HIV testing and prevention strategies: the UK perspective

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Prevention strategies

- Condoms, condoms, condoms
- Other behavioural interventions
- Circumcision
- PEP
- PREP
- Reducing the undiagnosed
- Early testing
- ART as prevention
What have we learnt from the HIV testing pilots in the UK?

Feasibility
Acceptability
Cost-effectiveness
Target populations reached
Sustainability

Estimated proportion of HIV-infected pregnant women diagnosed before delivery, and of exposed infants becoming infected with HIV:

- England and Scotland

Data source: Unlinked Anonymous surveillance and National Study of HIV in Pregnancy and Childhood

1. Includes previously diagnosed and those diagnosed through antenatal testing
2. Assumes vertical transmission rate of 26.5% in undiagnosed women and 2.2%, 1.4% and 1.1% in diagnosed women in 1999, 2000-2002 and 2003-2006 respectively.
3. These data contain reports received by the end of June 2009; 2008 estimates will improve significantly when further reports are received.
Testing guidelines

- Ensure testing is offered in the following settings
  - STI (GUM), antenatal service, TOP services, Drug dependency programmes, TB, Hepatitis B, hepatitis C and lymphoma services, explore community settings

- Universal offer of test to persons where diagnosed prevalence > 2 per 1000 population
  - New patients attending GP
  - New medical admissions

- Patients thought to be “at risk” of HIV infection

- Community testing

Feasibility, Acceptability and Effectiveness

- Universal offer of a HIV test in general practice and hospital setting is highly feasibility and acceptable to patients and staff

- Positivity rates were high in all settings

- Testing need to be voluntary and confidential but does not need to be risk based
### Acceptability HIV testing: Results from pilot studies

<table>
<thead>
<tr>
<th>Pilot project</th>
<th>Uptake of HIV testing</th>
<th>From Questionnaires Patient acceptability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute care units (hospitals)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>70%</td>
<td>95%</td>
</tr>
<tr>
<td>Brighton</td>
<td>91%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Other hospital settings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>London – ED</td>
<td>61%</td>
<td>95%</td>
</tr>
<tr>
<td>London – OPD</td>
<td>72%</td>
<td>93%</td>
</tr>
<tr>
<td><strong>Primary care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West London</td>
<td>67%</td>
<td>99%</td>
</tr>
<tr>
<td>Brighton</td>
<td>75%</td>
<td>97%</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>London - THT</td>
<td>-</td>
<td>92%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>97%</td>
</tr>
</tbody>
</table>

### Universal offer of HIV test in primary care and general medical admissions: Results from pilot studies

<table>
<thead>
<tr>
<th>Pilot project</th>
<th>SOPHID prevalence (15-59)</th>
<th>No. Positive</th>
<th>No. tests</th>
<th>Positivity per 1000 tests</th>
<th>Positivity per 1000 16-59</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute care units (hospital)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>8.3</td>
<td>4</td>
<td>383</td>
<td>10.4</td>
<td>11.8</td>
</tr>
<tr>
<td>Brighton</td>
<td>7.6</td>
<td>2</td>
<td>1413</td>
<td>1.4</td>
<td>-</td>
</tr>
<tr>
<td>Leicester</td>
<td>3.2</td>
<td>10</td>
<td>984</td>
<td>10.2</td>
<td>10.2</td>
</tr>
<tr>
<td><strong>Primary care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West London</td>
<td>8.3</td>
<td>0</td>
<td>1001</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lewisham</td>
<td>7.0</td>
<td>19</td>
<td>2713</td>
<td>7.0</td>
<td>7.0*</td>
</tr>
<tr>
<td>Brighton</td>
<td>7.6</td>
<td>2</td>
<td>596</td>
<td>3.4</td>
<td>3.4</td>
</tr>
</tbody>
</table>

*Data for patients aged 18-59
Universal offer of HIV test in other hospital settings: Results from pilot studies

<table>
<thead>
<tr>
<th>Pilot project</th>
<th>SOPHID prevalence (15-59)</th>
<th>Number Positive</th>
<th>Number of tests</th>
<th>Positivity per 1000 tests per 1000 16-59</th>
</tr>
</thead>
<tbody>
<tr>
<td>London-ED</td>
<td>8.3</td>
<td>4</td>
<td>2123</td>
<td>1.8</td>
</tr>
<tr>
<td>London-OPD</td>
<td>13.3</td>
<td>0</td>
<td>604</td>
<td>0</td>
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Access to Care

- **Pilot projects:**
  - Transfer to care varied from 67%-100%
  - Patients lost to follow up in primary care and community projects

- **London clinical outcome data**
  - 80% of patients receive a CD4 count within 28 days of diagnosis
  - 94% of patients receive a CD4 count within 91 days of diagnosis
Feasibility, Acceptability and Effectiveness

- Universal offer of a HIV test in general practice and hospital setting is highly feasibility and acceptable to patients and staff

- Positivity rates were high in all settings

Lessons learnt from pilots
  - It reduces perceived stigma and late diagnosis
  - Health Staff are the biggest barrier to its implementation
  - Training and education of all staff is paramount
  - Clear referral pathways are needed to ensure access to care
  - Support from HIV specialists in dealing with any reactive/positive results

Recommendation for universal offer

HIV testing in primary care and general medical admissions must be prioritised in areas of high prevalence areas (>2/1000 diagnosed 15-59 year olds)

Q: Should universal offer be expanded to other geographical areas (to ensure by-in from all health providers)?

Q: should we expand universal offer to all hospital admissions not just acute care?

Q: Should we set an age limit?
Targeting most at risk groups:
Results of DH pilot projects

<table>
<thead>
<tr>
<th>Community settings</th>
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<tbody>
<tr>
<td>Pilot setting</td>
</tr>
<tr>
<td>London - THT</td>
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<tr>
<td>London - GMI</td>
</tr>
<tr>
<td>London - GMI</td>
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<tr>
<td>Sheffield</td>
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Recommendation for most at risk groups

Most at risk populations must continue to be targeted for HIV testing

Community HIV testing services need to be appropriately targeted and established with strong community representation. To be successful, these initiatives require long term commitment
**Most at risk groups**

Q: Can we make existing health care services more accessible to those most at risk?
Q: What are the best venues for community testing services? How do we ensure their safety?
Q: How do we ensure the sustainability of community projects?
Q: How can the numbers tested in these services be increased?

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**Cost effectiveness**

- **Cost effectiveness data in the UK is lacking (some work underway)**

- **Questions**
  - Where should we expand testing? What are the best models and technologies?
  - What are the short-term and long term cost benefits of early diagnosis (including public health benefits)?
  - What is the cost-effective threshold for expanding HIV testing in the UK?
  - How often should we recommend testing?
Sustainability

Q: How do we sustain our efforts given tightening resources?

- Reaching non-HIV & GUM specialist
  - HPA audit
  - 11/17 medical professional organisations aware BHIVA guidelines
  - 4/17 aware of HIV testing related work within their specialty
  - 5/17 included HIV testing in their own guidelines

- Staff training and education
  - Do we need a roadshow? Who has the time?

- Engagement of commissioners and local champions
- Could we be doing more for those who test HIV negative?
- What about partner notification?

Next steps

- Time to test – from pilot phase to roll out
- Time to educate peers and general public
- Time to write up findings and share lessons learnt
- Ongoing research
  - best models and their cost effectiveness
  - Expansion of testing in other settings
  - Frequency of testing

- Monitoring our efforts
  - Getting the FACTS at Local level
  - Monitoring the impact of guidance and policy at the local and national level
Thank you

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