Analysis

Time to move towards opt-out testing for HIV in the UK

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- Article
- Related content
- Article metrics
- Rapid responses
- Response

Expanding HIV testing: we need to know 'what works' in the UK

We welcome the timely article by Hamill et al (1) and the accompanying editorial by Dodds et al (2) which reignite the discussion around HIV testing strategies in the UK. Continuing high proportions of undiagnosed HIV infections and late diagnoses clearly signify a preventable burden of ill health in the era of highly active anti-retroviral therapy (HAART).

In their article, Hamill et al suggest that opt-out testing in a wide range of settings would both reduce undiagnosed HIV and HIV-related stigma and should therefore be 'seriously considered' in the UK (largely referring to 2006 CDC guidelines(3)). In contrast the editorial by Dodds et al argue that this approach could increase stigma and discrimination against people living with HIV and instead propose intensifying the targeted approach directed at individuals at greatest risk of HIV infection.

There have been significant successes in increasing uptake of HIV tests in UK genito-urinary medicine (GUM) and antenatal (ANC) clinics over recent years, and as a result the large majority of new HIV diagnoses are from these settings. However we agree with Dodds and Weatherburn that there is a continued need and room for improvement, particularly in GUM clinics – where only half have a clear opt-out HIV testing policy (4). Several national level bodies, including the British Association for Sexual Heath and HIV (BASHH), the Expert Advisory Group on AIDS (EAGA) are considering recommending routine HIV testing (with opt-out) in GUM clinics. These are supported by the recent call for routine opt-out testing in GUM clinics by the National Aids Trust (NAT)(5).

It is doubtful, however, that sole reliance on GUM and ANC services will be sufficient to further reduce undiagnosed HIV at a population level. Community based surveys indicate that large proportions of

population groups at greatest risk have never attended a GUM clinic (38% of MSM and 59% of individuals from Black African communities) (6,7). Further, the HPA estimates that a quarter of undiagnosed infections in adults are in ‘low risk’ groups. Lastly, there is an increasing body of evidence on ‘missed opportunities’ for earlier HIV diagnosis in several UK healthcare settings (8,9,10). The need to expand HIV testing into healthcare settings outside of GUM and ANC is highlighted in the recent urgent communication by the Chief Medical Officer(11).

While roll-out of HIV testing into wider healthcare settings may provide opportunities, we should be cautious in uncritically adopting CDC guidelines in this country. Firstly, there are significant differences in the HIV epidemiology and health care systems between the US and the UK. In the UK, a large percentage of HIV infections are acquired abroad and access to the numerous GUM services is universal, free and confidential. Secondly, the CDC recommendations are based on US effectiveness and economic information, which may not be directly transferable to the UK. Thirdly, key to the CDC guidelines is the recommendation of, essentially, an initial large scale catch up intervention, to be scaled down quickly in settings where prevalence is found to be low, rather than an ongoing universal screening programme. This is of particular relevance to the UK, where in the face of resource constraints and lower HIV prevalence rates, prioritisation of HIV testing in different healthcare settings poses particular challenges. Lastly, while the US guidelines consider general consent to medical care sufficient to encompass consent to HIV testing, this may require legislative changes in the UK and is unlikely to be acceptable to clinicians and patients in all UK settings.

Both articles raise the issue of discrimination against people with HIV by non-HIV specialists in primary care and acute settings as arguments, either for, or against HIV testing in wider healthcare settings. These social issues, together with political and economic aspects are central to the decision whether to use targeted or universal testing, and opt-in or opt-out approaches. HIV related stigma is a perceived major barrier to both offer and uptake of HIV testing in wider healthcare settings in the UK (12,13). Tackling these issues through education of health professionals and communities will be key if expanding HIV testing into a wider range of settings in the UK is to be successful. The availability of effective treatments, which increasingly transform early diagnosed HIV infection from a fatal disease into a manageable complex chronic medical condition, makes a strong medical case for a paradigm change in HIV testing(14).

Any change to national policy on HIV testing should be informed by ‘what works’ within the UK. At present there is a limited body of UK evidence on the feasibility, acceptability, effectiveness and cost-effectiveness of different HIV testing strategies outside of GUM and ANC

settings. Hammill et al suggest a need for further unlinked anonymous sero -prevalence surveys in high prevalence areas and high prevalence settings. While this might support local buy-in, this approach will be costly and may further delay piloting of actual HIV testing interventions in wider UK settings. Selection of suitable settings could be guided by estimates using local target population characteristics, published and grey literature, and routinely available surveillance data. An example is the successful implementation of routine diagnostic HIV testing in London Tuberculosis clinics, given increasing rates of Tuberculosis and HIV co-infection in London (15,16). Primary care and community based settings are likely to provide significant opportunities for early detection of asymptomatic infection, but at present it is unclear what approaches or criteria should be used, whether at area, healthcare setting, or individual level. Possible pilots could include targeted testing of new entrants to the UK at registration with primary care, or testing of sexual partners of women diagnosed through antenatal screening.

Expanding HIV testing outside GUM settings has been recommended in the 2001 National Strategy for Sexual Health and HIV and in several national documents since, yet to date there has been no specific guidance on how to implement these recommendations. While there is consensus among key stakeholders on the need to increase HIV testing to reduce late diagnoses and undiagnosed HIV, there is less agreement on the way forward. Improving knowledge on 'what works' and how we will address the social impacts in the UK context will allow us to develop evidence informed HIV testing strategies and to make a more convincing case to non-HIV specialist clinicians and decision makers.

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