SH&BBV

TAYSIDE

Human Immunodeficiency Virus (HIV)

Testing Guideline

Version 3.0

NHS
Tayside

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1. BACKGROUND

1.1 Purpose

This guideline describes good practice for HIV testing in Tayside. It is to guide NHS staff and other agencies on all aspects of HIV testing.

1.2 Epidemiology

There are an estimated 105,200 people living with HIV in the UK (2019) and 94% of these are diagnosed and aware of their infection[1]. 98% of people diagnosed with HIV in the UK are on treatment, and 97% of those on treatment are virally suppressed which means they can't pass the virus on. Of all the people living with HIV in the UK, 89% are virally suppressed.

When HIV first emerged in Scotland in the 1980s people who inject drugs (PWID) and men who have sex with men (MSM) accounted for the majority of positive tests. Infections in MSM account for the largest proportion of prevalent infection in Scotland. There has been a significant decline in new HIV diagnoses in the UK in the past few years as a result of increases in testing and HIV prevention therapies (e.g. Pre-exposure prophylaxis (PrEP) and treatment as prevention (TasP)).

29% of new cases in Scotland were diagnosed late and half of these were at a very late stage with advanced HIV disease[2]. There has been an increase in diagnoses among people who inject drugs associated with an outbreak in NHS Greater Glasgow and Clyde commencing in 2015 and continuing at present. **Despite this recent outbreak HIV is not confined to people who have traditional "high risk" aspects to their lifestyle, and we advise staff to take a wider view when considering HIV testing.**

1.3 NHS Tayside responsibilities

NHS Tayside is committed to:

- reducing the proportion of undiagnosed HIV-infected individuals in Tayside
- reducing the proportion of late-stage HIV diagnoses
- supporting its workforce and that of its partners to deliver HIV testing in a variety of settings

NHS Tayside is committed to providing:

- HIV testing performed in a sensitive, non-judgmental and confidential manner
- results which are accurate and delivered in a timely manner
- health promotion advice and public health interventions which accompany the testing process
- prompt review of all new positive individuals without undue delay including reviewing missed opportunities for testing

2. HIV TESTING: WHY?

2.1 To reduce the proportion of undiagnosed infections

It is estimated that 6% of people infected with HIV in the UK are unaware of their HIV status[1].

2.2 To prevent the morbidity and mortality associated with late stage disease (CD4 <350 cells/mm3)

People diagnosed with HIV late have an eightfold increased risk of death in the year following diagnosis compared to those diagnosed promptly. In 2019, 29% were diagnosed late in Scotland[2.]

2.3 To prevent the onward transmission of HIV infection

Undiagnosed HIV-infected individuals account for the majority of newly transmitted infections. Transmissions are more likely to occur during primary HIV infection and in late stage disease. Evidence shows that a diagnosis of HIV results in behavioural changes that reduce the risk of onward transmission as does effective anti-retroviral therapy. Diagnosis and intervention in pregnancy reduces the risk of transmission from 25% to less than 1%.

3. HIV TESTING: WHO?

3.1 Who can do an HIV test?

It should be within the competence of any doctor, midwife, nurse or trained healthcare professional to obtain consent for and conduct an HIV test.[3]

Within Tayside a number of non-healthcare staff such as harm reduction workers and social workers have also been trained to deliver testing for HIV using dry blood spot tests or point of care tests.

3.2 Who should be offered an HIV test?

3.2.1 Universal screening (“opt-out”):

All individuals accessing the following services should routinely be offered and recommended HIV testing regardless of their risk. The individual has the option to refuse a test*

a. Sexual health services
b. Termination of pregnancy services
c. Antenatal services[4]
d. Addiction and substance misuse services
e. Prisons
f. Healthcare services for Hepatitis B, C, TB and Lymphoma

Individuals commencing chemotherapy or immunosuppressive or immunomodulatory therapy should be offered an HIV test in line with relevant NICE/speciality guidelines (GPP).

The offer of an HIV test should be integrated into routine practice to normalise HIV testing.

