Parliamentary Office of Science and Technology

postnote

December 2007 Number 297

HIV IN THE UK

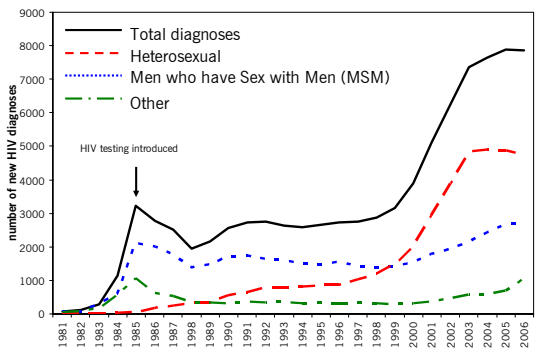
HIV and AIDS are one of the four most expensive areas of infectious disease, costing the NHS £400m per year for treatment alone.[1] New HIV diagnoses in the UK continue to rise. The populations most affected by the virus have shifted considerably in recent years. Men who have Sex with Men (MSM) remain at most risk of contracting HIV but diagnoses are also particularly concentrated among Black Africans. UK-born heterosexuals are also at increasing risk. This POSTnote presents current infection and diagnosis trends, and discusses whether policies for HIV testing, education, and prevention reflect these changing patterns.

Trends

Human Immunodeficiency Virus (HIV) is the virus which causes AIDS (Acquired Immune Deficiency Syndrome). HIV is now considered a chronic disease (as opposed to a fatal one) that can be effectively managed via medication for many years. Although overall HIV prevalence is low in the UK, new diagnoses have risen almost every year since 1981 (see Figure 1). The number of new HIV diagnoses made in 2006 is triple that of 1997.[2] In 2006, there were approximately 73,000 people living with HIV in the UK.[2]

Data collected by the Health Protection Agency (HPA)[2] showed that in 1999, for the first time, more heterosexuals than MSM were diagnosed with HIV, and this is still the case today. Women constituted 35% of all diagnoses in 2006, up from 18% in 1996. Among the non-UK born, women formed the majority of HIV cases.[2] Most heterosexual men and women were infected in Sub-Saharan Africa before coming to the UK,[3] so MSM still account for the majority of individuals acquiring HIV within the UK. These trends have resulted in disproportionate HIV prevalence among MSM and Black Africans.

Figure 1. Annual HIV diagnoses in the UK by transmission route (source: Health Protection Agency 2007).



Data from 2003 has been adjusted for reporting delay.

Men who have Sex with Men (MSM)

As seen in Figure 1, HIV diagnoses are rising among MSM, which the HPA believes is largely due to increased testing as well as ongoing transmission. MSM remain the group proportionally at most risk overall.[2] Around one in 20 MSM aged 15-44 in the UK are HIV positive.[2] High risk behaviours continue in MSM communities; a recent study discovered 22-30% of MSM in London, Brighton and Manchester had had unprotected anal sex with a partner of different or unknown HIV status from themselves, in the previous year.[4] Diagnoses in MSM are primarily made up of white UK-born, the majority of whom acquire their HIV infection within the UK (see Box 1).

African communities and HIV

Black Africans now represent the largest number of new diagnoses of all UK ethnic groups. Almost 25,000 people born in sub-Saharan Africa were estimated to be living with HIV in the UK in 2006, a proportion 50 times that of whites.[2] Black Africans constitute 70% of heterosexual diagnoses, but only 1.3% of diagnoses among MSM.

Box 1. Place of infection
Around 84% of heterosexuals newly diagnosed with HIV in the UK probably acquired their infection abroad, usually prior to migration but also during travel abroad.[2, 3] The opposite is true for Men who have Sex with Men (MSM), among whom the vast majority (83%) acquire the infection in the UK.[2] New diagnoses among heterosexuals who acquired their infection in the UK are steadily increasing.

Other transmission routes

Children born in the UK to HIV-infected mothers account for a very small percentage of new HIV diagnoses.[2] Drugs, Caesarean births and bottle-feeding have reduced the risks of mother-to-child HIV transmission down to less than 2% among those diagnoses early.[2] HIV prevalence among Intravenous Drug Users (IDUs) has remained relatively stable, with 1.3% of the IDU population accessing drug services in England and Wales testing HIV positive.[2] HIV transmission through blood products and transfusions has been eliminated in the UK due to screening. Diagnoses of HIV infections acquired by these routes is shown on Figure 1 as 'Other'.

