TRANSFORMING THE UK'S RESPONSE TO HIV

NAT

HIV prevention in England's high prevalence local authorities: 2013/14 and 2014/15

Examining spending on primary HIV prevention and additional HIV testing

NAT February 2015

Our strategic goals

All our work is focused on achieving five strategic goals:

- effective HIV prevention in order to halt the spread of HIV.
- early diagnosis of HIV through ethical, accessible and appropriate testing.
- equitable access to treatment, care and support for people living with HIV.
- enhanced understanding of the facts about HIV and living with HIV in the UK.
- eradication of HIV-related stigma and discrimination.

Our vision

Our vision is a world in which people living with HIV are treated as equal citizens with respect, dignity and justice, are diagnosed early and receive the highest standards of care, and in which everyone knows how, and is able, to protect themselves and others from HIV infection.

NAT is the UK's leading charity dedicated to transforming society's response to HIV.

We provide fresh thinking, expertise and practical resources.

We champion the rights of people living with HIV and campaign for change.

Contents

Executive Summary

In 2014 NAT surveyed all high prevalence local authorities in England.[1] We asked for information for 2013/14 and 2014/15 on health promotion services targeting people who are HIV negative ('primary HIV prevention') and which are delivered outside the clinic setting. We also asked for information on HIV testing services commissioned outside the sexual health clinic.

Local authorities took over responsibility for public health, including HIV prevention, in April 2013. This survey is the first attempt since that change to try to assess, at least for high prevalence areas, what is being commissioned for primary HIV prevention. It is in the context of continuing high numbers of people being diagnosed with HIV and no evidence of any decline in transmission rates over the last decade. There are significant costs from ongoing transmission, most importantly for the individuals who acquire HIV, a serious long-term condition, but also for the public purse in terms of treatment costs.

We conclude that investment in primary HIV prevention and HIV testing is inadequate. We must emphasise that disinvestment in HIV prevention has been a long-term trend predating April 2013. Much of local authority spending is based on historical decisions from earlier years. We trust the information in this report will support local authorities in their aim of improving and promoting public health, and HIV prevention in particular.

Gathering information on HIV prevention spending is a difficult task. Spending is not necessarily categorised by local authorities as 'HIV prevention' even when that is one of its aims and effects. For example, programmes addressing the sexual health of men who have sex with men (MSM) may well prevent HIV transmission as well as the transmission of a range of other STIs.

NAT was specific as to what we were including and what we were excluding in our request for information, but this is not an exact science. We focussed on spending on primary HIV prevention (a priority in the Government's Framework for Sexual Health Improvement in England) and on HIV testing services outside the sexual health clinic. These interventions are essential to effective HIV prevention and are commissioned by local authorities.

We must stress, however, that effective HIV prevention requires a combination of interventions going beyond primary HIV prevention – for example, reducing STI transmissions, HIV treatment, safer sex support for people living with HIV, and legal and social interventions.

1 Public Health England defines local authorities as having a high prevalence of HIV if there is greater than two people in every 1000 living with diagnosed HIV.

Summary and conclusions

- We found, for 2013/14, £9,473,341 was spent on HIV prevention in high prevalence local authorities and for 2014/15, £10,317,272. To take the amount for 2014/15, this constitutes less than 1% of the local authority public health allocation for these high prevalence local authorities for 2014/15.
- These amounts are lower than some other recent estimates. This is partly due to the exclusion of sexual health clinic services, support services for people living with HIV and sexual health interventions which did not have HIV prevention as a primary objective. Such services are of course also important in HIV prevention. But the Government's Framework for Sexual Health Improvement makes clear that 'primary HIV prevention' remains an essential element if we are to succeed in reducing rates of HIV transmission.
- Spend per capita on HIV prevention is higher in London than in high prevalence areas outside London. This is partly due to the existence of the London HIV Prevention Programme, the focus of which is explicitly on primary prevention, but is also accounted for by slightly higher spend at a local authority level. This may be because prevalence is also higher in London.
- A significant reduction in HIV transmission in England will not be achieved unless we substantially increase the overall amount being spent on HIV prevention by local authorities. From April 2016 it is currently planned that the ring-fence for public health funding will be removed. It is likely that other significant and underfunded local needs will draw on those funds, reducing further the amount available for public health interventions, including primary HIV prevention.
- There is wide variation in spending by local authorities on primary HIV prevention. Some local authorities are investing considerable sums in HIV prevention and developing innovative projects which aim to meet local need. However, there is no overall relation between local authorities' HIV prevalence and their approach to HIV prevention, either in amounts invested or in interventions commissioned.[2] It is unacceptable that a number of local authorities with high HIV prevalence are spending little or nothing on HIV prevention. There is a concern that removal of the public health ring-fence at a local level will compound this.
- It is essential that there is a national response to HIV through a national HIV prevention programme as well as a local response. The national HIV prevention programme provides important strategic direction, investment, research, materials and initiatives to complement and support local commissioning.
- Around a third of people living with HIV in England live in London, and around 45% access HIV care in London. A city-wide approach through the London-wide HIV prevention programme therefore adds real value, ensuring that there is adequate coverage of prevention activity across the capital and strengthening local authority-based commissioning.
- Detailed information on local authority HIV prevention was patchy - some local authorities gave very full accounts of their HIV prevention work, others provided little or no information. Most health promotion was described as 'outreach' in local authority responses and covered a variety of interventions. For example, condom distribution, small media distribution, work in bars, clubs and social events, and sexual health information campaigns. A significant proportion of the HIV prevention work commissioned is intended to target groups at increased risk such as MSM, black African men and women, and other black and minority ethnic (BME) groups.
- A total of 35 out of 58 local authorities surveyed were not investing anything in HIV testing outside the sexual health clinic in 2014/15. This is simply not good enough. There is evidence to suggest that local authorities could do a lot more to extend testing opportunities in GP and hospital settings, as well as in the community, in line with NICE guidance. Poor implementation of NICE public health guidance on HIV testing is seriously limiting

2 This is apart from contributions to the London-wide HIV prevention programme which are calculated based on HIV prevalence in that local authority.

the potential for HIV treatment to reduce HIV transmission in England. There was an increase in expenditure on HIV testing outside the sexual health clinic between 2013/14 and 2014/15, which is welcome.

- Local authorities often had difficulty disaggregating their HIV prevention activity from other sexual health interventions, or from wider contracts with HIV support organisations.
- It is essential to stress the importance of support services for people living with HIV in maintaining adherence to treatment and in supporting safer sex. These services make a vital contribution to secondary HIV prevention. We are concerned that the pressure on public health and social care budgets now and in the future will make it even more difficult for local authorities to fund these services.

NAT recommendations

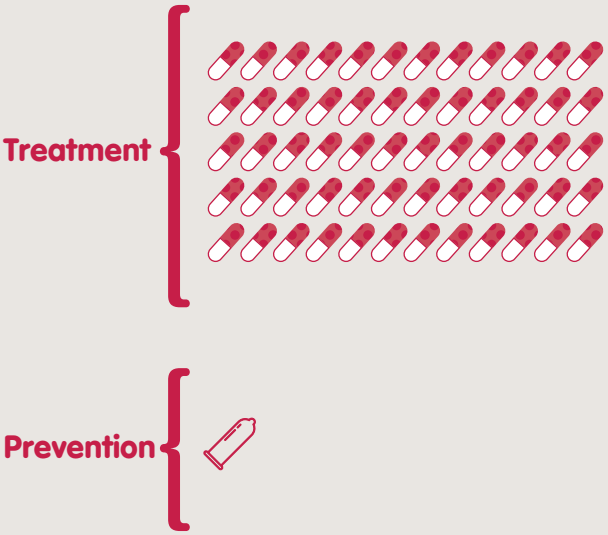
1. The Government should retain the public health budget ring fence beyond 2016 and the budget itself should be significantly increased if we are to invest what is needed to reduce HIV transmission in England.
2. The Department of Health should continue to fund the national HIV prevention programme at least at the current level of investment. Increased investment in the national HIV prevention programme should be seriously considered by the Government in order to go some way to better meeting prevention needs amongst higher risk groups in England.
3. Local authorities should substantially increase the amount they spend on primary HIV prevention.
4. Local authorities should provide targeted HIV prevention interventions, which are evidence-based and informed by local population prevention needs.
5. Local authorities should implement the recommendations for HIV testing which are set out in the NICE public health guidance.
6. Sexual health commissioners should clearly disaggregate, in contracts with HIV service providers, the indicative amounts to be dedicated to HIV prevention, with some information included on the intervention activity and on those being targeted.
7. Local authorities should have a clear understanding of which sexual health interventions provided in the local area are intended (at least as one of their aims) to reduce HIV transmission amongst those at increased risk of HIV, and which are not.
8. Public Health England should work with the national and London HIV prevention programmes and with local authorities to agree essential principles, objectives, types of intervention and outcome measures which local authorities can use to contribute effectively to primary HIV prevention in their local area.

In 2001/02 the Government allocated £55 million to local authorities to spend on HIV prevention. But today in 2014/15, with a higher number of annual HIV diagnoses than in 2001/02:

£10 million

Is being spent on primary HIV prevention across local authorities in England with a high prevalence of HIV.

55 times more is being spent by the NHS on HIV treatment and care in high prevalence areas than is being spent on HIV prevention.



60% of high prevalence local authorities are not investing in HIV testing services other than those in the sexual health clinic.

On average 70p per person is invested in HIV prevention in high prevalence areas.

The lifetime costs of HIV treatment and care for the

3,780 people

diagnosed with HIV in high prevalence areas in 2013 will be:

£1.2 billion

Of 58 surveyed local authorities:

- 7 are spending nothing at all on primary HIV prevention or on additional testing services,
- A further 5 are spending less than £50,000 in one year,
- And 13 less than £25,000 in one year.

A: Introduction

A1: The importance of HIV prevention

Significant numbers of people continue to acquire HIV in the UK. 6,000 people were diagnosed in 2013. Whilst the number of new diagnoses has declined from its peak in 2005 this is mainly a result of a decline in migration to the UK of people who had unknowingly acquired HIV in their country of origin before arrival here.

In the UK HIV disproportionately affects men who have sex with men (MSM) and the black African population. 3,250 MSM were newly diagnosed in 2013, the highest number since the epidemic began.[3] Higher diagnosis rates amongst MSM are not only because more people are getting tested for HIV but also because of 'ongoing high rates of transmission'.[4]

Recent research and modelling suggests that the high and undiminishing HIV transmission rate amongst MSM is a result of increases in testing and treatment (which should have preventive benefit) being counteracted by an increase in condomless sex over the same period. The same research found that even higher rates of HIV testing and treatment access would reduce incidence, and that the continuing rate of condom use is still having a powerful protective benefitfor MSM.[5]

PHE has also looked again at diagnoses of African men and women and recalculated the proportion considered to have acquired HIV in the UK.

They concluded that, 'Over the past five years, an estimated 1,000 black African men and women probably acquired HIV in the UK annually'.[6] Previously, many UK-acquired diagnoses in these communities were wrongly assumed to have been acquired overseas.

HIV treatment has had an enormous effect on the prognosis for people living with HIV, with most people who are diagnosed in good time able to expect a normal life expectancy. Having said this, the effects of an HIV diagnosis for an individual can still be significant. As well as coming to terms with a long-term health condition such as HIV, the daily treatment regime, possible side effects and heightened risk for certain other health conditions, there continues to be stigma associated with HIV. This can present real personal and social challenges. And of course many people continue not to be diagnosed in good time, which increases the risk of short and longer term ill-health and death.