**Where an HIV test has been recommended and refused this should be carefully recorded in the patient's medical record. Reasons for declining a test should be explored to ensure that these are not due to incorrect beliefs about the virus or the consequences of testing. Written information about HIV testing should be given to the patient and the test re-offered at a later date.*

3.2.2 Testing of risk groups:

Opportunistic HIV testing should be routinely offered and recommended to the following individuals, regardless of their clinical presentation. Testing should be undertaken at the earliest opportunity in both primary care and medical specialty settings. The individual has the option to refuse a test*

a. All individuals diagnosed with any sexually transmitted infection
b. All sexual partners of individuals known to have HIV**
c. All men who disclose sexual contact with other men
d. All female sexual contacts of men who have sex with men
e. All individuals reporting a history of injecting drug use
f. Sex Workers or people involved in Commercial Sexual Exploitation
g. Trans women and consider for Trans men
h. All individuals originating from a country of high HIV prevalence (>1%)***
    i. Sub-Saharan Africa
    ii. Caribbean
    iii. Thailand
i. All individuals reporting sexual contact with someone from a country of high HIV prevalence regardless of where that contact occurs***
j. All at risk children (See appendix 3 for detailed guidance on defining risk and HIV testing children)

** Repeat testing may not be indicated for monogamous partnerships if subsequent episodes of sexual contact were known to be protected by TasP (i.e. the person living with HIV was on ART with a maintained undetectable viral load). Repeat testing will also be influenced by other potential risk behaviours of the person without HIV.

*** People originating from high risk countries should be tested at first presentation to health services. Re-testing thereafter should be guided by additional risk as above including sexual contacts (new or untested) from high risk countries. People from low risk countries who have travelled to high risk countries should be tested if they report high risk exposures including sexual contact or invasive medical procedures.

The offer of an HIV test should be integrated into routine practice to normalise HIV testing.

3.2.3 Testing on clinical grounds:

HIV testing should be routinely offered and recommended to any individual presenting with symptoms where HIV enters the differential diagnosis or with conditions epidemiologically linked to HIV. See table 1 for a full list of conditions where HIV testing is recommended. The individual has the option to refuse a test*.

a. Suspected primary HIV infection (seroconversion illness)

Up to 80% of individuals will present with symptoms within 2 - 4 weeks of infection. Making a diagnosis at this stage will allow the patient into early monitoring and care, prevent presentation with advanced immunosuppression and contribute to the prevention of onward transmission.

Individuals may present with any combination of the following transient symptoms:

- Fever
- Rash
- Pharyngitis
- Myalgia
- Headache/aseptic meningitis
- Lymphadenopathy

Recommendations:

All adults presenting with a “glandular fever”-type illness where the EBV IgM is negative should be offered an HIV test.

All adults admitted with aseptic meningitis should be recommended to have an HIV test.

b. Symptomatic HIV infection (see table 1)

HIV is a multi-system disease and may present to a number of clinical services. Where HIV falls within the differential diagnosis of any presenting complaint an HIV test should be recommended regardless of the presence or absence of particular risk factors. A risk assessment is therefore not necessary. Table 1 lists clinical indicators for HIV infection and the associated rationale for HIV testing.

Table 1: AIDS-defining conditions in people living with HIV and indicator conditions by specialty

Specialty	AIDS-defining conditions in people living with HIV	Indicator conditions
Dentistry		
	Kaposi's sarcoma	Oral hairy leukoplakia Unexplained oral candidiasis
Dermatology		
	Herpes simplex, ulcer(s) >1 month Kaposi's sarcoma	Exanthema Herpes zoster Seborrhoeic dermatitis Severe or atypical psoriasis
Ear, Nose and Throat		
		Mononucleosis-like illness Oral hairy leukoplakia Unexplained lymphadenopathy Unexplained oral candidiasis
Gastroenterology / Hepatology		
	Cryptosporidiosis diarrhoea >1 month Isosporiasis >1 month Candidiasis, oesophageal	Anal cancer/dysplasia Hepatitis A Hepatitis B or C (acute or chronic) Unexplained chronic diarrhoea Unexplained weight loss
General practice / Emergency Medicine		
	Symptomatology fitting any of the listed conditions	Symptomatology fitting any of the listed conditions
Genitourinary medicine		
	Herpes simplex, ulcer(s) >1 month	Sexually transmitted infections
Haematology		
	Lymphoma	Unexplained leukocytopenia/ thrombocytopenia >4 weeks Unexplained lymphadenopathy
Infectious Diseases / Internal medicine		
	Mycobacterium avium complex or Mycobacterium kansasii, disseminated or extrapulmonary	Candidaemia Herpes zoster

