Preventing AIDS: The British Experience

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The UK is described by the Department of Health in London as “a relatively low prevalence country for HIV infection.” The word “relatively” is the key. By comparison with the huge numbers of cases seen in much of sub-Saharan Africa, for example, HIV/AIDS is a minor problem in the UK. However, that is no grounds for complacency, as shown by the need for an official target for further reduction, which is a 25% decrease in new diagnoses of HIV infection by the end of 2007. To see how achievable this might be, we need to look at the ways in which new cases are currently arising. Last year saw 7,750 new diagnoses of HIV infection in the UK, but the more detailed breakdown is available up to the end of 2004.*

As of Dec 31, 2004, there were an estimated 58,300 people over the age of 15 years living with HIV in the UK, and this number is rising not only because of new diagnoses but also because of successful anti-HIV drug regimens. Male-to-male transmission remains an issue, at a plateau of around 1,800 new diagnoses annually. Heterosexual intercourse accounts for 4,000 new diagnoses each year, but most of those are acquired outside the UK. Injecting drug use accounts for just 150 new cases; mother-to-child transmissions number only 130 or so (the introduction of antenatal testing as a routine will have helped here); HIV infection due to blood transfusions or blood products is now very rare, most cases being acquired overseas; occupational HIV exposure is also very uncommon.

Clearly the 2007 target (i.e., 25% decrease in new diagnoses) can be met only by making a significant impact on the two main sources, which are HIV transmission via same sex or heterosexual intercourse. The early willingness of British health officials and politicians to recognise the potential danger of HIV and do something about it when the world found out about this virus more than 20 years ago explains much of the early success. Still, as elsewhere in the world, pendulums swing back and prevention messages need repeating, especially now that anti-retroviral drugs mean that HIV infection is no longer seen as a death sentence, at least in countries such as the UK where such treatment is affordable. However, public health guidance and policy needs sensitive handling because so many British cases of HIV infection are either acquired outside the country or arise in ethnic minority groups, and more generally, it is difficult to see how prevention can be further enhanced in the UK other than by reinforcement of existing advice.

The budget statement in April 2006 did contain a tax concession on condoms, by which the value added tax (a sort of sales tax) would be only 5% instead of the typical 17.5%. Though generally welcomed, this looks like a cosmetic gesture. The non-use of condoms is hardly likely to be based on price. More controversial is post-exposure prophylaxis (PEP). When exposure has been occupational (e.g., a needlestick

*Readers can download time trends for the different categories of infection source from the website of the Health Protection Agency, the UK's equivalent of the U.S. Centers for Disease Control and Prevention, at <http://www.hpa.org.uk>.

accident involving a healthcare worker) the British PEP guideline is clear, but the same document¹ appears more tentative when it comes to exposure via sexual intercourse. This guidance, from February 2004, is currently being revised, but the British Association for Sexual Health and HIV has lately issued its own advice. That guideline² recommends, provided the source individual is known to be HIV positive, PEP where the exposure has been due to receptive or insertive anal or vaginal sex. As with the U.S. guidelines,³ a further proviso is that the exposure is not more than 72-h old. The indications for PEP are still being debated, and there is the potential to make some impact on prevention. However, any impression on national HIV statistics will be lessened by the simple fact that so many people who are HIV positive are not aware of their status.

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