HIV testing would be implemented by GPs, and that this required an investment in training, in order that testing provision did not alienate people accessing services.

There was a similar divergence of views over the issue of 'targeting'. This could not be attributed to a particular professional grouping. There were strong advocates for the Guidance among some of the CBOs interviewed, who felt that all opportunities to increase access to testing should be used, but equally, there were strong views that the Guidance was discriminatory, and was targeting people for HIV testing on the basis of race. There was also agreement among all groups that Black African communities may feel stigmatized in the short-term, and some respondents felt that in the longer-term (once access to HIV has been normalized), feelings of stigmatization would reduce.

It is clear from this fieldwork that if providers believe that the language used in the published NICE Guidance is discriminatory, the initial barrier for implementation will be provider (and not service user) attitudes. Respondents suggested that the NICE Guidance more clearly with an approach that was based on the assessment of sexual risk taking, even if epidemiologically, the main target groups have been identified.

For many respondents working in areas with high numbers of Black Africans, the NICE Guidance validated existing initiatives, such as community engagement, and extending HIV testing outside of sexual health care settings. Many respondents felt that it was thus very relevant. Some CBO respondents viewed it as a useful tool to advocate for greater investment by health authorities in local HIV testing initiatives.

11. Appendix A – Sample breakdown

In-depth Interviews	Area
Manager	East Midlands
Specialist Clinical Pharmacist - HIV/GUM	East of England
Head of Medical Services	London
Consultant Community Gynaecologist and Service Manager	London
Sexual and Reproductive Health Commissioner	London
General Practitioner	London
Practice Nurse	London
Lead for Sexual Health	London
Director of Policy and Campaigns	London
HIV Manager	London
Senior Policy and Practice Manager	London
Director	London
Director	London
General Practitioner	London
General Practitioner	London
Manager	London
HIV/GUM Service Lead	North East
Executive Director of Public Health	North East
General Practitioner	North East
Lead Sexual and Reproductive Health Nurse	North West
Consultant in Public Health	North West
Chief Executive	North West
Pharmacy Manager	South Central
Senior Health Advisor	South East Coast
Health Promotion Specialist	South West
Nurse Co-ordinator	West Midlands
Consultant in Public Health	West Midlands
Lead General Practitioner	West Midlands
Service Development Officer	West Midlands
Regional Delivery Manager	West Midlands
Focus Group 1 - London (North)	
Consultant in Integrated Sexual Health & HIV	
Sexual and Reproductive Health Special Registrar	
Manager Sexual Health & HIV Team	
HIV Liaison Nurse	
Senior Commissioner – Sexual Health & Maternity Services	
Health Improvement Manager	
Consultant in Emergency Medicine	
Community Pharmacy Lead	
Focus Group 2 - London (South)	
Clinical Nurse Lead for Sexual Health	

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Senior Health Adviser and Clinic Manager/Acting Sexual Health Lead
HIV Trainer
Commissioning Manager Maternity Services
Coordinator
Staff Nurse, Accident and Emergency
Focus Group 3 - West Midlands
Health Advising Team Leader
HIV Clinical Nurse
HIV awareness and prevention Trainer and Groupworker
Health Adviser
Strategic Programme Lead Sexual Health
Senior Commissioning Manager Maternity & Children's Health
Health Promotion Specialist
Clinical Nurse Manager
Pharmacist
Specialist for African Communities
Specialist Sexual Health Nurse, African Communities
Focus Group 4 - South East Coast
Lead Consultant, GUM clinic
HIV Nurse Consultant/PhD Research Fellow
Lecturer in Sexual Health & HIV
Public Health Lead (Sexual Health)
Maternity Services Commissioner
Sexual Health Promotion Specialist
Consultant Pharmacist (HIV/Sexual Health)
Ffena/NAHIP Focus Group Discussion
Health Promotion Specialist
Consultant
Lay Advocate
Director
Head of Policy & Deputy Chief Executive Officer
Volunteer
Programme Development Officer

12. Appendix B – Example Recruitment letter



Dear Colleague

DRAFT NICE Intervention Guidance: Increasing the Uptake of HIV Testing Among Black Africans in England

Options UK, in partnership with the Centre for Sexual Health & HIV Research at University College London, has been commissioned by the National Institute for Health & Clinical Excellence (NICE) to conduct fieldwork as part of the consultation on the above public health intervention guidance.

The guidance outlines recommendations about effective and cost effective interventions concerning HIV testing for black Africans communities. This fieldwork aims to explore the acceptability, feasibility and potential impact of the draft guidance, in particular its recommendations.

