# APPENDIX 1.

## UNGASS COUNTRY PROGRESS REPORT

**UNITED KINGDOM (January 2008- December 2010)**

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1. STATUS AT A GLANCE

1.1 The Department of Health (DH) and the Health Protection Agency, have completed the monitoring report for UNGASS 2010 on behalf of all four UK health departments. In completing the report, the DH was very grateful to the Terrence Higgins Trust and National AIDS Trust for completion of Part B of the National Policy Composite Index on behalf of civil society (submitted separately). They did this in consultation with other civil society organisations and people living with HIV. The HPA led on completion of the detailed Core Indicators numbers three to 25 as set out in the UNAIDS Reporting Guidelines.

1.2 The UK has a relatively low prevalence of HIV and AIDS. In their 2009 annual report the Health Protection Agency (HPA) estimated that there were 83,000 persons living with HIV in the UK in 2008 (both diagnosed and undiagnosed), equivalent to 1.3 per 1,000 population in the UK (1.8 per 1,000 men and 0.88 per 1,000 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 2008, 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) published their review of progress on the English strategy. DH formally responded to this in July 2009.

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 in the UK. In their latest annual report, published in November 2009, the HPA reported that:

- At the end of 2008, an estimated **83,000 people** (of all ages) were living with diagnosed or undiagnosed HIV in the UK.

- Over a quarter (**27% 22,400**) of those living with HIV were unaware of their infection.

**Numbers seen for HIV care**

- A reported **61,213** HIV-diagnosed individuals were seen for care in the UK during 2008, representing an increase of **8%** on 2007. The increase reflects both the rise in the number of HIV diagnoses and the decrease in HIV-related deaths since the introduction of antiretroviral therapies.

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2. Independent Advisory Group on Sexual Health 2008
In 2008, among all diagnosed persons accessing HIV-related care in the UK, 50% were heterosexual, 42% were men who have sex with men (MSM), and 2.4% were injecting drug users.

New diagnoses

- 7382 new diagnoses were reported in 2008. This represents a slight decline on previous years, predominantly due to fewer diagnoses in people who acquired their infection abroad.

Men who have sex with men (MSM)

- Men who have sex with men (MSM) remain the group at highest risk of acquiring HIV in the UK. In 2008, an estimated 2,800 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 around 58% of new HIV diagnoses in 2008, compared to 38% that occurred among MSM. In 2008, there were an estimated 4,260 diagnoses attributable to heterosexual contact.
- 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 an estimated 700 in 2004 to an estimated 1,080 in 2008. 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 a peak of around 1726 in 1994 to 571 in 2008. AIDS diagnoses have dropped from a peak of 1882 in 1994 to 700 in 2008.

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 remains low with an estimated 185 new diagnoses in 2008.
Uptake of testing

- The uptake of voluntary HIV testing in GUM and antenatal clinic settings continues to increase. In GUM clinics this increased to 93% in 2008 compared with 77% in 2004.

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 2008, 95% of pregnant women accepted an HIV test. Consequently at least 90% of HIV-infected pregnant women had their HIV diagnosed before giving birth. This represents an increase from about 70% in 1999.

Late diagnosis of HIV

- In 2008, an estimated 32% (2,310/7,218) of adults aged over 15 years were diagnosed with a CD4 cell count lower than 200 within three months of diagnosis.

- The proportion of adults diagnosed late was lowest among MSM (20%) compared with heterosexual women (36%) and heterosexual men (44%). 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.

- The proportion diagnosed with a CD4 cell count lower than 350 (the threshold at which revised guidelines from the British HIV Association recommend treatment were 43%, 61% and 66% respectively.

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, targeted health promotion programmes for gay men and African communities, confidential and voluntary self-referral HIV testing services and dedicated funding for NGOs.

3.2 Antiretroviral therapies (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, including HIV, the Department of Health published the first ever national strategy for sexual health and HIV in England. HIV was prioritised in four of the five goals which also address increasing rates of other sexually transmitted infections (STIs) and unplanned pregnancy.

