TRANSFORMING THE UK'S RESPONSE TO HIV

NAT

Community HIV Testing:

Evaluation Toolkit

August 2020

Acknowledgements

This publication is kindly supported by Public Health England (PHE) through the HIV Prevention Innovation Fund. It is one of two resources developed as part of NAT's Community HIV testing project.

NAT would like to thank the Community HIV Testing Project Advisory Group who supported throughout this project:

Nicky Connor, Public Health England

Sophie Nash, Public Health England

Chamut Kifetew, HIV Prevention England

Takudzwa Mukiwa, HIV Prevention England

Denis Onyango, Africa Advocacy Foundation

Steve Worrall, Positive East

Peter Bampton, LGBT Foundation

Lauren Duffy, LGBT Foundation

Pat McCusker, Yorkshire MESMAC

Paul Steinberg, London HIV Prevention Partnership

Richard Scarborough, Commissioning Manager, Manchester

Jordi Casabona, Center for Epidemiological Studies on STIs, HIV and AIDS of Catalonia

Dr Ann Sullivan, Chelsea and Westminster Hospital NHS Foundation Trust

Additionally, we would like to thank staff and volunteers from the following organisations who generously contributed their time and expertise:

Actionplus Foundation, Africa Advocacy Foundation, BHA for Equality, LGBT Foundation, METRO, MESMAC Newcastle, Middlesbrough Council, Midlands Partnership NHS Foundation Trust, NAZ, Positive East, Sahir House, Shine, Spectra, Terrence Higgins Trust, Tower Hamlets Council and Yorkshire MESMAC.

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1. Introduction

1.1 Who is this toolkit for?

- **Community Testing Providers (CTPs)**: (Most commonly) voluntary sector organisations that deliver community-based HIV testing interventions. The toolkit also aims to support organisations that don't currently offer testing but are interested in doing so.
- **Commissioners**: In England responsibility for the commissioning of sexual health, including HIV testing, lies predominantly with upper tier local authorities. HIV Prevention England (HPE) provides additional funding for community testing through national campaigns, and some NHS Trusts subcontract CTPs to deliver HIV testing in the community.

1.2 What is community testing?

The term 'community testing' is used to describe a diverse range of interventions. For the purpose of this toolkit, we are mainly addressing HIV testing that is:

- Led by community organisations
- Delivered outside of traditional healthcare settings
- Designed to engage specific populations, particularly those at increased risk of HIV who may not be accessing traditional health services
- Accessible and acceptable to the target population/s
- Designed and delivered with the involvement of the target population/s.

We know that there are examples of community-based HIV testing delivered by or in collaboration with NHS providers, for which some of the information here will still be useful and relevant.

1.3 What is this toolkit for?

This toolkit aims to support community testing providers (CTPs) to evaluate their HIV testing interventions. It will also support commissioners to consider the specific objectives of community testing services that they commission and the data which will help them to assess progress.

Unlike clinic-based sexual health services (SHS), which collect and report data using England's centralised STI surveillance system (GUMCAD), the data collected and reported by CTPs is not standardised. Instead it varies according to each specific organisation and the requirements of their funders.

Public Health England (PHE) collects some national data on community testing through their annual community testing survey, but not all CTPs collect the same data and are able to submit to this survey consistently. This toolkit therefore hopes to support greater consistency of data collection in order to improve national understanding of community testing.

The toolkit does not replicate existing guidance on the evaluation of sexual health interventions produced by PHE and others[1]. Rather it builds on existing guidance in the specific context of community HIV testing and proposes some standardised indicators to support evaluation.

This toolkit complements NAT's *Community HIV testing: Intervention design toolkit*, supporting CTPs and commissioners to ensure that evaluation is built into the design of community testing interventions so that lessons are learned and interventions continuously improved.

1.4 What is evaluation?

Evaluation seeks to determine whether an intervention is meeting its objectives. It tells us not only whether or not something is working, but why that might be and what could be improved. It is an iterative process and an important part of quality assurance and ongoing service design.[2]

Evaluation is often seen as complex and resource-intensive. This does not have to be the case. If well integrated into intervention design, evaluation is simply one component of project management.

There are three main types of evaluation relevant to community testing:

Formative evaluation – helps to shape an intervention before it begins. It is about understanding the needs of the target population and considering how to best meet those needs. It is central to intervention design (see NAT's Community HIV testing: Intervention design

1 See 'Key resources' box on p.5
2 See NAT's *Community HIV Testing: Intervention Design Toolkit.* [https://www.nat.org.uk/nat-topic/community-testing]

Key resources

This toolkit has been informed by a number of resources that explore different components of evaluation. Alongside this toolkit, we particularly recommend that CTPs review Public Health England's *Evaluation framework workbook* and the 'Self-Evaluation Tool' appended to COBATEST's *Guide to doing it better*.

Public Health England:

- Evaluation of interventions in sexual health, reproductive health and HIV services: an introductory guide, 2018[a]
- Sexual health, reproductive health and HIV: evaluation framework workbook, 2018[b]
- Evaluation of interventions in sexual health, reproductive health and HIV: list of standards and metrics, 2018[c]
- Evaluation in health and wellbeing: overview, 2018[d]

COBATEST Network (an initiative linking community-based voluntary counselling and testing services [CBVCTs] across Europe):

- A Guide to do it better in our CBVCT centres: core practices in some European CBVCT centres, 2017[e]
- Core Indicators to Monitor Community-Based Voluntary Counselling and Testing (CBVCT) for HIV, 2017[f]

Centers for Disease Control and Prevention (USA): Evaluation Guide for HIV Testing and Linkage Programs in Non-Clinical Settings, 2012[g]

NHS: Evaluation Works: an [online] toolkit to support commissioning of health and care services[h]

a [https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-services-evaluation-resources]
b [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/717640/SHRH_Evaluation_Workbook_Form.pdf]
c [https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-services-evaluation-resources]
d [https://www.gov.uk/government/publications/evaluation-in-health-and-well-being-overview]
e [https://cobatest.org/wp-content/uploads/2019/07/edat-guide-to-do-it-better.pdf]
f [https://cobatest.org/conferences-and-publications/]
g [https://stacks.cdc.gov/view/cdc/26216/]
h [http://www.nhsevaluationtoolkit.net]

toolkit) and can include methods such as needs assessments and pre-testing of materials. It can also be undertaken while an intervention evolves to inform service revision.

Process evaluation – assesses whether an intervention is being implemented as planned. Process monitoring is the routine collection of information relevant to delivery, for example, the number of venues attended, whether certain protocol was followed and how this compares to expectations. There will also be some overlap with outcome evaluation as some process-related data, for example, data on the number of clients who receive an HIV test, is essential to exploring how and why an intervention was effective. Process evaluation should be conducted on an ongoing basis with results feeding into programme development.

Outcome evaluation – aims to inform about the impact of an intervention over time, and whether it has achieved the intended objectives. Outcomes are the changes that the intervention achieves and may be shorter or longer-term. Increased understanding of safer sex amongst the target population is an example of a longer-term outcome. Assessing outcomes is challenging and it can be difficult to assess whether observed changes are a direct result of the intervention. However, thoughtful planning around what outputs will indicate that outcomes are being achieved can support effective outcome evaluation.

In determining how best to evaluate sexual health interventions, Public Health England advise:

> *"When planning a project always set out to undertake thorough process evaluation, before going on to assess whether the resources exist to undertake an outcome evaluation…*
>
> *Pragmatic evaluations are those that tend to select the most appropriate evaluation methods and approaches according to the resources available."* [3]

This toolkit will focus predominantly on process and outcome evaluation.

1.5 The scale of your evaluation

CTPs will generally have limited resources for evaluation. It is important to ensure that data is not being collected unnecessarily and that evaluation processes put in place are proportionate and designed to assess the intervention against clear objectives.

Who is evaluation for?

