MINUTES OF THE 91st MEETING OF THE EXPERT ADVISORY GROUP ON AIDS
22 February 2012

Chair: Professor Brian Gazzard

Secretariat: Dr Linda Lazarus (HPA)
Dr Alison Brown (HPA)

Members:
Dr Chris Conlon
Mr David Crundwell
Dr Matthew Donati
Ms Ceri Evans
Dr John Green (am only)
Dr Jeremy Hawker
Ms Ruth Lowbury
Dr Helen McIlveen
Ms Beatrice Osoro
Sir Nick Partridge (till 11.15)
Dr Keith Radcliffe
Dr Alison Rimmer

Apologies:
Prof Deenan Pillay
Dr Anton Pozniak
Dr Susan Sellers
Dr Ewen Stewart

Observers:
Mrs Moji Ajeneye (MHRA)
Dr Su Brailsford (NHS BT/HPA)
Dr Naresh Chada (DHSSPS Northern Ireland)
Dr Valerie Delpech (HPA)
Professor Noel Gill (HPA)
Lt Col Peter Hennessy (MoD)
Ms Julie Lucas (DH)
Ms Kay Orton (DH) (am only)
Dr Nicola Steedman (Scottish Government)

Invited:
Prof Jane Anderson (BHIVA Chair)
Prof Andrew Phillips (UCL)

Apologies:
Mr Gerry Robb (DH)
Mrs Tracey Gauci (Welsh Assembly)

Agenda item 1 Welcome, introductions, apologies and announcements

1. The Chair welcomed everyone to the meeting and introduced Dr Nicola Steedman as the new representative from the Health Protection Team at the Scottish Government. Julie Lucas, deputising for Gerry Robb, was welcomed back. Also welcomed were Prof Jane Anderson, Chair of BHIVA, who had been invited to provide BHIVA's perspective on agenda items 5 and 6 and Prof Andrew Phillips, Professor of Epidemiology and Biostatistics at University College London, who was invited to present agenda item 4.

2. The Chair spoke briefly about the sad news of the death of Professor Donald Jeffries who died at the end of 2011. Professor Jeffries had served as an EAGA member from 1992-2002 and then as its Chair. There had been a number of obituaries, including an excellent one in the BMJ[1]. The committee stood for a moment in silence in appreciation of Professor Jeffries's contribution to EAGA and other areas of public health policy.

3. Members were reminded that discussions at EAGA were confidential. Papers, unless in the public domain, were also to be treated as confidential. Dr Hawker declared a conflict of interest for agenda item 5 in his capacity as Registrar of the Faculty of Public Health.

Agenda item 2 Minutes of the last meeting (19 October 2011)

4. The minutes were agreed as an accurate record without amendment.

[1] http://www.bmj.com/content/344/bmj.e922

Agenda item 3 Matters arising

Agenda item 3.1 *Report from the Secretariat* *Paper EAGA(90)1*

5. The report from the Secretariat was noted. The Secretariat thanked members for returning their updated declarations of interests. The register for 2011 would be included in EAGA's Annual Report and members would have the opportunity to check their entries for accuracy when the draft report was circulated.

Agenda item 3.2 *Correspondence between the Chief Executive of the National Policing Improvement Agency and the EAGA and AGH Chairs*
Paper EAGA(91)2

6. Members agreed that the protocol for managing blood-borne virus exposure incidents in the workplace, as set out in the revised (not yet published) guidance from the Advisory Committee on Dangerous Pathogens (ACDP), was better and clearer than that developed by the National Policing Improvement Agency (NPIA). The police model was felt to be overly prescriptive. Any document should refer to the need to work with local NHS providers of services on implementation. Members also identified training and education for the police service around exposure to and acquisition of HIV and other blood-borne viruses as an important adjunct to the work on management of incidents.

Agenda item 4 Reconstructing the MSM epidemic in the UK: model of HIV transmission, progression and the effect of ART

7. Modelling work to gain a better understanding of the undiagnosed HIV fraction and its role in driving the HIV epidemic had been identified at the last meeting as a topic of interest to EAGA. Professor Andrew Phillips had been invited to present some recent work funded as part of an NIHR programme grant for applied research on the Comprehensive Assessment of the Prevention Role of Antiretroviral therapy (CAPRA).

