EXPERT ADVISORY GROUP ON AIDS

Providing expert scientific advice on HIV

ANNUAL REPORT 2011

Introduction

1. This report from the Expert Advisory Group on AIDS (EAGA) covers the period 1 January 2011 to 31 December 2011.

Role of EAGA

2. The Expert Advisory Group on AIDS (EAGA) is an advisory non-departmental public body which is non-statutory. It was established in 1985 with the following terms of reference:

   "To provide advice on such matters relating to HIV/AIDS as may be referred to it by the Chief Medical Officers of the Health Departments of the United Kingdom".

3. Under the proposed Public Bodies Reforms announced in October 2010 and updated in December 2011, EAGA is to be reconstituted as a Departmental Expert Committee, which will be hosted by Public Health England.

EAGA Membership

4. EAGA membership comprises experts in a range of relevant medical and scientific specialties and disciplines (e.g. epidemiology, genitourinary medicine, general practice, infectious diseases, perinatal HIV, occupational medicine, public health and virology) and also includes members from the HIV voluntary and community sectors. A list of members who served during 2011 is attached at **Annex A**.

5. Terms of membership ended for two members in 2011. Re-appointments were offered to 13 members plus the Chair for a further term during 2011.

EAGA Observers

6. The Government Departments and Agencies listed below have Observer status at EAGA.

   - Department of Health
   - Department of Health, Social Services and Public Safety, Northern Ireland
   - Health Protection Agency
   - Medicines and Healthcare Products Regulatory Agency
   - Ministry of Defence
   - Scottish Government
   - Welsh Assembly Government
   - UK Blood Services

Code of practice and register of members' interests

7. EAGA works to a code of practice based on the Government Office for Science's Code of Practice for Scientific Advisory Committees (2011) and the Cabinet Office's Model Code of Practice for Board Members of Advisory Non-Departmental Public Bodies (October 2004). The code covers issues such as the seven principles of public life set out by the Committee on Standards in Public Life, the role of the chair and members, the handling of EAGA papers and declarations of members' interests. The register of members' interests is attached at **Annex B**.

Epidemiology of HIV/AIDS

8. EAGA receives regular updates on the UK's HIV epidemic from the Health Protection Agency (HPA) and its collaborators (e.g. Health Protection Scotland) including copies of published reports. Regularly updated and detailed information from surveillance systems is published on the HPA's website: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIVAndSTIs/SurveillanceSystemsHIVAndSTIs/

9. The key findings from surveillance in 2010[1] were presented to EAGA at their 90th meeting, as follows:

   - By the end of 2010, an estimated 91,500 people were living with HIV in the UK, of whom 24% remained undiagnosed and were therefore unaware of their infection. It was projected that 100,000 people would be living with HIV by 2012.
   - 6,660 people were newly diagnosed with HIV in 2010. The number of infections probably acquired within the UK (3,640) (almost exclusively through sexual transmission) exceeds those acquired abroad (3,020).
   - An estimated 3000 new diagnoses were made in men who have sex with men (MSM), the highest number ever reported in one year.
   - Genito-urinary medicine clinic activity data were interrogated to identify factors predictive of HIV seroconversion among MSM. Neither re-attendance at clinic within a year nor diagnosis of an acute sexually transmitted infection correlated with HIV incidence.
   - One in seven people diagnosed in 2010 overall, and one in four MSM, were likely to have acquired their infection recently (i.e. within the last 6 months). Rates of recent infection were highest in young MSM. These proportions were based on applying the avidity (RITA) test for recent infection to nearly half of all new diagnoses in 2011.
   - The UK was the only country routinely returning RITA results to patients. A survey of clinicians found no adverse events as a consequence of informing patients that they may have been infected recently.
   - From 2012, the unlinked anonymous (UA) survey of GUM clinic attendees would only be applied to residual urine specimens from men not known to be

[1] From *HIV in the United Kingdom: 2011 Report*. Available from: http://www.hpa.org.uk/Publications/InfectiousDiseases/HIVAndSTIs/1111HIVintheUK2011report/

positive and not having an HIV test at that visit. These data remained critical to estimating the undiagnosed fraction.