HIV transmission is not only a serious health problem

3 Public Health England HIV Surveillance Data Tables (2013 data sited), Table 1A 'Adjusted accounts for HIV diagnoses by year of diagnosis, probably exposure group, and percentage of infections acquired in the UK', available at: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVData/#1._National_HIV_Surveillance_Data_Tables
4 Public Health England 'HIV in the United Kingdom: 2013 report' pp.9-10
5 Phillips A et al 'Increased HIV incidence in men who have sex with men despite high levels of ART-induced viral suppression: analysis of an extensively documented epidemic' PLOS 1 13 Feb 2013; Birrell P et al 'HIV incidence in men who have sex with men in England and Wales 2001-10: a nationwide population study' Lancet Infectious Diseases Vol 13 April 2013

6 Public Health England 'HIV in the United Kingdom: 2013 report' p.4

for the individual. It also has implications for public funds. A recent estimate of the average lifetime treatment cost is £360,777.[7] Public Health England stated that if the estimated 4,000 UK-acquired HIV infections diagnosed in 2011 had been prevented, £1.9 billion in lifetime treatment and clinical care costs would have been saved from the NHS budget.[8]

In summary, HIV remains a serious infectious disease and public health challenge which should be addressed through effective preventive measures at both national and local levels. What in fact are we doing to prevent the transmission of HIV, and what more could and should we do? This report from NAT aims to provide part of the answer to this important question.

6,000

people were diagnosed with HIV in 2013.

£360,777

is the estimated average lifetime treatment cost for one individual with HIV.

7 http://www.bhiva.org/documents/Conferences/2012Birmingham/Presentations/Posters/Epidemiology-and-Surveillance/P178.pdf
8 Health Protection Agency 'HIV in the United Kingdom: 2012 Report', p.18

A2: What is HIV prevention?

Over the last ten years there has been significant change in how HIV prevention is conceptualised.

Experts now advocate 'combination prevention',[9] based on evidence that for HIV prevention to be effective there has to be a combination of approaches addressing structural, biomedical and behavioural factors.

Structural factors are the social, cultural, economic and political conditions that contribute to HIV transmission.

Biomedical approaches include, for example, STI diagnosis and treatment, use and provision of condoms, post-exposure prophylaxis (PEP), use of anti-retrovirals (ARVs) to prevent mother-to-child transmission, and opioid substitution therapy for people who inject drugs. Biomedical interventions need structural and behavioural interventions to accompany them, to ensure they are accessible, known about and appropriately used.

Behavioural interventions are perhaps what most people think of as 'traditional' HIV prevention work. They might involve small or mass media work explaining HIV, the risks of transmission and how to practice safer sex, as well as promotion of condom use, partner reduction and HIV testing. They might include risk reduction counselling linked to HIV testing services.

This survey of local authority HIV prevention activity is largely focussed on behavioural interventions and on HIV testing, which is a biomedical intervention. We must, however, emphasise that NAT believes in combination prevention. The activities we are investigating, whilst essential, are not by themselves sufficient for a comprehensive prevention approach.

9 See UNAIDS discussion paper 'Combination Prevention' 2010 http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2007_Combination_Prevention_paper_en.pdf

A3: HIV prevention in England – current national policy

In 2013 the Department of Health published a Framework for Sexual Health Improvement in England which addresses a broad range of factors and influences on sexual health and HIV.[10] The Framework states that to improve the nation's sexual health we must 'continue to tackle HIV through prevention and increased access to testing to enable early diagnosis and treatment'. HIV prevention has increasingly been linked to HIV testing in recent years both nationally and internationally. This reflects our understanding of the impact of taking effective treatment, which makes it extremely unlikely that HIV will be passed on.

The Framework takes a 'life course' approach. Prevention should be evidence-based, responsive to local needs and 'targeted at those populations at most risk of infection'. The principle of targeted interventions for those most at need was reflected for many years in two national HIV prevention programmes – CHAPS, for men who have sex with men (MSM), and NAHIP, for black African men and women. The principle is now reflected in the current national HIV prevention programme, HIV Prevention England, which targets both MSM and black African men and women. In 2013 75% of those newly diagnosed with HIV were MSM and/or of black African ethnicity.

In the section entitled 'Primary prevention', the Framework states that 'Prevention of HIV remains a priority, through evidence-based interventions including health promotion and support for sustained behavioural change including condom use. This is challenging, and interventions should include support for people with diagnosed HIV both to protect their sexual health (for example to avoid STIs) and reduce onward transmission. A variety of primary prevention programmes, which take account of HIV prevalence will be needed'.

In addition to this emphasis on primary prevention activity, the Framework contains important content on HIV testing, treatment as prevention, awareness of primary HIV infection, stigma and addressing needs around drugs and alcohol use – all of which are relevant to HIV prevention.

10 'A Framework for Sexual Health Improvement in England', Department of Health (2013)

A4: Difficulties in analysing HIV prevention activity

Until 2001/02 there was a national ring-fenced 'special allocation' budget for HIV prevention, distributed amongst local areas according to a weighted formula. In 2001/02 the budget was £55 million. When the ring-fenced budget was abolished the Government committed to monitoring future local prevention expenditure. This, however, did not happen.

Others have attempted to estimate the amount being spent on HIV prevention in England. Difficulties in analysing information on HIV prevention activity repeatedly emerge as an issue.[11] This is largely due to inconsistency in defining what constitutes HIV prevention, and what services to include within it.

When NAT looked at HIV prevention in England in 2007 we noted that our survey 'confirms the findings of other reports that information on HIV prevention expenditure (and indeed on sexual health expenditure generally) is hard to find, and when available varies in the definitions and categories employed'.[12] We called for consistent definitions to be developed to assist comparative and longitudinal analysis of HIV prevention activity.

However, in 2013, the HIV prevention needs assessment for London found that 'the data on HIV prevention spend in London is still not robust. The process of trying to identify local spend has highlighted variation in the way local authorities categorise their spending. There have also been challenges in disaggregating spend on HIV prevention where this is included in broader contracts. It became apparent that some local authorities have included HIV social care costs, or funding for wider sexual health contracts (for example, the C-Card scheme for young people), whereas others have not'.[13]

It is disappointing that no progress has been made on this issue over the last decade. Mindful of such difficulties, NAT aimed in this survey to be specific in our request for information on prevention activities, both in what is included and what is excluded. The 'Methodology' section (A6) explains this in more detail. We have by no means solved all the difficulties discussed above, but we believe we can have some confidence in our analysis and comparisons.

11 Earlier analysis of HIV prevention funding and background on earlier prevention interventions can be found in the following research papers: Edward King, Michael Rooney and Peter Scott (1992) HIV prevention for gay men: a survey of initiatives in the UK (London; North West Thames Regional Health Authority). Will Anderson, Ford Hickson and Clive Stevens (1994) Health purchasing, HIV prevention and gay men: Results of a survey into the purchasing of HIV prevention work for gay men and bisexual men by health authorities in England (London; Health Education Authority).

12 NAT 2007 'Commissioning HIV Prevention Activities in England' p.17

13 HIV Prevention Needs Assessment for London' 2013, ADPH, PHE, London Councils p.25

A5: New responsibilities for HIV prevention in England

A5.1 Local authorities

Responsibility for HIV prevention has changed with recent reforms to the NHS and public health in England. Local authorities are now responsible for commissioning HIV prevention services for their community as part of their new public health responsibilities. Sexual health clinics of course have a preventive impact on HIV transmission and local authorities are 'mandated' (legally required) to provide a sexual health clinic service in their local area. However, other HIV prevention interventions, for example, community HIV prevention work, are not mandated. It is up to each local authority to determine need and decide on whether and how to meet it.

Currently local authority public health budgets are ring-fenced for public health activity. From 2016 the ring-fence may be removed. This would give local authorities the discretion to redirect their public health funding. Even with the current ring-fence, we understand public health budgets are under significant pressure, and much of the funding has to be spent on commissioning sexual health clinic services. It is, therefore, interesting to see just how much (or how little, in some cases) local authorities feel able to do on HIV prevention, while the ring-fence is in place, given these broader responsibilities.

Local authorities are required to provide HIV testing within sexual health clinics. To increase uptake they may also choose to commission HIV testing services in community settings, drug treatment services, and in primary care and secondary care. Late HIV diagnosis is one of the Public Health Outcome Indicators which should guarantee some focus on the issue, especially in those authorities with higher rates of late diagnosis.

It is possible for local authorities to jointly commission services. For example, several authorities may contribute funding with one council taking the lead in procurement and contract management. The London HIV Prevention Programme is funded by London local authorities and overseen by a steering group of Directors of Public Health. This programme is intended to supplement the delivery of more locally targeted HIV prevention services at individual borough level, through the provision of complementary city-wide services which benefit from economies of scale and cross-borough delivery (outreach, condom distribution and media/communications).

A5.2 Public Health England and the national HIV prevention programme

Public Health England works nationally to support the delivery of public health outcomes. For HIV prevention this is in partnership with local authorities and a national programme for HIV prevention, called HIV Prevention England.

HIV Prevention England is the national HIV prevention programme and is intended to benefit MSM and black African communities, working with Public Health England, NHS clinics, and local communities.[14] The programme should supplement, but not replace, prevention work carried out by local authorities which are encouraged to align their work with the programme.[15] Some of the interventions are undertaken on a national basis, such as research, the development of media products and National HIV Testing Week.[16] In addition, HIV Prevention England contracts with local delivery partners to provide specific HIV prevention interventions at a local level.

In assessing HIV prevention activity in high prevalence local authorities in England we approached three separate kinds of body:

i High prevalence local authorities – for local public health activity on HIV prevention

ii The London HIV Prevention Programme - for London-wide activities funded jointly by London local authorities

iii HIV Prevention England (HPE) – for activity undertaken by HPE's local delivery partners in high prevalence areas.

14 For more information see http://www.hivpreventionengland.org.uk/
15 'Commissioning sexual health services and interventions: best practice guidance for local authorities' Department of Health, 2013
16 In 2014 National HIV Testing Week runs from 22 to 30 November. A briefing paper is available for local authorities at

A6: Methodology

NAT wished to provide stakeholders with some baseline information on what is being commissioned for HIV prevention in England. We were conscious this is a substantial task and wanted to focus the project in a way which was practicable and effective. To that end, we decided only to approach local authorities with what Public Health England define as 'high' HIV prevalence, i.e. where there are two or more people living with diagnosed HIV per 1,000 individuals.

At the point of writing to local authorities the latest data on HIV prevalence in England was for 2012. NAT targeted the 64 local authorities that were identified as being high prevalence in 2012 (see Appendix 1 for the list). Based on the data now available, we know that in 2013 there were 66 local authorities in England classified by PHE as having a high prevalence of HIV. These local authorities accounted for 68% of people living with diagnosed HIV and 63% of new HIV diagnoses in that year.

This report therefore does not take account of all local authority HIV prevention commissioning in England, but we would expect it to account for a significant proportion of it. It does reflect local HIV prevention in those areas where there is the most significant need.

The aim of the research is to provide an overview of the primary HIV prevention services being commissioned in high prevalence areas in England, how much is being spent, on what kinds of activity, and whom services are intended to benefit. We were interested in the two financial years following the implementation of the new public health arrangements, 2013/14 and 2014/15.

A6.1 Who we wrote to

In March 2014 NAT wrote to the Director of Public Health (DPH) in each local authority classified as having a high prevalence of HIV (>2 in 1,000 individuals are diagnosed as living with HIV).

