The epidemiology of HIV in the UK

the use of surveillance in monitoring HIV prevention initiatives

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Outline

- **Background and context**
  - Surveillance methods
- **Epidemiology of HIV in the UK**
  - New diagnoses
  - Late diagnoses
  - Mortality
  - Incidence
- **Use of surveillance data**
  - Heath care planning and delivery
  - Health policy
  - Targeting and monitoring health promotion
- **Conclusions**

Surveillance methods

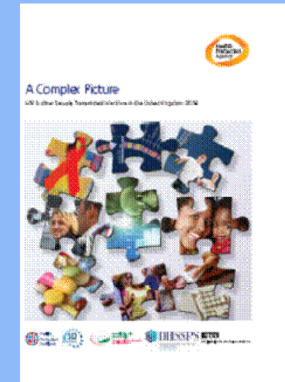
Unique features of HIV

- Long incubation period infection → disease
- Epidemic in 2 distinct parts:
  - 'incident cases' - monitoring of health promotion activities
  - 'care end' – monitoring of HIV care and outcomes- disease and deaths
- Heterogeneous transmission risks (eg: IDU, sexual, vertical) & risk perception
- Stigma and discrimination
- Highly politicised
- Mobility, migration
- Criminalisation

HPA Surveillance methods use to monitor HIV

- Individuals newly diagnosed (HIV and AIDS new diagnoses)
  (incidence and resistance monitoring)
- Persons attending for HIV care (SOPHID, CD4)
- Persons accessing GUM clinics (KC60, UA, Waiting times)
- Women attending for Antenatal care (UA/ Screening uptake/newborn DBS)
- Persons attending drug services (UA
- **Special Studies**
  Myasha
  Insight
  NONOPEP
- **Modelling Work**
  Calculations of Number of persons living with HIV

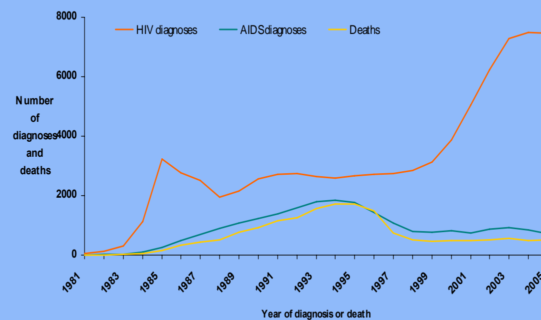
Epidemiology of HIV in the UK



HIV and AIDS diagnoses and deaths, UK

Overall
- >70 000 diagnoses
- > 17 000 deaths

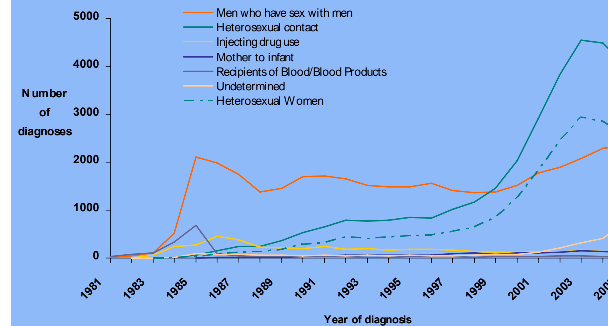
In 2005
- 7 500 diagnoses
- Approx half of infections were acquired outside UK
- Mean age diagnosis
  - 29 (1996) to 33 (2005) in hets
  - 33 to 35 in MSM
- 800 AIDS
  - 90% at time of diagnosis
  - PCP and TB most commonly
- A third presented with CD4 <200
- 500 deaths



Numbers will rise, for recent years, as further reports are received.

Clinician reports of new HIV/AIDS diagnosis

HIV diagnoses by exposure category, UK



Heterosexually - 4500
- 85% acquired outside UK

Women - 3000

Children (<16)- 120

MSM - 2400
- 85% acquired in UK

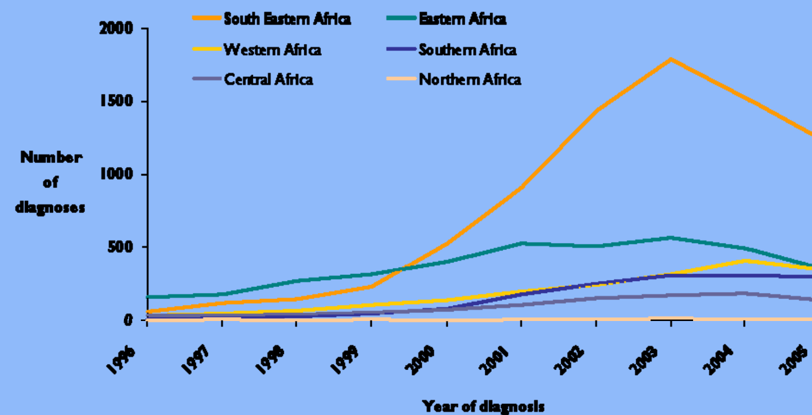
IDU - 150

Numbers will rise, for recent years, as further reports are received.

Clinician reports of new HIV/AIDS diagnosis

Impact of migration

HIV diagnoses in England, Wales and Northern Ireland by African region of infection where the infection is attributable to heterosexual contact in Africa



Clinician reports of new HIV/AIDS diagnosis

Individuals diagnosed with HIV in the UK who probably acquired their infection in Africa 2000-2005

Rank	Country where HIV acquired	Number of diagnoses made in the UK (2000-2005)		Percentage of diagnoses (as % of infections acquired in Africa) 2000-2005	
		Female	*Male*	Female	*Male*
1	Zimbabwe	4370	*2343*	25.1	*13.5*
2	South Africa	972	*514*	5.6	*3.0*
3	Uganda	871	*472*	5.0	*2.7*
4	Zambia	591	*332*	3.4	*1.9*
5	Nigeria	511	*350*	2.9	*2.0*
6	Malawi	486	*258*	2.8	*1.5*
7	Kenya	410	*221*	2.4	*1.3*
8	Congo/Zaire	333	*146*	1.9	*0.8*
9	Ghana	270	*172*	1.6	*1.0*
10	Cameroon	213	*100*	1.2	*0.6*

Footnotes:

Number of diagnoses will rise as further reports are received

Data to end December 2006

HIV prevalence in women giving birth in England: 2005

World region of birth	Positive	Tested	Prevalence
C & E Asia	1	3,593	0.03%
Southern Asia	5	20,180	0.02%
SE Asia	7	3,245	0.22%
Eastern Europe	3	4,507	0.07%
S & W Europe	19	8,148	0.23%
Sub-Saharan Africa	512	21,315	2.40%
C America & Caribbean	22	2,693	0.82%
UK	75	178,493	0.04%
Rest	12	15,820	0.08%
Unknown	64	14,423	0.44%
Total	720	272,417	0.26%

Includes previously diagnosed, those diagnosed through antenatal screening and those remaining undiagnosed

