NATIONAL AIDS TRUST RESPONSE TO DEPARTMENT OF HEALTH INTERIM UNGASS REPORT

Introduction

This paper is the response of the National AIDS Trust (NAT) to the Department of Health interim report on its UNGASS commitments. The DH report includes a section for civil society to complete and NAT contributed extensively to that section. This response will therefore focus and comment only on the section containing the Department's self-assessment of its performance. This NAT response also identifies some global issues which it is hoped the UK country delegation can champion at the summit to take place in New York from 31 May to 2 June 2006.

Following on from this response, NAT will in the near future and in advance of the summit produce a report summarising comprehensively its assessment of the UK's fulfilment of its UNGASS commitments.

Overview of the HIV and AIDS epidemic/National response to the AIDS epidemic

These sections contain a good overview of the current epidemiology of HIV in the UK. The section on injecting drug users should take account of the recent information from the Health Protection Agency which reported that the number of injecting drug users (IDUs) infected with HIV had reached the highest level since 1992, coinciding with an increase in risk taking behaviours in this group.[1]

In the 'Major challenges ..' section, more should be made of the challenges in responding to HIV in African communities, with a particularly high rate of undiagnosed HIV infection amongst African men (39%), an unwillingness amongst many to attend GUM clinics (the VCT information included is all in the GUM setting), significantly later presentation for care, high levels of stigma within the community and difficulties caused by the constraints of the immigration process.

National Expenditure on HIV and AIDS

With the end of ring-fenced funding for HIV prevention and treatment and the delegation of responsibility for funding decisions to the local level, it is now extremely difficult to get a national picture of the money being spent on HIV, trends in expenditure, what funds are being spent and how effectively. For the sake of completeness the DH should include in its report the amount being spent on HIV treatment and care (a calculation is included, for example, in the recent HPA publication 'Health Protection in the 21st Century' 4.3.2).

In the DH Implementation action plan for the national strategy for sexual health and HIV there was a commitment to monitor investment, 'Following mainstreaming of the HIV budgets, levels of investment in HIV prevention, treatment and care will be closely monitored, including any impact on the voluntary sector. Data on levels of NHS investment will be collected via the Service and Financial Framework, and any issues of

[1] See HPA press release 16 March 2006 'HIV in injecting drug users reaches highest levels for a decade'

serious concern will be addressed by the relevant Strategic Health Authority or, as a last resort, by the DH ..'. This has not been done to our knowledge, and certainly such comprehensive information has not been made publicly available. The Department should fulfil its commitment as stated in the national strategy Implementation Action Plan to monitor local spend. It is unacceptable that no national picture is readily accessible of patterns of expenditure for HIV.

Strategic Plan

The national strategy for sexual health and HIV was a welcome document and catalysed in the short term some important actions. Its limitations are implicit in some of the DH responses, for example the fact it did not deal with migration issues, and the fact it did not have clear resourcing commitments or a monitoring and evaluation process.

The DH response states that the strategy is multi-sectoral. It is true that the DFES is involved in sex and relationships education issues, and with the Teenage Pregnancy Strategy. NAT does not, however, consider this to be sufficiently multi-sectoral to meet the expectations of the UNGASS commitments or the needs of people living with HIV in the UK and affected communities. Departments such as the Home Office, the Department of Work and Pensions and those parts of Whitehall dealing with poverty and social exclusion need to be integrated into a properly comprehensive national HIV strategy.

The recent draft Action Plan on HIV-related stigma and discrimination was limited to the Department of Health. This demonstrates the lack of a genuinely multi-sectoral approach to HIV from the Government. NAT's response to the draft Action Plan (available at www.nat.org.uk) and the responses of other organisations pointed out the numerous actions required from other government departments if such stigma and discrimination are to be addressed successfully.

NAT considers '**9**' to be too generous a score for the UK's HIV strategic planning. The national strategy in relation to HIV has been hampered by not being genuinely multi-sectoral, by having no review, monitoring or evaluation process, and thus being left behind by events. Over time, its relevance has declined, with no high-level political opportunities for review and re-focus. Instead, PSA targets have ignored specific reference to HIV, the goal of a reduction by 25% of new HIV infections by 2007 is no longer discussed, and by the time of the Choosing Health White Paper the Government found it acceptable to focus on sexual health without a substantive mention of HIV.

Political Support

HIV is a stigmatised condition and one which affects often marginalised, minority and disempowered communities. Therefore active and explicit political support for HIV interventions and for the human rights of people living with HIV is essential.

The DH report claims that the head of state and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year. If this is the case, such public statements have passed the UK HIV sector by. To meet the purpose of the question, the statements have to be about HIV in the UK. Whilst there may be discussion of HIV at home when questioned in Parliament or when the subject is raised by select committees or in debate, NAT does not consider that the Government does genuinely meet this

UNGASS standard. To meet the standard, NAT considers that evidence is needed of a key statement or speech from the Prime Minister or another senior Minister concentrating on HIV in the UK, and accompanied by government press release.

The DH report accepts that there is no multi-sectoral taskforce to respond to HIV in the UK but makes no commitment to remedy this failing. The claims made in the DH report for multi-sectoral working require some further examination. The Independent Advisory Group on Sexual Health and HIV (SHIAG) is cited as a multi-sectoral body. Its members certainly include a range of experts, such as NHS and social care providers as well as NGOs which may work across a range of settings. But there are no independent experts taken from sectors such as refugee work, education, the criminal justice system, business, and the trade union movement.