It is important to consider the needs of different stakeholders when conducting evaluation. In the case of community testing, stakeholders include:

- Service users
- Programme delivery staff and volunteers
- Programme managers/leads
- Commissioners and funders
- Public Health England

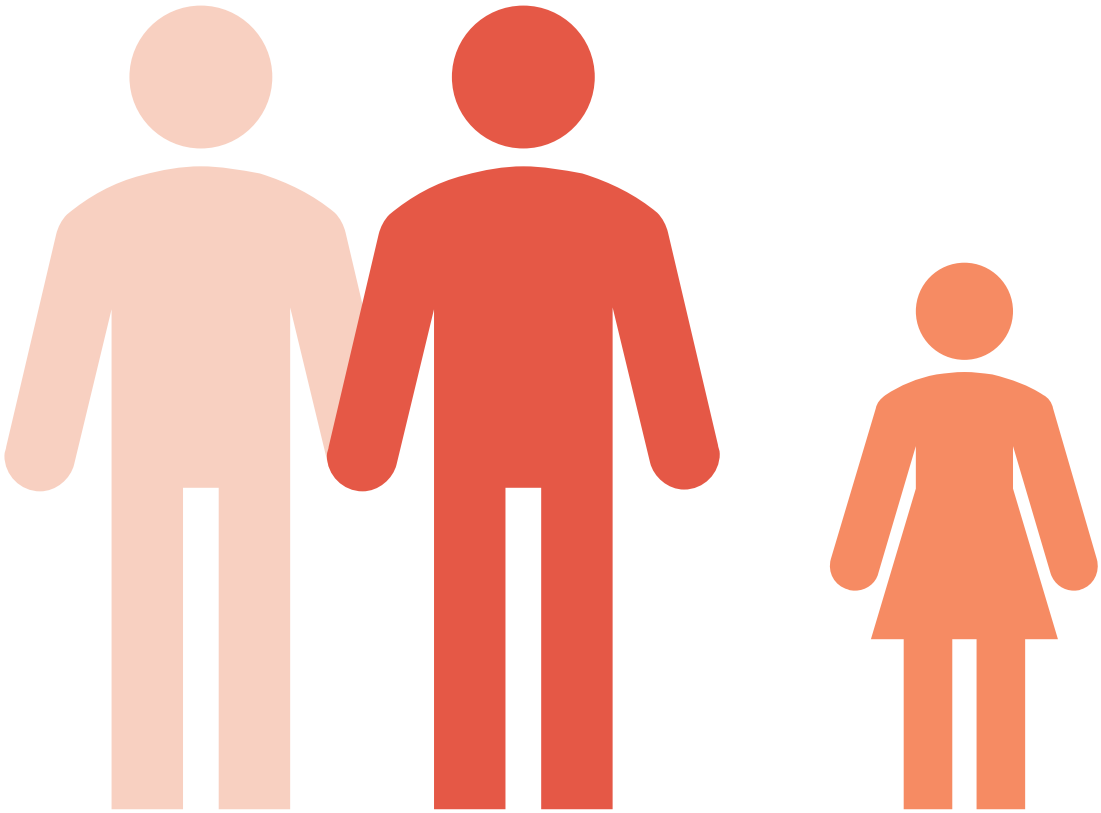
Some stakeholders may need to be closely involved in designing and/or delivering the evaluation process, while others can be consulted or merely informed.

Support with evaluation

Evaluation of community testing tends to be conducted internally. External support is not necessary and is likely to be unfeasible due to the limited resources available to CTPs.

However, some universities or voluntary groups may be willing to support this process by providing volunteers with relevant expertise. One community testing intervention in the North of England engaged a local university to lead its evaluation process, enabling a more complex approach.

CTPs may also benefit from sharing their experiences of and learnings from evaluation with each other, especially when working with similar target populations.



3 Public Health England (PHE), 2018, *Evaluation of interventions in sexual health, reproductive health, and HIV Services: an introductory guide* [https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-services-evaluation-resources]

2. Setting goals

2.1 Identifying the problem

To establish an intervention's objectives it is important to clearly define the problem it seeks to address. Broadly, community testing seeks to tackle the following problem:

Although HIV diagnosis rates continue to decline, 1 in 14 people living with HIV are still undiagnosed, and late diagnosis remains persistently high.[4] This is in part because some people are not accessing traditional sexual health services, or are not accepting the offer of an HIV test when they do, for reasons such as stigma or lack of awareness or perceived risk.

This definition may be used as a starting point, but CTPs should articulate the specific problem that their testing intervention aims to address. Consideration should be given to:

- Local HIV prevalence and proportion of late diagnoses
- Which group/s are disproportionately affected
- Why these groups are disproportionately affected
- Why individuals from these groups are not accessing traditional services
- Existing service provision (by both SHS and CTPs).

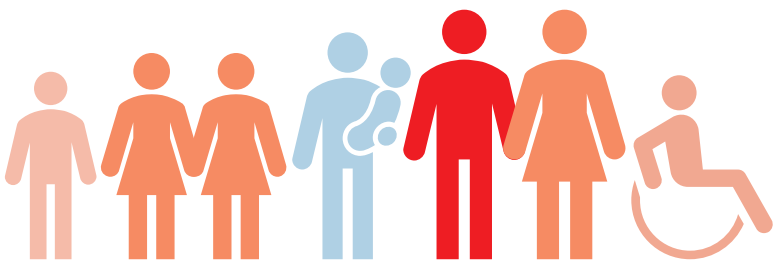
Defining the problem provides the rationale for your intervention and helps to identify which of the objectives and indicators discussed below are relevant to your specific intervention. It can be helpful for CTPs to revisit and review this process to ensure that interventions remain appropriately focused, or to adjust the objectives if the problem has changed.

2.2 Objectives and activities

Objectives describe the goals of community testing intervention. These will be related to the specific problem you are seeking to address, and may include the following:

- Increasing testing and diagnoses in order to reduce levels of undiagnosed and late diagnosed HIV
- Reducing stigma by increasing knowledge and awareness of HIV
- Normalising HIV testing amongst key populations
- Empowering people to manage their own sexual health and wellbeing
- Providing a gateway into treatment, care, and other services relevant to clients' needs
- Linking clients into the wider health system (including primary care).

From these higher-level objectives CTPs should identify key activities that they believe will contribute towards achieving them. To do this they should consider what activities will help them to achieve success. This may be thought of as a simple theory of change for a project. Examples can be seen in **Table 1**. CTPs can refer to NAT's *Community HIV testing: Intervention design toolkit* for further support in developing their planned activities.



4 PHE, 2019, *HIV in the United Kingdom: Towards Zero HIV transmissions by 2030*, 2019 report [https://www.gov.uk/government/publications/hiv-in-the-united-kingdom]

Table 1. Example objectives and activities

Objective	Activities
Increasing testing and diagnoses in order to reduce levels of undiagnosed and late diagnosed HIV.	• Effectively recruit the target population • Test members of the target population/s, including first-time testers and people not accessing SHS • Deliver results to all clients • Ensure that all clients with a reactive result are linked into SHS for confirmatory tests.
Reducing stigma by increasing knowledge and awareness of HIV.	• Conduct regular outreach activities in areas accessible to the target population • Provide accessible and appropriate information to all clients about HIV: how it is and is not transmitted, treatment and care, living with it, etc • Discuss HIV prevention techniques with all clients, and methods of safer sex • Provide information about local condom schemes, PEP and PrEP.
Providing a gateway into treatment, care, and other services relevant to their needs.	• Identify relevant local services and establish referral pathways • Conduct risk assessments with all clients to identify services appropriate to their needs • Refer relevant clients to SHS for PEP, PrEP or full STI-screening • Refer all reactive clients to local SHS for confirmatory testing, and follow up to ensure attendance • Refer relevant clients to other internal or external services such as drug & alcohol services and mental health support.

2.3 SMART goals

These activities can then be turned into measurable SMART goals (Specific, Measurable, Achievable, Relevant, Timely - see PHE's Evaluation… an introductory guide for support)[5]. They should describe the intervention's main activities and outputs in a measurable way and should relate to the desired objectives of the intervention. Monitoring these is key to process and outcome evaluation.

Below is an example of one SMART goal that might be used (alongside others) by a CTP aiming to raise awareness of HIV and increase testing amongst Latin American MSM:

SMART goal:

In one year, x% of clients tested for HIV by the CTP will be Latin American MSM

Specific: Latin American MSM.

Measurable: x% of all clients tested for HIV.

Achievable: x set based on local HIV data (see section A of NAT's Community HIV testing: Intervention design toolkit), service capacity, and previous years' performance.

Relevant: Latin Americans are a growing demographic group in the area. There is limited data of how HIV affects the community and therefore the CTP wishes to improve this and ensure that Latin American MSM are counted as part of their MSM community testing programme. The CTP has links into the community and evidence of low awareness of HIV and testing as well as the existence of broader health inequalities and higher rates of late diagnosis of HIV.

Timely: one year.

This SMART goal would be used alongside others and could be made even more specific to give greater insight into testing practices, for example:

In one year, x% of Latin American MSM tested for HIV by the CTP will be first time testers.

Objectives and goals may need to be revised as the intervention progresses and should be established through a process of stakeholder engagement. Defining good SMART goals that enable effective assessment of the intervention relies on identification of indicators. This is explored throughout the next section.

5 PHE, 2018, *Evaluation… an introductory guide, op. cit.*

3. Quantitative analysis

To evaluate the performance of community testing interventions against their objectives, CTPs can use a range of numerical ***indicators***. Indicators are the things that the CTP measures to test their performance and selecting good indicators is vital to process and outcome evaluation.

Using SMART goals can help a CTP to identify the most relevant indicators for their project. Indicators may be assessed by the CTP in relation to their outputs (e.g. process indicators); may be collected by the CTP in order to assess outcomes (e.g. use of population-level surveys, see section 3.4); or may be drawn from data collection done by others (see section 3.4).

CTPs may wish to seek expert advice and explore additional methods of quantitative analysis not covered by this toolkit.