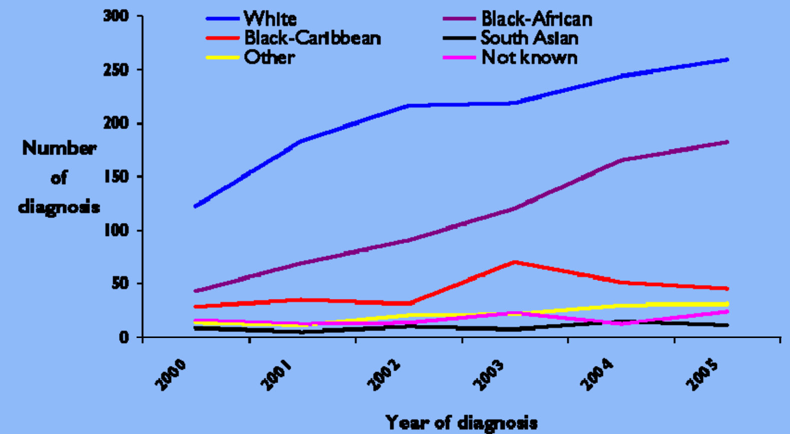
Unlinked anonymous testing of newborn infant dried blood spots and NSHPC

Populations living with diagnosed HIV aged 15 to 59, England: 2005

	Black African	Black Caribbean	Indian/ Pakistani/ Bangladeshi	White
HIV-diagnosed individuals	15,750	1,185	473	20,246
Population	442,300	384,500	1,522,400	26,977,300
Percent living with diagnosed HIV	3.6%	0.3%	0.03%	0.08%

Census of individuals accessing HIV-related care and ONS 2004 population estimates (based on 2001 census)

HIV infections acquired in the UK through heterosexual contact by ethnicity



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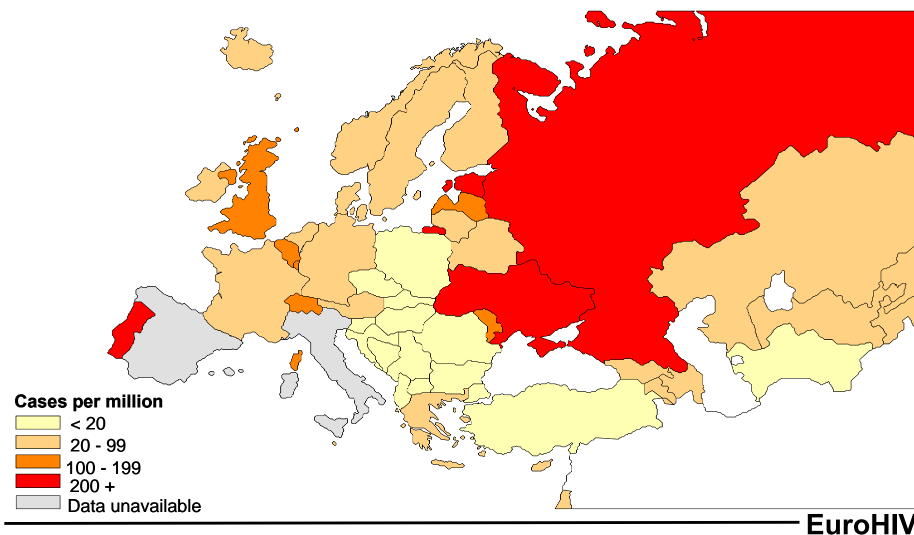
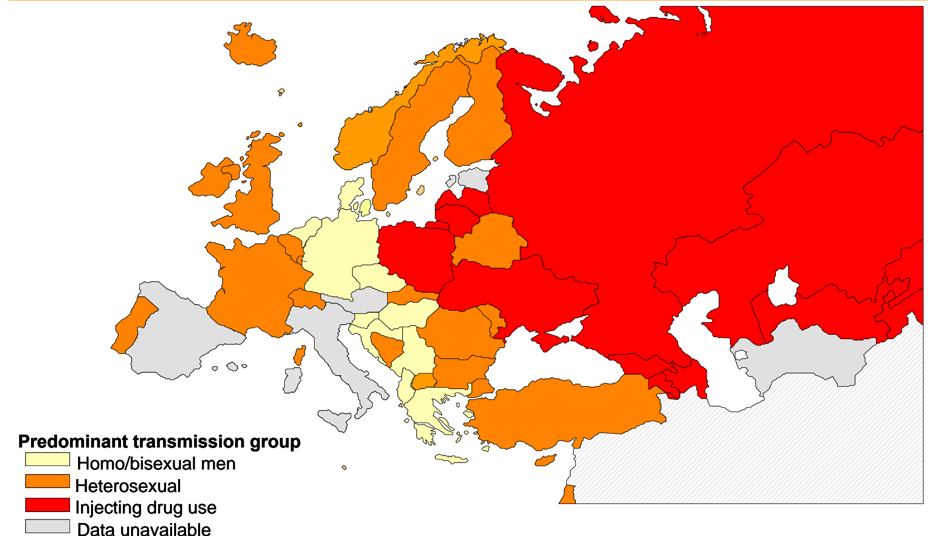
Clinician reports of new HIV/AIDS diagnosis

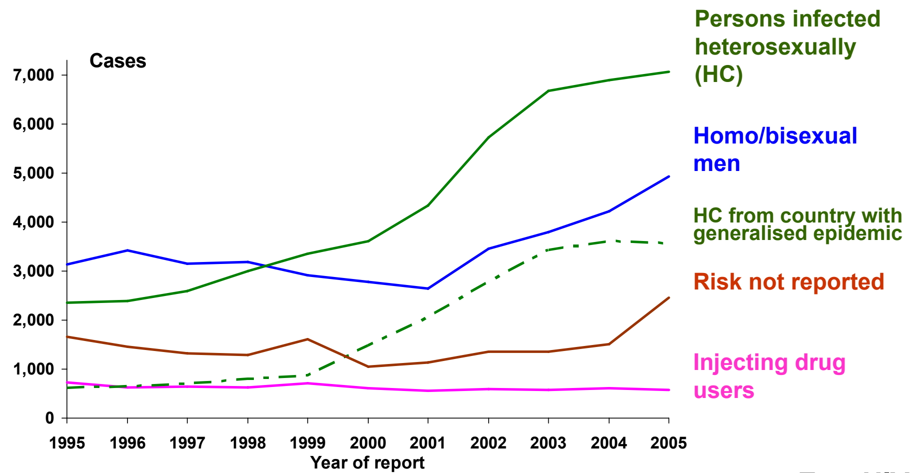
Newly diagnosed cases of HIV infection reported in 2005, WHO European Region



Predominant route of transmission of newly diagnosed cases of HIV infection reported in 2005, WHO European Region



HIV infections newly diagnosed by transmission group, western Europe*, 1995-2005



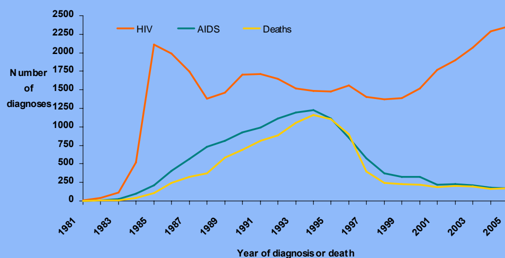
EuroHIV

* Belgium, Denmark, Finland, Germany, Greece, Iceland, Ireland, Israel, Luxembourg, San Marino, Sweden, Switzerland, United Kingdom

