**NHS England and NHS Improvement:** **Equality and Health Inequalities Impact Assessment (EHIA)**

**A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal.**

**1. Name of the proposal (policy, proposition, programme, proposal or initiative):**

**2. Brief summary of the proposal in a few sentences**

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| This Clinical Commissioning Policy outlines the commissioning criteria for the use of tenofovir alafenamide (TAF) for Human Immunodeficiency Virus type 1 (HIV-1) treatment in adults and adolescents. It is an update to the current policy “Tenofovir alafenamide for treatment of HIV-1 in adults and adolescents”.  The Clinical Commissioning Policy “Tenofovir alafenamide for treatment of HIV-1 in adults and adolescents” was first published in July 2016 and updated and re-published in February 2017. An EHIA was not completed at the time because it was not part of the policy development process. This is the first EHIA to be prepared for this policy.  The aim of TAF is to supress the virus, reducing the consequences of immunosuppression which include increased mortality, morbidity, and poor health related quality of life.  If the virus is supressed, the ability for an individual to transmit the virus is negligible.  Tenofovir alafenamide (TAF) is available in fixed dose combinations, with one or multiple other HIV drugs. This proposed policy update outlines the use of tenofovir alafenamide as a bioequivalent alternative to tenofovir disoproxil fumarate (TDF) in people for whom TDF is contraindicated at treatment initiation or who develop complications during treatment. TAF offers benefits of reduced toxicity in individuals at certain risk of renal or bone impairment.  This policy has been updated in line with the PrEP indication for TAF (2112 PrEP reimbursement) and renal parameters have been simplified. The revision of this has been undertaken by a Policy Working Group (PWG) consisting of HIV experts, a public health specialist and specialised commissioner for NHS England. This policy recommends that TAF is made available as an option for adults and adolescents living with HIV who meet the criteria outlined in the policy. |

**3. Main potential positive or adverse impact of the proposal for protected characteristic groups summarised**

Please briefly summarise the main potential impact (positive or negative) on people with the nine protected characteristics (as listed below). Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below. Please note that these groups may also experience health inequalities.**

