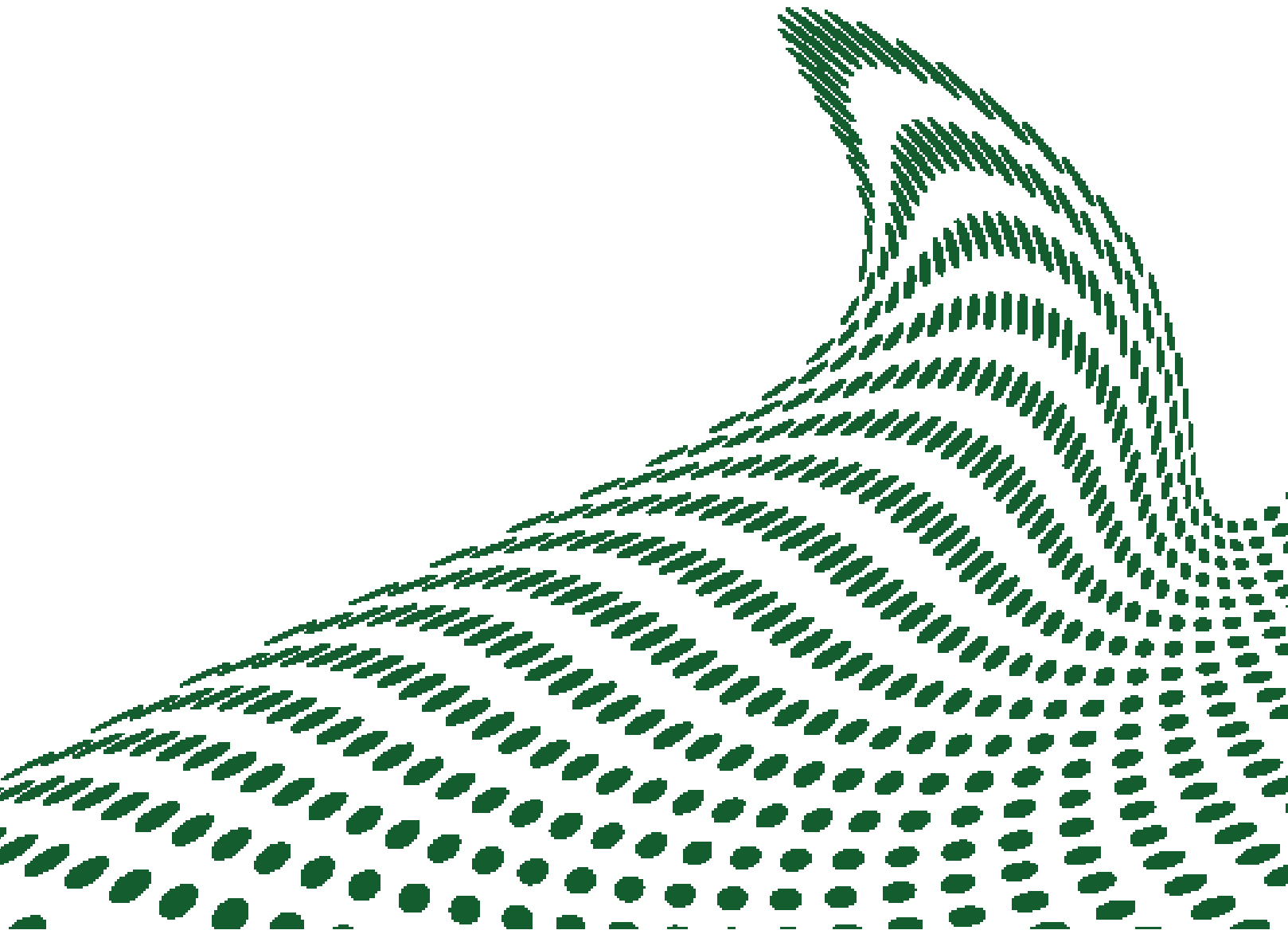
## Future Commissioning of London HIV Prevention Services
### Project Steering Group

# HIV Prevention Needs Assessment for London



This report was commissioned by the Association of Directors of Public Health (ADPH) London and written by Elaine Rashbrook

Public Health England

LONDON COUNCILS

In February 2013 the Leaders' Committee at London Councils recognised the shortcomings of the Pan London HIV Prevention Programme (PLHPP) approach to HIV prevention. In response, the Association of Directors of Public Health (ADPH) London, working with London Councils, designed the Future Commissioning of London HIV Prevention Services (FCLHPS) Project to oversee a London-wide needs assessment over the summer of 2013. The FCLHPS project included six work streams:

- Epidemiological review
- Evidence review update
- A Call for Evidence
- Stakeholder engagement
- Segmented insight research
- Mapping of current HIV prevention.

The overall findings of the needs assessment are published in this report. ADPH London and London Councils will develop an options paper for a meeting of the leaders of the 33 councils in London, due to take place in November 2013.

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Acknowledgements:

With thanks to colleagues and members of the steering group who have contributed to this report.

## London HIV prevention needs assessment – a report for the Steering Group

Introduction

- Julie Billett, Chair of the HIV Prevention Needs Assessment Steering Group and Director of Public Health, Camden and Islington

Forewords

- Councillor Teresa O'Neill, Vice Chair, London Councils and Executive Member for Health
- Dr Yvonne Doyle, Regional Director, Public Health England (London) and Professor Kevin Fenton, National Director Health and Wellbeing, Public Health England

## Introduction by Julie Billett, Chair of the Steering Group and Director of Public Health, Camden and Islington

This report presents the findings of an HIV prevention needs assessment for London, undertaken between June and October 2013, on behalf of the London Directors of Public Health. It draws out the key findings of the various workstreams that made up the needs assessment, and the implications of these findings for the future of HIV prevention programmes and services in London.

My hope is that this report and the more detailed, companion reports from each workstream, will be used by Local Authorities, service providers and users across London to inform and support future commissioning and delivery of HIV prevention services. The outputs from this needs assessment are intended to complement more detailed local intelligence, analysis and assessments of need.

The needs assessment was overseen by a multi-disciplinary steering group, comprising representatives from Public Health England, London Councils, HIV and sexual health commissioners, several fellow Directors of Public Health, and epidemiological and academic experts in the field of HIV. I would like to thank all members of the steering group for their time, expertise and invaluable contributions to the task of guiding and overseeing this work. My thanks also go to Elaine Rashbrook for her hard work in writing this summary report and assuring the quality of the needs assessment process and its outputs, as well as to other colleagues at Public Health England for their advice and ongoing support in relation to this important public health challenge. I would also like to thank everyone who led and contributed to the individual workstreams, including the many and varied stakeholders and service users who shared their rich and thoughtful insights with us. Finally, my particular thanks go to Fraser Serle and the project team for all their hard work in coordinating, supporting and driving this programme of work forward.

**Foreword by Councillor Teresa O'Neill, Vice Chair, London Councils and Executive Member for Health**

On 1 April 2013, local authorities took over a range of public health responsibilities, among them HIV prevention. We have been delighted to welcome public health back into local government and are committed to delivering successfully on these agendas for our citizens and communities.

In London we face a significant public health challenge with the highest prevalence of HIV across the UK. The recent evidence of an increase in new HIV diagnoses – reversing a previous downward trend since 2003 – shows that boroughs are taking on these new responsibilities at a time when we need to refocus attention and energies.

There are real advantages to be gained through local authorities' leadership on HIV prevention. We are able to use our detailed knowledge of our local communities and their needs to tailor approaches and to link up with wider services. Through the London Directors of Public Health and London Councils, on the project to deliver this needs assessment and in many other ways, boroughs have also demonstrated that we can work effectively together where this adds value.

As you would expect from organisations that have faced a 35% cut in funding in the last 4 years, and are facing further cuts in the future, all local authorities will be very focused on getting value for money for every penny of taxpayer funding we spend. In all our HIV prevention commissioning we will be looking for real evidence of impact, while keeping costs to a minimum.

This needs assessment is therefore a welcome tool that brings together the latest evidence of what works in HIV prevention. It will provide a useful source of information to underpin local commissioning decisions and help boroughs to target their spending to greatest effect.

We will want to keep the needs assessment up to date, through reviews at appropriate points. It is therefore vital that robust evaluation forms a regular part of all services and that we all learn from experience to continue to hone services so that they meet the needs of people most at risk of contracting HIV. I welcome Public Health England's role in helping to complete this needs assessment and their offers to continue to work with boroughs to help them to prevent the spread of HIV in the capital.

**Foreword by Dr Yvonne Doyle, Regional Director, Public Health England (London), and Professor Kevin Fenton, National Director of Health and Wellbeing, Public Health England**

HIV is a major public health issue for London. The latest figures show that, in 2012, 2,832 people were newly diagnosed with HIV across the Capital. This represents almost half (48%) of all those newly diagnosed in England. HIV is tightly bound up with health inequalities – 57% of new infections were reported in men who have sex with men (MSM) and 27% in people of black African heritage. HIV is also implicated with the hepatitis viruses and other sexually transmitted infections (STIs), including shigella.

Although there are considerable variations across London, the city has consistently high rates of HIV infection. Thirty two of the 33 boroughs are areas of high HIV prevalence (>2 cases of diagnosed HIV per 1,000 population).

Advances in therapy mean that people living with HIV who are diagnosed in time and access high quality care can, in 2013, have a near normal life expectancy. It is a matter of considerable concern that an estimated one in five people living with HIV in London are unaware of the fact. Almost half (44%) of people with HIV are only diagnosed once the infection is in its later stages. Prompt diagnosis is the gateway into treatment and care, with better health outcomes for the individual, coupled with reduced infectiousness and less risk of onward transmission of HIV. The importance of reducing late presentation of HIV is reflected by its inclusion within the Public Health Outcomes Framework (PHOF), which gives a necessary focus to reducing the number of "people presenting at a late stage of diagnosis".

The responsibility for HIV prevention commissioning is now with local authorities who are well placed to respond to the particular needs of their communities by securing locally sensitive HIV prevention interventions. Reaching people and populations most at risk of contracting or transmitting HIV, promoting relevant messages about HIV prevention, ensuring easy access to testing with seamless transition to high quality care for people who test HIV positive, coupled with services that foster positive attitudes, increase knowledge and encourage healthy behaviours are all key features of an effective HIV prevention programme.

This needs assessment is a crucial step in moving the London HIV prevention agenda forward. Bringing together the work commissioned by the London Directors of Public Health, led by Julie Billett, Director of Public Health, Camden and Islington, it draws on published literature, intelligence about what works in practice, the views of key stakeholders and service users, flagging up the acceptability of, and preferences for, particular interventions and approaches, pointing to those areas where attention should be focused to deliver the best possible outcomes. Now commissioners from across the system, service providers and the public must act on

this report, working collaboratively to reduce HIV acquisition and transmission in the Capital.

This is an unprecedented opportunity for London amongst the greatest of global cities to demonstrate real leadership on changing the trajectory of this complex epidemic. Through the promotion of cohesive, collaborative, joined-up working, by adopting innovative approaches to secure early diagnosis and intervention, whilst integrating cutting edge behavioural and biomedical approaches, there is a chance to end the epidemic.

Dr Yvonne Doyle  Professor Kevin Fenton

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In this report, the following terminology is used to describe people affected by HIV and HIV prevention interventions.

**MSM** – men who have sex with men. This includes not only men who define themselves as gay or bisexual but all men (including those who might define themselves as heterosexual) who may have sex with men. (The term defines the sexual route through which men may be exposed to the risk of HIV, rather than the sexual orientation by which the individual may define themselves).

**Black African** – this includes people with black African heritage. This is the standard ethnic group category used in the 2011 UK census and in the epidemiological review which forms part of this needs assessment. This term and definition is also used in NICE guidance on increasing the uptake of HIV testing among black Africans in England (March 2011).

**PWIDs** - people who inject drugs. People injecting any substance including: crack cocaine, opiates, performance/image enhancing drugs (including steroids) and novel psychoactive substances (also referred to as legal highs/party drugs).

**Sex workers:** people who provide sexual services to another person in return for some form of payment.

# Executive summary and recommendations

This report presents the findings of an HIV prevention needs assessment for London, undertaken between June and October 2013, on behalf of the London Directors of Public Health. It draws out the key findings of various workstreams that were commissioned as part of this needs assessment, and their implications for the future of HIV prevention programmes and services in London. The aims of the needs assessment were to:

- Describe and understand the changing epidemiology of HIV in London;
- Provide an overview of HIV prevention services and programmes currently provided across the capital;
- Review the evidence for the effectiveness and cost-effectiveness of HIV prevention interventions; and
- Capture a wide range of stakeholder views on current and future HIV prevention services in London.

It is hoped that this report and the other published outputs from the needs assessment will serve as a useful resource for London boroughs when commissioning HIV prevention services to meet the needs of their local populations. The question of what HIV prevention services could be commissioned at a London level is not specifically addressed within this report, but is the subject of a separate options paper, which drew heavily on the findings from this needs assessment.

HIV continues to be a major public health issue for London, with 2,832 people newly diagnosed HIV positive in London in 2012. This reverses the trend of decreasing incidence seen between 2003 and 2011. Of those people newly diagnosed in 2011, almost a third of people were born in the UK, 46% were white, 27% were black and 74% were men. Men who have sex with men (MSM) accounted for 57% of all new cases. The median age for diagnosis in 2011 was 36 years, the same as 2010. Of note is that the proportion of new cases in people age 50 or more is rising.

Due to the high quality of clinical care in England and improvements in antiretroviral therapy (ART) a majority of people who are HIV positive and have been diagnosed promptly can expect a near normal life expectancy. There are over 32,000 people living with HIV in London who are accessing treatment and care. However, one in five Londoners with HIV is undiagnosed and it is estimated that over 50% of all HIV transmissions are associated with people who are not aware they are HIV positive. Based on 2012 data, all London boroughs, with the exception of Havering, now have a prevalence level at which HIV testing should be expanded. Rolling out HIV testing at sufficient scale and with pace into clinical settings other than sexual health services, and into targeted non-clinical settings, is an important part of finding those

people living with undiagnosed HIV and referring them into treatment and other services.

The burden of HIV falls disproportionately on two main populations, MSM and black Africans, both of which are very diverse groups. There are smaller significant groups 'at risk' of HIV and these include people who inject drugs (PWID) and sex workers. People living with HIV are also an important target group in terms of secondary prevention.

The process of developing this needs assessment has been constrained by some practical and methodological constraints and limitations, and has highlighted gaps in our knowledge. This report is a pragmatic, not academic, document which has been produced within a tight timeframe. By necessity, this meant that the scope of the needs assessment was limited. For example, it does not include a theoretical framework for behaviour change or an up-to-date review of changing knowledge, attitudes and behaviours amongst key populations at risk of HIV. During the course of this work, it also became apparent that there are significant gaps in the evidence (particularly in relation to the cost-effectiveness of HIV prevention interventions).

HIV prevention services are currently provided across London through several programmes. Despite difficulties in identifying and quantifying exact levels of spend on HIV prevention, it is possible to make the following observations.

- Since April 2013, boroughs have commissioned HIV prevention services to meet local needs. The annual budget allocated to HIV prevention varies between boroughs but amounts in total to an estimated £10.5m. This figure includes some social care and support services for PLWHIV, as well as some wider sexual health programmes.

- In 2013/14, on an interim basis pending completion of this HIV prevention needs assessment, London boroughs agreed to extend some contracts that had formed part of the previous Pan-London HIV Prevention Programme (PLHPP) the previous year. This previous programme has been funded by all London PCTs and the contract was due to terminate on 31 March 2013. In 13/14 the £1.03m budget funds five projects aimed at men who have sex with men (MSM), and contributions from boroughs are weighted according to HIV prevalence.

