



UK investment in HIV prevention 2015/16 and 2016/17

Examining UK expenditure
on primary HIV prevention
and HIV testing



Our strategic goals

All our work is focused on achieving five strategic goals:

- effective HIV prevention in order to halt the spread of HIV.
- early diagnosis of HIV through ethical, accessible and appropriate testing.
- equitable access to treatment, care and support for people living with HIV.
- enhanced understanding of the facts about HIV and living with HIV in the UK.
- eradication of HIV-related stigma and discrimination.

Our vision

Our vision is a world in which people living with HIV are treated as equal citizens with respect, dignity and justice, are diagnosed early and receive the highest standards of care, and in which everyone knows how, and is able, to protect themselves and others from HIV infection.

NAT is the UK's policy charity dedicated to transforming society's response to HIV.

We provide fresh thinking, expertise and practical resources.

We champion the rights of people living with HIV and campaign for change.



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EXECUTIVE SUMMARY

HIV remains a significant public health issue for the UK. Despite vast improvements in treatment and prevention technologies, HIV incidence remains stable and high. In 2015 NAT (National AIDS Trust) showed that investment in public health was under significant pressure and that primary HIV prevention was under threat and under-prioritised in those areas where the need was at its highest.

In 2016 NAT requested information from 230 public bodies across the UK with commissioning responsibility for HIV prevention. NAT asked them, for the financial years 2015/16 and 2016/17, what they spent on primary HIV prevention and testing (excluding HIV testing provided as part of mandated open access sexual health clinic services). 99% of the requests received a response.

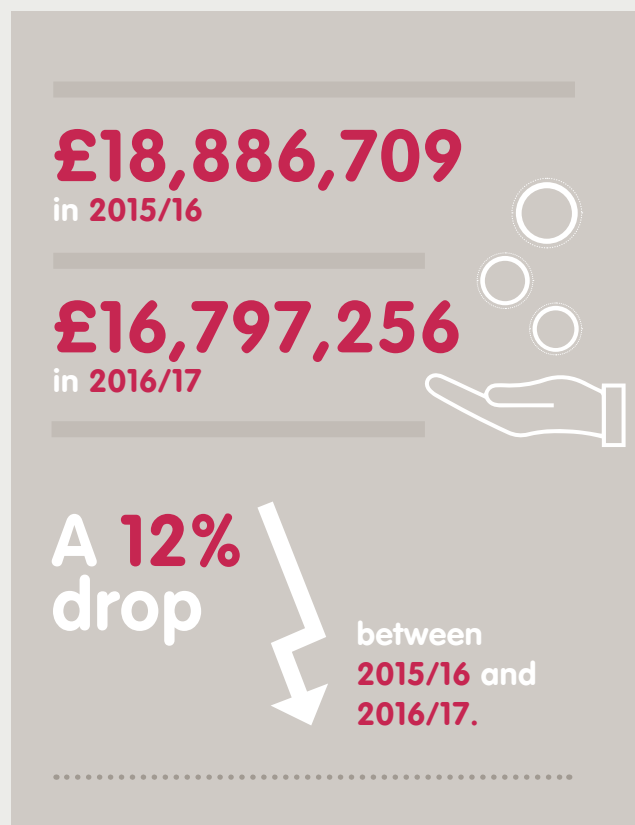


PRIMARY HIV PREVENTION WAS DEFINED AS:

Services which have as an exclusive aim or as one of their primary aims the prevention of HIV transmission and as their intended recipients people identified as at significant risk of acquiring HIV. This includes the promotion and practice of HIV testing.

HIV PREVENTION FUNDING IS DIMINISHING, FAST

UK-wide reported expenditure on primary HIV prevention and testing was:



Between 2015/16 and 2016/17:

- In England, HIV prevention and testing expenditure dropped by 11%.
- In Scotland, HIV prevention and testing expenditure dropped by 14%.
- Expenditure in Wales and Northern Ireland was far lower, with less than £100,000 reported in both nations. But the low level of investment remained relatively stable over the two years.





In 2016/17, the most recent financial year:

- A quarter of local authorities in England did not commission any primary HIV prevention or testing.
- Four in five high prevalence local authorities commissioned some form of HIV testing outside of that provided in sexual health clinic services. This does indicate a positive trend since NAT's 2015 report, where only two in five high prevalence local authorities reported funding these HIV testing services.

Since April 2015:

- In England's high prevalence local authorities spending has dropped by almost a third (29%) over two years.
- In London, where all boroughs have a high prevalence of HIV, local expenditure has dropped by over a third (35%) over two years.

These figures are an estimate based on reported expenditure. The figures do include contracts which are not solely for HIV prevention, such as contracts which also include HIV support services. Therefore, this may be an over-estimate of spending on primary HIV prevention and testing. However, this is the most comprehensive and accurate overview available.

KEY TRENDS AND ISSUES

Contracts are being consolidated

There was an increasing trend for HIV prevention activity to be included within wider contracts. These were either contracts incorporating support for people living with HIV, or contracts for integrated sexual health services (ISHS). For example, in 2016/17, 28% of reported expenditure in England was for contracts which were also for the delivery of HIV support services. 53 local authorities did not report spending on primary HIV prevention services, but 23 of these said that this was now delivered through the ISHS. There was also far less direct

expenditure reported on HIV testing than in the previous survey (of 2013/14 and 2014/15) as much of this was rolled into wider HIV prevention contracts.

This consolidation may well represent a cost-effective way of achieving outcomes across multiple services when faced with ever diminishing resources. However, it is much harder to assess where investment is targeted. NAT does have some concerns that with this consolidation, the accountability of services is diminished unless there is clarity on how expenditure is broken down.

More is spent on areas with high HIV prevalence than low, but it's still decreasing

As of 2015 38% of local authorities had an HIV prevalence of greater than two diagnosed per 1,000; they are therefore considered to have a high prevalence of HIV. Over half of all local spending on HIV prevention is in these high prevalence areas. Across all local authorities in England in 2016/17 the average spend was £0.44 per capita (population aged 15-59) on HIV prevention. When low prevalence local authorities (less than two per 1,000) are removed, the average per capita spend is £0.66. This was a significant drop from £0.80 in 2015/16.

In London spending is lower than other high prevalence areas. Per capita it was £0.67 in 2015/16 and 0.52 in 2016/17. This represented a reduction of funding of more than a third since 2014/15.

In general, health promotion contracts are becoming less specific in their target groups

Health promotion spending has reduced in England and Scotland. This reduction is largely seen in targeted services. In England, there has been a noticeable squeeze in health promotion funding for bespoke services targeting men who have sex with men (MSM) or black and minority ethnic groups (BME). For example, between 2015/16 and 2016/17, funding for BME targeted health promotion contracts dropped by more than 50% in London. Local contracts specifically for work targeting



MSM in London are now worth around half what they were four years ago in 2013/14. In the rest of England there was a 9% reduction in BME contract value and 21% reduction in MSM contract value between 2015/16 and 2016/17.

A much higher proportion of contracts across the UK were for services that targeted a range of groups. Local authorities usually reported that the contracts did specify that the service should be for people at increased risk of HIV and often even specifically referenced MSM and BME groups as part of this. However, they were not clear on how much of the service cost was dedicated to different forms of targeted work.

The settings for HIV testing are changing

Expenditure on HIV testing was only indicative, as so much of the testing is now incorporated into wider HIV prevention contracts and local authorities and health boards were often not able to separate out funding specifically for HIV testing. A significant proportion of community testing services were provided as part of wider HIV prevention contracts; therefore, it was often not possible for local

authorities to report expenditure. In England, three quarters of local authorities reported commissioning HIV testing services, outside of those provided in a sexual health clinic. This was largely due to the high number participating in the National Home Sampling Service, coordinated by PHE. In Scotland all contracts for HIV prevention included a testing element, usually community HIV testing. NICE guidelines recommend HIV testing on registration in primary care and on admission in secondary care settings in areas of high prevalence. Unlike in the two years 2013 - 2015, London boroughs are no longer investing in HIV testing in secondary care settings. But, investment in primary care was considerably higher; half of London local authorities reported expenditure in this area. Outside London this was also a more common service to commission, 21% of local authorities commissioned primary care testing in the rest of England, but a great deal of the expenditure was in lower prevalence areas. Provision still falls way short of meeting NICE guidelines which recommend HIV testing on registration with a GP in high prevalence areas.

SUMMARY OF RECOMMENDATIONS

Recommendations for England

1. The Government should continue to fund the National HIV Prevention Programme at least at the current level.
2. The Government must address the inadequacy of public health funding by increasing the public health budget and should take steps to ensure that plans to move to business rates retention in local authorities do not compromise public health and lead to increased health inequalities, including in HIV.

3. PHE should consider how services delivered through an integrated sexual health service (ISHS) should be reported by local authorities through the annual returns process to ensure that transparency and accountability are not diminished.

Recommendations to local authorities in England

4. All local authorities in London should continue to value the London HIV prevention programme as a critical London-wide approach



to HIV prevention which complements local activity.

5. Commissioners funding joint HIV support and prevention contracts should ensure transparency as to the disaggregation of funding between the services and that resources provided meet the costs associated with both services.
6. Local authorities commissioning an integrated sexual health service (ISHS) should know how this service meets their local HIV prevention needs and the expenditure allocated to these needs. Local authorities should ensure that providers have, or are accessing, expertise in HIV prevention for their key populations.
7. Local authorities with a high prevalence of HIV must address the HIV prevention needs of their local population through sexual health and HIV prevention services targeted at the highest risk populations; relevant services must not be disproportionately cut relative to reductions in the overall public health budget.
8. Local authorities with an HIV prevalence of below two per 1,000 should be mindful of the potential for rates to increase in their area and should address their local HIV prevention and testing needs.
9. All local authorities should ensure that they are meeting NICE HIV testing guidelines that are relevant to their area, providing adequate testing opportunities for their population, outside of the sexual health clinic.

Recommendations for Scotland

10. NHS Health Boards in Scotland should work to maintain their existing infrastructure,

provision and expertise in HIV services, and in HIV prevention specifically, as further cuts at the level reported here will make provision unsustainable.

11. NHS Health Boards should ensure that organisations are adequately funded to fulfil the broad range of outcomes, across prevention and support, that are included in their contracts.
12. The Scottish Government and NHS Scotland should support NHS Health Boards and work with community organisations to provide a wider range of testing services, including greater provision of home sampling and primary care testing services.

Recommendation for Wales

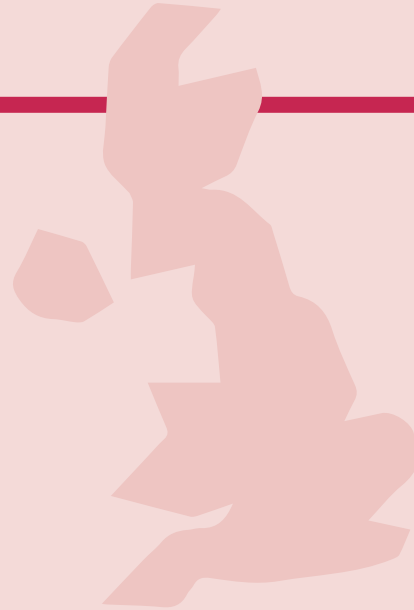
13. HIV prevention activity in Wales is insufficient and the Welsh Government should work with Public Health Wales and local Health Boards to increase investment in HIV and broader sexual health prevention activities as a matter of urgency and to address gaps in infrastructure.

Recommendations for Northern Ireland

14. Greater clarity is needed on public health commissioning responsibility in Northern Ireland and how this relates to sexual health and HIV services. This should be set out clearly as part of an up-to-date strategy for sexual health and HIV in Northern Ireland.
15. Local investment in HIV prevention must be increased and should be targeted at meeting local prevention needs. This must include increased HIV testing provision to address the high late diagnosis rate in Northern Ireland.



A: INTRODUCTION



In 2015 NAT published HIV prevention in England's high prevalence local authorities: 2013/14 and 2014/15.¹ Based on a survey of all local authorities with a high prevalence of HIV in England, the report gave a comprehensive overview of what HIV prevention and testing services were being commissioned across these areas at that time.

In England, public health responsibilities were from April 2013 transferred away from NHS bodies to a newly established public health function within local authorities following the passing of the Health and Social Care Act 2012 (the Act). The data NAT collected for the 2015 report was important in chronicling what happened to HIV prevention services in the immediate aftermath of this transfer.

In 2015 NAT showed that investment in primary HIV prevention in high prevalence areas in England did increase between 2013/14 and 2014/15. But, it was a fraction of what it had been in the past despite no reduction in prevention needs. This was not an immediate result of the structural changes brought about by the Act, but was a trend that dated back over upwards of 15 years. However, the changing commissioning landscape and the bite of austerity undoubtedly compounded the challenge for investment. HIV prevention was under-prioritised and under-resourced.

In 2016 NAT followed-up this work with a more ambitious survey of spending in 2015/16 and 2016/17, this time targeting all public bodies with commissioning responsibility for HIV prevention and testing services across the United Kingdom.

NAT went to all upper tier and unitary authorities in England, all local authorities and NHS Boards in Scotland, all local authorities and Health Boards in Wales, and all Health and Social Care Trusts in Northern Ireland. Altogether 230 requests for information about HIV prevention spending were submitted under the Freedom of Information Act 2000 and 99% of those responded.

This report, on the data collected from these information requests, provides a unique insight into what services are commissioned in the UK, how this has changed over time, and how commissioning bodies are managing the continued transformation of health structures and ever tightening budgets. The report will consider what this means for public health outcomes in HIV and makes recommendations on how to ensure that the UK's response to HIV meets need.

SECTION A: INTRODUCTION
A.1 HIV IN THE UK



A.1 HIV IN THE UK

HIV remains an important public health issue in the UK. In 2015, 101,200 people were living with HIV in the UK; an estimated 13,500 of those were unaware of their HIV status.²

Each year in the UK around 6,000 people are diagnosed with HIV and HIV incidence (transmission) remains consistently high.

Men and women from black and minority ethnic (BME) populations, in particular the black African population, and men who have sex with men (MSM) continue to be disproportionately affected by HIV in the UK.

MSM

Despite good testing coverage amongst MSM through sexual health clinics, the number of MSM who are undiagnosed has been consistent over the years as HIV incidence remains consistently high in this group. In England, it is estimated that, on average, 2,800 men who have sex with men acquired HIV each year for the past five years.³ Therefore, increasing opportunities for MSM to test for HIV should be a public health priority.

Heterosexual men and women

HIV testing coverage in sexual health clinics is not as high amongst heterosexual men and women as MSM. In 2015 only 14% of STI clinics in England achieved 80% HIV test coverage for heterosexual men and women.⁴ This is concerning given a higher proportion of heterosexual men and women living with HIV are unaware of their status. Other HIV testing opportunities, such as community testing, testing in primary care or at home, are important as they offer great potential for reaching those at higher risk within this population, especially those who would not consider accessing sexual health services.

IN 2015:


 **101,200** people were living with HIV.


31,600 women were living with HIV.


69,500 men were living with HIV.

 **47,000** men acquired the virus through sex with men.


ONE IN 17 men who have sex with men is living with HIV in the UK.