The DH report claims that political support has increased since 2003, and raises its score from '**8**' to '**9**', giving as a reason the publication of the Choosing Health White Paper. Whilst the White Paper certainly increased the political profile for sexual health in general, it has to be viewed as a backward step in terms of political support for HIV. In what was an extensive document, HIV was only mentioned twice in passing, without any substantive discussion. Furthermore, gay and bisexual men, and African communities, the two groups most affected by HIV in the UK, were completely ignored. This is not mainstreaming, it is neglect. Whilst a national sexual health awareness campaign and shorter waiting times for GU clinics will both no doubt have some beneficial effect on the response to HIV, HIV cannot be adequately addressed solely by broader sexual health interventions. This is because of the stigma associated with the condition, the specific marginalised communities affected, and the complexities and seriousness of the condition itself.

Prevention

NAT shares the concerns expressed by the DH in its report over the possible diversion of funds away from HIV prevention at a time when there is evidence of increased risk-taking behaviour amongst MSM, increasing numbers of heterosexuals diagnosed who were infected in the UK (albeit this increase is from a low base), and concerns at rising incidence in some black Caribbean communities and amongst IDUs.

This response has already emphasised the need for the DH to monitor the resources invested into HIV prevention at both national and local levels, the design of services and the populations targeted, as well as evaluations of outcome.

The DH must act to ensure prevention funding increases so as to keep pace with need – resources appear to be stagnating or declining whereas the numbers living with HIV in the UK have more than doubled in the last ten years. If a return to ring-fenced funding is not a possibility, there needs to be high-level consideration within Government as to how best to incentivise prevention expenditure, whether through PSA targets, through planning taking place at a more consistently regional level, or through other means.

The recent announcement of a cut in VAT on condoms is a commendable attempt to make one preventive tool more accessible. Prisoners, despite the theoretical commitment to equivalent healthcare from the Government, are currently denied vitally important preventive interventions, including the possibility of needle exchange programmes and readily accessible condoms.

The DH report should acknowledge the point made by the civil society commentators, that sex and relationships education (SRE) is not a compulsory and assessed part of the national curriculum, and is currently too biological in focus. NAT, along with many other organisations, are calling for SRE to become a compulsory part of the national curriculum.

The DH report states that work is being done on the media response to HIV – if this refers to the work begun recently by NAT, this is a welcome acknowledgment by the Government of its importance. We look forward to discussions as to how the DH and other government departments can support this important work.

The effectiveness of a prevention response cannot of course only be assessed in terms of value of contracts. The National Strategy has a goal of a 25 per cent reduction in new infections in the UK by 2007. It is already clear that new infections will have increased significantly rather than decreased. It is vital that the Department of Health join the HIV sector in a fresh consideration of what might help reduce onward transmission of HIV.

The recent advent of criminal prosecution for HIV transmission is one worrying example of what appears to be 'policy drift' around HIV. In 1998 the Government in response to a Law Commission report came out with a clear position against the prosecution of reckless disease transmission. In 2003, however, the courts began to interpret a nineteenth-century law as grounds for such prosecutions. Whatever one's view of the merits of such prosecutions, there can be no denying there are far-reaching implications for HIV prevention as understood to date in the UK. Clinical advice and liability, prevention interventions targeted at those living with HIV, partner notification, confidentiality of patient information, these are just some of the issues profoundly affected by prosecution. The DH has, however, taken a purely reactive approach. The implications for HIV prevention from criminal prosecution require a more thought-through and engaged response, reasserting the key principles of effective HIV prevention and assessing whether they can be satisfactorily maintained if HIV transmission is increasingly dealt with in the framework of the criminal law. The Government must legislate to end prosecution for the reckless transmission of HIV and other diseases.

Care and support

NAT strongly contests the positive assessment given by the DH on the provision of HIV care and support. The recent effective withdrawal of free NHS care, including HIV treatment, from failed asylum seekers and other undocumented migrants harms a particularly vulnerable population and contravenes the right to health as found in Article 12 of the International Covenant of Economic, Social and Cultural Rights, to which the United Kingdom is a signatory. It also risks public health (for more information see www.nat.org.uk).

This is part of a pattern of dealing with migrants at various stages of the immigration process which harm those living with HIV. As a recent report of NAT makes clear, the dispersal of asylum seekers has in many instances harmed the care and treatment of those living with HIV. NAT trusts that the new dispersal policy recently agreed by the National Asylum Support Service (NASS) will be implemented effectively to ensure continuity of care. It is also apparent that the detention of people in immigration removal

centres is in a number of cases resulting in interruptions to treatment and poor standards of care.

The DH report should acknowledge such difficulties and shortcomings and commit itself to the highest standards of HIV treatment and care for all migrants whilst resident in the UK.

Monitoring and Evaluation

Funds should be available to ensure the HPA can monitor HIV to the standard necessary to protect and promote public health and inform an effective response. NAT are concerned that resources have not as yet allowed an anonymous serosurvey of HIV and other blood borne viruses in prisons (the last was in 1997).

International issues

DFID's record on international development and HIV has been a good one. No doubt there will be an important emphasis in New York on the provision of HIV treatment to all who need it. We are confident the UK Government will support this. There should be consideration of the challenge such a roll-out will bring to health systems and the particular problem of adherence in resource-poor settings, with implications for the spread of drug-resistant HIV.

DFID has rightly stressed the need to engage with prevention as well as treatment. The UK Government has a commendable record in supporting research into the development of new prevention technologies such as microbicides and vaccines, having contributed about £50 million to microbicide development and £40 million to vaccine development. Such technologies offer the best hope for a long-term solution to the HIV pandemic and will bring particular benefits to women, who are disproportionately affected by HIV. Trials are already having a positive effect on local health infrastructures. NAT would urge the UK country delegation to place an emphasis on the continuing need for up-scaled focus and resources on the development of new prevention technologies, in particular microbicides and vaccines, and on the importance of other wealthy countries following the UK's lead.

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