- The national HIV Prevention England (HPE) programme is a three year, Department of Health-funded programme running from 2012 through to 2015. Of the £2.45m annual national programme budget, £955k is spent with specific benefit to London; £400,000 of this is spent on social marketing and digital/online health promotion services. The HPE programme also supports

additional, locally focused programmes for black Africans and MSM in London.

In terms of what we know works in HIV prevention, based on the findings of the evidence review undertaken in 2011, and updated in 2013 as part of this needs assessment to include any recently published reviews and primary studies, effective interventions broadly fall into the following categories:-

- ***HIV testing***: Testing is a critical component of prevention efforts because when people learn they are infected, they can take steps to protect their own health and prevent HIV transmission to others. Linkage into HIV care pathways helps ensure people diagnosed with HIV receive timely treatment and care, leading to improved outcomes for the individual and helping to reduce their risk of transmitting HIV to others. Negative tests also provide an opportunity for behaviour change.
- ***Condoms:*** People who are living with, or at risk of HIV infection should have easy access to condoms. The availability of low or no costs condoms is an important measure to reduce HIV and STI risk in a range of target populations, including MSM, people from African communities, young people, people living with HIV and sex workers. Condom distribution also provides an opportunity to deliver key sexual health and HIV promotion and prevention messages.
- ***Information and awareness rising through a range of communication channels and media:*** Evidence supports the use of mass media campaigns in raising awareness and increasing uptake of testing and signposting to services, and there is an emerging evidence base for the delivery of targeted HIV prevention messages using the internet and social media. Such technologies potentially offer greater reach in certain target populations.
- ***Outreach interventions:*** Interventions that engage with people in target population groups in their own social, community or other settings/environments can be effective in increasing knowledge and awareness, reducing sexual risk behaviours and increasing testing. Such interventions need to be targeted and tailored to fit with the culture and environment in which they operate. The outcomes achieved by such interventions and approaches will differ according to specific outreach intervention type.
- ***Behavioural interventions:*** Individual and small-group behaviour change interventions have been shown to reduce risk behaviours among people living with diagnosed HIV, as well as in people who are at high risk of HIV infection.
- ***Educational, knowledge and skills-based interventions***: Educational, information and skills-based interventions, including sex and relationships education in schools, but also educational and knowledge-based interventions

in other settings, can be effective in increasing knowledge and awareness of HIV and sexual health risks and measures to reduce risk.

- ***Harm reduction measures in people who inject drugs (PWID):*** Substance misuse treatment and needle exchange schemes are both effective measures for reducing HIV transmission in PWID.

The evidence review also noted an emerging evidence base in relation to new biomedical and technological innovations, such as the use of HIV medications prophylactically (pre-exposure prophylaxis or PrEP) in high risk HIV negative people, and home testing and sampling.

Detailed below are those effective interventions supported by the 2011 and 2013 evidence reviews, in relation to specific population groups:-

***Adult men (general population):***
2013 review: educational interventions (particularly information/knowledge-based interventions).
2011 review: skills building (general), interpersonal skills training, counselling, testing/screening, service promotion and peer group support.

***Adult women (general population***):
2013 review: educational, supportive and media interventions.
2011 review: information/knowledge, skills building (general) and interpersonal skills training.

***MSM****:*
2013 review: limited evidence of effectiveness for motivational interventions, and evidence for education and health promotion, supportive approaches, media interventions and pre-exposure prophylaxis (PrEP).
2011 review: group interventions, behavioural interventions (to reduce risky sexual behaviour), counselling and cognitive behavioural therapy (CBT) interventions, condom schemes (supported by grey literature only), testing (supported by NICE guidance), screening, interpersonal skills training, skills building (general), peer support.

***Black African groups***:
2013 review: behavioural, educational, media and supportive interventions.
People living with HIV: motivational interventions for reducing risky sexual behaviour; education, supportive and media interventions.
2011 review: information/knowledge, skills building, screening/testing, interpersonal skills training, counselling, condom distribution and media.

***People who inject drugs (PWIDs):***
2013 review: opioid substance therapy and education/supportive interventions.

2011 review: information/knowledge, interpersonal skills training, condom skills training, condom distribution, peer support, antiretroviral therapies, needle exchange schemes.

***Sex workers***:
2013 review: supportive (counselling) interventions.
2011 review: peer to peer interventions at community level to reduce sexual risk behaviour (only tentative evidence).

***Adolescents***:
2013 review: supportive, education, media and testing interventions.
2011 review: information/knowledge, skills based, including skills building (general), interpersonal skills training, condom-use skills, training and role playing.

Members of the public involved in the focus groups and some stakeholders expressed support for a broader population approach to HIV prevention, as there are concerns about the stigma associated with interventions targeted at specific communities. Members of the public in key target groups for HIV prevention have trust in the NHS brand and access health information from a range of sources, particularly the internet.

The following recommendations are made to support and inform the future of HIV prevention commissioning in London:

## Strategic recommendations

1 There would be value in establishing a vision for HIV prevention in London and a clear strategic framework for the commissioning and delivery of HIV prevention programmes and services across the capital. Such a vision and framework should be designed to support and enable borough-led commissioning of HIV prevention services, increase coordination between borough, London and national activities, and enhance value through supporting increased consistency and quality of interventions and services, and sharing of information about new evidence and evaluations. London's unique features, such as high levels of population mobility and migration, and the nature of HIV as a communicable disease that does not respect borough boundaries, requires effective coordination of responses across London.

2 The significant opportunities afforded by local authority commissioning of HIV prevention services should be maximised. As well as integrating HIV prevention into wider sexual health services and programmes, there are potential opportunities to address HIV and sexual health risks alongside other risk behaviours, for example, alcohol and substance misuse. There are also

opportunities to use Councils' leverage and sphere of influence in relation to the wider determinants of health to reach and support populations at increased risk of HIV.

3 HIV prevention should be firmly embedded within the emerging sexual health governance arrangements that are being established in London, to improve strategic coordination and communication across strategic partners, including local authorities, Public Health England and NHS England. The growing focus on the prevention benefits of anti-retroviral treatment for HIV infection, as well as the impact on treatment and care services if more people are tested and diagnosed, highlight the need for an integrated approach to commissioning HIV prevention, testing and treatment services. These governance arrangements could also provide a mechanism for addressing emerging sexual health issues (for example, shigella and hepatitis C) across London.

4 HIV prevention services and interventions should be firmly focused on outcomes, and robust monitoring and evaluation (including economic evaluation) of commissioned services is critical if we are to strengthen the evidence base for HIV prevention, and demonstrate the impact and value of HIV prevention programmes.

5 Evidence for new approaches to HIV prevention is emerging all the time. In London, commissioners and providers across the system should work together to develop and evaluate new innovations and service models and share lessons widely.

6 A broad, population-based primary prevention approach should be considered, in order to raise awareness and increase knowledge of HIV and key prevention messages in the general population, including amongst young people. This should complement a targeted approach for key 'at risk' groups including black African and MSM. Older (that is 50 years and above) MSM should be a particular focus given the rising number of infections in this group.

7 There is a need for more research into knowledge, behaviours and attitudes in relation to sexual and health risk–taking behaviours in London. For example, population surveys amongst key target populations would enhance our understanding of changing sexual health behaviours and risks in the capital, support the development of new intervention methodologies and approaches grounded in behaviour change theory, and also potentially offer a means of tracking the impact of HIV (and other sexual health) prevention efforts across London.

8 Develop understanding of cost effectiveness particularly in relation to which interventions are most effective in terms of spend and outcomes, and what level (local, London-wide) is needed to achieve critical mass.

## Commissioning recommendations

1. When commissioning HIV prevention interventions, commissioners should consider a 'combination' approach, capitalising on the multiple available prevention interventions now available, that are evidence-based and focused on knowledge, skills and behaviours as well as access to high quality services. These interventions should be targeted to the right populations, delivered at sufficient scale to maximise their impact, and should address both primary and secondary prevention.

2. Whilst DsPH in London should provide strategic leadership and coordination for HIV prevention efforts across the capital, there would be benefit to resourcing some coordination capacity between the various commissioners and stakeholders across the capital, to support integration between borough, London and national programmes, to develop a range of commissioning support tools, such as specifications, standards and outcome frameworks, as well as supporting evaluation and sharing of best practice.

3. HIV testing in settings outside of sexual health services should be expanded at scale and with pace in London, given the high prevalence of HIV across the capital. Expanding and normalising HIV testing is an important measure to increase uptake of testing and prevent HIV. Although testing is increasing across London, implementation of expanded testing is patchy. Evidence and learning from the introduction of routine HIV testing in primary and secondary care settings across London should be shared with commissioners across the system to inform future approaches to testing. Testing providers should also ensure they are making the most of health promotion opportunities when a test result is negative.

4. Condoms should be promoted and provided at scale, with a strong communications message supporting condom use. There are opportunities to rationalise current condom distribution programmes and significant potential benefits from doing so in terms of economies of scale.

5. Drug treatment services should maintain their focus on harm reduction approaches (particularly needle exchange schemes) and work collaboratively with public health commissioners and sexual health service providers to

understand and address the emerging issue of HIV spread associated with recreational drug use in MSM.

6. Public and patient engagement should be integral to the commissioning, planning, delivery and evaluation of HIV prevention services.

7. Digital media and technologies offer scope for reaching target audiences at scale as well as the potential to target people via the digital means and channels through which they now socialise. These new approaches should be explored, developed and evaluated.

# 1. Introduction

This report presents and synthesises the findings of an HIV prevention needs assessment for London, undertaken between May and October 2013, on behalf of the London Directors of Public Health (DsPH) working with London Councils. It draws out the key findings from each of the separate workstreams (further details of which are provided in section four and in the appendices to this report) and their implications for the future of HIV prevention programmes and services in London. The aims of the needs assessment were to:

- describe and understand the changing epidemiology of HIV in London;
- provide an overview of the HIV prevention services and programmes currently provided across the capital;
- review the evidence for the effectiveness and cost-effectiveness of HIV prevention interventions; and
- capture a wide range of stakeholder views on current and future HIV prevention services in London.

This report offers a number of strategic recommendations for a future approach to HIV prevention in London, as well as high-level commissioning recommendations regarding what interventions, services and programmes are needed to meet current and future need, and respond to gaps in prevention activities, both identified and emerging. It does not specifically answer the question of what services or interventions should be commissioned at a London-wide or borough level, as this is addressed in a separate options paper. Recommendations regarding the future commissioning of HIV prevention services in London will be put forward to the Leaders' Committee of London Councils for a decision in November 2013.

The decision regarding what HIV prevention services should be commissioned to meet local population needs, and whether these are commissioned in collaboration with other boroughs, rests entirely with each London borough.

## 2. Structure of this report

This report is structured as follows:

Section 3 sets out the background and context for this HIV prevention needs assessment in London.

Section 4 details the methodology of how the needs assessment was undertaken, including its limitations.

Section 5 provides an overview of the epidemiology of HIV in London, noting key trends and emerging issues.

Section 6 summarises what we know about HIV prevention services and activities currently commissioned across the capital.

Section 7 provides a focus on key population risk groups, drawing together the relevant findings from each of the separate workstreams to identify key issues and themes in relation to each of these population groups.

Section 8 highlights where there are still significant gaps in our knowledge.

Section 9 presents a discussion of the findings and emerging themes.

Section 10 sets out a series of recommendations regarding the future approach to, and commissioning of, HIV prevention programmes and services in London.

Appendices A-I contain a guide to the terminology used in the report, the executive summary of each of the workstreams and a table showing commissioning responsibilities for HIV.

## 3. Background and context

The Health and Social Care Act 2012 introduced a series of major reforms to the health and care system in England. A key component of these reforms shifted significant public health responsibilities, across all three domains of public health (health improvement, health protection and healthcare public health) from the NHS to local authorities. As of April 2013, local authorities are now responsible for commissioning comprehensive sexual health services, including sexual health promotion and HIV prevention services, contraception, sexually transmitted infection (STI) testing and treatment. Clinical Commissioning Groups and NHS England also have commissioning responsibilities for other critical aspects of sexual health

services, which means that clear lines of communication and joined up working between all parts of the system are crucial for best outcomes (see appendix I).

Local authorities are ideally placed to improve the sexual health of their populations and to reduce rates of STIs, given the range of public health and other services they now provide, their influence both directly and indirectly over the wider determinants of health, and their deep understanding of and close work with local communities. The recent changes to the public health landscape present an opportunity to commission services in new ways that respond to local needs.

Across London, local authorities inherited a widely differing set of local HIV prevention services and activities on 1 April 2013, reflecting historical differences in funding and priorities. At the time, they were faced with an immediate commissioning decision regarding the continued existence of the Pan London HIV Prevention Programme (PLHPP). This programme ran between April 2008 and March 2013. It was funded by all London Primary Care Trusts (PCTs) and delivered a programme of HIV prevention services and activities targeting men who have sex with men (MSM) and black African communities. Against a backdrop of a changing epidemic, increasing HIV prevalence in London, and concerns about the efficacy of the existing PLHPP, the Leaders' Committee of the 33 London boroughs agreed to roll over only a limited number (five out of 18) of the PLHPP contracts (with an annual value of £1.03m) until the end of March 2014.

It was agreed that a robust, HIV prevention needs assessment was required to inform the future commissioning of HIV prevention services by the London boroughs, as well as establishing whether there was a case for commissioning some services at a London level. A decision on future arrangements will be made at the Leaders' Committee of London Councils in November 2013.

Against a backdrop of shrinking resources for local government, a focus on services that meet local need, deliver desired outcomes and provide value for money is paramount. Across London, spend on sexual health services, including HIV prevention, accounts for the single largest proportion of the public health grant. Moreover there are upward pressures on local authorities' sexual health budgets, not least due to rising rates of STIs. Ensuring a strong focus on sexual health promotion and prevention, early diagnosis and treatment of STIs and HIV, and access to a comprehensive range of contraceptive services will deliver not only improved sexual health outcomes for patients and residents, but also savings in terms of health, care and wider societal costs.

The Public Health Outcomes Framework[1] includes a specific indicator for HIV in the health protection domain. The indicator relates to the proportion of people diagnosed with HIV who present at a late stage of infection.

A reduction in the rate of new infections and of late HIV diagnosis is a key marker of the effectiveness of HIV prevention efforts. Earlier diagnosis of HIV and rapid access to treatment and care is vital to improve health outcomes for people diagnosed with HIV, and also reduces the risk of HIV transmission.

# 4. Methodology - how the needs assessment was undertaken

The London Directors of Public Health, working closely with London Councils, established a Steering Group in May 2013 to oversee a programme of work to inform the future commissioning of HIV prevention services in London. The Steering Group, Chaired by Julie Billett, Director of Public Health for Camden and Islington, comprised Directors of Public Health and public health consultants from across London, representatives from London Councils, sexual health commissioners, HIV epidemiologists from Public Health England and academia, and members of the project management team, who provided overall coordination and support to the programme. A number of workstreams were established, and various organisations and individuals were commissioned to deliver reports in the following areas:

- Epidemiological review of HIV in London, to update the May 2013 'HIV epidemiology in London' report, using 2011 data. This was undertaken by Public Health England.

- Review of the evidence for the efficacy and cost-effectiveness of HIV prevention interventions, undertaken by Matrix. The purpose of this review of published, peer-reviewed studies was to build on and update the previous evidence review undertaken by PHAST in 2011[2].