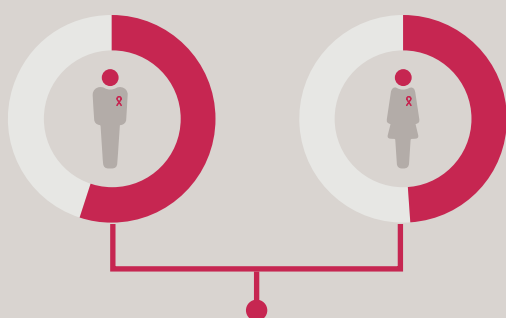
 In London, this figure is **one in seven.**



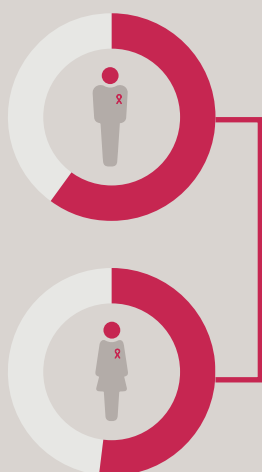
ONE IN 45
black African
men is living
with HIV.



ONE IN 23
black African
women is living
with HIV.



55% of HETEROSEXUAL MEN
and **49% of WOMEN** were
diagnosed late in 2015...



In the
**BLACK
AFRICAN**
population,
this was **60%**
and **52%**
respectively.

Late diagnosis

39% of those diagnosed with HIV in 2015 were diagnosed late. This was even higher among heterosexuals, particularly those from the black African population. There are numerous reasons why it is important to reduce rates of late diagnosis. The most pertinent are the implications for the health of the individual. Late diagnosis increases the risk of mortality and the risk of developing AIDS-defining illnesses. Late diagnosis also indicates that a person has been living with HIV for at least three years, increasing the likelihood that the virus has been passed on to others.

HIV acquired in the UK

In 2015 more than half of people diagnosed with HIV in the UK were also born in the UK. In previous years, the proportions of those born in the UK and thought to have acquired the infection in the UK were lower. The shift upwards is due to changing migration patterns. It is now thought that many UK-acquired diagnoses were previously wrongly assumed to have been acquired abroad. Although HIV diagnoses are declining among heterosexual men and women in the UK, the decline is less steep for HIV acquired in the UK.

The continued high levels of HIV acquisition in the UK and high number of undiagnosed individuals demonstrate the need for preventive action on HIV.

The financial impact

As well as the health implications, HIV has a financial impact. In 2013/14 the UK spent £570 million on HIV treatment.⁵ The average lifetime treatment cost for HIV is approximately £360,000.⁶ But NAT's previous report showed that in high prevalence areas of England only £1 was spent on HIV prevention for every £55 spent on HIV treatment. Additionally, only 40% of local authorities with a high prevalence of HIV were commissioning HIV testing outside of that provided in sexual health clinics.

This report looks further at what has happened in these authorities since then and at what has happened in other parts of the UK over the two financial years 2015/16 and 2016/17.

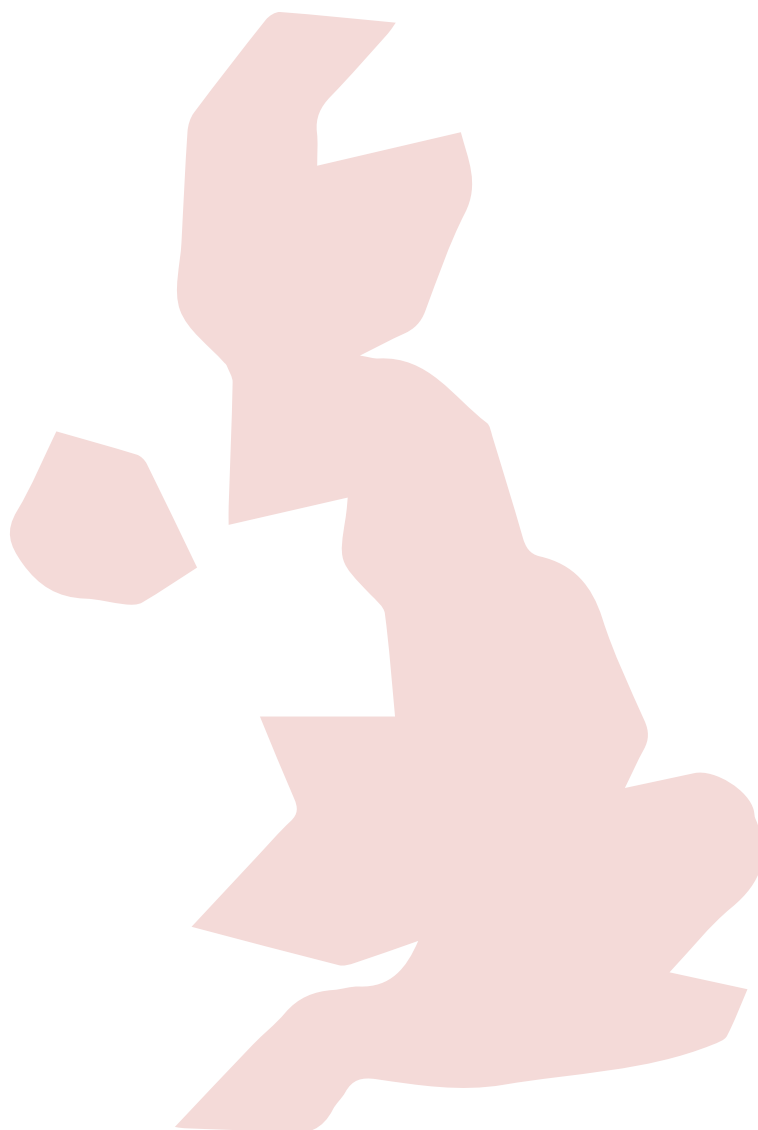
SECTION A: INTRODUCTION

A.1 HIV IN THE UK



CLASSIFICATION OF HIV PREVALENCE

Local authorities are considered to have a high prevalence of HIV if they have a diagnosed prevalence of two or more and less than five per 1,000 people. In 2016 PHE and NICE introduced an additional classification of extremely high prevalence which refers to a diagnosed prevalence of five or more per 1,000 people. However, reference to areas of high prevalence in this report are for a combination of these two categories. Those with a prevalence of less than two per 1,000 are considered low prevalence in this report.





A.2 WHAT IS HIV PREVENTION?

HIV prevention includes a range of activities that contribute towards the prevention of HIV transmission. The difficulties associated with clearly defining HIV prevention have been a common feature documented in attempts to monitor investment in the area.⁷ Ultimately, effective HIV prevention strategies will combine approaches addressing structural, biomedical and behavioural factors.⁸ The preventive impact of services may be direct or indirect. It is therefore impossible to accurately document all resources allocated to services which may have a preventive impact on HIV.

This report will concentrate on primary HIV prevention, intended to have a direct impact, which NAT defines as:

“Services which have as an exclusive aim or as one of their primary aims the prevention of HIV transmission and as their intended recipients people identified as at significant risk of acquiring HIV. This includes the promotion and practice of HIV testing.”

The definition is similar to that used in the 2015 report and therefore comparisons can be drawn between both sets of data. NAT has excluded many services which are also recognised as having an important part to play in an effective combined approach to HIV prevention. For example, sexual health clinics, effective HIV treatment, sex and relationships education in schools, and support for people living with HIV, all have a role. However, the multiple objectives and outcomes of such services make it very difficult to separate out the HIV prevention element. These services complement but do not replace targeted primary HIV prevention.

SECTION A: INTRODUCTION

A.3 THE FREEDOM OF INFORMATION REQUESTS



A.3 THE FREEDOM OF INFORMATION REQUESTS

58 upper tier or unitary local authorities in England contributed data to the 2015 report. These represented areas with a high prevalence of HIV in England. But this time NAT broadened the survey to the whole of the UK and went to all areas rather than focussing only on those with a high prevalence of HIV.

In 2014 NAT wrote directly to Directors of Public Health for the information. However, a significant proportion of them passed the letter directly on to teams responsible for Freedom of Information (FOI) requests. This allowed many local authorities to accurately record such requests and process them in a timely manner. In 2016, while there was a concern that using FOI requests could cut off potentially useful dialogue with commissioners, it was felt that given the volume of FOI submissions required for the most recent survey (230), the benefits of using the FOI system outweighed this concern. NAT therefore acquired the data for

this review using information requests under the Freedom of Information Act 2000.

It was important to capture all spending on primary HIV prevention. England’s local authorities have a clear responsibility for public health, however, in Scotland, Wales and Northern Ireland this is not the case. In Northern Ireland NAT approached Health and Social Care Boards and not local authorities. It also was discovered much later in the process that there was a precedent for national funding in Northern Ireland which needed to be accounted for. In Scotland and Wales both local authorities and NHS bodies were approached.

Table 1 shows which local bodies were sent FOI requests in each of the 4 nations.

NAT would like to thank all commissioning bodies who responded to the FOI request for their time.

Nation	Local government	NHS
England	151 upper tier and unitary authorities	
Scotland	32 local authorities	14 NHS Boards
Wales	21 local authorities	7 Health Boards
Northern Ireland		5 Health and Social Care Trusts

TABLE 1. THE NUMBER OF FOI REQUESTS SENT TO LOCAL GOVERNMENT OR NHS BODIES IN EACH NATION OF THE UK

SECTION A: INTRODUCTION

A.3 THE FREEDOM OF INFORMATION REQUESTS



NAT asked these bodies to report on spending, for the years 2015/16 and 2016/17, on the following services:

Primary HIV prevention: Services which have as an exclusive aim or as one of their primary aims the prevention of HIV transmission and as their intended recipients people identified as at significant risk of acquiring HIV.

Testing: We include in this definition HIV testing services directly commissioned by local authorities but excluding those provided by GU/sexual health clinics.

Commissioning bodies were asked whether they have any contracts specifically for these services and if they have any other contracts with key performance indicators relevant to HIV prevention or the sexual health of key populations. A table was provided to allow commissioners to categorise the spending on these contracts by the intervention type and who the services targeted. The FOI request can be seen in full in the Appendix.

The FOI received a 99% response rate.





A.4 ANALYSING THE DATA

The information request separated out two main types of intervention. These were health promotion activity with the primary aim of preventing HIV and HIV testing services. This categorisation was used in NAT's 2015 report.⁹

A.4.1 HEALTH PROMOTION

NAT ask how much was spent on health promotion with a primary aim of HIV prevention for:

- Men who have sex with men (MSM)
- Black and Minority Ethnic groups (BME)
- Other

As well as an expenditure figure for the financial years 2015/16 and 2016/17, respondents were asked to give a brief description of the service and/or relevant key performance indicators (KPIs). The qualitative data collected demonstrated shifting approaches in commissioning practice even between these years and 2014/15.

These emerging trends and common issues with the reported data were considered in the analysis:

i) Target groups could not be specified

There were a large proportion of contracts for services carrying out targeted work with both MSM and BME groups as key populations affected by HIV, but where it was not possible to allocate expenditure specifically to one or the other. There was also some prevention activity reported for other groups, such as limited work with people who inject drugs and sex workers. Therefore, for the purposes of data analysis a combined category of 'not specified' was created to account for prevention activity where an amount could not be allocated to MSM or BME groups. This approach allowed basic comparison with data used for the 2015 report.

“Outreach Programme that provides health education and HIV prevention messages, targeting specifically high risk individuals that include MSM and BME groups in local areas of high HIV prevalence. Facilitates the sign up to specific free condom schemes for MSM & BME as appropriate.”

A London borough programme commissioned at £25,000 in 2015/16

ii) Support services for people living with HIV were delivered through the same contract

Often HIV prevention services were commissioned as part of a wider contract or grant with an HIV service provider that also provided HIV support services through the same funding arrangement. In these cases, commissioners consistently claimed that it was not possible to separate out expenditure specifically for HIV prevention. NAT recorded when expenditure was likely to have not been used solely for HIV prevention and so the report gives two figures, one for combined services and one for primary HIV prevention only. This is discussed further later in section B.1.1.

“HIV Prevention and Support annual contract value 2016/17 £156,810 (one contract to provide HIV prevention and support)”

Local authority in north east England

iii) HIV prevention was part of an integrated sexual health service (ISHS)

Several local authorities in England reported no contracts for health promotion for HIV prevention but stated that this activity would be included within their wider contract for an integrated sexual health service (ISHS). Commissioners were usually not able to specify what was spent on health promotion within these contracts,



often paid on an outcomes basis. There is likely a wide variation in activity among providers of ISHS contracts, with some sub-contracting prevention activity, some leading on activity themselves and others concentrating predominantly on clinical services. This is discussed further in section B.1.2.

“...commissioned an Integrated Sexual Health Service (ISHS) through a Prime Provider model, therefore the content of the contract and the budget has been incorporated into the ISHS service specification. The ISHS are subcontracting the third sector provider...”

Local authority in north west England

A.4.2 HIV TESTING

This report does not look at HIV testing provided as part of sexual health screening within sexual health clinics. It also does not look at HIV testing provided in primary and secondary care when clinically indicated. The data collected by FOI request was linked to HIV testing commissioned by local authorities for public health purposes in these settings:

- Primary care
- Secondary care
- Community
- At home (through home-sampling).

Much of the data reported for home-sampling was expenditure on PHE’s national home-sampling service, delivered in partnership with local authorities who have opted-in.

The most significant issue with the data on testing was that compared with the previous years, there was less direct expenditure on testing reported. This does not mean it was not commissioned but rather that it was part of wider contracts for HIV and sexual health prevention. When it was clear that there was investment in HIV testing in a specific setting but no expenditure amount was given, this was recorded.

A.4.3 POPULATION DATA

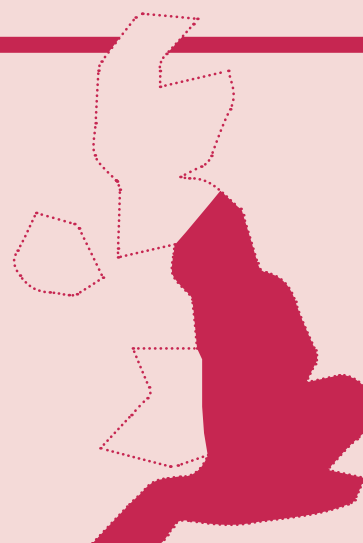
To make fair comparisons and give a contextual view of expenditure in an area, it was important to be able to calculate spending on a per capita basis. This was done for the report in 2015 and it enabled NAT to demonstrate that there was not a relationship between the HIV prevalence of an area and how much they were spending on HIV prevention, taking into account the local population size. In 2015 the population aged 15-74 was used based on ONS population estimates for the two relevant years.¹⁰

For this report the available data was slightly different. The most recent and accurate population data by local authority is for 2015. For the current report this data has been used to calculate per capita spend for both financial years. HIV prevalence figures reported by PHE are given based on the population range 15-59 which corresponds with easily available population estimates for local authorities in England.¹¹ Therefore, all per capita calculations in this report are based on the population estimate for people aged 15-59 and direct comparisons are not made with per capita figures reported in 2015.

In Scotland, Wales and Northern Ireland the data available was different to that for England. In Scotland, there were overall population figures for each health board area, as well as an overall number of people living with HIV, but a breakdown of prevalence was not available.¹² In Wales and Northern Ireland there is an overall population figure for the country and the number of people living with HIV and in care. However, there is no prevalence breakdown.



B: ENGLAND



Of the four nations England has the highest prevalence of HIV. All areas in the UK with a high prevalence of HIV are in England. This includes the whole of London, where all 32 boroughs have a high prevalence of HIV. Of the 88,769 people who accessed care for HIV in the UK in 2015, 91% lived in England and 41% lived in London.¹³

Local authorities in England have had responsibility for public health since April 2013. A Director of Public Health has overall responsibility for managing this function in upper tier and unitary local authorities. As part of their public health responsibilities local authorities are required to provide open access sexual health services, including STI treatment services. This does not include HIV treatment which is provided through NHS England.