- The proportion of infections diagnosed late (defined as a CD4 count <350 cells/µl) had declined from 59% (2001) to 50% (2010) but remained unacceptably high. This had led to the proposal that a late HIV diagnosis indicator be included in the public health outcomes framework. Individuals diagnosed late have a tenfold higher risk of dying within a year of diagnosis, compared with those diagnosed promptly.
- 69,400 people living with a diagnosed HIV infection received care in 2010 and over 90% attended HIV services regularly. One in 5 adults accessing care was over 50 years old, with a consequent rise in co-morbidities. Clinical outcome indicators showed that standards of care were very high nationally and across all risk groups.
- Prevalence of antiretroviral drug resistance in untreated individuals with subtype B HIV infection (a proxy for having acquired the infection in the UK) declined from 16% in 2002 to 11% in 2009. This indicates the effectiveness of high-quality treatment in preventing the spread of resistant virus.

Main items of business

10. EAGA met on three occasions during the period of this report - on 9 February 2011 (88th meeting), 22 June 2011 (89th meeting) and 19 October 2011 (90th meeting). The substantive items discussed and their outcomes are summarised below except where these were consultations to which EAGA submitted a formal response. These are listed separately. EAGA's annual Work Plan can be found at **Annex C**.

88th meeting, February 2011

- **New advice about management of HIV-infected healthcare workers**
  A Tripartite Working Group (TWG) was established to review policies relating to blood-borne virus infected healthcare workers (HCWs). Its membership was drawn from EAGA, the Advisory Group on Hepatitis and the UK Advisory Panel for Healthcare workers Infected with Blood-borne Viruses together with some additional experts. The TWG focused on HIV-infected HCW policy and considered worldwide evidence around HCW-to-patient transmissions of HIV, the results of patient notification exercises conducted in the UK (consequent upon HIV diagnosis of HCWs who had been performing exposure-prone procedures), and a comparison of international policies on restriction of the working practices of HIV-infected HCWs. The TWG report was subsequently submitted to the Health Departments for consideration at the end of April 2011.

  The key recommendation was that HIV-infected healthcare workers should be permitted to perform exposure-prone procedures if they are on combination antiretroviral drug therapy and have a plasma viral load suppressed consistently to very low or undetectable levels (i.e. below 200 copies/ml). EAGA developed an implementation framework that was included in the consultation document that was subsequently launched by the Department of Health on 1 December 2011 (see: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_131532).

Separate consultations were conducted by the Health Departments in Scotland, Wales and Northern Ireland.

- **HIV Testing Kits and Services Regulations 1992**
  This legislation makes it a criminal offence to sell, supply, or advertise for sale or supply, HIV test kits to the public. Department of Health officials sought EAGA's views on the desirability of amending or repealing these regulations. EAGA had last given an opinion on this topic in 2007 and had concluded, at that time, that there was no justification for change.

  Subject to reassurance that the testing technology was now good enough (see below under meeting 89), both in terms of simplicity of test kit use and accuracy of results, EAGA supported the creation of a legal supply of regulated HIV self-test kits for direct sale to the general public. If the 1992 Regulations were repealed or amended to allow this, the manufacturers of HIV point-of-care tests (POCTs) would need to re-write their package inserts to be appropriate for a lay user (including advice on needing to confirm the result with a medical practitioner and not to take any medical decisions based solely on the result) and apply to have them certified for home use. A public health campaign might be needed to inform the consumer where to purchase, and how to recognise, regulated kits. EAGA felt the need for medical supervision, as stipulated in the Regulations, was outdated – the key issue was around clinical governance for those testing positive. To preserve certain provisions within the Regulations, such as constraints on advertising, EAGA felt that amending the legislation would be preferable to repealing it entirely.