- Review of evidence and information about HIV prevention interventions submitted via a "call for evidence". This call for evidence endeavoured to capture non-peer reviewed and/or unpublished evidence relating to the effectiveness and cost effectiveness of HIV prevention interventions, projects and services. This was undertaken by Dr Peter Keogh Consultancy.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216160/Improving-outcomes-and-supporting-transparency-part-1A.pdf
[2] http://www.northwestlondon.nhs.uk/publications/?category=1669-HIV-d

- Stakeholder surveys, interviews and meetings. The purpose of this work was to identify gaps, key priorities, issues and challenges in HIV prevention in London, and to elicit stakeholder views on potential future models and commissioning arrangements, undertaken by Paul Fraser Associates.

- In-depth focus groups with key at-risk populations for HIV (MSM and black African groups), undertaken by Resonant Media.

- Mapping of current HIV prevention services, interventions and spend in London, undertaken by Paul Fraser Associates.

The remit of the needs assessment, as determined by the Steering Group, was to focus on HIV prevention (including HIV testing and health promotion interventions) in order to inform the future commissioning of HIV prevention services and interventions in London. HIV treatment and care were outside the scope of the needs assessment, as commissioning responsibility for these services now rests with NHS England. However, the Steering Group in undertaking its work recognised the importance of not viewing HIV prevention as a set of isolated or stand-alone activities and the need for HIV prevention to be integrated with HIV treatment and care pathways, and with other sexual health services. The need to understand sexual risk taking behaviours within the context of other health behaviours and risks was a recurring theme in Steering Group discussions, and also emerged strongly from stakeholder discussions.

**PHE's role**

PHE has supported the work by undertaking the epidemiological review, and along with Steering Group members, helping with quality assuring the outputs from each of the workstreams.

PHE London has produced this report by synthesising the findings from all the various workstreams into a single narrative. The report takes account of emerging issues, highlights where action or research is needed, and makes a number of pragmatic recommendations. To synthesise these findings from the different sources of information, an approach based on answering key commissioning questions (see section 7) was used. This is not intended to be an academic study but a pragmatic report to inform future commissioning decisions.

PHE will also be undertaking an equity impact assessment to determine where commissioning decisions for HIV prevention could impact on health inequalities and on population groups with protected characteristics.

# 5. Overview of the HIV epidemiology

HIV is a major public health issue for London. In 2012, 2,832 people were newly diagnosed with HIV in London clinics, an increase of 8% from 2011. Worryingly, this increase in the number of new diagnoses reverses the downward trend seen between 2003 and 2011, which was thought to be due to changing patterns in migration. In 2012, London accounted for 48% of all new HIV diagnoses in England.

Men who have sex with men and black African populations account for 57% and 27% of new HIV diagnoses in London respectively and consequently should be considered the two major high risk groups for HIV in the capital.

Almost a third (30%) of people newly diagnosed with HIV in 2012 were born in the UK (where country of birth was reported). Among those born abroad, 32% were born in Africa.

In 2012, 50% of people with newly diagnosed HIV were white, and 27% were black Africans (down from 50% in 2003). White males accounted for 46% of the newly diagnosed.

Almost three quarters of people diagnosed with HIV in 2012 were male (74%). However, in heterosexually acquired cases, it was females who predominated (62%). Almost one third of people with heterosexually acquired HIV diagnosed in 2011 probably acquired HIV in the UK. The 2011 figure is almost double the number of heterosexuals infected in the UK in 2002.

Due to the effectiveness of anti-retroviral treatments (ART) for HIV and increasing survival, and as thousands of people are being newly diagnosed with HIV each year, the number of people living with diagnosed HIV is growing year on year. There were 32,499 London residents accessing HIV care in 2012, a 4% increase on the previous year, and nearly six in every 1000 Londoners aged 15-59 years have a diagnosis of HIV. In 2012, the majority of London residents accessing HIV were male (69%).

Eighteen out of the 20 local authorities with the highest diagnosed prevalence rate of HIV in the country are in London. Lambeth is the local authority with the highest HIV prevalence in the country, at 14 per 1,000. Every London borough has seen an increase in the numbers of people living with HIV since 2007, and 32 out of 33 local authorities in London have reached the prevalence threshold at which expanded HIV testing should be introduced[3]. Even “low prevalence” boroughs have smaller geographical areas within them with high diagnosed HIV prevalence.

[3] NICE, Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among men who have sex with men. 2011.

The prevalence of HIV is strongly associated with deprivation in London, with significantly higher prevalence of HIV in more deprived areas compared to more affluent areas. HIV prevention should be regarded as an important aspect of tackling health inequalities.

The most common route of acquiring HIV in those diagnosed in London in 2012 was through sex between men (57% of new diagnoses). Sex between men and women was the second most common route of infection accounting for 1,144 (40%) of new diagnoses in London; this is down from 60% in 2003.

People who inject drugs (PWID) account for a very small proportion of new HIV diagnoses each year (c.2% in 2012). This reflects the success of harm reduction measures, such as needle exchange schemes, targeting this risk group.

The median age at diagnosis of HIV in London in 2011 was 36 years and the proportion of new diagnoses in people aged 50 years and over is rising. In 2011 this proportion was 13%, having doubled from 6% in 2002. People aged 15-24 years account for fewer than 10% of new HIV diagnoses in London.

An estimated one in five Londoners with HIV is undiagnosed, and it is estimated that over 50% of all HIV transmissions are due to people who are not aware that they are HIV positive. Nationally, heterosexuals with HIV are more likely to be undiagnosed (27%) than MSM (20%) and PWID (17%).

These figures highlight the importance of increasing awareness, availability and uptake of HIV testing, and the active transitioning of people who are HIV positive to expert care as a critical component of HIV prevention in London. In 2010, it was estimated that 35% (14,000) of 40,000 MSM living with HIV infection in the UK (both diagnosed and undiagnosed) had a viral load of over 15,000 copies/ml and were at significant risk of passing their infection onwards. Of the 14,000 ‘infectious’ MSM, 62% were undiagnosed and only 5% were receiving ART. Thus, frequent testing, early diagnosis and engagement with treatment are crucial in containing the spread of the virus.

The epidemiology highlights that the majority of new HIV diagnoses in London are among MSM, with a rising trend and 1,604 new cases in 2012 (adjusted for missing information). It is estimated that the overall prevalence rate of HIV (diagnosed and undiagnosed) in MSM in London is one in 12. The vast majority of new infections in MSM were acquired in the UK and there is major concern about unsafe sexual behaviours amongst MSM, particularly the emerging evidence of links to recreational drug use. Drawing on data from a number of sources, it is evident that transmission is continuing and substantial numbers of new infections are occurring. Among MSM,

higher levels of other sexually transmitted infections (STIs), and recent outbreaks of shigella, are seen together with increasing HIV infections.

There is variation across London for MSM in terms of the burden of HIV. The highest numbers of MSM living with diagnosed HIV are in more central areas of London. Lambeth, Southwark and Westminster each have more than 1,000 residents who are MSM living with HIV (2011 data). Camden, Islington and Tower Hamlets each have more than 800 residents who are MSM living with HIV.

In 2011, the local authorities with the highest percentage of newly diagnosed MSM, as a percentage of the London total, were Lambeth (15% n=164) and Southwark (11% n=125) followed by Camden (6% n=89), Westminster (7% n=81), Tower Hamlets (6% n=63), Lewisham (5% n=55) and Wandsworth (4% n=49).

In 2012, 777 black Africans were newly diagnosed with HIV (adjusted for missing information). Twenty-seven per cent of new HIV diagnoses in 2012 were in black Africans, down from 50% in 2003. There is significant variation across London, with black Africans accounting for 70% of all new HIV diagnoses in Bexley in 2011, but only 3% in the City of London (although numbers of overall cases for each are small). It is acknowledged that black Africans are not a homogenous group, but made up of individuals and communities with varying cultures and beliefs. Thirty per cent of black Africans are believed to have acquired HIV in the UK and the absolute number of infections diagnosed has declined slightly since 2006. Black Africans (and in particular black African men) are more likely to have undiagnosed HIV and to be diagnosed late compared to MSM. The vast majority of infections in black African populations are heterosexually acquired.

There are 10,900 black Africans living with diagnosed HIV in London (2012), which is one third of all Londoners with HIV. This has increased by 3% from 2011, and represents a 62% increase since 2003. Among black Africans living with diagnosed HIV, there are twice as many women as men.

# 6. HIV prevention services, activities and spend in London

HIV prevention services in London are currently funded in three main ways: through each local authority's public health grant to fund local activity, through the PLHPP (which in turn is funded by local authority contributions from their public health grant, weighted according to local HIV prevalence) and by the HIV Prevention England (HPE) programme, funded by the Department of Health (DH).

The data on HIV prevention spend in London is not robust. The process of trying to identify and quantify local spend has highlighted variation in the way local authorities categorise or define spend on certain programmes and services, as well as challenges in disaggregating spend on HIV prevention where this is included in contracts for a broader range of services. It became apparent that some local authorities have included funding allocated to HIV social care costs, or wider sexual health contracts (for example, the C-Card scheme for young people), whereas others have not. Therefore, the figures below must be treated with considerable caution and only regarded as indicative.

Spend on HIV prevention in London largely reflects historical patterns of commissioning, and it is uncertain how this spend relates to need, given the lack of accurate, disaggregated information on spend by risk group or by specific intervention type.

*Local authority commissioned programmes for HIV prevention in London – estimated total spend £10.5m*

Spend by local authority, where information has been supplied, showed that:

- The largest spend by target population group is for people living with HIV, totalling approximately £3.8m (this includes social care and support services as well as secondary prevention).
- The second largest category of spend was for young people (£1.9m).
- The spend on black African communities is £1.m.
- Spend on interventions or services targeting MSM at a local level amounts to approximately £795k although this is supplemented by some London-wide activities (see below).

In terms of spend by type of intervention, condoms and HIV testing accounted for approximately £959k and £843k respectively.

*Pan London HIV Prevention Programme – total spend £1.03m*

Each London borough currently contributes to this programme. There are five contracts that focus on delivering group work, health promotion interventions, counselling and condoms, all targeting MSM. Individual borough contributions are based on Survey of Prevalent HIV Infections Diagnosed (*SOPHID*) figures. Whilst SOPHID data remains the best way to calculate “fair share” contributions by London boroughs to the PLHPP, there is a need to update these calculations based on the most recently available prevalence data.

*HIV Prevention England (HPE) programme in London – London spend £955K*

The DH has committed £2.45m a year to HPE for three years (from 2012 to 2015), of which £955K is spent with specific benefit to London, equivalent to about 39% of the total programme budget. The bulk of the contract is for Terence Higgins Trust (THT) to deliver social marketing and digital/online health promotion services (£400,000). There are also targeted programmes for MSM (£167K) and black African communities (£123K) across London.

# 7. Focus on key population risk groups

In this section, the following questions are considered in relation to key population groups at risk of HIV.

- What does the literature, including peer reviewed studies and the 'call for evidence', tell us about what works?
- What do stakeholders and people in key population groups at risk of HIV think about the issue?
- What are the key gaps and challenges?
- Where do people in key risk groups access information and support?
- What are the important features or characteristics of HIV prevention services?

## 7.1 MSM

*Epidemiology*

MSM are a high risk group for HIV and other sexual transmitted infections (STIs). In London, over half of new HIV diagnoses, 80% of all syphilis and over half of all gonorrhoea diagnoses are in MSM. In 2012, 1,604 MSM were newly diagnosed with HIV (adjusted, an increase of 14% on 2011). This represents a 39% rise over the past decade. In 2011, 55% of MSM diagnosed with HIV were born abroad and 83% of new infections were acquired in the UK. The peak age for new diagnoses among MSM is 25-29 years.

In 2011, over half of all new diagnoses in MSM were residents of eight central London boroughs: Lambeth, Southwark, Westminster, Camden, Tower Hamlets, Islington, Wandsworth and Lewisham.

There is considerable concern about increasing sexual risk taking behaviours in MSM associated with recreational drug use. This new trend needs to be addressed through broader interventions targeting sexual and other health-related risk-taking behaviours, and indicates the need for a more integrated approach between substance misuse and sexual health services. It is imperative that people are able to

continue accessing needle exchange schemes to minimise risk associated with injecting drug use.

*Effective interventions*

In MSM, the evidence is strongest for interventions to reduce sexual risk behaviours, raise awareness of risk and encourage uptake of testing, through behavioural interventions and counselling (both small group and 1:1). There is some emerging evidence that motivational behavioural interventions are effective in increasing uptake of testing amongst MSM. Small group and 1:1 behavioural or "counselling" interventions reported via the call for evidence reported subjective and observed (objective) positive behaviour change.

National testing guidelines for the UK were produced by the British HIV Association in 2008[4] and endorsed by the National Institute of Clinical Excellence (NICE) in 2011[5] (see Box 1 NICE Guidance on promoting HIV testing among men who have sex with men – overview of recommendations (2011)). The 'call for evidence' review found that HIV testing in community, primary care and clinical settings is both feasible and acceptable to users.

Evidence of effectiveness also supports the use of educational approaches to build skills and increase knowledge. Whilst MSM generally have higher levels of knowledge and awareness of STIs than other population groups, they have low awareness of other, associated infections such as Hepatitis C and shigella, which is of considerable concern. Therefore there is a clear need to ensure that education and awareness raising interventions include information about sexual risk-taking, signs and symptoms of STIs (including HIV), promoting regular STI screening and information on where to find services. Multi-media interventions using the internet show some evidence of effectiveness. The 'call for evidence' review described interventions that achieved high levels of target population coverage using social media approaches. There is a growing trend for MSM to use social networking sites and smart phone apps to socialise and meet sexual partners. The 2013 literature review found that interventions to address condom skills and condom use were effective in general (i.e. not specifically for MSM). The 2011 literature review found 'insufficient evidence' to support or reject condom distribution for MSM, but condom distribution schemes were strongly supported by responses to the 'call for evidence' (2011). The 'call for evidence' described a condom distribution scheme targeted at MSM in commercial gay venues, which showed high levels of acceptability and uptake, as measured by self-reported surveys.

[4] BHIVA, BASHH, BIS. UK National Guidelines for HIV testing, 2008
[5] NICE. Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among men who have sex with men, 2011.

**Box 1: NICE Guidance on promoting HIV testing among men who have sex with men – overview of recommendations (2011)**

- Ensure interventions to increase the uptake of HIV testing are hosted by, or advertised at, venues that encourage or facilitate sex between men. This is in addition to general, community-based HIV health promotion (for example, locations such as bars could be involved, as well as GP practices).

- Primary and secondary care: offer and recommend an HIV test to patients who have not previously been diagnosed HIV positive and who fit into one of the following categories: registered with a practice in an area with a large community of men who have sex with men, or registered with a practice in an area with a high HIV prevalence (more than two diagnosed cases per 1000 people 15-59), or disclose that they have sex with other men.

- Secondary and emergency care providers should offer and recommend HIV testing to all men admitted to hospital who have previously tested negative for HIV, or have never been tested, and who: are admitted in areas with a high prevalence of HIV, or disclose that they have sex with other men, or have symptoms that may indicate HIV or HIV is part of the differential diagnosis.

- Outreach: provide rapid point-of-care tests. Offer tests via outreach in venues where there is high-risk sexual behaviour or in venues sited in areas where there is high local prevalence of HIV. This could include community or voluntary sector premises, public sex environments (such as saunas or cruising areas) or other venues identified during the planning exercise. Tests should be undertaken in a secluded or private area, in line with British HIV Association (BHIVA), et al. guidelines.

*Views of stakeholders and users specific to MSM*

There is increasing interest in a broader 'risk-based' approach to improving health amongst MSM. Including HIV prevention within wider approaches to health improvement is seen as potentially more effective than a narrow, HIV-prevention focused approach, and offers local authorities the opportunity to leverage their other commissioning responsibilities and influence across the wider determinants of health to improve sexual health.