Outside of these requirements local authorities have a degree of freedom as to how they achieve their public health goals. Services such as primary HIV prevention are not legally required, but should be commissioned by local authorities based on their assessment of local need. Local authorities are held to account on their public health activity through the Public Health Outcomes Framework (PHOF). The PHOF has indicators against which local authorities are monitored. The most relevant indicator to this

report is that on late diagnosis of HIV, although there are others on sexual health.

National HIV prevention investment

National investment in HIV prevention is underpinned by the Department of Health 2013 *Framework for sexual health improvement in England* as well as the PHOF. Within the parameters of these frameworks PHE published a strategic action plan for 2016 – 2019 Health promotion for sexual and reproductive health and HIV. This action plan has informed the ongoing development of a national programme of HIV prevention activity, funded by central government and commissioned by PHE. The main programme, HIV Prevention England (HPE) is currently worth £1.2 million a year and is coordinated by Terrence Higgins Trust (THT). As well as HPE, PHE also has a £600,000 Innovation Fund and has invested £200,000 in setting up the National HIV Self-Sampling Service (See Table 2 in B.1 for a full breakdown). These national services are critical to complement and support infrastructure for local prevention activity.

London-wide HIV prevention investment

In London local authorities also contribute to a London HIV Prevention Programme. The programme is intended as a London-wide approach to HIV which complements, rather than replaces, the needs based activity of individual local authorities in this area. The programme was worth £1.2 million per year for the two financial years this report looks at.

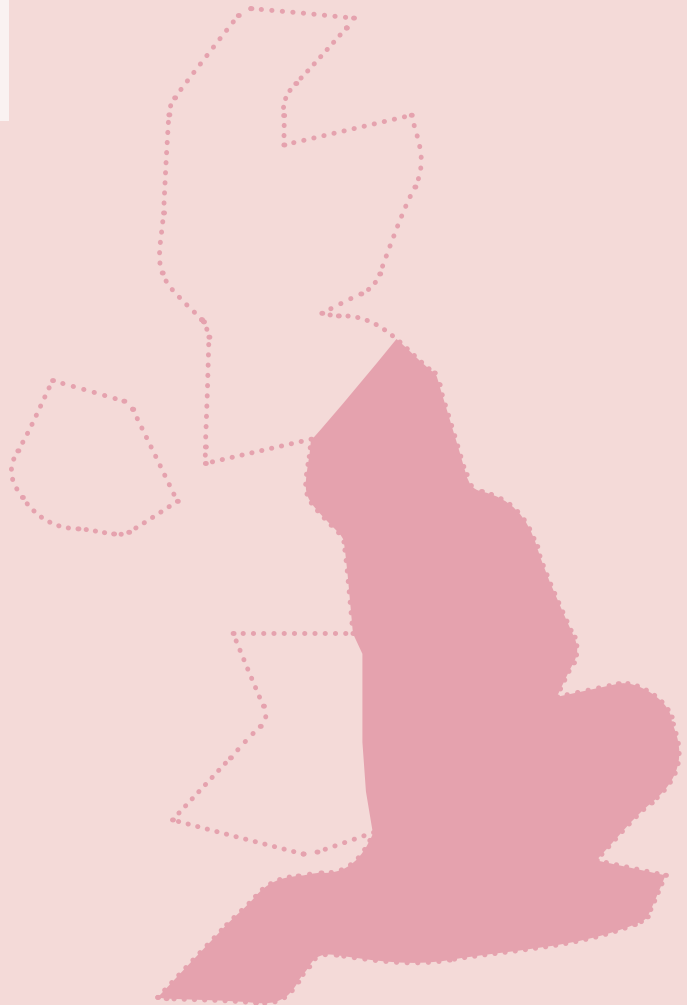


From April 2017 the budget for the London HIV Prevention Programme will reduce to £1.05 million per year, due to a reduction in the funding provided by contributing local authorities and the loss of funding to the programme of two London local authorities that have chosen to no longer contribute.

RECOMMENDATIONS

The Government should continue to fund the National HIV Prevention Programme at least at the current level.

All local authorities in London should continue to value the London HIV prevention programme as a critical London-wide approach to HIV prevention which complements local activity.



SECTION B: ENGLAND
B.1 OVERVIEW OF ENGLAND



B.1 OVERVIEW OF ENGLAND



		2015/16	2016/17
Local authority spending		£14,165,825	£12,355,738
National HIV Prevention Programme	HIV Prevention England (HPE)	£1,200,000	£1,200,000
	Innovation fund	£500,000	£600,000
	Home sampling service	£300,000	£200,000
	Monitoring and evaluation	£250,000	£250,000
	Late diagnosis project	£150,000	-
London HIV Prevention Programme		£1,200,000	£1,200,000
Total		£17,765,825	£15,805,738

TABLE 2.
TABLE SHOWING MAIN CONTRIBUTIONS TO NATIONAL EXPENDITURE ON PRIMARY HIV PREVENTION AND TESTING IN ENGLAND FOR 2015/16 AND 2016/17

NAT received information relating to all 151 upper-tier or unitary local authorities in England. 58 of these have a high prevalence of HIV (32 in London

and 26 in the rest of England). Table 2 shows reported expenditure by local authorities in England in more detail.

SECTION B: ENGLAND
B.1 OVERVIEW OF ENGLAND



2015/16	Proportion commissioning health promotion	Reported expenditure	Proportion commissioning HIV testing services	Reported expenditure	Total	Average per capita spend (pop. 15-59)
London	91%	£2,581,047	88%	£1,005,943	£3,586,990	£0.67
Rest of England	66%	£9,773,391	72%	£805,444	£10,578,835	£0.46
England Total	71%	£12,354,438	75%	£1,811,387	£14,165,825	£0.51
Amount of which was also to deliver support services*		£3,612,855	Amount which is exclusively for prevention and testing		£10,552,970	£0.47

2016/17	Proportion commissioning health promotion	Reported expenditure	Proportion commissioning HIV testing services	Reported expenditure	Total	Average per capita spend (pop. 15-59)
London	84%	£1,829,961	84%	£1,022,375	£2,852,336	£0.52
Rest of England	55%	£8,663,482	70%	£839,920	£9,503,402	£0.43
England total	62%	£10,493,443	73%	£1,862,295	£12,355,738	£0.44
Amount of which was also to deliver support services*		£3,449,441	Amount which is exclusively for prevention and testing		£8,906,297	£0.38

TABLE 3.
REPORTED EXPENDITURE ON HEALTH PROMOTION FOR PRIMARY HIV PREVENTION AND HIV TESTING SERVICES BY LOCAL AUTHORITIES IN ENGLAND IN 2015/16 AND 2016/17. THIS EXCLUDES THE LONDON HIV PREVENTION PROGRAMME.

**This is usually funding for specialist organisations to deliver both HIV prevention and support services for people living with HIV. In these cases, it has not been possible to allocate a specific amount of money to the prevention element. See A.4.1 i) and C.1.1 for more information.*

SECTION B: ENGLAND
B.1 OVERVIEW OF ENGLAND



Table 3 shows that in 2015/16 71% of local authorities in England reported some form of investment in health promotion for primary HIV prevention. However, this was considerably lower in 2016/17 at 62%.

A slightly greater number of local authorities commissioned HIV testing services for public health reasons. The proportion of local authorities commissioning these services decreased from 75% to 73% between 2015/16 and 2016/17.

In 2016/17
a quarter
of local authorities
in England
did not commission
any primary HIV
prevention
or testing.

Reported expenditure
on HIV prevention
and testing by
local authorities
in England
reduced
by 11% between
2015/16
and 2016/17.

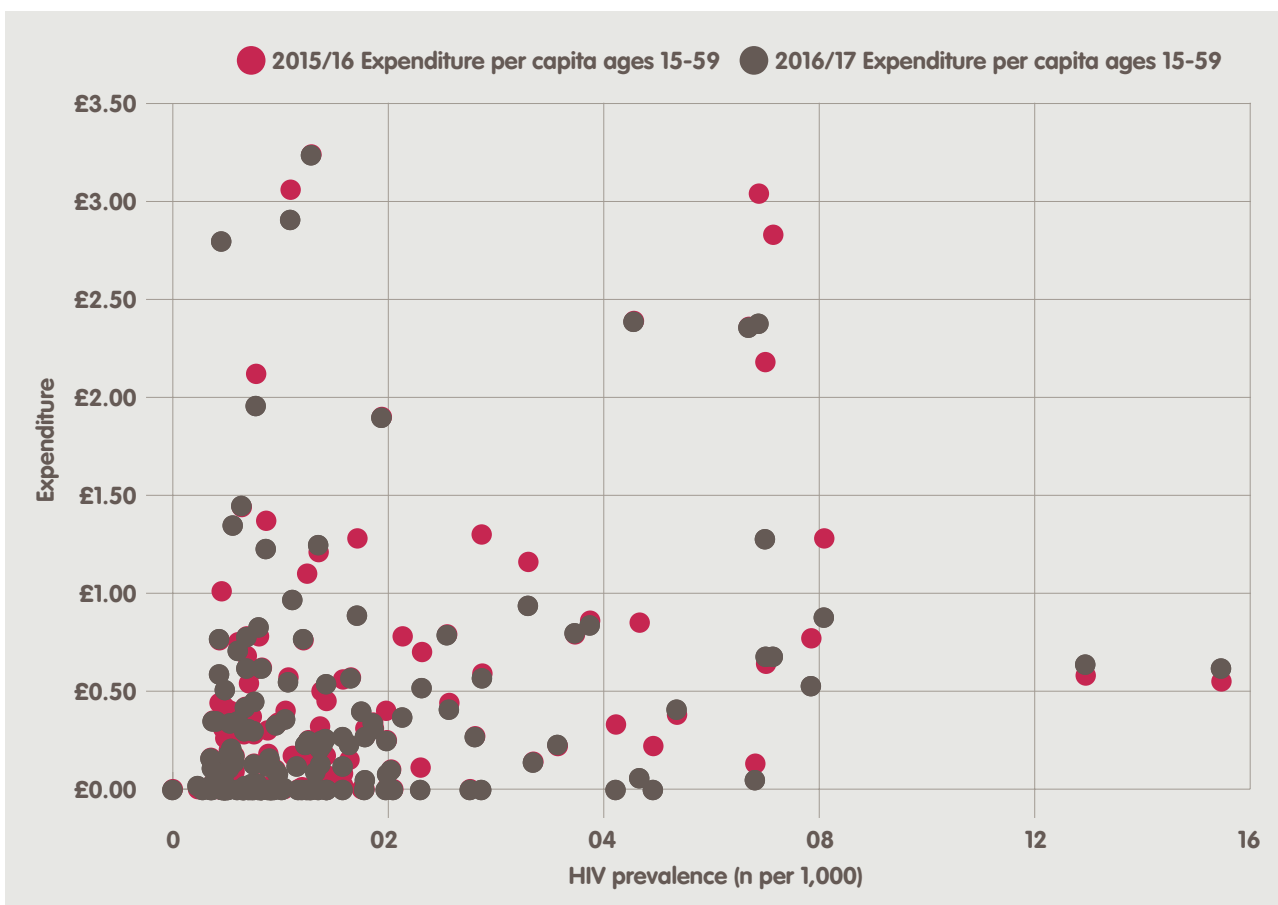


CHART 1. PER CAPITA SPEND ON PRIMARY HIV PREVENTION AND TESTING FOR THE POPULATION AGED 15-59 IN ENGLAND'S LOCAL AUTHORITIES, COMPARED WITH LOCAL AUTHORITY HIV PREVALENCE (N PER 1,000). One outlier, with a per capita spend of £10 and a prevalence of 3.81 per 1,000, has been removed from this chart to enhance readability.



Chart 1 shows overall reported expenditure per capita for each local authority compared with HIV prevalence. It would be expected that spending would increase as local authorities rise in prevalence. However, as can be seen, this is not always the case. Most local authorities spent below £0.50 per capita or nothing, even some with HIV prevalence rates of between 2 and 9 per 1,000. However, there are also some with relatively low prevalence which are reporting comparatively high spend per capita.

B.1.1 CONTRACTS THAT ALSO COVERED SUPPORT FOR PEOPLE LIVING WITH HIV

In both years, around one in five (21%) local authorities reported contracts for both HIV prevention and HIV support services. This represents 25.5% of funding in 2015/16 and 28% in 2016/17. When these local authorities are removed, the average per capita expenditure for those remaining was £0.38 in 2016/17.

“...commissioned a dedicated HIV prevention, testing and support service which includes HIV prevention...including specific populations such as MSM, and BME. It is not possible to provide a specific cost for each of these populations.”

Local authority in the east of England

This issue also emerged in the previous report where it was found that commissioners were often unable to disaggregate spending on HIV prevention from broader services. While this funding is not solely for HIV prevention, it has been included in the overall figures because HIV prevention outcomes are clearly a priority. These support services will have secondary prevention benefits as they support adherence to medication and the health and well-being of people living with HIV which in turn reduces transmission risks.

There is currently a documented trend for de-commissioning of support services altogether as they are often not seen as a priority for ever pressured social care budgets (particularly since the AIDS

Support Grant ended in 2010). Funding for support services through the public health budget is welcome; many public health commissioners see the real value in HIV support services for HIV prevention. It is also useful for many organisations to have the freedom to allocate funding across the range of services they provide. However, if part of a wider contract or grant, local authorities should be aware what proportion of the budget is allocated to which services.

Some organisations are expected to deliver on a broad range of outcomes in support and prevention, with limited and shrinking resource. Contracts should reasonably meet the costs associated with delivering the projected outcomes. Many organisations will not be achieving full-cost recovery for the services they deliver and will need to subsidise the services through charitable funding.

RECOMMENDATIONS

Commissioners funding joint HIV support and prevention contracts should ensure transparency as to the disaggregation of funding between the services and that resources provided meet the costs associated with both services.

SECTION B: ENGLAND
B.1 OVERVIEW OF ENGLAND



EXAMPLES

1. Commissioning of an HIV support, prevention and testing service in a London borough

One London borough commissioned a holistic service from a provider that combined HIV testing with secondary prevention and HIV care outcomes. The contract included a range of services and key performance indicators. Many of the outcome indicators within the HIV support elements of the contract were linked to their secondary preventive benefit.

While it is not clear how much of the budget was invested in testing services, there were outcome targets, providing some accountability. There was also a clear pathway for those tested within this service to access support on diagnosis. However, it is not clear from the explanation provided how a service like this meets the needs of those who test negative but are potentially at risk (primary HIV prevention), although there were some awareness-raising activities targeting young MSM.

Services supporting people living with HIV included:

- Support for newly diagnosed patients
- A self-management programme
- Treatment adherence support
- A peer support programme
- Mental health support and counselling
- Advice on housing and other issues
- A volunteer programme.

HIV prevention and testing services included:

- Testing 100 people from the black African or MSM communities
- Support for early testing among young MSM through awareness sessions in schools, colleges and universities.

The service had a range of targets, including to meet 50% of those newly diagnosed with HIV in local sexual health services each year. Outcomes were also measured using a Medication Adherence Scale, a depression scale and further participant questionnaires.

In 2015/16:

41 local authorities did not report expenditure on primary HIV prevention services, but

16 of those said that this was now delivered through their ISHS.

In 2016/17:

53 local authorities did not report expenditure on primary HIV prevention services, but

23 of those said that this was now delivered through their ISHS.

B.1.2 HIV PREVENTION WITHIN A WIDER INTEGRATED SEXUAL HEALTH SERVICE (ISHS)

An emerging trend was for HIV prevention services to be commissioned and delivered as part of a contract for an integrated sexual health service (ISHS). It varied as to how much information local authorities had on these services. For example, on one occasion a Local Authority reported expenditure on “health promotion marketing” through the service. However, most commonly, authorities simply gave a nod to the existence of prevention outcomes within the ISHS contract and had no information on, or did not report on, allocated expenditure to HIV prevention or HIV testing or the scale of these services.