Men who have sex with men

HIV and AIDS diagnoses and deaths for MSM

- MSM remain the behavioural group at greatest risk of acquiring HIV in the UK
- New diagnoses in 2005 were highest on record
- Incidence of HIV remains high (an estimated 3% of MSM attending sentinel GUM clinics have acquired their infection in the previous year)
- High risk behaviour for HIV/STIs continue to be reported
- Co-infection with other STIs are common



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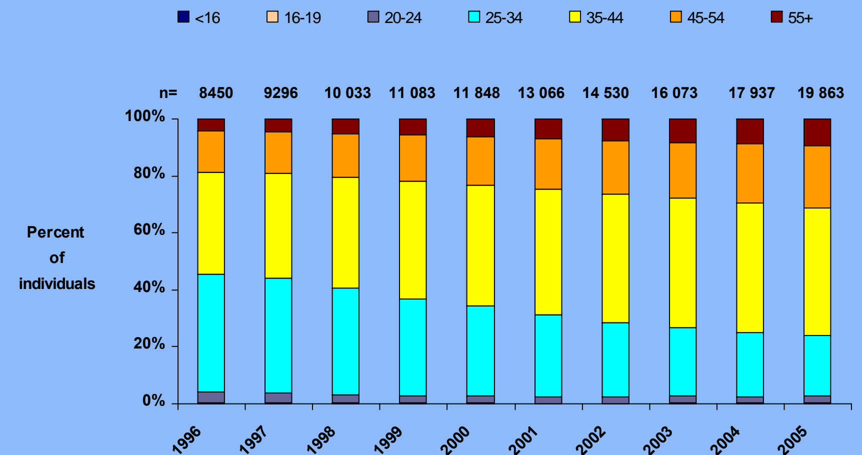
Clinician reports of new HIV/AIDS diagnosis

MSM accessing HIV care by age group, UK



Census of individuals accessing HIV-related care

The Strategic National Goal

The national strategy for sexual health and HIV

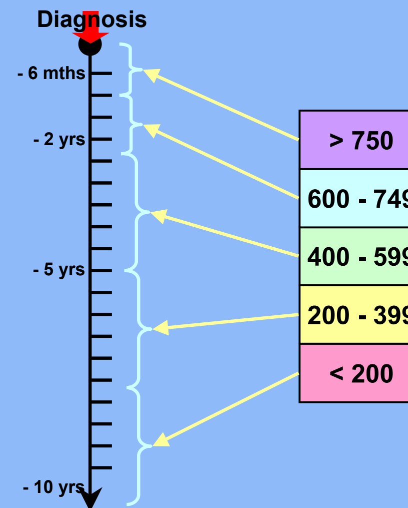
3.12 The target is *to reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by the end of 2007.*

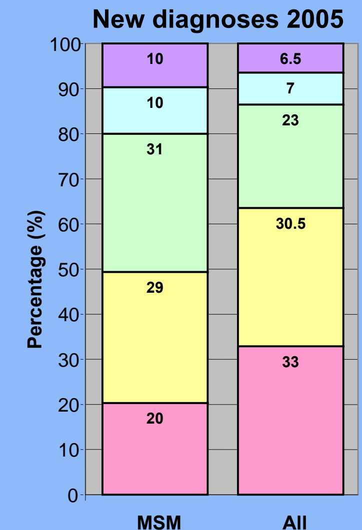
Strategic goal of *Making it Count*

To contribute to the national goal of reducing by 25% the annual incidence of HIV infection during sex between men, from approximately 1,300 infections per year to approximately 975 infections per year, by 2007.

Goal/ aim		Indicator	2001	2002	2003	2004	2005
25% reduction in newly acquired HIV infections by 2007	a	Unlinked anonymous prevalence monitoring: HIV incidence in undiagnosed HIV-infected MSM attending sentinel GUM clinics*	2.4%	2.5%	3.6%	3.0%	3.2%
	b	HIV/AIDS diagnosis reports: % (n) of HIV diagnoses aged under 25 (MSM)	8.8% (146)	9.5% (170)	9.3% (179)	9.1% (191)	11.9% (254)
	b	HIV/AIDS diagnosis reports: % (n) of HIV diagnoses aged under 25 (heterosexuals)	11.7% (329)	11.8% (431)	11.9% (515)	12.6% (531)	11.5% (439)
	b	CD4 surveillance: % (n) of individuals diagnosed with HIV with CD4 >750 cells/mm^3 (MSM)	11% (138)	11% (142)	9% (135)	11% (173)	9% (147)

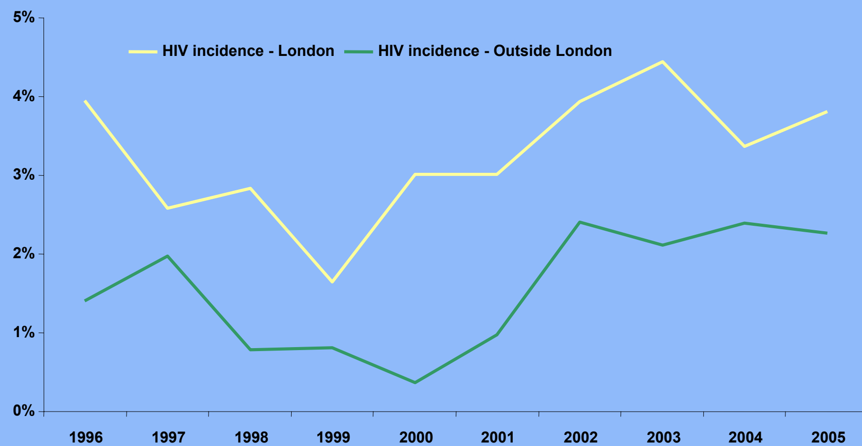
Proxy for Recent Infection





Time estimates for CD4 group based on Satten and Longini, 1996

Estimated HIV incidence among MSM attending GUM clinics

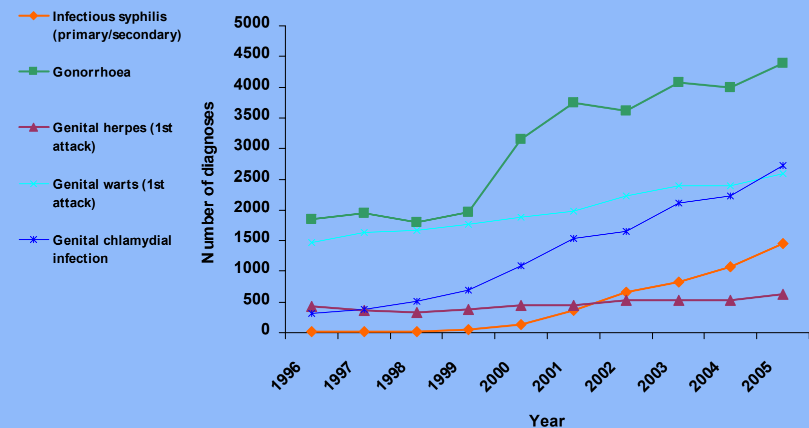


Estimated using the Serological Testing Algorithm for Recent HIV Seroconversion (STARHS).

