HIV PREVENTION AND THE WIDER UK POPULATION

What HIV prevention work should be directed towards the general population in the UK?

1. Background

The early years of the HIV epidemic in the UK were characterised by a number of high profile public information campaigns warning people of the risks of HIV infection and advising the sexually active population to adopt safer sex behaviours to avoid infection. Two of those most often recalled are the 'icebergs' and the 'tombstone' campaigns.

Over time HIV prevention resources and interventions became focussed on those most at risk of HIV infection in the UK – men who have sex with men (MSM) and, more recently, also African men and women. There are national HIV prevention programmes for both these communities (CHAPS for MSM and NAHIP for African men and women) as well as targeted work at a local level. There have been no HIV prevention campaigns aimed at the general public for many years in the UK and general sexual health campaigns aimed at younger sexually active heterosexuals – such as 'Condom Essential Wear' and 'Sex Worth Talking About' have consciously omitted HIV from their messages.

There remains a statutory requirement in England that all children are taught the biological facts about HIV, but this information is limited in scope and variable in quality. Sex and relationships education (SRE) is only compulsory in Wales and Northern Ireland - and in all four nations of the UK much more needs to be done to ensure consistent high quality education on HIV for young people. More information on what NAT is doing to secure effective HIV education in schools can be found on our website (www.nat.org.uk).

2. What do we know about public understanding of HIV transmission risk?

Research commissioned in 2000, 2005, 2007 and 2010 from Ipsos MORI by NAT has documented a decline in public knowledge about how HIV is transmitted. In 2000, for example, 91% of respondents knew that sex without a condom between a man and woman could result in HIV being transmitted but by 2010 it was 80%. There had been a similar decline from 88% to 80% in those who knew of HIV transmission risk from sex without a condom between two men. There was also very low knowledge of HIV risk from sharing needles or syringes with only 45% of respondents identifying this as a way HIV can be passed from person to person in 2010. There was particularly poor understanding of HIV transmission risk in London, although London has the highest rates of HIV in the UK. In all the surveys ignorance of HIV transmission risk was strongly associated with more negative and judgemental attitudes towards people living with HIV.[1]

[1] NAT 2011 'Public Attitudes towards HIV 2010'

The 2010 survey also asked respondents whether they agreed with the statement, 'I know enough about how to prevent HIV transmission during sex'. Whilst 75% said they agreed with this statement, 11% did not and 6% were unsure. Furthermore, men were more likely to disagree with the statement than women (14% vs. 9%), and there were higher rates of disagreement amongst young people aged 16-24 (18%) and single people (15%). Those who disagreed with the statement (i.e. thought they did not know enough to protect themselves from HIV infection) were less likely to identify sex without a condom as an HIV transmission risk compared with respondents overall - in other words, they tended to be right in their concern.

3. Who is at risk of HIV infection in the UK?

It is important to distinguish between HIV diagnoses in the UK and HIV infections in the UK. Many of those diagnosed in the UK have in fact been infected overseas. If we are to assess vulnerability to HIV infection as a basis for where to target HIV prevention work, we should identify who is actually being infected in this country and who may be protected by appropriate preventive measures.

Over the last five years, where probable place of infection is reported, amongst MSM diagnosed with HIV about 82% have been infected in the UK and 18% abroad. Amongst heterosexuals, where probable place of infection is reported, over the last five years 30% have been or have possibly been infected in the UK and 70% abroad (mainly in Africa). (If you remove those possibly infected in the UK and look only at those confidently reported as infected here, over the last five years 22% of heterosexuals diagnosed with HIV have been infected in the UK.)

So if you look beyond diagnosis to likely place of infection for all people diagnosed in the last five years who were sexually infected with HIV, 44% of them were infected in the UK. Of those infected in the UK, 65% were MSM and 35% were heterosexual. MSM therefore remain the group most vulnerable to HIV infection in the UK.

It should be noted, however, that over recent years the number and proportion of those infected heterosexually in the UK has been increasing, though from a low base. Of the total newly diagnosed infections acquired heterosexually, the estimated proportion acquired in the UK increased from between 15% and 21% (694 - 966/4,699) in 2003 to between 23% and 33% (749 - 1,052/3,204) in 2009.