“As HIV prevention forms part of a block Integrated Sexual Health contract the authority does not hold detailed financial information relating to HIV prevention for specific groups as indicated by the table provided. However I can advise that the costs of health promotion and marketing element of the contract were £155,472 in contract year 1 (Oct 15-Sept16) and £148,448 in contract year 2 (Oct 16-Sept 17).”

Local authority in north west England

“We can advise since February 2015 the Council has commissioned an Integrated Sexual Health Service which is providing the full range of sexual health services including Level 2 and 3 services across the borough. Included within that contract is the provision of HIV prevention and education.”

Local authority in north west England

It is likely that the level of prevention activity and the stringency of the outcomes included in the contract varies across local authorities commissioning an integrated service. How the contract holders meet these outcomes will also vary significantly. This will often involve sub-contracting to other organisations to deliver certain aspects of the contract, however, information on sub-contracting may not be held by the local authority in any detail.

Use of this model for funding sexual health services is growing. Again, it does raise questions concerning whether local authorities have clarity on how they are meeting local public health needs, as well as around transparency and the accountability of local authorities for the services they fund. Local authorities report their public health spending to PHE annually and some may find it difficult to determine their expenditure on mandated open access sexual health services as opposed to prevention activity. The information reported to PHE will therefore become increasingly opaque.

RECOMMENDATIONS

Local authorities commissioning an integrated sexual health service (ISHS) should know how this service meets their local HIV prevention needs and the expenditure allocated to these needs. Local authorities should ensure that providers have, or are accessing, expertise in HIV prevention for their key populations.

PHE should consider how services delivered through an integrated sexual health service (ISHS) should be reported by local authorities through the annual returns process to ensure that transparency and accountability are not diminished.

SECTION B: ENGLAND

B.2 ENGLAND'S HIGH PREVALENCE LOCAL AUTHORITIES



B.2 ENGLAND'S HIGH PREVALENCE LOCAL AUTHORITIES

In 2015 NAT looked only at high prevalence areas of England. In this section and section B.3 on London (where all local authorities have a high prevalence of HIV) there is comparison with previously collected data for 2013/14 and 2014/15.

In both 2015/16 and 2016/17 just above half of reported local authority expenditure on HIV prevention was in high prevalence areas. For HIV testing this proportion was much higher at 86% and then 71%. This is largely due to high levels of spend on testing in London.

Reported expenditure in high prevalence areas is considerably lower than that reported in 2013/14 and 2014/15. Chart 2 and Table 3 show high prevalence local authority spending on primary HIV prevention and testing, excluding contributions to the London HIV prevention programme, for the four years we have data.

Despite an increase between 2013/14 and 2014/15, spending has now dropped to below that which was spent four years ago. When we consider inflationary effects, this reduction is even greater.

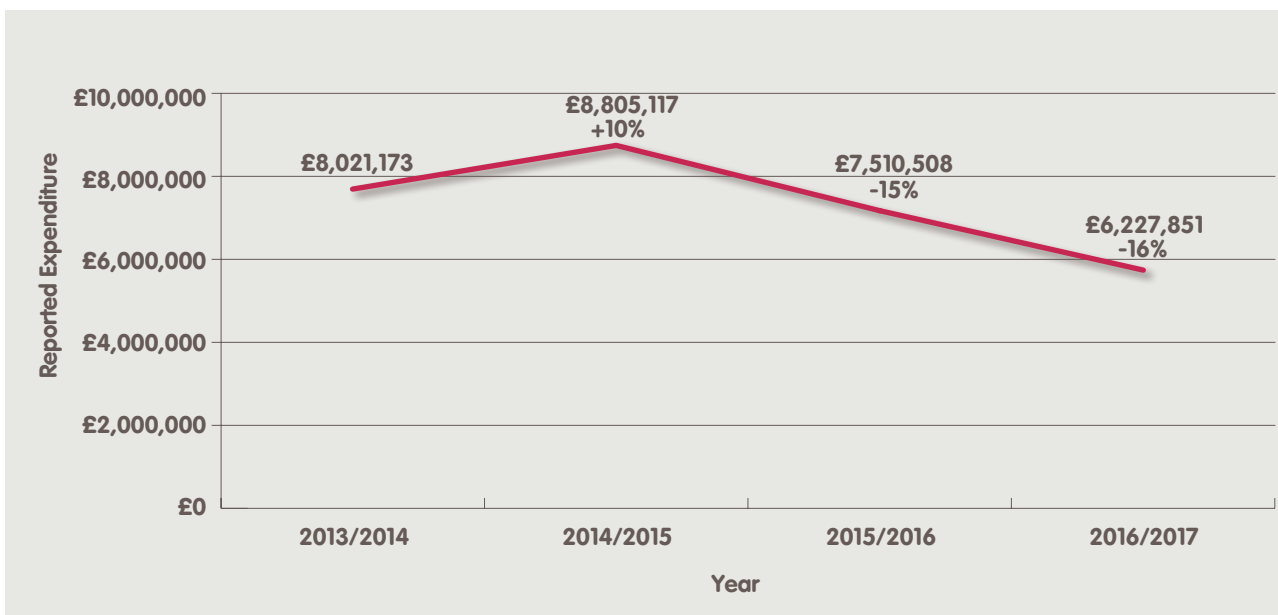


CHART 2. LOCAL AUTHORITY REPORTED EXPENDITURE ON PRIMARY HIV PREVENTION AND TESTING IN HIGH PREVALENCE LOCAL AUTHORITIES IN ENGLAND (EXCLUDING THE LONDON HIV PREVENTION PROGRAMME) FOR FOUR YEARS FROM 2013/14 TO 2016/17

SECTION B: ENGLAND

B.2 ENGLAND'S HIGH PREVALENCE LOCAL AUTHORITIES



2015/16	Proportion commissioning health promotion	Reported expenditure	Proportion commissioning testing services	Reported expenditure	Total	Average per capita spend (pop. 15-59)
London	91%	£2,581,047	86%	£1,005,943	£3,586,990	£0.67
Rest of England	77%	£3,363,512	85%	£560,006	£3,923,518	£0.97
High prevalence areas (total 58)	84.5%	£5,944,559	86%	£1,565,949	£7,510,508	£0.80
Amount of which was also to deliver support services		£877,745	Amount which is exclusively for prevention and testing		£6,632,763	£0.79

2016/17	Proportion commissioning health promotion	Reported expenditure	Proportion commissioning testing services	Reported expenditure	Total	Average per capita spend (pop. 15-59)
London	84%	£1,829,961	84%	£1,022,375	£2,852,336	£0.52
Rest of England	65%	£ 3,116,671	81%	£308,844	£ 3,425,515	£0.83
High prevalence areas (total 58)	76%	£4,946,632	81%	£1,331,219	£6,277,851	£0.66
Amount of which was also to deliver support services		£911,311	Amount which is exclusively for prevention and testing		£ 5,366,540	£0.63

TABLE 4.
REPORTED EXPENDITURE ON HEALTH PROMOTION FOR PRIMARY HIV PREVENTION AND HIV TESTING SERVICES BY LOCAL AUTHORITIES IN ENGLAND WITH A HIGH PREVALENCE OF HIV (≥2 IN 1,000) IN 2015/16 AND 2016/17.

SECTION B: ENGLAND**B.2 ENGLAND'S HIGH PREVALENCE LOCAL AUTHORITIES**

The proportion of expenditure on contracts that also included support services increased between the two years. The value of these contracts was £877,745 in 2015/16 and £911,311 in 2016/17 (table 4). This could be indicative of growing consolidation of contracts in response to financial pressures in these areas. With incidence rates remaining high, the significant drop in HIV prevention funding in high prevalence areas since 2013 is very concerning.

Four in five high prevalence local authorities commissioned some form of HIV testing outside of that provided in sexual health clinic services. This does indicate a positive trend since NAT's 2015 report, where two in five high prevalence local authorities reported funding these HIV testing services.

The trend was not as positive for health promotion. In 2016/17, a quarter did not commission any health promotion for HIV prevention, double that of 2014/15, showing that some have de-commissioned these services. The average per capita expenditure is higher in high prevalence authorities than low. However, it still significantly decreased from £0.80 to £0.66 between 2015/16 and 2016/17.

Based on the FOI data, there has been a 29% reduction in reported expenditure on primary HIV prevention since April 2015. The impact of this steep decline may be yet to be seen. The Government cuts to the ring-fenced public health budget have probably been the main reason for the

lower levels of investment. As well as a £200 million in-year cut in 2015/16, this budget is being lowered by 3.9% each year until 2020/21.

In 2019 the ring-fence will be removed from this budget. The Government proposals for local authorities to retain 100% of their business rates will mean that local authorities will fund public health through locally raised funds. This may have its own implications for the prioritisation of HIV prevention activity.

RECOMMENDATIONS

Local authorities with a high prevalence of HIV must address the HIV prevention needs of their local population through sexual health and HIV prevention services targeted at the highest risk populations; relevant services must not be disproportionately cut relative to reductions in the overall public health budget.

The Government must address the inadequacy of public health funding by increasing the public health budget and should take steps to ensure that plans to move to business rates retention in local authorities do not compromise public health and lead to increased health inequalities, including in HIV.



B.3 LONDON



The total figure for HIV prevention and testing spending in London above includes £1.2 million per year on the London HIV Prevention Programme. It does not include any London-based activity of the National HIV Prevention Programme.

Excluding the London HIV Prevention Programme, in London in 2015/16 local authorities reported expenditure of £3,586,990 in primary HIV prevention and testing. This decreased by 20% to £2,852,336 in 2016/17. The average per capita spending of each local authority decreased from £0.67 to £0.52 between the two years. Approximately nine in ten

London local authorities were commissioning HIV prevention services.

These figures are shown in Chart 3 along with data for the two years 2013/14 and 2014/15, taken from the previous report. This trend is similar to that seen across all high prevalence local authorities (Chart 2), with an initial increase being followed by substantial decrease in investment in the two following years. The percentage reduction in London is even higher, with an overall decrease of 35% in local authority funding since April 2015.

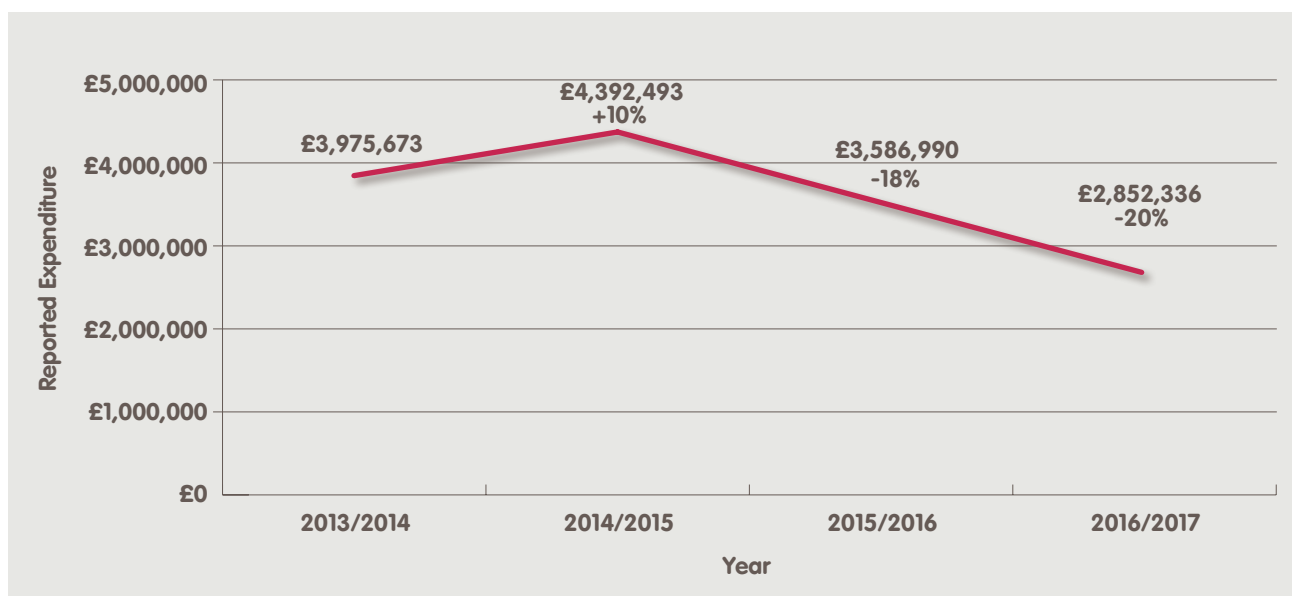


CHART 3. LOCAL AUTHORITY REPORTED EXPENDITURE ON PRIMARY HIV PREVENTION AND TESTING SERVICES IN LONDON ACROSS 4 YEARS, 2013/14, 2014/15, 2015/16 AND 2016/17, EXCLUDING THE LONDON HIV PREVENTION PROGRAMME.

SECTION B: ENGLAND

B.3 LONDON



Average per capita spend by London boroughs is also lower than in high prevalence areas outside London. In London in 2015/16 this was £0.67 compared with £0.97 elsewhere. In 2016/17 this dropped to £0.52 in London and £0.83 elsewhere (see Table 4).

B.3.1 HEALTH PROMOTION IN LONDON

Of the total expenditure reported for 2015/16 and 2016/17 above (excluding the London HIV Prevention Programme), £2,581,047 and £1,829,961 was reported as allocated to health promotion activity. It is highly likely that these funds also contributed towards HIV testing as local authorities commonly stated that testing was one aspect of a broader HIV prevention contract (see B.3.2 for more information).

Chart 4 shows that as well as a reduction in funding overall, there appears to have been a significant squeeze on population-targeted health promotion for HIV prevention. Funding for BME targeted interventions was fairly consistent for three years and then dropped by more than half in 2016/17. Similarly significant reductions in MSM specific health promotion were seen even earlier in 2015/16.

While the overall expenditure for primary HIV prevention where a target group is not specified has decreased, it is a larger proportion of health promotion funding in 2015/16 and 2016/17 than in the previous two years. This could again be indicative of consolidation of separate contracts, focussing on different groups, into single contracts.