Trend not significant.

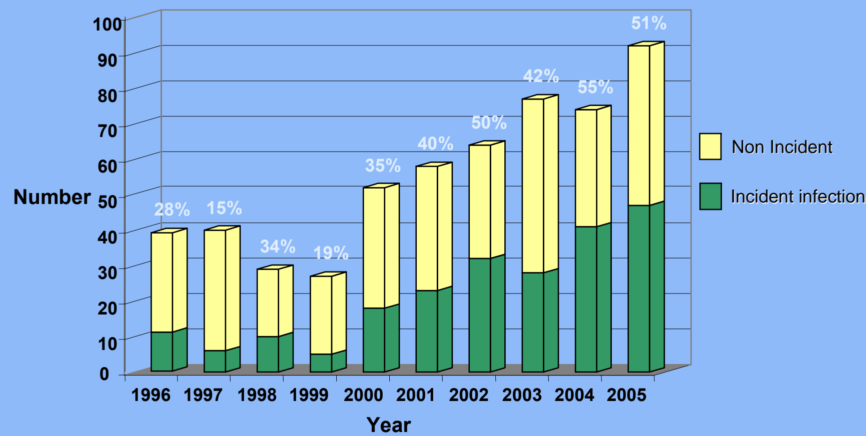
Unlinked anonymous testing of GUM clinic attendees

Diagnoses of selected STIs among MSM

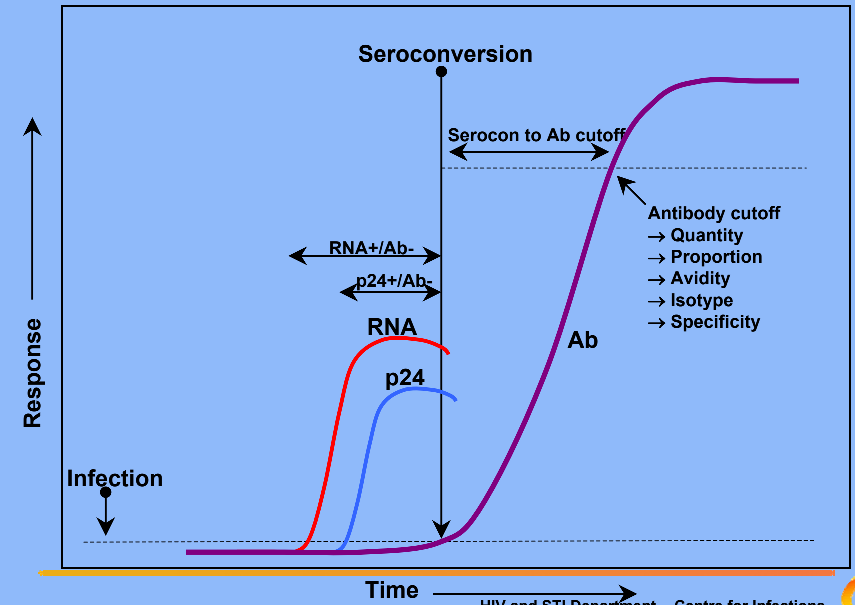


Routine GUM clinic returns

Incident infections on first diagnosis among MSM in Brighton



Early HIV Infection



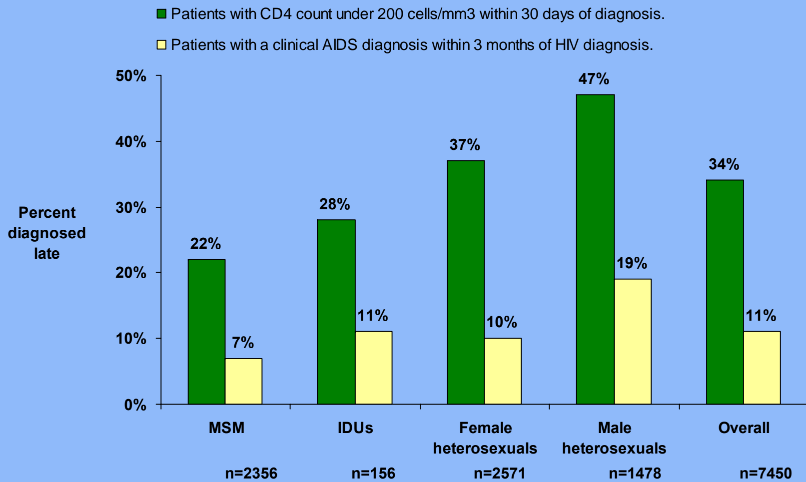
Parekh & McDougal. Indian J Med Res 2005

Developing Better Tools

- **Phase 1:**
  - London =10
  - Elsewhere = 7
- **Roll out HIV incidence testing to all new diagnoses**
- **Link Incidence to**
  - New diagnoses
  - Resistance
- **Targeted behavioural surveillance**
- **Developing robust statistical methods**

Impact of late diagnosis

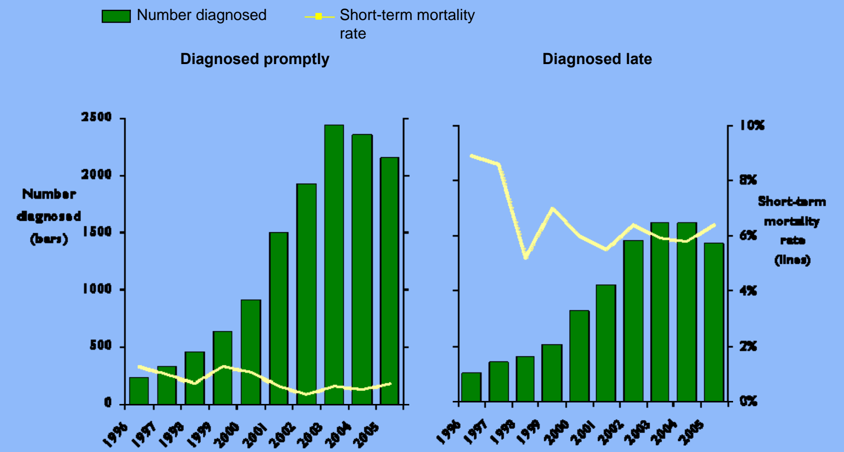
Late diagnosis of HIV infection, UK



Reports of HIV/AIDS diagnosis and CD4 Surveillance

HIV and STI Department - Centre for Infections

Pattern of diagnosis and associated short-term mortality rate among BME adults

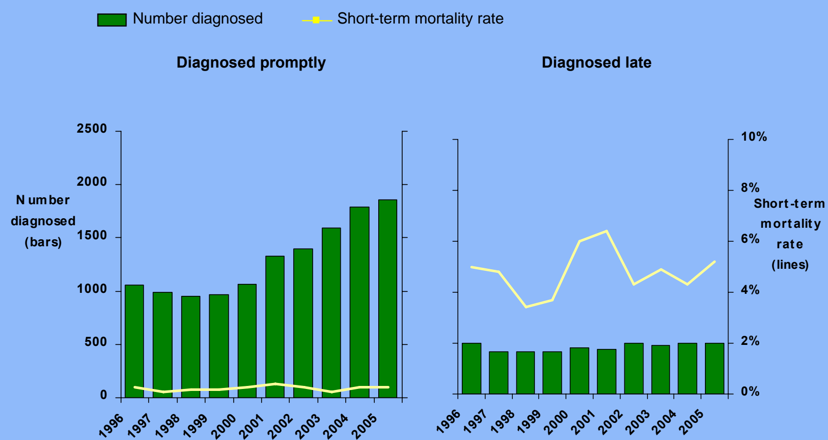


Late diagnosis CD4 count <200 cells/mm³; prompt diagnosis ≥200 cells/mm³.
Short-term mortality rate: percent of patients known to have died within a year of diagnosis.