8. The model was an individual-based stochastic simulation model[2] that aimed to reconstruct the history of the population of HIV-infected MSM in the UK, starting from 1980. The simulated dataset created by each run of the model included around 50,000 MSM, equating to around 10% of the MSM population, based on estimates from the National Survey of Sexual Attitudes and Lifestyles conducted in 2000. Key model parameters included those determining the number of new and long-term condomless sex partners, rate of transmission for a given viral load, and parameters relating to HIV progression with and without treatment. The model tracked the number of partnerships formed by people with HIV and their viral load at any given time. When compared with disease progression modelling, the data for modelling transmission were less reliable. Multiple simulation runs were used to identify parameters that gave a reasonable fit to observed data. Once a model had been built that accurately reflected the past, it could be used to predict the impact of different interventions on the future course of the epidemic.

9. Some insights from the model were presented and discussed. For example, it supported earlier findings on the major contribution to new infections from undiagnosed individuals, particularly those with acute (primary) infection.

[2] A type of model that reconstructs the likely clinical progression of individuals from HIV infection to death including diagnosis, treatment uptake, resistance etc. The parameters of the model are drawn from ranges of values informed by a variety of data sources.

10. The model, along with other data, predicted that HIV incidence in MSM was increasing over time and stood at around 0.5% in 2010. To address whether this was evidence that condom promotion was failing, the scenario of no condom use from 2000 onwards was simulated. This resulted in a massive rise in incidence in the subsequent decade, which did not parallel the real epidemic. Similar exercises were run to examine the effect of: (i) higher rates of testing – a more modest effect on the incidence profile (possibly testing rates had been over-estimated in the model); (ii) no ART use – a substantial effect on incidence but less dramatic than stopping condom use; (iii) starting ART earlier (at diagnosis) – some impact on reducing incidence.

11. For testing *per se* to reduce incidence it needed to impact on behaviour. Primary infection created a 'perfect storm' for transmission by combining high viral load/infectivity with a period of high-risk behaviour (assumed that the behaviour that led to HIV acquisition continued and promoted onward transmission).

12. There were a number of outstanding questions of current interest to EAGA that the model might address in future, e.g. was there any added public health benefit of condom use by an individual who had undetectable viral load (being addressed by the Partner study)? If there was widespread introduction of pre-exposure prophylaxis, would investment in condom promotion still be justified/would it matter if condom use declined? Which intervention had the greatest impact on incidence? Was immediate ART initiation at diagnosis likely to be cost-effective (i.e. did it reduce incidence)? What further investment in intensive combination prevention would be justified? Could the model inform recommendations on frequency of HIV testing?

13. Main gaps in knowledge to inform parameter values included longitudinal patterns of sexual behaviour and changes in behaviour upon diagnosis. These were partially being addressed through the START (Strategic Timing of Antiretroviral Treatment) and ASTRA (Antiretrovirals, Sexual Transmission Risk and Attitudes) studies. Better data were also needed on absolute transmission rates and still, to some extent, on the efficacy of condoms.

Agenda item 5 Impact of the health reforms on HIV prevention, testing, treatment and care (SP 1&2)

14. The Health and Social Care Bill, which would introduce a swathe of health reforms, was currently at the report stage (between the second and third readings) in the House of Lords. A briefing paper had been prepared by Sir Nick Partridge and circulated to members ahead of the meeting. Primarily for information, it aimed to summarise the issues (opportunities and challenges) for commissioning and delivery of HIV services over the next 18 months to 2 years. The briefing did not address the abolition of the Health Protection Agency and creation of Public Health England (also part of the Bill). The implications of this change for HIV and STI information systems had been discussed at EAGA previously.

15. The paper highlighted an initiative being led by the NHS Commissioning Board to establish a limited number of Strategic Clinical Networks (SCNs). While HIV services met a number of the stated criteria for inclusion, the lack of an existing managed clinical network and the high number of specialist units (>50) might preclude HIV from consideration, despite the high potential benefits to individual and public health. A managed network based on fewer, large specialist centres, combined with better use of

primary care, would concentrate expertise and help sustain training capacity for rarer HIV-related conditions.

16. An HIV National Clinical Reference Group, chaired by Dr Simon Barton, had been set up as part of transitioning arrangements for specialised commissioning. In addition to taking every opportunity to engage with the National Commissioning Board, the British HIV Association (BHIVA) planned to revise the 2007 standards for HIV clinical care (prepared jointly with the RCP, BASHH and BIS) and broaden these to include social care. The NHS Right Care Programme, under the leadership of Sir Muir Gray, was helping to fund two workshops in the south and north of the country, bringing together representatives of existing clinical networks, providers of health and social care for people living with HIV, third sector organisations, virologists, HPA and service users to inform the development of these standards. It was suggested that the earlier MedFASH standards for sexual health services should be 'mined' for any useful elements.

