

aids treatment update

Improving sexual health

This month we return our focus to HIV and sexual health policy and provision here in the UK, where the Government has just presented its response to the House of Commons Health Committee report into the nation's sexual health, and those services which support it – services shown to be buckling under the strain of rapidly rising sexual infections. In short, the Government is asking for our patience, arguing that the National Strategy on Sexual Health and HIV which is in place is appropriately wide-ranging, but is a longer-term solution rather than a quick fix. They've also committed to provide an additional £11 million of funds for sexual health care, no doubt welcome but substantially less than the annual top-up of £22-30 million which the Genitourinary Medicine field has asked for, based on the expanding caseload.

The Government note in their opening paragraph that the low HIV prevalence found in the UK today, relative to those in neighbouring western European countries, is in part the legacy of the availability of open-access Genitourinary Medicine clinics within the NHS. A national wait of ten or twelve days, on average, for a GUM appointment was the UK standard when the Health Committee reviewed sexual health in 2002, a rate which had doubled in a two year period. This does not bode well for the future. If a new performance indicator of a maximum 48 hour wait, which the Government hopes to introduce before 2005, is to be met, both the carrots and the sticks issued to healthcare purchasers will need to be bigger.

If there is one positive outcome in all of this, it's that the profile of sexual health and HIV services has rarely been higher. If you'd like to see the services you use, or provide, change for the better, this is your moment to have your voice heard.

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sex positive

2 the sexual health of people with HIV needs attention, but can we take the blame out of it? by edwin j bernard

In July, the US Centers for Disease Control and Prevention (CDC) released the very first American guidelines aimed at helping healthcare professionals communicate with their HIV-positive patients about what they can do to prevent transmitting the virus to others.¹

Taken at face value, these guidelines provide a clear and timely integration of HIV prevention and treatment, recognising that even when aware of the risks, altruism alone is often not enough to prevent onward HIV transmission. By suggesting that clinicians who see HIV-positive patients screen and treat sexually transmitted infections (STIs) and provide both information and ongoing support to help positive people reduce further HIV transmission by both sexual and injection routes, the guidelines provide a roadmap that may help both stem the tide of new HIV infections and also – although it is clearly a secondary aim of the guidelines – maintain the sexual health of HIV-positive people.

The guidelines are the first concrete sign of a major HIV prevention policy change in the US, first announced in April 2003 and expanded upon in Atlanta at the National HIV Prevention Conference in July. Further evidence of this policy shift, and its moral and ethical implications, is the CDC's intention to divert its HIV prevention budget from community-based HIV prevention organisations to pay for this new strategy. From next May, if they don't target HIV-positive people as their top priority, funding may disappear altogether.²

Some aspects of this policy are at best controversial – and at worst discriminatory – including the suggestion that all HIV-positive people should be encouraged to disclose their HIV status to their sexual partners and the

suggestion that partner notification be the norm. Additionally, appearing to place the responsibility for HIV prevention on HIV-positive people as opposed to focusing on 'at risk' communities as a whole, raises complex moral issues around guilt and blame.

The guidelines suggestion that the majority of HIV prevention work can be done in the clinic is also somewhat short-sighted. Aside from the obvious time-management issues, latest CDC estimates suggest that up to one third of HIV infections in the US are currently undiagnosed. Additionally, as Dr Carlos del Rio, of Emory University's School of Medicine said in his opening plenary at the Atlanta conference, only 60% of those who know they are infected with HIV are currently receiving care. The CDC estimates that 900,000 people are now living with HIV in the US; by focusing on diagnosed people in clinical care they are reaching only 40% of the total HIV-positive population.

Many activists may well agree with Debra-Fraser Houze, president of the National Black Leadership Council on AIDS, who recently told the Associated Press that a strategy "that only focuses on people who are already HIV-positive, and takes no responsibility for prevention among people who are not yet positive is insane and, I feel, genocidal."²

With current Bush administration policy prioritising sexual abstinence over condom use, it might be easy to feel smugly superior this side of the Atlantic over our own HIV prevention efforts. However, the consequences for HIV prevention due to the appalling state of Britain's sexual health as reported by the House of Commons Health Committee in June (and reviewed in this month's accompanying article) are sobering, and

it is possible that, questionable politics, ethics and legality aside, we could learn pragmatically from these US HIV prevention guidelines and apply them to the UK.