| Protected characteristic groups | Summary explanation of the main potential positive or adverse impact of your proposal | Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact |
| --- | --- | --- |
| **Age:** older people; middle years; early years; children and young people. | The age profile of newly diagnosed individuals with HIV demonstrates different risk profiles within patient population groups. There has also been a change in the age profile of newly HIV diagnosed individuals over the past 10 years, with males over 50 years increasing, whilst other at-risk groups in younger age brackets decreasing.    Older individuals feature as a higher proportion presenting late with HIV, and subsequently have a higher mortality. The impact of late HIV diagnosis on mortality within one year in 2019 was particularly marked among people aged 65 and over, at 59 per 1,000, compared to 31 in 1,000 of the overall late diagnoses. One-year mortality in those diagnosed promptly was 4 per 1,000 (UKHSA 2021 [report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf) in HIV populations).  This is important for the intervention proposed as with age also increases medical complexity. This can limit the available suitable antiretroviral (ART) options, making HIV (for a small number of patients), more difficult to treat.  This summary is supported by UK Health Security Agency (UKHSA) 2021 data in HIV populations.  The proportion of people aged 50 years or over among newly diagnosed people (first diagnosed in England) increased from 20% (740 out of 3,786) in 2016 to 25% (491 out of 1,989) in 2020. | Children under the age of 12 years and who weigh less than 35 kg are not included within this policy due to the safety profile of the drug not being established in this population.  The patient pathway recommends regular review every 3-6 months, to ensure that TAF still meets the needs of the individual. This allows for adaptions and new approaches if the health circumstances of an individual change. The pathway suggests a multi-disciplinary team (MDT) approach to capture a holistic assessment of the individual and their treatment options.  This policy, if agreed and published, will be reviewed at a future specified date to consider the results of longer-term outcomes from ongoing clinical trials to ensure the commissioning criteria reflect the most up to date evidence base. |
| **Disability:** physical, sensory and learning impairment; mental health condition; long-term conditions. | Disability is not known to be a risk factor for HIV-1 acquisition, however if HIV is not virally suppressed it can lead to complex medical conditions which increase an individual’s risk of mortality and can create morbidity. In addition, other health co-morbidities, for example heart disease, kidney disease and bone problems, can limit the use of some ART drugs.    This could mean that individuals with HIV-1 infection may have other complex or long-term health conditions including other physical, sensory, or additional needs. | This policy outlines that TAF provision should be initiated and reviewed by a specialist multi-disciplinary team of professionals who are responsible for ongoing patient care. The decision for TAF provision is dependent on shared decision making with the patient and MDT assessment of suitability, which considers an individual’s long-term health conditions and their unique circumstances and concurrent health needs. |
| **Gender Reassignment and/or people who identify as Transgender** | Public Health England 2019[[1]](#footnote-2) data demonstrated that from 2015, 67 new HIV diagnoses have been recorded among trans[[2]](#footnote-3) people: 11 diagnoses in 2018, 16 in 2017, 16 in 2016 and 24 in 2015. Six trans people diagnosed in 2018 were aged 35 to 49 years, 6 were white and 7 were diagnosed late. | All patients who meet the inclusion criteria would be considered for TAF treatment. The policy is therefore not considered to have an adverse impact on this protected characteristic group. |
| **Marriage & Civil Partnership:** people married or in a civil partnership. | There should be no direct negative or positive impact on this group as marriage/civil partnership has not been identified as a high risk group. | All patients who meet the inclusion criteria would be considered for TAF treatment. |
| **Pregnancy and Maternity:** women before and after childbirth and who are breastfeeding. | Uptake of HIV screening in pregnant women who engage with antenatal care remains high. During the financial year 2019/2020, coverage exceeded 99% with 661,250 pregnant women tested for HIV. Positive HIV diagnosis remained low and 11.9 per 100,000 women were newly diagnosed with HIV during pregnancy. Most of these women would already be diagnosed before pregnancy. In 2020, <5 infants born from HIV positive mothers were diagnosed with HIV in England.[[3]](#footnote-4)  Pregnancy is a key time to achieve viral suppression to reduce vertical transmission to the child.  