

**HIV**

**Proposed Action Plan in Scotland**

**Phase One: May 2009 to March 2011**



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This is a draft HIV Action Plan produced by the Scottish Government under the guidance of the HIV Action Plan Group. Comments on the draft plan can be made directly to the Sexual Health and HIV Team at the Scottish Government or through engagement in one of the meetings taking place during February and March 2009.

**All comments should be returned no later than the 31 March 2009 to [hivplan@scotland.gsi.gov.uk](mailto:hivplan@scotland.gsi.gov.uk) Further copies of the action plan can be downloaded from SHIVAG, Health Protection Scotland and NHS Health Scotland websites or can be obtained by calling 0131 244 2568.**

**2 February 2009**

# **HIV Proposed Action Plan in Scotland Phase One: May 2009 to March 2011**

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# Section One: Context

## 1.1 Introduction

The recent XVIIth International AIDS conference in Mexico called for a renewed Government focus on HIV prevention but called for a multi dimensional and cross sector response that links HIV prevention and care. A report by the Global HIV Prevention Working Group (2008) recommends that Governments should

*“develop and implement national AIDS strategies and operational plans that are tailored to the particular dynamics of national epidemics, integrate prevention and treatment services, and bring prevention interventions to a scale sufficient to have measurable impact”.*

This action plan outlines how the Scottish Government will lead an increased focus on the prevention of HIV transmission in Scotland. It will also identify how the provision of high quality care and treatment for people with HIV can be delivered across Scotland.

Developing a plan of this kind takes time to review evidence, current policy and best practice; however, it should not prevent us from acting upon the things that we already know need to happen or increasing availability of existing activities where there is evidence of success. The Scottish Government's approach to an HIV action plan will therefore have two phases: we will outline in phase one those things that we can take action on now and during that period consider the evidence to inform our priorities for continuous improvements leading to a phase two plan from March 2011.

This HIV Action Plan attempts to emphasise the need for focussed action across Scotland in response to a recent increase in HIV diagnoses. We aim to reduce the transmission of HIV and to ensure that those living with HIV achieve optimal health and well being. Our approach will be to prevent infection where possible, to detect infection early, and to provide high quality treatment and ongoing support to those who need it. We will co-ordinate and pursue best practice in prevention and models of care across Scotland. We will overcome organisational and professional silos to ensure effective co-ordination and where necessary re-design services to improve effectiveness and efficiency. An integrated approach which includes harnessing the distinct and valuable contributions of both the voluntary and statutory sector is core to this action plan. Each theme requires work which integrates the psychosocial with the biomedical.

There are four main themes in this action plan:

- To reduce the transmission of HIV in Scotland
- To reduce the levels of undiagnosed HIV in Scotland
- To ensure the effective co-ordination of prevention, care and treatment activities in Scotland
- To increase monitoring, evaluation and research to support the plan

## 1.2 Background

### a) Prevalence of HIV

HIV transmission is increasing in Scotland, with 453 newly diagnosed HIV infected persons reported in 2007 (Figure 1). The balance of transmission routes in Scotland have changed over the years but there are still groups of people who are at greater risk of HIV infection than others. Successful developments in treatment of HIV have led to an environment where people with HIV using treatments are living longer – as a result there is less fear of death associated with HIV and perhaps a reduction of risk taking behaviours may be considered less important.

### b) Responses to HIV

The reduced mortality rate has meant that at a policy level HIV is not the priority it once was. As a result, HIV prevention activities across Scotland are inconsistent and in some instances are neither evidence informed nor specifically targeted at those who are most at risk of infection. On the other hand, those areas that have prioritised HIV activity and have renewed their efforts in this area have been able to produce comprehensive action plans designed to achieve change (Burtney and Hosie 2007), although the impact of these plans is yet to be evaluated. Access to HIV treatment in Scotland is good although there are variations in models of care. In response to this, the Scottish Government commissioned the Scottish Public Health Network (ScotPHN) to undertake a national health care needs assessment of treatment and care services for people living with HIV (Johnman, 2009). The strategic recommendations from this work have been incorporated into this action plan.