In fact, the publication of these guidelines raises two important questions for the UK: how should people with HIV be targeted for HIV prevention and what is the most effective way to spend limited HIV prevention resources?

Dr Martin Fisher is Consultant Physician at The Elton John Centre, Brighton General Hospital, Sussex and also the Chair of the HIV Special Interest Group within The Medical Society for the Study of Venereal Diseases (MSSVD, now merged with the Association for Genitourinary Medicine to form the British Association for Sexual Health and HIV).

"I don't think from a clinical perspective that what the Americans are proposing is particularly radical," he says. "They suggest at diagnosis that you do a sexual health screen – that's current UK practice anyway. You discuss routes of transmission – that's something that everyone gets as part of pre-test discussion. There are attempts made at partner notification – I think that's standard practice at most places in the UK where consent is given. And that you provide information on an ongoing basis – I don't think that really differs with what most HIV treatment centres would claim to provide, albeit maybe not as effectively as one would like.

"Clearly where America differs from the UK is their advocating compulsory disclosure of status to any sexual partners, and although they don't mention it, you can feel in the background the issue of legislation."

Although there are no current moves to legislate against HIV transmission in England and Wales, the recent Stephen Kelly case has rendered the legal position in Scotland uncertain and may still have implications in the rest of the UK. "We need to watch criminal and civil law like a hawk and make sure that doesn't happen," says Jack Summerside, Head of Terence Higgins Trust's Living Well with HIV Service, and one of the people being consulted by the MSSVD for forthcoming new UK guidelines that include the sexual health of individuals with HIV infection.

Yet, despite the fact that here in the UK we have kept HIV treatment in or close to STI treatment clinics – unlike the US where the primary care physician (or GP) is the main HIV treatment provider – the integration of HIV and sexual health is currently less than adequate. "I think we are all guilty of sometimes focusing in completely on HIV and the sexual health bit does sometimes go out of the window," admits Dr Fisher.

Dr Rak Nandwani, a Glasgow-based HIV Consultant, is also heavily involved with the UK guidelines as a member of the MSSVD HIV Special Interest Group, a project he sees as evolving naturally from the group's earlier guidance on syphilis management in HIV-positive people.³ "We wanted to adopt a more holistic approach and to think about issues such as previous sexual assault or abuse as well as areas that clinicians might be more familiar with such as condoms, contraception, reproductive health and sexual dysfunction," recalls Rak.

"The forthcoming comprehensive guidelines from the MSSVD take on board all these areas, and as importantly, place an equal emphasis on the rights of HIV-positive people to have healthy sex lives, as well as considering the onward transmission of HIV and other STIs. The guidelines production started with the community perspective and developed with continued input from key stakeholders to ensure the views of those infected with the virus remain a central focus."

In the UK, some HIV clinics now offer their patients sexual health check-ups as part of their routine care, but sexual health service provision for HIV-positive people must be consistent UK-wide. "One of the key things that is currently lacking for HIV-positive people in the UK are clear pathways towards sexual health treatment," asserts THT's Summerside. "HIV-positive people need to know where they can get sexual health treatment that is delivered in a non-judgmental manner. That's the barrier that needs to be crossed, and it is more of a philosophical shift that is needed, requiring a reconfiguration of services, rather than extra spending."

Dr Fisher admits the problem "is usually on the clinician side, rather than the patient side," due to

sex positive continued

the clinician's reluctance to talk about sex, possibly due to cultural or time constraints, but believes the barriers are surmountable with clinician guidance and training. Summerside adds that the old assumption that HIV-positive people are too sick or too virtuous to have a healthy sex life, and the observation that, as he puts it rather bluntly, "dealing with willies and fannies is 'beneath' HIV specialists," are also to blame.

"All of us need to work out mechanisms that will work in our own settings to make sure that the overlooking of the sexual health needs of HIV-positive people doesn't happen," adds Dr Fisher. "Numerous clinics are now looking at nurse-led sexual health screening, where people with HIV would essentially have a fast-track service at a time of their choosing."

Those of us living with HIV can effect this subtle philosophical change ourselves by speaking out. One way is to ask for dedicated HIV sexual health services at your HIV treatment centres. Another is to bite the bullet and bring up sex with your clinician. "If you can talk about sex from day one with your clinician, the easier it will be thereafter," suggests Dr Fisher. "The longer you keep it under wraps the trickier it will be to bring it up. And if you find that you don't have a good rapport with your doctor talking about sex then either challenge them further, or think about finding somebody else to provide your sexual health care."