  In 2012, HIV self-testing took a step closer to becoming a reality, with approval by the US Food and Drug Administration of the first over-the-counter home-use rapid HIV test[2]. An application to the European licensing authorities for CE-marking was likely to follow.

- **Pre-exposure prophylaxis (PrEP) for prevention of HIV infection**
  This topic was discussed by EAGA on two occasions. Firstly, in the context of the results of a pivotal clinical trial (the iPrEx trial[3]) which demonstrated that a daily dose of Truvada (a combination of two antiretroviral drugs) reduced the risk of HIV seroconversion by 92% among men who have sex with men, provided they took the study drug regularly. By the next meeting (EAGA 89), a position statement on PrEP use in the UK was under development By BHIVA and BASHH (now published[4]), and a proposal was presented for conducting a clinical trial of the effectiveness of PrEP in the UK, embedded in a programme of intensified prevention. EAGA will continue to monitor ongoing and planned PrEP trials and consider their implications for UK health policy.

[2] http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm310542.htm
[3] Grant RM et al. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. NEJM 2010, 363:2587-99. Available from: http://www.nejm.org/doi/pdf/10.1056/NEJMoa1011205
[4] McCormack S, Fidler S and Fisher M. The British HIV Association/British Association for Sexual Health and HIV Position Statement on pre-exposure prophylaxis in the UK. Int J STD AIDS 2012; 23:1-4.

- **Work with the Crown Prosecution Service (CPS) on revised policy/guidance on prosecuting cases of intentional or reckless sexual transmission of infection**
  EAGA's advice was sought on updating/revising the CPS's policy (originally issued in 2008) in light of issues that had arisen during implementation. The key changes concerned the requirement for scientific and medical evidence before charging a suspect and ensuring non-co-operative suspects, who refused to give blood samples or access to medical records, could still be prosecuted. The changes were felt to be appropriate to balance the needs of justice with public health concerns.

  This policy demonstrates the practical uses of EAGA's advice and the need to understand the limitations of the science when applied in a legal context. It makes reference to the use of phylogenetics for determining direction of HIV transmission; reliability of information on recency of infection at the individual level (supportive rather than definitive) and cites adherence to antiretroviral medication (resulting in undetectable viraemia) and condom use as potential defences against a charge of recklessness[5]. Unlike in other jurisdictions, where exposure to risk of infection can be a criminal offence, infection has to have occurred in order for prosecution of reckless transmission to proceed in England and Wales.

89th meeting, June 2011

- **Economic impact of HIV infection**
  Scale of ongoing transmission in the UK: The Health Protection Agency presented an update on the HIV epidemiology in the UK. Projecting from current rates of new diagnoses, 100,000 people will be living with HIV (diagnosed and undiagnosed) by 2012. Around 3,800 infections are probably acquired in the UK each year. Each case prevented would save an estimated £250,000 over their lifetime. The vast majority of HIV-infected individuals are receiving appropriate treatment, but there is no evidence of declining transmission. For example, 1 in 3 young MSM (aged 15-24) diagnosed in 2009-10 were probably infected in the 6 months prior to diagnosis.

  Cost of treatment/cost-saving model: EAGA considered a model that aimed to demonstrate the cost-effectiveness of early HIV diagnosis and treatment. The model predicted a UK-wide saving over 5 years of £238 million (combined cost savings and life years saved) by shifting the proportion of HIV cases detected late (with a CD4 count <350 cells/ml) from 55% to 44%. EAGA highlighted concerns with the validity of some of the variables used to construct the model, especially relating to treatment costs and timing of starting treatment. Additional savings would accrue from reducing transmissions from those diagnosed more promptly.