17. The standards would focus on people living with HIV but the starting point would be ensuring prompt access to services for individuals unaware of their HIV infection. The standards would be built around the indicators in the Public Health and NHS Outcomes Frameworks. A wide group of stakeholders had been invited to participate in the development of the standards and a launch was planned for 29 November 2012, for World AIDS Day.

18. In conclusion, it was clear that there were a number of important initiatives under way, resulting from the health reforms. EAGA agreed that it was important to keep these under review and remain alert to significant developments.

Agenda item 6 **EAGA position statement on "HIV transmission within serodiscordant partnerships where the positive partner is on successful antiretroviral therapy": draft for discussion**

Paper EAGA(91)3

19. The Chair summarised the process by which the current draft position statement had been prepared and reminded members that BHIVA had also been asked by NAT to provide advice. Professor Anderson, Chair of BHIVA, had been invited to EAGA to share BHIVA's thinking and ensure a consistent response. The draft of the BHIVA guidelines for the treatment of HIV-1 infected adults with antiretroviral therapy 2012 (consultation version) included a new section on treatment to reduce transmission. This documented the convincing evidence of transmission risk reduction for heterosexuals, while contrasting it with the limited data concerning transmission risk reduction for MSM. Nevertheless, BHIVA stated that a similar effect might be seen in MSM. EAGA concurred with all of these conclusions.

20. BHIVA's draft guidelines were written as a guide for HIV clinical specialists. In presenting a summary of the evidence, EAGA had found that the line between public health and individual health messages had become blurred. For example, the public health benefit of treatment as prevention was potentially greater for HIV-infected individuals without regular partners than for those in stable serodiscordant relationships (because several partners might be protected/transmissions averted). However, HIV-infected individuals and their partners needed to understand the conditions to maximise protection if they chose antiretrovirals (ART) rather than condoms for HIV prevention. Members were reminded that the Swiss statement (which predated the results of the randomised controlled trials) had

been developed in the context of a legal system that prosecuted individuals for exposing sexual partners to risk of HIV infection in the absence of transmission.

21. EAGA had a role in highlighting to the CMOs and the UK Health Departments the implications of treatment as prevention for both the public health and the public purse. The fact that ART was so effective in reducing HIV transmission (>90%) against a background of safer sex counselling, condom provision and STI treatment was compelling.

22. HPA provided some preliminary data [now submitted for publication] relating to MSM to get an indication of the scale and potential impact of treatment as prevention. In 2010, there were 1600 MSM in HIV care who were not on treatment who had CD4 counts in the range 350-500 cells/µl and an 'infectious' viral load (i.e. >1500 copies/ml) and an additional 2300 with CD4 counts >500 cells/µl. A further 10,300 MSM were estimated to be undiagnosed and not in care. The potential additional costs for antiretroviral drugs alone for 3900 diagnosed but untreated MSM amounted to £21.45 million per annum if these patients chose to start treatment. The cost-effectiveness of this intervention needed to be examined as a matter of priority.

23. It was also noted that the guidelines on management of sexual and reproductive health for people living with HIV also addressed the impact of treatment on transmission in the context of natural conception.

24. There was still a need to translate the evidence for the general public and those providing behavioural advice to infected individuals. EAGA agreed to work with BHIVA to develop a joint statement.

Agenda item 7 Management of HIV-infected healthcare workers

Paper EAGA(91)4

7.1 Feedback from EAGA on consultation questions (SP3)

25. The consultation would close on 9 March 2012 and the majority of responses were likely to be submitted in the last few days. To date, there had been 14 responses, mostly from individuals who were supportive of the proposed changes, but had not necessarily responded to the consultation questions. The views of key stakeholder groups had yet to be received. Media coverage at the time of the consultation launch had been balanced.

26. EAGA members were invited to feedback any issues or concerns arising from the consultation document or the questions therein at the meeting, but no comments were offered.