### c) Public Spending in HIV

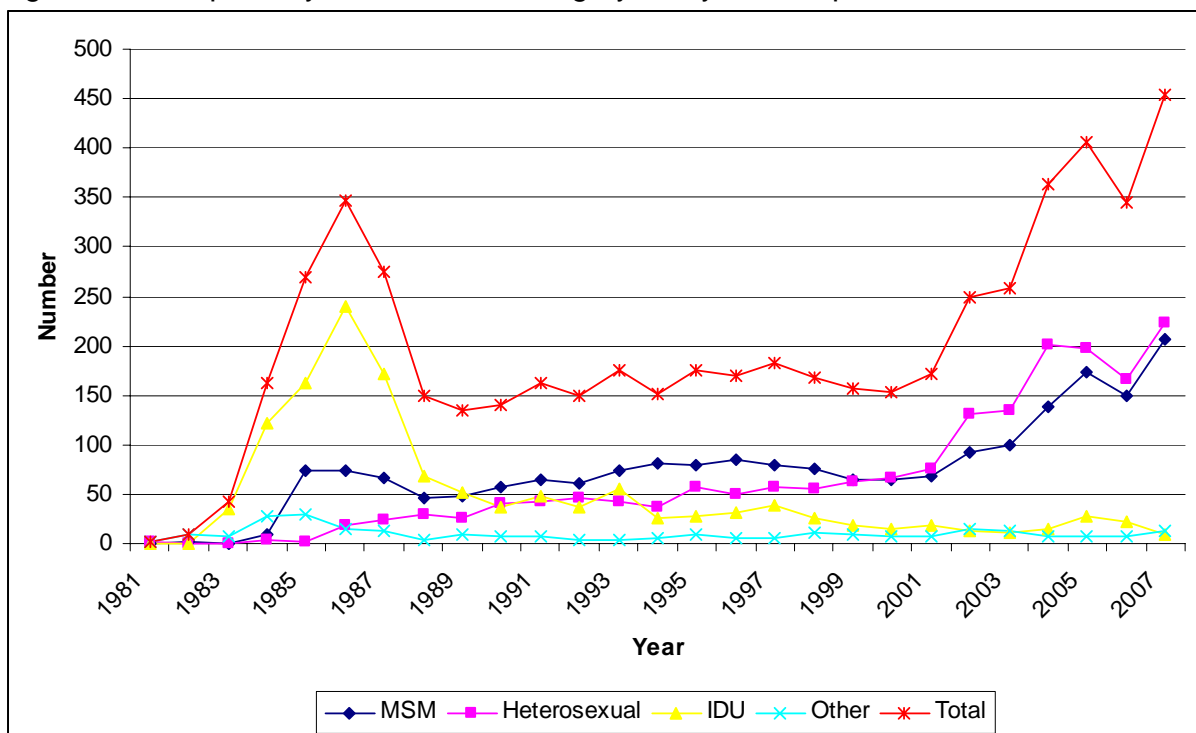
The Scottish Government continues to provide £9.5 million of Blood Borne Virus (BBV) Prevention Monies per year to NHS boards and their partners to prevent the transmission of blood borne viruses. An estimated £32 million per annum is spent on HIV care and treatment (Goldberg, 2008). The recent production of the Hepatitis C Phase II Action Plan for Scotland, (2008) and an increase in resources from the Scottish Government for its implementation has set a template for how the NHS in Scotland can

respond to infectious diseases and highlighted the value that could come from adopting a similar approach – albeit with more modest funding - with HIV. The funding being provided to support the Phase II Hepatitis C Action Plan includes a specific allocation for prevention activities. In this context it would seem that there would be value in reviewing how existing BBV prevention monies are used by NHS Boards in order to reduce any possible duplication, improve efficiency and impact and maximise the potential public health benefit.

### 1.3 Epidemiology

In 2007, Health Protection Scotland received reports of 453 newly diagnosed HIV infected persons from Scottish laboratories. This is the largest annual number since recording began in 1981. The increase in new HIV diagnoses in recent years has displayed a trend in the numbers of newly diagnosed heterosexuals and men who have sex with men (MSM) with HIV. There were more diagnoses in MSM (204) and in the heterosexual population (223) in 2007 than in any previous year. Much of this increase in diagnoses reflects the increase in testing, especially in the Genito Urinary Medicine (GUM) clinic setting, as a result of moving to an opt-out testing policy following recommendations in the Scottish Government's Respect & Responsibility: Strategy and Action Plan for Improving Sexual Health (2005). There is however, further continued evidence of transmission occurring among certain at risk populations in Scotland.

Figure1: HIV reports by transmission category and year of report, 1981-2007.



