

# 1 Summary

- The problem of HIV infection in the United Kingdom (UK) intensified during 2002. The estimated overall prevalence of HIV infection in adults increased over 12 months by 20%. By the end of 2002 there were an estimated 49 500 people living with HIV in the country. The key factors driving this increase were a possible expansion of HIV transmission in homo/bisexual men and continued migration of HIV-infected heterosexual men and women from sub-Saharan Africa.
- Despite the large increase in the use of combination anti-retroviral therapy (ARV) in individuals with diagnosed HIV infection, and the various targeted health promotion campaigns, the surveillance data suggest that HIV transmission may be increasing in homo/bisexual men. In 2002, 5.4% of homo/bisexual men in London attending seven genitourinary medicine (GUM) clinics were infected with HIV and were unaware of their infection, as were 4% of those aged under 25; a clear indication of continuing HIV transmission at relatively high levels.
- Monitoring recent HIV seroconversions, using a serological test algorithm, has shown that the incidence of HIV infection in homo/bisexual men attending 15 GUM clinics throughout England, Wales and Northern Ireland has risen in 2002 to over 3% per annum. Against the background of a sustained increase in homosexually acquired gonorrhoea over three years, 12% of homo/bisexual men who were aware of their HIV infection prior to their GUM clinic attendance and 38% of those who were previously unaware of their HIV infection, were also infected with an acute STI. While the uptake of voluntary confidential testing (VCT) for HIV in homo/bisexual men increased from 45% in 1997 to 62% in 2002, of those who could potentially have had their HIV infection diagnosed, 59% remained undiagnosed after leaving the clinic.
- The HIV situation in heterosexual men and women born in sub-Saharan Africa deteriorated in 2002. The annual number of infections newly diagnosed increased still further to over 2300, the prevalence of previously undiagnosed infection in heterosexual GUM clinic attendees increased to 4.9%; and overall HIV prevalence in pregnant sub-Saharan African women increased to 2.5%. The vast majority of heterosexuals born in sub-Saharan Africa, however, are not infected with HIV: 90% of GUM clinic attendees and 98% of pregnant women surveyed in 2002.
- Over the past five years there has been a steady increase in the number of diagnoses of HIV infection in people who are thought to have acquired their infection heterosexually within the UK, from 147 in 1998 to 275 reported so far for 2002. In heterosexual GUM clinic attendees born in the UK, prevalence of previously undiagnosed HIV infection increased three-fold in men since 1997 to 0.3% in 2002, while in women there has been no change.
- Overall, HIV prevalence in injecting drug users (IDUs) attending specialist agencies remained low, at less than 1%. Equipment sharing rates continued to be high. In those who had begun injecting in the previous three years, the prevalence of hepatitis C antibody was 14%.
- In 2002, increases in the major acute bacterial and viral STIs continued unabated. In England, Wales and Northern Ireland, 82 206 new diagnoses of genital *Chlamydia trachomatis* infections were reported, representing a 141% increase since 1996 and a 14% increase over the previous year. Increases of a similar magnitude were observed for gonorrhoea with 24 958 new infections being diagnosed in 2002, a 9% increase over the previous year. In Scotland, laboratory reports of chlamydial infection rose by 290% between 1996 and 2002. The most marked increases in the UK were however seen in new reports of infectious syphilis. In England, Wales and Northern Ireland, the 1232 reported cases in 2002 represented a 902% increase since 1996 and a 68% rise over the previous year. Rises in viral STIs such as genital warts and genital herpes infections were also seen, however these have continued to increase at a much lower rate than the bacterial STIs.
- The available surveillance data confirm the substantial variations in the distribution of HIV and STIs in the general population. High infection rates continue to be found amongst those with high rates of sexual partner change, in particular homo/bisexual men and young

heterosexuals. As the likelihood of STI transmission is dependent on the average duration of infectiousness, disease rates are also high among those with poor access to curative health services. This is particularly relevant in a context of recent increases in waiting times for GUM clinic appointments<sup>1</sup>. It is also highly relevant to population sub-groups for whom stigma or discrimination prevent access to and uptake of treatment and care services<sup>2</sup>.