Women with HIV-1 infection are encouraged to not breast feed, to avoid HIV transmission. The risk of transmission is higher in individuals who are not virally suppressed. | Pregnancy:  TAF has a limited amount of data for use in pregnancy (less than 300 pregnancy outcomes). However, the [summary of product characteristics](https://www.medicines.org.uk/emc/product/2314/smpc) (SPC) advises that TAF may be considered during pregnancy if necessary due to data for more than 1,000 exposed outcomes indicating no malformative nor feto/neonatal toxicity associated with the use of TAF.    The policy suggests that individuals’ suitability is assessed and discussed by a HIV specialist MDT.  This could assist with the clinical challenges of considering TAF use in pregnancy for this cohort.  Breastfeeding  The Summary of Product Characteristics (SmPC) data suggests the effects of TAF excretion into breast milk are unknown. Given these factors, the policy is not thought to exclude this patient cohort after appropriate discussion regarding the risks. |
| **Race and ethnicity**[[4]](#footnote-5) | Race and ethnicity data is collected in new diagnosis of HIV and in some ethnic groups a higher rate of new diagnosis of HIV is seen, as well as a slower rate of decline in new cases compared to other ethnic groups. Overall, there has been a reduction in HIV diagnosis over the past 10 years. Race and ethnicity data is important to capture as some groups experience health inequities in access to care and support for HIV.    These summary statements are supported by UKHSA data[[5]](#footnote-6):  The number of all new HIV diagnoses decreased by 33% in England (from 3,950 in 2019 to 2,630 in 2020). These declines in diagnoses were less apparent among gay and bisexual men who were living outside London, those of Black, Asian, Mixed or Other ethnicity ethnic groups, and those born abroad.  In 2020, the number of HIV diagnoses first made in England among heterosexual people decreased by 23% (from 1,310 in 2019 to 1,010 in 2020, adjusted for missing information). The decline was 40% among White heterosexuals (from 470 in 2019 to 280 in 2020) and Black Caribbean heterosexuals (from 50 to 30) but less pronounced among Black Africans (25%, 400 to 300) and among Asians (17%, 60 to 50). The decline in HIV diagnoses first made in England among heterosexual men and women is likely to have been impacted by reduced access to HIV testing in 2020 rather than longer term decreased transmission.  In 2020, a higher proportion of people diagnosed late with HIV were Black African (54%) and Black Caribbean/Black Other (43%) individuals than White (39%) or Asian/Other (34%).    The proportion of heterosexual men who were diagnosed late (first diagnosed in England and after correction for recent seroconversion) was high, with 55% (170 out of 310), compared with 50% (170 out of 340) among heterosexual women. The overall rate of late diagnoses for all heterosexuals was 53%. Rates were higher among Black African heterosexuals (59%), compared with White heterosexuals (51%). | All patients who meet the inclusion criteria would be considered for TAF treatment. The policy is therefore not considered to have an adverse impact on this protected characteristic group. |
| **Religion and belief:** people with different religions/faiths or beliefs, or none. | There should be no direct negative or positive impact on this group as religion and belief have not been identified as high risk groups. | The policy is inclusive of all individuals who meet the inclusion criteria. |
| **Sex:** men; women | Sex is not determined to be a risk factor for HIV infection, however in the UK, the new diagnosis of HIV, includes more men than women so this population could be reflected more in the patient population.    These summary statements are supported by UKHSA data[[6]](#footnote-7):  In 2020, 2,630 people were newly diagnosed with HIV in England (1,860 men and 770 women).[[7]](#footnote-8) | The policy is inclusive of all individuals who meet the inclusion criteria. |
| **Sexual orientation:** Lesbian; Gay; Bisexual; Heterosexual. | Sexual orientation has been identified as a risk factor for HIV acquisition.    This summary statement is supported by UKHSA data[[8]](#footnote-9):  Gay and bisexual men comprised 45% of all diagnoses first diagnosed in England in 2020; heterosexual women, 26%; heterosexual men, 24%; and people who inject drugs (PWID), 3% (adjusted for missing information).  In 2020, 55% and 51% of heterosexual men and women, respectively, were diagnosed at a late stage compared to 29% among gay and bisexual men. Between 2016 and 2020, the decline in the number of late diagnoses was steepest among gay and bisexual men (57% decline, from 380 to 160).    HIV incidence among gay and bisexual men in England declined by 91%, from an estimated peak of 2,730 (95% Crl 2,560 to 2,900) in 2011, to 400 (95% Crl 240 to 800) in 2019 to an estimated 250 (95% Crl 110 to 710) in 2020, equivalent to less than 1 per 1,000 gay and bisexual men in England. However, more conservative sensitivity analyses suggest up to 590 (95% CrI 200 to 2,050) new infections in gay and bisexual men in England in 2020 may have occurred, if we assume the extreme scenario that the lockdowns did not reduce new infections but did reduce the number of people testing and being diagnosed. | The policy is inclusive of all individuals, who meet the inclusion criteria. |