As for how the limited money allocated to HIV prevention should be best spent, Dr Fisher thinks "we need to use our resources more cleverly," a sentiment echoed by Summerside. "I'd be concerned if HIV prevention for HIV-positive people meant a reduction in effective work happening across the HIV prevention sector," he says. "It shouldn't be a case of either/or in terms of funding, taking money from population-targeting prevention campaigns to fund it. But then again it might

just mean that people spent their money a bit more wisely. It's the manner in which you do things, rather than resource implications." As an example, he suggests that every HIV clinic produce a brochure with information about all the services available there, including sexual health (which should include non-judgmental information on treating sexual dysfunction, accessing reproductive health services and dealing with relationship issues as well as STIs), as well as order and stock all the leaflets currently produced by NAM and THT about sexual health and HIV.

However, as Summerside points out, "Better practice is made more difficult because of the under-resourcing of sexual health in the present set-up." Currently, Primary Care Trusts – who decide where healthcare funds are spent at a local level – are encouraged to reach certain prioritised health-related targets, and sexual health is not one of them. The Health Committee recognised this flaw in their recommendations, but it will be a while before anything is done about it.

Rak Nandwani points out the somewhat different issues present in Scotland: "Strikingly, the variation in sexual health provision in the UK has been amplified by devolution. Apart from the negative implications of the Kelly case, there are other major differences in sexual health provision in Scotland which have positive implications for those with HIV. HIV prevention and public health remain the responsibility of Health Boards (similar to the former Regional Health Authorities in England) and so there's a more consistent approach. Boards such as Greater Glasgow have so far agreed to fully fund free sexual dysfunction therapies for those who are HIV-positive.

"The forthcoming Scottish Sexual Health and Relationships Strategy specifically identifies supporting the sexual health of those with HIV,"

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Rak notes. "Despite other obstacles such as the Scottish equivalent of Clause 28 being removed from the statutes, there remain major challenges north of the border to ensure that sexual health delivery takes on board that what might be the right approach for one person may be inappropriate for another with a different level of sexual activity, cultural background or – more controversially – degree of immune suppression. Much of the research on treatment of STIs with HIV stems from the era before effective therapy and immune reconstitution."

Still, philosophical shifts within, and even further funding of, HIV and GUM clinics, are not the only way forward in the UK. Dr Fisher believes that a multifaceted approach is the only way to address the sexual health needs of HIV-positive people, as well as all people who are living in high prevalence communities like gay men and Africans. "It's more than just clinical services," he argues, "and clearly one needs to look at community-based organisations and primary care as well as the GUM or HIV clinic. To imply that it can all happen in a consultation with a doctor is unbelievably simplistic."

One of the most notable current philosophical differences between the UK and the US is the inclusion of HIV-positive people in HIV prevention campaigns aimed at high prevalence communities. In particular, the CHAPS campaigns – which THT oversees with Government funding – for HIV prevention amongst gay men are carefully constructed so that they are meaningful to the HIV-positive, negative and untested people who see them.

"They don't say: 'This is how you can stay negative' as most US work still does," asserts Summerside. "I wouldn't recommend large-scale targeted prevention for HIV-positive people because that would be so hard to achieve without it looking like you were buttonholing. I think it's far more inclusive and community-building to include the needs of diagnosed infected people in mainstream work."

The forthcoming MSSVD guidelines on the screening and management of STIs, which includes the sexual health of people with HIV, will not shift sole responsibility of HIV prevention onto HIV-positive people, says Dr Fisher. "It will also look at issues like sexual dysfunction and reproductive health for positive people. It's very much about facilitating sexual health rather than taking a punitive approach."

But are HIV prevention and the sexual health of HIV-positive people really compatible, or are there different agendas here?

"Inevitably there are different agendas," says THT's Summerside. "But I would like to think that there would be a universal recognition that the best way to achieve HIV prevention goals with diagnosed HIV-positive people is through a supportive environment that works in both a clinical and community setting: good sexual health for its own sake, with a knock-on effect being the reduction in sexual transmission. In my most optimistic moments I think we can achieve that in the UK, and in my more pessimistic moments I think it could be as dreadful as in the US."