The majority of newly identified cases have been made in Lothian and Greater Glasgow & Clyde NHS Board areas and these urban areas are the main foci of HIV infection in Scotland. There was also, however, an increase in the number of reports from other areas, notably Grampian, Tayside, Fife, Lanarkshire and Highland NHS Boards during 2007.

#### **1.4 HIV testing trends**

HIV test uptake is increasing: the number of tests per year has more than doubled since 2002, rising to around 37,000 in 2007<sup>1</sup>. Most (82%) testing is performed in the GUM clinic setting where there has been a three-fold increase since 2002 (from 8000 to almost 25,000 per year). In Primary care (where tests originate from General Practice) there has been a 40% increase in testing since 2002, rising from 2000 to >2800 tests per year in 2007.

This important change in testing policy (Respect and Responsibility, 2005) has led to an overall reduction in undiagnosed infection in certain population groups. (HPS Weekly Report 2008). Also, in 2007, 95% MSM attending GUM with a Sexually Transmitted Infection (STI) risk were offered an HIV test and 94% accepted (HPS, unpublished, 2009). However, in contrast to the reduction in undiagnosed infection seen within unlinked anonymous samples of MSM attending the GUM clinic in Glasgow, the 2005 MRC Gay Men's Sexual Health Survey, which collected anonymous oral fluid samples to test for HIV antibodies from the commercial gay scene found 4% were HIV positive and 42% were undiagnosed, most of whom perceived themselves to be HIV negative. Among men who had not visited a sexual health clinic in the last year, 65% of the men who were HIV positive were undiagnosed (Williamson et al, 2008). The HIV prevalence in MSM attending clinical services and undergoing attributable (that is voluntary confidential named) testing has remained stable at around 3-4% during the past five years.

Data from the Unlinked Anonymous Prevalence Monitoring Programmes (HPS) indicate that recent testing policies have been effective at reducing undiagnosed HIV infection. Firstly, the antenatal screening policy, introduced in 2003, has been very effective at reducing the number of pregnant women (who proceed to live birth) in Scotland and who remain unaware of their HIV status – most HIV infections are now being diagnosed either before or during pregnancy. In 2007, data from the Unlinked Anonymous dried blood spot testing survey and the National Study of HIV in Pregnancy and Childhood,

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<sup>1</sup> Note that this is based on the number of individuals greater than 15 years of age undergoing testing in four NHS board areas: NHS Greater Glasgow and Clyde, NHS Lothian, NHS Grampian and NHS Tayside. It should be noted that the total tests figure excludes repeat tests within a calendar year and tests undertaken in the context of a screening programme, for example the antenatal screening programme.

NSHPC, database, indicate that 13 of 14 (93%) pregnant women knew about their infection prior to delivery; this compares with 63% (19 of 30) in 2002.

Secondly, there is monitoring of the HIV opt-out testing policy by anonymously testing for HIV the residual sera of a subsample of GUM clinic attendees undergoing syphilis testing. The percentage of those who are infected with HIV, not known to be antibody positive and who remain undiagnosed after their clinic visit has reduced in recent years. In MSM, during 2007, only one of 13 (8%) MSM whose status was unknown at the time of the clinic attendance remained undiagnosed; this compares with 50% (12/24) in 2003. There is also a welcome general downward trend in those remaining undiagnosed in both heterosexual men and women (HPS Weekly Report 2008; 42: 415-416). However, there are people in Scotland that remain undiagnosed and thus, unaware of their infection. Not everyone attends a GUM or antenatal clinic: 50% of MSM have never been to a GUM clinic and many people of African origin expect their GP to meet their health care needs (including sexual health) and therefore do not frequently attend GUM services.

In cross-sectional surveys of gay men in commercial gay venues in Glasgow and Edinburgh, the proportion of ever testers who had tested recently (in the calendar year of, or immediately prior to, the survey) varied but there was no real increase over time. Recent testing also decreased with age, from an average of 76.1% of the <25 years age group to 53.1% of the 25-34, 39.7% of the 35-44, and 41.1% of the >44 years age groups. The lack of change, and decline across age groups, in recent HIV testing rates suggest few men test repeatedly or regularly (Williamson, in press). Moreover, research addressing barriers to HIV testing in Scotland amongst MSM has shown that the most important barriers to testing amongst MSM are psychosocial rather than relating to service provision or beliefs about the process of testing itself (Flowers et al., 2003). The central importance of psychosocial factors shows that issues such as HIV related stigma remain core barriers to seeking regular testing for many at risk men.