HIV policy

The Government's 2001 *National Strategy for Sexual Health and HIV* outlined policies to reduce levels of unsafe sex, new HIV diagnoses, and undiagnosed HIV by 2007, via investing in prevention, improving outreach services, co-ordinating initiatives and extending information campaigns. A key target for a 25% decrease in newly acquired HIV infections by 2007 was not met; new diagnoses have increased significantly. The Department of Health (DH) argues that other targets were achieved; HIV testing increased and clinic waiting times declined.

In addition to the DH, several NGOs play a key role in HIV prevention work. Although these work together in many ways, they have specific aims and client groups. Charities argue that a new national strategy for HIV and sexual health**,** with revised aims, could respond better to the trends in HIV described above. The DH has commissioned an independent advisory board to review this. The National AIDS Trust (NAT) recommends that 'new and measurable' targets for HIV prevention be identified both nationally and locally.

Given the sustained transmission of HIV among MSM in the UK, the HPA supports the current Independent Advisory Group's review of the Sexual Health Strategy for England and suggests priority be given to considering primary prevention policy and programmes directed towards MSM.

Increasing numbers of new HIV diagnoses in the UK and shifts in patterns of infection have prompted debate on how to address the changing nature of the epidemic. Key issues include HIV surveillance and testing, the criminalisation of reckless HIV infection (see Box 2), access to treatment, and policies on HIV prevention and education.

Surveillance and testing

Individuals with HIV who are unaware of their status are up to three times more likely to pass on the virus than those who are aware of their infection. Reducing the amount of undiagnosed HIV would not only lower the number of subsequent infections but would also improve the prognosis for those individuals, by allowing them to receive medical attention at an earlier stage.[2]

Surveillance of undiagnosed HIV prevalence

Blood and saliva samples taken from consenting patients can be tested anonymously for research purposes, to help estimate HIV prevalence, including the previously undiagnosed proportion. Samples are permanently unlinked from all patient identifiers and anonymised. Cases identified in this way therefore cannot be informed of their HIV status. The HPA use such data to monitor infections; they show that approximately a third of HIV infections in the UK are undiagnosed.[2]

Access to HIV testing

Rapid, easy access to diagnostic services is viewed by the HPA as a 'key part of infection control'.[2] According to the largest HIV charity in the UK, the Terrence Higgins Trust (THT), fast access to Genito-Urinary Medicine (GUM) clinics and other testing centres helps to reduce undiagnosed HIV. In September 2007, 88% of GUM clinic patients were offered an appointment within 48 hours. Despite this, the HPA believes that while waiting times have been reduced, 'considerable scope for improvement' remains.[2] The THT believes that waiting times for sexual health services are still too long, with restrictive clinic opening times, both for walk-in and appointment sessions. It suggests that some of these apparent waiting time reductions were due to new appointment booking procedures rather than to seeing patients earlier. It also reports over half of clinicians having to turn away people seeking an initial diagnosis in 2006 due to lack of capacity.[5]

To encourage more widespread testing, NGOs such as THT are now offering HIV tests in less traditional settings, such as university campuses and community centres. Some of these, such as THT's 'Fastest' service, offer free testing with results within an hour. These have been successful in reaching people who had not previously been tested.

Opt-out HIV testing

Opt-out testing involves providing routine, informed testing for all unless specifically declined. The British HIV Association believes improved access to testing is important, and supports opt-out testing in relevant settings. This partially reflects new guidelines from the Centers for Disease Control and Prevention in the US which recommend routine opt-out testing for all 13-64 year olds accessing healthcare. This approach could help

to tackle the stigma surrounding HIV, as it makes no judgement with regards to who is at risk of contracting HIV. There is evidence that those most at risk are least likely to seek testing: anonymous data revealed undiagnosed HIV positive clinic attendees were less likely to accept an HIV test than those who were HIV negative.[2] Research suggests that patients are often poor judges of their own HIV risk and may not make informed testing decisions. Due to efficiency and cost-effectiveness concerns, the NAT propose beginning with targeted routine opt-out testing of those displaying symptoms or accessing pregnancy, tuberculosis or GUM services.