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sexual health crisis

6 as the British find yet more ways to be embarrassed by sex, we consider some potential remedies for the ills of our sexual health services by **anna poppa**

In June this year the House of Commons cross-party Health Committee published the findings of their inquiry into the state of Britain's sexual health, and the likely effectiveness of the Government's then new *National Strategy on Sexual Health and HIV* in tackling what the Committee called "most worrying and depressing trends in sexually transmitted infections (STIs), HIV/AIDS and unwanted pregnancy."

More recently, there's been a bit of good news, with signs of a drop in new cases of gonorrhoea amongst gay men, and some evidence of a reduction in the proportion of people whose HIV infection is diagnosed late in the course of disease. Overall, however, new cases of STIs continue to spiral upwards, and by the end of July, the Health Protection Agency was warning of a rise in syphilis cases amongst heterosexuals in south London.

The extent of the problem

The Health Committee's 120-page report, based on evidence submitted to them late in 2002, highlighted the extraordinary increases in STIs which have occurred in the UK since the late 1990s. The headline figures most widely quoted – that one in ten women have chlamydia, teenage pregnancy rates are the highest in Europe, and that a 500% rise in syphilis rates has occurred in the last six years – in fact masked more extreme trends in specific

communities. Between 1996 and 2001, syphilis cases in gay men rose by over 1600%. And in Brighton, the recorded increase in syphilis was 700%, regardless of route of acquisition.

Traditionally an open-access service, many genitourinary medicine (GUM) clinics had been forced to switch to an appointment-based service to manage the expansion in caseload. This approach appears only to have moved the patient queue outside the clinic door however, resulting in long waiting lists. And though nationally the average wait for a GUM appointment was reported to be twelve days for men and ten days for women (a doubling since 2000), again it looks like the average is being pulled hard by local variations. A clinic in Bristol reported turning away four hundred people every week, whilst a service in Manchester, where there's been a recent outbreak of syphilis and where HIV and STI rates are high, the waiting list was six to eight weeks long.

Of course the rising transmission rates and lengthy waits for care only act to fuel each other. Leaving people with an STI which is untreated extends the period of infectiousness and delays access to sexual health promotion interventions such as counselling and partner notification. Aside from further transmission, another likely outcome is for presenting cases to become more complex, placing a heavier burden on both the individual and on health care provision.

There's no one cause to these problems, and indeed the UK is not alone in experiencing a worsening in sexual health – syphilis outbreaks have been reported in the US, France, the Netherlands, Ireland and Norway, along with rises in gonorrhoea. Many professionals cite the chronic under-funding of GUM services and the speciality's lowly position within the NHS, and the medical profession, as important drivers. Changes in sexual behaviour are a further determinant. According to the ten yearly National Survey of Sexual Attitudes and Lifestyles, last completed in 2001, Britons today typically start having sex younger, have more sexual partners, more unprotected sex, more concurrent partnerships, and more commercial sex than they did in 1990.

The role of HIV

The introduction of effective HIV treatments, plus the growth in HIV diagnoses, have increased the number of Britons who are living with HIV (and requiring HIV care) significantly. The estimated rise from 2000 to 2005 is 47%. Because HIV care in the UK is provided by GUM clinics, or by specialist HIV treatment centres which tend to be connected to a GUM service, this expansion has added to the overall strain on our sexual health services.

A Consultant at the Chelsea and Westminster Hospital described how he regularly sees as many as twenty patients per three hour clinic, whilst the Homerton Hospital in East London reported that they are having to turn away people hoping to use their HIV services.

Whilst the increase in diagnoses reflects rises in various risk groups, the over-representation of African people amongst those recently diagnosed with HIV brings specific challenges for health care providers – few of which fit easily into a ten minute consultation.

It's the cost of HIV care, and particularly the direct costs of HIV drugs, which the Health Committee cite repeatedly as exerting the most significant pressure on available sexual health budget allocations, dragging resources away from other areas of service provision. Noting estimates that providers are under-funded by some £3,000-5,000 per patient per year of

diagnosis, the Committee offer this rather stark warning: "Unless resources are allocated to increasing the capacity of HIV clinics and care teams in general, HIV patients will have to wait longer for shorter consultations."

Latest UK STI data

The Health Protection Agency's (HPA) Communicable Disease Surveillance Centre released data on the transmission of STIs during 2002 in July. These showed that overall, the trend in STI reports continues to head upwards, reflected by a 15% increase in visits to GUM clinics in England, Wales and Northern Ireland compared to the 2001 level.