## **1.5 Transmission in Scotland**

### **Men who have sex with men (MSM)**

In MSM, the number of new HIV reports has more than doubled since 2001. There is evidence that an increase in incidence (new transmissions) in addition to increased testing has contributed to this rise (HPS, 2008). The prevalence in this group is second only to that among sub-Saharan Africans in Scotland.

An increase in HIV transmission in this group is consistent with other findings. The rates of other sexually transmitted infections (STIs) have been increasing since 2002, most notably syphilis, with a five-fold increase between 2002 and 2004. Although the number of diagnoses of gonorrhoea, including rectal gonorrhoea, in MSM decreased in 2007 for

the first time in ten years, the upward trend in the proportion of rectal gonorrhoea infections continued (SSHI report). Self reported increases in high-risk behaviour are evident from surveys of MSM recruited from the commercial gay scene of Scotland. Between 1996 and 2007, levels of respondents reporting 'any' Unprotected Anal Intercourse (UAI) increased from 32.2% in 1996 to 47.1% in 2007. Similarly, levels of respondents reporting UAI with over two partners in the preceding year increased from 8.3% to 20.4%. When these data are compared with the infection data, a temporal link is evident. A UK comparison of HIV negative men, and men who were and were not aware of their HIV positive status found that both undiagnosed and diagnosed men reported greater sexual risk and sexually transmitted infections than HIV negative men, demonstrating the potential for increasing levels of onward transmission of HIV. Risk was greatest among men who were aware of their HIV positive status and evidence of risk reduction was limited (serosorting was only reported by 19% while unprotected anal intercourse with partners of unknown or discordant HIV status was reported by 31%) (Williamson et al, 2008).

Most diagnoses (70%) are in those aged 25-44 and this has been consistent over the past 10 years. However, there has been an increase in the number of cases among all age groups and a notable increase in diagnosis in men who have sex with men under the age of 25, from 21 in 2005 to 37 in 2007.

Over half of the cohort living with HIV (63%) live and/or attend for care in Lothian and Greater Glasgow & Clyde NHS Boards. Analyses of data by presumed location of exposure indicates that 58% (119/204) of new reports in MSM in 2007 were presumed to have acquired their HIV infection in Scotland; this compares with 12% (27/218) of reports in heterosexual men and women. The majority (80%) of HIV transmissions in Scotland occur during sex between men. Hence this group offers the greatest opportunity for actions within Scotland to prevent new infections. However there are major challenges in terms of working with this population, for example, the impact of HIV related stigma within the gay community (Flowers et al., 2000a) and the complexities of multiple and distinct sexual cultures which mean prevention should be targeted at distinct locations (such as cruising areas, sex on premises saunas, the commercial gay scene, the internet), as well as targeting the particular individuals who regularly report engaging in risky conduct (Flowers et al., 2000b).

### **Non-IDU Heterosexual men and women**

Although new diagnoses among the non-IDU heterosexual population accounts for the largest increase in the past six years, this is not totally due to behaviour change in the indigenous heterosexual population among whom HIV prevalence remains about 1 in 1000. Heterosexually acquired infection in the UK (either with or without a high risk partner) remains low, averaging 30 cases per year between 2003-2006. Among non-IDU heterosexual men and women who probably acquired their HIV in Scotland, 27 cases of HIV were identified in 2007; the average number of cases per year between

2002-2006 is 25. When the data on heterosexually acquired infection is analysed by presumed geographical region of exposure; in 2007, 78% (169/218) acquired their HIV infection outside the UK. Furthermore, the increase in newly identified cases among non-IDU heterosexual men and women is mostly due to the rise in detections among infected men and women who probably acquired their infection in African countries (145/218, 66%). Since 2004, this group have made up almost 65% of all heterosexually acquired HIV diagnoses. These are mainly African Nationals from areas of high HIV prevalence, who have been infected in Africa and come to live in Scotland, mainly from countries in South East Africa.

At a UK level, two-fifths of all new diagnoses are among black Africans and they account for 69% of all new diagnoses of heterosexually acquired infection with 88% having most likely acquired the infection in Africa. Of note is that two thirds of these diagnoses are among women. Also, in 2007, 10% of this population were diagnosed with HIV and AIDS at the same time (HPA, 2008).

