Public Health England

Protecting and improving the nation's health

Annual epidemiological spotlight on HIV in London

2017 data

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by Josh Forde, Peter Kirwan, Rosalind Louth, Helen Corkin, Paul Crook

Published December 2018
PHE publications
gateway number: 2018706

PHE supports the UN
Sustainable Development Goals

Contents

1 Summary

HIV remains an important public health problem in London. In 2017, an estimated 38,600 people were living with HIV (PLWH) in London (95% credible interval (CrI) 37,900-39,800), which was 38% of all people living with HIV in the UK. This includes both diagnosed and undiagnosed people.

HIV prevalence among gay, bisexual and other men who have sex with men (MSM) aged 15 to 59 years was higher in London, with 134 (CrI 113-156) per 1,000 MSM estimated to be living with HIV, compared with 63 (CrI 53-76) per 1,000 in the rest of England.

New diagnoses

An estimated 1,549 London residents were newly diagnosed with HIV in 2017, accounting for 39% of new diagnoses in England. This represents a fall of 22% from 2016. There has been a longer term fall in the number of new diagnoses, due in the main to a fall in the number of new diagnoses in Black Africans who have acquired HIV abroad. However, since 2016 there has been an accelerated fall, due to a large drop in the number of new diagnoses in MSM.

The new diagnosis rate for London residents aged 15 years or older (21.7 per 100,000) remains much higher than that of England in 2017 (8.7 per 100,000).

In 2017, the highest proportion of new diagnoses in London residents were among MSM (63%, compared to 45% in 2008). However, the number of MSM in London newly diagnosed with HIV in 2017 (977, adjusted for missing information) represents a 22% fall from 2016, continuing a large fall observed the previous year.

There has been a long term trend for a fall in the proportion of newly diagnosed MSM who were UK-born. Of the MSM newly diagnosed with HIV in 2017, 24% were UK-born, compared to 42% in 2008. In 2017, 1 in 3 MSM newly diagnosed were from the European Union (excluding the UK), with the largest proportions from Spain, Italy and Poland. The remaining two-fifths born in the rest of the world included 1 in 8 of the total newly diagnosed from Brazil. This is likely to reflect larger populations of MSM in London from these areas.

Heterosexual contact was the second largest infection route for new diagnoses in London residents in 2017 (33%) and numbers newly diagnosed have declined by 65% since 2008. Diagnoses in African born persons accounted for 52% of all heterosexually acquired cases in 2017 (n=207), compared to 67% (n=850) in 2008. Infections in UK born persons accounted for 21% of all heterosexually acquired cases in 2017.

Injecting drug use accounted for 2% of new diagnoses in London residents.

White populations represented 72% of London residents newly diagnosed with HIV and Black Africans 18% (a declining proportion, 21% in 2016 and 35% in 2008). A small proportion of new diagnoses in 2017 were in black Caribbeans (4%).

The number of new diagnoses was highest in the 25-34 year age group in males and the 35-44 year age group in females in 2017.

Late diagnoses

Reducing late HIV diagnoses is one of the indicators in the Public Health Outcomes Framework. People who are diagnosed late have a tenfold risk of mortality within 1 year of diagnosis compared to those diagnosed promptly and they have increased healthcare costs.

It is of continued concern that a large proportion of London residents with HIV are diagnosed late (35% in London 2015-2017, defined by a CD4 count of less than 350 cells/mm^3 at diagnosis) although this compares favourably with the rest of England (41%). The proportion diagnosed late in London has remained steady since 2013-15 (34%), and represents a decline from 2009-11 (47%).

In London, heterosexuals were more likely to be diagnosed late (58% in males, 50% in females) compared with MSM (25%). By ethnic group black Africans were more likely to be diagnosed late than the white population (54% and 27% respectively). Among people who inject drugs, 42% were diagnosed late.

People living with diagnosed HIV

The 36,436 people living with diagnosed HIV in London in 2017 was 35% higher than 2008. This longer term increase is partly due to the effectiveness of HIV treatment, which has reduced the number of deaths from HIV.

The diagnosed prevalence rate of HIV in London in 2017 was 5.7 per 1,000 residents aged 15-59 years. This was more than twice as high than the 2.3 per 1,000 observed in England as a whole. All (33) local authorities in London had a diagnosed HIV prevalence rate in excess of 2 per 1,000 population aged 15-59 years in 2017, which is the threshold for expanded HIV testing. Seventeen local authorities had extremely high prevalence rates of diagnosed HIV in excess of 5 per 1,000.

The 2 most common probable routes of transmission for London residents living with diagnosed HIV in 2017 were sex between men (52%) and sex between men and women (43%).

In 2017, 48% of London residents living with diagnosed HIV were white and 31% were black Africans. However, due to the relative sizes of the white and black African populations the rate per 1,000 population aged 15-59 years was much higher in black Africans (26.0 per 1,000) than in the white population (4.6 per 1,000).

The population living with diagnosed HIV is ageing. In 2017, 44% of those living with diagnosed HIV in London were aged between 35 and 49 years, and 40% were aged 50 years and over (up from 17% in 2008). Males represented 71% of London residents living with diagnosed HIV in 2017 and females represented 29%.

