

Commissioning HIV Prevention Activities in England



National AIDS Trust
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Executive Summary

Overall conclusions

HIV prevention must become a public health priority for England - the need to invest in effective HIV prevention services is greater now than it has ever been. Effective commissioning is essential for HIV prevention to be properly funded, with resources meeting need and supporting activities which make a real difference.

The evidence of this and other surveys is that currently commissioning of HIV prevention demonstrates:

- good practice in many localities, though not consistently shared
- a sustained effort to meet the emerging HIV prevention needs of black African communities
- examples of innovation

but also

- poor use of and access to data and information
- a probable decline in HIV prevention funding during a time of increasing HIV prevention need
- inconsistent practice in relation, for example, to community involvement and evaluation
- inadequate support and skills building for commissioners
- and in many instances a lack of political priority.

The National AIDS Trust welcomes the forthcoming review by the Independent Advisory Group on Sexual Health and HIV of the National Strategy for Sexual Health and HIV, and trusts the findings of this report will prove useful in its consideration of HIV prevention. *[Action: Independent Advisory Group on Sexual Health and HIV]*

We recommend that new and measurable HIV prevention targets are identified and adopted at both national and local levels. To that end, we would urge the collection by the Health Protection Agency of HIV incidence data as soon as possible. *[Action: Department of Health; Health Protection Agency]*

Work to be undertaken by the Department of Health, with the support of the English HIV and Sexual Health Commissioners Group, on a new Sexual and Reproductive Health Commissioning Framework should address the needs around the commissioning of HIV prevention identified in this report. *[Action: Department of Health; English HIV and Sexual Health Commissioners Group]*

Executive Summary

Detailed Findings

Commissioning of HIV prevention

Primary Care Trust Local Delivery Plans (LDPs) in higher prevalence areas do not consistently give enough attention to the need for HIV prevention activity. This must be rectified.

[Action: Primary Care Trusts]

There should be greater consideration of the wider health needs of both gay men and African communities in LDPs as part of the health inequalities agenda. *[Action: Primary Care Trusts]*

The survey suggests often poor, incomplete or inaccurate understanding amongst many respondents of the local population and its HIV-prevention needs. *[Action: Primary Care Trusts; English HIV and Sexual Health Commissioners Group]*

Expenditure on HIV prevention

It is a cause for concern that a number of PCTs appear to consider HIV prevention to be adequately addressed simply through wider sexual health promotion, without additionally investing in specific targeted initiatives. *[Action: Primary Care Trusts]*

For the future, there needs to be clarity amongst PCTs as to how much is being spent on HIV prevention activities, based on consistent definitions. *[Action: Primary Care Trusts; Department of Health]*

Despite continuing significant numbers being infected yearly with HIV, larger at-risk populations and evidence of higher rates of risk-taking behaviour than ten years ago, HIV prevention expenditure over the same period has at best stagnated and quite probably declined in real terms. *[Action: Primary Care Trusts]*

HIV prevention activities

The survey suggests that HIV prevention has seen recent significant development for black African communities in high prevalence areas, which is appropriate and welcome.

Commissioning practice

Consistency in the use of some 'core' high quality and relevant documents and materials could well establish a greater transparency and effectiveness in the commissioning of HIV prevention.

The widespread reported use by many Commissioners of resources and guidance to inform their commissioning was encouraging, but there are still far too many PCTs not using resources which might improve and develop their commissioning practice.

The very limited use of those documents specifically drafted for HIV and sexual health Commissioners suggests a need to revisit available guidance for the commissioning of sexual health and HIV services.

Executive Summary

Overall, responses suggested an encouraging concern to involve black Africans and gay and bisexual men in the planning and commissioning of relevant HIV prevention services. There does, however, appear to be a need for greater clarity and consistency as to what constitutes effective community involvement in health service planning and delivery.

HIV prevention activities are not always evaluated and there is a lack of clarity as to what constitutes appropriate evaluation.

Our survey makes clear the urgent need for an increased level of interactive, peer and Department of Health support for sexual health and HIV commissioners in England. Appropriate action is needed from all responsible bodies. PCTs have the main and immediate obligation to ensure their commissioning meets local need. The Department of Health should ensure that commissioning of sexual health and HIV is given the necessary guidance, monitoring and support from the centre – a process now underway through the development of a Sexual and Reproductive Health Commissioning Framework .

There is an urgent need to communicate more effectively within PCTs what is currently known on the impact of HIV prevention activities, especially in relation to black African communities within the UK. There is also a need to plan and fund more research into HIV prevention interventions, particularly amongst black African communities in the UK.

[Action: All these issues of commissioning practice need to be addressed by Primary Care Trusts, the English HIV and Sexual Health Commissioners Group and the Department of Health working together to establish and monitor consistent best practice]

1 Introduction – the importance of commissioning HIV prevention activities

HIV remains one of the most serious public health challenges facing this country. There are now over 70,000 people infected with HIV in the UK, with one in three of this number undiagnosed. The numbers living with diagnosed HIV have trebled in the last ten years. New diagnoses now exceed 7,000 a year – there were 7,662 new HIV diagnoses in 2005, the last year for which we have complete data, compared with 2,665 in 1995.¹ And in 2005 we also had the highest ever number of HIV diagnoses amongst gay and bisexual men (2,500).

Overall HIV prevalence remains low at 0.1%, but the epidemic is concentrated in two often marginalised communities – gay and bisexual men and Africans – and prevalence within these communities is much higher. Prevalence amongst gay and bisexual men between the ages of 15 and 44 is estimated nationally at 5.2% (diagnosed and undiagnosed) – disaggregated as 8.4% in London and 3.6% in the rest of England and Wales. There are also very high numbers of gay and bisexual men living with diagnosed HIV in Brighton and Manchester. Prevalence of diagnosed HIV infection is estimated to be 3.6% amongst black Africans.

Whilst for most people living with HIV in the UK the advent of anti-retroviral therapy has radically transformed the implications of the disease, allowing them to live full and productive lives, there continues to be between 500 and 600 HIV-related deaths every year, often related to late diagnosis. Moreover, HIV infection unfortunately brings with it for many the experience of stigma and discrimination.

The significant increase in HIV prevalence has a number of causes. These include the fact that people with HIV are living longer as a result of effective treatment, and recent migration to the UK of people living with HIV (usually undiagnosed), both heterosexual from high prevalence countries and also men who have sex with men (MSM), often from the EU.

But prevalence is also a result of ongoing transmission of HIV within the UK. There are continuing significant levels of risk-taking behaviour amongst gay and bisexual men and some evidence of increased incidence amongst gay men aged over 34 in London. Aggregated statistics also disguise particular problems in sub-groups – for example, there is a much greater vulnerability to HIV infection amongst migrant and black and minority ethnic gay men.

Incidence might still be relatively low compared with some countries but this should not blind us to the disproportionate burden of physical and mental ill-health caused by HIV infection in particular communities, nor of the danger of incidence increasing if we fail to increase our efforts in HIV prevention. With numbers with HIV three times what they were ten years ago, with significantly larger gay and black African communities, and with evidence of increased risk-taking behaviour amongst gay men, the need to invest in effective HIV prevention services is greater now than it has ever been previously.