In 2007, a prevalence of 11% was observed in those undergoing attributable HIV testing whose likely exposure was in sub-Saharan Africa (10% in men and 12% in women). This represents an increase compared to 6% prevalence in 2006 (HPS, 2008).

### **IDUs**

New infections in injecting drug users (IDUs) are low and reducing; there were nine in 2007 which is the lowest annual number reported - six of the nine were infected outside Scotland. There is evidence to suggest that new diagnoses of HIV infection among this group are made among those who acquired their infection many years previously. Thus, transmission among IDUs appears to be rare – the prevalence of HIV among injectors having an attributable HIV test was 0.3% in 2007 and has remained (overall in Scotland) at below 1 in 100 for the past 9 years. However, the potential for transmission exists; in 2006/2007, 29% of IDUs indicated that they had shared a needle and syringe in the previous month and this was highest in those aged less than 20. This highlights the need to continue measures aimed at reducing risk taking behaviours in this group (Scottish Drug Misuse Database: [www.drugmisuse.isdscotland.org](http://www.drugmisuse.isdscotland.org)).

### **1.6 HIV Treatment and Care**

There are more people living with HIV in Scotland than ever before. At the end of December 2007, there were 5415 reports of individuals who had had HIV infection diagnosed in Scotland and 1346 were reported as having AIDS. Of the total number infected, 29% (1553) are known to have died, although some of these will have been from causes unrelated to their infection status. Thus, there is an estimated cohort of 3862 individuals, 69% (2668) of whom are known to attend clinical services for monitoring and treatment. The remainder include those who have not attended for

monitoring in 2007, who have been diagnosed in Scotland but have since left the country or who have died but have not yet been notified to Health Protection Scotland.

One of the most challenging implications of the large numbers of infections that continue to be diagnosed in Scotland is the increasing burden on treatment and care services and ensuring that all who need treatment and care receive it. However, there is evidence currently that:

- (i) a high proportion of those eligible for therapy are receiving it
- (ii) access to care and treatment is not restricted by exposure category, country of origin or geographical area of residence and
- (iii) of those accessing monitoring and treatment, 85-90% do so within one month of their first positive HIV report<sup>2</sup>. 70-80% of new diagnoses enter clinical care within one month of their first positive HIV report.

At the end of December 2007, 2668 (69%) were in clinical care and undergoing monitoring (i.e. those with a CD4 count taken in the previous 12 months). Over three quarters (79%) has received therapy at some time since their diagnosis. Almost all (99%) of those on therapy during 2007 were receiving triple therapy or higher.

There are clear links required between HIV prevention interventions, care and treatment. Antiretroviral therapy dramatically reduces the probability of onward transmission of HIV. There is evidence that most transmissions occur from those who are undiagnosed, or are diagnosed but not on treatment. However, UK surveys of gay men in commercial venues has shown that levels of sexual risk behaviour were highest among men living with diagnosed HIV and this group should be included in HIV prevention efforts (Williamson, 2008). In addition, delivery of prevention interventions by healthcare providers in settings where people receive routine HIV care or other services has been identified as a potential characteristic of successful interventions (Crepaz et al, 2006). Adherence to treatment requires intensive support and poor adherence can lead to the transmission of drug resistant viruses. Accessible and comprehensive treatment and care services are therefore an important component of any prevention strategy. Once more they present an opportunity for integrated work across both the voluntary and statutory sectors.

## **1.7 Late Diagnosis**

Late diagnosis is defined as those who register a CD4 count less than 200 cells per mm<sup>3</sup> or are registered with an AIDS diagnosis within four weeks of their first antibody positive HIV test. Early diagnosis allows the patient greater benefit from treatment and offers them the chance to change their behaviour and thus act to reduce further

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<sup>2</sup> These data are based on the analysis of aggregate data (2004 -2006) on those diagnosed with HIV who attend clinical services for monitoring and treatment.

transmission. Overall, there has been a reduction in the level of late diagnosis among all cases from 40% in 2001 to 34% in 2006 and likely reflects the increase in HIV testing. The data show a trend for MSM to be tested at earlier stages of their infection (but a substantial proportion are diagnosed late; in 2005, 22% of MSM diagnosed with HIV had a CD4 cell count less than 200 cells/ mm<sup>3</sup> and 7% had a clinical AIDS diagnosis (UK Collaborative Group, 2006) compared to heterosexual men and women but a high proportion of the latter group have acquired their infection overseas and thus, lacked the opportunity to have an earlier diagnosis in Scotland.