3.1 Selecting output indicators

This section looks at CTP-led output indicators, but understanding how these link to other relevant outcome indicators is important for telling the story of an intervention's effectiveness.

Many indicators give limited information in isolation, but are useful when compared to one another or with themselves over time. Collating and analysing data at regular intervals (i.e. monthly or quarterly) supports analysis of trends and enables findings to inform intervention improvement.

Organisational capacity for data collection and analysis may be limited so indicators should be chosen according to the specific objectives of the intervention. While this may differ slightly between CTPs, many interventions share common objectives, processes and desired outcomes. Use of consistent indicators for these supports national data collection.

A range of possible indicators based on data collected by the CTP are proposed in **Table 2** and explained in further detail in **Appendix A**. They draw on the current practice of CTPs and the main objectives of community testing. Each indicator is linked to one or more of the community testing objectives outlined in section 2.2.

Core indicators are those we recommend that all CTPs monitor.

Additional indicators should be monitored where relevant and feasible to support stronger evaluation. Well defined SMART goals are a useful way to determine which indicators are most useful.

Some indicators will be reported to funders (and/or Public Health England), while others will be for internal use only. It is vital that the time and resources required to monitor and analyse indicators is built into the costing of the intervention and reflected in funding arrangements.

CTPs will also need to carefully consider the potential barrier to testing that extensive data collection (required to monitor indicators) can create. Community testing is often sold on its speed, convenience and discretion, so it is important that evaluation efforts do not limit the accessibility of interventions.

This list of indicators is not exhaustive and CTPs will need to monitor further process-related indicators depending on the specific design of their interventions. Examples include indicators relating to client recruitment and client satisfaction (see also section 3.2).

Many CTPs offer HIV testing as part of a wider programme of services, such as other HIV prevention activities or STI screening. These are outside the scope of this resource.

3.2 Other process indicators

The indicators in the previous section all directly relate to the objectives of community testing and aim to support CTPs and commissioners to measure progress against these objectives.

In addition to the data required to monitor the indicators above, there may be other client and service level data important to monitoring whether the intervention is being implemented to plan and to inform future service development. Examples are given in **Table 3**.

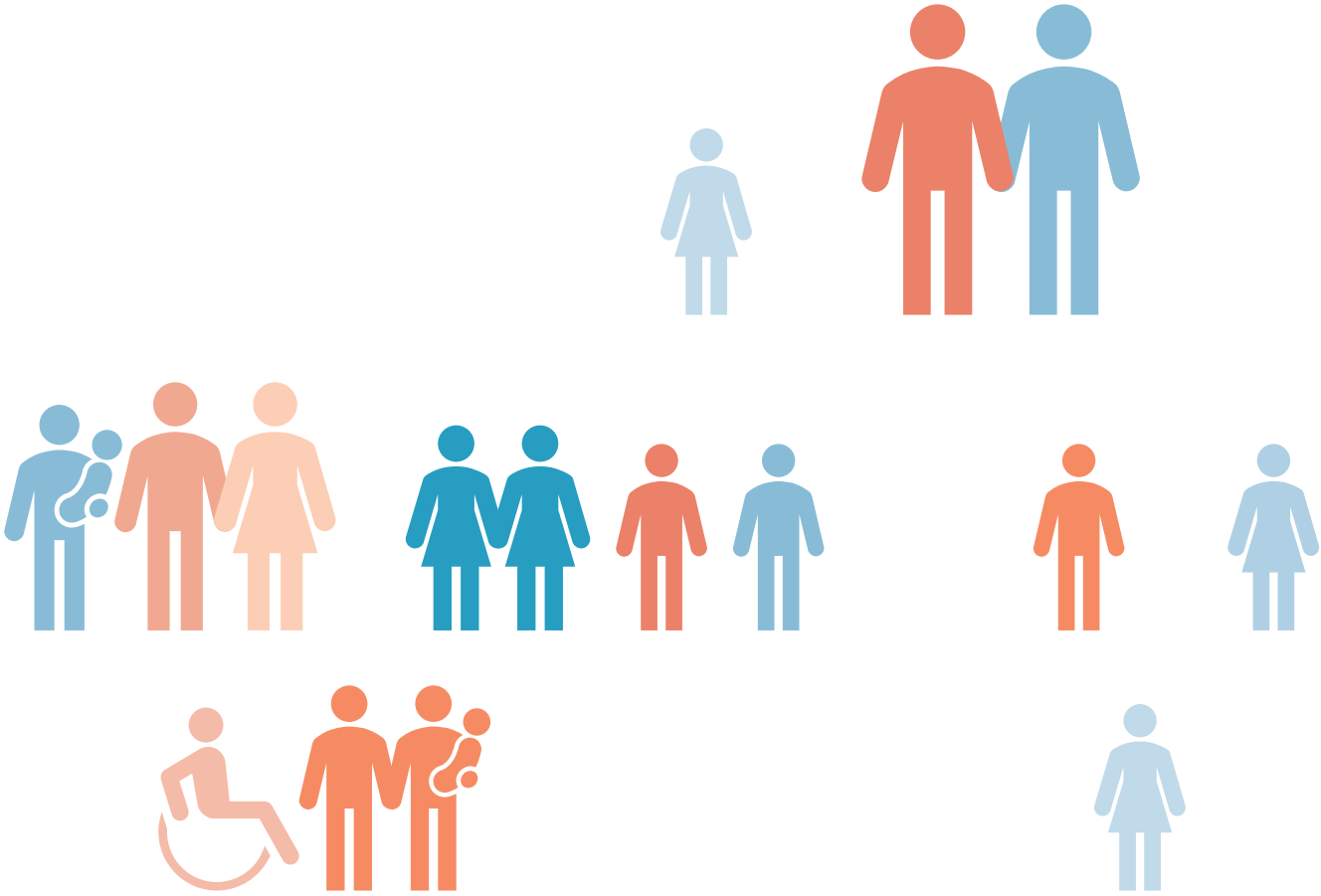


Table 2. Example output indicators

Example indicators	CORE	Increasing testing and diagnoses in order to reduce levels of undiagnosed HIV	Reducing stigma by increasing knowledge and awareness of HIV	Normalising HIV testing amongst key populations	Empowering people to manage their own sexual health and wellbeing	Providing a gateway into treatment, care and other services relevant to clients' needs	Linking clients into the wider health system (including primary care)	Relevant data source in Appendix B
	1. Number of HIV tests conducted	×						
	2. Number of clients tested for HIV	×						
	3. Proportion of clients who are from the target population/s	×		×				B.1
	4. Proportion of clients who have/have not previously tested for HIV (in any setting)	×		×				B.1
	5. Proportion of clients who have previously tested for HIV at the CTP	×		×	×			B.1
	6. Proportion of clients who have tested for HIV in the past year (in any setting)	×		×				B.1
	7. Proportion of clients tested for HIV who received their results	×				×		B.3
	8. Proportion of clients tested for HIV who received a reactive result	×				×		B.3
	9. Proportion of clients with a reactive result who were tested with a confirmatory test in SHS (clinic-based sexual health services)	×				×		B.3
	10. Proportion of clients with a reactive result who received a positive confirmatory test result	×				×		B.3
	11. Proportion of all clients tested for HIV who were referred/signposted to SHS for reasons other than a confirmatory test				×	×	×	B.3

ADDITIONAL							
12. Proportion of clients tested for HIV who were referred/signposted to other internal or external services (e.g. drug and alcohol services, mental health services, etc)				x	x		B.3
13. Proportion of clients who accepted an HIV test that was offered	x	x	x				B.1
14. Proportion of clients who have tested for HIV in the past year at the CTP	x	x	x	x			B.1
15. Proportion of clients who have tested for HIV multiple times in the past year (in any setting)	x	x	x				B.1
16. Proportion of clients who reported a risk of HIV acquisition in since last test or within defined time period	x	x	x	x			B.2
17. Proportion of clients who are registered with a GP				x		x	B.1
18. Proportion of clients with a reactive result with whom partner notification was discussed	x			x			B.3
19. Proportion of clients with a reactive result who were referred to an HIV support service	x			x	x		B.3
20. Proportion of clients with a positive confirmatory test result who were diagnosed late	x				x		B.3
21. Proportion of clients who completed a post-test assessment							B.3
22. Proportion of clients who report increased knowledge about sexual health		x	x	x			B.3
23. Proportion of clients who report increased confidence in talking about sexual health		x	x	x			B.3
24. Proportion of clients who report increased confidence/motivation in practising safer sex		x	x	x			B.3

3.3 Collecting data

To conduct any evaluation requires the collection of relevant data. Contextual information may be drawn from existing data sources (see section 3.4), but CTPs will need to collect new data about the intervention themselves. This involves eliciting client information, documenting results and referrals, and recording information about service implementation.

CTPs should only collect data that is useful and relevant. If data is not being used to inform service design or support evaluation, CTPs should consider whether collecting it is necessary. **Appendix B** details the data required to monitor each of the indicators listed in **Table 2** along with suggestions and example pro formas for internal use by the CTP. These can be used and adapted by CTPs to develop their own forms and processes that are proportionate to the intervention and meet their needs.