- Marked geographic variations in disease occurrence exist, with a concentration of the HIV and STI epidemics in Greater London. However, other parts of the country are not exempt from the burden of sexual ill health as demonstrated by the recent outbreaks of infectious syphilis<sup>3</sup> and ciprofloxacin resistant gonorrhoea<sup>4</sup>. In this year's report we therefore draw specific attention to those population subgroups that we believe deserve special attention and effort in our prevention activities.
- Based on the evolving HIV and STI epidemics, policy makers and others should give urgent consideration to:
  - a Reviewing and strengthening primary prevention efforts directed at homo/bisexual men
  - b Offering and recommending annual HIV testing to homo/bisexual men attending GUM clinics
  - c Promoting further voluntary confidential HIV testing of migrants from sub-Saharan Africa presenting at GUM clinics
  - d Developing further studies of the sexual behaviour within the UK of migrants from sub-Saharan Africa and HIV positive individuals in order to better inform primary and secondary prevention efforts
  - e As the numbers of HIV infections due to heterosexual transmission within the UK rises, surveillance resources devoted to risk factor follow-up of newly diagnosed HIV-infected heterosexuals should increase to ensure there is no loss of timeliness in monitoring this evolving situation
  - f Reducing the current lengthy waiting times to GUM clinics
  - g Stepping up the implementation of the National Chlamydia Screening Programme (by increasing the number of locally funded programmes) to reduce the prevalence of genital chlamydial infection and its sequelae
  - h Extending routine screening for infectious syphilis to sexually active HIV positive homo/bisexual men attending **all** centres providing treatment and care. Research is also needed to determine the impact of syphilis outbreaks on HIV transmission amongst homo/bisexual men
  - i In view of increases in gonococcal antimicrobial resistance, reviewing and disseminating updated national guidelines for the treatment of gonococcal infections which should encourage regular local audit of therapeutic efficacy
  - j Finally, as the public debate continues over the proposed Human Tissue Act<sup>5,6</sup>, continued emphasis of the public health value of large scale Unlinked Anonymous testing of clinical specimens that would otherwise be discarded is required

## 2 Introduction

This report summarises national surveillance data for HIV/AIDS and other sexually transmitted infections (STIs), which are monitored by the Health Protection Agency (England), the National Public Health Service for Wales Communicable Disease Surveillance Centre (CDSC), CDSC (NI), and SCIEH (Scotland) and national collaborators in England, Wales and Northern Ireland. It is the first combined publication on the epidemiology of HIV and STIs for the United Kingdom (UK) and brings together previous separate annual publications on HIV<sup>7</sup>, STIs<sup>8</sup> and the Unlinked Anonymous Prevalence Monitoring Programme<sup>9</sup>. In producing a single report, we hope not only to draw attention to the significant public health importance of these infections, but to build upon recent initiatives aimed at adopting more integrated approaches to tackling sexual ill health. It should also serve as a timely reminder of the morbidity and mortality that result from STIs (including HIV infection) in the UK.

The surveillance system outputs summarised in this report include HIV infection reports from clinicians and laboratories; AIDS cases and deaths reported by clinicians; the annual Survey Of Prevalent HIV Infections Diagnosed (SOPHID); reporting of CD4 counts; Unlinked Anonymous HIV surveys; data from KC60 statistical returns from genitourinary medicine (GUM) clinics and other enhanced surveillance programmes. A summary of the structure and objectives of the surveillance programmes is contained in Appendix E. Almost 650 000 tests were conducted on leftover serum and saliva specimens collected in 2002 as part of the Unlinked Anonymous Monitoring Programme. Large-scale application of the Unlinked Anonymous technique, to tissue specimens that would otherwise be discarded, continues to provide essential and otherwise unavailable information both on the prevalence of undiagnosed HIV infections and on the effectiveness of voluntary confidential testing programmes. More comprehensive tables and figures of data supplementary to this report, as well as electronic slides of the figures, are available at [http://www.hpa.org.uk/infections/topics\\_az/hiv\\_and\\_sti/hiv.htm](http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/hiv.htm).

The past year has seen the implementation of a range of new interventions aimed at improving sexual health. In England, for example, these include the appointment of the Independent Advisory Group on Sexual Health<sup>10</sup>; the Health Committee report on Sexual Health<sup>11</sup>; the All Party Parliamentary Group on AIDS report on Migration and HIV<sup>12</sup>; and most recently the Government's response to the Health Select Committee on Sexual Health<sup>13</sup>. Many of these have equivalents in other UK countries (Wales, Scotland and Northern Ireland), for instance, the *Come Clean*<sup>14</sup> campaign in Wales. All have drawn attention to the need for greater political will in tackling HIV and STIs in Britain and globally. In England, the gradual implementation of the *National Strategy for Sexual Health and HIV*<sup>15</sup> has seen the appointment of local sexual health leads in Primary Care Trusts (PCTs), greater investment in GUM clinics, phased local implementation of prevention interventions including hepatitis B vaccination in homo/bisexual men, chlamydia screening, and promotion of HIV testing. These are steps in the right direction and progress against key goals and aims of the English strategy are presented in Appendix B.

Nevertheless the immediate public health challenges remain consistent across the UK: increasing incidence and prevalence of HIV and STIs; rising costs of care; inequalities in disease distribution and determinants; and the associated mortality and long-term morbidity. From a health protection perspective, a renewal of focus is now required in which raising awareness about STIs and strategies to prevent their transmission; providing early and effective treatment; and undertaking effective surveillance in order to inform public health intervention must be prioritised.