**4. Main potential positive or adverse impact for people who experience health inequalities summarised**

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). Please state **N/A if your proposal will not impact on patients who experience health inequalities.**

| Groups who face health inequalities[[9]](#footnote-10) | Summary explanation of the main potential positive or adverse impact of your proposal | Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact |
| --- | --- | --- |
| **Looked after children and young people** | There should be no direct negative or positive impact on this group as looked after children and young people have not been identified as a high-risk group for HIV-1 infection. | Children living with HIV are managed in a specialist HIV child-focused service. Children under the age of 12 years and who weigh less than 35 kg are not included within this policy due to the safety profile of the drug not being established in this population.  It is proposed that by use of the specialist HIV MDT to determine suitability for TAF the individual health, emotional and developmental needs of the child are taken into consideration if TAF was proposed as a treatment option. |
| **Carers of patients:** unpaid, family members. | There is no identified potential negative or positive impact on carers of patients by this policy update. | The policy is inclusive of all individuals who meet the inclusion criteria. |
| **Homeless people.** People on the street; staying temporarily with friends /family; in hostels or B&Bs. | This group may be less likely to enter the patient pathway, due to access issues (e.g., not registered with a General Practitioner).     The lack of a permanent base for which follow-up appointments could be co-ordinated may be challenging in this cohort of patients.     If identified, those who are homeless could be at risk of adverse outcomes, due to lack of access to services, incomplete follow-up as well as environmental conditions which may exposure individuals to infection or potentially exacerbate underlying health issues. | NHS England is producing the TAF policy to increase access for anyone who may benefit from the intervention.    Commissioned providers should work with the patient and other relevant agencies (e.g. GP, Local Authority, charities) to mitigate the risk for homeless patients. |
| **People involved in the criminal justice system:** offenders in prison/on probation, ex-offenders. | In 2018/19, 57,635 people newly arriving at or transferring between prisons were tested for HIV, an increase of 39% since 2017/18. This testing identified 665 HIV infections in 2018/19, a test positivity of 1.2% (37)[[10]](#footnote-11). Between April 2020 and March 2021, 86% of people in the justice system were offered HIV testing within 7 days of reception (121,400 out of 140,800). Among those who were eligible, 49% were tested (49,900 out of 102,200).[[11]](#footnote-12)  All patients who met the inclusion criteria would be considered for treatment. This group is not identified at high risk for HIV-1 infection. | All individuals who meet the inclusion criteria can be considered for treatment with TAF. |
| **People with addictions and/or substance misuse issues** | Drug use, particularly injection is a risk factor for HIV acquisition. Other health concerns such as a person living with HIV and hepatitis can limit some available ART options.  Individuals with HIV and concurrent injecting drug use are at a higher rate or mortality.  This summary is supported by UKHSA data: [[12]](#footnote-13)  Among people recruited in England to the Unlinked Anonymous Monitoring (UAM) Survey of People Who Inject Drugs (PWID), HIV prevalence remained relatively stable and low over the past decade from 1.3% (95% confidence interval (95% CI) 0.88% to 1.8%) in 2011 to 1.2% (95% CI 0.44% to 2.6%) in 2020. | All patients who meet the inclusion criteria would be considered for treatment. |
| **People or families on a**  **low income** | This policy will promote access to TAF regardless of economic status. | All patients who meet the inclusion criteria would be considered for treatment. |
| **People with poor literacy or health Literacy:** (e.g. poor understanding of health services poor language skills). | This group may find it hard to understand their condition and the benefits and risks associated with different treatment options. It may also be harder for these individuals to understand and follow the drug directions. | Shared decision making is mandated within this policy and so clinicians will need to ensure that patients are well informed, this can be through various mediums including verbal as well as written shared decision-making tools, translated and Easy Read materials. The provision of TAF involves face-to-face assessment and verbal instruction, this can assist those with poor health or literacy skills.    It is proposed that a holistic MDT assessment of an individual is undertaken to assess their suitability for TAF. |
| **People living in deprived areas** | A national commissioning policy attempts to ensure there is equal access to treatment regardless of location, it will reduce variation in practice.  The UKHSA data demonstrates that some local authorities have a higher number of people living with HIV.    Overall, 80 local authorities in England had a “high-diagnosed-prevalence” (greater than 2 per 1,000 population aged 15 to 59 years) in 2020. Of these, 19 had an “extremely-high-diagnosed prevalence” (defined as greater than 5 per 1,000 population aged 15 to 59 years) including 16 London local authorities, Manchester, Salford and Brighton and Hove. [[13]](#footnote-14)  Of the total number of people estimated to have undiagnosed HIV infection, nearly twice as many live outside of London (3,000; 95% CrI 2,260 to 4,780) compared with those living in London (1,650; 95% CrI 1,200 to 2,470). | All patients who meet the inclusion criteria would be considered for treatment. |
| **People living in remote, rural and island locations** | A national commissioning policy attempts to reduce variation in practice by promoting equal access to treatment regardless of location. | This is an oral medicine and as such may not require frequent clinic visits. This will benefit those who live in remote, rural and island locations. |
| **Refugees, asylum seekers or those experiencing modern slavery** | In 2020, 24% (640) of those diagnosed with HIV were first diagnosed abroad.  The proportion of heterosexual men and women who probably acquired HIV in England and were also first diagnosed in England was 44% (160 out of 360) and 41% (160 out of 390), respectively. Among heterosexual men and women born abroad but diagnosed with HIV in England, 49% were estimated to have acquired HIV after arrival in England.[[14]](#footnote-15)  Individuals who are refugees, asylum seekers or those experiencing modern slavery could be more vulnerable to sexual violence and exploitation which may increase their risk of HIV acquisition.  This group may be less likely to enter the pathway, due to access issues (e.g. not registered with a General Practitioner).  The lack of a permanent base for which HIV care and follow-up and/or review appointments could be co-ordinated may be challenging in this cohort of patients.  If identified, those who are refugees, asylum seekers or those experiencing modern slavery could be at significant risk of adverse outcomes due to lack of access to services, incomplete follow-up as well as environmental conditions which may expose individuals to be more vulnerable due to their HIV-1 status. | NHS England is updating this policy to increase access for anyone who may benefit from the intervention.    Commissioned providers should work with the patient and other relevant agencies (e.g., GP, Local Authority, charities) to mitigate risk for refugees, asylum seekers and those experiencing modern slavery. |
| **Other groups experiencing health inequalities (please describe)** | Not applicable. | Not applicable. |