Reports of HIV diagnosis, deaths and CD4 cell counts

HIV and STI Department - Centre for Infections

Pattern of diagnosis and associated short-term mortality rate among MSM



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HIV and STI Department - Centre for Infections

Deaths among HIV infected individuals in the era of HAART

- **Over half are AIDS deaths**
  - 37% among IDU
  - 54% in MSM
  - 63% in heterosexuals infected in UK
  - 63% in heterosexuals infected outside UK
- **Late diagnoses accounted for a third of all deaths and two out of every AIDS related death**

HIV and STI Department - Centre for Infections

Undiagnosed HIV

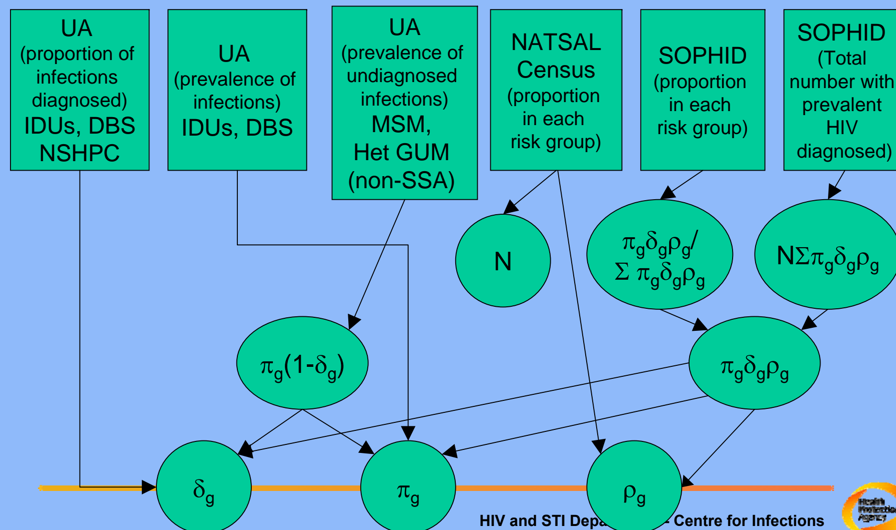
UK estimates of prevalent HIV infections – adults aged 15-59, 2005

Exposure Category	Number diagnosed	Number undiagnosed	Total
Sex between men	**19 000** (18 500 - 19 600)	**9000** (6600 - 12 400)	**28 000** (25 500 - 31 400)
Injecting drug use	**1400** (1300 - 1400)	**500** (400 - 600)	**1800** (1700 - 2000)
Heterosexuals	**23 100** (22 400 - 23 800)	**10500** (7500 - 15 100)	**33 600** (30 700 - 38 000)
Men	**8300** (8100 - 8600)	**5000** (3400 - 8600)	**13 400** (11 800 - 16 900)
African born	5200	2300	7500
Non-African born	3200	2600	5800
Women	**14 700** (14 200 - 15 200)	**5500** (3900 - 7000)	**20 200** (18 700 - 21 700)
African born	10 900	3100	14 000
Non-African born	3800	2300	6100
UK total	**43 400 (32 200 - 44 700)**	**20 100 (16 000 - 25 500)**	**63 500 (59 500 - 68 800)**

Multi-parameter Evidence Synthesis method - Goubar A *et al.* 2005, United Kingdom.

SOPHID, Health Protection Scotland, Natsal 2000, Unlinked Anonymous Programme, National Study of HIV in Pregnancy & Childhood, ICH.

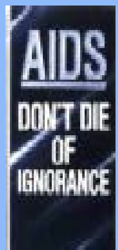
MPES:
Relationship between parameters π, ρ, δ and data



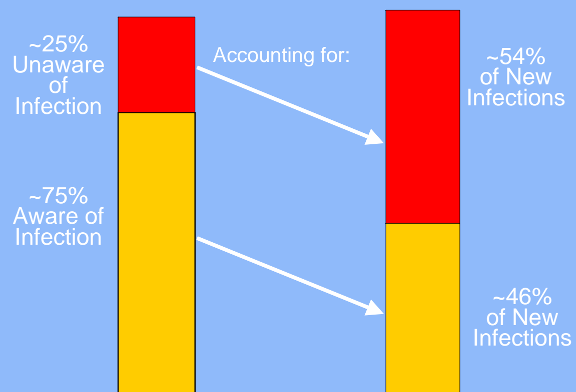
HIV testing

Success of testing in antenatal and GUM setting

?? Other settings



Disproportionate HIV transmission from those unaware of their infection

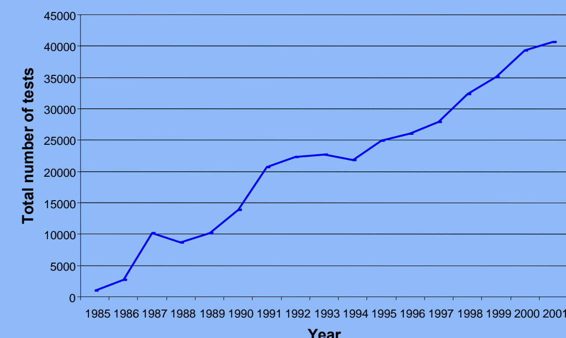


Marks G, Crepaz N, Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS. 2006 Jun 26;20(10):1447-50.