We would like to **invite you to take part in a participative workshop at X on X** to discuss the NICE guidance and recommendations. The workshop will take place at XX and will last no longer than 3 hours. With permission from those involved, Options UK will record the workshops and any data used from these recordings will be anonymous. Participants will then be sent a copy of the workshop transcript for checking of accuracy.

For further information about the methodology used in the fieldwork please see the NICE Methods Manual 2009 <http://www.nice.org.uk/media/2FB/53/PHMethodsManual110509.pdf>

We would be grateful if you could confirm your attendance via email by Friday 17th September using the form below.

The Project Manager from Options UK is Alexis Palfreyman (email: a.palfreyman@options.co.uk / Tel: 0207 430 5181). If you require any further clarification or information, please feel free to contact Alexis.

Many thanks for your help and cooperation.

Yours sincerely

Ibi Fakoya
Research Associate, UCL

Kevin Miles
Head of Options UK



Consultation on the draft public health intervention guidance *Increasing the Uptake of HIV Testing Among Black Africans in England*

PARTICIPATIVE WORKSHOP

Date:

Time:

Venue:

- I WILL be attending the workshop and agree for the workshop to be digitally recorded (sound only).

- I will NOT be attending the workshop but have nominated a suitable colleague who will attend in my absence. They agree for the workshop to be digitally recorded (sound only).

- I will NOT be attending the workshop and not able to suggest a suitable replacement.

Name of Person Attending:	
Job title:	
Organisation:	
Contact number:	
Email:	

13. Appendix D – Topic Guide



Topic Guide for Focus Groups

NICE Fieldwork for Testing Guidance on Increasing the Uptake of HIV Testing Among Black Africans in England

NOTE: moderator to make sure that all materials are available (handouts on agenda), copies of draft guidance (including specific considerations and recommendations), excerpts from guidance (PowerPoint projector and/or handouts).

TEA/COFFEE & REGISTRATION

WELCOME AND INTRODUCTION (slide 1)

- Introduce moderators (from Options UK, UCL – we are independent from NICE)
- Introduce NICE observers (if present)
- Introduce process – length (maximum 2.5 hours), reviewing through the draft NICE guidance, anonymity but job title will be listed in final report annexes
- Introduce process of NICE guidance: request from DH, review of effectiveness and cost-effectiveness, fieldwork testing of draft guidance (this activity), issuing of final guidance in March 2011.
- Outline the role of the participants: to discuss and give feedback on the guidance and particular recommendations based on their own experience
- Outline intention to record the focus group as explained in the introductory letter
- Moderator: any further questions on process of NICE Guidance at the end of the workshop

AIMS & OBJECTIVES FOR TODAY (slide 2)

- Feedback on the recommendations: are they relevant, acceptable, useable?
- Are they feasible? What would be their impact?
- Address each recommendation separately, followed by a general discussion related to all recommendations.
- Prioritise the recommendations
- Discuss the considerations section
- Comments on other sections of the guidance
- Stress this is *not* a discussion as to whether the recommendations should/should not be included, or the opportunity to query the effectiveness of cost effectiveness of the

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activities outlined in the recommendations

PARTICIPANT INTRODUCTIONS (slide 3)

- **Moderator** asks for participants to *briefly, in less than one minute*, introduce themselves, with a brief overview of their role/organisation, client groups, field of expertise and involvement with HIV testing (and HIV testing with Black Africans in particular)

DISCUSSION OF THE RECOMMENDATIONS SECTION (slide 4)

- **Moderator** to state that each recommendation will be put up on PowerPoint with a 15 minute time restriction per recommendation. Further comments can be in written form for registered stakeholders – we will discuss how to do this at the end of the group discussion.
- **Moderator** remind who the target audience for guidance is
- **Moderator** provide overview of context

Recommendation 1: planning services (slide 5)

a) **Who should take action: is this the correct target audience?**

b) **How useable is this recommendation?**

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

c) **Rate the feasibility of implementing this recommendation (High, medium, low)**

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

d) **What is the likely impact of this recommendation on existing practice?**

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

e) **Is this recommendation applicable to all settings?**

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Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 2: HIV testing provision and referral pathways (slide 6)

a) **Who should take action: is this the correct target audience?**

b) **How useable is this recommendation?**

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

c) **Rate the feasibility of implementing this recommendation (High, medium, low)**

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

d) **What is the likely impact of this recommendation on existing practice?**

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

e) **Is this recommendation applicable to all settings?**

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 3: promoting HIV testing and reducing barriers (slide 7)

a) **Who should take action: is this the correct target audience?**

b) **How useable is this recommendation?**

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

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c) Rate the feasibility of implementing this recommendation (High, medium, low)

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

d) What is the likely impact of this recommendation on existing practice?