**5. Engagement and consultation**

a. Have any key engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

|  |  |  |
| --- | --- | --- |
| **Yes X** | **No** | **Do Not Know** |

b. If yes, please briefly list up the top 3 most important engagement or consultation activities undertaken, the main findings and when the engagement and consultative activities were undertaken.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of engagement and consultative activities undertaken** | | **Summary note of the engagement or consultative activity undertaken** | **Month/Year** |
| **1** | Policy working group consisting of HIV clinicians, pharmacists, commissioners, patient group representatives | Policy working group meetings and drafts circulated for comments and amendments. | Q3 – Q4 2021 |
|  |  |  |  |
| **2** | Stakeholder testing (planned) | A two week period of stakeholder testing was undertaken. | **May 2022** |
|  |  |  |  |

**6. What key sources of evidence have informed your impact assessment and are there key gaps in the evidence?**

| **Evidence Type** | **Key sources of available evidence** | **Key gaps in evidence** |
| --- | --- | --- |
| **Published evidence** | An external review of available clinical evidence was undertaken to inform this policy. |  |
| **Consultation and involvement findings** | The proposed updated policy went out for stakeholder engagement in May 2022 for a 2-week period. Four responses were received; two from representatives of industry and two from national organisations.  Two respondents referenced the BHIVA guidelines which were in the process of being updated. | One respondent highlighted an article focused on the safety data between tenofovir alafenamide versus tenofovir disoproxil fumarate. This additional evidence was discussed and assessed to have no potential impact on the proposed updated policy. The evidence was presented to Clinical Panel who agreed that a repeat evidence review was not required.  The policy update was paused until the updated BHIVA guidelines were published. |
| **Research** | No pending research is known. | Not applicable |
| **Participant or expert knowledge**  For example, expertise within the team or expertise drawn on external to your team | A Policy Working Group was assembled which includes HIV specialists, a public health specialist and patient and public voice representatives. |  |