The National AIDS Trust has as one of its priorities 'securing political will, commitment and resources for HIV prevention based on need ...'. The commissioning process within the NHS is central to the effective support and resourcing of HIV prevention. There are some national HIV prevention programmes funded centrally by the Department of Health – in particular the CHAPS partnership, managed by the Terrence Higgins Trust, which works on HIV prevention amongst men who have sex with men (MSM), and the National African HIV Prevention programme (NAHIP) which is managed from within the African HIV Policy Network (AHPN). But these funds only provide additional and complementary support for local work and cannot substitute for targeted and effective local commissioning of HIV prevention activities, based on local need. PCTs receive funding from the Department of Health for HIV prevention as part of their overall resource allocation.²

The National AIDS Trust (NAT) decided to undertake a survey of the commissioning of HIV prevention activities in England. This was in the context of increasing levels of concern as to whether HIV prevention was being commissioned adequately in terms of resources, or effectively in terms of need. Recent reports underline concerns over current commissioning practice. For example, Terrence Higgins Trust's (THT) report 'Disturbing Symptoms 5' describes a 'loss of expertise in local sexual health service planning' and 'a continuing disconnect between national strategy and local action on sexual health'. Commenting on the THT survey findings, the report states, 'Despite the increasing importance of well-informed commissioning, more than two in five responding PCTs could not say that a local sexual health needs assessment had taken place in the last three years'.³

At about the same time as NAT's survey of HIV prevention commissioning, a survey was also carried out for the AIDS Funders Forum on the commissioning of HIV social care, support and information services across the UK.⁴ The report comments, 'NHS HIV commissioners occupy a range of job roles, have a range of backgrounds and skills and are rarely HIV specialists. Many have multiple other priorities and roles, few have received any formal training and many receive no ongoing support. Expertise in service development is not a common skill among commissioners'. The report goes on to state that 'Many NHS commissioners feel their role is to save money and monitor and remove existing contracts rather than commission new services'.

An important recent report from the Healthcare Commission, 'Performing better?'⁵, has also identified real concerns on the use of data to inform the provision of sexual health services at both national and local levels. For example, PCTs 'did not always have the information they required to allow them to target their programmes to help those most in need'. In relation to PCTs, the report recommends that they 'should focus on reducing inequalities in sexual health commissioning services in line with national standards, assessing local needs and evidence of good practice'.

2 'Resource Allocation: Weighted Capitation Formula' 5th edn Department of Health May 2005 - section 6 'HIV/AIDS component'

3 'Disturbing Symptoms 5: How Primary Care Trusts managed sexual health and HIV in 2006 and how specialist clinicians viewed their progress' Terrence Higgins Trust February 2007

4 'The growing challenge: A strategic review of HIV social care, support and information services across the UK' AIDS Funders Forum/Sigma Research March 2007

5 'Performing better? – A focus on sexual health services in England' Healthcare Commission June 2007

There is a disturbing mismatch between the problems in commissioning apparent from such research, and the ambitions for commissioning found in Government policy documents. These ambitions are communicated most recently in the consultation document and White Paper 'Commissioning framework for health and well-being' which sets out an important agenda to achieve:

- A shift towards services that are personal, sensitive to individual need and that maintain independence and dignity
- A strategic reorientation towards promoting health and well-being, investing now to reduce future ill health costs
- A stronger focus on commissioning the services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities

NAT's survey of HIV commissioning took place during the reconfiguration of PCTs in the latter half of 2006, as did the work relating to the reports cited above from THT and the AIDS Funders Forum/Sigma Research. Even though the NHS was in a state of flux in 2006, the continuing rate of change within the NHS has meant it hard to find a 'stable period' in which to carry out such a survey. But in any event, the merging of most PCTs into larger units (from 303 PCTs to 152) should not have necessarily meant the loss of expertise. Furthermore, this was an opportunity to get some sort of baseline data on HIV prevention commissioning pre-reconfiguration against which future progress in the newly established PCTs could be measured.

In advance of the final drafting and publication of this report, the survey findings were presented in a number of forums – the CHAPS conference in March 2007, the British HIV Association Conference in April 2007 and the English HIV and Sexual Health Commissioners Group meeting in April 2007. We are grateful for the questions and comments received, which have informed our interpretation of the data, our conclusions and recommendations.

Acknowledgments

The National AIDS Trust would like to thank all the Commissioners and other NHS staff who responded to the survey.

The project is continually indebted to the support, suggestions and analysis from the Health Protection Agency, in particular to Tim Chadborn and Tom Nichols, and to Jorgen Engmann and Valerie Delpech.

2 Technical Details and Sampling Methodology

A questionnaire (see Annex) with a response deadline of September 2006, was sent to Chief Executives in 137 PCTs out of the then 303 PCTs in England (this was done pre-'reconfiguration' of PCT and SHA boundaries). The 137 PCTs were sampled by the Health Protection Agency from four strata ranked by decreasing diagnosed HIV prevalence (see table below). The PCTs were ranked according to numbers living with diagnosed HIV [SOPHID] and overall population estimates for that PCT [ONS].

The following definitions were used:

Rank 1 - Number of HIV-infected MSM divided by the total population in the PCT is greater or equal to 0.15% or number of HIV-infected black Africans divided by the total population in the PCT is greater or equal to 0.15%.

Rank 2 - Number of HIV-infected MSM divided by the total population in the PCT is greater or equal to 0.05% or number of HIV-infected black-Africans divided by the total population in the PCT is greater or equal to 0.050% without either proportion being greater or equal to 0.15%.

Rank 3 - Number of HIV-infected MSM divided by the total population in the PCT is greater or equal to 0.025% or number of HIV-infected black-Africans divided by the total population in the PCT is greater or equal to 0.025% without either proportion being greater or equal to 0.05%.

Rank 4 - Number of HIV-infected MSM divided by the total population in the PCT is less than 0.025% and number of HIV-infected black-Africans divided by the total population in the PCT is greater than 0.025%

RANK	PCTs	SAMPLED	RESPONSES	WEIGHT
1	26	100%	16 (62%)	X 1.6
2	37	100%	19 (51%)	X 1.9
3	53	50% (27)	15 (56%)	X 3.5
4	187	25% (47)	30 (64%)	X 6.2

Of the 137 PCTs sampled, responses were received for 80 PCTs (there were 55 responses since some reported for more than one of the sampled PCTs). This was a response rate of 58%. Results were weighted to provide representative estimates for all 303 PCTs in England assuming that responses were representative of all PCTs in each rank.

Chief Executives were asked to pass the questionnaire on for completion to the person(s) responsible for commissioning HIV prevention activities in the PCT. Respondents were asked what their particular position in the PCT was. Responses were as follows:

RANK	1	2	3	4
COMMISSIONER	5 (38.5%)	2 (15.4%)	1 (8.3%)	4 (23.5%)
SEXUAL HEALTH LEAD	2 (15.4%)	6 (46.2%)	5 (41.7%)	5 (29.4%)
DIRECTOR OF PUBLIC HEALTH	2 (15.4%)	3 (23.1%)	4 (33.3%)	2 (11.8%)
PUBLIC HEALTH SPECIALIST	2 (15.4%)	2 (15.4%)	–	3 (17.6%)
HEALTH IMPROVEMENT MANAGER	1 (7.7%)	–	2 (16.7%)	1 (5.9%)
HEALTH PROMOTION SPECIALIST	–	–	–	2 (11.8%)
COMMUNITY LIAISON SPECIALIST	1 (7.7%)	–	–	–

This variety of respondents reflects other findings on the rapid turnover of staff in commissioning and the frequent difficulty (particularly amongst PCTs in ranks 2, 3 and 4) in identifying the individual in a PCT with clear commissioning responsibilities.⁶

⁶ See AIDS Funders Forum/Sigma Research 2007 'The growing challenge' section 2.2.1 for interesting and comparable information on NHS HIV Commissioners, length of time in post and background in sexual health or HIV, and Terrence Higgins Trust 'Disturbing Symptoms 5' 4.2 for a similar range of respondents and concerns expressed at 'a loss of expertise in sexual health planning'

3 Commissioning of HIV prevention

Respondents were asked how HIV prevention activities were commissioned – as an individual PCT or in a consortium. 85% of PCTs commissioned HIV prevention in consortia, with only 12% stating it was as an individual PCT.

A number of questions were asked about the PCT's Local Delivery Plan (LDP) which is intended to identify the health needs and service commitments and priorities over a three year period. The LDP is intended both to reflect national priorities and targets but also on the basis of a local health needs assessment to identify particular local health needs which should be addressed.