Rates differ across diseases and population groups. Chlamydia, the most commonly reported STI, increased by 14% on the 2001 level, and the increase occurred across all regions and age groups. Syphilis reports rose by 67% in men and 33% in women, and by 68% in gay men. The largest increases were seen in London and Manchester. Genital herpes diagnoses increased by 1% in men and 4% in women, and genital warts by 3% in men and 1% in women. Reports of genital warts in gay men rose by 10%, and generally increased most significantly in London and the South East and in Northern Ireland.

Whilst reported gonorrhoea cases rose by 8% in men and 10% in women, rates in gay men fell by 5%. The drop was greater amongst gay men in London, where around half of all reported cases within this risk group occur – here the fall was 11%. There was no decrease in men between the ages of 16 and 24, however. And 40% of all female gonorrhoea cases occurred in women under 20 years old.

In a separate report on the recent spread of syphilis in the UK, also published in July, the HPA warned of a further outbreak of the disease, this time affecting heterosexual people in South London. Close to a three-fold increase in reported heterosexual cases has occurred in the last year compared to the number diagnosed in 2001. A number of cases have occurred in people buying or selling sex, and others in people reporting unprotected oral or vaginal sex with casual partners. An incident control team has been set up to monitor the problem.

health committee report

The House of Commons Health Select Committee report on sexual health is online at <http://www.parliament.thestationery-office.co.uk/pa/cm200203/cmselect/cmhealth/69/69.pdf>

department of health

The Government's *National Strategy on Sexual Health & HIV*, and supporting documents, are online at <http://www.doh.gov.uk/sexualhealthandhiv/sexualhealthandhivstrategy.htm>

uk statistics

HIV data in the UK is gathered by the Health Protection Agency's Communicable Disease Surveillance Centre, online at http://www.phls.org.uk/di/cdsc/hiv_sti.htm

get involved

The Terrence Higgins Trust's advocacy website is an easy route to supporting the Trust's ongoing campaigns in favour of prioritising HIV & sexual health, and against compulsory HIV testing of asylum seekers. Online at http://www.advocacyonline.net/eSite/tht/content_camp.jsp

sexual health crisis continued

Late diagnosis of HIV

HIV-related illness continues to be a present threat in industrialised countries such as the UK, particularly where HIV treatment is absent or – as is more often the case – begun late in the course of disease as a result of late HIV diagnosis. A further report from the HPA, presented at this summer's International AIDS Society conference in Paris, explored recent trends in disease progression at HIV diagnosis in England and Wales.

The study population included people aged 15 or over who were diagnosed with HIV in England and Wales between 1997 and 2002, and who were assumed to have contracted HIV either via sex or injecting drug use. Late diagnosis was defined in two ways – firstly, as any case where an AIDS diagnosis occurred in the same month, or subsequent month as an HIV diagnosis; and secondly, where a CD4 count performed within thirty days of an HIV diagnosis was below 200 cells.

With the inclusion of reports received by the HPA up to March of this year, there were 19,748 newly diagnosed cases of HIV in England and Wales during the study period. Yearly totals increased substantially between 1997 and 2002, a rise attributed to the growth in diagnoses amongst heterosexual people, who formed 39% of new diagnoses in 1997 and 65% in 2002. While the overall difference in numbers of white people and black African people diagnosed throughout the study period was not large, the trend over time was for diagnoses amongst black Africans to become more common, forming 47% of all diagnoses made in 2002, compared to 20% in 1997.

Thirteen per cent of all diagnoses occurred in the same month or subsequent month as an AIDS diagnosis. The frequency dropped from 20% of all HIV diagnoses in 1997 to 10% in

2002. By exposure category, late diagnosis was more common in male heterosexuals (19%) than in any other group.

Those people who had a CD4 count available within 30 days of their HIV diagnosis were included in a multi-variable analysis, a technique which allows the influence of a number of different factors (variables) to be analysed simultaneously. Regrettably, the frequency of missing ethnicity data (in part the legacy of our pre-2000 lab-based reporting system for HIV diagnoses, coupled with the continued practice of misreporting under the newer clinician-based system) meant that it was not possible to include ethnicity in the multi-variable analysis. Nevertheless, a number of interesting conclusions could still be made. Late diagnosis was more common in older people, and in people diagnosed outside London. Heterosexuals were more likely to be diagnosed late than gay men, and heterosexual men more so than heterosexual women.