  Improvements in life expectancy: Published life expectancy data from the UK Collaborative HIV Cohort demonstrated that men and women aged 20 at HIV diagnosis could expect to live, on average, to 59.5 and 70.2 years respectively (compared with 77.8 and 81.6 years for the general population)[6]. Starting therapy

[5] CPS Policy (July 2011). Intentional or reckless sexual transmission of infection.
[6] May M et al. Impact of late diagnosis and treatment on life expectancy in people with HIV-1: UK Collaborative HIV Cohort (UK CHIC) study. BMJ 2011; 343:d6016.

later than guidelines recommend resulted in up to 15 years' loss of life. However, if patients survived the first 3 months following HIV diagnosis, they could expect a near-normal life expectancy if they had good adherence to medication.

- **Expansion of HIV testing**
  NICE issued public health guidance in March 2011 on increasing the uptake of HIV testing among men who have sex with men and black African communities in England[7,8]. EAGA was actively engaged in the consultation process and welcomed the guidance.

  EAGA also discussed expansion of HIV testing based on geographical targeting to areas where the diagnosed HIV prevalence is high (defined as >2/1000 population). A number of pilot studies had demonstrated the feasibility and acceptability of routinely offering an HIV test in hospital acute medical admissions units and to patients newly registering with general practitioners[9].

  A number of other initiatives around HIV testing were discussed, including a study of HIV testing among mental health inpatients and raising awareness among non-specialists of the adverse consequences of failing to offer HIV tests to patients at risk of infection[10]. Related matters where further evidence was required included determining the optimum frequency of testing for high-risk groups and additional cost-effectiveness data for different models of expanded HIV testing. Many provider-related, patient-related and setting-related barriers to HIV testing remained to be addressed.

- **Invasive pneumococcal disease (IPD) in HIV-infected individuals**
  EAGA received an update on IPD in HIV-infected individuals. Two national datasets (Health Protection Agency surveillance) had been linked to assess the occurrence of IPD in HIV-positive adults and compared it with the uninfected population. Matching of records demonstrated that the incidence of IPD is excessive among adults living with diagnosed HIV (being 50 times more common than in the general population aged 15-44). Three out of every five IPD episodes in this group could potentially be prevented with the newly available pneumococcal conjugate vaccine (PCV13)[11]. Some proposals for improving vaccination coverage rates among HIV-infected individuals were discussed.

- **Review of point-of-care HIV tests for suitability for self testing**
  Following on from the discussion about amending or repealing the 1992 HIV Testing Kits and Services Regulations at the 88th meeting, EAGA reviewed the commercially available point-of-care tests (POCT) for their suitability for home use. Ideally, a home test should perform as well as standard laboratory tests; be safe to use and dispose of; be easy to use and interpret results; be approved or

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[7] http://guidance.nice.org.uk/PH34
[8] http://guidance.nice.org.uk/PH33
[9] Health Protection Agency. Time to test for HIV: expanding HIV testing in healthcare and community services in England. 20 September 2011.
[10] Gillespie G and McCullough S. MPS Opinion: Spreading the use of HIV testing. MPS Casebook 2012; 20(2):6.
[11] Yin Z et al. Invasive pneumococcal disease among HIV-positive individuals, 2000-2009. AIDS 2012;26:87-94.

accredited; and be reasonably priced. Although laboratory testing of serum samples remained superior to POCT, self-test kits might have a role to play in diagnosing infection in people reluctant to attend traditional healthcare settings.

90th meeting, October 2011

- **House of Lords report on HIV and AIDS in the United Kingdom and Government response**
  A number of EAGA members and observers had given evidence to the House of Lords Select Committee on HIV and AIDS in the United Kingdom as individual experts in the field. The Select Committee's report was published in September 2011[12]. It made nearly 60 recommendations and placed a major emphasis on HIV prevention, at both national and local levels. The Government's response was published on 27 October 2011[13].

  The Select Committee covered a very broad range of HIV-related issues, including a number discussed at EAGA, such as expansion of HIV testing and provision of free HIV treatment for overseas visitors on public health grounds. EAGA welcomed the report and appreciated its influence in raising awareness of HIV as a public health problem and moving it up the ministerial agenda.