Respondents were asked whether HIV prevention was explicitly identified as a priority in the PCT's 2005/08 Local Delivery Plan (LDP); whether the LDP identified for implementation or continuation any specific HIV prevention activities; and whether either general health needs or HIV prevention needs of black Africans or gay men were mentioned in the LDP.

Overall 55% of PCTs had mentioned HIV as a priority in their LDP. Only 44% of PCTs had carried out a local health needs assessment relating to HIV prevention. The proportion which had carried out a relevant local health needs assessment was higher amongst rank 1 PCTs though even here it was only 69%, with 13% saying no, and 19% unable to answer.

Far fewer mentioned either the general health needs or HIV prevention needs of gay men or black Africans in their LDP.

These results reflect previous work undertaken by NAT and other sexual health organisations which revealed a low priority for HIV within LDPs.⁷ **Primary Care Trust Local Delivery Plans (LDPs) in higher prevalence areas do not consistently give enough attention to the need for HIV prevention activity. This must be rectified.**

There should be greater consideration of the wider health needs of both gay men and African communities in LDPs as part of the health inequalities agenda.

Knowledge of local population

Commissioning of HIV prevention activity must be on the basis of a well-informed understanding of HIV prevention 'need' in a particular locality, including data on size of vulnerable populations, numbers living with HIV, any indications as to HIV incidence, and so on. Questions were therefore asked to assess an understanding of the relevant local populations for targeted HIV prevention. Respondents were asked how many gay men and how many black Africans resided in their PCT in 2005/06, and how many people from each community were being seen for HIV care in the PCT in 2004/05 (2004 was the last year for which SOPHID data were available at the time of the survey⁸).

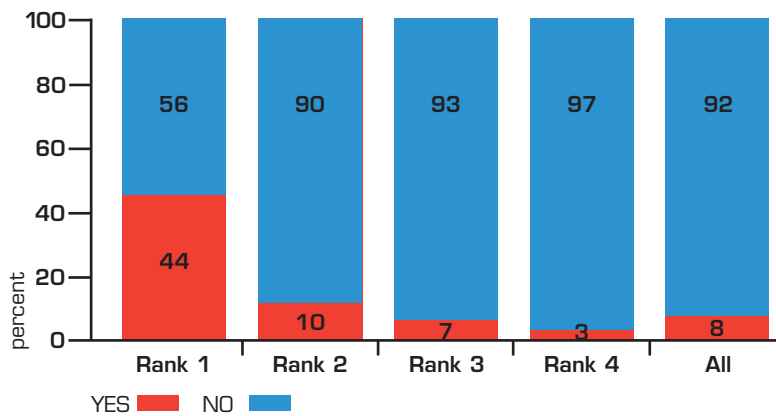
7 'Review of Primary Care Trust Local Delivery Plans 2005-08' Brook, fpa, MedFASH, NAT, THT 2006

8 SOPHID (Survey of Prevalent HIV Infections Diagnosed) is a cross-sectional survey undertaken by the Health Protection Agency of all individuals with diagnosed HIV infection who attend for HIV-related care within the NHS in England, Wales and Northern Ireland within a calendar year. Some discrepancy was allowed in answers to address the fact that SOPHID data are on a calendar year basis.

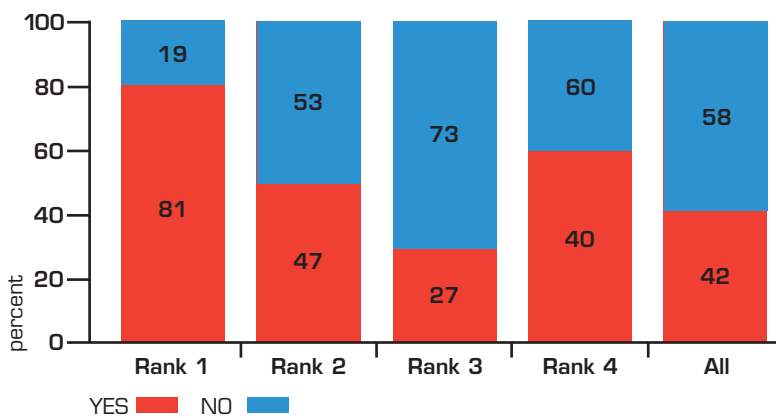
The question of numbers of gay men resident in a PCT was interesting because on the one hand this is not a census question and thus there is no one readily available set of data to provide a definitive answer. On the other hand some attempt to assess the size of the gay population in an area is necessary to plan targeted HIV prevention activities for this community. NATSAL⁹ proportions applied to local population data is one possible approach.¹⁰ Only 8% reported an estimate of the numbers of gay men in their PCT, but this rose to 44% in PCTs in rank 1. In other words, it was possible to come up with an estimate, but few PCTs attempted to do so.

By contrast, 42% reported the local population of black Africans and this rose to 81% amongst PCTs from rank 1.

3.1 Figure provided for gay/bisexual men population in PCT



3.2 Figure provided for black African population in PCT

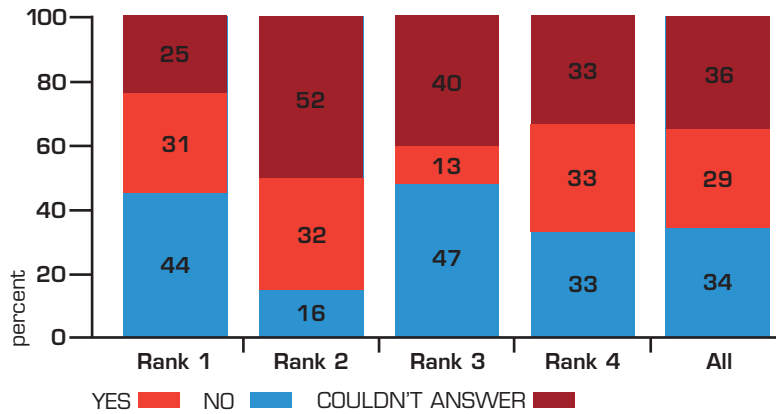


9 National Survey of Sexual Attitudes and Lifestyles II – 2000-01

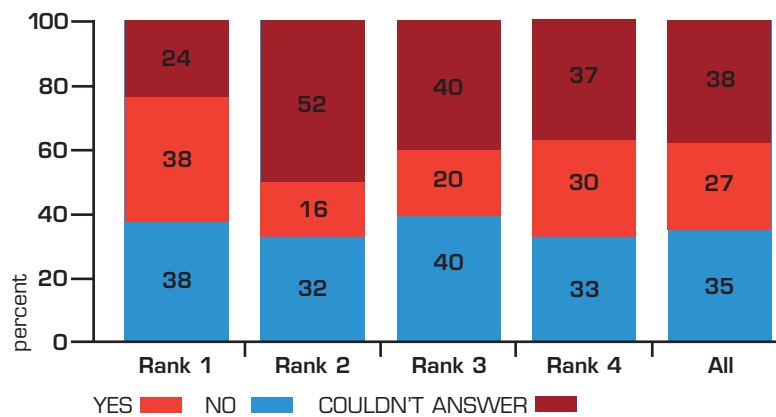
10 See para.4.2.4 of 'Sexual Health in England: an Updated Guide to National and Local Surveillance and Monitoring Data' Association of Public Health Laboratories May 2004. Data can also be used from the Gay Men's Sex Survey published by Sigma Research at www.sigmaresearch.org.uk

In relation to those being seen for HIV care, one third could not provide any numbers and another third provided numbers which did not match SOPHID data.¹¹ Underuse or incorrect use of SOPHID data is a matter for concern.

3.3 HIV numbers gay/bisexual men – accurate response



3.4 HIV numbers Black Africans – accurate response



The survey suggests often incomplete or inaccurate understanding amongst many Commissioners of the local population and its HIV-prevention needs.