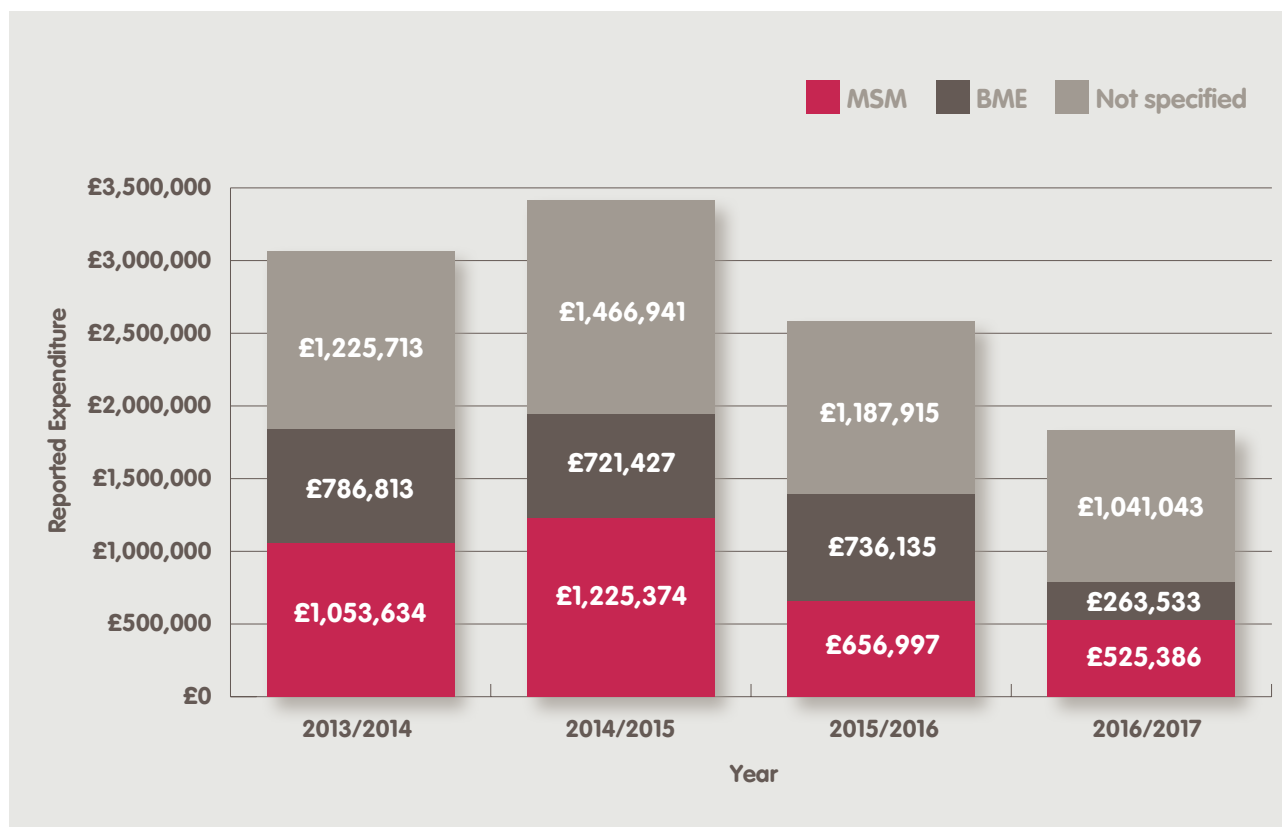


CHART 4. REPORTED EXPENDITURE ON HEALTH PROMOTION FOR PRIMARY HIV PREVENTION IN LONDON FOR THE 4 YEARS 2013/14, 2014/15, 2015/16 AND 2016/17 AND BY TARGET GROUP.



EXAMPLES

2. Different models for providing HIV prevention services to those at higher risk of HIV in London

A range of models have been reported for the delivery of health promotion activity for HIV prevention in London.

Some boroughs reported commissioning services to deliver HIV prevention outreach which was intended to be targeted at high risk groups, most commonly MSM and black African communities. Activity targeting these groups would often be included in the same contract. For example, one London borough commissioned one contract with a single provider and stipulated outreach work with black African communities and organisations, MSM communities and faith communities. Another smaller programme in London provided outreach targeting “high risk

individuals that include MSM and BME groups”. The programme also signposted these groups elsewhere, such as to free condom schemes, although it was not clear whether these schemes were provided by the same local authority.

Three local authorities in London are working together to commission a partnership of organisations, with one lead, to deliver a broad range of prevention services. Much of the activity targets black African and Caribbean communities but there is also specific sub-contracted work with vulnerable MSM engaging in chemsex. (Total contract value approx. £392,000.)

Another group of four local authorities have commissioned a joint service targeting at risk groups which includes outreach work, group sessions, one-to-one behaviour change interventions and a condom distribution scheme. (Total contract value approx. £74,500.)

B.3.2 HIV TESTING IN LONDON

NICE Public Health Guidelines recommend increased testing opportunities in areas with a high prevalence of HIV.¹⁴ Despite this there were three local authorities in London not commissioning any additional testing services in 2015/16 and this increased to five in 2016/17. This was, however, a significant improvement as 20 did not report spending in this area in 2014/15.

This is hopefully a positive trend and indicates that local authorities recognise the importance of investing in HIV testing. However, considering the significant increase in the number of local authorities commissioning these services, the actual increase in reported expenditure across the capital is modest. There are probably other contributing factors to the dramatic increase in the number of local authorities commissioning testing services.

NICE GUIDELINES ON HIV TESTING

The most recent NICE guidelines, *HIV testing: increasing uptake among people who may have undiagnosed HIV*, were published in 2016.

Recommendations include:

- Offering an HIV test on admission to hospital if in a high prevalence area
- Offering an HIV test on registration with a GP in a high prevalence area
- Offering an HIV test opportunistically at each consultation based on clinical judgement in areas of extremely high prevalence (>5 per 1,000)
- Increasing opportunities to test for HIV through options such as point of care testing (POCT) and self-sampling.

SECTION B: ENGLAND
B.3 LONDON



Firstly, in the previous report NAT stated that there were local authorities which “*did report major contracts which have been classified as ‘general prevention for HIV negative people’ and it is possible that these contracts involved some additional testing services*”. Therefore, there may have been a higher number commissioning HIV testing, especially in community settings, than the 11 and 12 reported for 2013/14 and 2014/15. Whilst a greater number of London local authorities reported commissioning

testing services in 2015/16 and 2016/17, there was still significant uncertainty about the amount being sent. Chart 5 shows the numbers of local authorities that reported commissioning testing services, split by whether they could give expenditure information, for the four HIV testing categories.

Secondly, a high number are participating in the PHE home sampling service which was launched in 2015.

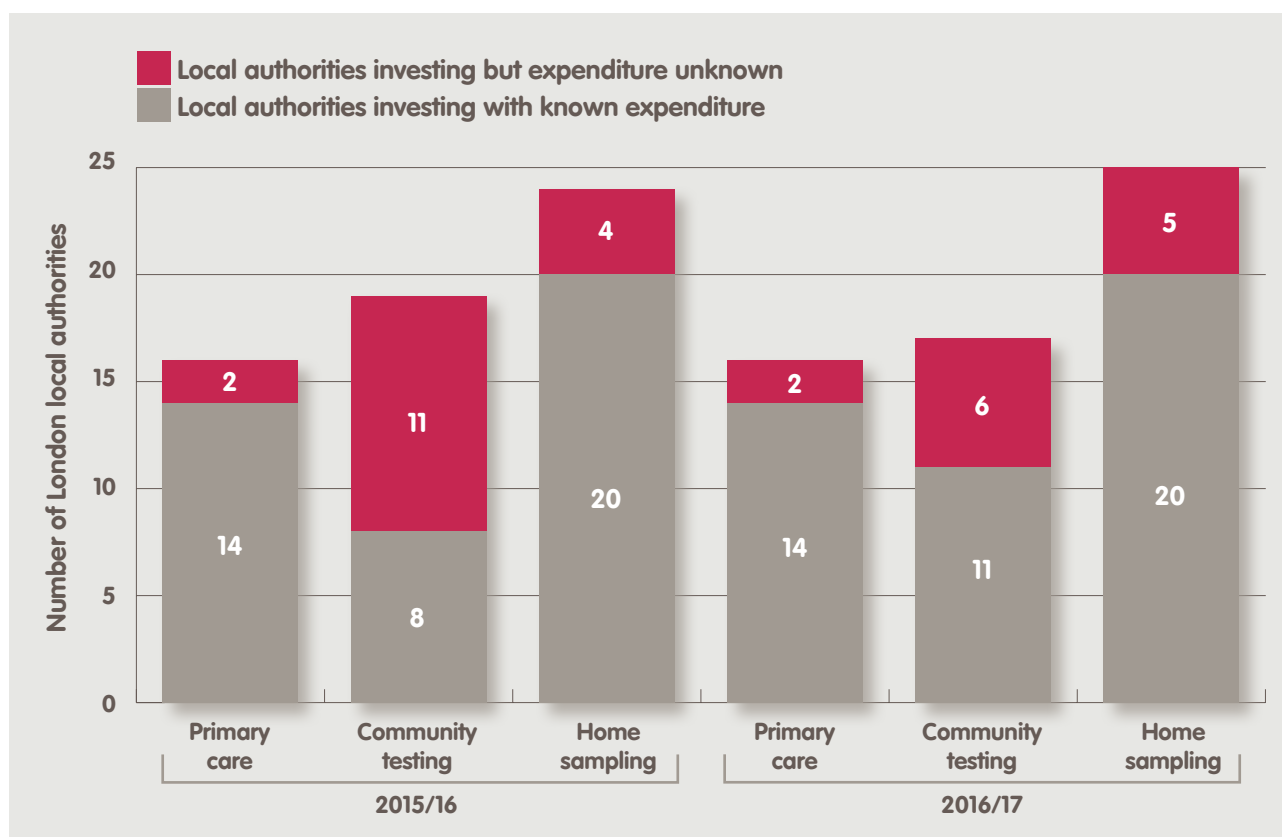


CHART 5. THE NUMBER OF LONDON LOCAL AUTHORITIES REPORTING INVESTMENT IN DIFFERENT FORMS OF HIV TESTING IN 2015/16 AND 2016/17

Local authorities provided a lot less information in this survey on who was being targeted by testing interventions compared with the survey of 2013/14 and 2014/15. This means that it is not possible to compare target groups with the results of the previous survey.

It was possible to look at the different forms of testing commissioned. Chart 6 shows reported expenditure on different forms of testing for the four years from 2013/14 to 2016/17. This is only an indicator of the actual investment however. For example, we know from chart 5 that we do not have expenditure details for 11 of those authorities investing in community HIV testing in 2015/16.

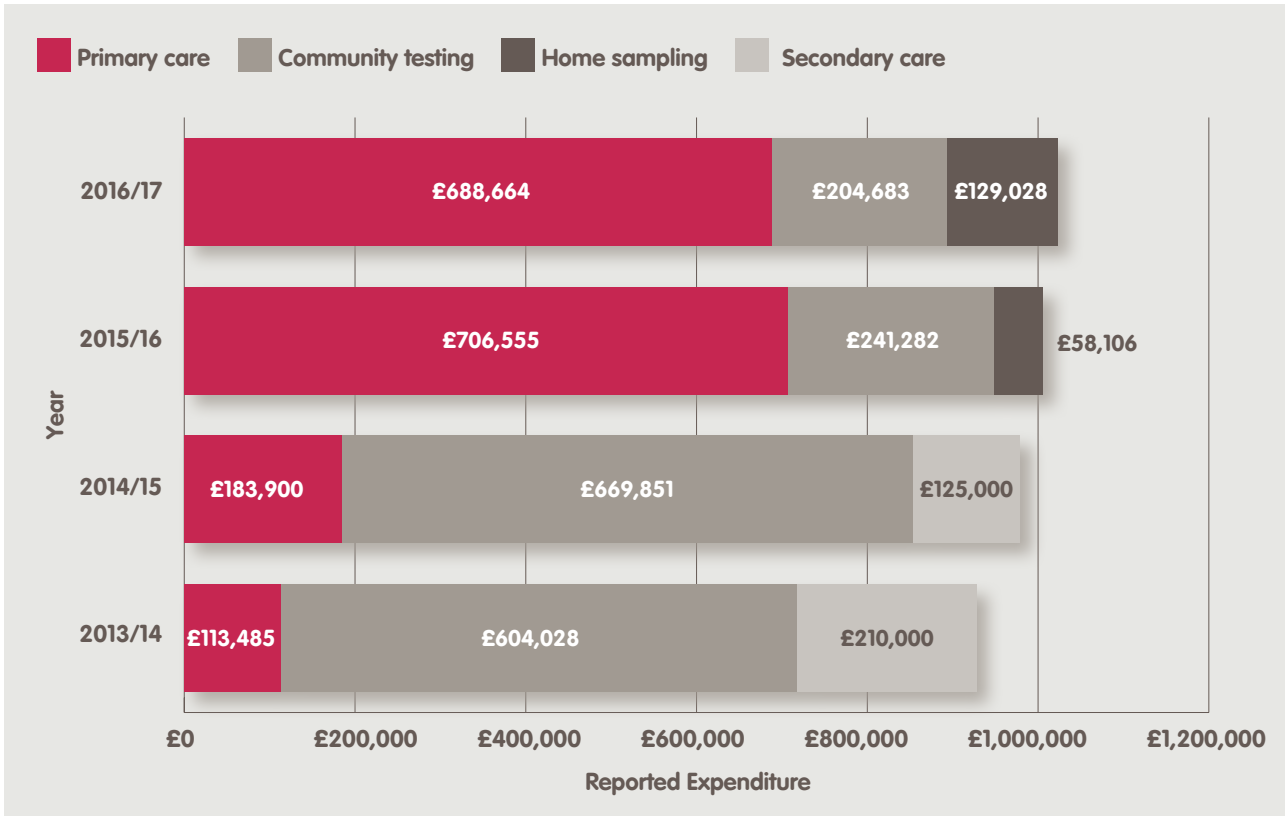


CHART 6. REPORTED EXPENDITURE ON HIV TESTING BY LONDON LOCAL AUTHORITIES IN THE FOUR FINANCIAL YEARS 2013/14 TO 2016/17, BROKEN DOWN BY TESTING SETTING.

Despite investment in the previous two years and recommendations by NICE, no local authorities reported providing HIV testing in secondary care in London in 2015/16 and 2016/17. Conversely, there is growing investment in home sampling, in line with the 2015 introduction of the national home sampling service.

There has been a significant and welcome increase in investment in primary care HIV testing by local authorities in London. 16 of the 32 London boroughs reported these services in both years, 14 of which could provide expenditure.

Investment in community testing, however, appears to have dropped dramatically, although much of the expenditure is unaccounted for. The actual number of London boroughs reporting investment in community testing went from 19 to 17. In 2016/17, despite a higher number reporting their actual expenditure (11), the reported investment is still lower than that for 2015/16.



EXAMPLES

3. Difficulties encouraging HIV testing in general practice in London

A significant proportion of London local authorities reported commissioning HIV testing through general practice. The reported expenditure would often depend on take up, by surgeries or by patients. For example, one London borough budgeted £24,000 for GPs to test all newly registered patients aged 18-59 years. However, they reported that the actual spend was far lower due to lack of uptake amongst GP surgeries. As a result, the local authority decided not to re-commission the service.

Some boroughs reported additional detail on how they were encouraging GPs to test for HIV. One had a service level agreement with GPs, contracting them (therefore, offering financial incentive) to increase their offer of a

full STI screen at registration and with BME and MSM patients. Another reported a programme of training with GPs to “*support them to have conversations with patients about HIV, increase confidence in offering testing and being prepared to give positive test results.*” However, again the take up of this training was low and the local authority is now exploring a more targeted approach whereby GP surgeries identified as being linked with late diagnosed patients are identified for intervention.

There is a great deal of work across the voluntary, professional and health sectors, looking at ways to enhance levels of testing in general practice. ViiV Healthcare’s campaign, ‘Is it HIV?’ is targeting GPs in areas of high prevalence of HIV in London and aims to improve GP awareness of HIV and confidence in suggesting a test.¹⁵ THT and the Royal College of General Practitioners (RCGP) also have a joint programme of work in this area.¹⁶



B.4 THE REST OF ENGLAND



Outside of London, local authority investment in primary HIV prevention and testing decreased by 10% in England. The average per capita spend dropped from £0.46 to £0.43.

Outside London around a fifth of the population aged 15-59 in England reside in local authorities with a high prevalence of HIV. Of the overall reported expenditure in England outside London, around two fifths was spent in these 26 high prevalence Local authorities.

Figure 1 shows how the proportion of spending in high prevalence local authorities in the rest of England compared with the proportion of the population represented by these areas. The per capita spend in these high prevalence local

authorities was on average £0.80 in 2015/16, compared with £0.32 in low prevalence areas.

This is to be expected as HIV should be identified as a local priority by areas with a high prevalence. However, three high prevalence local authorities outside London reported that they did not commission any primary HIV prevention or HIV testing in 2016/17, a further six were unable to report expenditure (see Chart 7). Overall expenditure in high prevalence areas was looked at in more detail in section B.2.