The HPA attribute the fall in late diagnoses to a parallel rise in provision of HIV tests, up 90% over the last six years. If this is indeed the primary driver, then access to HIV testing will need to be protected if this encouraging trend towards earlier diagnosis is to be maintained. In the context of failing sexual health services and the inevitable questions about GUM capacity raised by the Health Committee, how might this be achieved?

Developments in HIV testing

In their revised approach to preventing the spread of HIV, published in April, the US Centers for Disease Control (CDC) stress the need to make HIV testing a routine part of medical care, and to implement new models for diagnosing HIV outside medical settings.¹ Though the CDC's emphasis on testing as an HIV prevention tool has had many detractors,

in a country whose undiagnosed HIV population runs to an estimated 250,000, and appears well-represented amongst the 41 million Americans who have no healthcare insurance, there are many voices in the HIV community who advocate that provision of HIV testing is overdue for a re-think.

At a US prevention meeting in July, Etzel² and colleagues from the University of California argued that voluntary counselling and testing paradigms in use today are little changed since their inception in the mid-1980s, when an HIV diagnosis presented social and personal risks which, if not absent today, are certainly much reduced – and afforded few medical benefits given the lack of effective treatments. For Etzel, the field needs to recognise that considerably improved prognosis, reduced stigma, and the association between HIV diagnosis and reduced risk-taking, all require a less equivocal attitude to testing.

An alternate model for one of Etzel's chief bugbears, the counselling provided prior to an HIV test, was recently tested amongst GUM clinic users at the Royal Hallamshire Hospital, Sheffield.³ A leaflet providing information about routine tests performed at the clinic, and much of the information usually given in pre-test discussion, was offered to all clinic attendees. Following its introduction, clinic doctors were more likely to offer an HIV test to attendees (perhaps because perceived time constraints associated with pre-test counselling were removed), and attendees were more likely to request a test.

A change in the HIV testing protocol at the GUM clinic at Preston Hall Hospital in Maidstone, from the traditional opt-in model to a model of opt-out screening, together with the introduction of an information leaflet to replace pre-test discussion, raised the uptake of HIV tests such that the clinic has already met the Government's 2004 target for increased HIV screening amongst GUM clinic users.⁴ It also increased the number of HIV diagnoses, including two cases in women who would have been viewed as 'low risk' under the previous system.

More debate needed

Important as these protocol changes are, they arguably fall short of the type of radical change

in HIV testing policies which are present in the US, if not universally adopted. The Government's vision for expanding HIV screening beyond GUM clinics is focussed entirely on our already over-burdened primary care services, settings which have not traditionally had a strong role in HIV prevention or care.

In the US, poor access to medical care amongst communities at risk of HIV infection, together with the recent approval of the *OraQuick* HIV test, which delivers a result from a finger-prick sample in twenty minutes, have encouraged an increasing number of community organisations to move into HIV testing. A rare UK example of this practice can be found at THT Lighthouse, which also utilises rapid testing technology, itself in use in very few UK clinics at present. A recent CDC-led study found that healthcare professionals were able to perform the *OraQuick* test successfully after a training session lasting just twenty minutes, suggesting expanded use of this technology need not be overly-complicated.⁵

The roll-out of antenatal HIV screening in this country did not occur until supportive information on the cost-effectiveness of any change in policy and practice became available. Again this appears to be an area where we lag behind the US. Health economists at Yale have recently demonstrated that three-yearly routine, voluntary HIV screening, when performed in all but the lowest incidence populations, can be justified on both clinical and cost-effectiveness grounds – and that a one-off screening of the entire US population might also prove cost-effective.⁶

In the US, the CDC are currently exploring the implications of allowing over-the-counter sales of the *OraQuick* test, whilst here in the UK, the inclusion of a question on home HIV testing in this year's *Vital Statistics*, an annual survey of British gay men's sexual attitudes and behaviour,⁷ may be a sign of the HIV prevention field's increasing willingness to question received wisdom about what works, and what's acceptable. Home testing would likely be met with hostility by many in the HIV community, but if we're serious about dealing with the sexual health crisis we're faced with, we may need to archive our more dogmatic positions.