The English HIV and Sexual Health Commissioners Group is currently, with the support of the National AIDS Trust and the Health Protection Agency, working on a project to identify key sources of data and information for HIV and Sexual Health Commissioners on HIV prevention and testing need. It is hoped this will be a useful resource. It will be integrated into current plans of the Department of Health to provide website support for HIV and Sexual Health Commissioners.

¹¹ To address an ambiguity in the question, responses were assessed both on the basis of individuals being seen for care within the PCT and individuals resident in the PCT being seen for HIV treatment and care whether in the PCT or outside its boundaries – the responses were incorrect in both cases.

4 Expenditure on HIV prevention

Questions were asked on recent, current and projected levels of expenditure on HIV prevention, overall, and then on amounts targeting gay men and black Africans.

There were real difficulties for many respondents in answering questions on amounts of money spent on HIV prevention.

General comments on HIV prevention expenditure

A number responded that disaggregation was not possible because HIV prevention spend was integrated, or about to be 'mainstreamed', within a single sexual health budget. Moreover there was a sense that this was a growing trend, *'HIV prevention is likely to be further integrated into general sexual health and more general healthy lifestyle programmes'*. Sometimes such a process also meant probable decreases in funds specifically set aside for HIV prevention, *'There has been a lot of work that has been done over the years which is HIV specific. The budget is likely to decrease to integrate broader aspects of sexual health'*.

A number of respondents talked of the difficulty of making financial projections in the current NHS financial climate. They felt that in any event expenditure would not be meeting actual need. One respondent commented, *'Despite potentially rising need, financial constraints make it very unlikely that this work will attract increased investment'* and another said, *'Pressures on the HIV budget for treatment are increasing and there is no flexibility for an increase in the prevention element'*. One prediction for expenditure on HIV prevention was that it would *'stabilise or decrease due to PCT financial recovery'*.

Other typical responses included:

'No new money is available. Choosing Health funding is not available for HIV prevention in 2006/07.'

'The present financial/reconfiguration process means our services are currently under review.'

'This will not be a total increase in funding but refocusing.'

'In view of the financial difficulty and the recovery plans to turn round the deficit, it is very unlikely there will be an increase in funding.'

'This is impossible to answer. The host PCT is in financial crisis with an overspend of £20 million. There have been in excess of 1,000 redundancies at the local provider hospital and additional redundancies are sought by the PCT. Therefore, although we hope to maintain the level of resources this cannot be guaranteed.'

There was some good news, for example, *'Choosing Health funding enables a further £51k to be spent on HIV prevention activities which are targeted at black Africans and gay/bisexual men'*.

One response cited both financial pressures and mainstreaming when discussing the future expenditure on HIV prevention for black Africans, *'given the current position of financial pressures faced by PCTs there will be increased need to develop an evidence base for current initiatives. I would also expect broader health promotion activity to mainstream sexual health promotion'*.

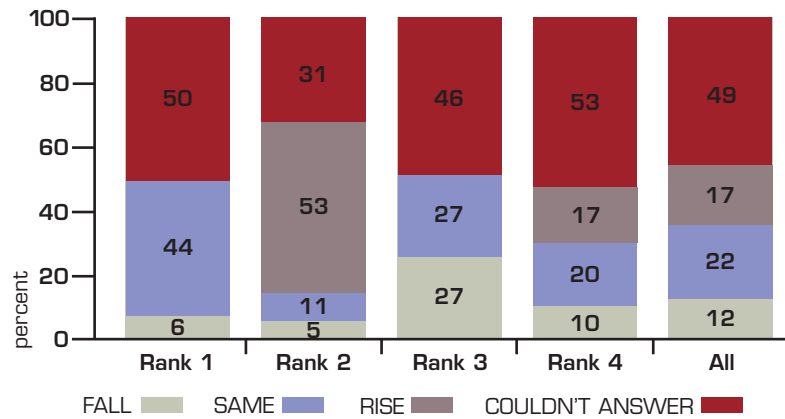
It is of course important both to increase funding for wider sexual health promotion and ensure that specific HIV-related interventions are effectively integrated into this wider work. But general sexual health promotion cannot and should not replace targeted HIV prevention activity for affected communities, nor result in and/or disguise what are effectively cuts in HIV prevention expenditure. **It is a cause for concern that a number of PCTs appear to consider HIV prevention to be adequately addressed simply through wider sexual health promotion, without additionally investing in specific targeted initiatives.**

Respondents were also asked whether HIV prevention expenditure overall, as well as HIV prevention expenditure for gay men and for black Africans, would increase, stabilise or decrease over the next five years. About half of PCTs were unable to answer the question (and this was frequently linked to continuing financial uncertainties), but for those that responded about 24% expected HIV prevention expenditure overall to decrease, about 33% to increase, and about 43% to stabilise. The most significant percentage who thought it would decrease were amongst rank 3 PCTs, with none in that rank, or in rank 1, thinking it would increase.

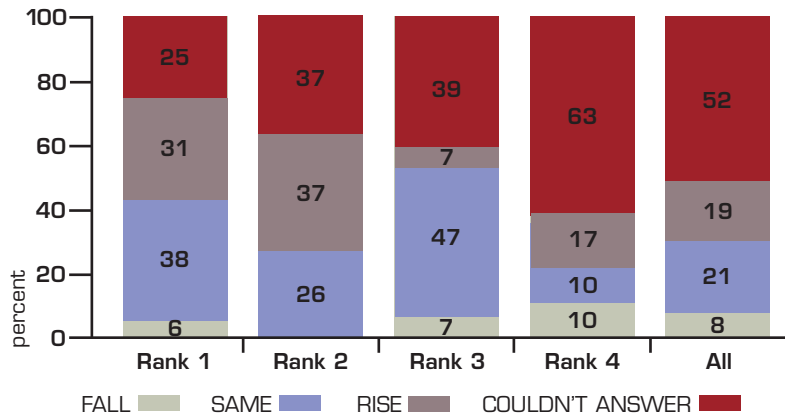
Financial uncertainties within the NHS at the time of the survey particularly affected information provided on 2006/07 and future financial years. It is hoped now that with greater stability returning to NHS budgets, there might be clarity and predictability for HIV prevention budgets. It is also hoped that the opportunity might be taken to review budgets to assess whether they are adequate to meet HIV prevention needs.

HIV prevention expenditure for gay men was mainly expected to stabilise (in two-thirds of PCTs) where an answer other than don't know could be given. For black Africans, 39% of PCTs overall expected a rise in expenditure (rising to about 42% in rank 1 and 58% in rank 2) but 17% expected a fall (where an answer other than don't know could be given). Recent significant increases in the numbers of black Africans living with HIV in PCTs, a particular phenomenon outside London, might be one explanation why there are more responses indicating an increase in HIV prevention expenditure for this community. There was no comment or evidence to suggest such increases were at the expense of expenditure on gay men.

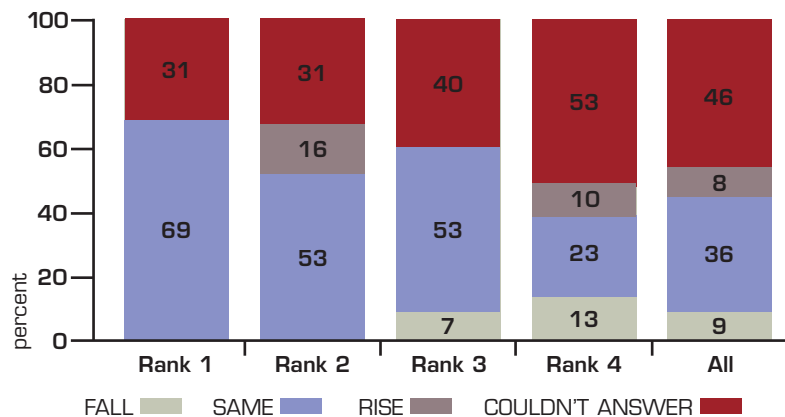
4.1 Projected overall HIV prevention expenditure



4.2 Projected HIV prevention expenditure for Black Africans



4.3 Projected HIV prevention expenditure for gay/bisexual men



Details of expenditure on HIV prevention

Amounts for HIV prevention expenditure were only provided for year 2005/06 for 61% of PCTs (80% in rank 1 but only about 50% for the other ranks). There was even less data on projected expenditure for 2006/07 (56%) and 2007/08 (45%).