We also wrote to one local authority which was close to this threshold; this was Havering, the only local authority in London not currently classed as high prevalence. This meant that we were able to look at London as a whole, as well as at borough level. City of London was removed from the analysis and its population data was incorporated into Hackney. This is because the population size is small and Hackney is responsible for commissioning services in this borough.

There are also local authorities, including in London, which jointly commission services and may share a DPH. These were written to in one letter but were asked for a breakdown by local authority.

In some cases the upper tier authority responsible for public health commissioning (and thus HIV prevention activity) covered a wider area than the lower tier council area or areas defined as high prevalence by Public Health England.

In these cases we wrote to the upper tier authority and asked for information on their HIV prevention commissioning in the whole of their upper tier authority area. This was true for nine upper tier authorities. This means that in total we sent 53 letters to Directors of Public Health.

We wrote to the London HIV Prevention Programme in April 2014 to gather similar information in relation to HIV prevention projects supported by that Programme.

We also asked HIV Prevention England for information on HIV prevention interventions they were funding in high prevalence areas through local delivery partners. This captures the additional local HIV prevention activity supported by public funds. Local commissioners will be taking account of such local activity when planning their own services.

In England, there are a mixture of single tier (unitary) and two tier authorities. In areas covered by two tiers, the upper tier will usually be known as the county or shire council and the lower tier as the district, borough or city council.

Public health allocations are distributed to unitary and upper tier local authorities, of which there are 152.

PHE data is collected at the lower tier authority level. Therefore, some of those authorities classed as high prevalence by PHE will be covered by a Director of Public Health in their upper tier authority. There are nine upper tier local authorities which have between one and three lower tier authorities classed as high prevalence within them.

NAT surveyed 58 upper tier/ unitary authorities, 32 in London and 26 outside of London.

A6.2 What we asked for

NAT asked local authorities to provide information on spend and activity on HIV prevention in the financial year 2013/14, as well as that planned for 2014/15. Specifically, NAT asked for details of resource allocated for the primary purpose of HIV prevention.

We defined HIV prevention services as:

Services which have as an exclusive or primary aim the prevention of HIV transmission and as their intended recipients, people identified as at significant risk of acquiring HIV.

We include in this definition HIV testing services directly commissioned by local authorities but excluding those provided by GU/sexual health clinics. [For the purposes of this report we describe these as 'additional HIV testing services'.]

NAT specified that we did not require information on:

- GUM (sexual health) clinic activity
- HIV clinic activity
- Other acute secondary care provision
- Harm reduction services for people who inject drugs
- Services for people diagnosed with HIV which may support safer sex
- Wider sexual health services and programmes that do not have as a primary aim the reduction in onward HIV transmission (such as generic condom distribution programmes).

All of the excluded services above are often cited as examples of HIV prevention activity. We agree that many of these services, and in particular sexual health clinic activity, HIV clinic activity and support services for people living with HIV, have a vital contribution to make to HIV prevention. Indeed it could possibly be argued, especially with the increased emphasis internationally on 'test and treat' as the way to reduce HIV transmission, that these services are the core of HIV prevention.

However, such services have multiple objectives and outcomes, making it hard to identify dedicated expenditure, activity and planning for HIV prevention. Omitting them from the survey helps us to compare like with like and maintain focus on HIV primary prevention activity such as outreach, small group and media work. We would gladly receive feedback for our next survey as to whether any or all of these omitted services should be included.

We should also note that our survey of local authorities asked for details of their own commissioning activity and does not include national interventions undertaken by HIV Prevention England, or local HIV prevention interventions funded from private and charitable sources.

We hope that this report will promote a debate as to what exactly, additional to mandated clinic services, is necessary for a local authority to meet its public health responsibility to protect residents from HIV transmission.

A6.3 Gathering responses

Letters requesting the information were sent on 6 March 2014 and local authorities were asked to respond within one month, by 6 April 2014. However, very few came back within this time period. Several responded only after three months, and one local authority responded after four months.

To support local authorities to respond, NAT provided a template which could be adapted for their needs. Most local authorities used the template or adapted it. However, some responded by letter or email with the information written in a different format.

An example of how the template table may be filled in is shown below.

Brief description of project/ activity stream	Intended recipients	Expenditure for 2013/14
HIV testing outreach in saunas	MSM	£15,000
Outreach work and small media distribution in community bars, clubs and social events	Black African men and women	£20,000

NAT made a decision only to formally submit FOI requests where absolutely necessary to provide authorities with flexibility. Some nevertheless interpreted the letter as an FOI request.

The advantage to an FOI request is that the process ensures a timely response. However, it can cut out information which may be provided through dialogue with commissioners.

In general, but not always, the data provided by FOI request had less qualitative and quantitative detail, compared with that provided directly by commissioners.

We are grateful to all the local DPHs and commissioners for the work they have put in to respond to this survey.

A6.4 Interpreting the data

A6.4.1 Categorising reported spending

NAT analysed the information provided by defining expenditure in one of two main categories; these were health promotion (an over-arching term) and testing. As stated earlier, testing is generally considered a critical aspect of HIV prevention, but it is different from other prevention interventions in that it is less of a behavioural intervention, and more of a biomedical intervention. We felt it would be useful to look in more detail at commissioning of additional HIV testing, it being widely discussed as a key prevention intervention.

We then further categorised the amounts according to target group and, where appropriate, intervention type. The categories used were:

Health promotion:

Non-specified health promotion for HIV negative people

Targeted intervention - MSM

Targeted intervention - black African population and other BME groups

Targeted intervention - sex workers

Targeted intervention - Substance users [this excluded harm reduction]

Testing:

Non-specified testing

Community testing - general

Community testing - targeted at MSM

Community testing - targeted at the black African population and other BME groups

GP testing

Secondary care testing

Pharmacy testing

Some local authorities stated that their primary aim for reported spending was the prevention of HIV, but did not specify a target group. It can be unclear whether this is because the intervention targets a number of at risk groups, which cannot be individually disaggregated, or because there is no specific intended target group. Where spending figures have been reported but a target group has not been specified for one of the above reasons, this has been classified as 'non-specified health promotion for HIV negative people'.

Also included under the general term 'health promotion' used here, are research projects designed to inform health promotion. This is a very small proportion of the overall funding reported by local authorities, featuring in the reported spend of one city outside of London for 2014/15 and as a jointly commissioned project between three local authorities in London in 2013/14.

Four local authorities responded with their spending for 2013/14 but were not yet able to provide data for 2014/15. This was despite the request being considered within 2014/15. We would hope that as the new public health arrangements become 'bedded in' it will be possible to communicate investment plans in advance of the beginning of the relevant financial year.

NAT followed up with these authorities over the summer and in most cases we were able to access up-to-date figures for 2014/15.

A6.4.2 Population data

Population data was used to determine per capita spending for the whole population in a local authority and, in relation to relevant targeted expenditure, for the two main populations at higher risk of HIV, MSM and the black African population.

Resident population data is taken from the 2011 census and using population projections produced

by the Office for National Statistics (ONS).[17] Local projections for 2013 have been used for the financial year 2013/14, and projections for 2014 for the year 2014/15. Population projections are available at a local authority level and are calculated based on predicted rates of births, deaths and migration.

We decided to base per capita spend on population data for ages 15-74 years. This is the age range used by PHE in their analysis of the HIV epidemic in the UK and we also felt it was a fair estimate of the target age range for HIV prevention interventions which are aimed at high risk groups. This is not to suggest that other sexual health and HIV education is not important, for example, at an earlier age in school. However, this is likely to take the form of broader sexual health work without the primary aim of HIV prevention.

Estimating the black African population

The 2011 census asked the ethnic group for each individual. This data has also been published to a local authority level. In particular, we are interested in the number of black African men and women, given the significantly elevated HIV prevalence in this group.

There are no forward projections for ethnic group breakdown. As the 2011 data was the most reliable source of information on this, the proportion of black African men and women in each local authority was applied to projected population data for 2013 and 2014.

Estimating the MSM population

The population of MSM was estimated using data from Natsal 3[18] which is also used by PHE and is seen as the most accurate available data source. This produced two percentage estimates, one for London (3.81% of the male population) and one for outside of London (2.36%). This proportion was applied to the projected resident male population for 2013 and 2014.

Estimating the MSM population is, however, problematic. For example, based on the above we estimate that there are just over 120,000 MSM in London between 15 and 74 years old in 2014/15. This is likely to be a low estimate of the potential target population.

Grindr, one of the most popular gay dating apps, tells us that in any month there are 700,000 individual users of Grindr in London (some may use more than one profile). One reason for the significantly higher number from Grindr is that it records those using the app within the London boundary rather than just residents. This may include individuals who work in London but reside outside the Greater London boundary, or visitors from the rest of the UK and overseas. Although we would also note that not all MSM use Grindr.

This raises the important question as to who should be the appropriate target of HIV prevention interventions. In addition to residents, should HIV prevention not also be targeting those who spend significant time in London and may be putting themselves and others at risk? Such data at least suggests that the Natsal/PHE approach may be underestimating the number of MSM. We should especially consider this if we are comparing per capita spend on targeted HIV prevention between MSM and the black African population. If we are underestimating the number of MSM, we will be exaggerating the gap between MSM and African per capita expenditure. Per capita spend on MSM of targeted interventions may only be useful for comparisons of MSM work across local authorities.

It will be interesting in future work we do in this area to find out how many high prevalence local authorities attempt to make their own calculation of the size of their local MSM population. We understand PHE plan further work estimating the size of the MSM population and this is welcome.

17 '2012-based Subnational projections for England', Office for National Statistics, 2014.

18 Natsal-3' (The national survey of sexual attitudes and lifestyles), 2014. Available online: http://www.natsal.ac.uk/natsal-3

B: An overview of HIV prevention in England

B1: Key findings

Total reported spend in high prevalence local authorities in England on services with a primary aim of prevention of HIV, as well as on additional HIV testing services outside the sexual health clinic was £9,473,341 in 2013/14 and £10,317,272 in 2014/15.

In London approximately £5.1m was spent in 2013/14, and this has risen to over £5.6m in 2014/15; these estimates are far less that the £10.5m estimated in the London Councils needs assessment published in 2013.

Spend per capita on HIV prevention is higher in London than in high prevalence areas outside London. This is partly due to the existence of the London HIV Prevention Programme, but is also accounted for by slightly higher spend at a local authority level, although this spend is inconsistent across the capital. This is also likely to be linked to higher HIV prevalence in London.

In 2013/14 around £1.2 million was allocated to additional HIV testing services across high prevalence areas in England, £1.55 million in 2014/15. These services are those provided in addition to testing available in sexual health clinics.

The following tables provide an overview of HIV prevention spending as reported to NAT by local authorities with a high prevalence of HIV, the London HIV Prevention Programme and HPE.

Where possible we have separated our findings for London from those for high prevalence authorities outside of London, drawing comparisons where appropriate. This is in recognition of the specific commissioning landscape in London. In London each borough is functioning as part of one city where the overall prevalence rate is higher than in other parts of the UK. Individuals will travel between areas more, and into the city. The commissioning environment is also different in that local authorities are also contributing to the London HIV Prevention Programme.

Table 1.