3.3 In 2007, the Government commissioned the Independent Advisory Group on Sexual Health and HIV (IAG) to undertake a review of progress made in implementing the national strategy. The IAG published their report in July 2008. It recommended a wide-ranging set of actions at the national, the regional and local level, to respond to the changing environment, including devolved decision-making in
the health service. The Government responded to the IAG’s review in July 2009.\(^3\) The current English strategy ends in 2011, and the Department of Health is already considering what further action is needed to sustain and increase improvements in sexual health and HIV outcomes and respond to new challenges. A major national consultative conference took place in February 2010, addressed by the Minister for Public Health, the Chief Medical Officer and attended by 400 participants including sexual health and HIV clinicians, planners of sexual health services, people living with HIV and other civil society representatives. The outcome of the conference, along with the IAG’s review, will inform the review process.

3.4 Action to implement the current English strategy has included:

- investing over £750,000 in eight pilots aimed at reducing undiagnosed HIV by considering options for more routine voluntary HIV testing in health and community-based settings in high prevalence areas,
- sustained and increased (20%) funding for the AIDS Support Grant which contributes to HIV social care services provided by local authorities,
- sustained funding for national HIV health promotion interventions for men who have sex with men (MSM) and African communities, the groups most at risk managed by NGOs (respectively the Terrence Higgins Trust and the African HIV Policy Network),
- funding of toolkits on HIV for Christian and Muslim faith leaders, developed by faith groups and the African HIV Policy Network and others,
- funding three NGOs for work on reducing HIV-related stigma,
- establishing an Independent Advisory Group on Sexual Health and HIV in 2003 to monitor implementation of the national strategy. Membership includes civil society and people living with HIV;
- launch of Sex. Worth Talking About awareness campaign (Nov 2009)

3.4 In England, the Department of Health set a national target to provide an appointment in a genitourinary medicine (sexual health) clinic within 48-hours of contacting the clinic. The target was met in March 2008 and excellent progress is being maintained. In May 2005, only 45% obtained an appointment within 48 hours. This is important for HIV prevention and care since the majority of HIV is diagnosed in GUM 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 Wales, the Welsh Assembly Government have recently consulted on the Sexual Health and Wellbeing Draft Working Paper. This refreshes their previous sexual health Strategy and will be launched in 2010. The paper contains action on HIV prevention, treatment and care.

3.6 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

\(^3\)http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103090
local levels. The Scottish Government published its HIV Action Plan in Scotland in November 2009. A strategic framework which aims to refocus action across Scotland, the plan promotes the importance of prevention in addition to good quality treatment and care. The overall aims of the HIV Action Plan are to

- Integrate HIV prevention, diagnosis, treatment and care
- Reduce HIV transmission and undiagnosed HIV through social marketing, education, service provision and guidance
- Improve performance management and accountability

3.7 The plan has a focus on vulnerable populations, MSM and those from areas of high prevalence, particularly African countries, as well as acknowledging the needs of the general population.

3.8 In [Northern Ireland](#) the Department of Health, Social Services and Public Safety (DHSSPS) issued a five-year Sexual Health Promotion Strategy and Action Plan in 2008. The Strategy aims to improve, protect and promote the sexual health and well-being of the population in NI. A key objective of the Strategy is to reduce the incidence of sexually transmitted infections including HIV. Planned action includes improved access to GUM and sexual health services, raising awareness of HIV for both the public and health professionals, with a particular focus on those most at risk, and preventative initiatives including community based programmes and outreach programmes. In addition, the DHSSPS also funds a number of voluntary organisations working in the field of HIV prevention through information, education and awareness raising.

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 monitoring, sustained evidence-based national HIV health promotion campaigns and programmes for the groups most affected by HIV and a programme of innovative pilots to reduce undiagnosed HIV.

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

- responded to Parliamentary debates and questions on HIV,
- included HIV in a key-note speech on sexual health at a major national conference,
- convened a meeting with HIV positive people and discussed their concerns on HIV-related stigma,
- met Chief Executives from the major HIV and sexual health charities,
- attended meetings of the Independent Advisory Group on Sexual Health and HIV,
- met with professional sexual health and HIV healthcare organisations;

4.3 In addition the Department of Health has:
• published an Equality Impact Assessment for National Sexual Health Policy⁴,

• spoken about HIV prevention at major national conferences held by the Terrence Higgins Trust and African HIV Policy Network,

• participated jointly with officials from the Department for International Development and members of UK civil society at the 2008 UNGASS meeting,

• participated in the European Commission’s AIDS Think Tank, and

• worked with officials in the Ministry of Justice, the Crown Prosecution Service (CPS), and HIV NGO organisations to develop the CPS’s Guidance for Prosecutors on Prosecuting Cases Involving the Intentional of Reckless Sexual Transmission of Infection.