People with HIV have important other health needs. The 2017 Positive Voices Survey of people living with diagnosed HIV found that the top 3 chronic physical conditions reported by HIV patients in London were: high cholesterol, high blood pressure and asthma. Good mental health also remains an important factor in ensuring a good quality of life for people living with HIV: 32% of patients in London surveyed had a diagnosis of depression, compared to 19% in the general population; and 26% of patients from London had a diagnosis of anxiety, compared to 15% in the general population. In addition the survey found that Londoners living with HIV were more likely than the general population to use drugs, tobacco and consume alcohol: 33% of patients in London reported using drugs in the past 3 months, in comparison to 25% in people living with diagnosed HIV overall; 20% of patients are current smokers, versus 21% overall; 39% reported binge drinking versus 29% overall; and 23% were non-drinkers, versus 25% overall.

Continuum of HIV care

The UNAIDS treatment targets have been met and exceeded in London.[1] In London in 2017, 98% of HIV-diagnosed residents were receiving anti-retroviral treatment. Of these, 97% were virally suppressed (viral load <200) and were very unlikely to pass on HIV, even if having sex without condoms (untransmittable virus). This compares to 97% in the UK outside London receiving ART of which 97% were virally suppressed.

There was slight variation by borough and risk group regarding the proportion on ART in 2017 (overall range by borough 96-99%, MSM range 95-100%, heterosexuals 95-100%) and of those on ART virally suppressed (all range 94-98%, MSM range 92-99%, heterosexuals range 93-98%).

[1] UNAIDS. 90-90-90 An ambitious treatment target to help end the AIDS epidemic. 2014, Joint United Nations Programme on HIV/AIDS. 2014.

For London residents diagnosed in 2017, the proportion starting treatment within 91 days of diagnosis was 73% (1,011/1,381). This compares to 71% (1,773/2,488) in the UK outside London.

People living with undiagnosed HIV

London has also met the UNAIDS target of over 90% of people living with HIV estimated to be diagnosed. It is estimated that in 2017, 5% (Credible Interval (CrI) 4-8%) of people living with HIV in London, were undiagnosed.[2] This compares favourably with the 9% (CrI 6-15%) who are undiagnosed in the UK outside London, although caution should be applied when interpreting these data as these are estimates based on models.

This equates to an estimated 2,000 (CrI 1,400-3,200) undiagnosed people in London, including an estimated 1,000 MSM (CrI 500-2,100) and 900 heterosexuals (CrI 700-1,300), including 450 black African heterosexual men and women (CrI 350-600).

In London, the proportion undiagnosed varied by exposure group with the highest proportion undiagnosed being among people living with HIV who inject drugs (9%, CrI 3%-20%), who are non Black African heterosexuals (7%, CrI 4%-12%) and MSM (5%, CrI 3%-10%).

HIV testing

A total of 365,770 HIV tests were conducted in specialist sexual health services (SHSs) in London, an increase of 5% since 2013. The HIV testing coverage at specialist SHSs in London was 72%, which is higher than England as a whole (66%).

HIV testing coverage in specialist SHSs in London is higher in heterosexual men (81%) than heterosexual women (65%), and highest in MSM (90%). Only 13% of 38 specialist SHSs met or exceeded BASHH HIV testing coverage guidelines (meets or exceeds 80% testing coverage) for heterosexual women in 2017. The equivalent figure for heterosexual men was 55%, and for MSM, 87%.

Condom use

Condoms remain an important component in the prevention of HIV and STIs. However, among MSM there has been an increase in condomless anal sex with casual partners since the early 2000's; in 2016, 60% of gay and bisexual men participating in the

[2] PHE. Progress towards ending the HIV epidemic: 2018 report: www.gov.uk/government/publications/hiv-in-the-united-kingdom

London Gay Men's Sexual Health Survey, reported condomless anal sex in the 3 months prior to interview[3], compared to 43% in 2000.[4]

Stigma

HIV-related stigma and discrimination can negatively impact quality of life and prevent people from being tested for HIV. Results of the 'Positive Voices' survey in 2017 identified that for Londoners with HIV:[5]

- 14% said they had not told anyone, other than healthcare professionals, about their HIV status (20% of women and 12% of men)
- 25% said they had needed help disclosing their HIV status in the previous year (29% of women and 23% of men)
- 14% reported that they were worried about being discriminated against in a healthcare setting in the past year
- 8% reported avoiding seeking healthcare when they needed it in the past year
- 4% said they had been refused healthcare or delayed a treatment or medical procedure in the past year

Public health implications

Free and effective antiretroviral therapy (ART) in the UK has transformed HIV from a fatal infection into a chronic, manageable condition. People living with HIV in the UK can now expect to live into old age if diagnosed promptly. For many people, treatment means 1 daily tablet with no or few side effects.

There are a number of approaches to the prevention of HIV transmission and continued funding in prevention activities remains critical to curb the HIV epidemic. Prevention should be targeted at MSM and black African people who are the population groups most at risk of HIV. Many of those at particular risk may not speak English as a first language and prevention activities need to be linguistically and culturally appropriate.