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No NSF for sexual health and HIV

As this newsletter went to press, details emerged of the Government's response to June's damaging Health Committee report into sexual health, the subject of our lead article this month. Whilst sharing concern over the Committee's findings, the Government continues to have no plans to develop a National Service Framework for Sexual Health and HIV, one of the Committee's key recommendations, and a move which would have guaranteed 'priority status' to these areas in health commissioning strategies.

Standards on the provision of HIV treatments within managed networks, commissioned from the Medical Foundation for AIDS and Sexual Health, are to be published in October, and more covering sexually transmitted infections, reproductive health and psychosexual services are in development. The Government "expects" Primary Care Trusts to use these standards to inform service provision. News that sexual health continues to carry a very low profile in the delivery plans of Strategic Health Authorities (see below), suggests these expectations may go unmet.

An additional £11 million is to be provided to fund service improvements, the majority of which will be spent either on reducing waiting times for a GUM appointment, or on phasing-out a now discredited test used in the diagnosis of chlamydia. A new performance indicator for

GUM services is to be introduced, such that waiting times should not exceed 48 hours.

In recognition of the need to reduce undiagnosed HIV infection, an additional £400,000 is to be routed into health promotion work with gay men and people from African communities. These funds will be used to promote the benefits of HIV testing and to evaluate models of testing in community settings.

The British HIV Association's guidance on the use of HIV treatments received a clear endorsement over the Committee's suggestion that HIV drug therapy should fall under the remit of the National Institute for Clinical Excellence. Countering any suggestion of significant problems regarding access to HAART, the Government note BHIVA's recent audit of HIV clinical care which found no evidence that therapy was being withheld where clinically indicated.

Reference: The Government response to the Health Committee report on sexual health, session 2002-3 is online at http://www.doh.gov.uk/sexualhealthandhiv/pdfs/response_to_health_select_comm_three.pdf

HIV missing from local health plans

Strategic Health Authorities continue to leave HIV and sexual health off their plans for

healthcare purchasing and provision, in favour of disease areas Government itself has marked out as higher priorities. A survey of Local Delivery Plans, performed by a group of HIV and sexual health organisations, found less than a third made any mention of HIV. Despite the acknowledged poor state of sexual health service provision in the UK, none made a commitment to improve the standard of service available, or to any additional investment.

Twenty-four of 28 Strategic Health Authorities in England (the tier above Primary Care Trusts, which purchase healthcare on behalf of local residents) provided their Local Delivery Plans for 2003 to 2005 for review by THT, National AIDS Trust, Medical Foundation for AIDS and Sexual Health, Brook and fpa. Of the seven plans which mentioned HIV, five were in London and two in Southern England, implying a North-South divide remains a feature of HIV commissioning, despite the guidance on HIV and sexual health targets contained in the Government's *National Strategy on Sexual Health and HIV*.

Other areas of sexual health fared little better. While sexual health featured in 40% of submitted plans, and teenage pregnancy in 62%, none mentioned contraception and abortion services.

Reference: Report online at <http://www.tht.org.uk/report.htm>. Details of your local Strategic Health Authority are online at http://www.nhs.uk/root/localnhsservices/list_orgs.asp?ot=Q__

Patient & public involvement sought

NHS users are being given the opportunity to voice their opinions about health policy in new consultative forums being established by the Government. Recruitment to the new, independent, Patient and Public Involvement (PPI) Forums is open until December. According to the Government, it is hoped that the PPI Forums "will play a vital role in making sure patients' and the public's views are heard and acted upon by all those involved in making decisions about health."

Just under 600 PPI Forums will be established across the UK, and the government is hoping that they will act as an independent watch on the quality of local healthcare, as well as helping to shape health policy.

A majority of PPI Forum members will be patients and members of the public, but it is also intended to involve voluntary and community organisations with an interest in healthcare.

For more information on recruitment, an application pack can be requested by calling 0845 120 7115. Information is provided online at <http://www.maketimeforhealth.org/>

News from NAM

NAM's Director, Caspar Thomson writes: This issue of *AIDS Treatment Update* marks the end of an era. It is the final issue, after five years, to be edited by Anna Poppa. Anna joined NAM in July 1998 bringing with her a wealth of HIV knowledge and experience gained from her roles as Head of Health Promotion at Body Positive London, and Editor of the *Body Positive Newsletter*. Barely a year after the introduction of HAART in the UK this was a period of considerable, exciting and fast moving change in HIV treatment. ATU played a very important role in enabling people to keep abreast of new developments and in helping them to make sense of the changing landscape. Always quick to identify emerging issues, ATU has often cut the news, drawing new concerns to the attention of the HIV community. Today it holds a position as one of the most authoritative sources of HIV treatment information available and we are very grateful to Anna for what she has achieved.