The HPA states that the offer and recommendation of an HIV test to all GUM clinic attendees at every attendance is probably one of the most effective and efficient ways to achieve earlier HIV diagnosis; opt-out testing upon registration with a GP is another option. A pilot scheme in high-prevalence areas and for those at increased risk would test feasibility and effectiveness. The THT supports GP-led testing, but is concerned that GPs may currently be reluctant to offer tests because of a widespread belief that they are required to provide pre- and post-test counselling. In September 2007, the Chief Medical Officer stated that a short pre-test explanation from a GP could suffice.

Box 2. Criminalising reckless HIV infection

Since the first prosecution under British law in 2003, at least thirteen people have been convicted of recklessly infecting another with HIV. The Crown Prosecution Service produced a consultation in 2006 to consider proposed guidelines for prosecution, but so far no conclusions have been reached.

The Expert Advisory Group on Aids (EAGA), a non-departmental public body advising the Department of Health, criticises the approach in its consultation response, claiming it further stigmatises a disease that can already be very isolating and marginalising for those affected.

The EAGA response also claims prosecution may be a disincentive to HIV testing for those who believe ignorance of their HIV status will prohibit prosecution. Those living with HIV may be more reticent about sharing information about their sexual partners with sexual health providers, as this could be used against them in any future criminal proceedings. Although the NAT and THT support prosecution in a small minority of cases, this is reserved for where there has been intentional infection or deception about HIV status. No charges of malicious infection have been upheld in the UK, suggesting deliberate infection is very rare.

Access to treatment services

Undocumented migrants, or failed asylum seekers diagnosed whilst awaiting deportation, are entitled to access GUM services (including HIV testing), but not free secondary care HIV treatments. According to the African HIV Policy Network (AHPN) some migrants see little point in testing if they cannot access treatment, and fear that accessing services could lead to deportation. Others are unaware they are entitled to some services. The AHPN cite cases of people being billed as much as £34,000 for their HIV treatment. It argues this is a false economy, as unmonitored HIV infection can escalate to an emergency admission where treatment cannot be refused and would ultimately cost the NHS far more. Anti-retroviral treatments also reduce an individual's infectiousness, indicating the public health benefits of wider access to treatment. Proposals are currently being considered by the DH and the Home Office to restrict free primary care, such as access to GPs, for these groups.

Proposals on universal access free treatment in the UK have prompted concerns about 'treatment tourism' (where those with HIV travel to access free treatment). However, there is little evidence to suggest this is widespread. The majority of the non-UK born living with HIV are resident in the UK for nine months or more before they test positive, suggesting their HIV status is incidental to their migration.[5]

HIV prevention and education

The 2004 White Paper *Choosing Health*, pledged £300m to sexual health, much of which was allocated to Primary Care Trusts (PCTs). However, according to a NAT report[6] government funding for HIV prevention has decreased in real terms since 1997, despite large increases in HIV diagnoses and rising patient demand for sexual health services. PCTs act as key providers of NHS-funded prevention activities, but there is reported variability between trusts in how money allocated for sexual health/HIV prevention is spent (see Box 3). Charities believe that PCTs in high prevalence areas pay insufficient attention to prevention, and clinicians surveyed by THT suggest that money designated for HIV/GUM should be ring-fenced.[5]

Box 3. The role of PCTs in HIV prevention

PCTs commission HIV prevention activity, often as part of wider sexual health/health promotion aims. A 2006 survey by the Independent Advisory Group on Sexual Health and HIV (which monitors progress and informs government on the National Strategy) found that only 30 out of 191 PCTs actually spent all of their 2004 allocated *Choosing Health* money on sexual health.[7] A smaller proportion of this amount was dedicated to HIV prevention and treatment, with acute need often favoured above prevention spending.

In November 2006, the Department of Health announced that it would invest an extra £1m to target HIV prevention in MSM and Africans through the Terrence Higgins Trust and the AHPN. This is especially welcomed because it provided the organisations with direct funding for the areas of greatest need. NGOs agree, however, that more investment in preventative work is needed.

HIV education

HIV prevention begins with education, to inform people of the risks HIV poses and how these can be avoided. An IPSOS MORI poll for NAT reports that one in five adults

agree that they do not know enough about their own likely risk of HIV.[8] Misconceptions about HIV abound; the same poll discovered fewer people were able to identify correctly the ways in which HIV is transmitted in 2005 than in 2000. The study also found 17% of people were not worried about HIV since treatments are now available. This low level of knowledge translates into low levels of condom use; only 46% of the respondents replied they would always use a condom with a new partner, and 15% would 'never' or 'rarely' use one.