The focus group conducted with MSM as part of this needs assessment offers some limited, albeit interesting insights into how and where MSM like to receive information and from whom. These findings should be treated with caution, as numbers were small. The NHS emerges as a trusted brand and as a credible source of health information and advice. This extends to NHS sexual health clinics, which are widely used and valued for their expertise and anonymity. GPs are not perceived as experts in this field, but as generalists, and some concerns were expressed by this group

about disclosure of information to insurance companies by GPs. In terms of future local authority branding of sexual health and HIV prevention services, findings from the focus group suggest MSM associate councils with refuse collection and council tax, rather than health. This is a potential risk for the new system.

Three key priorities for MSM when accessing services were confidentiality, convenience and credibility. Web-based resources and interventions, which largely focus on increasing knowledge and awareness and signposting to services, were regarded as accessible, convenient and confidential.

Stakeholders also recognised the potential to deliver internet-based interventions at scale in a cost-effective way, although the importance of tailoring messages and interventions to meet the needs of diverse sub-groups within the "MSM" target population was also noted.

There was little awareness amongst MSM of the national HPE programme or of PHE, although both the THT and the National Aids Trust are recognised and acknowledged as reliable, trusted brands and sources of information, advice and support for MSM.

Overall, feedback from stakeholders and users suggests that HIV prevention services would benefit from a continued association with the NHS, whether directly through NHS clinics/providers or through other specialist outlets and settings.

Accessible and regular HIV testing amongst MSM was regarded as a vital component of HIV prevention. Some stakeholders also emphasised the importance of testing being set firmly within the context of an HIV pathway, including prevention and behaviour change messages and interventions (for example, to promote consistent condom use or fewer sexual partners), as well as clear links into diagnosis, treatment and care. There were specific comments supporting *home sampling* as opposed to *home testing* (home sampling is where individuals take a test at home and send it off for analysis, as this is seen as cost effective, confidential and ensures a positive result is appropriately linked into sexual health services and HIV treatment.) Home testing can be undertaken without any link into onward referral services, and therefore some stakeholders were concerned about its promotion and usage.

*Current services and spend*

For the reasons outlined earlier in this report, it is not possible to accurately disaggregate the amount or proportion of total spend by London boroughs on HIV prevention activities targeting MSM. Many of the services and programmes

commissioned locally, such as condom distribution or HIV testing, are accessible to all HIV risk groups, not just MSM. In terms of the range of interventions currently funded at a local (that is, borough level) the bulk of spend is on condom distribution, HIV testing and outreach.

Local spend is currently supplemented by the interim PLHPP in 2013/14, which totals £1.03m and funds the following interventions directed towards MSM: health promotion, group work, condoms and counselling. MSM are also a key target group for the national HPE programme, and are able to access the digital/online health promotion service provided by THT as part of the HPE programme in London.

## 7.2 Black Africans

*Epidemiology*

In London in 2012, 777 black Africans were newly diagnosed with HIV, representing 27% of all new HIV diagnoses (adjusted). The number of black Africans newly diagnosed with HIV each year is declining, and there was a 51% reduction between 2002 and 2011. High rates of STIs are seen in black Caribbeans in London but this population group only accounts for 5% of all new HIV diagnoses. In absolute terms, the largest number of black Africans living with diagnosed HIV are in Newham, Southwark and Lewisham. The highest numbers of new diagnoses were made in black Africans aged 35-39 years. Black Africans are more likely to be undiagnosed and diagnosed late compared to MSM.

*Effective interventions*

Behavioural interventions to build skills and educational interventions to increase knowledge and develop a better understanding of risk are largely effective.

The 2011 evidence review suggested that culturally-specific interventions to increase knowledge were effective in black African populations; however user feedback from the focus groups conducted with black Africans as part of this needs assessment indicates that this targeted, culturally-specific approach is felt to increase stigma and alienate people from their local community.

Condom distribution, in conjunction with 'personalised' resources for black African users, had high levels of user acceptability. Given the insights about knowledge, attitudes and behaviours in some black African groups from both the focus groups and from previous studies6, there is a case for both educational interventions to increase knowledge of risks, and how to protect one's health and that of one's sexual partners, as well as to reduce stigma, promote condom use and HIV testing. Users

[6] Sigma Research. Bass Line 2008-9. The African Health and Sex Survey – London Strategic Health Authority data report. 2009

welcomed condom schemes, although some UK-born black Africans men view these primarily as a contraceptive method only, rather than providing protection against STIs. Focus groups with black Africans identified a belief within this group that everyone is at risk of HIV and scepticism about data showing certain groups were more 'at risk' than others. There was a general view that HIV prevention campaigns and interventions should be aimed at the population more generally as this could also reduce the stigma that can result from targeted campaigns.

There is some evidence that HIV testing among black ethnic groups is increasing in London. The epidemiological review included sentinel surveillance data which suggests that testing amongst black or black British groups has increased faster than that overall (36% vs. 19% tested overall) in the four years from 2008 to 2011 (antenatal clinics excluded). Black or black British groups accounted for 7% of tests outside antenatal clinics (where ethnicity was recorded). These groups were more likely to test positive (4.0% vs. 1.4% overall). Given that black Africans are generally diagnosed at a later stage of infection than MSM, there is a need to use evidence based approaches to increase testing in this 'at risk' group, in line with NICE guidance[7] (see Box 2 NICE guidance – Increasing the uptake of HIV testing among Black Africans in England, 2011).

*Views of stakeholders and users specific to black Africans*

Black Africans are more likely to be diagnosed at a later stage of infection than MSM. Prevention strategies need to normalise and encourage regular HIV and other STI testing amongst black Africans. Stakeholder feedback emphasised the view that black Africans are a very diverse population group. Views, experiences and attitudes differ greatly for a number of reasons including culture, faith, age, gender, length of time or reason for living in London, and social class. Stakeholders noted differences between first, second and third generation black Africans.

As with MSM, there is trust in the NHS brand as a credible source of information, advice and support on HIV and sexual health more generally. Black African groups also expressed an interest in a wider healthy living, fitness and wellbeing agenda, which potentially gives scope to integrate sexual health promotion and HIV prevention with other interventions and programmes that tackle health issues on a broader front, including smoking, alcohol and drugs. The effectiveness of this approach remains largely untested however.

[7] http://www.nice.org.uk/nicemedia/live/13417/53595/53595.pdf

**Box 2 – NICE guidance – Increasing the uptake of HIV testing among Black Africans in England, 2011.**

**Plan, design and coordinate activities to promote the uptake of HIV testing among local black African communities.**

- Work in partnership with those running existing community activities to promote HIV testing and the benefits of early diagnosis and treatment, and to raise awareness of local services and how to access them.
- Recruit, train and encourage members of local black African communities to act as champions and role models.

**Planning services – assessing local need – collect data about local need**

- Planning services – develop a strategy and commission services in areas of identified need & diagnosis.
- Ensure there is a local strategy to increase the uptake of HIV testing among local black Africans.

**Promoting HIV testing for black African communities**

- Produce promotional material tailored to the needs of local black African communities.
- Work with black African community organisations to promote HIV testing.
- Use venues that local black African communities frequent.

**Reducing barriers to HIV testing for black African communities**

- Ensure staff offering HIV tests emphasise that the tests are confidential.
- Ensure staff are able to recommend HIV testing.
- Ensure HIV testing services can offer rapid tests to people who are reluctant to wait for results

*Current services and spend*

The same caveats about interpreting information on current spend and activities targeting black African communities apply as for MSM. Although the interim PLHPP in 13/14 (totalling £1.03m) supports activities directed towards MSM only, interventions and services directed towards black Africans account for an estimated £1.6m of expenditure. The HPE programme being delivered in London includes specific local engagement work targeting black African communities. Black Africans are the other major population group targeted by the digital/online health promotion service provided by THT as part of the HPE programme.

## 7.3 People with undiagnosed HIV

Approximately 1 in 5 people living with HIV in London are unaware of their status. This is important because people who are undiagnosed are at risk of passing on their infection to others, and are more likely to have poorer health outcomes if diagnosed late. In the UK, heterosexuals with HIV are more likely to be undiagnosed (27%) than MSM (20%). Just under half of people diagnosed with HIV in London in 2011 were diagnosed late and just under a quarter were diagnosed very late. While there are excellent treatment options now available for people diagnosed with HIV, these are most effective if the infection is diagnosed early. Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services and a reduced response to anti-retroviral treatment.

It is estimated that 52% of new HIV transmissions occur from individuals who are unaware of their infection. Diagnosis and treatment of HIV can itself reduce onward transmission, as treatment reduces the infectivity of patients who are responding to and adhering to their treatment regime. A positive HIV diagnosis can also enable individuals to engage with HIV treatment and care services, and modify and adapt their sexual health behaviours to reduce the risk of onward transmission.

An earlier HIV diagnosis can reduce lifetime costs by between one-half and two-thirds compared to costs associated with a later stage HIV diagnosis.

*Effective interventions*

The promotion of regular HIV testing amongst key at-risk populations and increased routine HIV testing in general medical services, including in general practice and hospitals in high prevalence areas, needs to be a central component of any HIV prevention strategy. It is recommended that expanded testing is conducted in areas of high HIV prevalence defined as >=2/1000 persons aged 15-59[8] .The latest available data from 2012 (published in September 2013) show that all London boroughs, except Havering, are now above this high prevalence threshold, yet not all these London boroughs commission expanded HIV testing. Increasing testing and consequently the treatment of HIV infected individual's needs to be seen as an integral part of any HIV prevention strategy ("treatment as prevention").

There is concern amongst some stakeholders regarding the current patchy provision of expanded HIV testing across London. In addition, some stakeholders warned against HIV testing on its own being regarded as a prevention tool, noting that HIV testing should be backed up with behavioural and lifestyle interventions to reduce risk taking. Robust evaluation of expanded testing pilots was regarded as essential to further build the evidence base in this area, assess feasibility, acceptability and

[8] BHIVA, BASHH; BIS. UK National Guidelines for HIV testing. 2008

cost effectiveness of alternative models. Sharing learning across London should also support wider roll-out of expanded testing.

The split of commissioning responsibilities between Clinical Commissioning Groups and local authorities presents additional challenges when introducing routine HIV testing in clinical settings outside of GUM and sexual health services, such as A&E. Some stakeholders expressed concern at the lack of HIV testing undertaken in primary care in London. These concerns could relate to a number of reasons, including HIV testing not being commissioned in some places. This is especially important with repeat attendees at services or patients showing symptoms associated with HIV.

The 'call for evidence' submissions relating to expanded HIV testing reported acceptability of, and sustained increases in HIV testing in primary care, with many good models of interventions targeting primary care practitioners.

There was strong support for specialist training in sexual health clinical skills for general practitioners and practice nurses. A scheme cited as being effective was the *Sexual Health in Practice* (*SHIP)*[9] training programme. This programme was developed in Birmingham and has been piloted in north London, and highlights the need for practical and infrastructure support for practices, especially if universal screening of newly registered patients is the aim.

*Current services and spend*

The HIV prevention service mapping identified 12 boroughs that commission HIV testing, amounting to £843K (or 8%) of the overall spend on HIV prevention by London local authorities. However, this figure should be interpreted with considerable caution, as many boroughs were not able to disaggregate spend on HIV testing from larger sexual health contracts, nor is it clear whether this spend supports "expanded testing" outside of GUM and other sexual health services (e.g. locally commissioned services in primary care).

### 7.4 People who inject drugs

*Epidemiology*

People who inject drugs (PWIDs) are vulnerable to HIV through the sharing of injecting equipment, as well as through sexual transmission. Just 1% of new HIV diagnoses in London are attributed to injecting drug use. In 2011 there were 10 centres in London that participated in unlinked anonymous testing of PWID. The

[9] http://www.ship.bham.nhs.uk/

prevalence of HIV in people who inject drugs in London was 3.9% in 2011, and this has changed little over the last ten years. However, this is three times the prevalence amongst PWID in England (1.3%).

HIV remains uncommon among PWID in the UK, unlike some other parts of Europe[10]. The low and stable prevalence of HIV in PWID is likely to reflect the success of on-going measures to prevent transmission among this target group, including needle exchange programmes across London. Needle and syringe sharing is less common than a decade ago, although around one-sixth of people who inject drugs continue to share needles and syringes.[11]

High risk sex is associated with new drug taking behaviours and these people are largely invisible to the drug and alcohol services.

*Effective interventions*

There is some evidence of effective interventions using educational approaches to increase knowledge and build skills amongst PWIDs, as well as opioid substance therapy for reducing HIV transmission among PWIDs. There is also evidence that internet-delivered media interventions are ineffective for this population group.

Harm reduction approaches have wider benefits for PWIDs. Priority should be given to preventing the spread of infections among this group and to reducing the harm caused by infections. Evidence-based interventions include drug treatment and primary care services that ensure easy access to information and advice, preventing blood-borne virus transmission and safe disposal of used equipment, vaccinations for hepatitis B, tetanus vaccination and, where indicated, hepatitis A vaccination, diagnostic testing for HIV and hepatitis C.[12]

Easy access to needle exchange schemes continues to be very important in reducing risk of HIV and other blood borne viral infections.

*Stakeholder views specific to people who inject drugs*

A number of respondents highlighted the vital role of drug treatment and needle exchange schemes in preventing HIV transmission in this at risk population group, attributing the low numbers of new HIV diagnoses in PWIDs to the early introduction of these measures in London and the UK more widely. At a time of severe financial

[10], 11 Health Protection Agency. Shooting Up: Infections among people who inject drugs in the UK 2011. An update: November 2012

,[12] Health Protection Agency. Shooting Up: Infections among people who inject drugs in the UK 2011. An update: November 2012

pressure on local authorities, stakeholders underlined the importance of continuing these harm reduction programmes and services, which are now commissioned locally by London boroughs, as part of their new public health responsibilities.

*Current services and spend*

No funding for HIV prevention interventions targeting PWID was specifically identified through the service mapping. This is unsurprising given that the focus of the mapping exercise was on identifying spend within sexual health budgets, rather than services or spend in other areas, such as substance misuse. Some boroughs indicated they have adopted integrated approaches, for example, tackling HIV as part of interventions and services focused on reducing blood borne viruses. There is an opportunity to approach the issue of PWID in relation to HIV in a more co-ordinated way to tackle this comprehensive problem.

## 7.5 Sex workers

Street-based sex workers tend to experience very low standards of general and sexual health and frequently experience violence at the hands of clients. Street-based sex workers are more likely to use drugs and alcohol, share needles and have unprotected sex than parlour-based sex workers[13]. Sex workers face barriers to accessing sexual health services owing to the environment and the context of their work, which puts them at risk of HIV. Female and male sex workers experience discrimination because of their work and the criminalisation of prostitution. Stigmatisation, reinforced by the spread of HIV, has created further barriers to sex workers accessing social and health services.

The 2011 and 2013 published evidence reviews and the “call for evidence” review identified very limited evidence relating to HIV prevention in sex workers (within the parameters of their reviews). The evidence shows that behavioural interventions were not effective in reducing HIV incidence in this particular population, whereas counselling interventions were effective. The identified spend on this target group amounts to approximately £494k per annum, although, as before, this should be interpreted with caution, as some boroughs were not able to disaggregate spend targeting this population group from larger contracts.

## 7.6 Other

*This section sets out some of the evidence in relation to the general population and young people.*

The published evidence review (2013) reported that, for adult men, the interventions studied were mostly educational and taken from American studies. The educational

[13] http://www.rcn.org.uk/development/practice/social_inclusion/sex_workers

interventions appear to be effective and, within this category, information/knowledge focused interventions have the largest number of supportive study outcome findings. There is equivocal evidence for 'supportive' interventions. The 2011 review noted there was little evidence for the general adult male population, but there was some evidence of effectiveness for condom negotiation skills and negotiation training.