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

e) Is this recommendation applicable to all settings?

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 4: providing HIV testing outside sexual health settings (slide 8)

a) Who should take action: is this the correct target audience?

b) How useable is this recommendation?

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

c) Rate the feasibility of implementing this recommendation (High, medium, low)

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

d) What is the likely impact of this recommendation on existing practice?

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

e) Is this recommendation applicable to all settings?

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 5: training (slide 9)

a) Who should take action: is this the correct target audience?

b) How useable is this recommendation?

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

c) Rate the feasibility of implementing this recommendation (High, medium, low)

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

d) What is the likely impact of this recommendation on existing practice?

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

e) Is this recommendation applicable to all settings?

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 6: community engagement (slide 10)

a) Who should take action: is this the correct target audience?

b) How useable is this recommendation?

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PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

c) **Rate the feasibility of implementing this recommendation (High, medium, low)**

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

d) **What is the likely impact of this recommendation on existing practice?**

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

e) **Is this recommendation applicable to all settings?**

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

All Recommendations (slide 11)

a) **What are the potential consequences of the recommendations for improving health/tackling health inequalities**

b) **What factors could impact positively or negatively on the implementation and delivery of the recommendations.**

c) **What could improve the recommendations?**

(PROBE: language, style, length and sequencing of content for each recommendation)

d) **Sequencing: does the sequencing of the recommendations make sense? If not, why not and how could it be improved?**

e) **Importance of the recommendations**

Which recommendations are most important to increasing uptake of HIV and why? Do

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each of the recommendations carry equal weight or some be prioritised above others?

PROBE: any differences between respondents and encourage discussion between respondents, and probe differences between importance overall and importance for local settings.

PROBE: *If there is lack of consensus within group*, moderator to ask participants to rank recommendations and draw consensus using ranking tool (below). These are then collated and analysed to ascertain priority level of recommendations. The rationale for differences need to be probed (ie are differences related to provider-commissioner differing agendas etc)

Recommendation	Rank in order of importance 1 = highest importance 6 = lowest importance
1 - planning services	
2 - HIV testing provision and referral pathways	
3 - promoting HIV testing and reducing barriers	
4 - providing HIV testing outside sexual health settings	
5 - training	
6 - community engagement	

OTHER SECTIONS OF THE GUIDANCE (slide 12)

Moderator: show the considerations section and ask participants to re-familiarize themselves with it

- What are your views on the usefulness of the considerations section?
- Is there anything that is not included in the considerations section that should be?
- Do you have any other comments on any other sections of the guidance document?

Probe: language, length, style - what changes, if any, would be useful?

THANK PARTICIPANTS & CLOSE (slide 13)

Individuals will be sent copy of interview transcription for accuracy checking and a copy of full fieldwork report once it is available (ie post going to PHIAC committee). If individuals have further comments, these can be submitted in writing via the NICE website as a registered stakeholder.



Topic Guide for Telephone Interviews

NICE Fieldwork for Testing Guidance on Increasing the Uptake of HIV Testing Among Black Africans in England

NOTE: interviewer to make sure that the respondent has received relevant documents (agenda, aims and objectives, process of NICE guidance, template for ranking, and draft guidance with relevant recommendations excerpts) and has reviewed these before the interview begins.

Consent to interview and permission to record should be obtained before the recorded interview begins.

INTRODUCTION

- Introduce interviewer (from Options UK – we are independent from NICE)
- Introduce process – length (approximately 45-60 mins), reviewing through the draft NICE guidance, anonymity but job title will be listed in final report annexes
- Outline the role of the respondent: to discuss and give feedback on the guidance and particular recommendations based on their own experience
- Outline the purpose of the interview: not whether the recommendations should/should not be included, or on their cost effectiveness, but on their relevance, usability, acceptability and feasibility.
- Interviewer clarifies that permission to record the interview has been given by the respondent.

AIMS OF INTERVIEW

- Feedback on the recommendations: are they relevant, acceptable, feasible, useable?
- Address each recommendation separately, followed by a general discussion related to all recommendations.
- Prioritise the recommendations
- Discuss the considerations section
- Comments on other sections of the guidance
- Stress this is *not* a discussion as to whether the recommendations should/should not be included, or the opportunity to query the effectiveness of cost effectiveness of the

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activities outlined in the recommendations

Recommendation 1: planning services

f) Who should take action: is this the correct target audience?

g) How useable is this recommendation?