	Mycobacterium, other species or unidentified species, disseminated or extrapulmonary Salmonella septicaemia, recurrent Cytomegalovirus, other (except liver, spleen, glands) Herpes simplex, ulcer(s) >1 month/ bronchitis/pneumonitis Atypical disseminated leishmaniasis Reactivation of American trypanosomiasis (meningoencephalitis or myocarditis) Cryptococcosis, extrapulmonary Histoplasmosis, disseminated/extrapulmonary Coccidioidomycosis, disseminated/extrapulmonary Talaromycosis (penicilliosis), disseminated	Invasive pneumococcal disease Mononucleosis-like illness Oral hairy leukoplakia Unexplained chronic renal impairment Unexplained fever Unexplained lymphadenopathy Unexplained oral candidiasis Unexplained weight loss Visceral leishmaniasis
Nephrology		
		Unexplained chronic renal impairment
Neurology		
	Progressive multifocal leukoencephalopathy Cerebral toxoplasmosis	Guillain–Barré syndrome Mononeuritis Multiple sclerosis-like disease Peripheral neuropathy Subcortical dementia
Oncology		
	Cervical cancer Non-Hodgkin lymphoma Kaposi's sarcoma	Anal cancer/dysplasia Malignant lymphoma Primary lung cancer Unexplained lymphadenopathy Unexplained weight loss
Obstetrics and Gynaecology		
		Cervical dysplasia
Ophthalmology		
	Cytomegalovirus retinitis	

Primary Care		
	Symptomatology fitting any of the listed conditions	Symptomatology fitting any of the listed conditions
Respiratory		
	Pneumonia, recurrent (two or more episodes in 12 months) Mycobacterium tuberculosis, pulmonary or extrapulmonary Pneumocystis carinii pneumonia Candidiasis, bronchial/tracheal/ pulmonary	Community-acquired pneumonia Invasive pneumococcal disease

3.2.4 Testing the source in an exposure incident:

Individuals who have been the source for a potential HIV exposure incident (e.g. the source patient in an occupational needlestick injury) should be tested. The individual has the option to refuse a test*. The NHS Tayside guideline for occupational post-exposure prophylaxis contains a patient information leaflet for the source patient.

4. HIV TESTING: HOW?

4.1 Where can HIV testing be carried out?

An HIV test can be undertaken in any out-patient or in-patient clinical setting. Consideration should be given to the patient's confidentiality when discussing HIV testing in the ward setting.

4.2 What kind of risk-assessment should I undertake?

If the individual has signs and symptoms for which HIV is in the differential diagnosis then testing should be carried out regardless of the presence or absence of specific risk factors.
Risk assessment for asymptomatic individuals may inform the manner by which results are conveyed. Consideration should be given to providing results face-to-face for anyone identified as being at high risk of infection. See appendix 1 for a simple risk assessment questionnaire. This can be completed by either the staff member or individual and filed within the medical record. Dates should be recorded for any risk identified.

4.3 What information does the individual need before testing?

- Individuals should be aware that they are being tested for HIV
- Individuals should be aware of the benefits of testing including early diagnosis, prevention of onward transmission and access to treatment and care if positive
- Individuals should know when and how the result will be available to them, including the means by which a positive result would be delivered

- Individuals within a window period should be advised when to retest
- Individuals should be reassured that the result will not be given to any third party without their prior consent
- Individuals should be given written information regarding HIV testing (Patient information leaflet: Having a HIV test)
- Children and young people, those with learning difficulties or mental health problems, and those where English is not a first language, may need additional support and time

4.4 What kind of consent do I need to obtain?

Informed consent is required and verbal communication is sufficient.[5]

4.5 What if the patient lacks capacity to consent?

In rare settings where the HIV status of an individual would influence their clinical management, but the patient may lack the capacity to consent to testing; examples include: the unconscious patient, an individual with learning difficulties, dementia and young children. If the lack of capacity is deemed to be temporary, then testing should be deferred until capacity is regained unless immediately necessary to save life or prevent serious deterioration.

If the lack of capacity is deemed to be permanent, the doctor in charge of the patient's care will need to decide if HIV testing is in the best interest of the patient. The implications for third parties are important but should not override the interests of the patient. HIV testing should be undertaken in line with the terms of the Adults with Incapacity Act Scotland (2000)[6] however consideration should be given to maintaining the patient's confidentiality. The specialist HIV team are available to support other teams in these difficult circumstances. Discussion of these issues with colleagues is essential to ensure that the decision to test or not to test is a consensus view.