The Health Protection Agency (HPA) estimates that in 2009 there were 3,500 UK-acquired infections newly diagnosed. Out of this number between 20 and 25% (700-875) were neither Africans nor MSM.[2] There was a similar percentage for the preceding few years.

The 'non-African/non-MSM public' accounts of course for the overwhelming majority of people living in the UK. So HIV prevalence in this group remains extremely low - at fewer than 1 in 1,000. But it is clear that this group does make up a significant percentage of new HIV infections occurring in the UK, with major implications of course for those infected and related care and cost implications for healthcare and wider support services.

4. How are non-African heterosexuals being infected in the UK?

The Health Protection Agency does attempt to collect data on who someone newly diagnosed with HIV was infected by, but this information is not always filled in and there are difficulties in interpreting the data received. Amongst the African men and women infected in the UK it does appear that the significant majority of their partners were themselves African. Amongst white British men and women infected the picture seems more mixed (as well as incomplete). Whilst significant percentages of partners were African, comparable percentages of partners were from the UK. It is not apparent how many of the men who infected women with HIV have also had sex with men.[3]

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[2] HPA communication to NAT
[3] This information communicated from the HPA.

Of the approximate 3,700 UK born adults (aged 15 years or above at diagnosis) diagnosed in the UK between 2002 and 2010 who acquired HIV through heterosexual contact and who are of non black-African ethnicity, around 1,300 acquired HIV whilst travelling abroad.

5. What are the implications for HIV prevention in the UK?

We are seeing a gradual increase in the number and percentage of heterosexuals being diagnosed with HIV, having been infected in the UK, who are not African. There is also evidence of an increasing number of British heterosexuals getting HIV when travelling abroad, especially in South East Asia, and to a lesser extent the Caribbean, and often from sex with commercial sex workers.

There are no national or local HIV prevention programmes which target the wider heterosexual population and NAT's research demonstrates a declining knowledge in the general population of the key ways in which HIV can be transmitted.

An HIV prevention campaign for the whole population designed on the same basis as the targeted programmes for MSM and black Africans will simply not be cost effective, given the low risk for non-African heterosexuals in terms of HIV prevalence and incidence in this group. But on the other hand the absolute numbers of non-African heterosexuals living with HIV are not insignificant and the principle of universal access to appropriate HIV prevention means that doing nothing is also unacceptable and a denial of the right to health.

A number of approaches are possible to meet this HIV prevention need:

- ***Integrate HIV into wider sexual health information and campaigns.***

The most recent sexual health campaigns targeting younger people referred to a number of STIs but omitted HIV. NAT expressed concern at this omission and the Department of Health responded positively to our point and agreed to include reference to HIV in future campaigns. There have, however, been no major new campaigns developed since the change of government in 2010.

This leads to a wider question of whether we have in the UK sufficient and appropriate sexual health information and campaigns aimed at the general public. In particular in relation to HIV and certain other STIs there is a question as to whether sexual health campaigns focussed exclusively on younger people are adequately meeting the needs of older adults who may be at risk . The median age for HIV diagnosis is 35 and 21% of people living with HIV are over 50.

More broadly, and looking beyond specific 'campaigns', there are numerous websites and resources which provide sexual health and safer sex information to the general public. HIV should be identified in these resources as a risk in unsafe sex (though of course less likely to be transmitted than many other STIs) and clear and accurate information should be provided on HIV, how to prevent its transmission and what to do if you have put yourself at risk.

- ***Consider broader HIV prevention campaigns in areas with high HIV prevalence.***

New UK National HIV Testing Guidelines recommend routine HIV testing for all new GP registrants and all general medical admissions in PCTs with significant HIV prevalence (2 or more per 1,000 diagnosed with HIV, which is deemed to mean probably 1 or more per 1,000 undiagnosed). This raises the interesting question of whether, given the prevalence, wider HIV prevention work targeted at the whole local population may also be effective. Of course the main beneficiaries of such HIV prevention work will be those in the communities most at risk (and especially those who do not access community media and settings where targeted work and materials may be available). But there would also be a benefit to those non-African heterosexuals in those areas.