Total reported spending on primary HIV prevention in local authorities in England with a high prevalence of HIV in 2013/14

2013/14	Health Promotion spending	Additional testing services	Total	Per capita (population 15-74)
London				
Local authority commissioning	£3,048,160	£927,513	£3,975,673	£0.63
London HIV Prevention Programme	£930,418	n/a	£930,418	£0.15
HIV Prevention England	£197,250	£43,000	£240,250	£0.04
			London total: £5,146,341	£0.81
Outside London				
Local authority commissioning	£3,802,218	£243,282	£4,045,500	£0.51
HIV Prevention England	£169,500	£112,000	£281,500	£0.04
			Outside London total: £4,327,000	£0.55
Total	£8,147,546	£1,325,795	£9,473,341	£0.66

Table 2.

Total reported spending on primary HIV prevention in local authorities in England with a high prevalence of HIV in 2014/15

2014/15	Health Promotion spending	Additional testing services	Total	Per capita (population 15-74)
London				
Local authority commissioning	£3,413,742	£978,751	£4,392,493	£0.68
London HIV Prevention Programme	£973,505	n/a	£973,505	£0.15
HIV Prevention England	£204,000	£55,000	£259,000	£0.04
			London total: £5,624,998	£0.87
Outside London				
Local authority commissioning	£4,015,426	£397,198	£4,412,624	£0.55
HIV Prevention England	£142,150	£137,500	£279,650	£0.03
			Outside London total: £4,692,274	£0.59
Total	£8,748,823	£1,568,449	£10,317,272	£0.68

B2: Overview of London

2013/2014

£5,146,341

was spent on HIV prevention in London in 2013/14.

£3,975,673

was on local authority commissioned services (excluding the London HIV Prevention Programme and HPE).

2014/2015

£5,624,998

is the estimated spend on HIV prevention in London in 2014/15.

£4,392,493

was on local authority commissioned services (excluding the London HIV Prevention Programme and HPE).

In total the per capita spending in London increased from £0.81 to £0.87 over the two years.

B2.1 Local authority-based commissioning in London

When looking only at local authority commissioning in London, just less than a quarter was spent on additional testing services (i.e. those not already provided in sexual health clinics). The remainder was spent on health promotion activities and this increased from a reported £3,048,160 to £3,413,742.

As well as this spending, all local authorities in London contribute to the London HIV Prevention Programme and contribution amounts are calculated based on HIV prevalence.

The graphs below show per capita (population aged 15-74) funding for HIV prevention in both years compared with the prevalence of HIV in a local authority. This is spending through local commissioning, and does not include contributions to the London-wide programme which are proportionate to prevalence. The relationship between prevalence and spending appears weak for both years. The pattern is similar for both 2013/14 and 2014/15.

There are five London local authorities spending nothing on HIV prevention outside of the amount they contribute to the London-wide programme; this reduced to four in 2014/15.

One clear conclusion which can be drawn from the graphs below is that there is variation in approach

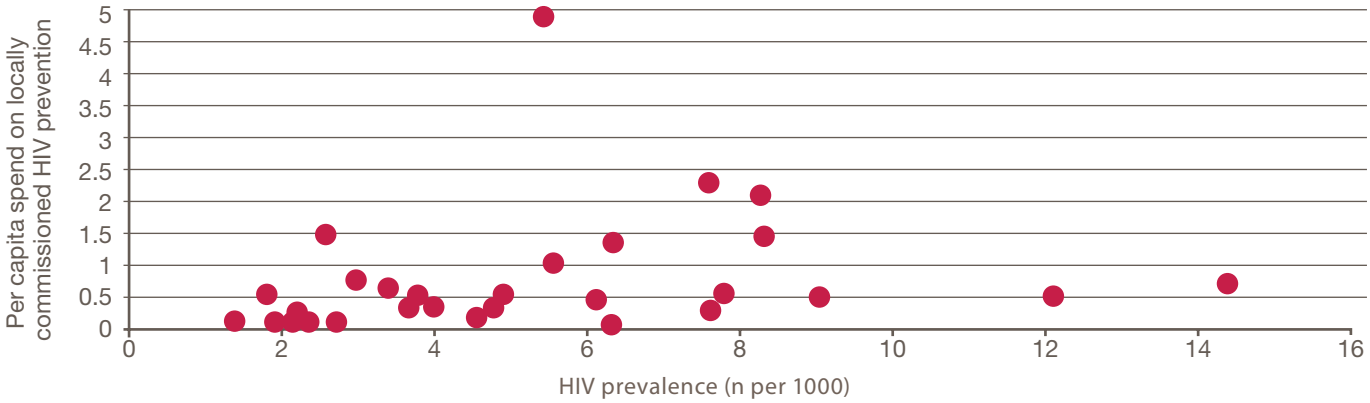


Fig. 1 Per capita spend by local authorities in London on locally commissioned HIV prevention, compared with HIV prevalence (n per 1000), in 2013/14

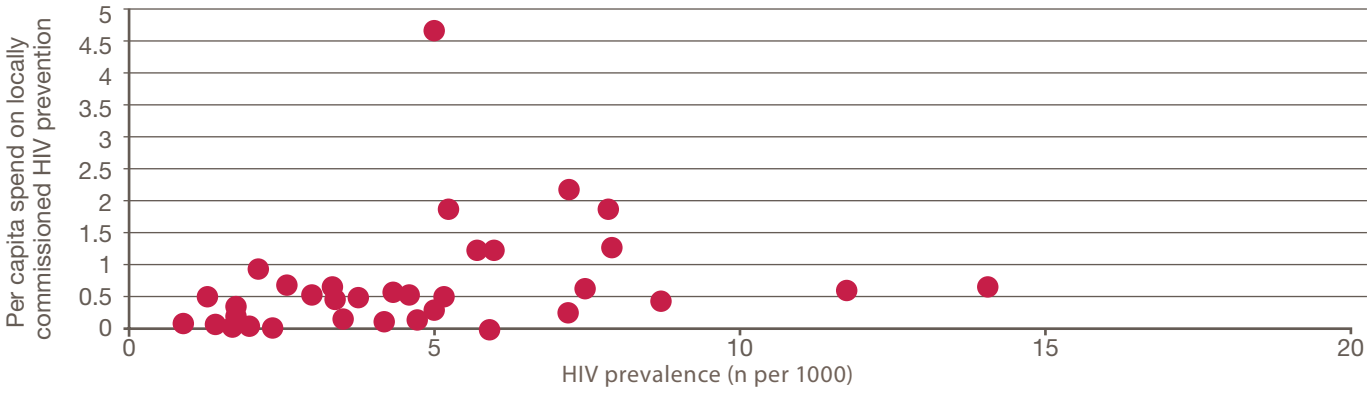


Fig. 2 Per capita spend by local authorities in London on locally commissioned HIV prevention, compared with HIV prevalence (n per 1000), in 2014/15

towards HIV prevention across the capital. The London-wide programme is now a signficantly smaller version of that previously running up to 2013 and in this context the HIV Prevention Needs Assessment for London stressed the opportunities presented by local commissioning.[19] Our findings, however, indicate that some authorites are relying solely on the London HIV Prevention Programme to meet their residents' needs.

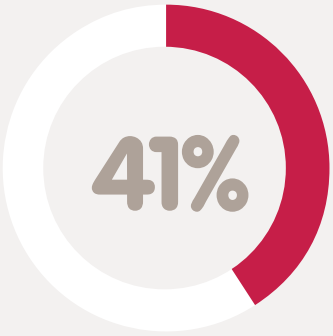
B2.2 London HIV Prevention Programme and HPE activity in London

All of the £930,418 funding for the London HIV Prevention Programme in 2013/14 was allocated to health promotion services targeting MSM. In 2014/15 overall funding for the programme is £973,505. £456,818 of this is allocated to prevention targeting MSM. The further £516,687 has been used in 2014/15 to commission condom distribution services for black African men and women as well as mass media work. We should note that spending through the Programme will increase to £1.2 million in each of 2015/16 and 2016/17, and contracts are being procured for this period.

HPE also commissioned a range of services through local delivery partners in London, worth £240,250 in 2013/14. Approximately 41% of the funding, £98,750, was allocated to services working with black African men and women in London (more information on this in section C), the remainder was allocated to services targeting MSM. These amounts increased slightly in 2014/15 giving a total of £259,000.

Approximately 18% of the HPE budget for London, £43,000, was spent on additional HIV testing in 2013/14. This again increased slightly to 21%, £55,000, in 2014/15. While these are not negligible amounts, it is a small proportion of the total spent on additional testing across London (around £1m/year).

For a more detailed breakdown of HPE spending see Appendix 2.



of HPE funding was allocated to services working with black african men and women in london in 2013/14.

19 'HIV Prevention Needs Assessment for London'; Association of Directors of Public Health, Public Health England and London Councils; November 2013.

B3: Overview of high prevalence local authorities outside London

2013/2014

£4,327,000

was spent on HIV prevention in high prevalence local authorities outside London

£4,045,500

was on local authority commissioned services (excluding HPE).

2014/2015

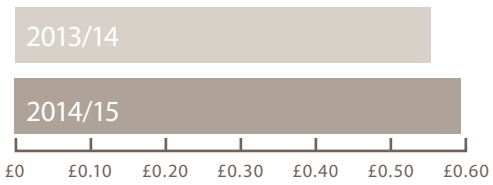
£4,629,274

was spent on HIV prevention in high prevalence local authorities outside London.

£4,412,624

was on local authority commissioned services (excluding HPE).

Per capita spending, based on the population aged 15-74, increased from £0.55 in 2013/14 to £0.59 in 2014/15.



B3.1 Local authority commissioning outside London

Local authorities outside London are less comparable to one another than those in London. However, the broad comparison between London and outside London is still interesting and shows that investment is generally lower outside London, probably because generally prevalence rates are lower.

In 2013/14 a small proportion of local authority commissioning for HIV prevention, £243,282, was used to commission HIV testing in high prevalence authorities outside London. This increased to £397,198 in 2014/15. However, this was not evenly distributed. Two local authorities, both in major cities, were responsible for a significant proportion of additional testing funds. The variation in commissioned activities is perhaps even more concerning outside London where individuals are less likely to be accessing services in other areas. If, for example, community testing is not available in an individual's local authority, they are unlikely to come across it.

As with London, the relationship between HIV prevalence in a local authority and spend per capita on HIV prevention appears quite weak (see graphs below). For 2013/14 four authorities reported no spending on services with HIV prevention as a primary aim, and three reported none for 2014/15. Apart from HPE-commissioned services there will be little in terms of publicly funded HIV prevention in these local authorities. There may be local voluntary organisations trying to meet this need from other funding sources.

B3.2 HPE services outside London

HPE commissions prevention services through local delivery partners outside London. These contracts were worth £281,500 in 2013/14 and £279,650 in 2014/15.

As is the case in London, this funding is allocated to services for more than one high risk group. In 2013/14 £98,500 was allocated to services working with black African men and women; this accounts for 35% of the funding and the remaining 65% was allocated work with MSM.

In 2014/15 the proportion allocated to working with black African men and women increased to 45% (£125,000).

The split between testing and other health promotion services is quite different from that seen in London, with a greater proportion of investment directed to testing services, 38% (£112,000) in 2013/14 and 49% (£137,500) in 2014/15. More detailed information on HPE spending can be found in Appendix 2.