4.6 HIV testing and confidentiality

The same principles of confidentiality apply to HIV and HIV testing as to any other medical condition/investigation. The result of an HIV test should be given directly by the testing team to the patient and not via any third party unless previously agreed with the patient. Sexual health clinics are able to provide anonymous HIV testing which may be more acceptable to some individuals. The medical record for investigations carried out within sexual health clinics is held separately from hospital and primary care records.

5. HIV TESTING: PRACTICALITIES

5.1 Which sample should I take?

The NHS Tayside HIV screening test is performed on a venous blood sample obtained by venepuncture.

5.2 Which blood tube do I use?

A single yellow-topped vacutainer.

5.3 What kind of a test is it?

A fourth-generation test is used in Tayside and is the gold standard. It detects the presence of HIV antibody and antigen. The test will typically become positive in infected individuals within 45 days of exposure.[3]

A negative result on a 4th generation test performed at 45 days post exposure is highly likely to exclude infection.

Post-exposure prophylaxis, PrEP and early ART initiation in acute infection can blunt the HIV antibody response. Anyone with atypical HIV tests on PrEP should undergo repeat testing 4 and 8 weeks after PrEP cessation.

5.4 How do I request an HIV test?

Using ICE in General Practice:

- Go to main screen
- Select MM - sexual health O&G and BBV
- Select other SRH, GU,BBV, O&G tests
- Tick HIV Screening test

Using ICE in a hospital setting:

- click on the Microbiology panel (on the middle near the top)
- click on “HIV screening test”

5.5 Are there alternative tests?

5.5.1 Dried blood spots tests (DBS)

HIV antibody and antigen testing can be performed on dried blood spots. This involves taking a finger prick of blood onto a special paper card, drying this card and sending it to the lab. It is currently used in a number of services such as harm reduction for people who use drugs and should be limited to those with poor venous access that prohibits venepuncture (DBS policy).

5.5.2 Home sampling (HIV postal test)

Home sampling involves collecting a sample of blood at home and posting to a laboratory for testing. There are no current nationally funded home sampling schemes.

5.5.3 Point of care tests (POCT) – rapid tests

NHS Tayside

The Alere Determine® HIV 1/2 Ag/Ab Combo test is in use within Tayside sexual and reproductive health service. This POCT is a fourth generation assay and able to detect both antibody and antigen separately. It is not as sensitive or specific as the standard laboratory test and service users will be recommended to give a venous blood sample for standard laboratory testing. The advantage to the POCT is that results can be given within 20 minutes and prolonged anxiety whilst waiting for test results, which can be a barrier to testing, can be avoided in higher risk groups.

Self testing

Self testing kits are available free through the Terrence Higgins Trust Fastest programme https://test.tht.org.uk/order and HIV Self Test Scotland www.hivtest.scot. These are fingerprick blood tests with the results available after 15 minutes. These are third generation tests with a window period of 90 days. Results of self-administered tests are considered 'reactive'* when they indicate the presence of HIV antibodies or antigens. As there is a small possibility of a false-positive result, a single rapid diagnostic test is not sufficient to diagnose HIV and confirmatory laboratory testing is required.

5.5.4 HIV RNA or DNA tests

HIV-1 viral load assays are not recommended for diagnostic testing in individuals with symptoms of primary HIV infection. There is only a marginal advantage over fourth generation screening assays for detecting primary HIV infection and there is a higher risk of false positive results with this assay.[7]

The only indication for HIV nucleic acid detection assays for diagnosis is in infants born to HIV infected mothers in the first 18 months of life. During this period an antibody test is unreliable due to maternal antibodies.

6. HIV TESTING: THE RESULTS

6.1 How long does a laboratory test result take to come back?

Most results will be visible on ICE two working days after the blood arrives in Medical Microbiology in Ninewells. It is possible to use ICE to check when the sample has been received; the status of the request will change from REQ to REC.

Some exceptional situations may call for a more rapid result. It is usually possible for the laboratory to perform the screening test the same day the blood arrives if:

- the case has been discussed with the duty virology consultant on bleep 4449 before the sample arrives and rapid testing agreed

AND

- the sample arrives in the lab before 4pm during a working day (Monday to Friday)

After the rapid screening test has been performed, the result will be phoned to the requesting team.

6.2 How should I communicate results?

Negative results should be communicated to the patient within 14 days. Positive results should be communicated to the patient within a maximum of seven days of the sample being taken[8].

It is necessary to agree with the patient an acceptable means of communicating their results and to obtain accurate and up-to-date contact details (phone number, address). You should document an agreed plan for the patient should you fail to be able to contact them by the agreed means. This might include communicating the results via their general practitioner.