7.2 Risk of viral rebound from below 50 copies/ml (SP4&5)

27. EAGA discussed the implications of the paper by Doyle *et al*. (SP4) for the Tripartite Working Group's proposals on the management of HIV-infected healthcare workers (HCWs). The study found the probability of viral load rebound from <50 copies/ml to >400 copies/ml to be up to 13% over a 12-month period. Factors predicting rebound were the viral load at the start of the observation period (40-49 copies, <40 copies or RNA negative) and how long the viral load had been suppressed to <50 copies/ml. Resistance was detected in fewer than half of patients who experienced rebound to >400 copies/ml, suggesting poor adherence was a major driver.

28. One fact relevant to the HCW proposals that was missing from the paper was the highest level of rebound that occurred. It was agreed that it would be helpful to be able to predict the likelihood of an HIV-infected HCW experiencing a viral load rebound. The practical utility of this information was questionable. Would it mean that those HCWs found to have a viral load level at the higher end of 'undetectable' using a very sensitive assay would need more frequent monitoring? For those experiencing rebound in the study, it was suggested that this was probably an indirect maker of suboptimal adherence. It was anticipated that HCWs would be very assiduous about adhering to therapy.

29. EAGA concluded that no changes were needed to their advice for implementation of the new HIV-infected HCW policy as a result of this study.

7.3 HIV elite control – implications for HIV-infected healthcare workers (tabled Annex 1)

30. A member had reviewed the literature on HIV elite control. A working definition of an 'elite controller' was an individual with viral load maintained below the limits of assay detection for at least 12 months, based on at least three separate viral load measurements, who was not receiving antiretroviral therapy. It had not been determined whether non-progression of HIV disease in such cases was due to a host factor (immunity, for instance) or a viral factor (such as a non-pathogenic virus).

31. The prevalence of elite controllers in the HIV-infected population was low (0.2-0.55%). It was recommended, and accepted, that this rare phenomenon should be mentioned in any new guidance on management of HIV-infected HCWs but that any cases arising be referred to UKAP for advice on a case-by-case basis. UKAP would be able to seek advice from EAGA if needed.

Agenda item 8 HIV testing and follow-up into care

8.1 Access to and retention in HIV care - national data on loss to follow-up (SP6)

32. HIV-infected individuals fell out of care for a range of different reasons and might re-present as inpatients when they became seriously ill. The degree of autonomy granted to HIV patients was much greater than in other specialities, where non-attendance at clinic appointments by patients with serious long-term conditions would usually be reported to the patient's GP and the GP's help enlisted to encourage the patient back into follow-up. Loss-to-follow-up (LTFU) was due to be audited by BHIVA in 2012. The SOPHID database would be interrogated to identify patients truly lost to follow-up (i.e. not known to have transferred their care to another centre). There were important clinical questions to address around the impact on patient outcomes of intermittent attendance or transfer of care. Consideration might also be given to introducing a specific CQUIN or standard to prioritise reductions in LTFU.

33. Quality of care indicators had been included in the 'HIV in the UK: 2011 report' (Information Paper 1) and demonstrated excellent standards of care in the UK. For example, 89% of HIV-infected adults had their first CD4 count recorded within a month of diagnosis, serving as a surrogate of prompt transfer of the patient into care.

34. The latest data on LTFU for England, Wales and Northern Ireland were presented. 94% of patients seen for care in 2009 were seen again in 2010, with 90% on average in continuous care. Of the 6% (3772) overall who were LTFU, most (2825) were previously diagnosed

but proportionately more newly diagnosed patients defaulted from care (11% versus 5%). No geographic variation was observed and the age and risk group predictors of LTFU were the same as previously reported (SP6), i.e. female gender, younger age, black African ethnicity, recent diagnosis and not receiving antiretroviral therapy. Clinic input was needed to distinguish between true LTFU and those who had simply left the country after receiving initial care. The BHIVA audit would seek to refine the data.

35. An estimated ~5% of patients changed clinic each year. Matching algorithms (using soundex, date of birth and sex) to de-duplicate records and link them over time were validated to ensure accuracy. However, matching algorithms were particularly challenging when women changed their names with marital status or name reversal occurred (e.g. more frequent with foreign names). It was also not possible to trace transfers to immigration removal centres because of the change from NHS to private healthcare provision. Overall, the data were encouraging.