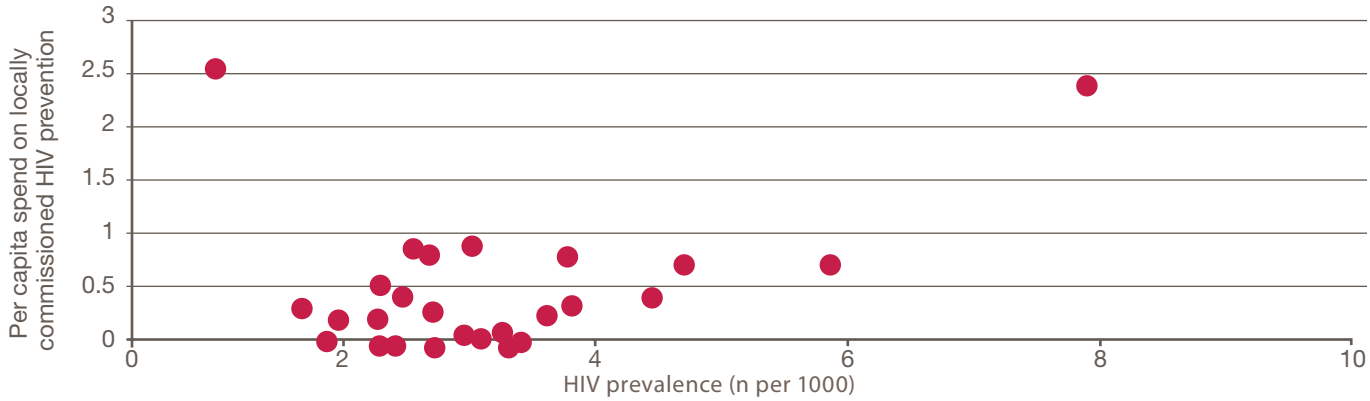


Fig. 3 Per capita spend by local authorities outside London with a high prevalence of HIV on locally commissioned HIV prevention, compared with HIV prevalence (n per 1000), in 2013/14

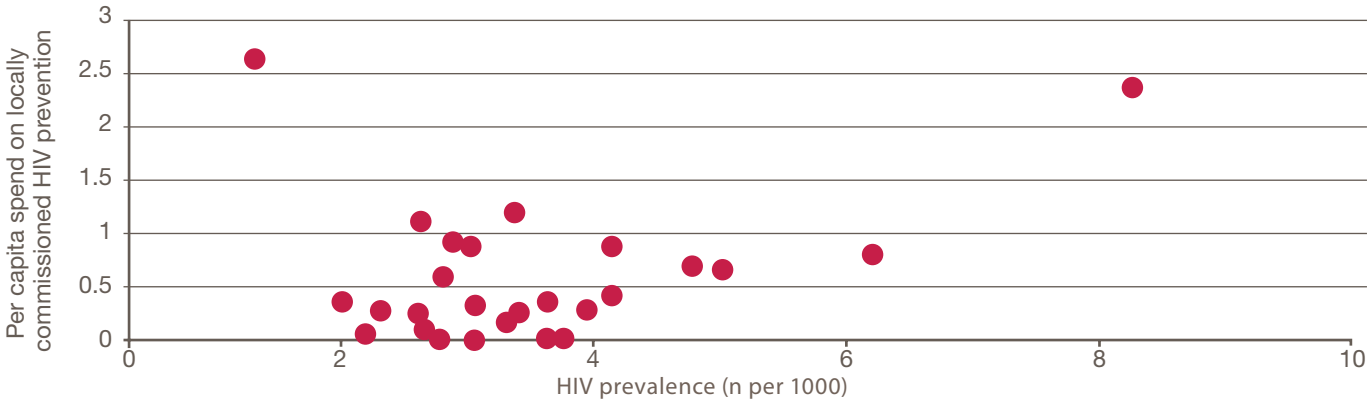


Fig. 4 Per capita spend by local authorities outside London with a high prevalence of HIV on locally commissioned HIV prevention, compared with HIV prevalence (n per 1000), in 2014/15

C: Health promotion for primary HIV prevention

C1: Health promotion in London

'Health promotion': Is here used as an overarching term incorporating a range of intervention types. Examples include: free condom schemes, media campaigns, outreach work, group-based support and information sessions, 1:1 counselling and support, and information leaflet distribution. Health promotion may also include targeted work with people at higher risk of HIV, or non-targeted work aimed at the general population. This term does not include the additional HIV testing interventions referred to in this report but does in effect include all other activity cited in responses with HIV prevention as a primary aim.

From the information provided by local authorities we have separated out health promotion activity according to whom it targets. Further information on the analysis of the data can be found in Section A.

Table 3.

Health promotion in London by funding source and for years 2013/14 and 2014/15

	2013/14 (£)	2014/15 (£)
Local authority commissioning	£3,048,160 (24 of 32 local authorities reported some spending)	£3,413,742 (24 of 32 local authorities reported some spending)
London HIV Prevention Programme	£930,418	£973,505
HIV Prevention England	£197,250	£204,000
Total	£4,175,828	£4,591,247
Per capita (whole population 15-74	0.66	0.71

In 2013/14:

Reported spend on health promotion to prevent HIV transmission in London was £4,175,828, £0.66 per capita.

The mean figures for local authority commissioned services (not including contribution to the London HIV prevention programme) were £96,440 in spend and £0.50 per capita, whereas the median figures were lower at £52,000 and £0.36 per capita, reflecting the variation in spending by local authorities.

There is a huge variation in approach to HIV prevention across the city. Eight local authorities reported no relevant locally commissioned health promotion apart from their contribution to the London HIV Prevention Programme, a further six spent less than £25,000, but one local authority spent as much as £710,839. Thirteen local authorities in London were spending more than £100,000.

In 2014/15:

Reported spend on health promotion activities to prevent HIV transmission in London increased slightly to £4,591,247, £0.71 per capita.

For local authority commissioned services the mean spend figures were £108,030 and £0.54 per capita; the median values were again lower at £79,969, £0.39 per capita. Although the gap is smaller between the two figures than in the previous year, it still indicates variation in spend between local authorities.

Thirteen local authorities reported spent above £100,000 a year, including one at £710,839. Five reported spending less than £25,000, and a further eight reported no spend at all on health promotion activities in their area, apart from their contribution to the London HIV Prevention Programme.

Such health promotion activity was often described generically as 'HIV awareness support' or 'outreach' without any further detail. For example, 'HIV awareness support targeting MSM' was referred to by one local authority.

Outreach activities included work with local businesses, at events, clubs and schools, and small media distribution. One local authority commissioned one-to-one motivational interviewing for both African and MSM communities as well as one-to-one therapeutic interventions. Another two specified jointly commissioned work amongst male sex workers and amongst Latin American MSM.

Four local authorities referred to HIV awareness support for both African and Caribbean communities and a further two for African communities alone.

Mentoring activity was also mentioned, as was work with young people from African communities which included signposting to GU and CASH services. Two local authorities mentioned group work with BME/African communities and also commissioned one-to-one work with those same communities. However, most of the one-to-one and group work in London appears to have been funded by HIV Prevention England.

C2: Health promotion outside London

Table 4.

Health promotion in local authorities outside London with a high prevalence of HIV by funding source and for years 2013/14 and 2014/15

	2013/14 (£)	2014/15 (£)
Local authority commissioning	£3,802,218 (21 of 26 local authorities reported some spending)	£4,015,426 (21 of 26 local authorities reported some spending)
HIV Prevention England	£169,500	£142,150
Total	£3,971,718	£4,157,576
Per capita (whole population 15-74	0.50	0.52

In 2013/14:

Reported spend on health promotion to prevent HIV transmission in high prevalence local authorities outside London was £3,971,718, £0.50 per capita.

The variation between local authorities was significant. A large difference can be seen between the mean amount £146,239 and the median £41,200 in 2013/14. Per capita the figures are closer, indicating some, but not all, of the variation could be down to resident population size (the mean is £0.49, the median is £0.29).

In 2014/15:

Reported spend on health promotion for HIV prevention in high prevalence authorities outside London was £4,157,576, £0.52 per capita.

Per capita spending is more or less the same across the two years. This spend is not evenly distributed across those authorities surveyed; variation is still significant. The mean amount is £154,440 and the median is £55,647. Per capita the mean spend on health promotion was £0.52, whereas the median was £0.31 further demonstrating this.

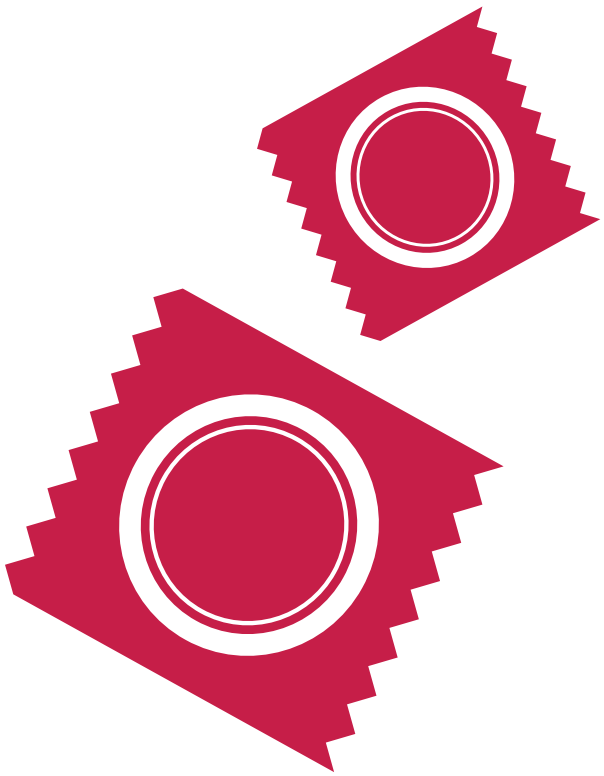
Outside London there was interesting work commissioned which was linked to clinic services. For example, one local authority had commissioned the referral of MSM who presented asking for PEP or with repeat STIs in clinic to THT services. Another had worked with local Clinical Commissioning Groups to agree that late HIV diagnoses are 'serious incidents' to be investigated. Two authorities were directly commissioning clinics to engage in outreach activities, for example, with young and BME MSM.

Outreach work amongst MSM was referred to by eleven local authorities with some giving more detailed information on setting. For example, local Pride events, gay venues, public sex environments or online were all mentioned. The target group was sometimes described more specifically, for example, 'young gay men'. The content of the intervention was also sometimes disclosed, for example, condom and lubricant distribution, small media dissemination or publicising of sexual health services.

Outreach work amongst African communities was reported by nine local authorities, with work in bars, clubs and at events, condom distribution, sexual health information and campaigns all being referred to.

One local authority referred to outreach work amongst people who inject drugs. Two local authorities referred to work commissioned amongst East Europeans and one amongst the black Caribbean population.

Prevention work amongst sex workers, including in one case HIV testing interventions as well as broader HIV prevention and sexual health promotion, was much more commonly mentioned outside London than in London (reported by five local authorities outside London). One local authority additionally mentioned HIV testing and prevention work amongst male sex workers.



C3: More on who is being targeted by health promotion

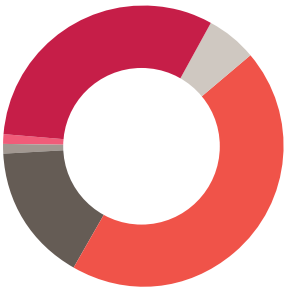
- General intervention for negative people
- Targeted intervention - African community
- Targeted intervention - MSM
- Targeted intervention - sex workers
- Research - MSM
- Research - African Community
- Targeted intervention - substance users

The graphs below show the basic distribution of health promotion interventions in London and outside of London for 2013/14 and 2014/15 by intended beneficiaries.