The patient should have results communicated to them as agreed at the pre-test discussion. Face-to-face provision of HIV test results is strongly encouraged for:

- ward-based patients
- individuals more likely to have an HIV-positive result
- those with mental health issues or risk of suicide
- those for whom English is not their first language
- young people under 16 years
- those who may be highly anxious or vulnerable

6.3 What if the test is negative?

The patient with a negative 4th generation laboratory test result 45 days or more since last risk should be assured that HIV infection has been excluded.

It is good practice to offer health promotion advice around risk reduction or behaviour change to those individuals at higher risk of repeat exposure to HIV infection and screening for other sexually transmitted infections. Individuals at high risk of sexually acquired HIV can be referred to the Sexual Health Advisers for risk reduction support (01382 632600). People who use drugs can be referred to the Harm Reduction Service (01382 204248).

6.3.1 In what circumstances should repeat testing be arranged?

A repeat test should be organised if a patient tests negative but reports a high risk exposure in the last 45 days.

Specialist sexual health clinics have a system in place to recall high-risk individuals attending their service who defer testing until the window period is complete.

Patients with symptoms compatible with primary HIV infection who test negative should have a repeat test one week later and another at 45 days after their last risk.

Annual screening should be recommended for MSM, sex workers and people who use drugs according to national UK guidance.[3]

6.4 What if the test is positive?

In the context of symptoms and signs of HIV, a positive test indicates infection. A confirmatory test will be carried out on the same sample and a second sample requested for further confirmation.

Post-test discussion when a patient tests positive should follow good clinical practice for any situation where bad news is being conveyed. The result should be given face to face in a confidential environment and in a clear and direct manner. If a patient's first language is not English, consideration should be given to utilisation of an appropriate confidential translation service (email: tay.interpretersbookings@nhs.scot).

When a positive result is being given by someone who is not an HIV specialist, it is essential to have clarified knowledge of local specialist services and consult the pathway for onward referral (Appendix 2). It is recommended that any individual testing HIV positive for the first time is seen by a specialist (HIV clinician, specialist nurse, sexual health advisor or voluntary sector counsellor) at the earliest possible opportunity (See section 8). More detailed post-test discussion (including assessment of disease stage, consideration of treatment, and partner notification) will be performed by the HIV specialist team.

Any clinical department which has adopted universal screening for HIV must have a written policy describing how positive results will be managed.

6.5 What if the patient does not attend for a positive result?

It is the responsibility of the testing team to ensure that the results of any medical investigations requested are received and acted upon. If there is no means of contacting the patient or if attempts are unsuccessful then please contact the specialist HIV team (see section 8 for contact details) for further support and advice. The best interests of the patient and the public in this scenario outweigh any concerns regarding the sharing of medical information.

7. HIV TESTING: FREQUENTLY ASKED QUESTIONS

Patients should be provided with an information leaflet which is available here.

7.1 "Will HIV testing affect my life insurance?"

The Association of British Insurers (ABI) states that it is standard practice to ask about positive HIV tests. The result of a negative test should not be requested, need not be disclosed and if it is, will not affect the terms of any policy. The ABI have updated their guidance to let people living with HIV know that they can get life insurance, and that they do not need to cancel an existing policy if they become HIV positive. Further information can be found on the ABI website.

7.2 "If I don't have any risk factors, why should I be tested?"

Although the prevalence of HIV is much higher in "traditional risk groups" such as people from endemic areas or MSM, HIV can affect anyone. The people most likely to present with late stage disease are those who have no traditional risk factors for HIV infection.

7.3 "If I have HIV, I'd rather not know…"

Although HIV cannot be cured, the outcome is very good. A diagnosis would allow access to treatment and monitoring which have been shown to significantly reduce the mortality and morbidity associated with the infection. Furthermore, identifying the infection will allow other at-risk individuals to be tested.

7.4 "If the test is positive, who else do I have to tell?"

The medical team will not disclose the positive result to any third party (i.e. parties out with the medical team) without the patient's consent. We recommend that patients are given time to process their own diagnosis and over time, the HIV specialist team will work with the patient to identify other people who may be at risk of having HIV and contacting them can be done anonymously if preferred. It is important for the patient's general practitioner to know their HIV status in order to offer them the best possible quality of care.