8.2 Audit of HIV patients lost to follow-up

36. A complementary presentation examined clinic-level data from a local audit of HIV patients LTFU (i.e. not attended the clinic for >12 months) between 2007 and 2010. The need to review paper records had been a major obstacle to conducting the audit. The process would be much simplified in future as the clinic had switched from paper to electronic notes. After excluding patients known to have died or formally transferred their care to another clinic (as documented in the notes) or gone abroad, 42 individuals (6% of the total clinic cohort) were found to have defaulted from care. There was evidence of attempts to recall these patients in 7 cases.

37. Carefully worded letters, to protect confidentiality, were sent to all 42 patients and resulted in 2 re-engaging in care. The reasons given for not attending clinic were feeling well and healthy/not bothering and being needlephobic. It was concerning that 18 of the 40 LTFU were on antiretroviral medication at the time of their last visit. Median CD4 counts were high (432 cells/μl) but some were dangerously low.

38. Checking against the SOPHID database revealed that a further 3 patients had transferred their care to other centres. While it was reassuring that patients who failed to turn up to one clinic were being seen elsewhere, there were a number of lessons to be learned from the audit. Maintaining up-to-date patient contact details was critical and the process for patient recall needed to be formalised and to involve other healthcare providers, particularly GPs, wherever possible.

39. A number of questions and suggestions were raised in discussion.

- A big unknown was the number of patients who had left the country or been misclassified as a new patient elsewhere (because they could not be matched in the SOPHID database). Initial analysis indicated that a higher proportion of those LTFU had their country of birth recorded as ‘born abroad’ versus UK-born.
- The Personal Demographics Service was another option open to clinicians trying to trace missing patients.
- Also worth considering was whether it was in the patient’s best interests to breach their confidentiality and contact their GP for help with re-engaging the patient in care (where the patient was not known to have disclosed their HIV status to their GP). This was

another reason why patients should be encouraged to disclose their HIV status to their GPs.

- It was noted that non-attendance rates had declined dramatically in other clinics by pre-phoning or SMS messaging.
- A robust approach was taken to ensure patients with gonorrhoea or chlamydia attended clinic for treatment. Was it time to give greater priority to recalling HIV patients?

40. It was observed that, in the diagnostic virology setting, if an antenatal specimen was reactive in the screening HIV test or a sample sent for screening was inadequate, there was a policy in place describing the follow-up action to be taken if the requested further sample had not been received within 10 working days of the request. In practice, this meant laboratories had to have a system to identify when follow-up samples were not received and a mechanism to contact the relevant clinical team[3]. This standard had been introduced to prevent delays in diagnosing and treating infectious diseases in pregnant women that could result in harm to their unborn child.

Agenda item 9 Update on PrEP initiatives Paper EAGA(91)5

41. The proposal developed by the HPA in partnership with the MRC Clinical Trials Unit (CTU) for a randomised open-label trial of pre-exposure prophylaxis (PrEP) in men who have sex with men (MSM) and submitted to the National Institute for Health Research (NIHR)-Health Technology Assessment programme in July 2011 had not been funded. The basis for rejection of the proposal included the high cost (despite free provision of the trial drug, which meant the trial represented good value for money) and the fact that efficacy had already been demonstrated. However, it was critical to measure effectiveness, as efficacy could change due to risk compensation on moving from a placebo-controlled to an open-label trial design. The HPA and MRC-CTU planned to conduct a pilot to test the trial design and collect data to inform a further bid to NIHR. Funding was also being sought elsewhere. The potential benefits were wider than just PrEP delivery and included rejuvenated prevention services in GUM.

42. The licensing of Truvada (manufactured by Gilead), which was the combined antiretroviral drug used in the iPrEX trial and proposed for the UK trial, was important to the long-term sustainability of the PrEP initiative. The current license was for treatment of HIV infection, although Gilead had applied to the FDA for approval to extend the indication to cover HIV prevention (PrEP). A similar application to the European licensing authorities was likely to follow. Meanwhile, Gilead had agreed to supply Truvada for the duration of the trial free of charge and, by the time the trial was completed, Truvada would be off-license. This would have a positive impact on the cost-benefit ratio, i.e. making PrEP more affordable. (It was felt that differential pricing of Truvada for treatment (off-license) and Truvada for prevention (new license) would be unsustainable, but was a potential issue.)

43. Three questions were posed to EAGA in Paper EAGA(91)5.

(1) Should PrEP research in MSM be a priority for the HIV prevention research agenda?