England's high prevalence local authorities

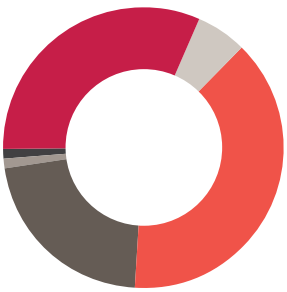
2013/14

- £2,574,802 **(32%)**
- £1,295,119 **(16%)**
- £524,650 **(6%)**
- £25,000 **(<1%)**
- £3,677,977 **(45%)**
- £49,998 **(1%)**



2014/15

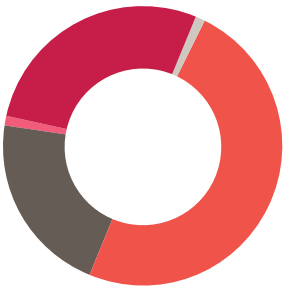
- £2,801,123 **(32%)**
- £1,875,960 **(22%)**
- £560,612 **(6%)**
- £25,000 **(1%)**
- £3,413,628 **(39%)**
- £72,500 **(1%)**



London

2013/14

- £1,175,713 **(28%)**
- £855,563 **(21%)**
- £50,00 **(1%)**
- £49,998 **(1%)**
- £2,044,554 **(49%)**



2014/15

- £1,371,941 **(30%)**
- £1,344,614 **(29%)**
- £95,000 **(2%)**
- £1,789,692 **(39%)**

Outside London

2013/14

- £1,399,089 **(35%)**
- £439,556 **(10%)**
- £474,650 **(12%)**
- £25,000 **(1%)**
- £1,633,423 **(41%)**

2014/15

- £1,429,182 **(34%)**
- £541,346 **(13%)**
- £465,612 **(11%)**
- £25,000 **(1%)**
- £1,623,936 **(39%)**
- £72,500 **(2%)**

Percentages may not add up to exactly 100% due to rounding up and down.

C3.1 Higher risk groups

London

In both London and outside of London the largest proportion of funding is reported as allocated to work with MSM. This does appear to contradict the findings of the London needs assessment (2013), which estimated spending in 2012/13 on the black African population to be higher than on MSM at around £1m compared with £765,000. However, there will be differences in which services are included between that study and the current one, and investment in testing is higher for the black African population as we will see later. Significant spending on MSM was also reported by one London local authority in this survey, which does inflate the figure.

There is also a high proportion of funding categorised as 'general prevention for the HIV negative population'. We believe that a lot of this will be targeted at higher risk populations but the specific breakdown was not available. For example, a local authority might issue a general contract for HIV prevention in at risk populations. This is discussed in C3.2.

£2,044,554 in 2013/14 and £1,789,692 in 2014/15 was allocated to health promotion amongst MSM. The allocation to health promotion targeting the black African population was lower in both years at £855,563 in 2013/14 and £1,334,614 in 2014/15. The shift in focus of the London HIV Prevention programme, which increased the amount spent on work with the black African population and concurrently decreased spend on MSM, is the main reason for the significant changes in the figures from year to year.

By calculating the per capita data based on MSM population figures for ages 15-74, and those for the black African population ages 15-74, the difference in resource allocation to health promotion appears quite stark. In London in 2013/14 it stood at approximately £17.99 for the MSM population in London compared with £1.91 for the black African population. It is worth noting, however, that the MSM figure is increased significantly by reported spend of over £700,000 in one authority. The mean per capita spend on MSM health promotion by individual local authorities was £8.54, and the median was £0[20], showing that the large figure is due to high spending by a few local authorities, rather than consistent investment in MSM health promotion.

The resident population of MSM in London is lower than the black African population at 118,567 (estimate based on Natsal data) compared with 444,764 (estimated based on census data), and this does partly explain the significant difference in per capita investment. But it should also be remembered that the estimated population of MSM in London is very likely to be a low estimate, and does not take account of visitors to or those that work in the capital. Per capita is likely to be a crude measure not only because of the difficulty in estimating this population, but also because it does not take account of the types of interventions which may be effective for different groups and their relative costs, or the level of HIV risk and how this might relate to investment. For example, HIV incidence and prevalence rates are higher among MSM and therefore the risk may be considered higher.

Outside London

Outside London the proportion of health promotion funding allocated to services targeting MSM is again higher than that for the black African population.

20 The median is £0 because more than half of local authorities reported no spending on health promotion targeting MSM.

Spending by local authorities on services for MSM in 2013/14 was £1,633,423, whereas £439,556 of spending was for work with the black African population. In 2014/15 the amounts reported were £1,623,936 and £541,346. The proportion of people in London who identify as black African is higher, at 7%, than in most other high prevalence authorities outside London where the average is 2.1%. Per capita spend on health promotion for MSM is £18.09, whereas for the black African population it is £2.60; these increase to £18.68 and £3.18 in 2014/15. However, the discussion above on the limitations of looking at per capita data to compare investment and effectiveness of investment in the two populations, holds true here also.

C3.2 Where target group is 'not-specified'

In London and outside of London a significant proportion of spending is not linked to any identified target groups (see 'General intervention for HIV negative people in the graphs'). It can be assumed that a significant proportion of this will also be targeted at higher risk groups but that the services reported cannot be clearly disaggregated by beneficiary group. Some of this may however, represent spending on general population interventions. The local authority may consider this reaches significant numbers of those at risk of HIV given identified local needs and HIV prevalence.

One London borough is spending £5,000 on an HIV awareness campaign using billboards; intended recipients are defined broadly as "Young people, adults, all those at risk of HIV". Another peer support project specifies "black African and MSM populations, alongside faith groups and heterosexuals", as intended recipients of the service. This implies that within the service as a whole there is targeted activity alongside general awareness-raising. Four local authorities specifically referred to work around World AIDS Day (WAD) or HIV Testing Week (one used WAD to raise awareness of HIV amongst substance users).

It is particularly difficult to distinguish for whom funding is allocated when it is incorporated into block contracts with providers. For example, two London boroughs jointly commission GU and prevention services from one hospital trust. A proportion of this funding is for HIV and STI prevention and this amount has been reported. However, how this funding is then allocated to different target groups by the trust is not known.

"This funding is for dedicated, adult focused sexual health prevention activity taking place outside clinics. It is targeted at vulnerable groups including, MSM, Black African community and commercial sex workers."

In this case we decided to include the amount reported as it was clear that groups at higher risk of HIV were being identified. In other cases, where general sexual health promotion was cited but without any suggestion that HIV or that those at risk of HIV were a priority, we did not include the intervention (for example, in some of the schools work cited).

In other cases where the target group was not specified, prevention was a part of a broader contract for HIV-specific support services. Some local authorities were able to identify the primary prevention element of the contract, whereas others were not.

"At the moment we are unable to provide this specific detail within the timescales allocated to FOI…In seeking to provide the information requested, a lengthy manual exercise would be necessary."

The authority quoted above provided a list of HIV support service providers along with their agreed grants for the financial year 2013/14, but they were unable to identify separately how much should be allocated to prevention and by which services. NAT is concerned that the 'primary prevention' elements in HIV service specifications and in contracts with providers are not always discretely identified and costed. We recommend such practice going forward.

C3.3 Research

A small but significant amount of money (£49,998) was reported in London in 2013/14 for research to support health promotion among MSM. This

research, jointly commissioned between three local authorities, is the only piece of research which was specifically identified in London. It was mentioned that research on HIV testing and African communities was carried out in previous years:

"Last year [2012/2013], we commissioned local 'community insight' research to better understand the barriers and enablers to HIV testing among African communities. The findings of this research will complement the national evidence base to inform local commissioning decisions…."

In 2014/15 a local authority outside London reported funding a piece of research on mobile phone-based interventions and how they work within the African community. £72,500 is allocated to this. As with research commissioned in London, the findings have the potential to be important in developing prevention interventions with this group in the future. Having said this, research funding is a very small proportion of HIV prevention investment in both years.

C3.4 Sex workers

In London only a small amount of funding has been reported as allocated to interventions targeting sex workers. £50,000 in 2013/14 and £95,000 in 2014/15. In the first year the reported amount is represented by one local authority, whereas three authorities reported funding in this area in 2014/15.

It is unlikely that these figures tell the whole story as sexual health and HIV may also be covered as a part of other commissioned projects that work with sex workers in London; this would not necessarily have been reported here.

The London needs assessment estimated funding for HIV prevention among sex workers at £494,000; however, this was stated with caution due to the difficulty in disaggregating services for this group from larger contracts. This indicates that some of the funding classified in this report as 'general intervention with HIV negative people' may also be allocated to projects targeting sex workers. The quotation from one local authority above in C3.2 includes commercial sex workers as a key target group.

The proportion of funding allocated to health promotion among sex workers outside London is significantly higher than in London, starting at 12% in 2013/14 and decreasing to 11% in 2014/15 (compared with 1% and 2% in London). In terms of funding this represents £474,650 in 2013/14 and £465,612 (with one local authority stating the amount was still to be confirmed). This funding outside of London is also represented by reported spending by six different authorities in both years indicating that it is more commonly identified as a priority group for HIV prevention work outside of London.

D: HIV testing beyond GU services

HIV testing is now agreed to be an important intervention to prevent HIV transmission in the community. Local authorities have to provide HIV testing through sexual health clinic services, and it is in this setting that a majority of tests will take place. However, there is recognition that many people find it difficult to access testing through sexual health services, perhaps due to convenience, but also because of stigma associated with attending sexual health settings. NICE recommends the expansion of HIV testing services outside the sexual health clinic to reach both MSM and black African communities. Recommendations include routine HIV testing in high prevalence local authorities in both primary care and secondary care, as well as consideration of community-based HIV testing.

Budgets to provide sexual health clinic services will include the vast majority of HIV testing provided at a local level. However, the funding reported here is for additional testing, for example, point of care tests in community settings or testing in GP practices and hospitals. A small amount of testing in a pharmacy setting has also been reported. We describe such testing services as 'additional testing' for the purposes of this report.

Local authorities explained that it could be difficult to provide accurate figures for some testing because the amount spent would often depend on take up. For example, one local authority has for two years budgeted £20,000 maximum spend on HIV testing in local hospitals. However, this is based on an uptake of 70% of patients, and in reality uptake has been far lower.

Some local authorities referred to use of their testing budget to 'train' staff and 'promote' testing in GP and hospital settings. This is likely to be important in ensuring that the option to test is taken up more frequently and that testing in these environments is successful in reaching new people.

D1: Additional testing commissioned in London

Table 5.

Funding for additional testing services commissioned in London in 2013/14 and 2014/15, broken down between local authority funding and HPE funding.

	2013/14	2014/15
Local authority commissioning of testing	£927,513 (11 of 32 local authorities reported some spending)	£978,751 (12 of 32 local authorities reported some spending)
HIV Prevention England commissioning of testing	£43,000	£55,000
Total	£970,513	£1,033,751
Per capita (whole population 15-74)	£0.15	£0.16

The level of funding available for additional testing services makes up a far smaller proportion of HIV prevention spending through local authority commissioning than that allocated to broader health promotion.

The figures for local authority commissioning in London represent spending across 11 local authorities in 2013/14 and 12 in 2014/15 (out of a total of 32). Nine of these commissioned testing in both years, meaning five local authorities reported funding testing in only one of the years, and 18 did not report any spending in either year. Some of these authorities did report major contracts which have been classified as 'general prevention for HIV negative people' and it is possible that these contracts involved some additional testing services. However, it still seems as though there may be an issue with the visibility and reach of testing in a considerable portion of London.