8. CONTACTS WITHIN THE SPECIALIST HIV TEAM

For advice and support contact:

HIV Care Co-ordinator
Sexual Health Service
South Block, Level 7
Ninewells Hospital
Dundee, DD1 9SY
Telephone: 07768 058301

HIV Specialist Nurses
Sexual Health Service
South Block, Level 7
Ninewells Hospital
Dundee, DD1 9SY
Telephone: (01382) 496554 Ext. 36554

Any patient who is symptomatic and newly diagnosed requires urgent assessment.
Please refer urgently to the Infectious Disease Team via email: tay.id@nhs.scot
This email account is checked daily Monday to Friday.

Tayside Sexual and Reproductive Health Service
01382 425 542

9. RESOURCES

For Professionals

British HIV Association/British Association for Sexual Health and HIV and British Infection Association adult HIV testing guidelines 2020. Available here

E-learning Modules:

E-learning for Healthcare: Sexual Health and HIV (consists of modules that can be tailored to your requirements)

TURAS: HIV Pre-exposure Prophylaxis for Practitioners

TURAS: Recognition and diagnosis of HIV infection

Local training courses are available at www.sexualhealthtayside.org/professionals/training/

For Patients

A printable A4 leaflet on HIV testing is available here.

Easy Read information on all aspects of HIV prevention, testing and treatment available from National AIDS Map: www.aidsmap.com/topic/testing-health-monitoring

For local information please visit Sexual Health Tayside Website: www.sexualhealthtayside.org

10. REFERENCES

1. Trends in HIV testing, new diagnoses and people receiving HIV-related care in the United Kingdom: data to the end of December 2019. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/939478/hpr2020_hiv19.pdf

2. HIV in Scotland: update to 31 December 2019. Available from: https://hpspubsrepo.blob.core.windows.net/hps-website/nss/3085/documents/2_hiv-in-scotland-2019-annual-report.pdf

3. BHIVA/BASHH/BIA Adult HIV testing guidelines 2020. Available from: https://www.bhiva.org/file/5f68c0dd7aefb/HIV-testing-guidelines-2020.pdf

4. NICE Clinical Guidelines (2019). Antenatal care for uncomplicated pregnancies. Available from: https://www.nice.org.uk/guidance/cg62/chapter/1-Guidance#screening-for-infections

5. General Medical Council. Decision making and consent. Available from: https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf?la=en&hash=BE327A1C584627D12BC51F66E790443F0E0651DA

6. Scottish Government (2000). Adults with Incapacity (Scotland) Act 2000. Available at: http://www.legislation.gov.uk/asp/2000/4/contents

7. Gokengin D et al. 2021 European Guideline on HIV Testing in Genito-urinary medicine settings. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/jdv.17139

8. Healthcare Improvement Scotland (2011). Standards for HIV Services. Available at: http://www.healthcareimprovementscotland.org/programmes/long_term_conditions/hiv_treatment_and_care/hiv_standards.aspx

