UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON AIDS (UNGASS) - PROGRESS REPORT 2008

UNITED KINGDOM

1. STATUS OF THE UK REPORT

1.1 The Department of Health (DH), on behalf of all four UK health departments has completed the monitoring report for UNGASS 2008. In completing the report, the DH was very grateful to the following HIV civil society organisations and people with HIV for agreeing and completing Annex B of the National Policy Composite Index on behalf of civil society: Yusef Azad (National AIDS Trust), Paul Clift, Robert James (Birchgrove Society), Lisa Power (Terrence Higgins Trust) and Winnie Sseruma. We also acknowledge the contribution of the staff of the HIV and STI Department of the Health Protection Agency's (HPA) Centre for Infections, for completing and commenting on the indicators relevant to the United Kingdom. The Department for International Development has reported on the global indicators relevant to the UK.

1.2. The UK has a relatively low prevalence of HIV and AIDS. In their latest annual report[1] the Health Protection Agency estimated that there were 73,000 persons living with HIV in the UK in 2006 (both diagnosed and undiagnosed), amounting to **121 persons living with HIV per 100,000** population in the UK (167 among men and 76 among women).

1.3. UK governments have prioritised action on HIV since reports of the first cases of AIDS in the 1980s. In 2001 in England, the Department of Health published the National Strategy for Sexual Health and HIV which has been complemented by similar strategies and frameworks in Scotland, Wales and Northern Ireland. In 2007, the DH commissioned the Independent Advisory Group on Sexual Health and HIV, (set up by the Department of Health in 2003 to support and advise on implementation of the English strategy) to review progress on the English strategy and make recommendations.

1.4. The main UNGASS indicators relevant for the UK are set out in the Appendix.

2. OVERVIEW OF HIV IN THE UNITED KINGDOM

2.1 The Health Protection Agency, on behalf of Health Protection Scotland, the National Public Health Service for Wales and the Department of Health, Social Services and Public Safety Northern Ireland, publish an annual Report on HIV and other sexually transmitted infections in the UK. In their latest report for 2006, published in November 2007[2], they reported that:

- At the end of 2006, an estimated **73,000 people** (of all ages) were living with diagnosed or undiagnosed HIV in the UK, and **69,400** in the 15-59 age range. This latter figure represents a **9%** increase from 2005.

- Approximately **21,600 (31%)** of those living with HIV in the 15-59 age range were estimated to be undiagnosed. This represents an improvement of **1%** compared to 2005.

[1] The UK Collaborative Group for HIV and STI Surveillance. *Testing Times, HIV and other Sexually Transmitted Infections in the United Kingdom 2007*, London: Health Protection Agency, Centre for Infections. November 2007 http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/AnnualReport/2007/default.htm

Numbers seen for HIV care

- **52,083** HIV-diagnosed individuals were seen for care in the UK during 2006, representing an increase of 10% on 2005. Increases reflect both the rise in the number of HIV diagnoses and the decrease in HIV-related deaths since the introduction of antiretroviral therapies.

- In 2006, among all diagnosed persons accessing HIV-related care in the UK, 51% were heterosexual, 43% were men who have sex with men (MSM), and 2.8% were injecting drug users.

New diagnoses

- The number of new diagnoses in 2006 was estimated to be **7,800.** This was similar to estimates for 2004 (7,650 and 2005 (7,900) probably indicating that the annual number of new HIV diagnoses is stabilising.

Men who have sex with men

- Men who have sex with men (MSM) remain the group at highest risk of acquiring HIV in the UK. In 2006, an estimated **2,700** diagnoses were attributable to sex between men, and, where reported, **83%** of infections were probably acquired in the UK.

- There has been a steady rise in HIV diagnoses in MSM since 2000, the result of a number of factors, including increased HIV testing among MSM, continued transmission of HIV and improved reporting.

Heterosexually acquired HIV

- The major factor contributing to the rapid rise in the number of new HIV diagnoses since 1999 has been increased diagnosis of infections acquired through heterosexual contact in high HIV prevalence areas, mainly Africa.

- Heterosexually acquired infection accounted for **59%** of new HIV diagnoses in 2006, compared to **36%** that occurred among men who have sex with men (MSM).