In 2016/17 although the proportion of the funding on high prevalence areas is still high, the per capita spending in these areas dropped to £0.66. In low prevalence areas, it was £0.29 in 2016/17.

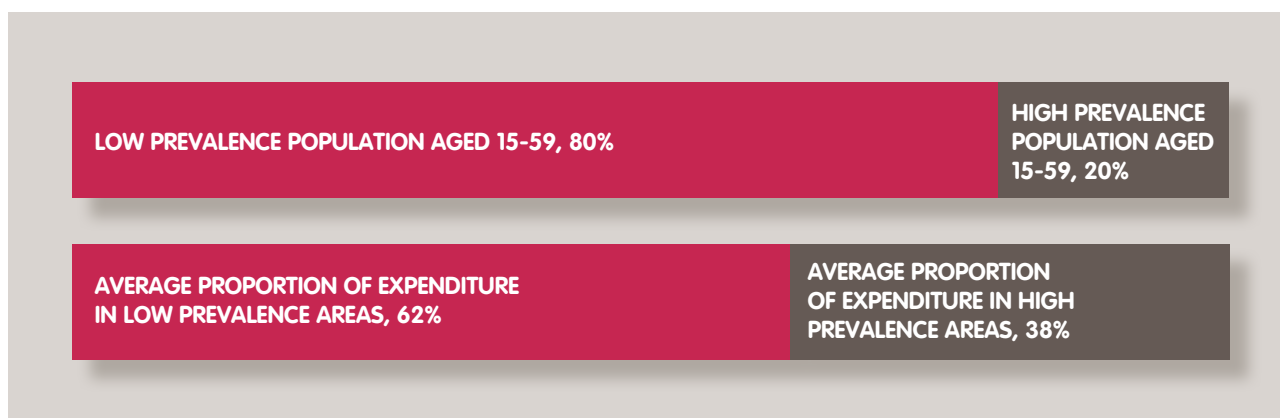


FIGURE 1. PROPORTION OF POPULATION IN HIGH AND LOW PREVALENCE AREAS AND AVERAGE PROPORTION OF EXPENDITURE (FOR 2015/16 AND 2016/17) IN HIGH AND LOW PREVALENCE AREAS OF ENGLAND, OUTSIDE LONDON

SECTION B: ENGLAND
B.4 THE REST OF ENGLAND

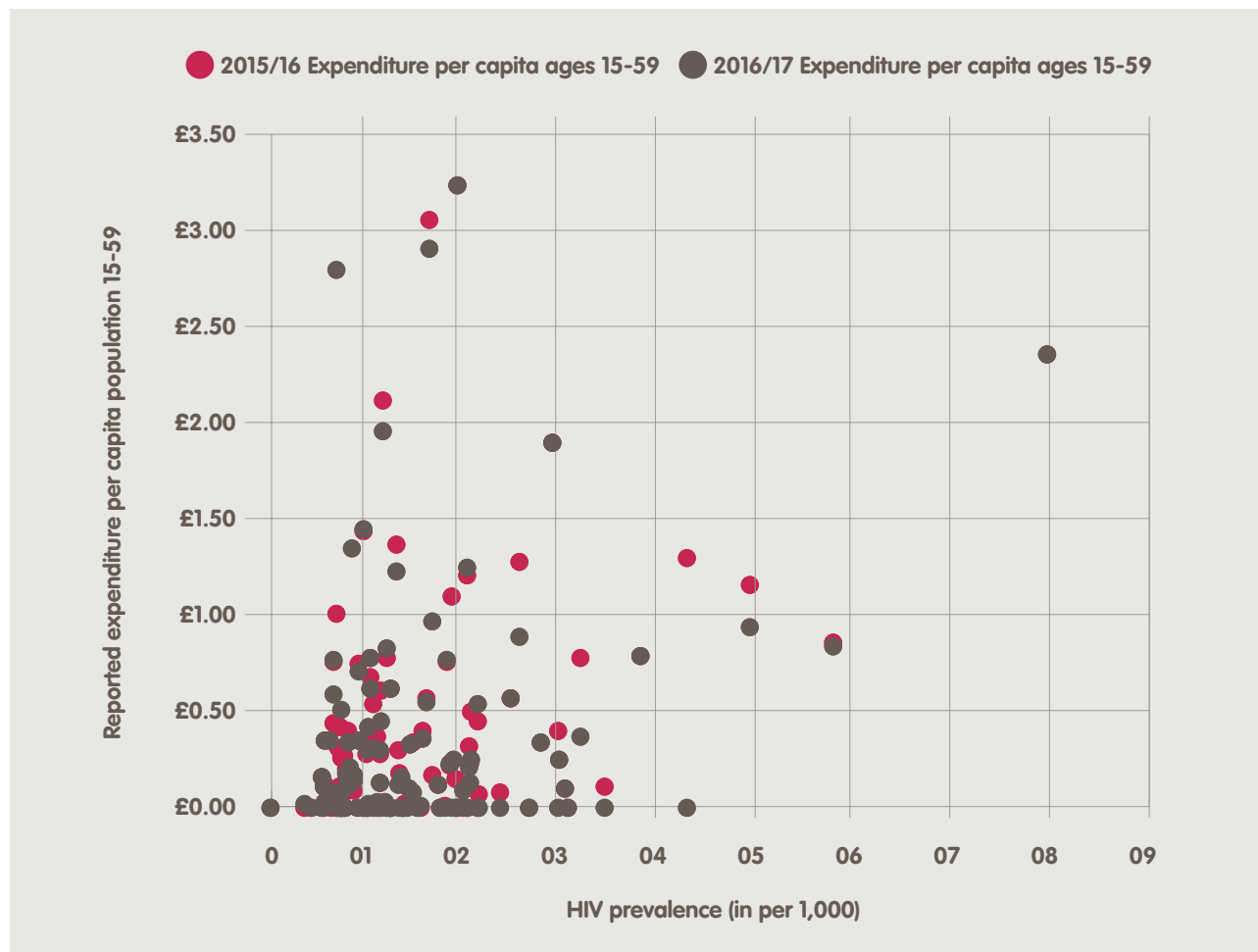


CHART 7. PER CAPITA SPEND ON PRIMARY HIV PREVENTION AND TESTING FOR THE POPULATION AGED 15-59 IN ENGLAND’S LOCAL AUTHORITIES OUTSIDE OF LONDON, COMPARED WITH LOCAL AUTHORITY HIV PREVALENCE (N PER 1,000). One outlier, with a per capita spend of £10 and a prevalence of 3.81 per 1,000, has been removed from this chart to enhance readability.

The categorisation of high prevalence (≥ 2 per 1,000) does not indicate that HIV prevention should not be a public health priority for those below this threshold. Many of these lower prevalence local authorities still have a significant population of people living with HIV, which could rise without prevention effort. These local authorities may also have significant rates of late diagnosis. In chart 7 there are several authorities with a prevalence between one and two per 1,000 reporting no expenditure in both years. This is potentially very concerning and these local authorities should be mindful of the risk of prevalence rises.

RECOMMENDATIONS

Local authorities with an HIV prevalence of below two per 1,000 should be mindful of the potential for rates to increase in their area and should address their local HIV prevention and testing needs.

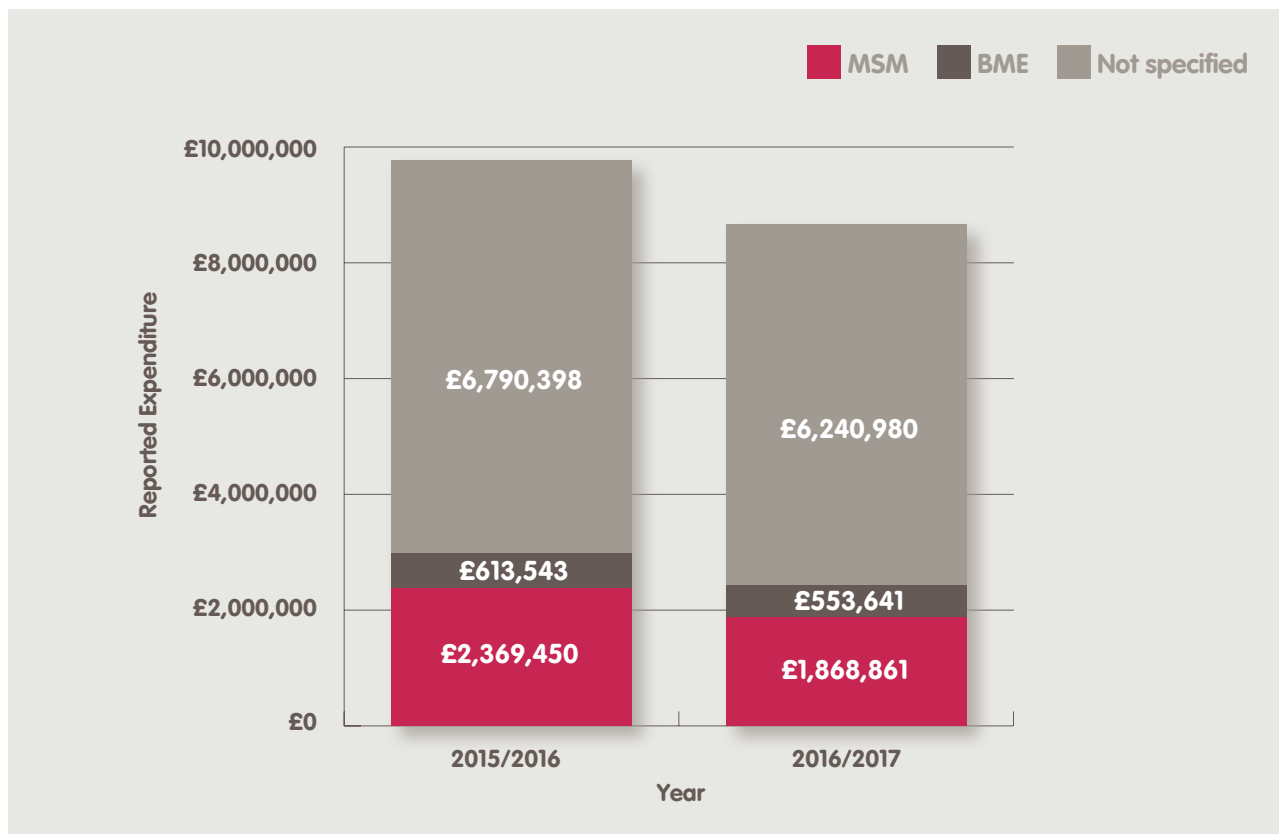


CHART 8. REPORTED EXPENDITURE ON HEALTH PROMOTION FOR PRIMARY HIV PREVENTION IN LOCAL AUTHORITIES IN ENGLAND, EXCLUDING LONDON, IN 2015/16 AND 2016/17 AND BY TARGET GROUP.

B.4.1 HEALTH PROMOTION IN THE REST OF ENGLAND

The 10% drop in overall HIV prevention spending in England outside London is fully represented by cuts in health promotion expenditure which dropped overall from £9,773,391 to £8,663,482.

As in London, a smaller proportion of funding is for contracts specified as being allocated to MSM or BME groups (see chart 8). It is highly likely that the remaining expenditure, classed as ‘not specified’ is also targeted in some way but that local authorities are unable to identify how the expenditure is allocated.

As was indicated by the data shown in chart 7, the spending is not evenly distributed across the

country. In 2015/16, across 119 local authorities, 42 were not spending anything at all on health promotion, 7 high prevalence and 35 low prevalence. In 2016/17, 56 were not spending anything on health promotion, 10 high prevalence and 45 low prevalence.

Areas with a low prevalence reported far higher levels of expenditure on contracts where the target group was not specified than those with a specific target group. While there were decreases in most areas, targeted interventions in low prevalence areas outside London have been particularly affected by a funding squeeze in 2016/17.

Investment in HIV prevention for BME groups is generally much lower outside of London. However, in high prevalence local authorities outside of London it has increased compared with 2013/14

SECTION B: ENGLAND
B.4 THE REST OF ENGLAND

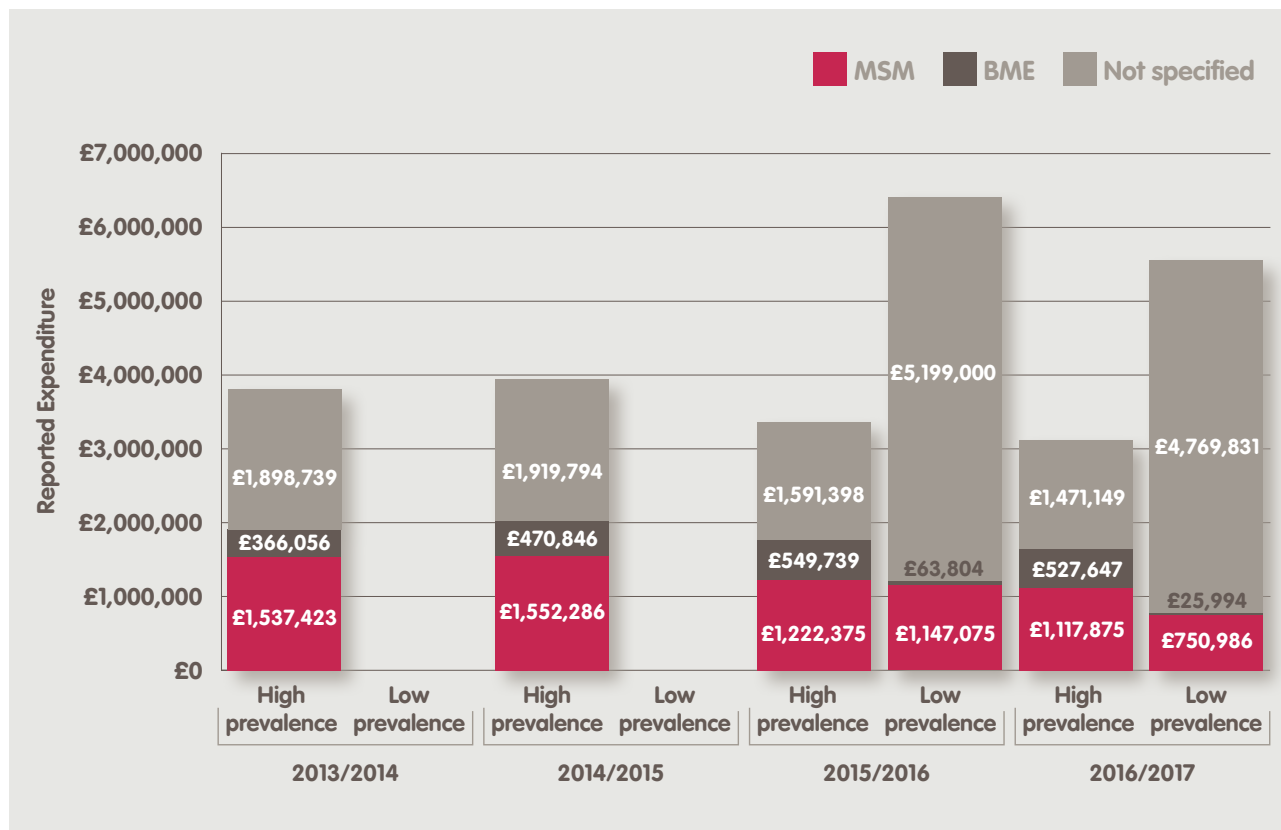


CHART 9. REPORTED EXPENDITURE ON HEALTH PROMOTION FOR PRIMARY HIV PREVENTION IN LOCAL AUTHORITIES IN ENGLAND, EXCLUDING LONDON, FOR THE 4 YEARS FROM 2013/14 TO 2016/17, BY HIGH AND LOW PREVALENCE AND BY TARGET GROUP. (DATA FOR LOW PREVALENCE LOCAL AUTHORITIES IN ENGLAND IS

and 2014/15; this is against the general trend (see chart 9). This additional investment in this area is welcome, but is probably not enough.