Appendix 1 Brief HIV risk assessment questionnaire

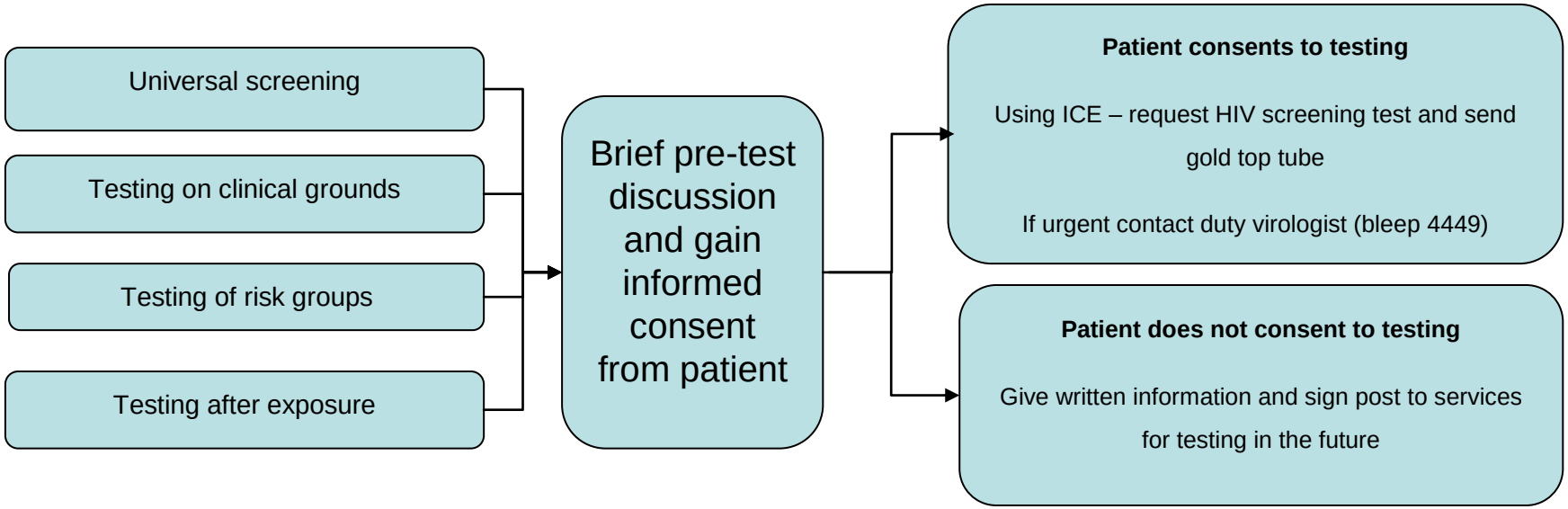
Have you ever been tested for HIV before?	yes (date) no
Have you ever had sex with someone you know to have HIV? If yes, was that person on effective HIV treatment with a suppressed viral load	yes/no yes/no
Have you ever injected drugs? Have you had sex with someone who injects drugs?	yes/no yes/no
(Male patients) Have you ever had sex with another man?	yes/no
(Female patients) Have you had sex with a man who is gay or bisexual?	yes/no
Have you had sex with someone from a high risk country? (Sub-Saharan Africa, Thailand, Caribbean)	yes (country) no
Have you ever paid for sex or been paid for sex?	yes/no
Have you ever been forced to have sex against your will?	yes/no
Have you had any tattoos or piercings done in a non-professional setting?	yes/no

Appendix 2 HIV Testing Pathway

Testing for HIV can be performed by any healthcare worker, including doctors, nurses and midwives.

Referrals to the NHS Tayside HIV team for support with testing or for care of a patient found to be HIV positive can be made by any agencies including:

- General Practice Teams
- Social Work Teams
- Substance Misuse Services
- Scottish Prison Service / Prison Healthcare
- Antenatal Clinic
- Voluntary Sector



NHS Tayside

Managing HIV test results

HIV test performed with patients consent

HIV negative result

Assess the need for retesting based on risk exposure and window period.

Give basic health promotion advice and sign post or refer to other agencies – TSRHS, Voluntary Sector, Social Work, Harm Reduction

HIV Positive Result

Virology lab will contact the testing team on the day of the positive screening test result.

The testing team will communicate the test result to the patient.

Additional support to the team and the patient is available from HIV nurse specialists on 01382 496 554.

Please refer urgently to the HIV team via email:

tay.id@nhs.scot

This email is checked at least once per day Monday – Friday.

Any patient who is symptomatic and newly diagnosed requires urgent assessment.

Please discuss with the on-call ID registrar (bleep 5075).

Appendix 3 Testing infants, children and young people for HIV

1. Introduction

Any infant/child/young person thought to be at significant risk of HIV infection, including all those with parents or siblings who are HIV-infected, should be tested for HIV. It is in the best interest of the infant /child/young person to be tested in these circumstances. This needs to be undertaken urgently in infants who are at risk of rapid disease progression.

2. Which children should be tested for HIV?

Infants and children:

- whatever their age where the mother or father has HIV, or may have died of an HIV-associated condition
- born to mothers known to have HIV in pregnancy
- born to mothers who have refused an HIV test in pregnancy
- who are presented for fostering/adoption where there is any risk of blood-borne infections[1]
- newly arrived in the UK from high-prevalence areas (they may be unaccompanied minors)
- with signs and symptoms consistent with an HIV diagnosis
- being screened for a congenital immunodeficiency
- in circumstances of post-exposure prophylaxis[2]
- in cases where there has been sexual abuse (*see* below)
- who have a sibling who is known to be HIV positive

3. Consent

Obtaining consent for HIV testing from children

In Scotland, children are defined as those under 16 years old.[3] Young people under 16 years accessing sexual healthcare (which would include HIV testing as part of a sexual health screen) without a parent or guardian should be assessed for competency to consent.[4]

Testing in a non-competent child

If a child lacks the capacity to consent, then the consent of one parent or carer with parental responsibility is sufficient. If you are aware of parental disagreement, refer to GMC guidance.[4]

Refusal of testing by a competent young person

This is a difficult area and varies according to country in the UK. In Scotland, parents cannot override a refusal to test by a competent young person.