The London HIV Prevention Programme (LHPP) is a London-wide sexual health promotion initiative funded by London local authorities aiming to increase HIV testing and promoting prevention choices for Londoners.[6] In addition, HIV Prevention England have been contracted to deliver, on behalf of PHE, a nationally coordinated programme

---

[3] Logan, L, et al. *Combination prevention and HIV: a cross-sectional community survey of gay and bisexual men in London*. in *Fourth Joint Conference of BHIVA with BASHH*. 2018. Edinburgh.
[4] Aghaizu, A., et al, *Sexual behaviours, HIV testing, and the proportion of men at risk of transmitting and acquiring HIV in London, UK, 2000-13: a serial cross-sectional study.* Lancet HIV, 2016. **3**(9): p. e431-e440.
[5] PHE. Progress towards ending the HIV epidemic: 2018 report. www.gov.uk/government/publications/hiv-in-the-united-kingdom
[6] doitlondon.org

of HIV prevention work. These programmes both work with MSM and black African people.

The UK was one of the first countries in Europe to witness a substantive decline in HIV diagnoses in gay and bisexual men. A combination of HIV prevention efforts has been a key reason for the decline. Increased HIV testing has led to earlier diagnosis and once people know they have HIV, they can be linked into care and offered treatment. Successful HIV treatment means HIV diagnosed people with an undetectable viral load cannot pass on the infection to others. Alongside correct and consistent condom use, early diagnosis through testing, and treatment of HIV to stop onward transmission, we now have PrEP- an HIV prevention drug.

Correct and consistent condom use remains an extremely effective way to prevent HIV transmission; however, in the UK uptake among key populations is insufficient. Work to improve condom use should address underlying factors that lead to risk taking behaviour, especially among MSM. These are diverse and may include low self-esteem, 'chemsex' (the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience) and sero-adaptive behaviour (modifying of sexual behaviour based on one's own HIV sero-status, the perceived HIV sero-status of a sexual partner, and/or differences in risk of transmission by different sexual acts).

While testing and treatment for HIV in the UK is free and available to all, large numbers of people living with HIV remain undiagnosed and rates of late diagnosis remain high. Late HIV diagnosis is associated with poorer health outcomes, including premature death. Furthermore, since the vast majority of people diagnosed with HIV are effectively treated, most new HIV infections are passed on from persons unaware of their infection.

HIV testing is pivotal in reducing HIV transmission as it decreases the number of people living with HIV who are unaware of their infection. Due to the relatively high numbers of MSM and black Africans who remain undiagnosed, HIV testing is particularly important for these groups and in MSM, where the incidence remains high. Partner notification following the diagnosis of HIV infection remains a highly effective way to detect undiagnosed HIV infections: in 2017 in England, 4.3% of partners of people diagnosed with HIV were also positive for HIV.[7]

Missed opportunities for HIV testing remain in England (2017):[8]

[7] PHE. Progress towards ending the HIV epidemic: 2018 report: www.gov.uk/government/publications/hiv-in-the-united-kingdom
[8] PHE. Progress towards ending the HIV epidemic: 2018 report: www.gov.uk/government/publications/hiv-in-the-united-kingdom

- less than half of MSM testing for HIV have had at least 1 HIV test at the same service during the previous year
- less than half of MSM who have had an anogenital bacterial STI were tested during the year following their STI diagnosis (4.4% positivity)
- a third of heterosexual women attending sexual and reproductive health (SRH) services in were tested for HIV, even though their HIV test positivity was the same as for women attending specialist SHSs
- uptake of testing at prisons is increasing but is low (71% of prisoners eligible were offered and 33% of these accepted a test in 2017/18)
- a high proportion of people who inject drugs in England who access a clinical service in the preceding year had not been tested for HIV (67%)

Symptoms due to HIV and AIDS may not appear for many years, and people who are unaware of their infection may not identify themselves to be at risk of HIV infections and therefore not test. However, anyone can acquire HIV regardless of age, gender, ethnicity, sexuality or religion and it is essential to challenge assumptions about who is at risk of HIV. As well as increasing awareness of HIV, efforts to reduce stigma and other socio-cultural barriers that prevent people from testing and seeking long-term care should be strengthened.

HIV Pre Exposure Prophylaxis (HIV–PrEP) is the use of antiretroviral agents by people who do not have HIV prior to a potential exposure to HIV to prevent acquisition of infection. Studies have shown that consistent use of HIV-PrEP can be an effective prevention intervention. HIV–PrEP has the potential, within a combination prevention approach, to have a significant role in the control of HIV transmission. The first phase of implementation is the 3-year clinical trial which launched in October 2017 which aims to recruit 13,000 participants in England.[9] As of October 2018, almost 9,000 participants had been recruited. Prior to this, MSM in London may have privately purchased PrEP and those not on the Impact trial may continue to do so.