HIV education also helps to reduce stigma about the disease. According to the APPGA this not only makes life more difficult for those affected by the disease, but also hinders prevention messages, as people disassociate themselves and avoid dialogue about the issue.

Sex and Relationships Education (SRE) in schools
Age-appropriate SRE is taught from primary school age onwards. The Department for Children, Schools and Families (DCSF) issued guidance in 2000 on how sex education is taught as a statutory component of science classes and to encourage additional SRE under the Personal, Social and Health Education framework (see Box 4).

Box 4. Sex and Relationships Education (SRE)
The DCSF stipulates three main elements of SRE: attitudes and values, personal and social skills, and knowledge and understanding. SRE is defined in DCSF guidance as being "lifelong learning about physical, moral and emotional development. It is about the understanding of the importance of marriage for family life, stable and loving relationships, respect, love and care. It is also about the teaching of sex, sexuality, and sexual health".

All schools must agree an SRE policy. However, only those aspects of SRE taught under National Curriculum Science are statutory. DCSF encourages schools to deliver a broader range of SRE using the non-statutory framework for Personal, Social and Health Education (PHSE).

The FPA (formerly the Family Planning Association) suggests that the non-statutory status of much of the education means the content and extent can vary between schools. The DCSF argues that this allows individual schools to take into account the religious and cultural needs of their pupils. However, critics suggest that with tight timetabling and limited teacher training, the optional aspects of SRE can be sidelined, the needs of homosexual students are often neglected, and the curriculum pays insufficient attention to the relationships within which sex take place. Discussions about relationships allow pupils to contextualise the biology of sex and to form their own opinions, thus supporting future sexual decision-making. This is difficult in a society as culturally and religiously diverse as the UK, but is viewed as vital by the APPGA in equipping pupils with the skills to implement their learning. It suggests that this is especially important as SRE is often the only formal information people will receive on HIV. The DCSF has made a commitment in the Children's Plan (2007) to review best practice in SRE.

Adult education
Opinion is divided about whether the general population should be targeted for educational campaigns. The APPGA believes prevention education should be extended for all adults, while the HPA fears this would merely increase preoccupation and testing among the 'worried well' (those with little real cause for concern). The HPA instead advocates targeted interventions to high risk groups rather than spreading resources too thinly. NGOs including the AHPN do provide adult education working with faith communities and the media. The NAT add that those at increased risk gain much of their information from mainstream sources in the same way as the general public, making mass media education an important way of reaching these individuals as well.

Overview

- HIV diagnoses in the UK are rising, with most infections now acquired via heterosexual transmission (although, mostly overseas).
- Men who have Sex with Men are the group at greatest risk of HIV in the UK, followed by Black Africans.
- In the drive to reduce undiagnosed HIV, better access to fast and multi-site testing is called for by many NGOs and professional bodies, with support for routine opt-out testing in GUM clinics.
- Many organisations also support universal free access to treatment for all those in the UK.
- The current position for prosecuting 'reckless' HIV transmission is under review.
- Despite rising infection rates, PCT spending on HIV prevention has decreased.
- Sex and Relationships Education varies from school to school as not all aspects are compulsory.
- The government is revising and updating the 2001 National Strategy for Sexual Health and HIV.

Endnotes

1 *Health Protection in the 21st Century*, HPA, Oct 2005
2 *Testing Times; HIV and other Sexually Transmitted Infections in the United Kingdom*, Health Protection Agency (HPA), 2007
3 *Migrant Health Infectious Diseases in Non-UK born Populations in England, Wales and Northern Ireland,* HPA, 2006
4 Dodds *Sex Transm Infect*, online ed. 2007
5 *Disturbing Symptoms*, Terrence Higgins Trust February, 2007
6 *Commissioning HIV Prevention Activities in England*, National AIDS Trust, 2007
7 *Annual Survey,* Independent Advisory Group on Sexual Health and HIV, 2006, www.dh.gov.uk
8 *Public Attitudes towards HIV*, National AIDS Trust MORI, 2006

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POST is grateful to Shanna Marrinan for researching this briefing, to the ESRC for funding her parliamentary fellowship, and to all contributors and reviewers. For further information on this subject, please contact the co-author, Dr Sarah Bunn, at POST.

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