A recruitment process is underway for Anna's successor and, in the meantime, one of our regular contributors, Edwin J Bernard has kindly agreed to take on the role of Acting Editor. Anna goes on to develop her freelance medical education consultancy and we wish her well. As Editor of ATU she has made an important contribution to the lives of people living with HIV. As a reader wrote, following ATU's 100th edition: "Thank you for playing your part in keeping me alive."

hiv scotland on the web

HIV Scotland, a voluntary sector policy organisation which supports the work of the HIV voluntary sector, has launched a new website for all things Scottish and HIV-related. The site features the excellent HIV Scotland Update, a monthly electronic newsletter of news, information and policy on HIV trends, treatments, national and international developments.

Reference: <http://www.hivscotland.com>



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about NAM

NAM is a charity that exists to support the fight against HIV and AIDS with independent, accurate, up-to-date and accessible information for affected communities, and those working to support them.

For more information, and details of our other publications and services, please contact us, or visit our website, www.aidsmap.com.

disclaimer

The publishers have taken all such care as they consider reasonable in preparing this newsletter. But they will not be held responsible for any inaccuracies or mis-statements of fact contained herein. Inclusion in this newsletter of information on any drug or clinical trial in no way represents an endorsement of that drug or trial. This newsletter should always be used in conjunction with professional medical advice.

thanks to our funders

NAM's treatments information for people living with HIV is provided free thanks to the generosity of:

African HIV Policy Network, British HIV Association, International HIV/AIDS Alliance, Scottish Voluntary HIV & AIDS Forum, The European Commission, Government of the United Kingdom - Department of Health, London HIV & GUM Commissioning Consortium, Birmingham area PCTs, East Surrey area PCTs, East Sussex, Brighton & Hove area PCTs, Manchester area PCTs, Manchester City Council, Newcastle PCT, Norfolk area PCTs, Salford Primary Care Trust, South West Essex PCTs, South East Essex PCTs, Stockport Social Services, Trafford North PCT, Trafford South PCT, West Sussex area PCTs, ActionAid, Crusaid, The Elton John AIDS Foundation, Lloyds TSB Foundation for England & Wales, M·A·C AIDS Fund, Peter Moores Foundation, St Stephen's AIDS Trust, Supporting the International Partnership Against AIDS in Africa (SIPAA), Abbott Laboratories, Boehringer Ingelheim (UK & International), Bristol-Myers Squibb Pharmaceuticals, Delphic Europe (for Tibotec Virco), Gilead Sciences, GlaxoSmithKline, Merck Sharp and Dohme, Positive Action GlaxoSmithKline, Vertex Pharmaceuticals, Visible Genetics, Roche Hepatitis C, Roche Molecular Diagnostics, Roche Products.

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To begin your subscription simply complete the form opposite and return it to NAM, or call or email us.

AIDS Treatment Update is also available on audio tape, and can be emailed to you as a pdf file. Call NAM on +44 (0)20 7840 0050 for details.

any questions

for an introduction to HIV treatment issues

NAM's information booklets are free to people with HIV. Titles include: **adherence, anti-HIV drugs, clinical trials, glossary, HIV & hepatitis, HIV therapy, lipodystrophy, nutrition, resistance, and viral load & CD4**. Please contact NAM for your copies.

HIV & AIDS Treatments Directory

This is a comprehensive guide to the medical aspects of HIV. Available at only £12.95 to people with HIV and £64.95 to professionals. Please contact us to order your copy.

www.aidsmap.com

Visit our website for the latest news and conference reports, a fully searchable treatments database, and The Wheel – your personal pill planer.

information forums in London

Each month an expert speaker discusses an HIV treatment-related topic. Entry is free. Future forums are advertised inside this newsletter and on our website.

THT Direct Phoneline

0845 1221 200
Mon-Fri 10am-10pm Sat-Sun 12-6pm

i-Base Treatment Phoneline

0808 8006013
Mon-Wed 12-4pm

NAM recommends that you discuss all your treatment decisions with your doctor.