The continuing transmission of HIV in MSM in the UK was indisputably a serious public health issue. PrEP was an intervention that was known to work, but embedding it into health policy was a challenge. The US authorities had accepted the clinical benefit of PrEP,

[3] Paragraphs 2.1.6 and 2.1.7 in "Infectious Diseases in Pregnancy Screening Programme: Handbook for Laboratories". Available from: http://infectiousdiseases.screening.nhs.uk/standards

so the less favourable view taken in the UK might have been influenced by health system considerations. Most of what was proposed as part of the trial for enhanced prevention services in GUM could be regarded as good practice. The trial was designed to gather data on many behavioural and other questions that would help refine the transmission model presented by Professor Phillips (agenda item 4). [EAGA subsequently identified pre-exposure prophylaxis studies as its highest priority for HIV-related research in response to a request for priorities from the Department of Health.]

44. (2) What suggestions are there to improve and strengthen possible future applications for funding of the PROUD trial?

    Emphasis should be on the public health benefit, the need to demonstrate that PrEP could work in the real-world environment, ability to reach the key high-risk group and the potential of the trial to encourage hard-to-reach MSM to attend GUM clinics.

45. (3) What research priority should be given to investigate the possible use and impact of PrEP in other populations vulnerable to HIV, other than MSM?

    PrEP research in heterosexuals in the UK was not a short-term priority both because the evidence about efficacy was currently unclear and because the lower transmission rate in this group meant an unfeasibly large sample size would be needed to conduct a statistically rigorous trial. To achieve equity was not sufficient justification for prioritising heterosexual research. The HIV epidemic was unequal in its impact on different population subgroups, as recognised in the tender for the new national prevention programme (see agenda item 11). Other randomised controlled trials would provide evidence of the benefit of PrEP for women. At some future date, it might be appropriate to conduct a cost-effectiveness study for female participants.

Agenda item 10 Briefing on standards for management of HIV-infected prisoners and immigration detainees Paper EAGA(91)6

46. The Secretariat had circulated a briefing paper with key guidance documents listed. There were examples of suboptimal practice on both sides of the care equation. On the one hand, lack of continuity of care and transfer information for patients moving within the prison estate or back into the community had the potential to compromise adherence to antiretroviral therapy. According to Home Office guidelines, the treating physician had to be informed before a prisoner was moved (to enable referral) but the short-notice of such moves sometimes meant this did not happen. On the other hand, anecdotal reports of clinicians not willing to be flexible/resourceful, when incarcerated patients were late for appointments or had notes missing, could be detrimental to public health.

47. The preliminary data from GUMCAD on the number of prisoners with HIV infection was in line with expectations. This data source had the potential to allow analyses comparing care quality indicators and other outcome measures between HIV-infected individuals ever-known to have been imprisoned and matched controls.

48. A survey of prison HIV healthcare was shortly to be conducted among BASHH and BHIVA members to audit compliance with existing guidance.

Agenda item 11 Update from DH covering charging regulations, testing kit regulations, guidance for Local Authorities on sharing information on STIs, tender for a national HIV prevention programme

49. HIV testing kits and services regulations 1992: The DH sexual health policy team were planning to work with the MHRA on repealing these regulations but other pressures had delayed progress. While the impetus to repeal the legislation was to remove the ban on direct sales to the public of HIV self-testing kits (the legislation pre-dated the internet as a marketplace, which made enforcement almost impossible), the regulations also prohibited provision of HIV testing services other than by, or under the direction of, a registered medical practitioner, or as technical services provided at the request of a registered medical practitioner or for screening blood donations. It was likely that routine clinical governance procedures had superseded the need for regulations to cover testing services, but officials were checking this.

50. NHS (Venereal Diseases) Regulations 1974 and the NHS Trusts and PCTs (Sexually Transmitted Diseases) Directions 2000: The regulations and directions governing confidentiality of sexual health care information were set to be repealed from 2013 coincident with the abolition of Primary Care Trusts. BHIVA, BASHH, HPA and abortion providers had been working together on new confidentiality provisions. These were to be clarified in the mandate for Local Authorities to remove any ambiguities concerning data sharing for public health monitoring purposes, and would apply not only to STIs but to broader sexual health issues.

51. Re-tendering for national HIV prevention programme contract: The current contracts with the Terrence Higgins Trust, African HIV Policy Network and fpa would be extended until 30 June 2012 to allow further time for the submission of tenders (revised deadline of 31 March 2012). The DH was seeking to let a single contract to save costs and maximise synergies, with the budget split 65:35 in favour of MSM work, based on the epidemiology. In future, responsibility for monitoring and evaluation of the contract would rest with Public Health England.