Refusal of testing by parents of a non-competent child or young person

If parents refuse testing that is clearly in the best interests of a non-competent child or young person then you should consider involving other members of the multidisciplinary team, an independent advocate or named/designated doctor for child protection before seeking legal advice. This also applies if both a young person has capacity and their parents refuse testing.

4. Recommendations for HIV Testing

Testing victims of child sexual abuse

Testing of victims of child sexual abuse should be considered in every case according to risk factors.[5] Testing should always be performed if post-exposure prophylaxis is to be given. Where parental consent is refused, refer to consent section of RCPCH guidelines on physical signs of child sexual abuse.[6]

Testing of children of known HIV-positive parents

Testing should be offered in all cases at risk of vertical transmission whether the risk was recent or not. Increasing evidence shows that children infected vertically can survive into teenage years without being diagnosed. Therefore, it cannot be assumed that older children of mothers with HIV do not require testing. This raises difficult issues of informed consent for these young people, particularly if they are unaware of the mother's diagnosis. Consent should be sought from the biological mother as by default she is also effectively being tested.

Testing of neonates, children and young people where the mother refuses consent and/or disclosure of her HIV status is a complex area. The overriding consideration must be the best interests of the child, and multidisciplinary decision-making and expert advice should be sought, including legal advice where appropriate. It is not acceptable to simply accept a mother's refusal. Referral to a paediatric centre with experience of management of HIV-infected children is strongly recommended.

Parents may need to be supported in making the decision to go ahead to test their children; paediatric HIV support is available nationally through the SPAIIN (Scottish Paediatric and Adolescent Infection and Immunity Network) and Children's HIV National Network (CHINN), details of which can be found on the Children's HIV Association (CHIVA) website, www.chiva.org.uk.

5. What do children need to know about having an HIV test?

One of the main reasons that parents do not want to test their children for HIV is because they are afraid to share the diagnosis with them. It should be explained to parents that a developmentally and age-appropriate explanation of the test should be given to children and that this does not necessarily mean using the term HIV.

1. Older children (usually those older than 11) should be asked to give consent for an HIV test
2. Younger children (usually five to ten years of age) can be told they are being tested for a 'bug' in the blood
3. Pre-school children and infants do not need any formal explanation of why they are having a blood test

6. Which tests are used for testing infants and children?

Children older than 18 months of age: HIV antibody test, as for adults.

Infants younger than 18 months of age: infants born to mothers with HIV receive transplacental maternal HIV antibodies which can usually be detected in the infant blood until about 18 months of age. Infants are therefore tested for genomic evidence of HIV by PCR. For details see Section 5.5.4 of the main document and BHIVA guidelines on the management of HIV in pregnancy.[7]

References

[1] Children's HIV Association of UK and Ireland . *Testing of looked after children.* Available at: http://www.chiva.org.uk/files/9214/2858/7673/Testing_of_looked_after_children.pdf

[2] Children's HIV Association of UK and Ireland (2015. *Post-exposure prophylaxis (PEP) Guideline*. Available at: http://www.chiva.org.uk/files/2814/3575/6995/CHIVA_PEP_2015_final.pdf

[3] UK Government (1995). Children (Scotland) Act 1995. Available at: http://www.legislation.gov.uk/ukpga/1995/36/contents

[4] General Medical Council (2018). *0–18 years: guidance for all doctors*. Available at: https://www.gmc-uk.org/-/media/documents/0_18_years_english_0418pdf_48903188.pdf?la=en&hash=3092448DA3A5249B297C4C5EAEF1AD7549EEB5C7

[5] British Association for Sexual Health and HIV guideline Children and YP 2021https://www.bashhguidelines.org/media/1268/children-and-yp-2021.pdf

[6] Royal College of Paediatrics and Child Health. The physical signs of child sexual abuse. An evidence-based review and guidance for best practice. Sudbury: Lavenham Press, 2015. Available at: http://www.rcpch.ac.uk/physical-signs-child-sexual-abuse

[7] BHIVA guidelines for the management of HIV in pregnancy and postpartum 2018 (2020 third interim update) https://www.bhiva.org/file/5f1aab1ab9aba/BHIVA-Pregnancy-guidelines-2020-3rd-interim-update.pdf