## Section Two: Reducing HIV transmission in Scotland

Currently, HIV transmission in Scotland is predominantly amongst men who have sex with other men. In order to reduce the transmission of HIV in Scotland there needs to be increased efforts to target this group with interventions (in relevant locations and settings) which are known to change risk taking behaviours. In addition, there is a particular need to identify sub groups of men having sex with men, primarily HIV positive men but also negative and untested men who are at increased risk of acquiring HIV, such as those regularly testing positive for STIs but not accepting the offer of an HIV test and those who continue to report engagement in unprotected anal intercourse.

A recent report completed by a sub group of the National Sexual Health Advisory Committee made a number of recommendations for action to reduce HIV transmission amongst MSM. In addition, UNAIDS published Practical Guidelines for Intensifying HIV Prevention calling on policy makers to “know your epidemic and your current response”. Within these guidelines, the epidemiological scenario in Scotland can be defined as concentrated – where prevalence is high in one or more sub-population but not circulating within the general population. As a result, this requires a response where interventions (and resources) are directed to the appropriate populations.

Identifying effective approaches to behaviour change within a target group without increasing the levels of stigma and discrimination already associated with that group is a constant challenge for public health interventions, but is one that we must not shy away from. There is evidence that behavioural approaches to HIV prevention can be effective (Lancet series 2008, Herbst 2007) – there is less agreement however on which will be most effective in Scotland – although this is likely to focus on promoting lower risk sexual practices, increased condom use, a reduction in partner numbers and increased frequency of testing. There is a need; first of all, to share guidance widely amongst professionals in all sectors across Scotland on what we know are useful approaches. Secondly there is a need to design evidence informed interventions which can be tested and evaluated within the Scottish context.

### Proposed Actions

**NHS Health Scotland should build on Scottish and international evidence and experience to produce evidence informed guidance specific to the prevention of HIV and other STIs amongst high risk men who have sex with men, targeting HIV positive men and those at particular high risk of acquiring HIV infection – these must lead to improvements in service delivery for this group.**

**NHS Boards individually, or in association with other Boards, and in conjunction with relevant voluntary agencies should undertake needs assessments to determine the sexual health needs of gay and bisexual men and people of African origin in their area and provide and evaluate evidence based targeted interventions which are developed with the full participation of community members.**

**NHS Health Scotland will lead the development of HIV social marketing interventions targeted at MSM building on the earlier work undertaken by NHS Greater Glasgow and NHS Lothian.**

**Voluntary Sector agencies working with the target groups highlighted in this plan shall produce clear action plans outlining their contribution to the prevention of HIV transmission in Scotland.**

## Section Three: Reducing levels of undiagnosed HIV

Recent changes in guidelines (Phillips et al 2007) about *when* to initiate HIV treatment mean that there is a new imperative to diagnose people earlier on within their HIV infection (CD4 = 500 within the USA and CD4 =350 within the UK). Moreover, policy changes outlined in the national sexual health strategy, Respect and Responsibility led to HIV testing being offered as part of routine sexual health screening within specialist sexual health services. This in turn has led to a reduction in the percentage of GUM clinic attendees who remain undiagnosed after their clinic visit (HPS Weekly report Focus 2 in Nov 2008).

The antenatal screening policy in Scotland (introduced in 2003) has led to most pregnant women with HIV being diagnosed either before or during pregnancy. However, there are still people in Scotland who remain undiagnosed and therefore unaware of their infection; this is a missed opportunity to prevent further spread of the infection and to ensure that people with HIV can benefit from the treatment and care services available to them.

A high proportion of those heterosexuals diagnosed late have acquired their infection overseas. It is not possible at present to identify the time gap between someone arriving in Scotland to that person presenting for an HIV test, to assess the likelihood of being able to reduce the length of time involved before a test is provided. However, the latest report suggests that most of the black Africans who are diagnosed late have been in the UK for more than two years before being diagnosed (HPA, 2008). This area requires further research. In the meantime, it is important that all healthcare providers are made aware of this high risk population and that an HIV test is offered to all men and women known to be from a country of high HIV prevalence (>1%) (BHIVA, 2008). Whilst the majority of people of African origin will have become infected abroad, there is evidence (from clinicians) of growing transmission amongst a small numbers of Africans in Scotland highlighting the need to consider this group as part of prevention activities.