4.4 Civil society and stakeholders enjoy regular access to officials in the sexual health teams as well as senior personnel in the Department of Health and other health departments.

National HIV health promotion programmes

4.5 Nationally funded HIV health promotion for gay men or men-who-have-sex with-men (MSM) reflect best practice both in the UK and internationally in that work is evidence-based, with priorities agreed after consultation with civil society and key stakeholders. The programme is strategic in its application which is underpinned by the Making it Count strategic framework. Vital Statistics⁵, the national Gay Men’s Sex Survey now in its 13th year, supports the evidence base for this work and attracts responses from 13,000 MSM. New health promotion work for African communities in England includes, publication of the strategic framework, The Knowledge, the Will and the Power (KWP), and supporting handbook setting out a plan of action to meet the HIV prevention needs of Africans living in England. The KWP is important since it reflects a consensus view on priorities from African HIV civil society groups in England. Other work includes the Bass Line survey ⁶ which identifies the sexual HIV prevention needs of African people living in England, the targeted Do it Right testing awareness campaign, toolkits on HIV for Muslim and Christian faith leaders and capacity building support for African community-based organisations engaged in health promotion.

Supportive legislative environment

4.6 In addition to sustained prevention interventions for individuals most at risk of HIV, the UK government has made a number of positive legislative changes, which support a social environment conducive to HIV health promotion and the challenging of HIV-related stigma and discrimination. These include the repeal of Section 28 of the Local Government Act, equalisation of the age of consent, the 2005 amendment to the Disability Discrimination Act, the Gender Recognition Act and Civil Partnership Act, and the Equality Bill.

⁵ http://www.sigmaresearch.org.uk/go.php/projects/project21
⁶ http://www.sigmaresearch.org.uk/go.php/reports/african
5. MAJOR CHALLENGES AND REMEDIAL ACTIONS

5.1 Today, the outlook for most people with HIV in the UK is much more positive thanks to the introduction of effective treatment over a decade ago. Treatment has transformed people’s lives and the vast majority of people with HIV can now plan for their future with a great deal of certainty than before. In the UK we have also seen increased uptake of HIV testing and the number of testing options has also improved including the availability of tests which can provide an immediate result. However, despite this success, reducing undiagnosed and late diagnosis of HIV remain a challenge. Over 25% of people are unaware of their infection. Undiagnosed HIV infection remains a public health issue with around 22,000 of the estimated 83,000 people living with HIV unaware of their infection which means they are unable to benefit from effective treatment and risk unwittingly passing HIV on to others. A continuing challenge is therefore to diagnose HIV earlier and reduce late diagnosis which is the single most important factor associated with HIV-related morbidity and mortality in the UK.

5.2 The majority of people test for HIV in a GUM clinic or through routine opt-out antenatal HIV testing. But we know from audit evidence that the vast majority of patients who present late have had previous contacts with healthcare professionals who, if they were aware of the latest information on HIV, including common presenting conditions, could have made the HIV diagnosis much earlier.

5.3 Action to reduce undiagnosed and late diagnosis includes:

- a greater focus on HIV testing in the national HIV health promotion campaigns for gay men and African communities,
- the Chief Medical Officer in England writing to the Medical Royal Colleges and Faculties inviting their feedback on action they are taking to raise awareness of HIV testing amongst their members, good practice and any barriers to testing,
- the Department of Health (DH) funding the NGO, the Medical Foundation for AIDS and Sexual Health to produce *Tackling HIV Testing* – a resource pack for secondary care. This provides useful information resources about offering an HIV test in secondary care and importantly, it also addresses the impact of stigma as a barrier to offering and accepting an HIV test,
- DH funding five major pilot projects trying out new approaches to routine HIV testing for adults in primary and secondary care in high prevalence areas (defined as diagnosed HIV of at least 2 cases per 1,000 of the local population). Settings include general practice, hospital admission units, emergency departments and an acute care unit,
- DH funding for three HIV testing pilots working with community-based organisations for gay men and African communities looking at options for testing in social settings,
- The Health Protection Agency will evaluate all eight testing pilots. Their findings will help increase our evidence-based on HIV testing and inform any changes to our current policy.
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: reports of HIV, AIDS and deaths 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 2008 was published in November 2009.

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. The Expert Advisory Group on AIDS provides an ongoing source of expert scientific advice on HIV/AIDS.7

7 http://www.advisorybodies.doh.gov.uk/eaga/