3.4 Other outcomes data

As identified in 3.1, CTPs should also identify broader population-level outcome data related to their objectives. Monitoring this data alongside CTP-led output indicators can help to contextualise the data collected by CTPs and enable comparisons with other/wider populations to be made over time.

Table 3. Example process indicators

Information	Possible options/ data collected	Explanation
Test type	Point of care test (blood, saliva); dried blood spot; self-testing; self-sampling.	Where more than one test type is offered, monitoring the uptake of different tests can demonstrate acceptability and inform service design. This data is also required for national data collection purposes.
Appointments	Drop-ins; pre-booked; numbers available; numbers booked; numbers delivered; number of clients who did not attend	This will help CTPs to understand the most successful system for reaching people the intervention is targeting.
Outreach sessions	Number of sessions delivered and where; number of interactions at sessions; number of staff and/or volunteers.	This will help to ascertain how much capacity and resource is expended on achieving outcomes and offers options for comparing the outcomes achieved through working in a range of outreach settings.
Local authority	The local authority in which the client resides (may be beneficial to do further analysis comparing areas within a local authority if possible – would require at least first part of client postcode).	CTPs may only be funded to test clients from specific local authorities, so monitoring this is critical. Where CTPs are able to test clients regardless of residence this data can inform where there is greatest geographical need and whether people travel out of area for testing. This may then inform where CTPs choose to conduct testing and outreach. Data can also be looked at more easily in the context of epidemiological data for the local authority, provided by Public Health England.

When analysing population-level outcomes, findings cannot easily be attributed to a specific intervention. Nonetheless, outcome analysis post intervention may help CTPs to understand how their performance against goals might be contributing to the bigger picture.

Population-level data that may be relevant to community testing interventions includes, but is not limited to, local HIV outcomes (disaggregated by population group) such as:

- New HIV diagnoses
- Late diagnosis rates
- Very late diagnosis rates
- Routes of HIV transmission amongst newly diagnosed.

CTPs may also consider their own local population-level evidence gathering. Examples include surveys of the local population or population groups, or qualitative analysis at a population level. Such activities will be resource intensive and do not replace intervention-specific quantitative and qualitative analysis, but may help to contextualise it.

Table 3. continued

Information	Possible options/ data collected	Explanation
How the client heard about the service	Physical outreach (specify venue); online outreach (disaggregated); marketing (disaggregated); referral (disaggregated by local services); personal recommendation; word of mouth.	Monitoring this is a key element of evaluating the impact of recruitment (see NAT's *Community testing: Intervention Design Toolkit* section B.2).
Reason for testing	Regular check-up; new relationship or sexual partner/s; condom failure; unprotected sex; sex with known HIV+ partner; shared needle(s) when injecting drugs; change in health status; opportunistic testing (outreach); recall (last test within window period); occupational reason; general concern; never tested before.	This supports risk assessment and can demonstrate whether or not the intervention is reaching people in need and who those people are.
Reason for testing with the CTP (as opposed to elsewhere)	Unable to get an appointment at SHS; more convenient time/location; more discrete; immigration concerns; same-day results; opportunistic (outreach) testing; personal recommendation; etc. Note: Consider offering option for open answer.	This is very useful to demonstrate the value of community testing and the barriers to testing in healthcare settings. This may inform commissioning decisions and can be used to improve testing in both community and healthcare settings.
Client feedback	Overall satisfaction with the service; accessibility of the service; staff friendliness/ability to answer questions; satisfaction with the testing space; willingness/intention to use again; willingness to recommend to a friend. Note: Consider offering option for open answer.	Collecting client feedback is vital to support understanding of the acceptability of the service.

4. Qualitative analysis

4.1 Why qualitative analysis is important

Qualitative data collection methods use narrative or descriptive data rather than numbers. This can provide valuable insight into the workings of a project, as well as helpful context and explanation for quantitative outcomes. For example, a CTP may want to know why higher numbers of people have shown interest in testing at some venues compared to others. To answer this, CTPs could use a mix of quantitative and qualitative methods. They could monitor and compare the uptake of testing at different times in each location, but could also survey clients, run ad hoc interviews or find ways to gather the observations of staff and volunteers to provide a better understanding of what conclusions might be drawn.

Quantitative indicators will often raise questions as well as provide answers. For example, indicator 4 in **Table 2** (the proportion of clients who have previously tested for HIV in any setting) tells us whether or not an intervention is reaching those who are not accessing testing in traditional settings. CTPs could then use qualitative questioning to explore the reasons for its success or failure (and the barriers to testing elsewhere); this could in turn influence intervention design.

Collecting and analysing qualitative data can be challenging and time consuming, and therefore quantitative data should form the bulk of community testing evaluation with qualitative analysis providing additional insights to support stronger conclusions. However, qualitative methodology can be scaled depending on capacity and CTPs should consider integrating it into design and evaluation. The following parts of this section summarise some of the methods that CTPs can consider.

4.2 Interviews and observations

The 1-to-1 nature of community testing interventions lends itself to the use of two common methods of qualitative data collection: interviews and observations.

Interviews

The pre- and post-test counselling that takes place during community testing is similar in form to an interview. In the case of community testing this will likely be semi-structured, with largely pre-determined questions but scope for more open discussion. Most of the pre-determined questions will support the collection of the quantitative data detailed above, but CTP staff may also ask open questions such as “What could we do better?”

It is important that this data is collected so that insights not captured by quantitative data items aren’t lost. Answers could be regularly discussed as a team in order to identify key themes and inform iterative intervention design. However, there is a risk that human biases will favour some insights over others. It is therefore important to record qualitative insights as accurately as possible and to ensure that qualitative data is gathered from a relatively broad sample so that conclusions are not skewed. If more capacity is available, recorded responses from interviews can be analysed for common themes and for insights that link to quantitative data.

Observations

Observations involve watching clients’ behaviour to gain insights beyond what the client says. For example, did the client seem comfortable in the testing space? Did the client seem confident talking about sexual health? Was the client noticeably concerned about being seen by others?

These observations can help to contextualise the quantitative data collected and provide further insight into the clients’ experience of the service. Staff and volunteers asked to provide these types of insights should receive training on how to do so appropriately and respectfully, and in a way that accurately reflects the experiences of clients.

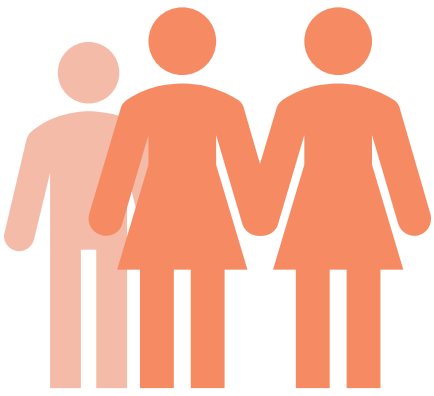
4.3 Narratives

Narratives describe the progress of an intervention during a given time period, contextualising and explaining the quantitative data collected. Narratives may be used internally as part of formative evaluation but should also be included in reporting to commissioners. This is important to ensure that interventions are viewed holistically and in a way that represents their value beyond diagnosing HIV.

The format that narratives take and the information they contain should be agreed between CTPs and commissioners. **Table 4** provides an example of a narrative template.

Table 4. Example narrative template.

Activities/Successes	
This describes or summarises what has taken place to supplement and contextualise the quantitative data provided.	Example: We established a regular monthly POCT (point of care testing) session at X venue and promoted this through a significant amount of physical outreach and flyering in the local area. Although testing uptake has been limited, it has steadily increased each month and we have been successful at engaging West African women. This is a group that we have struggled to engage with elsewhere due to stigma and concerns around visibility, so reaching this group has been highly valuable. As a result we have also developed a referral pathway with a local immigration support service.
Challenges	
This describes any challenges caused by internal or external factors that have hindered progress.	Example: One of our main community champions – the vicar of X Church – has moved to a different parish and his replacement is not currently receptive to working with us. This has resulted in a decline in the number of clients testing from this community. A notable member of the congregation with whom we have a longstanding relationship has arranged a meeting between us and the new vicar, so we hope to develop a more positive relationship in due course.
Opportunities	
This identifies any opportunities that have arisen during this period.	Example: We have developed a strong relationship with the sauna where we have been conducting physical outreach to promote testing and provide sexual health advice and free condoms every week. The owner was initially reluctant to countenance testing on-site but we have identified a suitable space and have arranged to meet with them next week to discuss. We will propose to conduct a survey of sauna users which we believe will demonstrate interest in and acceptability of testing on site, and will then suggest a monthly drop-in session at a time dictated by staff capacity and responses to the survey.



4.4 Case studies

Case studies provide an in-depth study of an individual client's experience of the intervention. This enables CTPs to explain the impact of their intervention as it may relate to individuals. It can also be an effective way of demonstrating the wider value of the intervention and should be a staple part of reporting to commissioners. How case studies are presented should be agreed between CTPs and commissioners. The following case study is an example based on a template used by Manchester's PaSH partnership.