Although undiagnosed infection has reduced among MSM in clinical settings, 42% of HIV positive men in the 2005 MRC bar survey were undiagnosed. Most of these men had previously tested HIV negative and still thought they were negative. This suggests there is a need to promote regular HIV testing to reduce undiagnosed infection among MSM (Williamson, 2008).

In addition to those from overseas, it is possible there are others who remain undiagnosed such as those with a history of injecting drug use who may have acquired their infection many years ago but who have remained well. The provision of successful

interventions for this group has led to a reduction in transmission of HIV, however, the potential for transmission still exists and prevention efforts should be continued (but aligned more closely to the prevention of Hepatitis C transmission as this presents a higher risk within this group).

All health and social care providers need to be equipped with the skills to assess risk. This means that all health environments should facilitate the disclosure of sex with other men through explicit inclusiveness and diversity policies, training in sexual history taking and risk assessment.

## **Proposed Actions**

**NHS Boards should ensure the implementation of the UK National Guidelines for HIV Testing 2008 (BHIVA, BASHH, BIS) to encourage “normalisation” of HIV testing; facilitate further increases in HIV testing and a reduction in levels of undiagnosed HIV.**

**The Chief Medical Officer and Chief Nursing Officer for Scotland will issue further guidance and a call to action to all doctors and nurses to assist in the early detection of those who are living with HIV. Particular emphasis should be placed on reaching people of African origin through primary care.**

**HIV Scotland, Waverley Care and NHS Health Scotland will build on international evidence and experience in Scotland to produce evidence informed guidelines specific to the prevention of HIV transmission and the reduction of HIV testing barriers amongst people of African origin – these must lead to improvements in service delivery for this group.**

## **Section Four: Ensuring effective co-ordination of prevention, care and treatment activities**

It is a priority for the Scottish Government to reduce the transmission of HIV in Scotland. In order to achieve this we need everyone to think “prevention” first and foremost. The links between prevention, care and treatment are strong and the improvement of care and treatment services can contribute to a reduction in the transmission of HIV and longer survival rates for those living with HIV (Lancet series, 2008).

Health Protection Scotland report that a high proportion of those eligible for therapy are receiving it and that 70-80% of new diagnosis enter clinical care within one month of their first HIV report. The use of anti-retroviral therapy (ART) has led to a significant increase in the number of people attending HIV care and treatment services in Scotland. Services have evolved over time leading to a variety of models of care across Scotland. In response the Scottish Government asked the Scottish Public Health Network (ScotPHN) to undertake a needs assessment of care and treatment services for people living with HIV. ScotPHN set out to “assess the capacity of people living with HIV to benefit from services and to make suggestions as to how such benefits may be delivered”. Their report Treatment and Care Needs Assessment: People Living with HIV (Johnman, 2009) makes a number of recommendations – those strategic recommendations are reflected below.

People living with HIV do not have equal access to sexual health service provision due to the range of service delivery models that exist across Scotland (Johnman, 2009). Access to these services is important to prevent the onward transmission of HIV but also to support those living with HIV to maintain good sexual wellbeing. The sexual health needs of people living with HIV should be seen as an integral part of their HIV care and treatment unless they prefer to seek these services elsewhere. The recent introduction of a QIS standard on sexual healthcare for people with HIV should ensure this need is met. With high levels of sexual risk behaviour recently found among MSM living with HIV, reducing undiagnosed infection would not be enough in itself to reduce HIV transmission. Sexual health and HIV services are ideally placed to deliver targeted HIV prevention efforts at people living with HIV. Equally, opportunities should not be missed by the voluntary sector in terms of the chance to work with positive people in innovative ways around HIV prevention, care and treatment.

A clear understanding of what constitutes effective prevention, care and treatment activity is not consistent across Scotland or indeed across sectors and professions. The voluntary sector has a key role to play not only in accessing local communities but in bridging the gap between prevention, care and treatment provision. There is a need for

NHS boards to lead the way in raising the issue of HIV prevention across all of its staff and amongst key partners. In particular, there is a need to build on the Chief Medical and Chief Nursing Officers letter (2007) to all doctors and nurses to ensure staff can identify high risk behaviours and sero-conversion illnesses and appropriate responses.