**7. Is your assessment that your proposal will support compliance with the Public Sector Equality Duty?** Please add an x to the relevant box below.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Tackling discrimination | Advancing equality of opportunity | Fostering good relations |
|  |  |  |  |
| The proposal will support? | X | X |  |
|  |  |  |  |
| The proposal may support? |  |  | X |
|  |  |  |  |
| Uncertain whether the proposal will support? |  |  |  |

**8. Is your assessment that your proposal will support reducing health inequalities faced by patients?** Please add an x to the relevant box below.

|  |  |  |
| --- | --- | --- |
|  | Reducing inequalities in access to health care | Reducing inequalities in health outcomes |
|  |  |  |
| The proposal will support? | X | X |
|  |  |  |
| The proposal may support? |  |  |
|  |  |  |
| Uncertain if the proposal will support? |  |  |

**9. Outstanding key issues/questions that may require further consultation, research or additional evidence.** Please list your top 3 in order of priority or state N/A

|  |  |  |
| --- | --- | --- |
| Key issue or question to be answered | | Type of consultation, research or other evidence that would address the issue and/or answer the question |
| 1 | N/A |  |
| 2 |  |  |
| 3 |  |  |

**10. Summary assessment of this EHIA findings**

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| This policy update does not unfairly discriminate those with a protected characteristic and will make a contribution to advancing equality of opportunity. The update to the existing policy will continue to provide an additional option for people living with HIV who have renal and/or bone disease. |

**11. Contact details re this EHIA**

|  |  |
| --- | --- |
| Team/Unit name: | Specialised Commissioning |
| Division name: | Blood and Infection programme of care |
| Directorate name: | Finance |
| Date EHIA agreed: |  |
| Date EHIA published if appropriate: |  |

1. Public Health England (PHE). 2019. HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk) [↑](#footnote-ref-2)
2. Trans is an umbrella term that refers to all people whose gender identity is different to the gender given at birth, this includes trans men, trans women, nonbinary, and other gender identities [↑](#footnote-ref-3)
3. UK Health Security Agency (UKHSA). 2021. [HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf) [↑](#footnote-ref-4)
4. Addressing racial inequalities is about identifying any ethnic group that experiences inequalities. Race and ethnicity includes people from any ethnic group incl. BME communities, non-English speakers, Gypsies, Roma and Travelers, migrants etc. who experience inequalities so includes addressing the needs of BME communities but is not limited to addressing their needs, it is equally important to recognise the needs of White groups that experience inequalities. The Equality Act 2010 also prohibits discrimination on the basis of nationality and ethnic or national origins, issues related to national origin and nationality. [↑](#footnote-ref-5)
5. UK Health Security Agency (UKHSA). 2021. [HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf) [↑](#footnote-ref-6)
6. UK Health Security Agency (UKHSA). 2021. [HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf) [↑](#footnote-ref-7)
7. New HIV diagnoses totals for men and women are based on gender identity and include trans people. The overall total includes people who identify as non-binary, in another way, and those with gender identity not reported. [↑](#footnote-ref-8)
8. UK Health Security Agency (UKHSA). 2021. [HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf) [↑](#footnote-ref-9)
9. Please note many groups who share protected characteristics have also been identified as facing health inequalities. [↑](#footnote-ref-10)
10. Public Health England (PHE). 2019. [HIV in the UK: Towards Zero HIV transmissions by 2030 (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/965765/HIV_in_the_UK_2019_towards_zero_HIV_transmissions_by_2030.pdf) [↑](#footnote-ref-11)
11. UK Health Security Agency (UKHSA). 2021. [HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf) [↑](#footnote-ref-12)
12. UK Health Security Agency (UKHSA). 2021. [HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf) [↑](#footnote-ref-13)
13. UK Health Security Agency (UKHSA). 2021. [HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf) [↑](#footnote-ref-14)
14. UK Health Security Agency (UKHSA). 2021. [HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf) [↑](#footnote-ref-15)