Case Study

Example: Client is a Latin American man who presented at an outreach POCT (point of care testing) session at a local library. He had not planned to attend but was using the library at the time.

Presenting issues

What issues did the client present with?

- Client was extremely anxious about his sexual health.
- Client has recently begun to have sex with men using hook-up apps. He does not feel confident navigating condom usage and has on several occasions been exposed to risk.
- Client had not accessed testing elsewhere due to fears around migration status and financial costs, and concerns about being seen by members of his community.
- Client also expressed concerns about not being in control of his alcohol usage.

Actions

What actions did you take?

- CTP conducted a POCT and referred client to their full-screening service the following day.
- The tester scheduled additional rapid HIV tests due to multiple window periods.
- CTP reassured the client that sexual health services are free at the point of use for everyone, and that clients should not be asked about their residency status.
- CTP referred client to their HIV prevention programme for Hispanic MSM: a series of Spanish-speaking workshop coverings topics including sexual health, drugs & alcohol.

Outcomes

What were the results of your actions?

- Client attended the full-screening service and additional HIV tests.
- Client did not test positive for HIV or other STIs but is now aware of how regularly he should be testing and the different services available to him.
- Client has been engaging well with the Hispanic MSM programme and reports increased confidence around sexual health and condom negotiation, and decreased alcohol use.
- CTP has referred client to a local organisation providing migrant support, and followed up to ensure that the client is attending.

5. Reflecting on findings

It is vital that evaluation findings are reflected on and used to inform decision-making. This will ensure that lessons are learned and that evaluation is an ongoing cycle of improvement.

For evaluation findings to be useful they need to be shared with key stakeholders including managers and funders. How findings are shared will depend on the needs of each stakeholder, but normally involves the periodic development of reports and presentations. These require CTPs to organise and assess findings, describe the context and limitations, and make recommendations for improvement.

When reflecting on findings it is important to keep the objectives in mind and to stay focused on the specific questions that the evaluation seeks to answer. Where successes are not achieved it should be remembered that we can often learn as much from what did not work as what did.

Support on how to present and share evaluation findings can be found in Step 5 of the NHS Evaluation Works toolkit[6] and in Step 6 of PHE's *Evaluation of interventions in sexual health… An introductory guide*.[7] A template evaluation report can be found in section 3 of PHE's *Sexual Health, Reproductive Health and HIV: Evaluation Framework Workbook*[8].

To be useful, evaluation findings must be regularly reviewed and acted upon. Recommendations developed should inform decision-making and influence future intervention design. This requires clear action plans for implementing recommendations to be put in place with agreed timelines and built-in staff capacity. The implementation and impact of recommendations can then be assessed as part of subsequent evaluations.

It is also worth considering whether evaluation findings may be of interest to a wider audience (e.g. fellow CTPs) and/or could be presented at a relevant conference to share learnings.

6 See: [http://www.nhsevaluationtoolkit.net/evaluation-cycle/review-act/]
7 PHE, 2018, Evaluation… an introductory guide, op. cit.
8 PHE, 2018, Sexual health, reproductive health and HIV: evaluation framework workbook, [https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-services-evaluation-resources]

6. Summary

Evaluation can seem complex and challenging but it supports better service design and ultimately, better outcomes. Good evaluation should help CTPs to demonstrate and communicate their impact. It should support funders and commissioners to maximise the value of their investment now and in the future. It highlights learning and areas for improvement. These may be at the process level, supporting better implementation of the intervention, or at a strategic level, affecting future intervention design.

Key points:

- Be clear about the overarching objectives of the intervention and what problem the intervention is trying to address. Make sure there is a clear logic as to why the service is designed to meet these objectives (see Community Testing: Intervention design toolkit). Base this on previous evidence and knowledge of what does and does not work and prepare to test this as part of the evaluation.
- Set SMART goals that link to the objectives and test the effectiveness of the activities. SMART goals are: specific; measurable; achievable; relevant; and timely.
- Review these SMART goals to identify key indicators of success for the intervention and prioritise indicators in terms of the most important. Core indicators should be monitored by all CTPs.
- Review or develop data collection processes at different points in the intervention delivery to ensure that data related to core indicators, and any additional indicators identified, can be safely collected. Aim for data collection that can be done efficiently and in a way which presents the least barrier to the accessibility and acceptability of the intervention.
- Identify external or population-level indicators of success that are also needed to monitor success against SMART goals.
- Identify gaps in knowledge that cannot be gathered through quantitative analysis alone and prioritise which to investigate further. Consider qualitative data gathering that will address these gaps in a way that is proportionate to the capacity of the CTP and the intervention.
- Ensure that qualitative data collection is as robust as possible and that data is recorded accurately to support effective analysis and drawing of conclusions.
- When presenting findings tell the story of the impact – back data-driven analysis up with narrative and real-life examples. Stay focused on the evaluation questions and ensure that both positive and negative findings are shared.
- Make iterative changes to the process and implementation as necessary throughout and consider more significant changes at a strategic level – findings from the evaluation should become the formative evidence for future changes to intervention design.

APPENDIX A – Example output indicators

A.1 Core indicators

1. Number of HIV tests conducted

Total number of HIV tests conducted over a set time period. This should be disaggregated by different test settings and different types of test.

2. Number of clients tested for HIV

Total number of clients tested for HIV over a set time period. This will differ from 'Number of HIV tests conducted' if some clients have tested multiple times.

This data should be disaggregated by gender, sexual orientation, ethnicity, country of birth, and age group. Further disaggregation (e.g. by religion) may also be explored depending on organisational capacity, local context, and the specific objectives that an intervention wants to assess against.

3. Proportion of clients who are from the target population/s

Many CTPs do not restrict testing solely to their target populations. Instead, population groups are targeted according to their level of need but testing is provided to anyone who requests it. To assess the effectiveness of a recruitment strategy, CTPs must identify the proportion of clients tested from each target population.

Target populations commonly include MSM and Black African adults, but may also include other demographics such as trans people, people who inject drugs, and Latin Americans. These should be agreed and defined collaboratively by CTPs and commissioners. Guidance on identifying target populations is provided in NAT's Community HIV Testing: Intervention Design Toolkit.

Numerator	Denominator	Calculation
Number of clients who are from X population	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

4. Proportion of clients who have/have not previously tested for HIV (in any setting)

Testing clients who have not previously tested for HIV (first-time testers) is a key priority to reduce rates of undiagnosed and late diagnosed HIV, and to prevent onward transmission of infection. Community testing is well-placed to reach first-time testers as it is effective in reaching people who are not accessing traditional healthcare.

Numerator	Denominator	Calculation
Number of clients who have/have not previously tested for HIV	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

5. Proportion of clients who have previously tested for HIV at the CTP

Return testers can demonstrate client satisfaction with the service and good testing practice. A CTP may also want to consider the risk profile for returning testers to help assess the impact of previous interventions. Alternatively, this indicator can help the CTP to assess if they are reaching new clients.

Numerator	Denominator	Calculation
Number of clients who have previously tested for HIV at the CTP	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

It may also be useful to calculate this as a proportion of those who have previously tested for HIV – monitored over time this can give some indication of changes in testing practices.

Numerator	Denominator	Calculation
Number of clients who have previously tested for HIV at the CTP	Total number of clients reporting previous testing for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

6. Proportion of clients who have tested for HIV in the past year (in any setting)

Key populations are recommended to test more frequently than the general population.[1] This indicator enables CTPs to compare the testing practices of their clients against recommended testing practices. Changes in this indicator over time can also help to demonstrate the impact of HIV prevention advice on the target population.

Numerator	Denominator	Calculation
Number of clients who have tested for HIV in the past year	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

In addition to calculating the proportion of all clients who have tested for HIV in the past year, CTPs may find it useful to calculate this as a proportion of those who have previously tested for HIV. This can provide further insight into testing practices.

Numerator	Denominator	Calculation
Number of clients who have tested for HIV in the past year	Total number of clients reporting previous testing for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

7. Proportion of clients tested for HIV who received their results

For CTPs that exclusively offer point-of-care testing this value will normally be 100% (except in exceptional circumstances e.g. where a client leaves before the result can be delivered). For CTPs that offer other types of test (e.g. dried-blood-spot or self-sampling), results may be communicated to the client by clinical sexual health services (SHS) at a later date. In this instance, SHS should be encouraged to provide aggregate or anonymised data pertaining to this indicator and indicator 8. This is vital to understand the impact of the evaluation on HIV testing and diagnoses.

Numerator	Denominator	Calculation
Number of clients who received their results	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

1 See UK Government guidance on HIV testing: [https://www.gov.uk/guidance/hiv-testing]

8. Proportion of clients tested for HIV who received a reactive result

This indicator (known as the reactivity rate) measures the success of an intervention in terms of diagnosing HIV. This is of course the fundamental aim of HIV testing, and is often the key indicator used by commissioners to evaluate effectiveness.