D2: Additional testing commissioned outside London

Table 6.

Funding for additional testing services commissioned in high prevalence local authorities outside London in 2013/14 and 2014/15, broken down between local authority funding and HPE funding.

	2013/14	2014/15
Local authority commissioning of testing	£243,282 (7 of 26 local authorities reported some spending)	£397,198 (11 of 26 local authorities reported some spending)
HIV Prevention England commissioning of testing	£112,000	£137,500
Total	£355,282	£534,698
Per capita (whole population 15-74)	£0.04	£0.07

Additional local HIV testing services are a lower proportion of overall HIV prevention spending outside London than across London boroughs. However, there was increased investment reported in this area in 2014/15, with funding from high prevalence authorities increasing from £243,282 in 2013/14 to £397,198 in 2014/15. This is mostly due to investment above £100,000 in two cities.

There was also an increase reported in the HPE budget which is largely represented by doubling of the investment in testing targeted at the black African population resident in these areas.

D3: More on who is being targeted by testing interventions

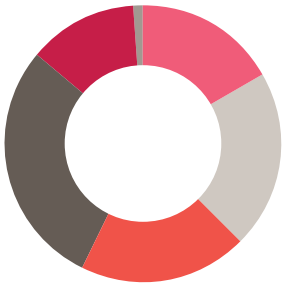
- GP testing
- Hospital testing
- Pharmacy testing
- Community testing
- Community testing - targeted MSM
- Community testing - targeted African population
- Testing - non-specific

The graphs below show the basic distribution of additional testing interventions in London and outside London for 2013/14 and 2014/15 by intended beneficiaries.

England's high prevalence local authorities

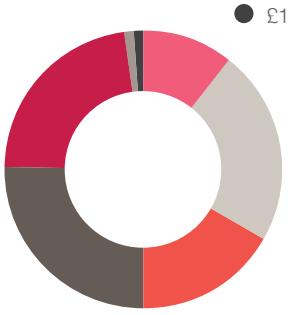
2013/14

- £218,333 **(17%)**
- £277,773 **(21%)**
- £269,500 **(20%)**
- £382,681 **(29%)**
- £176,818 **(13%)**
- £690 **(<1%)**



2014/15

- £174,866 **(11%)**
- £357,763 **(23%)**
- £269,500 **(17%)**
- £400,431 **(26%)**
- £363,566 **(23%)**
- £1,000 **(<1%)**
- £1,323 **(<1%)**



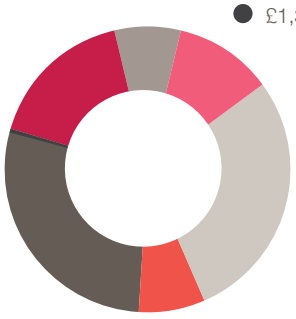
London

2013/14

- £210,000 **(22%)**
- £245,597 **(25%)**
- £81,500 **(8%)**
- £319,931 **(33%)**
- £113,485 **(12%)**

2014/15

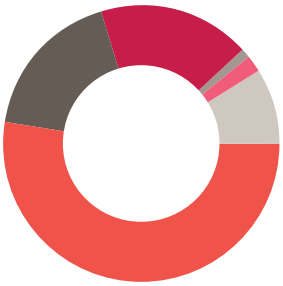
- £125,000 **(12%)**
- £325,097 **(31%)**
- £80,000 **(8%)**
- £318,431 **(31%)**
- £183,900 **(18%)**
- £80,000 **(8%)**
- £1,323 **(<1%)**



Outside London

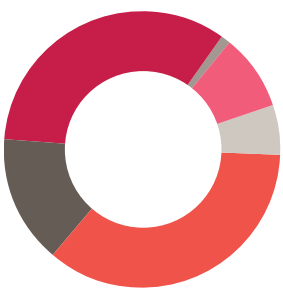
2013/14

- £8,333 **(2%)**
- £32,176 **(9%)**
- £188,000 **(53%)**
- £62,750 **(18%)**
- £63,333 **(18%)**
- £690 **(<1%)**



2014/15

- £49,866 **(9%)**
- £32,666 **(6%)**
- £189,500 **(36%)**
- £82,000 **(15%)**
- £179,666 **(34%)**
- £1,000 **(<1%)**



Percentages may not add up to exactly 100% due to rounding up and down.

D3.1 Higher risk groups

London

In London in 2013/14 £81,500 was spent on MSM testing representing activity in two boroughs and HPE funded testing, whereas in 2014/15 this was £80,000. Testing services targeting the black African population in London appear to be allocated significantly more funding. £319,931 was reported in 2013/14 and £318,431 in 2014/15.

It is unlikely that these are the only testing services to be targeted at these groups, and this is discussed in more detail below. The difference in the level of investment in testing between these two potential target groups may be explained by evidence of need. For example, evidence suggests that gay men are more likely to be comfortable accessing testing in a GU setting than many men and women from the black African population. There is also a much higher rate of late diagnosis amongst black African communities than amongst MSM. Thus the greater activity around targeted testing initiatives for African communities may well be a response to the elevated need.

As well as testing targeting MSM and black African men and women, some local authorities in London reported generic community testing (£245,597 in 2013/14 and £325,097 in 2014/15). For this no target groups were specified; however, it may be that some of this includes targeted community testing. There was also reported commissioning of routine testing for public health purposes which was not targeted, such as in a GP setting (£113,485 and £183,900) and hospital setting (£210,000 and £125,000).

Outside London

Outside London the distribution of target groups was very different from that in London. Testing services for MSM are more commonly commissioned outside of London than inside London, with testing targeting the black African population far lower as a proportion of overall testing spend. Unlike in London, in high prevalence areas outside the capital the distribution of target groups for testing services is similar to that of health promotion activity.

In 2013/14 £188,000 was spent outside London on locally commissioned testing services for MSM. A comparatively smaller figure of £62,750 was for testing services targeting the black African population and other BME groups. In 2014/15 there was an increase for both groups at £189,500 for MSM, and £82,000 for the black African population. This spending is however, distributed across a small number of local authorities.

It has already been noted that the population of black African men and women outside London is smaller as a proportion than that in London. This in part explains the disparity in investment in testing services for this group inside and outside London. Higher investment in testing for MSM outside London is also of note. It implies that there is a different approach being taken in areas outside of London to prevention amongst MSM.

One local authority mentioned HIV testing work amongst homeless people and one mentioned HIV testing among male sex workers.

D3.2 Additional testing in healthcare settings

In London, out of 32 local authorities, only seven in 2013/14 reported commissioning testing in GP settings; eight in 2014/15. There was a significant jump in reported funding of GP testing in London between the two years, from £113,486 (not including one local authority's spend which could not be disaggregated) to £183,900 (not including two local authorities' spending which could not be disaggregated).

Again, not all local authorities outside of London are investing in additional testing in GP settings. Out of 26 authorities surveyed outside of London, only three specified commissioning of HIV testing in a GP setting in 2013/14. In 2014/15 a total of six local authorities reported spending on GP testing. Investment in all types of testing increased outside London between the two years. GP testing received a considerable boost in funding (with a consequent increase as a proportion of overall testing spend), but this was concentrated in one specific area.

Two local authorities in London and two local authorities outside of London reported commissioning HIV testing in secondary care. One local authority in London and one outside of London also reported commissioning HIV testing in pharmacies.

8/32

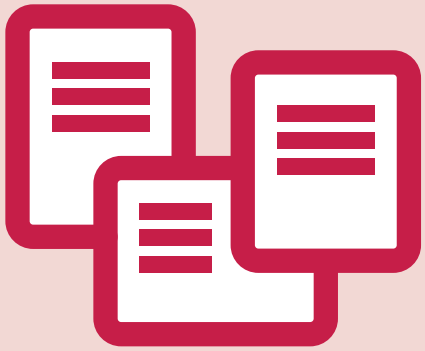
local authorities in London reported commissioning testing in GP settings in 2014/15.

£183,900

of funding was reported for GP testing in London in 2014/15.

E: Summary and conclusions

E1: Summary



'The future of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. The warning has not been heeded – and the NHS is on the hook for the consequences' NHS Five Year Forward Review, October 2014.

In 2014 NAT surveyed all high prevalence local authorities in England.[21] We asked for information for 2013/14 and 2014/15 on health promotion services targeting people who are HIV negative ('primary HIV prevention') and which are delivered outside the clinic setting. We also asked for information on HIV testing services commissioned outside the sexual health clinic.

Local authorities took over responsibility for public health, including HIV prevention, in April 2013. This survey is the first attempt since that change to try to assess, at least for high prevalence areas, what is being commissioned for HIV prevention. It is in the context of continuing high numbers being diagnosed with HIV and no evidence of any decline in transmission rates over the last decade. There are significant costs from ongoing transmission, most importantly for the individuals who acquire HIV, a serious long-term condition, but also for the public purse in terms of treatment costs.

Gathering information on HIV prevention spending is a difficult task. NAT was specific as to what was included and excluded in the information request and focussed on spending on primary HIV prevention (a priority in the Government's Framework for Sexual Health Improvement in England) and on HIV testing services outside the sexual health clinic.

These interventions are essential to effective HIV prevention and are commissioned by local authorities. However, effective HIV prevention requires a combination of interventions going beyond primary HIV prevention – for example, reducing STI transmissions, HIV treatment, safer sex support for people living with HIV, and legal and social interventions.

21 Public Health England defines local authorities as having a high prevalence of HIV if there are greater than two people in every 1,000 living with HIV.

Spending on HIV prevention

In 2013/14 £9,473,341 was reportedly spent on primary HIV prevention in high prevalence local authorities and in 2014/15 £10,317,272 was spent.

To take the amount for 2014/15, this constitutes less than 1% of the local authority public health allocation for these high prevalence local authorities.

These amounts are lower than some other recent estimates. This is probably due to the exclusion of sexual health clinic services, support services for people living with HIV and sexual health interventions which did not have HIV prevention as a primary objective. This is not to say that these services are not important in HIV prevention. But the Government's Framework for Sexual Health Improvement makes clear that 'primary HIV prevention' remains an essential element if we are to succeed in reducing rates of HIV transmission.

Spending is also lower than historical spending on HIV prevention. For example, in 2001/02 the Government allocated £55 million to local authorities for HIV prevention.

The amount spent on HIV prevention contrasts strongly with the amount we spend on HIV treatment and care. We estimate the costs of HIV treatment and care for high prevalence local authorities to have been about £555 million in 2013 – more than 55 times the amount we are spending on primary HIV prevention. The lifetime treatment costs of the 3,780 people newly diagnosed with HIV in high prevalence areas in 2013 is approximately £1.2 billion, compared with HIV prevention expenditure in these areas of £10 million.

£10,317,272

was spent on primary HIV prevention in high prevalence local authorities in 2014/15.

£55m

was allocated by the Government to local authorities for HIV prevention in 2001/02.

E2: Conclusions and recommendations

HIV prevention expenditure has been in decline for many years. However, significant progress will not be made in reducing HIV transmission in England unless local authorities substantially increase the amount being spent on HIV prevention. We acknowledge that the amount spent is not the only test of effectiveness – but it is a necessary prerequisite for effectiveness at scale.