It has been demonstrated that the advantages of ART extend beyond personal clinical benefit. It is now widely understood that effective HIV treatment results in an ‘undetectable’ viral load which protects individuals living with HIV from passing on the virus to others. The key message is that Undetectable = Untransmittable (U=U): Medicines to treat HIV can eliminate the risk of sexual and mother-to-child HIV transmission.[10] People with HIV who maintain an undetectable viral load for at least 6 months do not transmit HIV.

[9] www.prepimpacttrial.org.uk

[10] Prevention Access. Risk of sexual transmission of HIV from a person living with HIV who has an undetectable viral load. Messaging Primer & Consensus Statement 2016; Available from: www.preventionaccess.org/consensus

Revised guidelines from the British HIV Association and World Health Organisation recommend that patients start ART at diagnosis regardless of CD4 count both for clinical benefits and preventing onward transmission.[11] People living with HIV and their health care providers can discuss starting ART to reduce their risk of transmitting HIV to their sexual partners. The policy of immediate anti-retroviral therapy at HIV diagnosis is being implemented by NHS England which complements the current 'Treatment as Prevention' policy. As a result, the proportion of newly diagnosed people in care starting treatment within 91 days of diagnosis has increased.

As rates of other infections transmitted sexually, such as gonorrhoea, syphilis, lymphogranuloma venereum, hepatitis C (HCV) and *Shigella* have been shown to be higher in MSM who are HIV positive, it is important that MSM living with HIV are specifically made aware of the risks of these infections and how to prevent them.

The population of people living with diagnosed HIV is diversifying and growing older. It is critical that HIV and other services continue to evolve to meet the needs of older people living with HIV including the management of co-morbidities and other complex health conditions.

With progressive strengthening of combination prevention (including condom use, expanded HIV testing, prompt ART and availability of PrEP), HIV transmission, AIDS and HIV-related deaths could be eliminated in the UK. The inconsistencies between groups and geographies demonstrate that effective combination prevention needs to be replicated for all those at risk of acquiring of HIV, whoever they are and wherever they live.

In January 2018, The Mayor of London, signed the Paris Declaration on Fast-Track Cities Ending the AIDS Epidemic, along with London Councils, PHE and NHS England.[12,13] Fast Track Cities is a forum for improved joint working across the HIV pathway, seeking to enhance and build on work across London to date. The ambition is to cut rates of new HIV infection in the capital and eliminate discrimination and stigma associated with the condition. The sign up to the Fast Track Cities has indeed galvanised action to tackle HIV in the capital.

London has made much progress, particularly around exceeding the UNAIDS targets. While this progress needs to be maintained with sustained prevention efforts, renewed vigour is needed to tackle stigma - where reinforcing the message U=U is key, late diagnosis of HIV and prevention of STIs in HIV positive MSM.

---

[11] British HIV Association, Guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy 2015. (2016 interim update), BHIVA: London

[12] www.healthylondon.org/our-work/fast-track-cities-initiative

[13] www.fast-trackcities.org/cities/london

Key messages[14]

Although there has been steady progression in implementing combination prevention measures to end the HIV epidemic and the efforts are having a major effect, there still remain opportunities for further improvements. These key messages have been drawn together to support efforts to reach those living with HIV who are undiagnosed and to maintain high treatment and care standards.

Sexual health services should consider how they can:

- increase HIV test coverage among heterosexual attendees with an STI related need, including black Africans and people born in countries with high HIV prevalence
- increase HIV test coverage among gay, bisexual and other men who have sex with men, particularly those who have not tested recently or who have recently had a bacterial STI
- increase quarterly testing, including an STI screen, in gay, bisexual and other men who have sex with men if they are having unprotected sex with new or casual partners
- improve notification and testing of partners of heterosexuals and gay and bisexual men newly diagnosed with HIV

General practices and hospitals in high and extremely high prevalence areas should consider how they can better implement NICE guidance on offering HIV tests to patients.

Healthcare and other professionals should offer and recommend HIV and HCV tests to any patient who has injected drugs.

Prisons should consider how they can increase their ‘opt-out’ blood-borne virus testing activity for new receptions and transfers.

Local authorities should consider how they can:

- ensure that their population groups at increased risk can access HIV testing online and in community settings
- ensure that all commissioned HIV testing programmes have a well-defined referral pathway to HIV care for all people with a reactive/positive test result
- take account of the combination HIV prevention perspective when commissioning

[14] PHE. Progress towards ending the HIV epidemic: 2018 report. www.gov.uk/government/publications/hiv-in-the-united-kingdom

HIV care providers should:

- continue to monitor their key clinical indicators for HIV care, especially in people who inject drugs and people aged 15-24 years, to ensure the current high standard is maintained and to improve clinical outcomes
- discuss the individual and public health benefits of treatment with all people newly diagnosed with HIV, offering and recommending immediate ART, in line with the 2015 BHIVA guidelines
- adopt long-term condition care frameworks for the management of HIV to ensure the holistic needs of HIV patients are met, thereby supporting their general health and well-being − the focus should be on quality of life, prevention of co-morbidities, and incorporating principles of patient-centred care and self-management already in use for other long-term condition services
- continue to support comprehensive surveillance by reporting to PHE in a timely manner; high quality HIV public health data is essential to monitor progress towards the elimination of HIV in the UK

Recommendations to the public

All men who have ever had sex with another man should have an HIV test even if they consider themselves to be heterosexual.