For adult women, the 2013 published evidence review noted 15 studies, again mostly from the USA. The majority of study outcomes investigating education, supportive and media interventions showed evidence of effectiveness. The 2011 evidence review noted information/knowledge, skills building (general) and interpersonal skills-based interventions were effective.

For adolescents, support-based and educational interventions were most effective (2013 review), as were sport-based interventions and interventions using new digital media (HIV interactive communication delivered via the internet). Behavioural interventions, abstinence and peer education were all reported to be ineffective. The evidence was less certain around interpersonal skills training, as six studies supported this approach, whilst another six did not. In the 2011 review, information/knowledge and skills based training was effective, as was interpersonal skills training and condom skills training. HIV prevention educational interventions in schools have been shown through the evidence to be effective in increasing skills and knowledge among young people (albeit evidence drawn from USA experience).

The Government announced in 2013 that it has no plans to update the current guidance on personal, social and health education (PSHE) in schools or introduce new programmes in school. The mapping of current HIV prevention services and interventions undertaken, as part of this needs assessment did not seek to describe if or how HIV prevention is addressed through school-based sex and relationships education (SRE) programmes across London's boroughs.

# 8. Limitations and gaps in our knowledge

This section highlights the key limitations of the needs assessment and our knowledge of HIV prevention in London, as identified during the process of developing the workstreams and synthesising these into a single report.

*The scope of the needs assessment*

This needs assessment was a pragmatic response to the challenge of developing a set of recommendations to inform future HIV prevention commissioning in London, within a limited time frame over the summer of 2013. Given its London-wide focus, it was not possible within the time available to develop a very detailed picture of the scope, outputs, outcomes of, and spend on HIV prevention on a borough by borough basis. The epidemiological data guided the focus on where the epidemic is

concentrated, namely amongst MSM and black Africans. By necessity, this means there is less of a focus on the general population and other 'at risk' groups, such as PWID and sex workers. There were additional challenges in understanding the pattern of spend, because in some boroughs HIV prevention services are integrated within contracts for wider programmes and services, particularly sexual health and GUM services, and therefore disaggregating specific 'HIV prevention' spend was not possible.

*Methodological limitations of the workstreams*

There were some specific challenges in ensuring a robust methodology for each workstream within the funding and time available. By necessity, the published evidence review was conducted at a 'high' level, which inevitably meant there was a lack of granularity in the descriptions of the effective interventions. It should also be acknowledged that there was significant potential for bias in the 'call for evidence' and stakeholder engagement elements of the needs assessment, as self-selecting individuals participated and/or submitted information for inclusion.

*Limitations of the evidence*

The updated (2013) search for evidence of cost-effectiveness only revealed one additional study over and above the handful of studies identified in the 2011 evidence review. Many of those studies identified were undertaken in the USA (none were with black African populations) and therefore their transferability to a UK health system and London context may be limited. Furthermore, the primary and secondary outcomes reported in the cost effectiveness studies were so varied that it was difficult to identify where the 2013 study had added to the knowledge of the 2011 study. This gap in evidence means that the relative cost-effectiveness of different effective HIV prevention interventions is hard to establish.

*Scope*

There is a wide-ranging and substantial research literature on sexual and risk behaviours, knowledge and attitudes, access to and use of resources for HIV prevention and sexual health. This needs assessment would have been strengthened by adding this additional analysis as it would have improved our understanding of, for example, the changing prevalence of different risk behaviours over time and amongst different sub-populations.

# 9. Horizon scanning

A number of emerging developments relevant to the future commissioning of HIV prevention were identified during the course of this needs assessment. Each of these present different opportunities and/or threats to HIV prevention.

*Home testing kits*

The Department of Health will repeal the legislation that prevents the sale of home HIV testing kits from April 2014. The aim is to make it easier for people to access HIV testing and get into clinical care should they have a positive diagnosis. The impact of this national policy is not clear but boroughs may wish to consider how home testing fits with their existing local arrangements for HIV testing, especially in areas of high prevalence. However, as indicated earlier in this report, there is concern from some stakeholders that home testing may potentially fail to link patients into appropriate treatment and prevention services, whereas home sampling does facilitate these linkages, and was therefore viewed by some stakeholders in a more positive light.

*New technologies and treatments*

Digital technologies have the potential to offer more individualised prevention approaches and reduce intervention costs. There is emerging evidence (from the published literature review) that internet and social media-based approaches can be effective in delivering targeted messages to certain 'at risk' groups; it is more likely that increased knowledge is facilitated through this approach rather than behaviour change. Certain MSM populations, for example, appear increasingly to be using the internet and social media as a medium for socialising and meeting sexual partners. Whilst this trend poses a challenge to more traditional outreach methods for reaching these men, it creates significant new opportunities for delivering HIV prevention interventions in new ways using the same medium of digital technology.

New methods of primary HIV prevention using anti-retroviral drugs are emerging. Oral pre-exposure prophylaxis (PrEP) refers to the use of anti-retroviral drugs in HIV negative individuals to prevent HIV acquisition. Oral PrEP has been shown to reduce HIV incidence in several key at-risk populations including MSM, discordant heterosexual couples and people who inject drugs. However, adherence to the drug regimen is critical to the success of PrEP, which has proved difficult for some and is the reason why a number of studies have been stopped. Furthermore, concerns have been raised that risk compensation or disinhibition may negate the protective effects of PrEP. Nonetheless, PrEP is seen as a possible preventive tool, especially in those most at-risk populations. Currently, in the UK, a pilot trial of PrEP is being conducted among MSM (the PROUD trial) to inform the possible roll-out of PrEP.

*An integrated approach to health risks*

Some users and stakeholders expressed an interest in HIV prevention and sexual health promotion being integrated into broader health improvement interventions and approaches, which address a range of healthy lifestyles and behaviours. This approach offers potential benefit in terms of using existing healthy lifestyle services and programmes as mechanism for widening the reach of HIV prevention and sexual health messages and services, it could offer a more holistic approach to health improvement in certain populations at increased risk of HIV, and could also help to normalise and de-stigmatise HIV and STIs. Such approaches would need to be tested and evaluated to understand their feasibility, acceptability, and effectiveness.

*HIV prevention as part of wider sexual health plans*

A number of stakeholders commented that HIV prevention should not be seen in isolation but considered as part of a wider sexual health strategy, at a local level but also for London. Commissioning HIV prevention as a 'stand alone' intervention fails to acknowledge the wider sexual health and social context in which HIV transmission occurs. It also does not reflect that there are now large numbers of people living with diagnosed HIV who are a key target group for HIV prevention efforts, and whose needs have been de-prioritised historically through a focus on primary prevention.

As the mechanisms and processes for improving sexual and reproductive health within London start to take shape, it is an ideal opportunity to consider HIV prevention as an integral part of this, to consider how resources should be allocated, what the focus should be and how commissioning plans can be developed.

As well as having commissioning responsibilities that span sexual health and HIV prevention, local authorities are well placed to integrate HIV prevention and addressing sexual risk taking behaviours with other public health services where this joined-up approach is appropriate, for example, substance misuse services. There are also opportunities to use Councils' leverage and sphere of influence in relation to the wider determinants of health to reach and support populations at increased risk of HIV, for example, through schools or other youth services, or though adult social care services supporting people living with HIV.

London does not currently have an overarching vision or plan for HIV prevention, unlike some other major cities. Given that half of all new HIV diagnoses in England are in London, stakeholders strongly felt this was a significant omission. In particular, stakeholders indicated that the lack of an overall strategic plan has led to a fragmented approach to the commissioning of HIV prevention services, as there is

no overall framework to steer what should be commissioned and on what scale. The need for a coordinated approach was felt to be especially important, given the mobility of London's population and the epidemiology of HIV.

*HIV prevention messages*

Credibility of and trust in HIV prevention messages emerged as an important issue amongst users. From the limited user feedback and insights generated as part of this needs assessment the NHS brand is regarded positively in relation to HIV prevention messages and sexual health services more generally. As they take on their new public health responsibilities in relation to HIV prevention and sexual health services, Councils may wish to consider how HIV prevention services and interventions can be branded to encourage high levels of engagement with those services amongst key population groups, and promote high levels of trust and credibility.

*Local vs London level*

Each local authority is now responsible for securing appropriate HIV prevention services to meet the needs of their communities. This enables boroughs to consider the best way of tailoring services to meet the specific needs of their 'at risk' populations and to link HIV prevention into other local services and programmes. As in the past, the expectation is that the majority of HIV prevention services will continue to be locally commissioned.

There may be some circumstances, however, when collaborative commissioning arrangements between some or all London boroughs offer benefits over and above individual borough-based commissioning. For example, such collaborative arrangements may offer economies of scale, improvements in quality and outcomes owing to the ability to deliver services at a critical scale, or reflect the epidemiology of HIV in London.

For example, some 'at risk' groups are highly mobile and there may be a case for targeting interventions at places where people socialise, rather than where they live. Other interventions, such as communications and campaigns delivered through a variety of channels, including web-based interventions, could be commissioned at sufficient scale at London level, deliver consistent and visible messages to the target populations and audiences, and tailored to suit local circumstances and need as appropriate.

As each borough undertakes its own HIV prevention commissioning, stakeholders have suggested there is a case for this local work to be supported by an individual, with an overview and coordination role across London, who can provide support to boroughs and ensure HIV prevention provision is not fragmented, but fits within an

overall framework. This framework could sit within and join up to the emerging arrangements for sexual health across London.

*Relationships between commissioners and providers*

In terms of commissioning, some smaller, non-NHS providers report that they find the current commissioning and procurement arrangements hard to engage with and unduly weighted towards larger organisations. There was also concern expressed by some stakeholders about overly onerous contract management and reporting mechanisms, requiring large amounts of activity and performance data, which some providers struggle to supply within their limited resources. Going forward, there should be a stronger focus on outcomes rather than outputs in contract specifications, and a proportionate approach to performance monitoring and management.

# 10. Recommendations

This section has a number of recommendations, based on the synthesis of the various workstreams and emerging issues. These recommendations are organised into two categories, strategic and commissioning. Strategic recommendations are those that relate to the wider context, to ensure a vision, aim and objectives that provide a framework for an integrated approach to tackling HIV prevention. The commissioning recommendations relate to the more immediate issues for HIV prevention, where there is an urgent need to agree a way forward to address issues highlighted by epidemiology and evidence.

## Strategic recommendations

1 There would be value in establishing a **vision for HIV prevention in London and a clear strategic framework** for the commissioning and delivery of HIV prevention programmes and services across the capital. Such a vision and framework should be designed to support and enable borough-led commissioning of HIV prevention services, increase coordination between borough, London and national activities, and enhance value through supporting increased consistency and quality of interventions and services, and sharing of information about new evidence and evaluations. London's unique features, such as high levels of population mobility and migration, and the nature of HIV as a communicable disease that does not respect borough boundaries, requires effective coordination of responses across London.

2 **The significant opportunities afforded by local authority commissioning of HIV prevention services should be maximised.** As well as integrating HIV prevention into wider sexual health services and programmes, there are potential opportunities to address HIV and sexual health risks alongside other risk behaviours, for example, alcohol and substance misuse. There are also opportunities to use Councils' leverage and sphere of influence in relation to the wider determinants of health to reach and support populations at increased risk of HIV.

3 **HIV prevention should be firmly embedded within the emerging sexual health governance arrangements** that are being established in London, to improve strategic coordination and communication across strategic partners, including local authorities, Public Health England and NHS England. The growing focus on the prevention benefits of anti-retroviral treatment for HIV infection, as well as the impact on treatment and care services if more people are tested and diagnosed, highlight the need for an integrated approach to commissioning HIV prevention, testing and treatment services. These governance arrangements could also provide a **mechanism for addressing emerging sexual health issues** (for example, shigella and hepatitis C) across London.

4 HIV prevention services and interventions should be firmly focused on outcomes, and **robust monitoring and evaluation** (including economic evaluation) of commissioned services is critical if we are to strengthen the evidence base for HIV prevention, and demonstrate the impact and value of HIV prevention programmes.

5 Evidence for new approaches to HIV prevention is emerging all the time. In London, commissioners and providers across the system should **work together to develop and evaluate new innovations and service models** and share lessons widely.

6 **A broad, population-based** primary prevention approach should be considered, in order to raise awareness and increase knowledge of HIV and key prevention messages in the general population, including amongst young people. This should complement a targeted approach for key 'at risk' groups including black Africans and MSM. Older (that is 50 years and above) MSM should be a particular focus given the rising number of infections in this group.

7 There is a need for more **research into knowledge, behaviours and attitudes** in relation to sexual and health risk–taking behaviours in London. For example, population surveys amongst key target populations, which

would enhance our understanding of changing sexual health behaviours and risks in the capital, support the development of new intervention methodologies and approaches grounded in behaviour change theory, and also potentially offer a means of tracking the impact of HIV (and other sexual health) prevention efforts across London.

8 **Develop our understanding of cost effectiveness particularly** in relation to which interventions are most effective in terms of spend and outcomes, and what level (local, London-wide) is needed to achieve critical mass.

## Commissioning recommendations

1 When commissioning HIV prevention interventions, **commissioners should consider a 'combination' approach**, capitalising on the multiple available prevention interventions now available, that are evidence-based and focused on knowledge, skills and behaviours as well as access to high quality services. These interventions should be targeted to the right populations, delivered at sufficient scale to maximise their impact, and should address both primary and secondary prevention.

2 Whilst DsPH in London should provide strategic leadership and coordination for HIV prevention efforts across the capital, there would be benefit to resourcing some **coordination capacity** between the various commissioners and stakeholders across the capital, to support integration between borough, London and national programmes, to develop a range of commissioning support tools, such as specifications, standards and outcome frameworks, as well as supporting evaluation and sharing of best practice.

3 **HIV testing** in settings outside of sexual health services should be expanded at scale and with pace in London, given the high prevalence of HIV across the capital. Expanding and normalising HIV testing is an important measure to increase uptake of testing and prevent HIV. Although testing is increasing across London, implementation of expanded testing is patchy. Evidence and learning from the introduction of routine HIV testing in primary and secondary care settings across London should be shared with commissioners across the system to inform future approaches to testing. Testing providers should also ensure they are making the most of health promotion opportunities when a test result is negative.

4 Condoms should be **promoted and provided** at scale with a strong communications message supporting condom use. There are opportunities to

rationalise current condom distribution programmes and significant potential benefits from doing so in terms of economies of scale.

5 Drug treatment services should maintain their focus on **harm reduction approaches** (particularly needle exchange schemes) and work collaboratively with public health commissioners and sexual health service providers to understand and address the emerging issue of HIV spread associated with **recreational drug** use in MSM.

6 **Public and patient engagement** should be integral to the commissioning, planning, delivery and evaluation of HIV prevention services.

7 **Digital media and technologies** offer scope for reaching target audiences at scale as well as the potential to target people via the digital means and channels through which they now socialise. These new approaches should be explored, developed and evaluated.

## Appendices

Appendix A – Glossary

Appendices B-G are the summaries prepared by the authors of the individual workstreams as outlined in section 3:

Appendix B – Review of HIV epidemiology in London – executive summary
Appendix C – Review of call for evidence – executive summary
Appendix D - Report on segmentation – executive summary
Appendix E - Stakeholder engagement report – executive summary
Appendix F - Published literature review – executive summary
Appendix G – Behaviour change recommendations

Appendix H – PHE note on how 2013 published evidence review adds to the 2011 evidence review

Appendix I – Responsibility for commissioning of sexual health services from April 2013

Appendix J - Future Commissioning of London HIV Prevention Services Steering Group membership

## **Appendix A:** Glossary

**CASH:** Contraception and sexual health services

**CBT**: Cognitive behavioural therapy

**GUM:** Genito Urinary Medicine

**HIV:** Human immunodeficiency virus

**LES**: Local Enhanced Service – services commissioned from and provided by GPs and community pharmacists which are outside their core contract, and which are designed to respond to a specific local need or service requirement.