However, this alone does not reflect the value and impact of community testing interventions.[2] Furthermore, as rates of undiagnosed HIV decline, reactivity rates will decline too, and will inevitably vary between different groups. Commissioners must be mindful of this, and reactivity rates should be considered alongside a range of other indicators relevant to the intervention's specific objectives. They should also be interpreted in the context of local HIV prevalence amongst the target populations, and may be compared to reactivity rates in other local settings.

Numerator	Denominator	Calculation
Number of clients with a reactive result	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

Client follow-up and confirmatory test data

Indicators 9, 10 and 20 refer to confirmatory tests that clients should receive in a clinical setting in the event of a reactive or indeterminate result. As these tests are not provided by the CTP, accessing information can be challenging, and will not always be possible.

Most CTPs rely on client follow-up to gather this data (see NAT's Community HIV testing: Intervention design toolkit for detail). Follow-up is important to ensure that clients with reactive results receive confirmatory tests and are provided with any further support they may need. **Follow-up must be built into the service specification and funded accordingly.**

CTPs should consider what the most appropriate timeframes are for conducting follow-up. This may be dependent on the capacity of staff/volunteers, the specifics of the referral, and client preference. For example, some CTPs offer to call clients on the same day as a confirmatory test. Others might agree with clients that they will call within a week in recognition of other staff commitments or to give clients some time to process the result.

CTPs should also monitor the proportion of clients who could not be reached ('lost to follow-up'). This is important in order to evaluate the efficacy of follow-up and explore the reasons for any problems.

Although the majority of CTPs follow-up directly with the client, some CTPs have data sharing agreements in place with SHS. These agreements can cover clients' attendance, confirmatory test results, and CD4 count. If such an agreement is in place it must be clearly communicated to the client and they should give consent for this data to be shared. Such arrangements can make monitoring and evaluation easier and more robust.

9. Proportion of clients with a reactive result who were tested with a confirmatory test in SHS (clinic-based sexual health services)

Clients who receive a reactive result must be swiftly referred to SHS for a confirmatory blood test. To monitor referral pathways, CTPs should follow up with clients and/or with SHS (see NAT's *Community HIV testing: Intervention design toolkit*, section E) to confirm attendance. Where necessary, clients should be encouraged and supported to attend.

2 See section 1.3 in NAT's Community HIV testing: Intervention design toolkit, 2020 [https://www.nat.org.uk/nat-topic/community-testing]

When calculating this indicator clients who were not reached by follow-up should be excluded from the calculation but recorded elsewhere.

Numerator	Denominator	Calculation
Number of clients with a reactive result who were tested with confirmatory test	Total number of clients who received a reactive result (and were reached by follow-up)	Numerator / Denominator x 100

10. Proportion of clients with a reactive result who received a positive confirmatory test result

When following up to confirm that clients have attended confirmatory tests, CTPs should seek to ascertain whether results were positive or negative if the client consents to giving this information. This enables assessment of test accuracy and is also important to determine what further support should be offered to clients.

When calculating this indicator clients who were not reached by follow-up should be excluded from the calculation but recorded elsewhere.

Numerator	Denominator	Calculation
Number of clients with a reactive result who received a positive confirmatory test result.	Total number of clients who received a reactive result (and were reached by follow-up)	Numerator / Denominator x 100

Signposting and referrals

It may be necessary to signpost or refer clients to other services. Signposting involves providing a client with the necessary details to approach another service themselves. Referrals involve directly facilitating contact.

Referrals increase the likelihood of linkage but are not always possible or may be refused. CTPs should therefore consider what they can realistically offer (and monitor), and then define the following two indicators accordingly. Some CTPs may monitor both signposting and referrals (separately), while others may monitor one or the other.

If CTPs do offer to make referrals, it is important to monitor the uptake of these and record any reasons why people choose not to be referred. If signposting it may also add value to ask whether a person contacted the service if there is any follow-up with them.

11. Proportion of all clients tested for HIV who were referred/signposted to SHS for reasons other than a confirmatory test

Community testing is often a gateway to other sexual health interventions. Clients with reactive results may have other SHS needs and clients with non-reactive results may need to be referred to SHS for PEP, PrEP, full STI screening or contraception. CTPs may wish to disaggregate this indicator further to give details of a reason for signposting (aside from a reactive result).

Numerator	Denominator	Calculation
Number of clients tested for HIV who were referred/signposted to SHS for reasons other than a confirmatory test	Total number of clients tested for HIV	Numerator / Denominator x 100

A.2 Additional indicators

12. Proportion of clients tested for HIV who were referred/signposted to other internal or external services (for example: drug and alcohol services, mental health services, etc)

Community testing provides an opportunity to assess clients' wider health and wellbeing and refer clients to services relevant to their needs. Recording these referrals is vital both to understand local need (and inform intervention design) and to demonstrate impact. CTPs may want to disaggregate this indicator (for example by service referred to) depending on the intervention's specific objectives and client-base.

Numerator	Denominator	Calculation
Number of clients referred/ signposted to other services	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}}$ x 100

13. Proportion of clients who accepted an HIV test that was offered

In addition to the total number of clients who were tested for HIV, CTPs should consider monitoring the proportion of clients who accepted a test. This requires monitoring the total number of clients that were offered a test. The CTPs should consider defining a testing offer for this purpose, e.g. an initial approach in an outreach setting or, alternatively, an offer following pre-test discussion, and apply this definition consistently.

CTPs should disaggregate this between different settings as expected uptake will differ depending on context. This should also be disaggregated by types of test (if offering a range of different test types) to monitor the acceptability of different tests and inform intervention design.

For clients who decline a test, CTPs may wish to use qualitative questioning to explore the reasons why. Analysis of this data can then help to inform intervention design and transformation. It should also be noted that some clients may attend for a test but be denied one, for reasons such as intoxication. This proportion should also be monitored, and the reasons why explored.

Numerator	Denominator	Calculation
Number of clients tested for HIV	Number of clients offered an HIV test	$\frac{\text{Numerator}}{\text{Denominator}}$ x 100

14. Proportion of clients who have tested for HIV in the past year at the CTP

Return testers can demonstrate good testing practice and satisfaction with the service. It is important however that this is considered contextually rather than in a vacuum. For example, if one of your aims is to support clients to use self-testing services, you may not hope to see as many return testers as an intervention that aims to reach MSM who are not engaging in testing elsewhere. The indicators below may provide more insight into testing practice beyond those in the core indicators.

This can be calculated as a proportion of all clients testing for HIV, but also as a proportion of those who have tested previously in order to provide more detailed information.

Numerator	Denominator	Calculation
Number of clients who have tested in the past year at the CTP	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}}$ x 100
Number of clients who have tested in the past year at the CTP	Number of clients who report having previously tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}}$ x 100
Number of clients who have tested in the past year at the CTP	Number of clients who have tested in the past year in any setting	$\frac{\text{Numerator}}{\text{Denominator}}$ x 100

15. Proportion of clients who have tested for HIV multiple times in the past year

Clients from key population groups who regularly practice unprotected sex are recommended to test multiple times per year.[3] As community testing interventions target key populations, this indicator is important to monitor and should be considered alongside analysis of risk behaviours. It may also be useful to know this if the aim is to test those who have not tested or not tested recently.

This can be calculated as a proportion of all clients testing for HIV, but also as a proportion of those who have tested previously in order to provide more detailed information.

Numerator	Denominator	Calculation
Number of clients who have tested multiple times in the past year	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$
Number of clients who have tested multiple times in the past year	Number of clients who report previous testing for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$
Number of clients who have tested multiple times in the past year	Number of clients who have tested in the past year	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

16. Proportion of clients who report a risk of HIV acquisition since last test or within defined time period

Community testing aims to reach people at increased risk of HIV. Beyond using the broad demographic categories represented by target populations, this can be evaluated by monitoring the risks of HIV acquisition that clients have been exposed to. These risks should be discussed as part of the pre- or post-test discussion.

Many CTPs attempt to capture risks that have occurred since the client's last HIV test. Others choose to capture risks within a defined time period, such as in the last 3/6/12 months. There are limitations to each option and the decision should be based on the objectives of the intervention and what works best for the CTP and their target population/s.

Risks may include: unprotected sex; unprotected sex with multiple partners; unprotected sex with HIV+ partners; unprotected sex with partners from high prevalence countries; buying or selling sex; injecting drug use; chemsex; non-consensual sex; and recent STI diagnoses.

CTPs may wish to disaggregate this indicator by risk type (e.g. unprotected sex) – trends observed in risk type can help to inform the design of community testing interventions as well as the commissioning and delivery of other local risk prevention services.

It is important to note that HIV risks (or risk behaviours) have changed in the wake of U=U and PrEP. For clients on PrEP, or clients only having sex with HIV positive sexual partners who have undetectable viral loads, condomless sex is not an HIV risk.