Gay, bisexual and other men who have sex with men should have an HIV test at least annually.

Gay, bisexual and other men who have sex with men should test for HIV and have an STI screen every 3 months if they are having unprotected sex with new or casual partners.

Black African heterosexual men and women, and people born in countries where HIV is common, should have an HIV test, and repeat this every year if having unprotected sex with new or casual partners from countries where HIV is common.

Anyone who is diagnosed with HIV should accept the clinical recommendation that they start treatment immediately. Early treatment initiation enables people living with HIV to live a long and healthy life and minimises the risk of passing the infection to others. HIV treatment is free to all in the UK regardless of immigration or residency status.

A range of methods to prevent HIV acquisition are currently available in the UK. Resources are available that provide guidance on the combination of methods best suited to an individual’s health and circumstances.

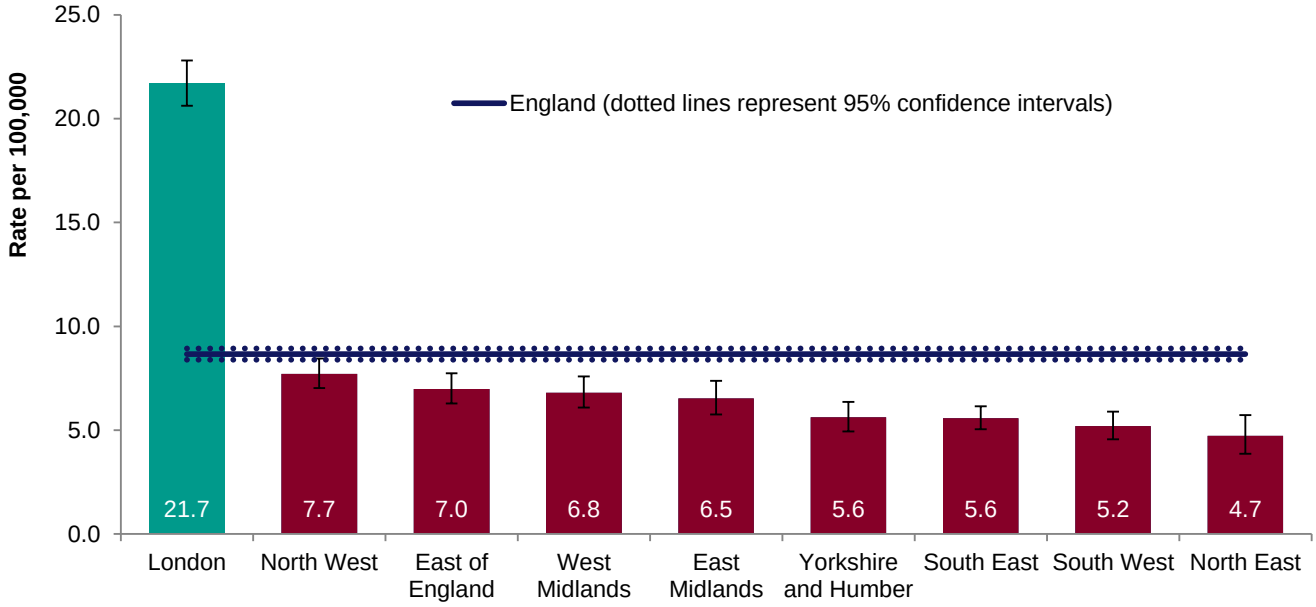
All HIV testing by the NHS is free and confidential for everyone, regardless of immigration or residency status.

There are many ways to get tested for HIV:

- go to an STI clinic or a community testing site (www.nhs.uk/Service-Search/HIV-testing/) (www.aidsmap.com/hiv-test-finder)
- ask your GP for an HIV test
- request a self-sampling kit online (www.test.hiv/) or obtain a self-testing kit