The overall lower investment in specific BME services compared with London can in part be explained by population differences, but this does not offer a full explanation. There may also be fewer organisations specialising in sexual health work with BME communities in many parts of England, compared with London or other major cities, reducing the scope for specialist contracted services. This sector has been particularly affected by public sector cuts in recent years. In the absence of infrastructure for specialist services, generalised sexual health services may be contracted to do work with BME groups alongside the other groups they work with.

“Within the contract for community level 2 SH services there is a post of HIV Outreach Worker, who works with MSM, BME and other at risk and vulnerable groups including sex workers.”

Local authority in the east of England



EXAMPLES

4. Targeted HIV prevention interventions in two of England's major cities

England's larger cities tend to have a higher prevalence of HIV than other parts of the country. In these cities, the epidemic does tend to impact on different groups with very different prevention needs, such as the gay community or African communities. Therefore, some have chosen to contract unique providers to target these groups.

One city in the north west of England reported two major contracts. One, targeting MSM, was worth £160,000 and one, targeting local black African communities, was worth £114,765. Both contracts included KPIs for:

- Point of care testing
- Condom and lubricant distribution
- Assertive outreach work in key community venues
- Group and one-to-one work
- Drop-ins.

Another city in the north east of England also reported two major contracts, one of which targeted MSM and was worth £131,610. The second contract, worth £97,420, specifically targeted women at increased risk of poor sexual health. The service worked with *“women from black and ethnic minority groups (including refugee and asylum seekers), lesbian and bisexual women and those questioning their sexual orientation, women involved in the adult sex industry and those who have experienced sexual violence.”* Both contracted services combined:

- Information
- Outreach
- Counselling and other one-to-one support
- Telephone support
- Group work.

B.4.2 HIV TESTING IN THE REST OF ENGLAND

Reported expenditure on HIV testing was relatively low compared with London. £805,444 was reported in 2015/16 and £839,920 was reported in 2016/17. However, these numbers are potentially very misleading as such a high number of local authorities reported commissioning HIV testing but were unable to provide expenditure. This was particularly the case for community HIV testing, where 47 local authorities in 2015/16 and 43 in 2016/17 were unable to provide expenditure for services they provided (see chart 10).

In 2015/16, 33 local authorities did not report commissioning any HIV testing services (other than those provided through the STI clinic); four of these were high prevalence local authorities and 29 low. In 2016/17, 36 local authorities reported no spending on HIV testing; this time five were high prevalence and 31 low.

There is some difference in how high and low prevalence local authorities outside London commissioned testing services. For example, although the number of local authorities reporting expenditure on primary care HIV testing decreased slightly between the two years, there was an increase in expenditure on primary care testing compared with 2013 - 2015. Chart 11 shows that this is due to a large increase in expenditure on primary care within some low prevalence local authorities. In fact, expenditure on HIV testing in all settings increased between the two years in low prevalence areas.

In contrast, there is a decrease in expenditure in high prevalence local authorities in all settings apart from home-sampling; this is characterised in the main by a steep reduction in funds for community HIV testing. The drop may not be as high as it seems as we know so many areas are unable to give expenditure figures for community testing. However, 10 high prevalence local authorities said that they were investing in community testing but couldn't give figures in 2015/16, and only one

SECTION B: ENGLAND
B.4 THE REST OF ENGLAND

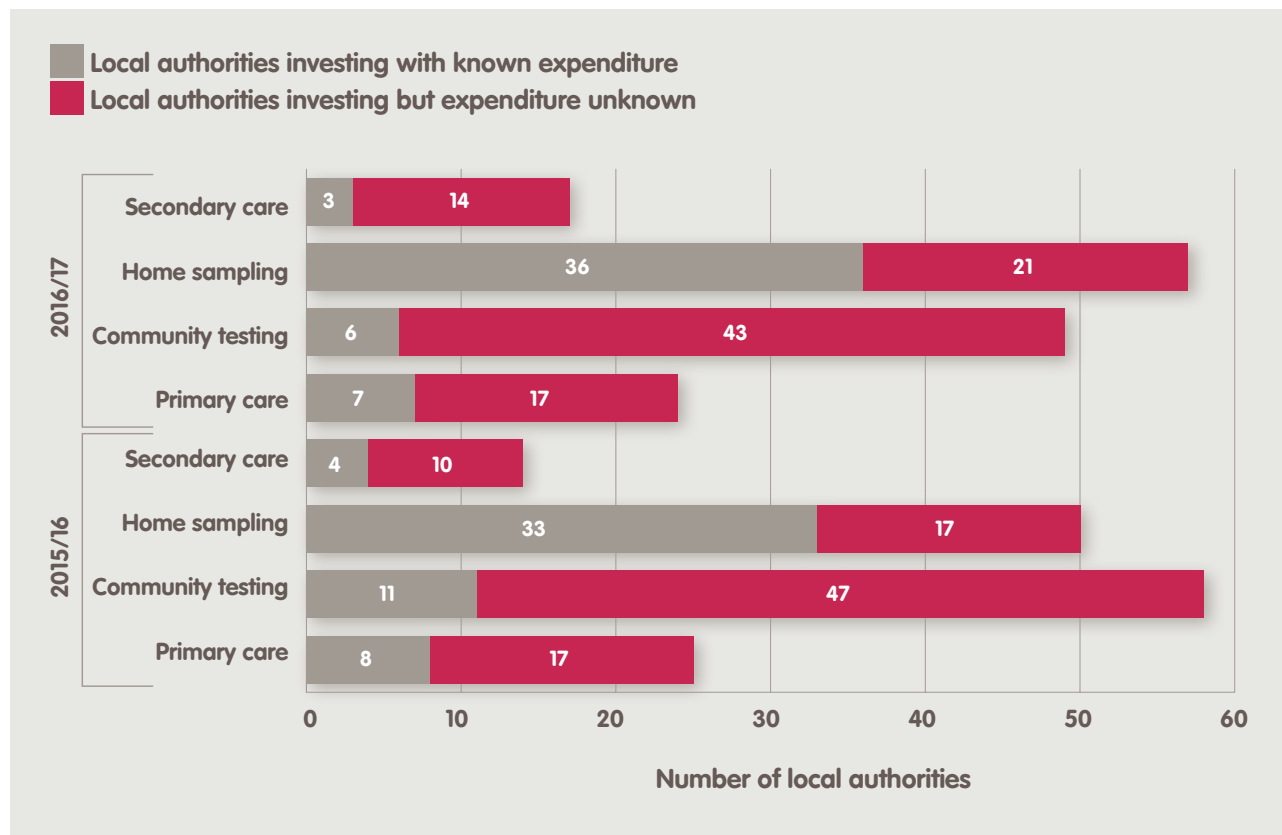


CHART 10. THE NUMBER OF LOCAL AUTHORITIES REPORTING INVESTMENT IN HIV TESTING IN DIFFERENT SETTINGS IN LOCAL AUTHORITIES IN ENGLAND, EXCLUDING LONDON, 2015/16 AND 2016/17. (NOT AVAILABLE FOR THE YEARS PRIOR TO 2015/16.)

more said this for 2016/17, yet the expenditure has dropped substantially. This reflects the fact that some high prevalence local authorities have stopped funding this altogether. For example, in 2016/17 one local authority de-commissioned a community HIV testing scheme that had been worth £95,000 in 2015/16.

RECOMMENDATIONS

All local authorities should ensure that they are meeting NICE HIV testing guidelines that are relevant to their area, providing adequate testing opportunities for their population, outside of the sexual health clinic.

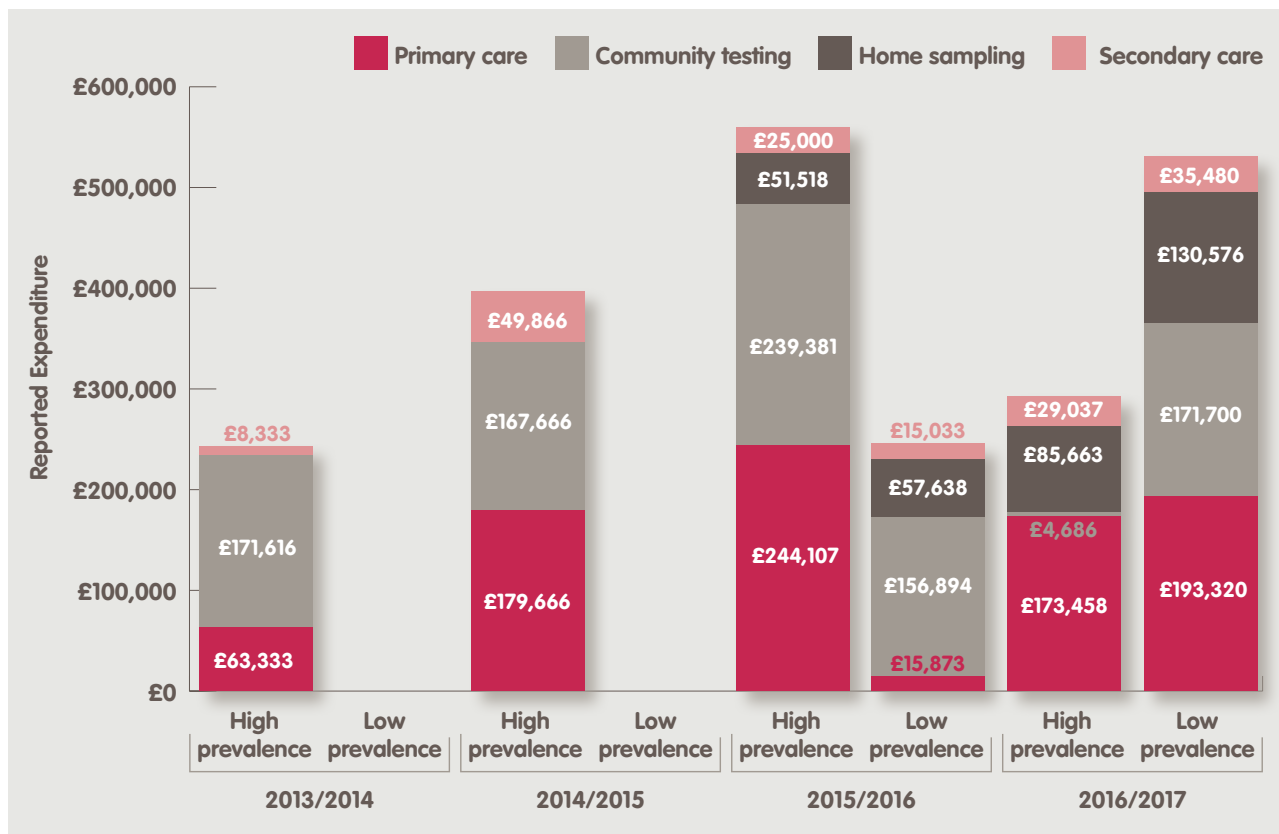
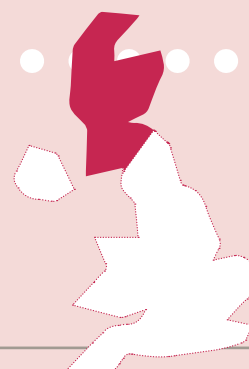


CHART 11. REPORTED EXPENDITURE ON HIV TESTING IN ENGLAND LOCAL AUTHORITIES, OUTSIDE LONDON, IN THE FOUR FINANCIAL YEARS 2013/14 TO 2016/17, BROKEN DOWN BY TESTING SETTING AND BY AREAS OF HIGH AND LOW PREVALENCE OF HIV.



C: SCOTLAND, WALES AND NORTHERN IRELAND

C.1 SCOTLAND



NAT submitted FOIs to 32 local authorities in Scotland and 14 Health Boards. West Dunbartonshire council did not respond to the FOI but all others did.

Table 5 shows that no local authorities reported commissioning these services. However, more than half of Health Boards were commissioning services for Primary HIV prevention and testing.

More than half of Scotland’s NHS Health Boards reported funding primary HIV prevention and testing. Boards that did not report expenditure on these services were mostly those with the smallest populations, such those serving Orkney, Shetland and the Western Isles.

One health board did de-commission their HIV prevention service, which targeted MSM, between the two financial years. The remainder of the drop in reported expenditure from 2015/16 to 2016/17 (a 14% reduction) was due to a reduction in contract values. In 2015/16 one health board reported funding of £240,000 for prevention amongst MSM.

In 2015:
8,364
people were living with HIV in
Scotland.

5,059
of those were diagnosed.

This was across three providers. However, in 2016/17 this was consolidated into a contract worth £200,000 with a single provider.

Although the average per capita spend of health boards in Scotland (£0.19 in 2016/17) is much lower than that of local authorities in England (£0.44 in

SECTION C: SCOTLAND, WALES AND NORTHERN IRELAND
C.1 SCOTLAND



2016/17), to an extent this is to be expected due to overall lower HIV prevalence in Scotland.

Around half of the reported expenditure for primary HIV prevention services in the two years is also for the delivery of support for people living with HIV. It is not possible to ascertain what proportion of the expenditure will have been on primary HIV prevention activity as opposed to support services. Therefore, these figures are an over-estimation of spending on HIV prevention and testing in Scotland.

“Project commissioned to deliver interventions that address HIV prevention and support needs of people from African communities... This includes working within the community to raise awareness and increase knowledge; tackle barriers to testing; provide DBS testing to community groups; provide support to HIV positive individuals to maximise engagement with treatment services.”

NHS Health Board in Scotland

2015/16	Proportion commissioning health promotion	Reported expenditure	Proportion commissioning testing services	Reported expenditure	Total reported expenditure	Average per capita (pop 15-59)
Health boards	64% (9 in 14)	£925,677	64% (9 in 14)	£23,913	£949,590	£0.24
Amount of which was also to deliver support services		4 contracts worth £397,800	Amount which is exclusively prevention and testing		£620,339	

2016/17	Proportion commissioning health promotion	Reported expenditure	Proportion commissioning testing services	Reported expenditure	Total reported expenditure	Average per capita (pop 15-59)
Health boards	57% (8 in 14)	£782,114	57% (8 in 14)	£37,500	£819,614	£0.19
Amount of which was also to deliver support services		4 contracts worth £387,800	Amount which is exclusively prevention and testing		£390,750	

TABLE 5. REPORTED EXPENDITURE ON PRIMARY HIV PREVENTION AND TESTING BY NHS HEALTH BOARDS IN SCOTLAND INCLUDING WHERE THIS SPEND IS ALSO ON HIV SUPPORT SERVICES.

SECTION C: SCOTLAND, WALES AND NORTHERN IRELAND
C.1 SCOTLAND



C.1.1 HEALTH PROMOTION IN SCOTLAND

The most significant target group for health promotion expenditure in Scotland was MSM, although this group also experienced the most significant drop in funding. Chart 12 shows that expenditure on MSM dropped from £566,699 to £422,050, a 26% decrease. However, expenditure on BME groups dropped only marginally.

The £146,000 reported under 'not specified' in both years is for a single contract. The health board reported the full contract value but specified that this was for work across higher risk groups and for support for people living with HIV.

“the service is expected to engage with all individuals and groups who may be at higher risk of HIV transmission... Total budget for all... (including prevention, support and safer sex material provision) is £146,000 per annum”

NHS Health Board in Scotland

EXAMPLES

5. An NHS Health Board with its own online hub for sexual health amongst MSM

Rather than contract an external organisation for HIV prevention activity, one NHS Health Board runs its own web-based service.