- **Antiretroviral treatment for HIV prevention**
  The HPTN 052 trial compared immediate versus deferred HIV treatment in stable (mostly heterosexual) partnerships where only one partner was infected. The trial was terminated early because of the clear benefits of immediate treatment, which reduced transmission risk by 96%, and generated significant optimism about the potential of treatment to prevent onward transmission of HIV[14].

  The HPA had assessed the potential impact of different strategies to reduce infectiousness at the population level. They found that, while treatment had almost certainly mitigated transmission and had a major role to play, it was not likely to change the epidemic trajectory on its own. The findings were consistent with other data about the disproportionate effect on the epidemic of newly infected individuals (seroconverters) and a core group of infected individuals who engaged in very high-risk sexual activities.

  However, reductions in transmission might be achieved by ensuring all those eligible for treatment were treated, greater efforts were made to diagnose new cases earlier by more frequent testing of those at risk, and ensuring those diagnosed were not only transferred promptly into care but were retained in care. At the individual level, there was now good evidence to support early treatment of the infected partner in a serodiscordant partnership.

[12] House of Lords report: No vaccine, no cure: HIV and AIDS in the United Kingdom (published 1 September 2011).
[13] Government Response to the House of Lords Report of Session 2010-12: No vaccine, no cure: HIV and AIDS in the United Kingdom (published 27 October 2010).
[14] Cohen MS et al. Prevention of HIV-infection with early antiretroviral therapy. NEJM 2011, 365:493-505. Available from: http://www.nejm.org/doi/full/10.1056/NEJMoa1105243

- **HIV eradication strategies**
  EAGA discussed developments in strategies to eradicate HIV infection as an alternative to the current requirement for lifelong antiretroviral treatment. Early clinical trials of gene therapy to treat HIV infection had begun. Another approach under investigation was intracellular vaccination using a fusion of two proteins combining antiviral activity with a cell-specific targeting function. The long-term goal of researchers is to find a functional cure for HIV infection that can be applied on a large scale and at reasonable cost.

For full details of EAGA's discussions, see the agendas and minutes of these meetings, which can be found at: http://www.dh.gov.uk/ab/EAGA/DH_094969#_2

Consultations

11. EAGA submitted a formal response to the consultation below in 2011. Full details can be found on the website at: http://www.dh.gov.uk/ab/EAGA/DH_094975

    - Healthy Lives, Healthy People: Transparency in Outcomes – Proposals for a Public Health Outcomes Framework: link to EAGA's response

    In addition, EAGA provided pre-consultation input to:

    - BASHH: Revised guideline on HIV post-exposure prophylaxis following sexual exposure

EAGA Subgroups

12. There were no subgroup meetings in 2011.

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Prepared by EAGA Secretariat: July 2012

Annex A

MEMBERSHIP OF THE EXPERT ADVISORY GROUP ON AIDS IN 2011

Name	Position	Interest represented	Term of appointment
Chair			
Professor Brian Gazzard	Professor of HIV Medicine/Director of Clinical Research, Chelsea & Westminster Hospital, London	N/A	Appointed 1 July 2005; re-appointed 1 March 2011
Members			
Dr Christopher Conlon	Consultant in Infectious Diseases, John Radcliffe Hospital, Oxford	Infectious disease	Appointed 14 February 2007; re-appointed 14 February 2011
Mr David Crundwell	Communications Consultant	Lay member	Appointed 1 July 2005; re-appointed 1 July 2011
Dr Matthew Donati	Consultant Medical Virologist, Health Protection Agency Regional Laboratory, Bristol	Virology	Appointed 2 February 2009
Ms Ceri Evans	Senior Sexual Health Adviser, West London Centre for Sexual Health, Charing Cross Hospital	Sexual Health Advice	Appointed 1 April 2006; re-appointed 1 July 2011
Professor Geoffrey Garnett	Professor of Microparasite Epidemiology, Department of Infectious Disease Epidemiology, Imperial College, London	Epidemiology	Term completed 28 February 2011.
Dr John Green	Chief Clinical Psychologist, Central & North West London NHS Foundation Trust and St Mary's Hospital, London	Clinical psychology	Appointed 1 April 2006; re-appointed 1 March 2011
Dr Jeremy Hawker	Regional Epidemiologist, Health Protection Agency	Public health	First appointed 1 March 2001; re-appointed 1 March 2011
Professor Clifford Leen	Consultant Physician, Regional Infection Unit, Western General Hospital, Edinburgh	Infectious disease	Term completed 13 February 2011.