- Although at a relatively low level there has been a steady increase in the number of diagnoses of HIV infection in people thought to have acquired their infection heterosexually within the UK, from 227 diagnoses in 2000 to an estimated 750 in 2006. Most of these individuals were probably infected by partners who had been infected outside Europe, mainly in Africa.

AIDS diagnoses and deaths

- By contrast, the number of AIDS diagnoses and deaths fell markedly after the introduction of antiretroviral therapies (ARVs) in the mid-1990s and they have remained relatively constant in recent years. Deaths among HIV-infected persons have fallen from **749** in 1997 to **497** in 2006. AIDS diagnoses have dropped from **1080** in 1997 to **666** in 2006.

Injecting drug users (IDUs)

- Following the introduction of needle exchange schemes and other harm minimisation interventions since the 1980s, transmission amongst IDUs remains very low. The total number of HIV cases among IDUs whilst low has risen from 131 in 2002 to 190 in 2006.

Uptake of testing

- Data collected for England are used to monitor progress towards the National Strategy for Sexual Health and HIV target of offering an HIV test to all new GUM attendees and to reach a 60% test uptake rate by 2007. In 2006, the HIV test uptake rate was 73% for all persons offered an HIV test compared to 66% in 2003.

- In the 16 GUM clinics in the UK that take part in a sentinel surveillance study, **88%** of attendees accepted a HIV test compared to 55% in 2003. In these clinics over the past decade (1997-2006), the uptake of a HIV test rose from 45% to **83%** among MSM and even more substantially among heterosexual men and women from 25% to **89%**.

- In all UK GUM clinics, voluntary confidential testing for HIV among MSM increased from 61% in 2001 to **85%** in 2006. In heterosexuals, uptake increased from 41% in 2001 to **72%** in 2006.

Pregnant women

- Diagnosis rates of HIV in pregnant women have increased since the introduction in 1999 of the universal offer and recommendation of an HIV test to pregnant women in England as a routine part of antenatal care. In the UK in 2006, it is estimated that more than **90%** of HIV-infected women were diagnosed before delivery. This represents an increase from about 70% in 1999.

Late diagnosis of HIV

- Of adults diagnosed with HIV in the UK in 2006, at the time of their diagnosis 33% (2,281/6,977) had a CD4 count[3] below the recommended threshold for starting therapy(<200 cells/mm3) - a similar proportion to 2005.

- The proportion of adults diagnosed late was lowest among MSM (20%) and higher amongst IDUs (37%), heterosexual women (36%) and heterosexual men (43%). A substantial percentage of late diagnoses among the latter two groups were due to persons having acquired their infection abroad many years prior to their arrival and subsequent diagnosis in the UK.

- Eight percent of adults diagnosed with HIV in 2006 had a clinical AIDS diagnosis within three months of their HIV diagnoses.

- The percentage of newly diagnosed, HIV-infected adults diagnosed late has declined over the last ten years from 37% in 1997 (989/2,670) to 33% in 2006 (2,281/6,977). This trend has been evident in the three major prevention

[3] An indicator of the extent to which HIV infection has affected the immune system.

groups: from 30% to 20% among MSM, from 44% to 36% among heterosexual women and from 52% to 43% among heterosexual men.

3. NATIONAL RESPONSE

3.1 UK Governments have prioritised action to respond to HIV and AIDS since the first reports of AIDS in the mid-1980s. Actions have included screening of the blood supply, early introduction of needle-exchange schemes and harm-minimisation programmes for injecting drug users, public education campaigns and targeted health promotion for groups at increased risk, confidential and voluntary HIV testing, "open-access" genito-urinary medicine (GUM) services (i.e. self-referral) and dedicated funding for NGOs.