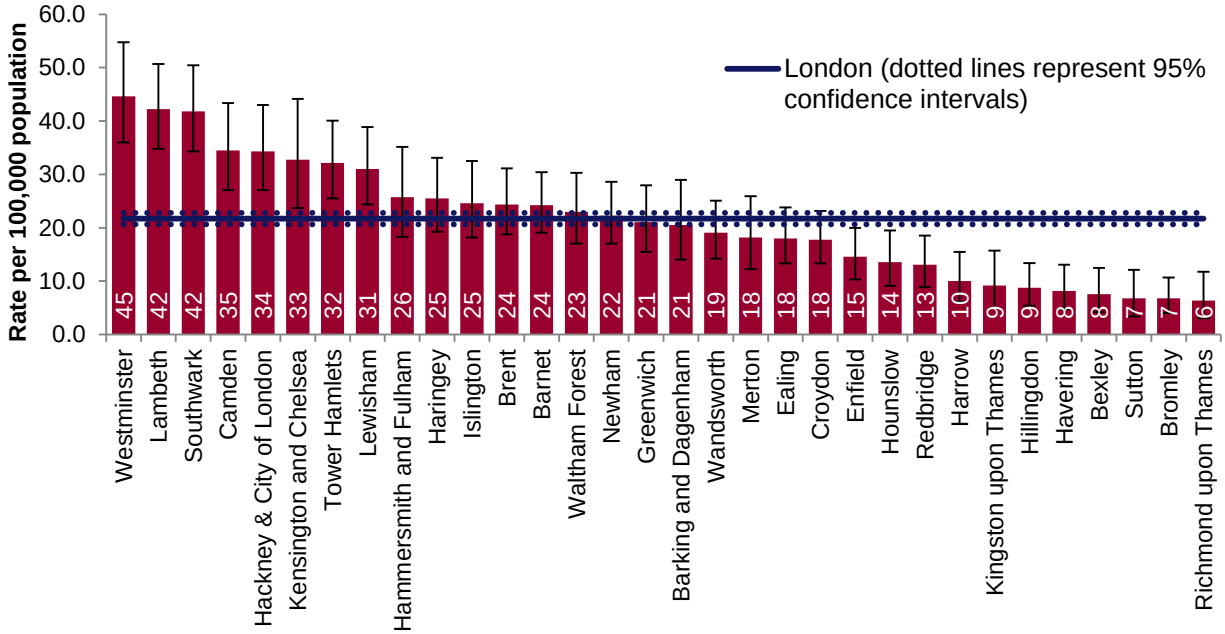
2 Charts, tables and maps

Figure 1: New HIV diagnoses per 100,000 population aged 15 years or older by PHE centre of residence, 2017



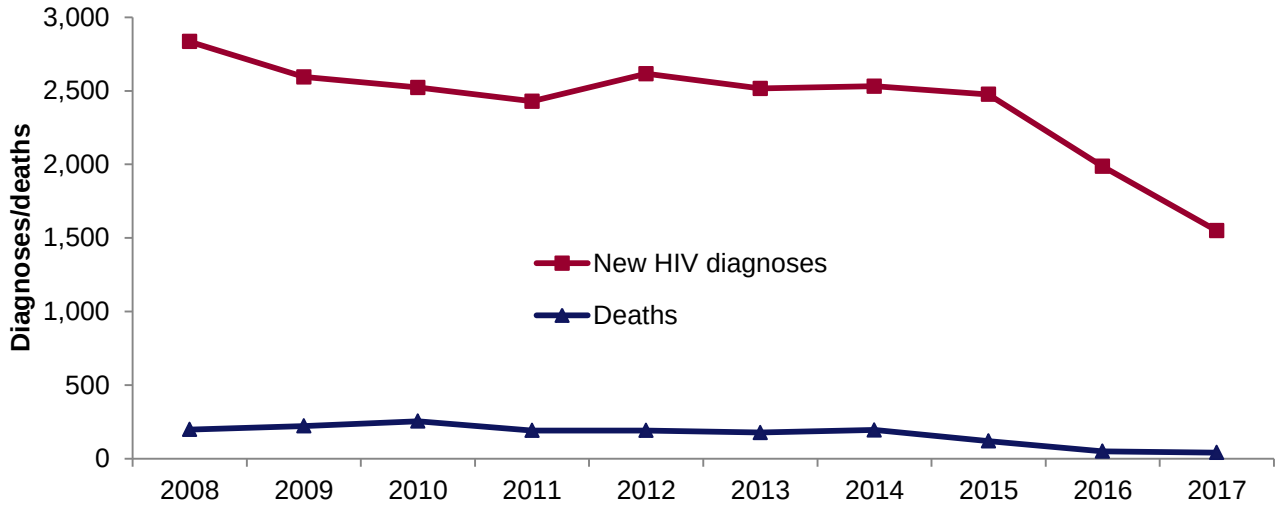
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.

Figure 2: New HIV diagnoses per 100,000 population aged 15 years or older by upper tier local authority of residence, London residents, 2017



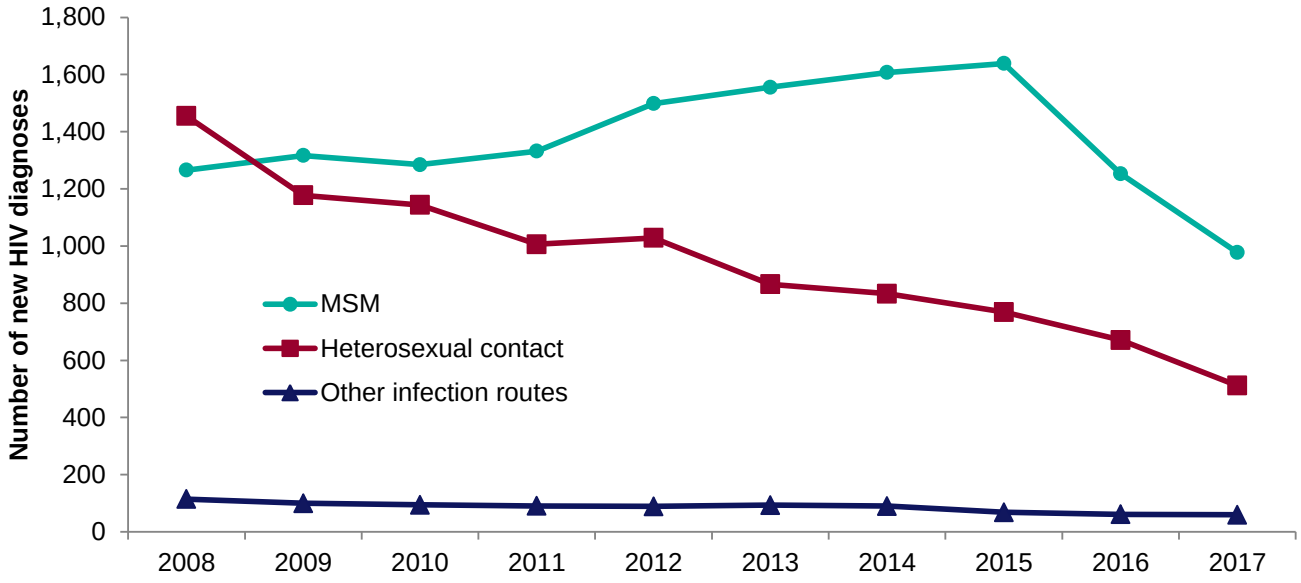
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.