Annex A

MEMBERSHIP OF THE EXPERT ADVISORY GROUP ON AIDS IN 2011 (continued)

Name	Position	Interest represented	Term of appointment
Ms Ruth Lowbury	Chief Executive, Medical Foundation for AIDS & Sexual Health (MedFASH)	Voluntary sector	Appointed 1 July 2005; re-appointed 1 July 2011
Dr Helen McIlveen	Clinical Manager Sexual Health and HIV, Northumbria Healthcare Foundation Trust	HIV/GUM nurse consultant	Appointed 2 February 2009
Ms Beatrice Osoro	Case Worker, Positively Women, London	BME groups affected by HIV	Appointed 2 February 2009
Sir Nick Partridge	Chief Executive, Terrence Higgins Trust, London	Voluntary sector	First Appointed 1 March 2001; re-appointed 1 March 2011. Elected Vice Chair 10 October 2005
Professor Deenan Pillay	Professor of Virology ,University College London and Head of HIV and Antivirals, Virus Reference Department ,Centre for Infections, Health Protection Agency	Virology	Appointed 1 July 2005; re-appointed 1 July 2011
Dr Anton Pozniak	Consultant Physician in GUM/HIV, Chelsea & Westminster Hospital, London	HIV medicine	Appointed 1 July 2005; re-appointed 1 July 2011
Dr Keith Radcliffe	Consultant in HIV/GUM, Whittall Street Clinic, Birmingham	HIV/GUM	Appointed 14 February 2007; re-appointed 14 February 2011
Dr Alison Rimmer	Consultant Occupational Physician, Sheffield Occupational Health Service, Northern General Hospital, Sheffield	Occupational medicine	First Appointed 1 March 2001; re-appointed 1 March 2011
Miss Susan Sellers	Consultant Obstetrician, St Michael's Hospital, Bristol	Perinatal HIV	Appointed 1 April 2006; re-appointed 1 March 2011
Dr Ewen Stewart	General Practitioner, Edinburgh	General practice	Appointed 1 July 2005; re-appointed 1 July 2011

Annex B

EXPERT ADVISORY GROUP ON AIDS (EAGA): REGISTER OF MEMBERS' INTERESTS 2011

MEMBER	PERSONAL INTERESTS		NON-PERSONAL INTERESTS		OTHER INTERESTS	
	Name of organisation	Nature of interest	Name of organisation	Nature of interest	Name of organisation	Nature of interest
Professor Brian Gazzard	Gilead, Pfizer, GlaxoSmithKline, Bristol-Myers Squibb	Consultant (ad hoc)	Gilead, Pfizer, GlaxoSmithKline, Bristol-Myers Squibb	Research and educational grants		None
Dr Christopher Conlon		None	Medical Research Council, Wellcome Trust	Research grants		None
Mr David Crundwell		None		None		Magistrate (until October 2011)
Dr Matthew Donati		None	Bristol-Myers Squibb, Sanofi Pasteur MSD	Conference/Lecture fees		None
Ms Ceri Evans		None		None		None
Dr John Green		None		None		None
Dr Jeremy Hawker		None		None	Health Protection Agency	Employee
Ms Ruth Lowbury		None	Abbott, Bristol-Myers Squibb, Gilead	Educational grants and speaker fees	MedFASH	Chief Executive
Dr Helen McIlveen		None		None	Blue Sky Trust Newcastle (HIV Third Sector Organisation)	Chairperson
Ms Beatrice Osoro		None		None	Positively UK	Staff member
Sir Nick Partridge		None		None	THT	Chief Executive
Professor Deenan Pillay	GlaxoSmithKline, Gilead, Boerhinger Ingelheim, Bristol-Myers Squibb	Consultant	GlaxoSmithKline, Gilead, Boerhinger Ingelheim, Bristol-Myers Squibb, Pfizer, Monogram Biosciences	Consultancy fees paid to Department		None