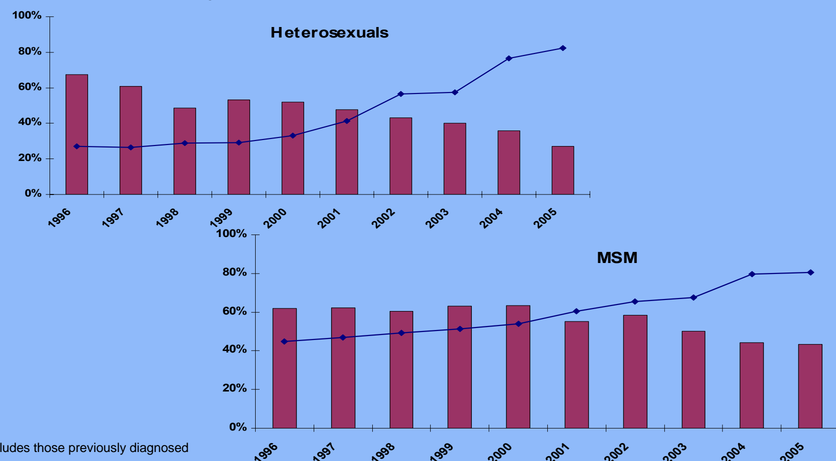
Number of HIV tests performed Denominator

- 1985 – 18 labs
- 1998 – 7 key sites
- Details ALL HIV test
- Testing patterns
- Link over time
- HIV incidence in repeat testers

- KC60 HIV screens
- 240 000 in 2001
- 820 000 in 2005



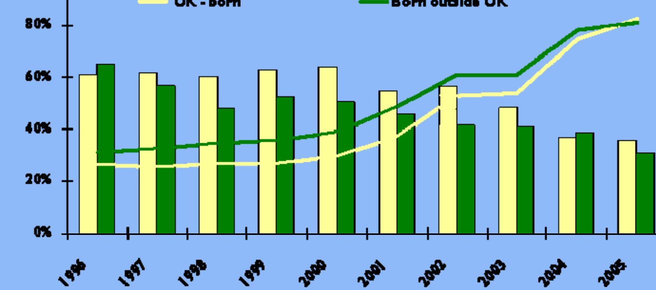
Uptake of Voluntary and confidential HIV test in GUM clinics, UK



VCT excludes those previously diagnosed

Unlinked anonymous testing of GUM clinic attendees

Percentage of GUM clinic attendees accepting an HIV test and percentage leaving the clinic unaware of their infection



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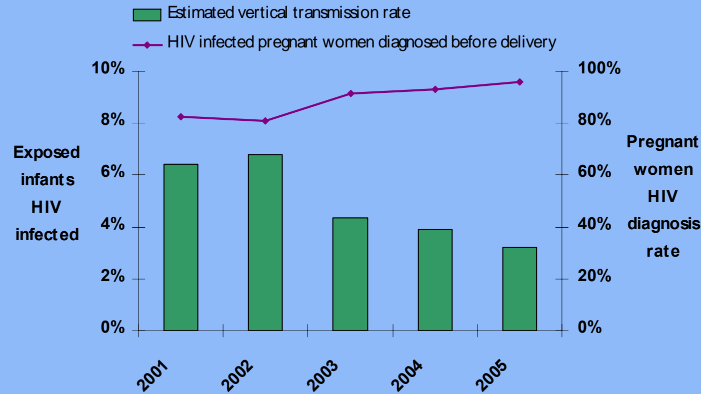
Unlinked anonymous testing of GUM clinic attendees

Pregnant women and newborn infants – HIV diagnosis and transmission rates, UK



Assumes a vertical transmission rate of 26.5% in undiagnosed women and 2.2% in diagnosed women.

Unlinked anonymous testing of newborn infant dried blood spots and NSHPC

HIV testing – we need to do more

- A third of persons infected are unaware of their status
- Late diagnoses leads to increased morbidity and death
- Offer of HIV testing in GUM and Antenatal setting works
- Missed opportunities for earlier diagnosis (BHIVA audit/ TB clinics)
- US guidelines recommending HIV tests for all 13-64 year olds as part of routine medical examinations in all care settings
- WHO guidance consultation
- NICE guidelines/ Sexual Health Strategy/ Chlamydia Screening Programme- expanding sexual health management into primary care

Challenges (1)

- How, when, where and who to test
  - 'normalise testing'
  - Opt-out vs Opt-in
  - Testing vs screening
  - Defining risk groups
  - frequency of testing
  - time of test- (point of care testing)
  - settings – general practice, FP, community
  - Targeted access (London vs other)
  - harm vs good

'*I was more surprised, more surprised that I'd gone so long testing negative* (Case age 25 to 34 years in INSIGHT study)'

Challenges (2)

- Increase awareness and skills among health professionals
  - Lack of confidence in pre-test discussion, fear of dealing with negative test
  - Referral mechanisms and pathways unclear
  - MedFASH guidance for primary care/ BASSH courses
  - Royal College of Physicians
- Evaluations of interventions
- Cost effectiveness
- Do the benefits outweigh the potential harm
  - Confidentiality
  - Criminalisation
  - Lack of access to treament

Discussion

- High and sustained rates of HIV/ STIs
  - Targeted behaviour modification and intervention strategies for MSM and black-African and black-Caribbean heterosexuals are essential
  - Challenges in monitoring impact of health promotion

- Early testing of HIV and access to treatment remains crucial in reducing undiagnosed infection and ill health and the transmission of HIV
  - Maintain high antenatal and GUM clinic screening
  - Reduce barriers to testing in other settings
  - Provide treatment access to those tested

Updating testing strategies

Yusef Azad
Director of Policy and Campaigns
National AIDS Trust

22 March 2007

The need for a testing strategy

- About one in three people infected with HIV in the UK are unaware of their infection [same as European average; in US about 25% unaware of their infection]
- There are significant rates of late HIV diagnosis – in 2005 34% were diagnosed with a CD4 count below <200 cells/mm^3 and 11% presented with AIDS
- HIV-related mortality has remained at roughly the same level for a number of years and is closely related to late diagnosis
- US modelling claims that a disproportionate amount of HIV transmission (54%) occurs from those whose HIV infection is not as yet diagnosed (25%)

A new testing context?

- Recommendation from the US Centre for Disease Control and Prevention (CDC) of routine opt-out HIV screening in all healthcare settings for all aged 13-64
- New BASHH Guidelines on HIV testing 2006 – from pre-test counselling to pre-test discussion
- New anti-discrimination protection in the UK for PLWH [Disability Discrimination Act 2005]

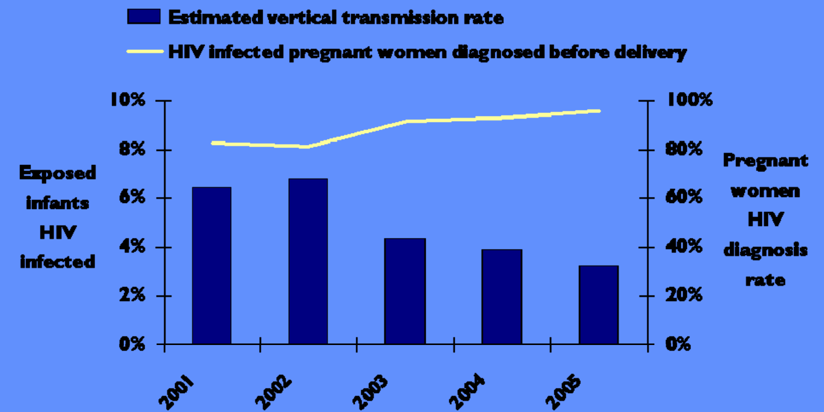
National Strategy testing targets

- 2000 introduction of antenatal HIV screening with aim of a 90% uptake and an 80% reduction in the number of children with HIV acquired from their mother by the end of 2002
- By the end of 2004 all GUM clinic attendees should be offered an HIV test on their first screening for sexually transmitted infections (and subsequently according to risk)
- By the end of 2004 increase the test uptake by those offered it to 40%; and to 60% by the end of 2007

Testing success - antenatal

- 95% of pregnant women living with HIV diagnosed before delivery in 2005 [83% in 2001]
- Likely proportion of children exposed to vertical HIV transmission who are themselves infected has decreased to 3% in 2005 from 6% in 2001

Pregnant women and newborn infants – HIV diagnosis and transmission rates



Assumes a vertical transmission rate of 26.5% in undiagnosed women and 2.2% in diagnosed women.