The public health budget

We are also very conscious of the severe budgetary pressure local authorities currently face. About a quarter of the ring-fenced local authority public health grant has to be spent on mandated sexual health clinic services before any decisions are made on other public health needs of the local population such as smoking, obesity, alcohol and substance misuse needs. The public health budget for 2015/16 was frozen at exactly the same amount as for 2014/15 – a cut in real terms. From April 2016 it is currently planned that the ring-fence for public health funding is removed. It is likely that other significant and underfunded local needs will draw on those funds, reducing further the amount available for public health interventions.

Recommendation:

1. The Government should retain the public health budget ring fence beyond 2016 and the budget itself should be significantly increased if we are to invest what is needed to reduce HIV transmission in England.

There is also serious concern regarding the national HIV prevention programme, currently HIV Prevention England, and whether this will be adequately resourced in the future. It is essential that there is a national response to HIV through a national HIV prevention programme as well as a local response.

The national programme makes a significant contribution to HIV prevention activity. It provides important strategic direction, investment, research, materials and initiatives to complement and support local commissioning. We have identified that local authorities take a varied approach to HIV prevention, and further de-regulation of public health budgets at a local level may compound this. This is even more reason to ensure that there is nationally coordinated HIV prevention.

Recommendation:

2. The Department of Health should continue to fund the national HIV prevention programme at least at the current level of investment. Increased investment in the national HIV prevention programme should be seriously considered by the Government in order to go some way to better meeting prevention needs amongst higher risk groups in England.

Local authority investment in HIV prevention

There is great variation amongst local authorities in how much they spend on HIV prevention and it has a weak relation to HIV prevalence in the local authority areas. In 2014/15 five local authorities in London are spending nothing on HIV prevention beyond a small contribution to the London HIV Prevention Programme, and three local authorities

outside London reported no HIV prevention spending at all. A further 24 local authorities are spending less than £50,000 (13 of them less than £25,000) on HIV prevention and additional HIV testing in 2014/15, despite having high HIV prevalence.

Some local authorities are investing considerable sums in HIV prevention and developing innovative projects which aim to meet local need. However, there is no overall consistency of approach by local authorities towards HIV prevention and often little relation to their local HIV prevalence, either in amounts invested or in interventions commissioned. We believe this is a result of a lack of consensus as to what is needed to prevent HIV transmission at a local level, an inconsistent approach to needs assessments, and an ongoing reliance on historical commissioning decisions.

It is possible that the recent excitement about the potential of HIV treatment to reduce transmission rates has added to the confusion as to what local authorities should do, given their public health responsibilities, to prevent HIV. However, it is unacceptable that a number of local authorities with high HIV prevalence are spending little or nothing on primary HIV prevention.

Recommendation:

3. Local authorities should substantially increase the amount they spend on primary HIV prevention.

Types of intervention commissioned

We asked local authorities to indicate the types of HIV prevention intervention they were commissioning. Information was patchy - some local authorities gave very full accounts, others provided little or no information. In some cases the lack of information was because the local authority did not know the prevention interventions which they were funding.

From responses received there appears to be little one-to-one or group work being commissioned by local authorities. Such interventions were in the main supported by HIV Prevention England. It is possible that some voluntary sector organisations are providing one-to-one and group interventions with local authority funds, but the local authorities are unaware of the details of the prevention they are funding.

Most health promotion was described as 'outreach' in local authority responses and covered a variety of interventions, including for example condom distribution, small media distribution, work in bars, clubs and social events, and sexual health information campaigns. Only a very few mentioned work with faith communities, anti-stigma interventions or work around problematic drug use and safer sex.

Most HIV diagnoses (75% in 2013) are still concentrated in two groups – men who have sex with men and black African men and women. There is a considerable amount of targeted HIV prevention and testing interventions – accounting for approximately 50% of overall spend in 2014/15 based on the responses we received (though we suspect there may be further targeted work not disaggregated in the data).

Recommendation:

4. Local authorities should provide targeted HIV prevention interventions, which are evidence-based and informed by local population prevention needs.

Commissioning of HIV testing

HIV testing is a key element in effective HIV prevention. Most HIV transmissions are from the undiagnosed who cannot benefit from the safer sex support which comes with a diagnosis or from the treatment which can make someone with HIV effectively non-infectious. There was an increase in expenditure on HIV testing outside the sexual health clinic between 2013/14 and 2014/15, which is very welcome. However, a total of 35 out of 58 local authorities in 2014/15 were not investing anything in additional HIV testing. There are some good examples of HIV testing in community settings, with innovation in groups targeted and in settings used.

Increasing testing opportunities in primary and secondary care, and in the community, is shown to be an effective way of reaching people otherwise not testing for HIV who may be at risk. NICE public health guidance recommends that routine HIV testing should be introduced in hospitals in high

prevalence areas and in GP practices. In 2014/15 less than a quarter of high prevalence local authorities reported commissioning some HIV testing in GP practices (14 out of a total of 58). Furthermore only four local authorities reported commissioning HIV testing in hospitals (secondary care) in 2014/15. Poor implementation by local authorities of NICE public health guidance on HIV testing is seriously limiting the potential for HIV treatment to reduce HIV transmission in England. It is unacceptable that so many local authorities with high HIV prevalence are not commissioning any additional HIV testing services outside the sexual health clinic.

There may have been some uncertainty on commissioning responsibility for these interventions. Recent clarification from the Department of Health and Public Health England, stating that it is the responsibility of local authorities to commission routine screening for public health purposes in secondary care,[22] should lead to an increase in routine population-based HIV testing in these settings.

Recommendation:

5. Local authorities should implement the recommendations for HIV testing which are set out in the NICE public health guidance.

Reflections on data collection

There was variation in how easy local authorities found it to respond to our questions on HIV prevention expenditure. Where local authorities had difficulty, there were a number of reasons for this, including:

- They had contracts with HIV support service providers where there was no disaggregation of prevention activity from other services. Alternatively there may have been a contract for prevention but with no disaggregation of the different types of activity or different groups targeted;
- There were broad sexual health interventions where it was unclear whether these met our requirement that HIV prevention should be 'a primary aim' and whether those at elevated risk of HIV were amongst those targeted.

Recommendation:

6. Sexual health commissioners should clearly disaggregate, in contracts with HIV service providers, the indicative amounts to be dedicated to HIV prevention, with some information included on the intervention activity and on those being targeted.

Broader sexual health interventions

The question of whether broader and integrated sexual health interventions have an impact in preventing HIV transmission is a complex one. Even in high prevalence areas, the substantial majority of new HIV diagnoses will be amongst smaller and specific populations, most notably MSM and black African men and women. In some parts of the country other groups such as black Caribbean communities and people who inject drugs may also be at elevated risk. For broader sexual health interventions to be considered a contribution to HIV prevention, we would expect:

- intervention documentation to make explicit reference to HIV transmission/diagnosis rates and to identify those at significant risk of HIV;
- the intervention to be designed so that those at elevated risk of HIV are amongst those to be exposed, in significant numbers, to the intervention.

It will not be helpful for our understanding of current HIV prevention activity to be confused by general sexual health interventions, important though they are, which could not have any significant impact on local HIV transmission rates.

It is essential to stress the importance of support services for people living with HIV in maintaining adherence to treatment and in supporting safer sex. These services make a vital contribution to secondary HIV prevention. We are concerned that the pressure on public health and social care budgets now and

22 'Making It Work: a guide to whole system commissioning for sexual and reproductive health' Public Health England September 2014

in the future will make it even more difficult for local authorities to fund the range of these services.

Recommendations:

7. Local authorities should have a clear understanding of which sexual health interventions provided in the local area are intended (at least as one of their aims) to reduce HIV transmission amongst those at increased risk of HIV, and which are not.
8. Public Health England should work with the national and London HIV prevention programmes and with local authorities to agree essential principles, objectives, types of intervention and outcome measures which local authorities can use to contribute effectively to primary HIV prevention in their local area.

Appendix 1: Upper tier and unitary local authorities in England written to by NAT

London

Barking and Dagenham
Barnet
Bexley
Bromley
Brent
Camden
City of London & Hackney
Croydon
Ealing
Enfield
Greenwich
Hammersmith & Fulham
Haringey
Harrow
Havering (not high prev)
Hillingdon
Hounslow
Islington
Kensington & Chelsea
Kingston Upon Thames
Lambeth
Lewisham
Merton
Newham
Redbridge
Richmond Upon Thames
Southwark
Sutton
Tower Hamlets
Wandsworth
Waltham Forest
Westminster

Outside London

Bedford
Birmingham
Blackpool
Brighton and Hove
Sandwell
Reading
Leeds
Leicester
Manchester
Luton
Milton Keynes
Nottingham
Salford
Slough
Southend-on-Sea
Wolverhampton
Coventry

Upper Tier authorities with responsibility for public health in districts with high prevalence (in brackets)

Dorset (Bournemouth)

East Sussex (Eastbourne, Hastings & Lewes)

Essex (Harlow)

Hertfordshire (Stevenage & Watford)

Norfolk (Norwich)

Northamptonshire (Corby & Northampton)

Oxfordshire (Oxford)

Surrey (Woking)

West Sussex (Adur, Crawley & Worthing)

Appendix 2: HIV Prevention England spending with local delivery partners in high prevalence areas

	London	Outside London	Total
2013/14			
Health Promotion			
Black African	86,750	73,500	157,250
MSM	110,500	96,000	206,500
Total	197,250	169,500	366,750
Testing			
Black African	12,000	25,000	37,000
MSM	31,000	87,000	118,000
Total	43,000	112,000	155,000
Overall total 2013/14	240,250	281,500	521,750
2014/15			
Health Promotion			
Black African	96,500	70,500	167,000
MSM	107,500	71,650	179,150
Total	204,000	142,1500	346,150
Testing			
Black African	18,000	54,500	72,500
MSM	37,000	83,000	120,000
Total	55,000	137,000	192,500
Overall total 2013/14	259,000	279,000	538,650

Acknowledgements

This project is kindly supported in part by a grant from MSD UK Limited.

With further thanks to:

Directors of Public Health and local authority sexual health and public health commissioners for their cooperation and support with collating the data in this report.

Paul Steinberg and Andrew Billington from the London HIV Prevention Programme.

Cary James and Paul Dobb from HIV Prevention England.

Dr Ford Hickson from Sigma Research, London School of Hygeine and Tropical Medicine.

We believe we make the most lasting and positive impact on the greatest number of lives by changing attitudes, behaviour, decisions and policies. This means that our work benefits the largest possible number of people with HIV, but it also means we do not receive funding from the national and local service contracts that so many charities rely on for ongoing support. As a small charity with a very large agenda and an important role in the world of HIV in the UK we rely on the support of our donors and volunteers.

To find out more about how you can support NAT go to www.nat.org.uk

SHAPING ATTITUDES
CHALLENGING INJUSTICE
CHANGING LIVES

You can help us continue to make a difference.
NAT relies on the support of people like you to continue our important work - shaping attitudes, challenging injustice and changing lives.

To find out about our plans for next year and how you can support us, visit:
www.nat.org.uk
www.lifewithhiv.org.uk
www.hivaware.org.uk

You'll also find us on Twitter @Nat_AIDS_Trust and Facebook

www.nat.org.uk

New City Cloisters, 196 Old Street, London EC1V 9FR
T: +44 (0)20 7814 6767 F: +44 (0)20 7216 0111 E: info@nat.org.uk

National AIDS Trust is a Registered Charity
No. 297977 and a Company Limited by Guarantee
No. 2175938, (registered in England and Wales)
Registered Office: New City Cloisters, 196 Old Street, London EC1V 9FR

TRANSFORMING THE UK'S RESPONSE TO HIV

NAT