Annex B

EXPERT ADVISORY GROUP ON AIDS (EAGA): REGISTER OF MEMBERS' INTERESTS 2011 (continued)

MEMBER	PERSONAL INTERESTS		NON-PERSONAL INTERESTS		OTHER INTERESTS	
	Name of organisation	Nature of interest	Name of organisation	Nature of interest	Name of organisation	Nature of interest
Dr Anton Pozniak	Bristol-Myers Squibb, Boehringer Ingelheim, Tibotec, Gilead, Roche, ViiV, Merck; LEPRA and St Stephens AIDS Trust	Consultant Board Member (charities)	Bristol-Myers Squibb, Boehringer Ingelheim, Tibotec, Gilead, Roche, Viiv, Merck	Consultancy fees paid to Department		None
Dr Keith Radcliffe		None		None	BASHH IUSTI	President Regional Director (Europe) & Trustee
Dr Alison Rimmer		None		None		None
Dr Susan Sellers	Medical Protection Society	Chair of Claims Advisory Group		None		None
Dr Ewen Stewart	Janssen Pharmaceutical Bristol-Myers Squibb	Member of Hepatitis C Advisory Board Member of Expert Working Group on Best Practice HIV Commissioning		None		None

BASHH - British Association for Sexual Health and HIV; BHIVA - British HIV Association; IUSTI - International Union Against Sexually Transmitted Infections; LEPRA – the British Leprosy Relief Association; MedFASH – Medical Foundation for AIDS and Sexual Health; MRC – Medical Research Council; NAT - National AIDS Trust; THT – Terrence Higgins Trust

Annex C

EXPERT ADVISORY GROUP ON AIDS
WORKPLAN 2011-12

Topics	Lead	Timescale
➢ HIV-infected healthcare workers and antiretroviral therapy	EAGA members of the Tripartite Working Group	Ongoing
➢ Prepare a surgical supplement to ACDP guidance in collaboration with others (e.g. AGH, UKAP, Royal College of Surgeons, ACDP/HSE)	Work with RCS and AGH (Alison Rimmer, Anton Pozniak)	tbc
➢ Review of devices for rapid HIV testing for suitability for self-testing	Matthew Donati	June 2011
➢ Cost savings of early diagnosis of HIV	Brian Gazzard (with input from BMS)	June 2011
➢ Gene therapy as potential 'functional cure' for HIV	Deenan Pillay	October 2011
➢ Ongoing review of surveillance data	HPA	October 2011
➢ HIV testing and follow-up into care: evidence and issues	Valerie Delpech, Ceri Evans, Ewen Stewart	February 2012
➢ Standards for management of HIV-infected prisoners and immigration detainees	Brian Gazzard + DH Leads	February 2012
➢ EAGA's remit and purpose in the context of Public Health England and restructured Department of Health	ALL	When appropriate
➢ Horizon scanning for emerging HIV issues	ALL	ongoing
➢ Test and treat and treatment as prevention strategies: o Expansion of HIV testing o Pre-exposure prophylaxis o Discordant couples management	ALL	ongoing
➢ Contribute to DH, NICE, BASHH, BHIVA consultations/reviews of guidance	As appropriate	As required