It was hard to see a general trend in expenditure over time from the results. Although there were some substantial changes in levels of funding identified within PCTs, these were fairly evenly split between significant rises in expenditure and significant cuts.

Some PCTs, whilst not always stating this in terms, clearly identified generic sexual health interventions such as condom distribution as HIV prevention expenditure whilst others confined their calculation to targeted HIV prevention activities to the two respective communities such as those identified in 'Making it Count' and 'Doing It Well'.

The Healthcare Commission report 'Performing better?' stated, 'There is limited data to assess changes over time in resources allocated to public health and the outcomes from deployment of these resources. Such an assessment is necessary if we are to more effectively measure specific progress on sexual health. The Department of Health, strategic health authorities, PCTs and the Healthcare Commission should ensure that this information is available as part of the system of assessment i.e information both on inputs (resources allocated) and outcomes from the budgets'.¹² Although the Department of Health said in the National Strategy for Sexual Health and HIV implementation action plan that 'levels of investment in HIV prevention, treatment and care will be closely monitored', this has not taken place.¹³

This 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. **For the future, there needs to be clarity amongst PCTs as to how much is being spent on HIV prevention activities, based on consistent definitions.**

Caution is necessary in any extrapolation of the figures provided on HIV prevention, both because many PCTs were unable to provide information and because it was apparent that wider sexual health funding was often included in their definition of HIV prevention expenditure. It has, however, always been the case, even under ring-fenced HIV prevention funding, that resources marked specifically for HIV prevention were used for other and wider purposes. It is striking that if one extrapolates from the data provided, a national figure for overall HIV prevention expenditure by PCTs in England would be £38 million in 2005/06. This would be no higher than expenditure in 1997, when the DH Stocktake Group also estimated expenditure on HIV prevention to be £38m¹⁴, although during the intervening period numbers living with HIV have trebled; there have been increases both in the numbers of men who have sex with men and the numbers of black Africans resident in the UK; and there have been significant increases in risk-taking behaviour amongst gay men.

Perhaps the strongest conclusion we can draw is that **despite continuing significant numbers being infected yearly with HIV, larger at risk populations and evidence of higher rates of risk-taking behaviour than ten years ago, HIV prevention expenditure over the same period has at best stagnated and quite probably declined in real terms.**

¹² 'Performing better?' Healthcare Commission June 2007 p.9

¹³ 'National Strategy for Sexual Health and HIV Implementation Action Plan' Department of Health June 2002 Action 4

¹⁴ The ring-fenced 'special allocation' for HIV prevention expenditure in 1997/98 was £52m, which rose to £55m for the last year of ring-fenced funding in 2001/02. The notional HIV prevention allocation for 2005/06 within the weighted capitation formula of PCTs' Resource Allocation from the Department of Health was £82.4 m. In 2005/06 the Department of Health provided £1.105 million for the CHAPS programme and £400,000 for NAHIP.

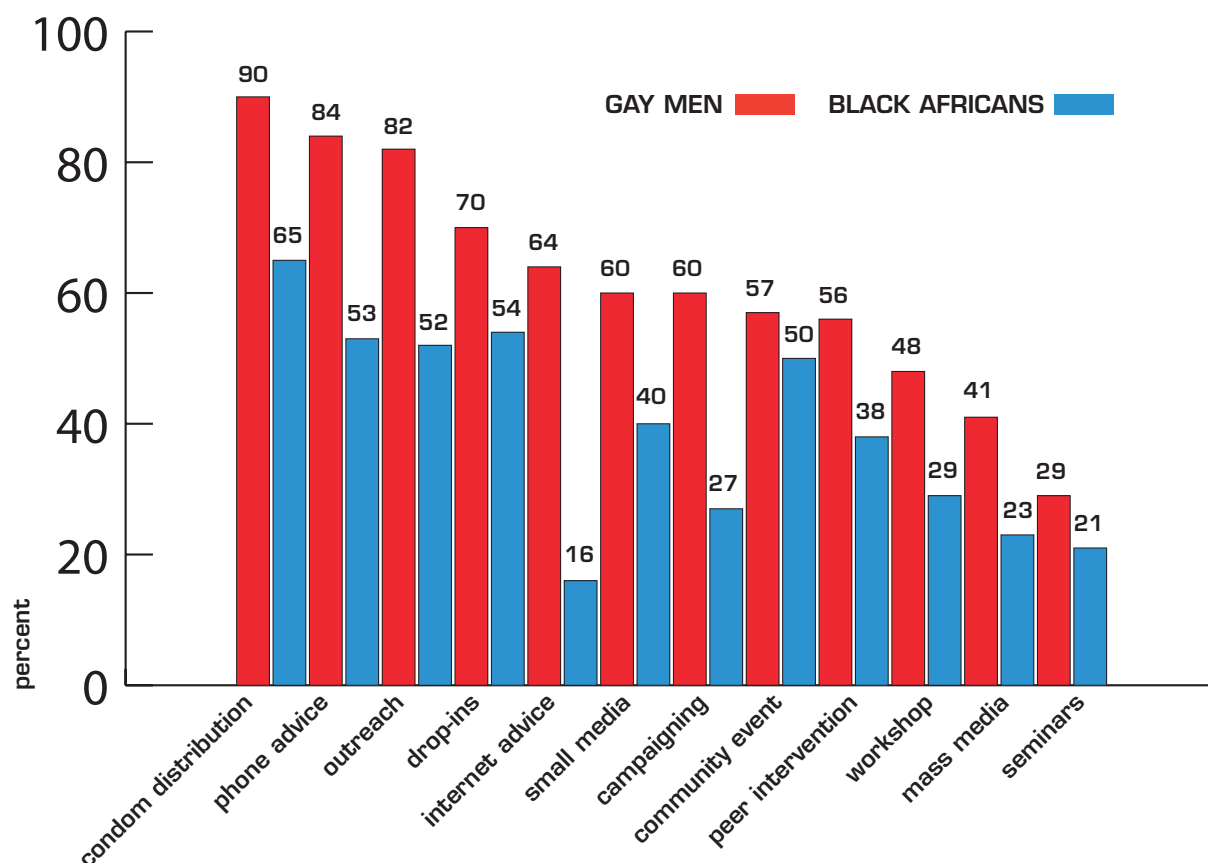
5 HIV prevention activities

Respondents were asked about what HIV prevention activities were funded by their PCT. Condom distribution, phone advice, outreach and drop-ins were the most commonly commissioned activities for gay men. For black Africans it was condom distribution, drop-ins, phone advice, outreach and community events.

Commissioning of all the possible HIV prevention activities listed was generally very high in high prevalence areas (apart from internet-based interventions for black Africans, which were low in all areas). In lower prevalence areas, certain activities were commissioned significantly less frequently, for example mass media and seminar work for gay men, and a number of interventions for black Africans including workshops, campaigns, mass media, seminars and the internet.

The survey suggests that HIV prevention has seen recent significant development for black African communities in high prevalence areas, which is appropriate and welcome. Interventions elsewhere for black Africans remain limited. Whilst again for PCTs with lower numbers of black Africans this may be appropriate, in-migration and dispersal of asylum seekers mean that PCTs need to be able to respond quickly and flexibly to often rapidly changing populations and need. In some instances historic HIV prevention provision may simply not have 'caught up' with current need.