**MSM:** Not only men who define themselves as gay or bisexual but all men (including those who might define themselves as heterosexual) who may have sex with men (the sex defines the nature of the intervention rather than the sexual orientation by which the individual may define themselves)

**NATSAL:** National Survey of Sexual Attitudes and Lifestyles (Natsal) is the largest scientific study of sexual behaviour since the studies of Alfred Kinsey in the US in the 1940s and 1950s. http://www.natcen.ac.uk/study/natsal

**National Enhanced Service:** National enhanced services (NESs) are services to meet local needs, commissioned to national specifications and benchmark pricing.

**PCTs**: Primary Care Trusts

**PEPSE**: Post-exposure prophylaxis is medication which is taken within 72 hours of unprotected sex to prevent passing HIV on to a partner
http://www.uhb.nhs.uk/pepse.htm

**PrEP**: Pre-exposure prophylaxis. It is a new HIV prevention method in which people who do not have HIV take a daily pill to reduce their risk of becoming infected. When used consistently, PrEP has been shown to reduce the risk of HIV infection among adult men and women at very high risk for HIV infection through sex or injecting drug use.
http://www.cdc.gov/hiv/prevention/research/prep/

**PLHIV:** People living with HIV

**PSHE**: Personal, social and health education, delivered in schools

**PWID**: People who inject drugs

**Shigella:** Shigellosis, also called bacillary dysentery, is caused by four species; *Shigella dysenteriae*, *Shigella flexneri*, *Shigella boydii* and *Shigella sonnei*. Bacillary dysentery is primarily a human disease often acquired by drinking water contaminated with human faeces or by eating food washed with contaminated water. Humans are the only significant reservoir of Shigella infection. In the UK most cases are associated with foreign travel, however, there are occasional reports of UK-acquired cases associated with sexual transmission, predominantly among men who have sex with men. http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Shigella/

**SHIP:** training in sexual health clinical skills to general practitioners and practice nurses in a local authority

**SOPHID:** Survey of Prevalent HIV Infections Diagnosed
http://www.hpa.nhs.uk/webc/HPAwebFile/HPAweb_C/1221482345551

**SRE:** Sex and relationships education in schools

**STIs –** Sexually Transmitted Infections

## Appendix B: Review of HIV epidemiology in London for the Pan London HIV Prevention Needs Assessment – Executive Summary

*Key findings*

HIV continues to be a major public health issue for London. In 2011 there were over 2,600 new HIV diagnoses made in London clinics. Despite a decline in new HIV diagnoses since 2004, which may reflect changing patterns in migration, the number of new HIV diagnoses reported in 2011 was 11% higher than in 2000.

*Key risk groups*

The key risk groups for HIV in London remain men who have sex with men (MSM) and black Africans. Sex between men was the most common route of infection for those diagnosed in 2011 in London (54%), while black Africans accounted for 30%.

Injecting drug use accounts for a relatively low number of HIV cases in London, just one per cent of all new HIV diagnoses. This may be related to the early provision of harm reduction measures such as needle exchange services across London. However, the prevalence of HIV in people who inject drugs (PWID) in London is three times higher than in England.

Over the last ten years there has been a doubling in heterosexually infected cases thought to have been acquired in the UK, albeit from low numbers.

High rates of STIs are seen in black Caribbeans, however, they account for five per cent of new HIV diagnoses in the capital which is in proportion to their share of London's population.

*Burden of diagnosed HIV*

Due to the effectiveness of HIV treatment, which has reduced the number of deaths from HIV, the number of people living with diagnosed HIV in London in 2011 was the highest ever reported.

Over 31,000 HIV-diagnosed London residents accessed care in 2011, representing a five per cent increase on the number seen in 2010 and almost double that seen in 2002. More than five in every 1,000 London residents aged 15 to 59 years have diagnosed HIV, which is more than double the rate in England. Londoners represent just under half of all people accessing HIV care in England.
*Local authority variation*

London local authorities (LAs) account for 18 out of the 20 LAs with the highest diagnosed prevalence rate of HIV in the country. Thirty London LAs had a prevalence of diagnosed HIV greater than two per 1,000 population in 2011 which is the threshold at which it has been recommended to expand routine HIV testing in the local population. There are areas of high prevalence in every LA in London.

Despite the high prevalence of diagnosed HIV across London there are notable differences between LAs in keeping with the variation in their resident populations. The diagnosed prevalence rate varies nine fold, the proportion of new diagnoses acquired through sex between men varies from 12% to 93%, and the proportion of new diagnoses in black Africans varies from three per cent to 70%.

*Undiagnosed HIV*

It is estimated that in 2011 one in five Londoners with HIV was unaware of their HIV status. If people are aware of their diagnosis, they can access effective treatment. This not only greatly improves their health, but also reduces their chances of infecting others. It has been estimated that over half of overall HIV transmission is due to people who are not aware of their diagnosis.

*Late diagnosis of HIV*

It is of particular concern that a large proportion of people with HIV are diagnosed late in London (44%), as defined by a CD4 count of less than 350 cells/mm$^3$. Reducing late HIV diagnoses is one of the indicators in the Public Health Outcomes Framework. People who are diagnosed late have a ten-fold risk of mortality within one year of diagnosis compared to those diagnosed promptly and they have increased health care costs.

*Focus on MSM*

An estimated one in 12 MSM in London have HIV. There is evidence of sustained transmission of HIV in MSM in London and concerns over high levels of unsafe sexual behaviour, facilitated by the use of recreational drugs. London has relatively high numbers of MSM, who are more likely to live in inner London LAs and these areas tend to have the highest numbers of MSM newly diagnosed with HIV. Over half of new HIV diagnoses in MSM were in residents of eight LAs; Lambeth, Southwark, Westminster, Camden, Tower Hamlets, Islington, Wandsworth and Lewisham.

The number of people newly diagnosed with HIV who have been infected through sex between men has risen by 20% over the last decade. The majority of MSM newly diagnosed with HIV are white (77%), born abroad (55%) and have been infected in the UK (83%). Compared to other risk groups they are less likely to be

diagnosed late and correspondingly when diagnosed, they are more likely to be shown to have been recently infected.

HIV should not be viewed in isolation. MSM have high rates of other sexually transmitted infections (STIs) (80% of all syphilis and over half of all gonorrhoea diagnoses in London) and recent outbreaks which have predominantly affected HIV positive MSM have been linked to unsafe sexual behaviour and use of recreational drugs, including injecting.

*Focus on black Africans*

Over half a million black Africans live in London, which represents seven per cent of the London population. The proportion of each LA's population that is black African ranges from one to 16%.

The diagnosed prevalence of HIV in black Africans is six times higher than white populations, reflecting the prevalence of HIV in their country of origin. The largest numbers of black Africans living with diagnosed HIV were in Newham, Southwark, Lewisham, Lambeth and Croydon.

Since 2003, there has been a fall in the number of new HIV diagnoses made among heterosexual men and women who acquired HIV in Africa, which is likely to be due to changing patterns of migration. Only 30% of black Africans are believed to have been infected in the UK and the absolute number of infections diagnosed has declined slightly since 2006. Those born in four African countries accounted for over half of new diagnoses in black Africans in 2011, most likely reflecting recent migration patterns and prevalence of HIV in these countries.

Black Africans are more likely than MSM to be undiagnosed or diagnosed late and less likely to be diagnosed with a recent infection.

*HIV testing*

Taking measures to improve diagnosis of HIV through normalising and expanding HIV testing is key to reducing late and undiagnosed HIV. However, expanded HIV testing as recommended by national guidance has not been commissioned widely across London.

There is encouraging evidence that HIV testing is increasing in primary and secondary care. HIV testing in genitourinary medicine (GUM) is also increasing although uptake of HIV testing varies markedly between clinics. Uptake in antenatal screening is very high.

Given the cost of long term treatment there are large potential cost benefits in preventing HIV through primary prevention and through ensuring that those infected are diagnosed and enter care. Preventing the estimated 1,100 HIV infections that were probably acquired in the UK and subsequently diagnosed in 2011 in London would have reduced future HIV-related costs by an estimated £354 million.

*Linking the epidemiology with prevention*

MSM and black African heterosexuals remain the groups at highest risk of acquiring HIV infection within London; efforts are needed to reinforce prevention and promote regular HIV testing within these populations.

Consistent condom use, having fewer sexual partners and avoiding overlapping sexual relationships all reduce the risk of becoming infected.

It is important that robust harm reduction measures for people who inject drugs, such as needle exchange services, also remain in place to ensure continued success in preventing infection in this group.

*MSM*

The evidence of on-going transmission of HIV amongst MSM suggests that the priority for primary prevention should focus on reducing risky sexual behaviour in MSM. Prevention activity should take account of emerging evidence of increased recreational drug use, including injecting, amongst MSM. Measures to reduce the harm from injecting will need to meet the needs of MSM.

Awareness needs to be raised amongst MSM that sero-sorting (choosing sexual partners assumed to be of the same HIV status as themselves) is unsafe. For HIV positive MSM it carries the risk of infection with another STI or hepatitis while for HIV negative MSM it carries the risk of HIV infection as a fifth of HIV positive MSM are unaware of their infection.

The high rates of STIs in MSM, and particularly HIV positive MSM, suggests that any coordinated prevention activity should have a broad remit to tackle STIs in general, rather than restrict activity to HIV prevention.

While MSM are less likely to be diagnosed late, given the evidence of on-going transmission, it is important that frequent HIV testing should be promoted in this group. MSM should have an HIV/STI screen at least annually, and every three months if having unprotected sex with new or casual partners.

*Black Africans*

As black Africans are more likely to be undiagnosed or diagnosed late, HIV testing of this group needs to be prioritised. It is a national recommendation that black Africans should have an HIV test and regular HIV/STI screening if having unprotected sex with new or casual partners.

To improve testing however, there needs to be targeted work at reducing stigma in this group, and also improvements in high prevalence areas in the commissioning of expanded HIV testing in acute clinical admission units and primary care.

## Appendix C: Report on the Call for Evidence – Executive Summary

Directors of Public Health issued a call for evidence of 'what works' in the primary and secondary prevention of HIV. The call sought submissions of evidence to support HIV prevention interventions. Responses were limited to 500 words and a pro-forma was supplied. The closing date for submissions was 5pm 9th August 2013.

Eighty-four responses were received. These varied in length and whether or not the pro-forma was used. An initial analysis sorted responses into four categories.

a. Responses describing a pilot or intervention (N=53)

b. Responses that presented 'grey' literature outputs of pilots or evaluations (that is, evaluations not published in peer reviewed publications) (N=8)

c. Narrative responses attending to over-arching or strategic aspects of commissioning (N=18)

d. Responses that presented 'needs' or 'behavioural' data (N=5)

Responses in categories (a) and (b) are covered in this report. Submissions in categories (c) and (d) are reported in an appendix in the companion report (see *The Future Commissioning of HIV Prevention in London Stakeholder Engagement Report).*

Responses describing interventions were entered into a charting framework and categorised according to intervention type. As few of the responses described evaluations and those that did were not experimental in design, the use of Cochrane or NICE tools was judged to be not appropriate for the types of evidence cited in responses. Analysis of the evidence provided showed a focus on:

- Evidence to show that the intervention is acceptable to intervention users or beneficiaries.
- Evidence to show that the intervention is feasible.
- Evidence of an outcome (for example a behavioural change).
- The 53 responses in categories (a) supported by the eight responses in category (b) were sorted into intervention types and are presented under the following five headings.

***Intervention type 1: Prevention***

*Screening/testing interventions*

*Community testing* – Six responses: Three are community testing sites; two describe testing in saunas; one describes HIV testing in a young person's sexual health clinic and one is a pilot to assess acceptability of testing as part of NHS Health Checks.

*Testing in Primary Care settings* – Three responses, one is borough wide sexual health training, one is a diffuse borough intervention and one is a focused intervention on four GP practices.

*Testing in other clinical settings* – Seven responses, the first is HIV testing in an acute medical unit, the second is the provision of health advisors to promote testing across a range of clinical settings. The remaining five describe pilots of interventions in various clinical settings.

*Other testing pilots* –Three responses; the first is a home-testing service; the second is an active recall to clinic intervention for MSM using a GUM clinic; the third is a pilot of a risk assessment and home testing service targeted at MSM using gay social networking sites.

Responses describing HIV testing interventions cite evidence of acceptability, feasibility, clinical benefit and cost-effectiveness of conducting HIV testing in a range of clinical settings and community settings.

They raise questions regarding the best ways of implementing HIV testing in primary care settings and signal caution with the recommendation that all new registrations at primary care practices should be offered testing.

There are good models of interventions targeting primary care practitioners with strong evidence of one intervention increasing number of HIV tests carried out at GP practices overall.

*Condom distribution scheme* - Two responses: The first targets MSM in commercial gay venues and the second describes personalised condom and information resource dissemination targeted at black African communities.

Condom distribution schemes show high levels of satisfaction amongst users of the scheme.

*Needle/syringe sharing* - One response describes a proposal for new needle exchange service targeting MSM injecting drugs in the context of sex in group situations.

***Intervention type 2: Support***

*Behavioural/therapeutic and peer /community group interventions* - Five responses: Two time-limited group work interventions aimed at sub-groups of MSM; one group interaction targeted at black African MSM and two Living Well Positive self-management courses.

Responses describing therapeutic group work cite evidence-based practice.

Internal evaluations of interventions using before/after approaches describe evidence of self-reported change along key behavioural and attitudinal indicators. Similar evaluations describe high levels of acceptability of group work interventions amongst those using them.

*Behavioural counselling/social support/mentoring/coaching/telephone hotlines* - Eight responses: Three intensive on-going or one-off interventions using CBT or other psychological approaches; two one-to-one interventions in community settings; one peer mentoring intervention, one self- assessment/reflection tool for use by MSM attending a GUM clinic, and one telephone information and advice service. Responses describing therapeutic one-to-one interventions cite evidence-based practice.

Internal evaluations of interventions using before/after approaches describe evidence of self-reported change along key behavioural and attitudinal indicators. Similar evaluations describe high levels of acceptability of the intervention amongst those using them.

Responses describing informational one-to-one interventions using before/after/follow-up approach report self-reported change in knowledge, testing intentions, attitudes and risky behaviours and high levels of acceptability amongst those taking part in the intervention.

*'Integrated' Support Programmes* - Two responses targeting MSM, both based on periodic assessment (initiated by health trainers/volunteers) using an outcomes focused common assessment tool (BASK). Men are referred into different services depending on assessed need. The first is London-wide and the second is borough-wide.

One response targeting black African communities: The Safer Partnership targets black African communities in South London. Interventions are inter-linked through three work-streams: one-to-one outreach, community mobilisation and condom distribution.

Before/After/Follow-up monitoring of integrated programmes show self-reported (subjective) and observed (objective) change along attitudinal and behavioural variables.

However it is not clear whether or not the programmatic element adds to effectiveness of the individual interventions administered as part of the programme.

***Intervention type 3: Media***

*Social networking*- Two responses: One social media component of a national HIV prevention campaign; one digital platform to support sexual health education and marketing campaigns.

*Website* - Three responses: one online risk assessment tool for MSM, one long-running health promotion website used by MSM, one 'synthesis' website currently in development.