3.2 ARVs have been widely available throughout the UK since their introduction in the mid-1990s and are prescribed in line with guidelines agreed by the British HIV Association (BHIVA). In 2001, in response to concern about increasing rates of sexual ill-health in England, including HIV, the Department of Health published the first ever national strategy for sexual health and HIV. HIV is prioritised in four of the five goals which also address increasing rates of other sexually transmitted infections (STIs) and unplanned pregnancy. Action on HIV has included:

- publication in 2007 of *Tackling Stigma*, the Department of Health's action plan on responding to HIV related stigma, including the funding of three new projects ;

- sustained and increased (20%) funding for HIV social care over three years from 2008/09;

- sustained and increased funding for national HIV health promotion interventions for men who have sex with men (MSM) and African communities, the groups most at risk;

- funding to support the development of HIV paediatric networks outside London (where they already exist) (2006);

- publication of Standards for HIV Care Services complementing BHIVA's treatment guidelines (2003);

- establishing an Independent Advisory Group on Sexual Health and HIV to monitor implementation of the national strategy. Membership includes civil society and people living with HIV (2003).

3.3 Additionally, publication of the *Choosing Health Public Health* White Paper (Nov 2004) in England further signalled the government's priority for improving sexual health services, including HIV. *Choosing Health* announced additional investment in sexual health services and a major new STI awareness campaign, *Condom Essential Wear*, launched in November 2006.

3.4 In England, the Department of Health has set a national target so that by 31 March 2008 everyone who needs one can have an appointment at a genito-urinary medicine (sexual health) clinic within 48 hours. In December 2007 **92%** of patients were offered an appointment, up from only 45% in May 2005. This is important for HIV prevention and care since the majority of HIV is diagnosed in GUM (sexual health) services and the earlier HIV is diagnosed the sooner a person can access

treatment and make any behaviour changes to modify the risk of onward transmission.

3.5 In **Scotland**, the Scottish sexual health strategy *Respect and Responsibility* incorporates HIV as an integral part of its ongoing action plan at both national and local levels. A stock taking review is underway to assess progress with delivering services and actions that aim to achieve the three over-arching aims of the Scottish strategy. The review will be complete at the end of March 2008. There is also a strong commitment to learn lessons from the global pandemic, particularly from sub-Saharan Africa to ensure best practice and identify specific and culturally appropriate ways of engaging with all communities living in Scotland. The Strategic framework for improving sexual health in **Wales** was launched in 2000. It aims to improve the sexual health of the population by ensuring that people have access to sexual health information, advice and services. It also seeks to reduce the incidence and prevalence of sexually transmitted infections in Wales. The Department of Health in **Northern Ireland** is addressing HIV through its Sexual Health Promotion Strategy and Action Plan issued in 2006.

4. BEST PRACTICE

4.1 Examples of best practice include: political engagement with civil society and other key players, a supportive legislative and policy environment, high quality epidemiological surveillance and sustained evidence-based national HIV health promotion campaigns for the groups most at risk of HIV.

4.2 Over the last two years, Ministers for Public Health in England have:

- spoken on HIV prevention at major national conferences held by the Terrence Higgins Trust and African HIV Policy Network;
- jointly led, with the International Development Secretary, the UK's official delegation to UNGASS 2006;
- hosted an event for World AIDS Day 2007 showcasing the full range of HIV prevention work funded by the DH, including new work on addressing HIV related stigma;
- met with professional sexual health and HIV healthcare organisations;
- participated in a meeting of the Sexual Health Independent Advisory Group

4.3 In addition, civil society and stakeholder enjoy regular access to officials in the sexual health teams as well as senior personnel in the Department of Health and other health departments. More recently, the Prime Minister hosted an event for the Terrence Higgins Trust and included the national and international priority for HIV in his webcast for World AIDS Day 2007.

4.4 In addition to sustained prevention and health promotion interventions for individuals most at risk of HIV, the UK government has made a number of positive legislative changes, which, indirectly support an environment conducive to HIV health promotion and the challenging of HIV-related stigma and discrimination. Examples include legislative changes such as the repeal of Section 28 of the Local Government Act, equalisation of the age of consent, civil partnerships and an amendment to Disability Discrimination Act to include HIV from the point of diagnosis.