5.1 'Which HIV prevention activities did you commission for gay men/black Africans in 2005-06?'



6 Commissioning practice

The survey finally asked a number of questions about commissioning practice, in particular the documents and other materials used by Commissioners in their work; involvement of affected communities in the commissioning and planning of prevention activities; evaluation of HIV prevention activities; and the kind of assistance needed in the future to support commissioning activity.

Documents/materials

In relation to HIV prevention amongst gay men, 11 responses mentioned 'Making it Count' and a further nine referred to 'THT' or 'CHAPS' without specifying a particular document. The National Strategy for Sexual Health and HIV and the MedFASH Recommended Standards were also commonly cited.

6.1 Top five sources used to inform the commissioning of HIV prevention activities

GAY MEN

ORGANISATION	NAME OF SOURCE	NUMBER
CHAPS/SIGMA	Making it Count	11
THT/CHAPS	Unspecified information	9
DH	National Sexual Health and HIV Strategy	9
	Local reports/consultations	7
MEDFASH	Recommended standards for NHS HIV services	6

BLACK AFRICANS

ORGANISATION	NAME OF SOURCE	NUMBER
NAHIP	Doing it Well	10
MEDFASH	Recommended standards for NHS HIV services	8
	Local reports/consultation	8
THT	Other reports/briefings	6
DH	National Sexual Health and HIV strategy	6

Where documents were cited, the vast majority of respondents found them 'helpful'.

21 responses made no mention of a single document or material (3 from rank 1, 6 from rank 2, 7 from rank 3 and 5 from rank 4); 3 responses mentioned only one document or material; 31 responses mentioned more than one document or material. Materials were more commonly cited in relation to gay men's HIV prevention activities than African (seven responses, in addition to those which made no mention of a single document, only referred to a resource or resources in relation to gay men).

This question is probably more than any other affected by staff change within a PCT. Even someone well informed on commissioning HIV prevention might not know the resources used by a predecessor to plan or commission HIV prevention activities in their PCT.

Whilst much of the material cited is very relevant to commissioning, the one specific resource dedicated to commissioning, the DH 'Effective commissioning of sexual health and HIV services' was not often referred to, nor was the document 'HIV and AIDS in African communities: A framework for better prevention and care'. This possibly suggests the need for updated and improved resources to support the commissioning of HIV and sexual health services. Even the most commonly cited resources, 'Making it Count' and 'Doing It Well', were only cited in a minority of PCT responses. Of course the range of resources used is to be welcomed, especially when they included local surveys and reports. But **consistency in the use of some 'core' high quality and relevant documents and materials could well establish a greater transparency and effectiveness in the commissioning of HIV prevention.**

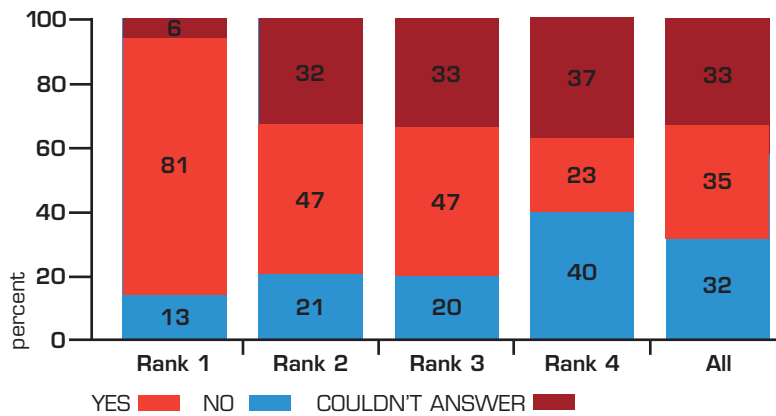
Overall, **the widespread reported use by many Commissioners of resources and guidance to inform their commissioning was encouraging, but there are still far too many PCTs not using resources which might improve and develop their commissioning practice.**

The very limited use of those documents specifically drafted for HIV and sexual health Commissioners suggests a need to revisit available guidance for the commissioning of sexual health and HIV services.

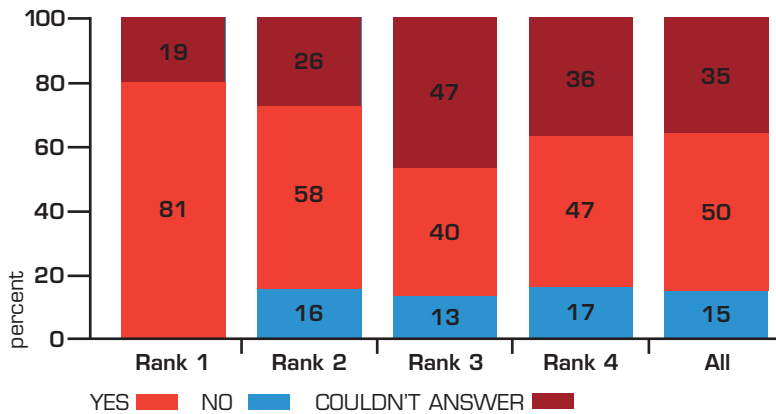
Community involvement

Overall half of PCTs said that they had involved gay men in the planning and commissioning of HIV prevention activities, a third had involved black Africans and a third in each case did not answer. The results were better for rank 1 PCTs where 4 out of 5 PCTs had involved both gay men and black Africans.

6.2 Black Africans involved



6.3 Gay/bisexual men involved



High levels of involvement of both gay/bisexual men and black Africans in high prevalence areas are very encouraging. The percentage of PCTs where there was a definite negative response on involvement was relatively low. The significant percentages of 'couldn't answers' especially outside rank 1 is of more concern. Of course changes in staffing can explain a loss of knowledge. But if community involvement is a process which is monitored and audited (which it should be) there should be readily accessible records which identify involvement processes.

Respondents were also asked, where involvement had taken place, to give some more detail. Methods of involvement varied. As would be expected, they included focus groups, surveys and representatives of relevant communities on sexual health and/or HIV strategy groups. Sometimes research undertaken into local community need was categorised as involvement also (especially if the researcher was from the community concerned).

The most common form of involvement identified was feedback from voluntary sector and service organisations, and from outreach workers and healthcare professionals. This can be a very effective involvement process, particularly where the organisation has undertaken some structured involvement and feedback process with the relevant community. It was not always, however, apparent that this had in fact taken place. There is a danger that professional or voluntary sector engagement is thought of as synonymous with community involvement, especially when the organisation is viewed as from or part of the community concerned.

There is a particular concern where the voluntary sector organisation is the one contracted by the PCT to provide prevention services – in one PCT involvement was defined as ‘discussing what was best’ with the contracted service provider.

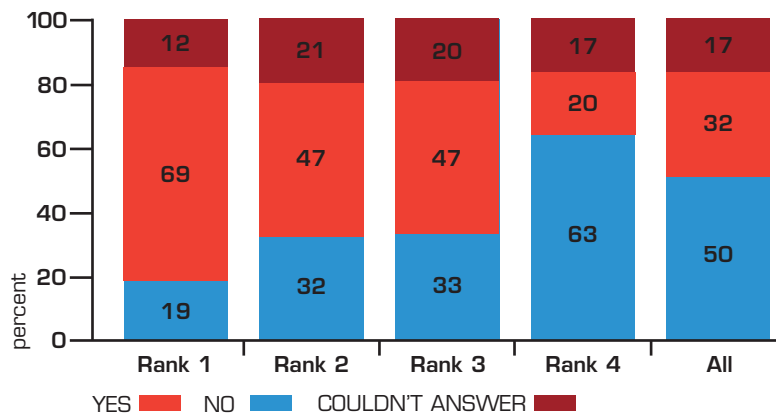
There did not appear to be a discernible pattern as to whether a PCT engaged with both communities, or one and not the other, or as to whether involvement processes were similar between the two communities within a PCT. An interesting example of the discrepancies which emerged was from one PCT where we were told *‘Black African individuals and community groups have been part of the whole process from tender, bid selection, staff interviews to development of steering group. The majority of the membership of the steering group are people from black African communities either as individual or community group representative’*, whilst for gay and bisexual men, *‘Informal links exist between professionals and members of the gay/bisexual communities’*.