## **Proposed Actions**

**NHS HIV care and treatment services should provide comprehensive sexual healthcare integrated with HIV in line with BHIVA guidelines.**

**Regional Managed Care Networks should be established to ensure the effective co-ordination and provision of HIV prevention, care and treatment across Scotland leading to provision of a core set of services provided by all care and treatment units in Scotland.**

**NHS Boards should evidence examples of joint working between clinical services, health improvement and voluntary service providers that have clear and specific outcomes designed to facilitate HIV prevention and positive treatment and care experiences for those living with HIV.**

**Quality Improvement Scotland should develop standards for HIV prevention, care and treatment. These should be developed in collaboration with service users and providers.**

**NHS Boards should identify plans for the increasing number of individuals who are likely to need access to provision of therapy, care and support over the next ten years.**

## **Section Five: Monitoring, Evaluation and Research**

A recent report to the National Sexual Health Advisory Committee identified a major gap in the direction, monitoring and accountability of HIV prevention activity in Scotland (Clutterbuck, 2008). It calls for a national guidance and monitoring structure for HIV prevention. In addition, the Scottish Government will increase its focus on performance management and the most effective use of the current Blood Borne Virus Prevention Monies through the identification of a Public Health lead for HIV within each NHS Board who will work with the Scottish Government, Health Protection Scotland and NHS Health Scotland to ensure the delivery of the HIV Action Plan.

There is a need to improve our understanding of what works to prevent HIV transmission. This can be met partly through an increase in local evaluation of current activity, increased evaluation and research skills and effective dissemination of learning and best practice. Evaluation of all interventions should be encouraged and focus both on process and outcome (in terms of measurable indicators of health). There is a further need to examine the evidence worldwide and to test interventions within the Scottish context. Consensus amongst stakeholders is essential to achieving effective interventions and activity across Scotland.

### **Proposed Actions**

**NHS Boards will identify a Public Health lead for HIV and the Scottish Government will establish an HIV Action Plan group to oversee implementation of the HIV Action Plan.**

**NHS Boards should assess the current use of their BBV prevention monies and re-prioritise spend according to the epidemiology in Scotland. The expectation is that at least 75% of resources will be spent on at risk groups such as MSM, African communities and people living with HIV.**

**HIV Scotland will work with SHIVAG, NHS Health Scotland and Health Protection Scotland to deliver a series of seminars on the themes in this action plan to enable consideration of the evidence and a consensus approach to deciding the priorities for the second phase of the HIV plan.**

**A national clinical system for HIV will be established to assist with patient management and to inform how well actions relating to clinical management are performing.**

**Health Protection Scotland will create a surveillance system to assist with the measurement of the incidence of HIV amongst MSM.**

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## HIV Action Plan Group Membership

### Membership

#### Chair

Mary Cuthbert, Head, Scottish Government Sexual Health and HIV Team

#### Members - external

Gordon Scott	SHIVAG
David Goldberg	Health Protection Scotland
Lesley Wallace	Health Protection Scotland
Roy Kilpatrick	HIV Scotland
Shirley Fraser	NHS Health Scotland
Dan Clutterbuck	NHS Borders, Chair of NSHAC MSM sub-group
Syed Ahmed	NHS Greater Glasgow and Clyde BBV Co-ordinator
Sheila Cameron	NHS Greater Glasgow and Clyde Laboratories representative
Bruce Fraser	Gay Men's Health
Martha Baillie	Waverley Care
Lisa Williamson	Medical Research Council
Ewen Stewart	Royal College of General Practitioners
Rak Nandwani	CMO Specialist Advisor in GUM
Nick Kennedy	NHS Lanarkshire ID Consultant
Gordon McKenna	NHS Highland GUM Consultant
Paul Flowers	Glasgow Caledonian University
Ailsa Spindler	Terrence Higgins Trust
Iain Ramsay	Learning Teaching Scotland
Nicky Coia	NHS Greater Glasgow and Clyde
John Logan	NHS Lanarkshire
Jim Sherval	NHS Lothian

#### From January 2009

Ray Fox	NHS Greater Glasgow and Clyde ID Consultant
Gwyneth Jones	NHS Dumfries and Galloway ID Consultant

#### Members – Internal

Dona Milne	Scottish Government Sexual Health and HIV team
Cheryl Paris	Scottish Government Sexual Health and HIV team

## Proposed HIV Action Plan Accountability Structure