CTPs should consider whether someone reporting possible exposure within the past three months could still be within the window period of the HIV test and recommend re-testing at the appropriate time/s.

Numerator	Denominator	Calculation
Number of clients who report risk of HIV acquisition	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

It may also be helpful to compare responses on risk to those on past testing history.

3 See UK Government guidance on HIV testing: [https://www.gov.uk/guidance/hiv-testing]

17. Proportion of clients who are registered with a GP

People using community testing services may not be accessing traditional healthcare services, including primary care. This puts them at risk and increases costs to the health system if mild health complications become severe. Calculating this indicator can therefore help to evaluate CTPs' success in reaching people who are not being engaged by traditional healthcare services.

Everyone is entitled to register with a GP free of charge, and we strongly recommend that all clients are encouraged to do so. Following up with individual clients to see if they have registered with a GP post-testing is unlikely to be within the capacity of CTPs. CTPs may instead compare this indicator against itself over time, and interpret any increase or decrease alongside indicators 5 and 14, though care should be taken in attributing cause.

Numerator	Denominator	Calculation
Number of clients who are registered with a GP	Total number of clients tested for HIV	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

18. Proportion of clients with a reactive result with whom partner notification was discussed

Partner notification (the process of notifying sexual partners that they may have been at risk of HIV) is often explained during pre-test counselling, but should always be discussed further in the event of a reactive result (see NAT's *Community HIV testing: Intervention design toolkit*).

Numerator	Denominator	Calculation
Number of clients with a reactive result with whom partner notification was discussed	Total number of clients who received a reactive result	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$
Number of clients with a reactive result who indicated that they intend to use partner notification services	Total number of clients who received a reactive result	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

CTPs could also record qualitative information about the success of the discussion to support understanding of effective communication and how to address concerns.

19. Proportion of clients with a reactive (or positive confirmatory) test result who were signposted/referred to an internal or external HIV support service by the CTP.

HIV support services are any services that meet non-clinical HIV-relevant needs of people living with HIV. Examples include peer support, advocacy and advice. Many CTPs themselves offer these services. Others are not able to provide ongoing HIV support but may refer clients to external HIV support services.

Responsibility for these referrals is with SHS following a positive confirmatory test result. However, some CTPs offer to refer clients at the point of delivering a reactive result to ensure linkage to care and support relating to a new diagnosis. Other CTPs do not do this on the basis that the immediate priority is linkage to SHS for a confirmatory test. Whether this indicator is relevant is therefore dependent on the intervention's design.

Numerator	Denominator	Calculation
Number of clients with a reactive result referred to support service	Total number of clients who received a reactive result (and were reached by follow-up)	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

20. Proportion of clients with a positive confirmatory test result who were diagnosed late

Reducing late diagnosis is a key objective of community testing but is difficult to monitor. Where clients receive reactive results and positive confirmatory tests, CTPs should seek to record if they were diagnosed late (CD4 <350 cells/mm3 within 91 days of HIV diagnosis). Where CTPs have information sharing agreements in place with SHS it may be possible to collect this information directly from the SHS. In most cases however CTPs will rely on accurate self-reporting from clients during follow-up.

Numerator	Denominator	Calculation
Number of clients with a positive confirmatory test diagnosed late	Total number of clients who received a reactive result	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

Post-test assessments

Evaluating the impact of community testing interventions on people's behaviour is difficult. The capacity of CTPs to collect and analyse relevant data is limited and measuring significant long-term behaviour change requires resource and carefully designed research methodology. However, CTPs can gain some insight on changes in clients' self-reported knowledge and intended behaviours by using post-test assessments. These involve clients responding to a series of questions after the test is completed. Examples of questions are provided in Appendix B.

Conducting post-test assessments may not be possible in every instance or in every setting. Community testing is often seen as quick and convenient, and CTPs should consider whether post-test assessments could create a barrier for some. Additionally, it may impact upon service capacity and waiting times. There are also limitations to do doing post-test assessment without pre-test assessment to offer comparison.

While recognising the limitations we recommend that CTPs do use them where possible. This because they are least resource-intensive means of assessing the immediate impact of the intervention.

CTPs may also consider further follow-up with clients in order to review the longevity of effects recorded in the post-test assessment and any impact on behaviour. Qualitative investigation with a proportion of clients may also be valuable.

21. Proportion of clients who complete a post-test assessment when offered

This is a key indicator for process evaluation. Where offered, low uptake of post-test assessments, for example, may indicate that more effective strategies are needed to ensure they take place. This indicator also helps to contextualise the data collected.

Numerator	Denominator	Calculation
Number of clients who take up/ complete a post-test assessment	Total number of clients offered a post-test assessment	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

22. Proportion of clients who report increased knowledge about sexual health

Post-test assessments can ask clients to compare their levels of knowledge after the testing session to their levels of knowledge before the session. This is a simple way of measuring short-term outcomes and can be tailored to the specific objectives of the intervention. Clients can be asked to self-assess their general level of knowledge about HIV and STIs, but they may also be asked to self-assess their knowledge about specific learning outcomes dependent on the CTPs objectives.

Numerator	Denominator	Calculation
Number of clients reporting increased knowledge about X	Total number of clients who completed a post-test assessment	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

23. Proportion of clients who report increased confidence in talking about sexual health

Promoting dialogue and normalising discussions around sexual health are key objectives of community testing. CTPs can use post-test evaluations to assess changes in confidence levels resulting from the intervention; this could measure confidence talking about sexual health broadly or to specific audiences.

Numerator	Denominator	Calculation
Number of clients reporting increased confidence talking about sexual health	Total number of clients who completed post-test assessment	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

24. Proportion of clients who report increased confidence/motivation in practising safer sex

Practising safer sex is central to managing sexual health effectively. All clients should be provided with tailored advice on safer sex. CTPs can use post-test evaluations to assess the impact of the intervention of clients' levels of confidence around practising safer sex.

Numerator	Denominator	Calculation
Number of clients reporting increased confidence/motivation in practising safer sex	Total number of clients who completed a post-test assessment	$\frac{\text{Numerator}}{\text{Denominator}} \times 100$

APPENDIX B – Data collection

To monitor the indicators in Appendix A, client data must be collected by CTPs. Most is routinely collected during testing sessions. Some data items will require additional client (or SHS) follow-up. This is vital to monitor confirmatory tests, linkage to healthcare, and referrals to other services. Post-test assessments are also required for indicators 23-24.

B1, B2 and B3 provide examples/template pro forma for use by staff and volunteers to gather and record data. CTPs can adapt these to their preferences and needs, and may need to develop further client-facing documents to ascertain some of the information below.

This appendix does not cover other process indicators (see section 3.2). CTPs will therefore need to develop further data collection instruments (or add to those below) according to the specific set of indicators they wish to monitor.

For additional resources on effective data collection, including guidance on the design of data collection instruments, see Step 4 of the NHS Evaluation Works Toolkit.[4]

B.1 Personal information

The pro forma below supports the monitoring of output indicators in Appendix A. It does not include data items for name/s, contact details, or contact preferences. These should be added to client-facing documents developed by CTPs.

The Characteristics and HIV testing history sections of the pro-forma contain questions that could be directly shared with or asked of clients. Other sections are to be completed by staff/volunteers.

B1 Personal information					
Client ID					
Test uptake					
HIV test offered	☐ Yes ☐ No	Reason if no:			
HIV test accepted	☐ Yes ☐ No	Reason if no:			
HIV test setting	Name/code:				
HIV test type	☐ POCT (blood)	☐ POCT (saliva)	☐ DBS (dried-blood-spot)	☐ Self-sampling kit	☐ Self-testing kit
Characteristics					
How do you identify your gender?	☐ Man (incl. trans man)	☐ Woman (incl. trans woman)	☐ Non-binary	☐ In another way	☐ Prefer not to say
Is this the same gender you were assigned at birth?			☐ Yes	☐ No	☐ Prefer not to say

4 [http://www.nhsevaluationtoolkit.net/evaluation-cycle/]

How do you define your sexuality?	☐ Gay	☐ Lesbian	☐ Bisexual	☐ Heterosexual	☐ Other
Which of the following groups do you have sex with? Select all that apply			☐ Men (incl. trans men)	☐ Women (incl. trans women)	☐ Non-binary people
How would you describe your ethnicity?	**White**	**Asian or Asian British**	**Black or Black British**	**Mixed**	**Other**
	☐ British	☐ Indian	☐ African	☐ White and Black African	☐ Arab
	☐ Irish	☐ Pakistani	☐ Caribbean	☐ White and Black Caribbean	Latin American
	☐ Gypsy/ Traveller	☐ Bangladeshi	☐ Other Black background	☐ White and Asian	☐ Other background
	☐ Other White background	☐ Chinese		☐ Other mixed background	If other background
		☐ Any other Asian background			
Country of birth					
Date of birth	DD/MM/YY				
Are you registered with a GP?				☐ Yes	☐ No
HIV testing history					
Have you had an HIV test before	☐ Yes	☐ No	☐ Don't know	☐ Prefer not to say	
If yes, when and where was your last test?	Date		Setting		
What was the result of your last HIV test?		☐ Reactive/ positive	☐ Non-reactive/ Negative	☐ Indeterminate	
Have you had multiple tests in the past year?				☐ Yes	☐ No
If yes, please tell us where					
PrEP					
PrEP use	☐ Current daily	☐ Current intermittently	☐ Previously taken	☐ Not used	
Eligible for PrEP				☐ Yes	☐ No
Reason if yes:					

Notes

Client ID: Each client must be clearly identified using a unique client ID. This is important to support confidentiality and data protection, eliminate duplicate records, and link information obtained from the same client at different visits.