4.5 Nationally funded HIV health promotion for men who have sex with men (MSM) reflect best practice both in the UK and internationally in that it is evidence-based, has priorities agreed after wide consultation with key stakeholders and is strategic in its application through the *Making it Count* framework which is regularly updated. The national Gay Men's Sex Survey, now in its 11th year, supports the evidence base for this work and attracts responses from 16,000 MSM. New work for African communities in England includes developing a national health promotion needs assessment and seeking consensus on priorities and work with faith leaders and communities. This is additional to information and awareness campaigns on HIV testing, condom use and a dedicated confidential helpline. In Wales, in addition to the provision of integrated services for HIV/AIDS by the NHS, the Welsh Assembly Government has funded various initiatives via the Terence Higgins Trust such as the `Better to Know' campaign which encourages those living in Wales from high-risk countries to come forward for testing, as well as providing training about HIV health promotion for professional groups. Further funding has been provided for the establishment and delivery of the Wales HIV Network. The Network brings together service users, providers and the voluntary sector to improve service provision.

5. MAJOR CHALLENGES AND REMEDIAL ACTIONS

5.1 These include empowering people with or affected by HIV to challenge HIV-related stigma and discrimination, within both communities and the broader social environment. Addressing HIV related stigma and discrimination was prioritised in the national strategy for sexual health and HIV (2001). HIV stigma can result in the most vulnerable people failing to seek advice and information, access testing services and adhere to HIV treatment. As part of new work on HIV-related stigma the Department of Health has published *Tackling Stigma* an action plan on addressing HIV stigma and discrimination. Action has included funding the publication of an information resource *HIV Stigma and You* (title currently under review). This provides information for people with HIV on how to deal with any stigma and discrimination and explains how the law can either protect or be a remedy. Other DH-funded work covers stigma in the media and in some healthcare settings.

5.2 Reducing late diagnosis of HIV by improving the offer and uptake of voluntary and confidential HIV testing is important in reducing undiagnosed HIV and improving HIV health outcomes. Since publication of the English strategy uptake of testing in GUM (sexual health) clinics has increased dramatically (see section 2) and more recently, we have focused attention on non-HIV specialist health care settings. As a first step, all UK Chief Medical and Nursing Officers have written to all doctors and nurses about the importance of improving the detection of HIV and offer of an HIV test in non-HIV specialist settings (including primary care) and highlighting good practice about this.

6. MONITORING AND EVALUATION

6.1 The UK Collaborative Group for HIV and STI Surveillance comprises national STI and HIV surveillance agencies in England, Wales, Scotland and Northern Ireland. Their Annual Report includes a detailed analysis of national and regional HIV surveillance data including: HIV reports from laboratories and clinicians, the Survey of Prevalent Diagnosed HIV infections (SOPHID) on people accessing HIV treatment and care, the Unlinked Anonymous Prevalence Monitoring Programme and the National Study of HIV in Pregnancy and Childhood. Data are supplemented by

mortality data from the Office for National Statistics and the Institute of Child Health. The report synthesising the data for 2006 was published in November 2007.

6.2 The Independent Advisory Group on Sexual Health and HIV also has a role in advising the Department of Health and monitoring implementation of the English national strategy for sexual health and HIV. They do this by means of their Annual Report and other expert reports[4]. The Expert Advisory Group on AIDS provides an ongoing source of expert scientific advice on HIV/AIDS.[5]

7 GLOBAL INDICATORS

7.1 Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low- and middle- income countries

- £481m (2006/07)

7.2 Amount of public funds for research and development of preventive HIV vaccines and microbicides. In 2006/07:

- International Partnership for Microbicides - £2.5 Million
- Microbicide Development Programme - £8.4 Million
- International AIDS Vaccine Alliance - £6 Million

[4] http://www.dh.gov.uk/assetRoot/04/12/10/44/04121044.pdf
[5] http://www.advisorybodies.doh.gov.uk/eaga/

Appendix

UNGASS INDICATORS REPORTED ON BY THE HEALTH PROTECTION AGENCY (see Excel spreadsheets)

1. Percentage of donated blood units screened for HIV in quality assured manner.

2. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.

3. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission.

4. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV.

5. Percentage of most at risk populations that have received an HIV test in the last 12 monthsand who know their result.

6. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.

7. Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse.

8. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.

9. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.

10. Percentage of most at risk populations who are HIV infected.

11. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV therapy.

12. Percentage of infants born to HIV infected mothers who are infected.