Figure 3: New HIV diagnoses and deaths, London residents, 2008-2017



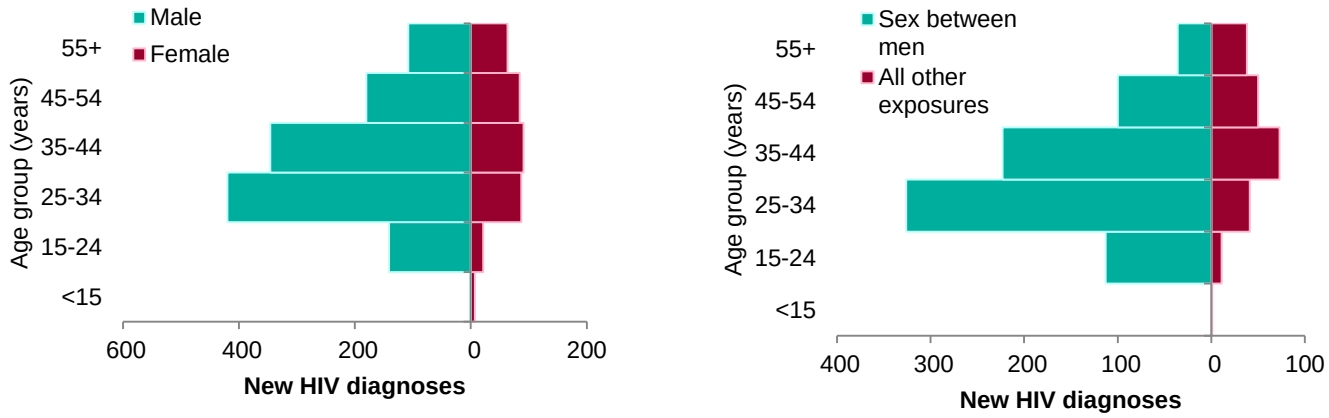
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.
*Numbers may rise as further reports are received. This will impact on interpretation of trends in more recent years.

Figure 4: New HIV diagnoses by probable route of infection (adjusted for missing route of infection information), London residents, 2008-2017 (please see footnote on interpreting trends)*



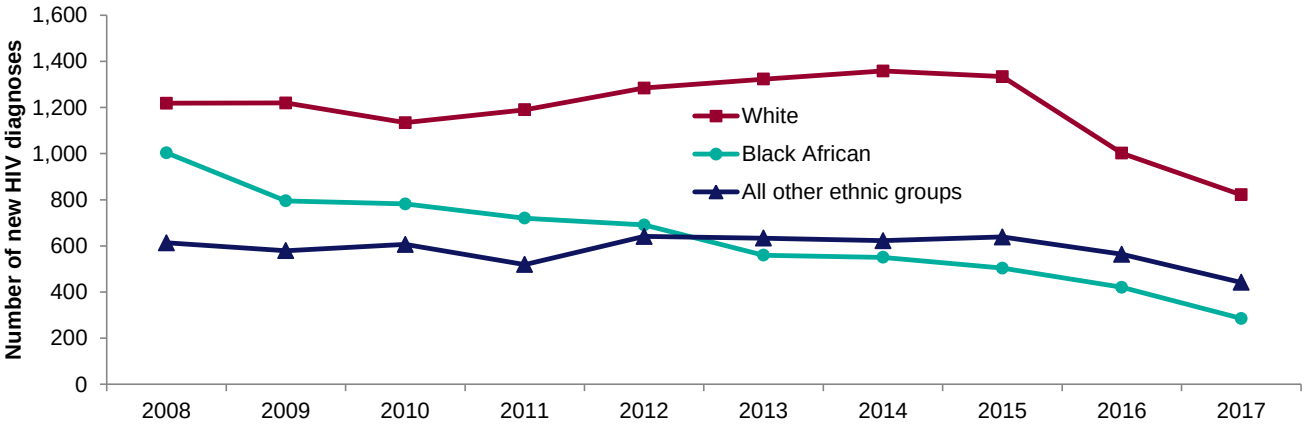
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.
*Numbers may rise as further reports are received and more information is obtained on area of residence of those diagnosed. This is more likely to affect more recent year, particularly 2017. Please see important note on data earlier in this report. This will impact on interpretation of trends in more recent years.

