Health Committee meeting

HIV prevention in London

Introduction

London has high rates of sexual transmitted infections. These present a significant public health risk for London. In particular, the number of people living with HIV continues to increase, and the number living with undiagnosed HIV remains high. The Mayor has made HIV prevention one of his key health priorities. The committee has therefore decided to use its June meeting to examine HIV prevention in London, to determine how the Mayor can support better sexual health across the capital.

HIV in London

Approximately 35,000 people are accessing HIV treatment in London – 40 per cent of the total UK figure. There were over 2,600 new cases diagnosed in London in 2014 of which around 60 per cent were diagnosed in men who had sex with men (MSM). Approximately 30 per cent of new diagnoses occurred through heterosexual sexual transmission.[1] Around 50 per cent of new diagnoses occurred in white people. Black African people make up approximately 22 per cent of new diagnoses. Specific high risk groups in London include sex workers, homeless people, and the prison population. Intravenous drug users are also at higher risk, although this group makes up less than 3 per cent of the London caseload.

Diagnosis

More than one in ten of people living with HIV in London are thought to be unaware of their HIV status. The lack of prompt diagnosis not only affects the health of the individual, but also increases the risk of further onward transmission. Late diagnosis remains a significant problem, particularly among heterosexual people living with HIV. In 2014, 37 per cent of people diagnosed with HIV in London were diagnosed late.[2] Nationally, late diagnosis is twice as likely in heterosexual men as it is in MSM. It is not clear to what extent this is replicated in London. Public Health England has called for expanded and scaled up testing to reduce undiagnosed infection and late diagnosis.

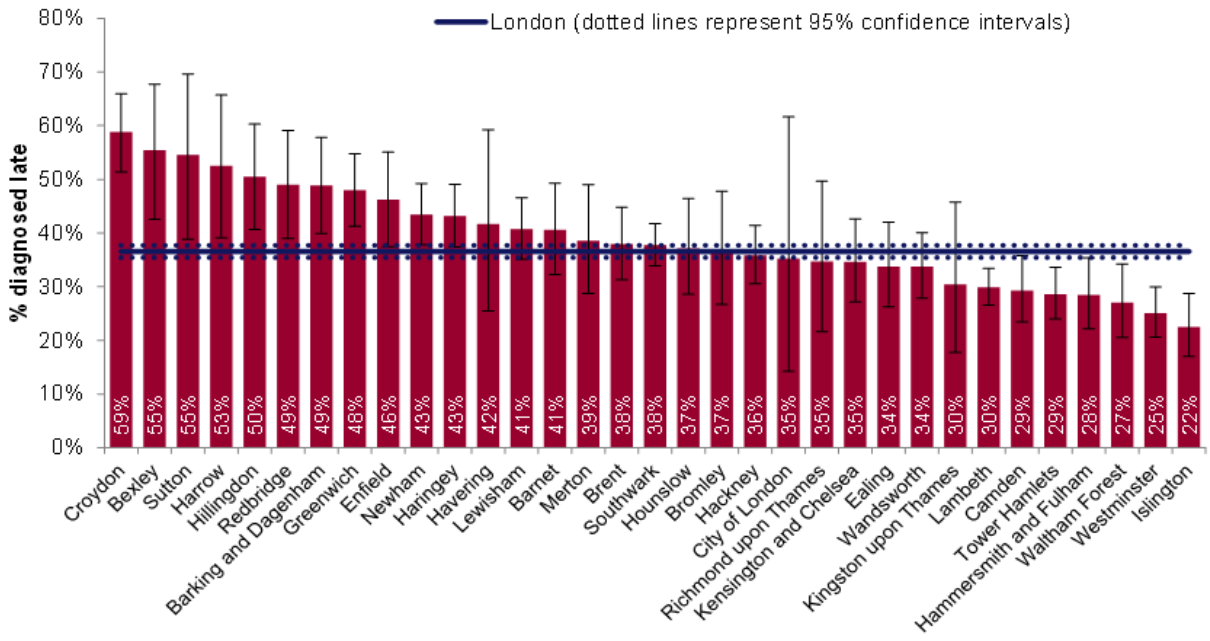
The reasons for late diagnosis are complex. Possible reasons for late diagnosis may include any or all of the following:

- Stigma relating to HIV and wider sexual health issues causing reluctance to get tested
- Lack of access to appropriate diagnostic facilities
- Lack of awareness of risk
- Disconnection between HIV testing and wider sexual/public health services
- Wider determinants of poor sexual health, including deprivation and alcohol/drug dependence

[1] The remaining 10 per cent is split between people who inject drugs (1-2%), and cases where transmission route is undetermined.

[2] Annual epidemiological spotlight on HIV in London: 2014 data (Public Health England)

The percentage of cases diagnosed late varies significantly across London



Source: Annual epidemiological spotlight on HIV in London: 2014 data (Public Health England)

Public awareness of sexual health issues

Poor understanding of HIV transmission routes can mean increased risk that people acquire HIV whether through unsafe sex or unsafe injecting practices. Poor knowledge of HIV can also feed into prejudice and stigma. Along with increasing the burden on people living with HIV, stigmatisation hampers public health efforts, by making people unwilling to get tested, or talk to their partners about sexual health risk.