52. Sexual health policy framework: Replacing the National Strategy for Sexual Health and HIV (2001), the framework would be taking a life course approach and was likely to include separate sections on HIV and teenage pregnancy. The document was designed to support implementation of the public health reforms and the NHS modernisation agenda, would be geared towards the new Local Authority audience and have a focus on the public health outcomes indicators, whilst being non-prescriptive. Publication was anticipated before the 2012 summer parliamentary recess.

53. Review of policy on charging overseas visitors for HIV treatment: DH had concluded its internal review on this topic. The compelling public health arguments set out in a paper prepared by BHIVA and BASHH, shared with EAGA at its 85th meeting, had informed the outcome of the review. Unlike other STIs and certain communicable diseases, treatment for HIV was currently not provided free of charge to all overseas visitors unless the infected individual was ordinarily resident in the UK. Lord Fowler had tabled an amendment to the Health and Social Care Bill on this topic and the Government intended to agree the principle of the amendment when it came up for debate in the House of Lords. [The debate took place on 29.02.12. See Hansard for details (amendment 161): http://www.publications.parliament.uk/pa/ld201212/ldhansrd/text/120229-0003.htm] DH planned to introduce a statutory instrument to amend the current exemptions to charges for

treatment for STIs to include HIV, with an effective implementation date of October 2012. Officials had begun discussions with BHIVA and HPA on clinical guidance to support implementation and to strengthen monitoring.

54. The clinicians on EAGA were asked for their views on whether such a change in policy would have a significant impact in practice. The covert nature of any existing 'health tourism' by HIV-infected individuals made it very hard to quantify. There remained a concern about creating an incentive for non-residents to come to the UK to seek HIV treatment. The wider availability of antiretrovirals in middle- and low-income countries meant there was less of a pull factor. Clinicians were not expected to police the system, but it was imperative to avoid abuse of NHS resources and some new monitoring arrangements would be needed to measure the impact.

Agenda item 12 Any other business

12.1 HIV PEP guidance: do we need an addendum? Paper EAGA(91)7

55. A member confirmed that EAGA's advice not to offer post-exposure prophylaxis (PEP) following occupational exposure to a source with undetectable viral load had been disseminated to the Association of National Health Occupational Physicians (ANHOPs). However, variations in practice almost certainly existed across the country, driven by differences in epidemiology and by the psychology of the presenting patient. Depending on the exposed individual's perception of risk, some insisted on being prescribed PEP against clinical advice and, conversely, others failed to complete the recommended full course. Some centres had switched to providing 3-day starter packs (rather than 5-day packs) to avoid wastage because of high rates of discontinuation. There were plans to address some aspects of PEP practice via a national audit.

56. EAGA agreed that an addendum would be useful to provide explicit advice about exposure to a source with undetectable viral load. Patients should be advised that there was no benefit to taking PEP under such circumstances, i.e. if the risk assessment concluded that the viral load was undetectable at the time of exposure. Other updating might be required depending on the findings of the proposed audit.

12.2 WHO guidance on hormonal contraception and HIV infection

57. WHO upheld its guidance on hormonal contraceptive use and HIV (Hormonal Contraception and HIV: Technical Statement released on 16 Feb 2012) which, in summary, placed no restrictions on the use of any hormonal contraceptive method for women living with HIV or at high risk of HIV infection. A technical consultation had been convened to review the findings of recent epidemiological studies. The experts recommended the continued use of hormonal contraceptives to prevent pregnancy but emphasised the need to also use condoms to prevent HIV acquisition and transmission. [Further data were presented at the Conference on Retroviruses and Opportunistic Infections in March.]

58. As the WHO guidance had not been changed, EAGA did not discuss it.

12.3 Review of 2011/12 workplan and planning for 2012/13 Paper EAGA(91)8

59. The Secretariat reviewed the topics on the current workplan, identified those that had been completed, others where the work was ongoing or remained topical and suggested that the surgical supplement to the ACDP guidance item be dropped due to lack of progress.

60. A draft workplan would be drawn up based on the suggestions received, combined with the topics of ongoing interest, and circulated to members for comment and for assignment of lead(s) and timescales.

Agenda item 13 Dates of future meetings

61. The next meetings will be on **Wednesday 13 June 2012** and **Wednesday 17 October 2012**. Timings to be advised nearer the dates.