The main website acts as a hub for information on sexual health and STIs and provides tools to monitor personal risk. The service has also developed a downloadable app containing all the information. A key component of the service is its role in signposting to local clinics, condom schemes, and support. Some of these services are also NHS-run. For example, there do appear to be MSM specific sexual health clinics running in the area which are linked to this service. Other signposted services, such as reference to THT Direct, do not appear to be receiving funding from the NHS Health Board itself.

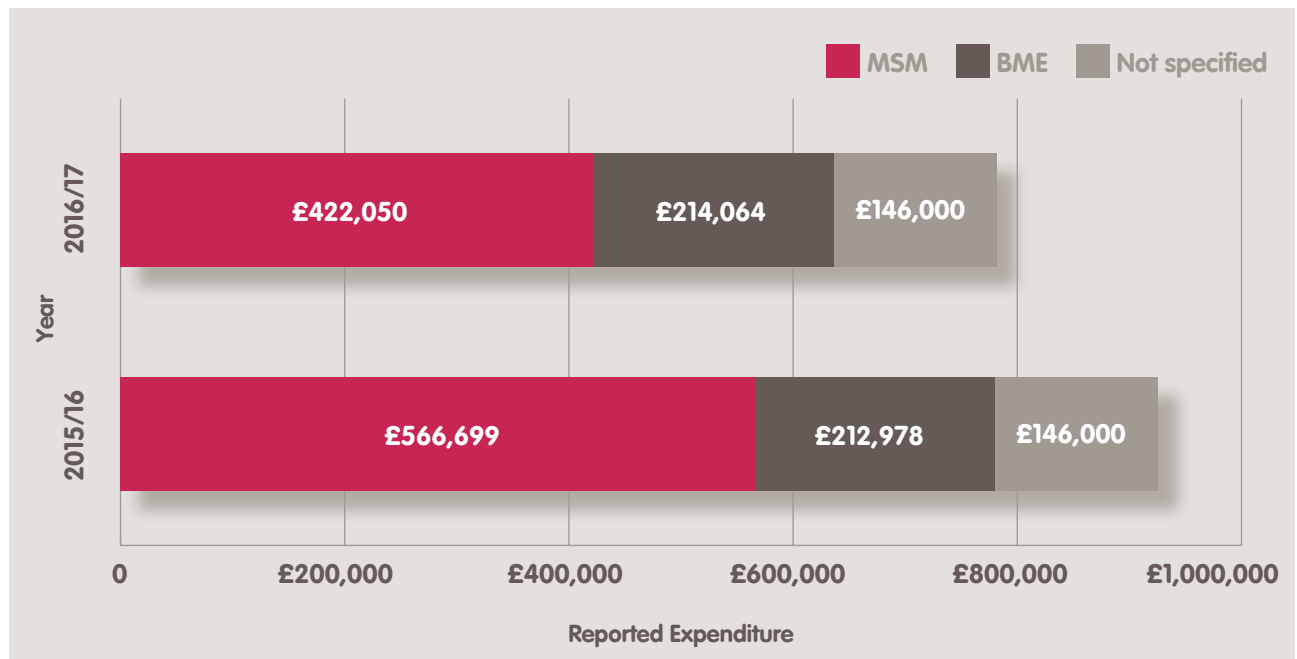


CHART 12. REPORTED EXPENDITURE ON HEALTH PROMOTION FOR PRIMARY HIV PREVENTION IN 2015/16 AND 2016/17 BY TARGET GROUP.



C.1.2 HIV TESTING IN SCOTLAND

Most of the HIV testing reported was community testing forming part of an overarching contract for HIV prevention. All boards reporting HIV health promotion carried out some form of HIV testing for public health purposes. No health boards reported additional HIV testing services unless they also reported health promotion for primary HIV prevention. This is unlike in England's local authorities, where there are areas which report only commissioning testing services without health promotion.

Primary care testing was less common in Scotland. However, given the relatively low prevalence, this is not surprising. In 2016/17 two NHS Health Boards reported that they were promoting HIV testing in primary care. One confirmed that 8,564 tests had been carried out by GPs in 2015. The same board had also paid for 449 HIV tests taken through drug services and 557 across two prisons. Given the recent spike in HIV diagnoses amongst people who inject drugs in Scotland, this is a welcome focus.

RECOMMENDATIONS

NHS Health Boards in Scotland should work to maintain their existing infrastructure, provision and expertise in HIV services, and in HIV prevention specifically, as further cuts at the level reported here will make provision unsustainable.

NHS Health Boards should ensure that organisations are adequately funded to fulfil the broad range of outcomes, across prevention and support, that are included in their contracts.

The Scottish Government and NHS Scotland should support NHS Health Boards and work with community organisations to provide a wider range of testing services, including greater provision of home sampling and primary care testing services.

SECTION C: SCOTLAND, WALES AND NORTHERN IRELAND

C.2 WALES

C.2 WALES



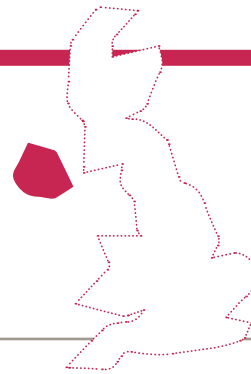
In 2015 1,877 people were seen for HIV treatment and care in Wales and 168 were newly diagnosed. New diagnoses have consistently been at over 100 a year since 2003, with an all-time high of 186 diagnosed in 2014. Late diagnosis rates are much higher in Wales at 51% than the UK average of 39%.

In Wales, only Abertawe Bro Morgannwg University Health Board reported expenditure for primary HIV prevention and testing out of a total of seven Health Boards. Cardiff and Vale University Health Board stated that HIV prevention was a part of their ISHS, but did not provide any expenditure figures or further information on this. No local authorities reported any expenditure.

Abertawe Bro Morgannwg University Health Board reported spending £98,605 in each year. However, support for people living with HIV was also included within the contract, meaning that less than this will have been expenditure on HIV prevention. The contract did include provision for community HIV testing.

RECOMMENDATION

HIV prevention activity in Wales is insufficient and the Welsh Government should work with Public Health Wales and local Health Boards to increase investment in HIV and broader sexual health prevention activities as a matter of urgency and to address gaps in infrastructure.



C.3 NORTHERN IRELAND

In 2015 934 people were seen for HIV treatment and care in Northern Ireland. 103 people were newly diagnosed, the highest number ever and significantly higher than the 57 diagnosed 10 years ago in 2005. In 2015 late diagnosis in Northern Ireland was lower than the UK average, at 29%. However, it had previously been considerably and consistently higher than the rest of the UK.

In Northern Ireland, local expenditure was again only reported by one Health and Social Care Trust. This was the Western Health and Social Care Trust which reported £21,947 for both years.

A review of the annual reports of charities based in Northern Ireland that specialise in HIV services demonstrated a precedent for the Public Health Agency and Department for Health and Social Care in Northern Ireland to fund some of these services. The Public Health Agency confirmed that it had two contracts for HIV prevention work with MSM. These were worth a total of £50,742 in 2015/16 and £51,352 in 2016/17. These contracts were delivered in partnership with voluntary organisations and included outreach and testing in high risk venues, safer sex promotion and specialist clinics for MSM.

There is not a clear line of accountability for HIV prevention and testing activity in Northern Ireland. This is reflective of the absence of an up-to-date strategy for sexual health and HIV, which outlines the role of national and local bodies and prevention aims.

RECOMMENDATIONS

Greater clarity is needed on public health commissioning responsibility in Northern Ireland and how this relates to sexual health and HIV services. This should be set out clearly as part of an up-to-date strategy for sexual health and HIV in Northern Ireland.

Local investment in HIV prevention must be increased and should be targeted at meeting local prevention needs. This must include increased HIV testing provision to address the high late diagnosis rate in Northern Ireland.



D: CONCLUSIONS



How commissioning responsibility for public health is distributed varies significantly between the nations. In England, much of the investment is managed by local authorities. In Scotland, Wales and Northern Ireland there is a local focus but this is managed through the NHS. Common to all four nations is the fact that public health funding is under extreme pressure and this does not appear likely to change. Public health is under-funded and under-prioritised across the UK and, as a result, so is HIV prevention.

This latest survey means that, for England's high prevalence local authorities, we now have longitudinal data on HIV prevention expenditure for the four years since the implementation of the Health and Social Care Act 2012. This shows the stark reality of the cuts – with overall expenditure down by around a third from already low levels in 2015. The National HIV Prevention Programme and the London HIV Prevention Programme are playing an ever increasingly significant role in HIV prevention in England, despite decreasing budgets, simply because the local investment is shrinking. These programmes are important but cannot substitute for consistent needs-based services at a local level.

In Wales and Northern Ireland provision is patchy and commissioning responsibilities are unclear. In Wales there is a need to significantly upscale HIV prevention activity and to ensure national coverage

of services. The Northern Ireland Government does invest in some of the long-standing services that exist there; but greater strategic backing and local action are needed to achieve a more sustainable and effective approach to HIV prevention.

Scotland has a vibrant HIV and sexual health sector, and this infrastructure is being supported by many NHS Boards. But not all are investing and the level of investment is decreasing. It dropped by 14% between 2015/16 and 2016/17. A lot of the contracts reported in Scotland were also for HIV support services and therefore HIV prevention investment is probably lower than reported here.

Decreasing investment in public health is a false economy. The Five Year Forward View highlighted prevention as a critical component of ensuring the long-term sustainability of the NHS in England. But the outcomes of public health investment are felt down the line, meaning it is not always a contender for immediate investment. While NHS funding has been protected, in England the public health budget has been dramatically cut. In other parts of the UK, public health has taken a back seat as funds are needed to meet the increasing demands on the NHS and on social care.

We need to radically increase investment in HIV prevention and take a more strategic approach across the UK. A full list of recommendations from this report can be found in the Executive Summary.



APPENDIX



INFORMATION REQUEST

RE. Local authority spending in 2015/16 and plans for 2016/17

NAT (National AIDS Trust) is asking for specific information on services commissioned for Primary HIV prevention; HIV testing services (outside of GU services) and support services for people living with HIV. It would be appreciated if your authority could provide us with the information set out in the questions below. For more information about this request and where to return it to, please contact us on the details at the bottom of this document.

Definitions for the purposes of this information request:

Primary HIV prevention: Services which have as an exclusive aim or as one of their primary aims the prevention of HIV transmission and as their intended recipients people identified as at significant risk of acquiring HIV.

Testing: We include in this definition HIV testing services directly commissioned by local authorities but excluding those provided by GU/sexual health clinics.

For the purpose of this exercise we are not looking to gather information on expenditure on the following:

- GUM clinic activity
- HIV clinic activity
- Other acute secondary care provision (apart from HIV testing commissioned in these settings for public health reasons)
- Harm reduction services for people who inject drugs
- Services for people diagnosed with HIV which may support safer sex
- Wider sexual health services and programmes that do not have as one of their primary aims the reduction in onward HIV transmission (such as generic condom distribution programmes)
- Contributions to the London HIV Prevention Programme.

APPENDIX



Primary HIV prevention and testing in 2015/16

Questions:

1. Did you have any contracts for primary HIV prevention (as defined above)?
2. Did you have any other contracts with specific HIV prevention KPIs, or specific prevention

KPIs relevant to STIs for MSM or BME groups, or is HIV prevention mentioned in any other contractual documentation?

3. If the answer to any of the above is yes, please fill in the following in relation to these services: (You may have more than one service which falls within an intervention type. Please use a new line for each service)

Intervention type	Service Description and other information (e.g. description of KPIs)	Expenditure in 2015/16	Is this contract commissioned for 2016/17 and if so what is the value of the contract
Primary HIV prevention (health promotion activity) for:			
Men who have sex with men (MSM)			
BME groups			
Other (please specify)			
HIV testing services (not including sexual health clinic services)			
Primary care			
Secondary care			
Community (if targeting specific groups, please describe)			
Home sampling			



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Paul Steinberg, Lead Commissioner and Programme Director for the London HIV Prevention Programme;

Pat Knowles, Senior Social Worker Regional HIV Team at Belfast Trust;

Kelsey Smith, Liam Beattie and colleagues at HIV Scotland;

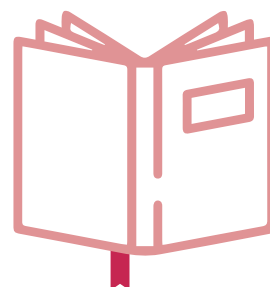
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NAT could not have completed this project without the support of our dedicated volunteers **Matt Tanner, Nuala Hurst Marshall, Rory MacFarlane** and **Samual Dick**.



REFERENCES



- ¹ 'HIV prevention in England's high prevalence local authorities', NAT 2015 http://www.nat.org.uk/sites/default/files/publications/Prevention_Report_2015-1.pdf
- ² 'HIV diagnoses, late diagnoses and numbers accessing treatment and care', Public Health England (PHE) 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/602945/HIV_diagnoses_late_diagnoses_and_numbers_accessing_treatment_and_care.pdf
- ³ 'HIV in the UK 2016 report', PHE 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/602942/HIV_in_the_UK_report.pdf
- ⁴ 'HIV testing in England: 2016 report', PHE 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/573596/HIV_testing_in_England_2016_Report_FinalNB301116.pdf
- ⁵ Figure given by Baroness Chisholm of Owlpen on 28 September 2016 in answer (HL1951) to a parliamentary question by Lord Brent of Blackwood <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2016-09-15/HL1951/>
- ⁶ Nakagawa F et al. Projected Lifetime Healthcare Costs Associated with HIV Infection. PLOS One 10(4): e0125018, 2015.
- ⁷ 'HIV prevention needs assessment for London', Association of Directors of Public Health (ADPH), PHE and London Councils, November 2013
- ⁸ 'Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections' UNAIDS Discussion Paper, September 2010 http://www.unaids.org/sites/default/files/media_asset/JC2007_Combination_Prevention_paper_en_0.pdf
- ⁹ See 'HIV prevention in England's high prevalence local authorities', NAT 2015 pp. 18 for more detailed explanation. http://www.nat.org.uk/sites/default/files/publications/Prevention_Report_2015-1.pdf
- ¹⁰ See 'HIV prevention in England's high prevalence local authorities', NAT 2015 pp. 18 for more detailed explanation. http://www.nat.org.uk/sites/default/files/publications/Prevention_Report_2015-1.pdf
- ¹¹ 'Diagnosed HIV prevalence by upper and lower tier local authority', PHE 2016 data table available at: <https://www.gov.uk/government/statistics/hiv-annual-data-tables>
- ¹² Statistics available on the HIV Scotland website <http://www.hivscotland.com/about-hiv/data-and-research/statistics/>
- ¹³ 'National HIV surveillance data tables', (see Table 8), PHE data available at: <https://www.gov.uk/government/statistics/hiv-annual-data-tables>
- ¹⁴ 'HIV testing: increasing uptake among people who may have undiagnosed HIV' NICE 2016, available at: <https://www.nice.org.uk/guidance/ng60>
- ¹⁵ 'New HIV Awareness in Primary Care campaign launched to increase primary care HIV testing' ViiV Healthcare press release, 20 September 2016: <https://www.viivhealthcare.com/media/press-releases/2016/september/new-hiv-awareness-in-primary-care-campaign-launched-to-increase-primary-care-hiv-testing.aspx>
- ¹⁶ 'HIV, Sexual and Reproductive Health project announced by RCGP' RCGP press release, 18 August 2016: <http://www.rcgp.org.uk/news/2016/august/hiv-sexual-and-reproductive-health-project-announced-by-rcgp.aspx>

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