*Mass media and Newspaper/magazines* - Two responses: One is a sexual health magazine aimed at MSM; the second describes a mass media campaign to raise awareness of PEP amongst MSM.

The two interventions using social networking approaches describe far higher than expected coverage with specific target groups.

Monitoring data and independent evaluation of a website aimed at MSM reports substantial coverage, high levels of user satisfaction and self-reported attribution of change in sexual risk behaviour and intention to use sexual health service to visiting the site.

Monitoring data and independent evaluation of a magazine aimed at MSM report high levels of user satisfaction and self-reported attribution of change in sexual risk behaviour, and intention to use sexual health service after encountering the magazine.

One intervention demonstrates strong potential for mass media advertising, when properly targeted, to bring about substantial changes in knowledge, behaviours and intentions where the knowledge base is low to begin with.

*Intervention type 5: Educational and support interventions on a community level*
In this category are interventions that are educational or support interventions in approach but work on a community level to change community norms or practices.

Two responses describe interventions to work with community leaders. The first carries out work with church leaders and congregations; the second works with community leaders and proprietors in a range of settings.

Two responses describe interventions working around football tournaments. The first is a combination of community workshops, outreach and point of care testing (POCT) at community football events; the second is a one-off football tournament.
Two responses describe multiple-methods, or the *s*imultaneous use of a wide range of approaches to carry out community-based work with black African communities, the first with adults and older people and the second with younger people.

The community-based interventions describe evidence of feasibility and acceptability of interventions as well as satisfaction amongst those using them.

Some cite evaluations reporting self-reported changes in behaviours and attitudes as a result of contact with the intervention.

*Other interventions* -Two responses*:* The first is a capacity building intervention for black African community organisations and the second describe the activities of a medium-sized agency.

The agency response reports self-reported change on a range of key dimensions as a result of service use from internal evaluative activities.

## Appendix D: Stakeholder engagement report – executive summary

The following activities were undertaken to elicit views from the widest range of stakeholders feasible within the timeframe allocated:

- A series of one-to-one and small group stakeholder interviews
- A series of telephone stakeholder interviews
- An online questionnaire which was distributed across all London commissioners
- A Call for Evidence
- Stakeholder events, including the London sexual health commissioners and a large scale multi-organisational stakeholder event
- A seminar organised by the South West London Sexual Health Network lead
- Use of the London Councils website and newsletter email list which encouraged wider participation and feedback

The delivery team acknowledge that some stakeholders may not have been able to participate due to short time frames. The stakeholder engagement provides a narrative as well as acting as a source of expert opinion.

There was general agreement that the HIV prevention services currently provided in London are based on historical models. As part of this engagement process, there was enthusiasm for a more holistic approach to the public health interventions, which should now encompass a broader range of health determinants, including substance misuse, smoking cessation and alcohol use.

In terms of the future model, many stakeholders cited the Marmot review, (Fair Society, Healthy Lives 2010) into health inequalities stating that it gave a broader and more relevant context to risk. The majority of stakeholders were clear that there were missed opportunities by having such a narrow definition of HIV prevention for people's health seeking behaviour.

<u>What HIV prevention needs to be provided?</u>

A combination approach, rather than one universal approach to HIV prevention recognises the range of factors that influence an individual's relationships and safer sex behaviour. It also offers a menu of interventions with clear patient pathways and strong referral processes needed to enable providers to meet the different needs of individuals. HIV testing is an effective primary clinical prevention initiative, and HIV treatment is an effective secondary clinical HIV prevention initiative. Primary and secondary prevention initiatives cannot be delivered in isolation. The division between primary and secondary prevention work is deemed unhelpful.

HIV testing as the means to an end is seen as a limited approach without the back up of behavioural change interventions to add value and support to the individual. HIV negative diagnoses are an often missed opportunity as more attention needs to

be given to health promotion interventions for individuals to remain negative. There is an opportunity to introduce HIV testing in a broader range of community and primary care settings and a need to incorporate much broader risk factors into the intervention portfolio (including alcohol and drug use).

The availability of consistent quality information and resources is regarded as central to HIV prevention. There is an overwhelming sense that HIV prevention is failing to evolve at the same speed as societal changes and that embracing new technology is far too slow and ad hoc. There is no consensus on the effectiveness of mass HIV prevention media campaigns. The reach of campaigns is generally limited by size of budget. There are high levels of social media use amongst both gay men and black African communities although patterns of usage differ.

It is acknowledged that people like to access information about health and available services in an anonymous and confidential manner and that new technology can facilitate this. However, without some form of co-ordination the potential for duplication is a waste of time and resources. Any London-wide HIV programme needs to complement HIV Prevention England activity and would see all boroughs agreeing to the key messages to deliver simultaneously. However, the methodology for delivering the messages could be targeted to local needs.

It is recognised that interpersonal (face to face) interventions help people make healthier life choices, including reducing risk taking behaviours. Interpersonal interventions acknowledge the complexities of individual lives which clinical/medical models and population based approaches often do not; however, they are time consuming and expensive. The push to increase HIV testing as a prevention tool was seen as potentially undermining the individual 'one to one' interventions. 'Warm referrals' offer a solution to the problem of people being lost to follow-up; stipulating this and joint working arrangements in Service Level Agreements (SLAs) between clinical and third sector organisations can facilitate better referral pathways for patients/service users.

The availability of condoms and the promotion of their use was seen as an essential HIV prevention intervention. There were a significant number of stakeholders who felt that messages about promoting condom use had faded and that there needed to be more high profile promotion of their use.

Better value for money could be achieved by using one centralised purchasing system for condoms, increasing Council purchasing power. At present there are a plethora of local free condom distribution schemes targeting different populations: gay men, black African people and young people as well as the Pan-London freedoms scheme (which distributes condoms to gay venues) and C-Card schemes for young people.

Businesses where sex on premises is known to occur need to make a bigger contribution, with the provision of free condoms being made a requirement of their license agreements.

Almost all stakeholders cited the lack of consistent SRE in schools as a gap. Young people in London are learning about sex from the internet and therefore there is no way to ensure that they are getting high quality, factual information. The need to educate young gay men about safer sex was a particular concern considering the HIV prevalence rates in London.

**How to deliver HIV prevention for London**

Most stakeholders were concerned as to how to better align clinical service provision with the HIV prevention agenda, with the role of GUM and community clinics in HIV prevention increasing. Given that London Councils are now responsible for commissioning GUM services, there are major opportunities to improve the role of GUM in HIV and STI prevention and to identify additional and alternative settings to increase uptake of HIV/STI testing.

There was overwhelming consensus from stakeholders that there needs to be a lead commissioning HIV and Sexual Health coordinator for London with the formal delegated responsibility to support all 33 London Councils. They would work closely with public health leads, policy organisations, third sector organisations, the London local area teams at NHS England and service users, in order to develop a robust, strategic, evidence based commissioning plan for London.

There is a sense that present commissioners are "**too reliant on the perceived wisdom of current providers"**, and that this needs to be addressed to reassure providers that there will be strong accountability for decision making and governance arrangements. Commissioning needs to address the 'broader determinants of health' and be less 'siloed' into individual health topics.

Some stakeholders expressed concern that there was little incentive for local authorities to prioritise HIV prevention as they will not be responsible for the lifetime drug costs for those living with HIV. HIV treatment and care costs are the responsibility of NHS England.

Stakeholders agree that commissioners should clearly define their expectations, defining excellence and setting the parameters for providers. This will rely on excellent communication channels with robust SLAs used to monitor and evaluate the purpose, outputs and outcomes of a range of interventions. SLAs need to encompass identified cultural norms, and challenge perceived wisdoms, and could have an element of evaluation development as well as a standard evaluation framework. SLAs should specify that clinical providers engage with third sector providers, and include joint working with accessible and seamless referral pathways.

There was consensus on the need for an integrated tariff for sexual health services, including HIV testing, especially now that there are major opportunities to address HIV and sexual health at one clinical intervention point. This would help local Councils know they were paying like for like, especially with the opportunities to provide integrated services across GUM and reproductive health.

There needs to be consistency in the methodology used to evaluate the effectiveness of HIV prevention methods. Stakeholders felt that this could be developed in partnership between public health and providers. There was recognition that a standardised tool was not applicable to every aspect of delivery but that SLAs could take account of any local borough variations. A sexual health balanced scorecard could be introduced as a standardised tool with local metrics to account for variations.

There was also a clear message from stakeholders that the data collated should be used to inform any future commissioning intentions. A transparent process would be welcomed in order to allow for flexibility and programme development on a borough, multi-borough and London-wide basis. Service user voices should be actively encouraged as part of the data collection, and providers should foster a culture that encourages and enables those voices to contribute and to be heard.

**Challenges**

Stakeholders believe that assumptions about the homogeneity of gay men, men who have sex with men (MSM) and black African communities are unhelpful. However, there was consensus that interventions and activities specifically targeted should remain a priority for future commissioned HIV prevention. Migration into London poses particular challenges, with new cohorts of gay men and black African people arriving.

Gay venues are no longer the predominant way in which gay men socialise. Smart phone apps designed for men to meet for sex are increasingly popular, with MSM able to organise and access sex in the borough in which they live with ease. There needs to be far greater partnership work developed to address the complexity of drug and alcohol use amongst MSM.

It was thought that stigma and discrimination continues to play a major role in late diagnoses. An absence of disclosure, lack of consistent condom use and, for many women, domestic violence associated with HIV disclosure all need to be addressed. Creating consistent support within local communities at risk of HIV is seen by the majority of stakeholders to be an important part of an effective HIV prevention programme.

There was a clear message from stakeholders that political will is required to ensure consistent provision of PHSE/SRE, particularly for young gay men/MSM.

Stakeholders identified a need to review the current commissioning arrangements for GUM/sexual health services and their role in HIV prevention.

## Conclusions

In determining what is now required for future HIV prevention commissioning in London, stakeholders suggested revisiting the menu of interventions, and the financial allocations and allowing for increased flexibility in programme development. Stakeholders saw a need to use broader London-wide risk prevention strategies that take advantage of economies of scale and directly acknowledge the broader determinants of health in individual's lives. This should include information and targeted support on substance misuse, smoking and alcohol.

In summary HIV prevention in London needs to:

- Prioritise the prevention of poor sexual health;
- Have strong leadership and joined up working;
- Focus on outcomes;
- Address the wider determinants of sexual health;
- Commission high-quality services with clarity about accountability;
- Meet the needs of more vulnerable groups;
- Obtain good quality intelligence about services and outcomes for monitoring purposes.

## Appendix E: Report on segmentation – executive summary

Six focus groups were held in September 2013 to explore the perceptions of high-risk groups (gay men and black Africans) to sexual health services and HIV prevention information in London.

There was a high level of commonality in the perspectives of the black African groups and the group of gay men although there were some variations and differences. The key findings are summarised below, and where there were differences between groups, these have been highlighted.

*Knowledge of sexual health and HIV*

- All of the groups believe that health is a priority
- Gay men are more aware of their sexual health and have a higher level of awareness and understanding of HIV
- While HIV is an issue for all, it seemed to be more of an issue for gay men who "live" with the danger of contracting the virus. Gay men recognised that they are at high risk but highlighted that other groups are also at risk.

In the black African groups those born outside the UK had a high awareness of HIV but those who were UK born did not have confidence in the statistics and felt that they are not a special group - everyone is at risk.

*Accessing media and information*

All groups search for information on the internet – and sexual health clinics provide information and support to all groups.

All groups access mainstream media and read the free London papers Metro and Evening Standard. Some of the gay men also access gay community media to gain the 'gay perspective'. The black African groups did not know of or use UK-based 'black' media, they do however access publications about their home countries.

*Sources / organisations for HIV information*

- All felt that it is important that any messages should come from a credible and respected source. The NHS is seen by all to be the most credible source of information and felt that messages should be seen to come from either the NHS or Department of Health. Local authorities were not seen as credible in this area – they are more associated with bins and Council Tax

Gay men were more likely to know about specialist groups (such as Terence Higgins Trust and National AIDS Trust) while black African groups were less aware of specialist support and were concerned about accessing support from community groups because of confidentiality issues.

*Messages and channels for HIV information*

- All groups agreed that the key message that needs to be "out there" is that HIV can affect anyone and everyone. HIV does not discriminate nor should awareness programmes be seen to
- All groups talked of the need to avoid discrimination in advertising and awareness raising materials and were concerned that "tailored" literature would only serve to promote the concept that HIV is a "gay" or a "black" disease alienating them further from the wider community
- All groups agreed that the channels of communication should allow individuals to read and absorb the message at a time and place that suits them – and that these messages should reach the whole population. There was also agreement on the fact that there is a need for much better education in schools
- Confidentiality is something that is important to everyone – and is more important than convenience, since many are prepared to go outside their area for services like HIV testing to ensure confidentiality.

## Appendix F: Published literature review – executive summary

### Introduction

This report details the work undertaken by Matrix for the Future Commissioning of London HIV Prevention Services (FCLHPS) project steering group. It represents the evidence review update element of the project, and is undertaken by updating the review of published literature (2001-2011) produced by Inner North West London Primary Care Trusts and Public Health Action Support Team (PHAST) on behalf of the Pan London HIV Commissioning Group in July 2011.

### Aim

To support the Pan-London HIV Prevention Programme Needs Assessment by undertaking a high quality pragmatic rapid evidence review of published literature on the effectiveness and cost effectiveness of HIV prevention interventions to update that undertaken in 2011.

### Method

Two complementary methodological approaches were adopted to update the earlier review:

- A review of reviews (2011-2013) repeating the methods of the previous report covering the period 2001-2011.
- A review of primary studies (2010-2013) to supplement the updated review of reviews.

In both, only publications of appropriately high quality study designs undertaken in OECD countries were included (i.e. 2+ Cochrane level of evidence quality or higher – see Appendix 2).

### Results

A total of 24,003 titles were found from the combined electronic searches of reviews and primary studies.

Following review of the abstracts of these publications, 23,707 were excluded after screening against the project's inclusion and exclusion criteria; and the full texts of the remaining 296 titles were obtained and further screened for inclusion into the update review of reviews and the review of primary studies.

On completion of the full text screening, 21 reviews and 100 primary studies were included in the reviews of primary studies, and data was extracted from these studies. Only two of the included studies concerned cost effectiveness.

## Limitations

The report sets-out the findings of an update to a previous review. Consequently it includes only the most recent evidence published over a relatively limited period of time (2010-2013), and alone it does not represent a comprehensive overview of all relevant evidence.

Also, both elements of the work employ pragmatic rapid review methods. The review of primary studies aims to provide a supplementary overview to the review of reviews stream of work, at a similar level of detail. Full detailed analysis of the included primary studies is not feasible within the time and resources committed to the project, and would entail additional work at a further level of granularity and quality assessment/critique of included reviews and studies.

As would be expected from the methods employed, the following limitations of the review should be recognised, and appropriate cautions applied in the use of the findings.

- Our consideration of effectiveness is based on the reported conclusions of authors of reviews and investigators of primary studies alone. The quality of individual reviews and studies has not been individually assessed in detail, other than against our adopted general Cochrane inclusion/exclusion criteria. This means that no assessment has been made of statistical methods, sample size, effect size, and measures to control for biases.

- The analysis does not include meta-analysis and so no empirical insight can be provided into the appropriate relative weight to the findings of reviews or studies, or between the reviews and primary studies elements of the review can be given to findings.

- The analytic currency/metric for the overall consideration of effectiveness across included studies adopted in the original PHAST report is unclear. Our report has adopted outcome measure as the currency/metric in all included reviews and studies; however, it is not possible to definitively determine the consistency of this with the analysis in the earlier report.