Overall, responses suggested an encouraging concern to involve black Africans and gay and bisexual men in the planning and commissioning of relevant HIV prevention services. There does, however, appear to be a need for greater clarity and consistency as to what constitutes effective community involvement in health service planning and delivery.

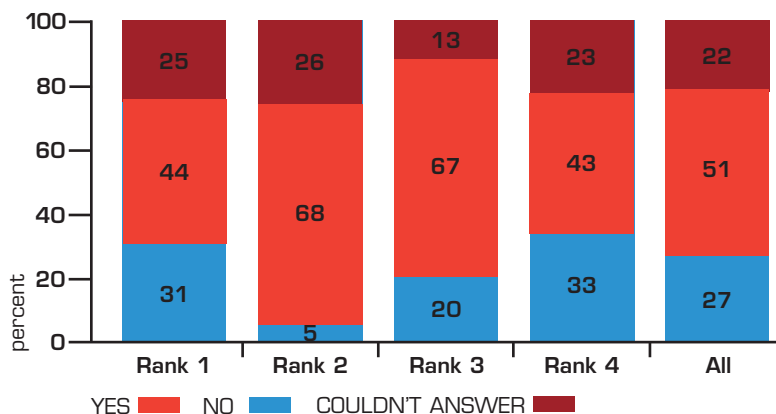
Evaluation of HIV prevention activities

Respondents were asked whether HIV prevention activities targeting gay men/black Africans had been evaluated in the last three years. Overall, half of PCTs stated that they had evaluated activities targeting gay men, and a third had evaluated activities targeting black Africans. About a fifth of PCTs did not answer for both types of prevention activity. Evaluations of activities targeting black Africans was more common in high prevalence areas but this was not the case for gay men's HIV prevention activities.

6.4 Black African evaluations



6.5 Gay/bisexual men evaluations



Questions must be raised, however, as to the rigour and impact of some of the evaluations. Where evaluations had taken place, there was a further question asking for details of the evaluation and its key findings. This was only occasionally answered. Whilst amongst respondents there was a sense in many cases that an evaluation had taken place, its impact is questionable when no lessons or findings can be cited.

There was great variation in the kind of evaluation activity specified – sometimes needs assessments were classified as evaluations of previous and current work, ‘feedback from the service provider’ was cited, monitoring of service level agreements (SLAs) as well as properly independent audit. One stated that because the intervention was informed by ‘Making it Count’, any evaluation had only to address details of delivery and clarity of message. Another commented, *‘There are inconsistencies between PCTs in prioritising this area of work and many interventions aren’t monitored and are funded historically without SLAs’.*

Another respondent said there was an evaluation process linked to SLAs but *‘Whilst these activities in themselves are monitored, very little evidence about the influence of these interventions on attitude and behaviour change is available’.*

HIV prevention activities are not always evaluated and there is a lack of clarity as to what constitutes appropriate evaluation.

Future assistance for commissioning

Respondents were asked in relation to the following how helpful they would be in improving future planning or commissioning of HIV prevention activities. The percentages against each option were those who thought it would be ‘a lot of help’.

Expert contacts (e.g e-networks)	53%
Web-based information	45%
Printed materials (e.g briefings etc)	32%
Training events	24%
Conferences/seminars	16%

The vast majority of these options were considered to be of at least some help, but there was a definite preference for networks and the flexibilities of web-based information over more traditional printed materials and events.

Current work supporting the development of the English HIV and Sexual Health Commissioners Group, and proposals for a web-based resource for HIV and sexual health commissioning hosted by the Department of Health are welcome attempts to meet commissioning need which, it is hoped, will reflect the priorities of respondents for assistance and networking.

The ‘Commissioning framework for health and well-being’ from the Department of Health outlines an important agenda of improvement for commissioning across the NHS. **Our survey makes clear the urgent need for an increased level of interactive, peer and Department of Health support for sexual health and HIV commissioners in England. Appropriate action is needed from all responsible bodies. PCTs have the main and immediate obligation to ensure their commissioning**

meets local need. The Department of Health should ensure that commissioning of sexual health and HIV is given the necessary guidance, monitoring and support from the centre – a process now underway through the development of a Sexual and Reproductive Health Commissioning Framework.

Other commissioning needs

Finally, respondents were asked 'Is there anything else you would find helpful in enabling you to improve commissioning or planning of HIV prevention activities for Black Africans and gay/bisexual men in the future?'. They were also given space to add any further comments they might wish to make on commissioning HIV prevention services.

The most frequent comment was on the need for more 'evidence-based information' to inform commissioning of HIV prevention, and 'more evidence of "what works"'. This was repeatedly and particularly mentioned in the context of African HIV prevention work. There were comments on the need to evaluate further the effectiveness of interventions amongst black African communities and on the relative absence of literature and research on HIV transmission and successful prevention amongst black African communities in the UK – *'we have very little information with regards to African population in terms of sexual health knowledge and risk-taking behaviour ... we are still trying to find a pathway for targeted African HIV prevention programme'*.

Particularly in the current financial climate, the requirement for evidence of need and effectiveness is becoming increasingly important when arguing for expenditure and investment. **There is an urgent need to communicate more effectively within PCTs what is currently known on the impact of HIV prevention activities, especially in relation to black African communities within the UK. There is also a need to plan and fund more research into HIV prevention interventions and their effectiveness, particularly amongst black African communities in the UK.**

7 Conclusion

In their comments a number of respondents wrote of the difficulty of maintaining political focus and expenditure on HIV prevention with the end of ring-fenced funding and the absence of any HIV-specific national PSA (Public Service Agreement) targets. The publication of this report coincides with the decision of the Independent Advisory Group on Sexual Health and HIV (SHIAG) to undertake a review of the National Strategy. We strongly support and welcome this initiative, and conclude our report with the following proposals for consideration by the Strategy review and interested parties:

HIV prevention must become a public health priority for England - the need to invest in effective HIV prevention services is greater now than it has ever been. Effective commissioning is essential for HIV prevention to be properly funded, with resources meeting need and supporting activities which make a real difference.

The evidence of this and other surveys is that currently commissioning of HIV prevention demonstrates:

- good practice in many localities, though not consistently shared
- a sustained effort to meet the emerging HIV prevention needs of black African communities
- examples of innovation

but also

- poor use of and access to data and information
- a probable decline in HIV prevention funding during a time of increasing HIV prevention need
- inconsistent practice in relation, for example, to community involvement and evaluation
- inadequate support and skills building for commissioners
- and in many instances a lack of political priority.

The National AIDS Trust welcomes the forthcoming review by the Independent Advisory Group on Sexual Health and HIV of the National Strategy for Sexual Health and HIV, and trusts the findings of this report will prove useful in its consideration of HIV prevention.

We recommend that new and measurable HIV prevention targets are identified and adopted at both national and local levels. To that end, we would urge the collection by the Health Protection Agency of HIV incidence data as soon as possible.

Work to be undertaken by the Department of Health, with the support of the English HIV and Sexual Health Commissioners Group, on a new Sexual and Reproductive Health Commissioning Framework should address the needs around the commissioning of HIV prevention identified in this report.

National AIDS Trust
August 2007

Commissioning HIV Prevention Activities for Black Africans and Gay/Bisexual Men in England

CONFIDENTIAL



The **National AIDS Trust (NAT)** is the UK's leading independent policy development and campaigning voice on HIV and AIDS. A registered charity, we develop policies and campaign to halt the spread of HIV, and improve the quality of life of people affected by HIV, both in the UK and internationally.