It is not clear how successful previous efforts to educate Londoners about sexual health, including HIV, have been. The National Aids Trust (NAT) has conducted public surveys on knowledge and attitudes to HIV since 2000. The surveys appear to indicate that knowledge and understanding of HIV transmission is declining. For example, in 2000, 91 per cent of respondents knew that sex without a condom between a man and woman could result in HIV being transmitted. By 2010 this had fallen to 80 per cent. The most recent survey (2014) has also identified that Londoners tend to show lower levels of awareness and understanding of HIV, and lower levels of support for people living with HIV, than people in other parts of the country.[3] NAT has suggested that this may be in part due to the fact that London's younger population have grown up without the high profile public health campaigns about sexual behaviour and HIV risk that were developed when HIV/AIDS first emerged.

[3] http://www.nat.org.uk/media/Files/PDF%20documents/Mori_2014_report_FINAL.pdf

HIV testing

Effective testing, especially of at risk groups, is a key component of prevention strategy. Nationally, PHE evidence has found that HIV testing coverage is generally better for MSM than for other groups. Heterosexual women notably have significantly lower take up of testing services than heterosexual men (62 per cent vs 77 per cent).[4]

HIV test coverage measures the percentage of eligible new STI clinic attendees who had an HIV test. The British Association for Sexual Health and HIV recommends at least 80 per cent coverage for HIV tests offered to people attending GUM clinics. London's testing coverage is variable, depending on both geographical location and sexual preference. PHE figures show that London GUM clinics are achieving higher testing coverage for MSM than they are for heterosexual people.[5] There is also considerable variation in testing coverage across CCG footprints: Hillingdon has the highest coverage (85 per cent) and Bexley the lowest (67 per cent).[6]

PHE has called for expanded testing outside of STI services to increase accessibility amongst populations who do not regularly present to STI clinics.

Commissioning HIV services in London

From 1 April 2013 a range of public health responsibilities, including the commissioning of HIV prevention services, transferred from the NHS to local authorities. A Pan-London HIV Prevention Programme had been jointly commissioned by the London Primary Care Trusts, but was due to come to an end in March 2013.

London Councils commissioned a needs assessment to consider the case for future pan-London commissioning. In light of this work it agreed to commission a three-year £3.4 million London HIV Prevention Programme to deliver a limited number of key HIV prevention services. The services are aimed at MSM and black African communities (the groups at highest risk of contracting HIV) and include media campaigns, condom distribution and some outreach work. There is no guarantee this will continue beyond 2017 and boroughs remain responsible for any additional HIV prevention commissioning required to meet the needs of their communities.

The role of the Mayor

The new Mayor's election manifesto included a pledge to 'renew focus on prevention of and screening for HIV, working with boroughs on collective commissioning and provision of prevention services and ensuring that effective information on HIV reaches the right audiences.' HIV prevention services are the only aspect of public health that London boroughs currently commission collectively. It would therefore be of interest to determine the extent to which these arrangements are working effectively, and how the Mayor,

[4] HIV in the UK- situation report 2015 (Public Health England)
[5] Ibid.
[6] Public Health England http://fingertips.phe.org.uk/profile/sexualhealth/data#page/3/gid/8000057/pat/6/par/E12000007/ati/102/are/E09000002/iid/91525/age/1/sex/4

through the London Health Board and other channels, could offer practical support to efforts to improve HIV prevention. This could potentially inform future work on other sexual and wider public health services.

The Mayor has a statutory duty to produce a strategy to promote the reduction of health inequalities among Londoners. HIV is linked to health inequality in a number of ways: there are established statistical links between income and educational levels and HIV prevalence, and certain communities are disproportionally affected by HIV: notably men who have sex with men (MSM) and people from some black African communities. There is also evidence of variation in access to appropriate diagnostic and support services across London.

HIV was a priority topic for the previous Mayor's health team. Health team work in this area mainly supported national and international health promotion events, building on existing campaign materials and media coverage. The previous Mayor also appointed Annie Lennox as a mayoral ambassador on HIV, to promote awareness. There may be further opportunities in the future for the current Mayor to expand upon this work

Suggested approach

The committee will hold one meeting on this topic in June. The purpose of the meeting is to establish the current landscape for HIV in London, and to assess whether the current and planned activity to improve prevention and screening uptake is adequate. The committee could also explore the policy levers available to the Mayor to fulfil his manifesto commitment; in particular, ensuring that consistent and effective information on sexual health is reaching all of the right audiences.

Key questions

The committee would seek to address the following key questions:

- What are the current trends in HIV in London and who is most at risk of infection?
- What are the key challenges for HIV prevention?
- What needs to be done to raise public awareness about HIV and reduce stigma?
- How is London's response to HIV being co-ordinated?
- What are the key challenges facing HIV/sexual health services in London?
- How can the Mayor support HIV prevention efforts?

Possible guests

- Paul Steinberg, Programme Lead, London HIV Prevention Programme (can attend)
- Julie Billett, HIV Prevention Lead, Association of Directors of Public Health (can attend)
- Terence Higgins Trust (delivers HIV programme contracts and frontline support)
- Representatives from third sector organisations e.g. NAZ Foundation and London Friend, working with at-risk communities on engagement

Output

The committee will write to the Mayor setting out its key findings and possible areas for mayoral action in the forthcoming term.