- Given the nature of review publications, it is likely that the current update review of reviews will overlap with evidence already covered in the previous review; and some of the studies included in our review of primary studies may be incorporated into reviews included within our update review of reviews.

- Whilst many of the included primary studies are based on research in large urban centres of population in OECD countries, none are UK-based. Consequently caution is needed in interpreting their generalizability to the UK and London context. For instance and in particular, the majority of studies

examining interventions in black ethnic groups are from the USA, and depending on the study design and intervention in question, their findings may not be valid of black ethnic groups in London.

- The update review excludes evidence generated in research in non-OCED countries, some of which may be considered to have some level of relevance to London.
- Many HIV prevention interventions are multi-faceted and as a result are difficult to classify by type in a single exclusive category, for instance knowledge focussed interventions may also aim to bring about motivational or behaviour change. Furthermore, included reviews may examine, categorise, and group interventions differently to individual studies. As a result there is a limit to the accuracy of classification of interventions against a single taxonomy and limits to the extent to which the review and primary study findings can be easily compared in a piece of work of this granularity.
- Evidence was not found for all potential interventions and some interventions are mentioned in the findings of the review of reviews and not in the review of primary studies, and vice versa. The absence of evidence on an intervention does not imply that it cannot be effective. However, the fact that evidence of effectiveness exists for some but not other interventions may still legitimately influence decision-makers.

**Findings: Effectiveness**

In light of the caveats set-out above, care needs to be given in the confidence and consequently the weight given to the findings alongside the findings of the other streams of work making-up the wider FCLHPS review.

Bearing this in mind, the following tentative conclusions can be made regarding the effectiveness of interventions in relation to key population groups.

Adult males

No evidence was found regarding general populations of adult males in the review of reviews update.

The review of primary studies found evidence of effectiveness from five studies for educational interventions (particularly information/knowledge interventions).

Adult females

No evidence was found regarding general populations of adult females in the review of reviews update.

The review of primary studies found evidence of effectiveness from fifteen studies for educational, supportive, and media interventions.

MSM

The review of reviews update included two reviews on MSM. These found limited evidence of effectiveness for motivational interventions, and that circumcision was ineffective.

The review of primary studies found fourteen studies, and overall these appeared to find that educational, prevention, supportive, media interventions and PrEP were effective in MSM.

Black ethnic groups

The review of reviews update included three reviews of interventions in black ethnic groups. These found evidence that behavioural interventions were effective, and that the balance of evidence suggested that motivational interventions (e.g. skills building) were ineffective.

The review of primary studies found fourteen studies that considered black populations, and suggested that education, media, and support interventions to be effective.

People with HIV

The review of reviews update included two reviews of interventions in people with HIV. They suggest that motivational interventions were effective in reducing risky sexual behaviour, and that behavioural interventions were ineffective in changing condom use.

The review of primary studies found ten studies that considered people with HIV. Overall they appeared to find that educational, supportive, and media interventions were effective.

IDUs

The review of reviews update included just one review of interventions in IDUs, and this found that opioid substance therapy was effective in reducing HIV incidence.

The review of primary studies found six studies that considered IDUs, which suggested that education and support interventions were effective, and media interventions were ineffective.

Sex workers

The review of reviews update included just one review of interventions in sex workers, and this found that behavioural interventions were ineffective.

The review of primary studies found two studies that considered sex workers, which found that supportive interventions were effective.

Adolescents

The review of reviews update included five reviews of interventions in adolescents. Overall, support-based interventions were the most effective by primary category, while behavioural intervention was found to be ineffective. By secondary category, a sport-based intervention and a new digital media were the most effective. Abstinence and peer education were found to be ineffective.

The review of primary studies found twenty-six studies which considered adolescents, and suggested that education, support, media, and testing/screening to be effective.

**Findings: Cost effectiveness**

In relation to cost effectiveness, the evidence review found just two studies, both from the US, that were eligible for inclusion. This suggests that little new relevant cost-effectiveness evidence has emerged since the previous review.

One study found that PrEP in high risk MSM could be considered cost effective, and the other that HIV screening in settings such as A&E and STI clinics is more cost effective than in in-patient setting, due to the better outcomes associated with earlier detection of HIV.

## Appendix G: An approach to including behavioural and needs research evidence into London HIV prevention needs assessment and future commissioning

This needs assessment included stakeholder engagement work as well as various reviews of evidence as follows:

- A rapid evidence review of published literature on the effectiveness and cost effectiveness of HIV prevention interventions consisting of a review of reviews and a review of primary studies.
- A call for evidence of 'what works' in primary and secondary HIV prevention.
- A review of HIV epidemiology in London.

The first review has yielded evidence of the relative effectiveness of interventions. The second has yielded largely descriptive data of what is happening 'on the ground'. The third has provided an overview and analysis of HIV and STI epidemiology in London as it applies to particular groups.

However, there exists a very substantial research literature which examines sexual and other risk behaviours (for example prevalence of risk behaviours over time and amongst different sub-populations), knowledge and attitudes (for example, perceptions of risk and knowledge around HIV), access to and use of resources (for example condoms, or clinical interventions) interpersonal, social and cultural factors mediating HIV risk (for example cultural norms, gender inequality safer sex negotiation).

This research comes from a range of disciplines mainly, though not exclusively aligned to the social sciences (for example psychology, social psychology, sociology, anthropology, economics etc.). It can be both theoretical and applied and is often interdisciplinary in nature. It employs quantitative, qualitative and mixed-method approaches, ranging from large scale longitudinal or cross-sectional surveys to in-depth interviews. It is often carried out to address particular questions or problems arising in the HIV prevention field (for example, what are the factors influencing risk perceptions of young MSM? Why do black African people in London test later for HIV?). It can have an international, national or local focus. It exists predominantly in peer-reviewed outputs but also substantially in 'grey' policy or community outputs (especially in the UK). This research generally plays a key role in planning, designing and considering the evaluation of HIV prevention interventions on regional, national and international levels. If used in conjunction with a planning framework and epidemiological data, this research helps us identify variation in HIV prevention needs across a population as well as describing the specificity of need.

As this research literature is so substantial and wide-ranging, it is not really feasible or useful to conduct an overall review. Rather, it is generally considered more useful

to define a topic for which a review is necessary (for example, 'MSM and recreational drug use' or 'Young people's use of clinical sexual health services') and then follow a standardised process to generate a literature review. This process generally is as follows[14][15][16][17][18]

- Define a search strategy
    - Set search parameters of time, region etc.
    - Set inclusion/exclusion criteria
    - Specify electronic research databases (for example, PSYCHINFO or EMBASE) and a format for inclusion of grey literature.
- Conduct electronic searches.
- Conduct grey literature searches.
- Critically appraise each research output using standardised tools appropriate for the methodology used in the research.
- Derive a list of high quality research outputs ideally from a range of disciplines and using a range of methodological approaches.
- Conduct an analysis of these outputs drawing out the main findings under dominant themes.
- Write up a synthesis document that brings together findings and makes recommendations for practice.

Although systematic, the process of reviewing this literature for the purposes of planning requires some interpretation of findings and expertise in setting the most appropriate research questions. It is on-going and this is appropriate as this is a very fast-moving and productive research field. Moreover, as different interventions are planned, different questions emerge leading to new reviews.

[14] For an example of a review of this type, see: Lorenc, T, Marrero-Guillamo. I, Llewellyn, A, Aggleton, P, Cooper, C, Lehmann. A, Lindsay, C (2011) HIV testing among men who have sex with men (MSM): systematic review of qualitative evidence. *Health Education Research* 26 (5): 834–846

[15] Crepaz N, Marks G, Liau A, Mullins MM, Aupont LW, Marshall KJ, Jacobs ED, Wolitski RJ; HIV/AIDS Prevention Research Synthesis (PRS) Team. (2009)Prevalence of unprotected anal intercourse among HIV-diagnosed MSM in the United States: a meta-analysis. AIDS. Aug 24;23(13):1617-29.

[16] Marks G, Crepaz N, Janssen RS. (2006) Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS. Jun 26;20(10):1447-50.

[17] Marks G, Crepaz N, Senterfitt JW, Janssen RS. (2005) Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. J Acquir Immune Defic Syndr. Aug 1;39(4):446-53

[18] Crepaz N, Hart TA, Marks G. (2004) Highly active antiretroviral therapy and sexual risk behavior: a meta-analytic review. JAMA. Jul 14;292(2):224-36.

The question of the status and role of this body of research evidence has emerged periodically throughout the needs assessment process; however there are some difficulties with reviewing this literature at this stage of the needs assessment:

- It is not amenable to the kind of overall review that can be carried out on evaluative research.
- Key topics or questions have not been specified at this stage.

However, it is advisable to put in place a process whereby this literature can be the subject of review as individual interventions and programmes of interventions are planned in the near future. As key questions or information needs emerge, commissioners should collaborate with internal and external research colleagues to define questions or topics for review and oversee the conduct of reviews and interpretation of findings to ensure high quality. This will ensure that interventions are evidence-based both in terms of what is likely to work, but also in terms of what is needed.

## Appendix H: PHE summary on how 2013 published evidence review for the efficacy and cost-effectiveness adds to the 2011 evidence review

This is a summary of the key findings of the evidence review undertaken by Matrix which adds to the review of published literature (2001-11) produced by Inner North West London PCTs and PHAST on behalf of the pan London HIV commissioning group in July 2011.

The 2011 review was conducted to assess the extent to which the Pan London HIV prevention programme was supported by evidence and to consider whether the programme/services should continue or be decommissioned.

The 2011 review was limited in its scope and process, (it did not include a service review, and the literature review omitted primary studies), but it did have a search criteria that enabled identification of a range of interventions (not exclusively those of the Pan London Programme) and reached some findings with regard to evidence of effectiveness, which are summarised in table 2 below.

The 2013 update covers the published evidence only (the grey literature review has been commissioned separately). The authors of the 2013 review have followed the approaches adopted in the original review, which limited the scope and methods of their review. Also, the tight timeframe means a rapid review method was adopted which limits the power of methods and granularity of analysis. The findings are expressed in terms of effectiveness of 'outcomes' rather than 'interventions' as in the 2011 review.

Table 1: Comparison of the methodology of the 2011 and 2013 evidence reviews

| **2011** | **2013** |
|---|---|
| Included systematic reviews and grey literature | Included systematic reviews and primary studies |
| Looked at effectiveness of interventions | Looked at effectiveness of outcomes |
| Purpose: searched for evidence of effectiveness for HIV Prevention that might then be applied to the Pan London programme | Purpose: to add to the published literature since 2011 review |

What follows is an assessment of how the 2013 review has added to our understanding of the evidence. Given the differences in the scope of the reviews, it is difficult to make direct comparisons between types and levels of evidence. The assessment therefore looks at effectiveness in terms of 'high level' approaches that could be commissioned.

Table 2: Summary of high level evidence of effectiveness from both 2011 and 2013 literature reviews

| **Population** | **2011 review: evidence of effectiveness identified** | **2013 review: additional evidence of effectiveness** |
|---|---|---|
| MSM | Group interventions: to reduce risk behaviour using Behavioural interventions (BI) using multiple approaches<br><br>Counselling (CBT) small group and 1:1 addressing perception of risk, and to encourage testing | Motivational intervention for HIV testing<br><br>Educational approaches for skills building, information/knowledge<br><br>Plus evidence for prevention, support, and multi-media interventions<br>Website/internet (although also studies showing lack of effectiveness for web approaches).<br>One study showed PrEP to be effective. |
| Black Africans | Voluntary counselling for testing<br>Interventions linked to broader determinants<br>Culturally specific interventions to increase knowledge | Behavioural intervention for skills building<br>The majority of educational intervention studies were effective, as were the media and support interventions. |
| People living with HIV | Behavioural intervention for partner notification | Motivational interventions for reducing risky sexual behaviour.<br>Educational interventions were effective, as were supportive and media interventions |
| Adult population – females | Information/knowledge, skills building(general) and interpersonal skills training were effective | Educational interventions and prevention were effective. Media interventions (notably multi media) were effective. |
| Adult population – males | Condom negotiation skills and negotiation training<br><br>(nb very few studies targeted at general male population) | Evidence of effectiveness was more common in educational studies, including promoting condom use, risk sexual behaviour and knowledge. Also educational interventions, particularly information/knowledge |

| | | |
|---|---|---|
| Young people | Effective interventions include information/knowledge, skills based (including skills buildings), interpersonal skills, condom-use skills training and role playing | Support based interventions were most effective. Also evidence for sport based intervention and new digital media via the internet.<br>Nb: abstinence and peer education are ineffective |
| PWIDs | Evidence for education approaches, information/knowledge, skills building. | Education and support interventions were effective (nb media ineffective) |
| Cost-effectiveness | Effectiveness ratings varied: Peer HIV testing is 'relatively' cost effective, teacher led & community based behavioural interventions were 'moderately' cost effective. HIV testing in non-specialised health care settings (in the US) were cost effective | One review was identified that found HIV testing in primary care to be cost effective |

## Appendix I: Sexual Health Commissioning Responsibilities from April 2013[19]

| 33 local authorities commission: | 32 CCGs commission | NHS England commissions |
|---|---|---|
| Comprehensive sexual health services, including:<br><br>Contraception, including Local Enhanced Services (implants) and National Enhanced Services (intra-uterine contraception) and all prescribing costs, but excluding contraception provided as an additional service under the GP contract<br><br>Sexual transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing<br><br>Sexual health aspects of psychosexual counselling, and<br><br>Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion, services in schools, colleges and pharmacies | Most abortion services<br><br>Sterilisation<br><br>Vasectomy<br><br>Non-sexual health elements of psychosexual health services<br><br>Gynaecology, including any use of contraception for non-contraceptive purposes | Contraception provided as an additional service under the GP contract<br><br>HIV treatment and care (including drug costs for post-exposure prophylaxis after sexual exposure)<br><br>Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs<br><br>Sexual health elements of prison health services<br><br>Sexual assault referral centres<br><br>Cervical screening<br><br>Specialist foetal medicine services |

19 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144184/Sexual_Health_best_practice_guidance_for_local_authorities_with_IRB.pdf

## Appendix J: Future Commissioning of London HIV Prevention Services Steering Group membership

Core Members
Dr Somen Banerjee, Director of Public Health (Interim), Tower Hamlets
Julie Billett, Director of Public Health, London Boroughs of Camden & Islington (Chair)
Helen Charlesworth-May, Director of Integrated Commissioning, London Borough of Lambeth
Elizabeth Clowes, Assistant Director, Commissioning, Social Inclusion, Lambeth Integrated Commissioning Team, London Borough of Lambeth
Jeffrey Lake, Consultant in Public Health, Barnet & Harrow Public Health Team
Dr Mike Robinson, Director of Public Health, London Borough of Croydon
Fraser Serle, Project Manager, Paul Fraser Associates

Advisory Members
Addicus Cort, Principal Policy and Projects Officer, Health & Adult Services Team, London Councils
Dr Paul Crook, Consultant Epidemiologist, Public Health England (London)
Professor Jonathan Elford, School of Health Sciences, City University London
Dr Anthony Nardone, Consultant Epidemiologist, HIV/STI Department, Public Health England
James Odling-Smee, Director of Communications, London Councils
Vikki Pearce, Project Management Support, Paul Fraser Associates
Elaine Rashbrook, Public Health Consultant, Public Health England (London)
Dr Emma Robinson, Assistant Director, Health Protection, Lambeth & Southwark Public Health Team
Paul Steinberg, HIV Prevention & Sexual Health Commissioning Manager (LSL), London Borough of Lambeth
Sarah Sturrock, Interim Strategic Lead for Health and Adult Services, London Councils