NAT, with the support of the **Health Protection Agency**, is currently investigating the commissioning of HIV prevention activities for Black Africans and gay/bisexual men in England. The results of the study will be used to map current commissioning practice and make recommendations to improve HIV prevention commissioning for these groups.

Your PCT has been selected to form part of a sample of English PCTs. We would be grateful if you would complete this questionnaire with reference to current HIV prevention activities in your PCT.

If you are not the person best placed to complete it, we would be grateful if you could pass the questionnaire to that person. This should be the person with responsibility for commissioning HIV prevention activities for Black Africans and gay/bisexual men within your PCT.

All responses will be treated in confidence and any use of the information provided will be on the basis of strict anonymity. We will not reveal the details of individual respondents or their PCT to anyone else.

The questionnaire can be completed electronically (by checking or adding information to the grey boxes) and returned by e-mail to **sheonaidh.cumming@nat.org.uk** . Alternatively, it can be printed and returned by post to the address below.

We look forward to your response to this important survey.

About You

We have selected your PCT as part of a sample of PCTs in England. Please note, this questionnaire should be completed by the person best placed to tell us about the commissioning of HIV prevention activities for Black Africans and gay/bisexual men in your PCT.

Please restrict your answers to HIV prevention activity only, excluding activities relating to HIV treatment and care.

Name: _____

Professional Title: _____

Address:

Telephone: _____ E-Mail: _____

About Your PCT

1. Which of the following best describes how HIV services are commissioned for your Primary Care Trust (PCT)? (Please tick one response only)

By your PCT alone

As part of a commissioning consortium of PCTs (if yes, please list the PCTs involved).

As part of a consortium where one or more partners are not PCTs.

2. How many people of Black African ethnicity resided in your PCT in 2005/6?

Don't Know

3. How many gay/bisexual men resided in your PCT in 2005/6?

Don't Know

4. How many people from the following groups were seen for HIV treatment or care in your PCT in 2004/5?

Number of Black Africans Don't Know

Number of gay/bisexual men Don't Know

About You

5. Has your PCT (either alone or as part of a consortium) undertaken a local health needs assessment relating to HIV prevention?

Yes No Don't Know

If yes, when was it done?

6. Is HIV prevention specifically mentioned as a priority in the Local Delivery Plan 2005-8 for your PCT?

Yes No Don't Know

7. Are any specific HIV prevention activities identified for continuation or implementation in the Local Delivery Plan 2005-8 for your PCT?

Yes No Don't Know

If yes, please specify.

8. In the Local Delivery Plan 2005-8 for your PCT, are the general health needs of the following groups specifically mentioned?

	Yes	No	Don't Know
Black Africans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gay/bisexual men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. In the Local Delivery Plan 2005-8 for your PCT, are the HIV prevention needs of the following groups specifically mentioned?

	Yes	No	Don't Know
Black Africans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gay/bisexual men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. If available, please include a weblink to your LDP:

HIV Prevention Funding

11. What was the total expenditure on HIV prevention for your PCT over the last two years?

2004/5 2005/6

12. What was the expenditure on HIV prevention in your PCT for the following groups over the last two years?

	2004/5	2005/6
Black Africans	<input type="text"/>	<input type="text"/>
Gay/Bisexual men	<input type="text"/>	<input type="text"/>

About You

13. What is the likely total expenditure on HIV prevention for your PCT for the next two years?

2006/7	2007/8
<input type="text"/>	<input type="text"/>

14. What is the likely expenditure on HIV prevention in your PCT for the following groups for the next two years?

	2006/7	2007/8
Black Africans	<input type="text"/>	<input type="text"/>
Gay/Bisexual men	<input type="text"/>	<input type="text"/>

15. Please indicate your views about the likely total expenditure on HIV prevention for your PCT over the next five years.

In my PCT I think expenditure on general HIV prevention activities will...

Increase	Stabilise	Decrease	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please say why you think this...

In my PCT I think expenditure on HIV prevention activities specifically targeting Black Africans will...

Increase	Stabilise	Decrease	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please say why you think this...

In my PCT I think expenditure on HIV prevention activities specifically targeting gay/bisexual men will...

Increase	Stabilise	Decrease	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please say why you think this...

About You

Interventions Commissioned for 2005/6

16. For 2005/6, are there any HIV prevention activities commissioned for your PCT to specifically target the following groups?

	Yes	No	Don't Know
Gay/bisexual men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black Africans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asylum seekers/refugees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prisoners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injecting drug users	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)			

17. Which of the following types of HIV prevention activities did you commission for Black Africans in 2005/6?

Drop-ins	<input type="checkbox"/>	Outreach	<input type="checkbox"/>	Seminars	<input type="checkbox"/>
Workshops	<input type="checkbox"/>	Peer intervention	<input type="checkbox"/>	Community events	<input type="checkbox"/>
Telephone advice	<input type="checkbox"/>	Internet advice	<input type="checkbox"/>	Mass media (posters)	<input type="checkbox"/>
Small media (leaflets)	<input type="checkbox"/>	Campaigning work	<input type="checkbox"/>	Condom distribution	<input type="checkbox"/>
Other (please specify)					

18. Which of the following types of HIV prevention activities did you commission for gay/bisexual men in 2005/6?

Drop-ins		Outreach	<input type="checkbox"/>	Seminars	<input type="checkbox"/>
Workshops		Peer intervention	<input type="checkbox"/>	Community events	<input type="checkbox"/>
Telephone advice		Internet advice	<input type="checkbox"/>	Mass media (posters)	<input type="checkbox"/>
Small media (leaflets)		Campaigning work	<input type="checkbox"/>	Condom distribution	<input type="checkbox"/>
Other (please specify)					

19. Does your PCT provide access to post exposure prophylaxis (PEP) to people who may have been exposed to HIV through sexual contact?

Yes	No	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About You

20. If yes, how is PEP for people exposed to HIV through sexual contact funded?

From an HIV prevention budget

From an HIV treatment and care budget

From another budget (please specify)

Commissioning Practice

21. Please state below what, if any, documents or other materials were used to inform the commissioning or planning of HIV prevention activities for 2005/6.

How helpful were these resources?

Available information on HIV prevention for Black Africans...	Helpful	Unhelpful	Don't Know
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Available information on HIV prevention for gay/bisexual men...

1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Have people from the following communities been involved in the commissioning and planning of HIV prevention activities for 2006/7?

Black Africans	Yes	No	Don't Know		Gay/bisexual men	Yes	No	Don't Know
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please state how they have been involved

If yes, please state how they have been involved

23. Have any HIV prevention activities in your PCT been evaluated in the last three years?

Evaluation(s) of general HIV prevention activities

Yes No Don't Know

If yes, what were the activities and what were the key findings from the evaluation(s)?

About You

Evaluation(s) of activities specifically targeting Black Africans

Yes No Don't Know

If yes, what were the activities and what were the key findings from the evaluation(s)?

Evaluation(s) of activities specifically targeting gay/bisexual men

Yes No Don't Know

If yes, what were the activities and what were the key findings from the evaluation(s)?

24. How helpful would the following be in improving future commissioning or planning of HIV prevention activities for Black Africans and gay/bisexual men?

	Little or no help	Some Help	A Lot of Help
Printed materials (e.g. briefings etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Web-based information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expert contacts (e.g. e-networks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conferences/seminars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


25. Is there anything else that you would find helpful in enabling you to improve commissioning or planning of HIV prevention activities for Black Africans and gay/bisexual men in the future?

Black Africans

Gay/bisexual men

26. Please provide any further comments on your experience of commissioning HIV prevention services for African communities and/or gay and bisexual men.

MANY THANKS



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