- ***Encourage people to think about the risk of HIV from their own, and their partner's, previous sexual partners.***

Although improved data collection is needed, it does appear that a significant group of non-African heterosexuals infected with HIV are people who have a sexual partner from a high prevalence community, be it an MSM or someone from a region of high HIV prevalence (for example, sub-Saharan Africa or the Caribbean).

It is important when considering HIV prevention messages to avoid stigmatisation. But it may be possible to state simply that there is a particular risk of HIV infection to MSM, African heterosexuals, injecting drug users, and to their sexual partners. An open discussion of the possible risk of HIV infection will inform sexual behaviour and encourage safer sex and HIV testing.

- ***Raise awareness of the risk of HIV infection when travelling abroad.***

To address the increasing number of British heterosexuals acquiring HIV when travelling, information and advice around the need for safer sex when abroad and the exploitative nature of commercial sex work, particularly in South East Asia and the Caribbean, should be widely distributed. The HPA, Foreign & Commonwealth Office (FCO), GPs, travel agencies and tour operators should work together to disseminate effective information to reduce HIV transmissions amongst British travellers abroad.

- ***Integrate HIV prevention information into wider anti-stigma campaigns.***

Evidence from NAT's public attitudes surveys suggests a close association between good knowledge of how HIV is transmitted and supportive, non-stigmatising attitudes to people living with HIV. HIV stigma and discrimination remain far too pervasive and NAT recommends a national strategy to address HIV stigma and discrimination.

Anti-stigma initiatives whether national, local or developed for specific settings (for example, the NHS or the police), including accurate information as to how HIV is and is not transmitted in the UK, and on how to avoid infection, can both reduce stigma (which is itself a preventive benefit) and inform the wider public on how to have safer sex.

- ***Ensure sex and relationships (SRE) in schools is compulsory and consistently includes good information on HIV and how to avoid HIV infection***

This paper has primarily focussed on communicating directly on HIV with the wider UK adult population. But we must also invest in future generations. At this early stage in life it is of course impossible to know how each young person's sex life will develop, the sexual partners they will have and the choices they will make. Investing in comprehensive, high quality SRE around HIV meets the needs of young gay and bisexual men, of young people from higher prevalence communities and of the young sexually active population generally who may in the future need HIV-related information in order to stay safe.

- ***Establish a national HIV prevention programme which includes the prevention needs of the wider public, in addition to gay and African communities, within its remit***

Current national HIV prevention programmes for MSM (CHAPS) and African communities (NAHIP) have historically agreed a framework to guide prevention work in the relevant community, as well as funding national research and materials to support these aims. Funds are currently also available to catalyse activity at a local level (but not to replace local funding).

The HIV epidemic in the UK has, however, changed. With nearly 25% of newly infected people no longer being either MSM or African men and women, it is vital that the needs of the wider population are now addressed at a national level. It may be best to have a single national HIV prevention programme which covers both wider population work and targeted work focussing on the needs of MSM and African men and women.

It will be particularly important that Public Health England also encourage and supports local authorities to take account of the wider HIV prevention needs of their community in their local Health and Wellbeing Strategies.

6. What further research is needed?

More research and data are also needed as we consider the case for wider HIV prevention work, beyond that targeted at most at risk groups.

- The HPA should be supported in asking for fuller information from clinics on the details of those diagnosed and their sexual partners.
- The impact, reach and effectiveness of any initiatives to provide the wider population with HIV prevention information should be evaluated.
- Questions about sexual behaviour and HIV testing should continue to be included in broader health surveys (such as the Health Survey for England and the NATSAL survey) and the frequency of data collection should be increased to monitor changes in behaviour.
- Research would be useful on the extent to which HIV education and prevention initiatives aimed at the general public reach at risk groups, supplementing, as opposed to merely duplicating, targeted prevention work.

NAT

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