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

h) Rate the feasibility of implementing this recommendation (High, medium, low)

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

i) What is the likely impact of this recommendation on existing practice?

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

j) Is this recommendation applicable to all settings?

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 2: HIV testing provision and referral pathways

a) Who should take action: is this the correct target audience?

b) How useable is this recommendation?

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

c) Rate the feasibility of implementing this recommendation (High, medium, low)

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PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

d) What is the likely impact of this recommendation on existing practice?

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

e) Is this recommendation applicable to all settings?

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 3: promoting HIV testing and reducing barriers

f) Who should take action: is this the correct target audience?

g) How useable is this recommendation?

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

h) Rate the feasibility of implementing this recommendation (High, medium, low)

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

i) What is the likely impact of this recommendation on existing practice?

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

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j) Is this recommendation applicable to all settings?

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 4: providing HIV testing outside sexual health settings

f) Who should take action: is this the correct target audience?

g) How useable is this recommendation?

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

h) Rate the feasibility of implementing this recommendation (High, medium, low)

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

i) What is the likely impact of this recommendation on existing practice?

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

j) Is this recommendation applicable to all settings?

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 5: training

f) Who should take action: is this the correct target audience?

g) How useable is this recommendation?

PROBE: the level of detail, whose health will benefit, who should take action and what

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action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

h) Rate the feasibility of implementing this recommendation (High, medium, low)

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

i) What is the likely impact of this recommendation on existing practice?

What are the potential consequences of this recommendation? How and why each recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

j) Is this recommendation applicable to all settings?

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

Recommendation 6: community engagement

f) Who should take action: is this the correct target audience?

g) How useable is this recommendation?

PROBE: the level of detail, whose health will benefit, who should take action and what action is to be taken. Is it realistic/practical? Is it acceptable for service providers and service users? How could this recommendation be made more useable?

h) Rate the feasibility of implementing this recommendation (High, medium, low)

PROBE: rationale for ranking recommendation as low/medium/high - what factors would affect its feasibility? What about financial implications/feasibility? What would make the recommendations more feasible?

i) What is the likely impact of this recommendation on existing practice?

What are the potential consequences of this recommendation? How and why each

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recommendation is likely to impact on current practice/policy or service provision?

PROBE: for individuals, organisations, and groups

j) Is this recommendation applicable to all settings?

Are there likely to be differences in high/low prevalence settings and those with different ethnic mix profiles? How are these likely to impact on the recommendations?

All Recommendations

- f) What are the potential consequences of the recommendations for improving health/tackling health inequalities**
- g) What factors could impact positively or negatively on the implementation and delivery of the recommendations.**
- h) What could improve the recommendations?**

(PROBE: language, style, length and sequencing of content for each recommendation)

- i) Sequencing: does the sequencing of the recommendations make sense? If not, why not and how could it be improved?**
- j) Importance of the recommendations**

Which recommendations are most important to increasing uptake of HIV and why? Do each of the recommendations carry equal weight or some be prioritised above others?

PROBE: any differences between respondents and encourage discussion between respondents, and probe differences between importance overall and importance for local settings.

PROBE: *If there is lack of consensus within group*, moderator to ask participants to rank recommendations and draw consensus using ranking tool (below). These are then collated and analysed to ascertain priority level of recommendations. The rationale for differences need to be probed (ie are differences related to provider-commissioner differing agendas etc)

Recommendation	Rank in order of importance 1 = highest importance
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	6 = lowest importance
1 - planning services	
2 - HIV testing provision and referral pathways	
3 - promoting HIV testing and reducing barriers	
4 - providing HIV testing outside sexual health settings	
5 - training	
6 - community engagement	

OTHER SECTIONS OF THE GUIDANCE

Moderator: show the considerations section and ask participants to re-familiarize themselves with it

- What are your views on the usefulness of the considerations section?
- Is there anything that is not included in the considerations section that should be?
- Do you have any other comments on any other sections of the guidance document?
Probe: language, length, style - what changes, if any, would be useful?

THANK PARTICIPANT & CLOSE

You will be sent copy of the interview transcript for accuracy checking and a copy of full fieldwork report once it is available (ie post going to PHIAC committee).

If individuals have further comments, these can be submitted in writing via the NICE website as a registered stakeholder.