Unlinked anonymous testing of newborn infant dried blood spots and NSHPC

Testing success - GUM

- Substantial increase in number of HIV tests offered from 241,275 in 2001 to 820,893 in 2005
- Substantial increase in the number being offered test – GMSS 2005
- In 2005 70% of those attendees offered a test accepted the offer [KC60 returns]

National Strategy ‘undiagnosed’ target

- Reducing by 50% the number of previously undiagnosed HIV infected people attending GUM clinics who remain unaware of their infection after their visit by the end of 2007
- Significant progress to 2005 –
  - MSM 55% [2001] to 43% [2005];
  - Heterosexuals 48% [2001] to 27% [2005] [UA sentinel clinics]
- More to do amongst MSM in particular?

Further work in antenatal and GUM settings?

- Maintain antenatal success – some concern at first signs of impact of charging; issue of women who arrive in labour and whose HIV status is unknown
- Would expanded rapid testing in GUM settings increase uptake? What do we know of current availability and what are the cost implications of comprehensive rapid test roll-out?
- How do routine offers work in antenatal and GUM settings? Should we be working towards a more explicit and consistent policy of opt-out routine HIV screening for all in GUM?

Testing in secondary care

- What about testing in other parts of secondary care? Late diagnoses in Brighton 2000/05 26% presented in secondary care with probable HIV-related symptoms but no test offered *Roberts J et al* HIV Medicine Vol 7 Suppl 1
- Failure to test routinely in TB clinics – London data from 2002/03: only 56% offered an HIV test, 83% of this number took the test, and 17% of those tested were HIV positive [see *Thorax* 2006;61:271-274]
- and what about dermatology, respiratory care, for example?

Testing in community settings

- Recent Sigma Research study of THT fasTest - service 'highly acceptable' to users
- Users less likely to have previously had an HIV test compared with those testing in sexual health clinics
- 52% chose fasTest because result available at same visit, 32% because it was 'more convenient', 16% because they had difficulty getting a GU appointment

Testing in primary care

- c.5% only of HIV diagnoses reported to the HPA originate from testing in primary care
- Evidence of significant lost opportunities to test and diagnose in primary care – BHIVA 2006 75% of Africans diagnosed had visited GPs in the previous two years but with no discussion of HIV testing *Burns F et al* HIV Medicine Vol 7 Suppl 1
- DH ambition to increase HIV test availability in primary care at least since 2001 – with what success? what have been the barriers?

Home testing

- HIV Testing Kits and Services Regulations 1992 – home *sampling* kits **not** illegal in the UK. Do people know this? How extensively are they used?
- Early US study – 0.9% of results positive; 60% of all users and 49% of those who tested positive had never tested before.
- Is there any prospect of home testing being introduced? on the EAGA agenda.

Developing new targets?

- Do GUM-based testing/undiagnosed targets effectively address testing 'need'?
- Should we introduce targets for availability of HIV testing in primary care and community settings?
- Should 'success' be measured by a reduction in the proportion of late diagnoses? Or the median time for individuals between infection and diagnosis? Or an overall reduction in the percentage of people undiagnosed?

Testing cultures

- What should our 'testing cultures' be in gay and African communities?
- GMSS 2004 – 43% of gay men never tested; Mayisha II – 53% of African men and women never tested
- Is there value in a 'regular check-up' approach, or should we advocate a more risk-related self-assessment?
- Is there a danger in a regular testing culture reinforcing rather than challenging risk-taking behaviours? [see for example INSIGHT study]

Barriers to testing

- What impact are and should criminal prosecutions having on testing strategies and practice?
- Charging certain categories of migrant for treatment and care
- Stigma and Discrimination – see Mayisha II and *Elford J* et al HIV Medicine Vol 7 Suppl 1 March 2006

Questions for discussion

- Is it time to change our ‘testing culture’ in the UK?
- Should we be aiming to move most HIV testing out into primary care and community settings? If not, why not? If so, how?
- Is there a case to roll out opt-out screening more widely, and if so in what contexts?
- Are there useful targets we could collectively work towards?

Prevention in a changing context

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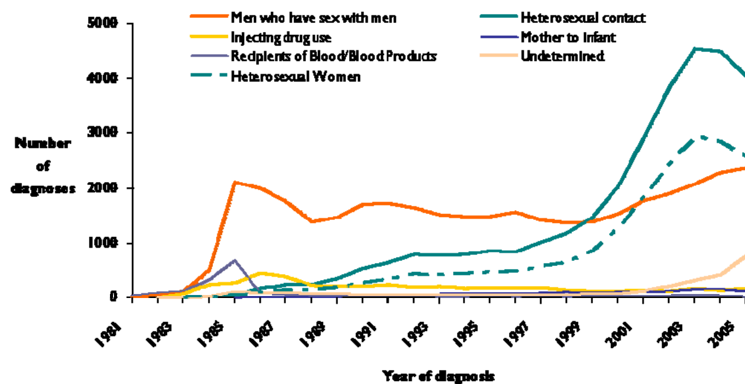
Understanding need – HIV diagnoses



What does this tell us?

- There has been an increase in HIV diagnoses over the past decade
- HIV diagnoses are principally confined to 'at risk' groups

What does it not tell us?

- Whether there has been a corresponding increase in HIV transmission in the UK
- Whether there has been a marked change in the level of undiagnosed HIV in the UK

Understanding need – HIV transmission, African communities

Review of behavioural research and epidemiology suggests:

- Majority of HIV transmission likely to have occurred abroad
- Lower levels of risk behaviour than for some other UK populations:
  - Over 70% of women and 58% of men had no new sexual partners in the past 12 months
  - More men than women report 2 or more sexual partners in last 12 months (20% c/w 8%)
  - Faithfulness to the partner regarded as important value
  - 90%+ of partners are opposite sex
  - Over half of people report condom use at last sexual intercourse
  - Frequency of concurrent relationships, with inconsistent condom use
  - Approx. half of Mayisha 2 respondents had been tested for HIV

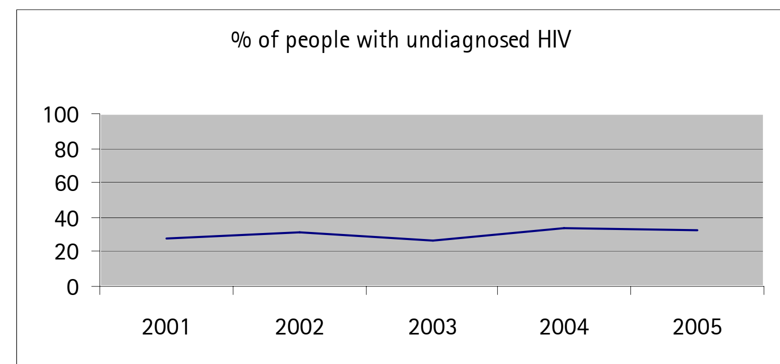
Understanding need – HIV transmission, Gay men