Test uptake: If also offering screening for other STIs the CTP should add equivalent data collection items for each STI that is screened for. CTPs may also wish to monitor whether HIV tests were offered/ accepted alongside STI screening to evaluate the impact of this on test uptake.

Sexual orientation: This is distinct from sexual practice. For example, a patient may define their sexual orientation as heterosexual but report having had sex with a person of the same sex. It is important for the purposes of national data collection and CTP-level monitoring and evaluation that data on both sexual orientation and sexual practice is collected which is why the pro forma includes a two-step question.

Ethnicity: The pro forma contains standardised categories and subcategories that should be recorded by asking clients to self-identify. However, CTPs may wish to further narrow down these options based on specific objectives and contexts.

Country of birth: This should be recorded for all clients. When analysing data and/or reporting to funders CTPs may wish to aggregate this data using the following categories according to whether they were born in the UK, elsewhere in Europe or from a high prevalence country. A high prevalence country is defined as one where HIV prevalence is greater than 1%.[5]

Date of birth: This should be recorded for all clients. Age in years can then be calculated by CTPs. How this data is aggregated will depend on the requirements of funders but we recommend increments of 5 years (16-19, 20-24, 25-29, etc) to provide a useful level of insight.

HIV testing history: If a client has previously received a reactive or positive result the reasons for re-testing should be explored. We know from CTPs that some clients may have tested elsewhere but want to 'confirm' the result before engaging with SHS, while others may have previously been diagnosed and on treatment but are using community testing as a way to re-engage with care. In either case it is important that clients are supported to receive any clinical care that they need.

Eligibility for PrEP: This is subject to change based on future commissioning arrangements. Guidance should be sought from Public Health England.

B.2 Data on HIV risk

How CTPs monitor and record risk can depend on service design and funding requirements. Some CTPs may choose to align their data collection with that collected by GUMCAD - England's surveillance system for STIs.[6] Others have developed their own data items based on what works best for them and their target population/s.

The pro forma below identifies risks since last HIV test, but can be adapted to another time period (e.g. within the last 3 months) if necessary.

The items covered in B2 are not exhaustive and CTPs should consider which indicators are most relevant to the specific objectives of the intervention and the needs of the target population. CTPs should also consider which questions require follow-up dependent on answers given.

This form is intended for internal use only in order to support data analysis. It is not intended to be shared with a client or read to a client verbatim. Some of the questions may not be appropriate and a CTP should offer training to staff and volunteers on how to ask questions to ascertain the information as

5 See Public Health England (PHE), 2019, HIV in the UK: towards zero HIV transmissions by 2030, 2019 report: appendixes, Appendix 2 [https://www.gov.uk/government/publications/hiv-in-the-united-kingdom]

6 See PHE, 2020, GUMCAD STI Surveillance System: Data Specification and Technical Guidance [https://www.gov.uk/government/publications/gumcad-data-specification-and-technical-guidance]

recorded below. Involving members of the target population in the design of questionnaires can ensure that questions are relevant, non-stigmatising and culturally sensitive.

B2 Data on HIV risk			
Risks since last HIV test			
How many sexual partners?	Men (incl. trans men):	Women (incl. trans women):	Non-binary:
Were any of these new sexual partner/s?		☐ Yes	☐ No
Unprotected sex?		☐ Yes ☐ Insertive Anal ☐ Receptive Anal ☐ Vaginal	☐ No
Condomless sex?		☐ Yes	☐ No
Unprotected sex with a known HIV positive partner/s?		☐ Yes ☐ Anal ☐ Vaginal	☐ No
Unprotected sex with partner/s of unknown HIV status?		☐ Yes	☐ No
Unprotected sex with partner/s from high prevalence countries?		☐ Yes	☐ No
Report experience of non-consensual sex		☐ Yes	☐ No
Other STI diagnosis		☐ Yes	☐ No
If yes, which STI/s:			
Injected recreational drugs?		☐ Yes	☐ No
Reports sharing injecting equipment		☐ Yes	☐ No
			☐ Unsure
Did any of the above risks occur within the last 3 months?		☐ Yes	☐ No
Did any of the above risks occur within the last 72 hours?		☐ Yes	☐ No
Monitoring wider risk factors			
Bought or sold sex		☐ Yes	☐ No
Active sex worker		☐ Yes	☐ No
Difficulty negotiating safer sex		☐ Yes	☐ No
Alcohol use assessed		☐ Yes	☐ No
Alcohol use assessed as problematic		☐ Yes	☐ No
Used recreational drugs in the last 3 months		☐ Yes	☐ No
Which drugs?			
Sex under the influence of recreational drugs (before or during) in last 3 months		☐ Yes	☐ No

Notes

Unprotected sex: Sex where a condom is not used/fails AND neither of the following apply:

- Partner on effective HIV treatment
- Client on PrEP

Condomless sex: Much of the data above relates to HIV risk. Monitoring condomless sex can ensure that broader STI risk is captured and may indicate a need for wider screening.

Alcohol use: CTPs may wish to implement the alcohol use disorders identification test (AUDIT) for which guidance is available online.[7]

Recreational drug use: CTPs may also wish to review the drug use disorders identification test (DUDIT) and consider the aims of the intervention and the needs of the key populations they are working with.[8]

B.3 Results and follow-up

The information in B3 may be collated via a contact management system or other database. Some of the information will be recordable immediately after the test, whereas some will require follow up.

B.3 Results and follow-up			
HIV test result	☐ Reactive	☐ Non-reactive	☐ Indeterminate
Results received by client		☐ Yes	☐ No
If yes, how was the client informed?			
Confirmatory test result	☐ Positive	☐ Negative	☐ Unknown
Late diagnosis	☐ Yes	☐ No	☐ Unknown
CD4 count at diagnosis if known			
Partner notification discussed		☐ Yes	☐ No
Intention to use partner notification		☐ Yes	☐ No
Signposting/referrals			
Referred to SHS		☐ Yes	☐ No
Reason for referral	☐ Confirmatory test (reactive result)	☐ Confirmatory test (indeterminate or risk in window period)	☐ STI screening
	☐ Condom provision	☐ PEP	☐ PrEP
	☐ Contraception		
Referred to HIV support service		☐ Yes	☐ No
If yes, which service/s:			
Referred to another service/s		☐ Yes	☐ No
If yes, which service/s:			

7 Alcohol use disorders identification test (AUDIT) [https://www.gov.uk/government/publications/alcohol-use-screening-tests]
8 Drug use disorders identification test (DUDIT) [http://www.emcdda.europa.eu/best-practice/eib/dudit]

Post-test assessment *(examples only - requires separate questionnaire to be adapted for the aims of the service)*			
Post-test assessment conducted	☐ Yes	☐ No	Reason
Increased knowledge about sexual health reported	☐ Yes	☐ No	☐ No change
Increased confidence talking about sexual health	☐ Yes	☐ No	☐ No change
Increased confidence practising safer sex	☐ Yes	☐ No	☐ No change
More likely to seek an HIV test in the future	☐ Yes	☐ No	☐ Not sure

Notes

Late diagnosis: It is important to note that late diagnosis is defined as having a CD4 cell count <350 cells/mm3 within 91 days of HIV diagnosis. As such, even if a client does not have a CD4 cell count <350 cells/mm3 upon diagnosis, they will need to be contacted later to confirm that their CD4 count did not reach <350 cells/mm3 during the 91 days afterwards. Acquiring this information may not always be possible. If it is not, this data item should be recorded as 'Unknown'. Having a data sharing agreement in place with SHS will make this data item much easier to collect.

Referrals/Signposting: There is value in monitoring both signposting and referrals. Whether this is feasible will depend on the capacity and specific objectives of each CTP.

Post-test evaluation: These are examples of how this data may be recorded by the CTP. Each CTP will need to consider what questions they wish to cover in a post-test assessment.

Example questions to use:

As a result of today's session:		
1. My knowledge and awareness of HIV and other STIs has improved.		
☐ Strongly agree	☐ Agree	☐ No change
2. I feel more confident talking about my sexual health.		
☐ Strongly agree	☐ Agree	☐ No change
3. I feel more confident about practising safer sex.		
☐ Strongly agree	☐ Agree	☐ No change
4. I am more likely to seek an HIV test in future.		
☐ Strongly agree	☐ Agree	☐ No change

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