- New HIV infection rates amongst gay men appear to have stabilised (although is ongoing)
- Detailed review of behavioural research & epidemiology suggests:
  - use of risk reduction measures by positive & negative gay men
  - men with undiagnosed HIV likely to account for a significant % of HIV transmission
  - No evidence of increasing HIV incidence in under 35s in London
  - risk behaviour changes with age, to peak when gay men are in their 30s
  - worsening of sexual health of positive gay men
  - changing gay male population as a result of migration, potentially increases proximity to HIV, esp in London
  - lack of awareness amongst some groups of men to their proximity to HIV, as distinct from a rise in complacency
- As such, headline SDUAI stats mask a lot of 'churn' beneath the surface

Understanding need – HIV transmission, injecting drug users

- HIV infection in IDUs has increased since 2000
- Levels of reported needle and syringe sharing increased in late 1990s and haven't declined since
- Recent increases in HIV transmission
- 33% of IDUs haven't tested for HIV
- 50% of IDUs have HCV; 50% of whom are undiagnosed
- Increasing proportion of IDU HIV transmission occurring in UK (but still nearly 50% outside UK)

Understanding need – undiagnosed HIV

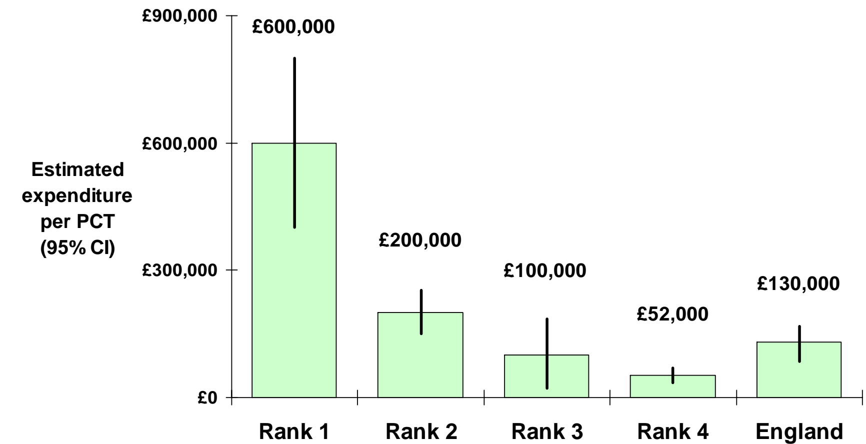


Source: HPA annual HIV/STI reports

Review of evidence suggests:

- Limited success at reducing undiagnosed HIV
- People with undiagnosed HIV are likely to account for a disproportionate amount of HIV transmission
- Potential role of sero conversion in HIV transmission
- Little evidence of intentional transmission from people diagnosed with HIV
- HIV awareness raising and outreach encourage African people to test, fear of stigma, deportation, lack of entitlement to free treatment and negative views about HIV reality discourage
- Level of awareness of proximity to HIV risk, and differing attitudes about the benefits of knowledge of HIV status affect gay men's decisions about taking an HIV test

Total expenditure on HIV prevention per PCT (2005/06)



Understanding resourcing for HIV prevention work

Key issues:

- An almost certain absolute and relative decline in targeted HIV prevention investment since 1997/8
- An increase in the relative importance placed upon nationally funded prevention programmes – CHAPS & NAHIP
- Uneven application of evidence base within local prevention commissioning

Understanding the HIV prevention evidence base

Cost effective HIV interventions

- Free condom provision for medium and high risk groups
- Outreach HP and safe sex programmes for high risk hard to reach groups
- Provision of HIV risk reduction messages in gay scene venues
- Safer sex skills training /cognitive behavioural intervention for MSM
- Peer led interventions for MSM
- High quality integrated Sex and Relationships Education
- Needle exchange provision to prevent HIV in injecting drug users
- Behavioural HIV risk reduction sessions for high risk women
- PEP for men having receptive anal intercourse with men
- Highly Active Antiretroviral Therapy (HAART)
- Antenatal HIV screening

Renewing prevention strategy – key challenges

- HIV cannot be considered a preventable epidemic
- Visibility of PWHIV is lower than in the past, yet there is a need to increase this
- Reducing the contribution of people with undiagnosed HIV in onward transmission
- HIV prevention is not a national NHS priority (but room for optimism in London)
- Need to improve evidence base amongst African communities
- Need to increase awareness of HIV amongst African communities
- More potential to reduce undiagnosed HIV amongst African people yet fewer opportunities than amongst gay men

Renewing overall prevention strategy – suggested themes

- Maintaining an emphasis on what "works"
- Expanding the evidence base through innovation and evaluation
- Integration of prevention and testing programmes (inc. therapeutic interventions)
- Maximise access to ARVs
- Growth in work with people diagnosed with HIV
- Maintained national HIV prevention programmes with gay men and African people
- Change in legislation to allow non medically supervised HIV POCTs
- Renewed focus around condom use
- Strengthened SRE in schools to provide foundation skills and knowledge

Renewing prevention strategy – suggested themes, gay men

- Expanded access to tailored community based sexual health services to enable regular HIV/STI check ups, and systematic vaccinations
- Co-ordinated national HIV screening initiative to achieve a step change in levels of undiagnosed HIV
- Maintain and expand access to PEPSI
- Establish a major focus on work with positive gay men
- Expand work with gay men in greatest need, to over serve them
  - Men in their 30s
  - Men with over 30 sexual partners each year
  - Men who use sex on premises venues
- Development of balanced portfolio of risk reduction approaches, including:
  - Condoms
  - Partner selection
  - Partner reduction
  - "strategic positioning"
  - STI status
  - Viral load assessment
  - Withdrawal

Renewing prevention strategy – suggested themes, African people

- Establish equivalent strategic framework to Making it Count
- Investment in developing the evidence base
- Strengthen HIV prevention foci – "learning about your partner" and "don't bring it into the home"
- Strengthen work with peers and influential leaders
- Strengthen access to specialist HIV prevention expertise for African communities
- Strengthen work to establish role models
- Maintain and strengthen focus on community development work

Renewing prevention strategy – suggested themes, injecting drug users

- Maintenance of risk reduction programmes, inc. needle/syringe exchange programme and methadone maintenance
- Maintenance of IDU HIV health maximisation programmes
- Expand access to HCV diagnosis and treatment, as a vehicle for dual diagnosis work

Questions

1. Are we happy that we know why HIV transmission is occurring at current levels?
2. What is a realistic aspiration for a reduction in HIV incidence?
3. Are the suggested future themes the right ones? Do they need to be more radical? If so how?
4. What should be the priorities?

Thank you

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