Figure 5: Number of new HIV diagnoses by age group and gender (A) and probable route of infection in males (B), London residents, 2017



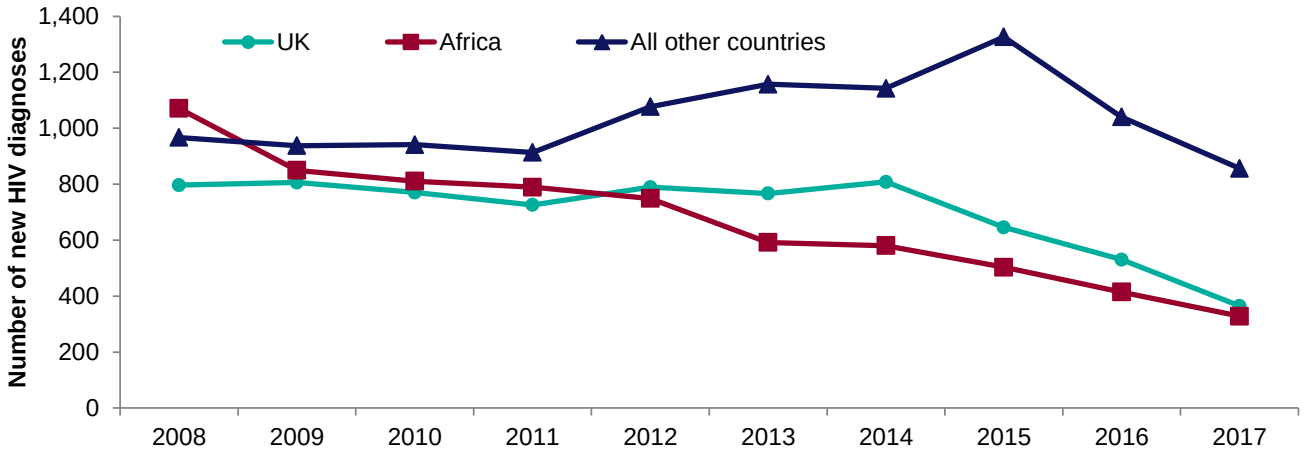
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.

Figure 6: Number of new HIV diagnoses by ethnic group (adjusted for missing ethnic group information), London residents, 2008-2017 (please see footnote on interpreting trends)*



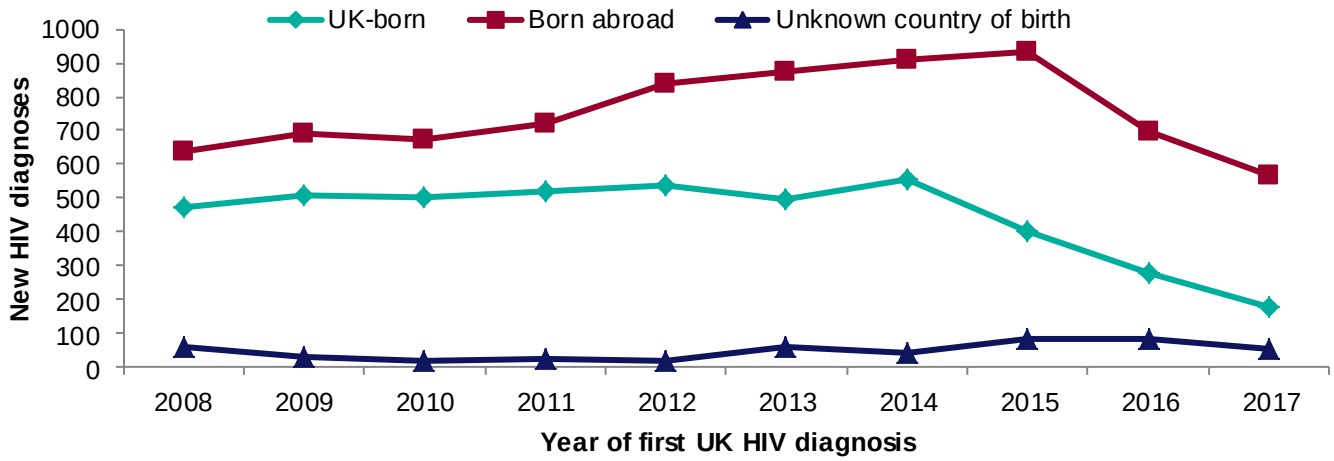
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.
*Numbers may rise as further reports are received and more information is obtained on area of residence of those diagnosed. This is more likely to affect more recent year, particularly 2017. Please see important note on data earlier in this report. This will impact on interpretation of trends in more recent years.

Figure 7: Number of new HIV diagnoses by world region of birth (adjusted for missing world region of birth information), London residents, 2008-2017 (please see footnote on interpreting trends)*



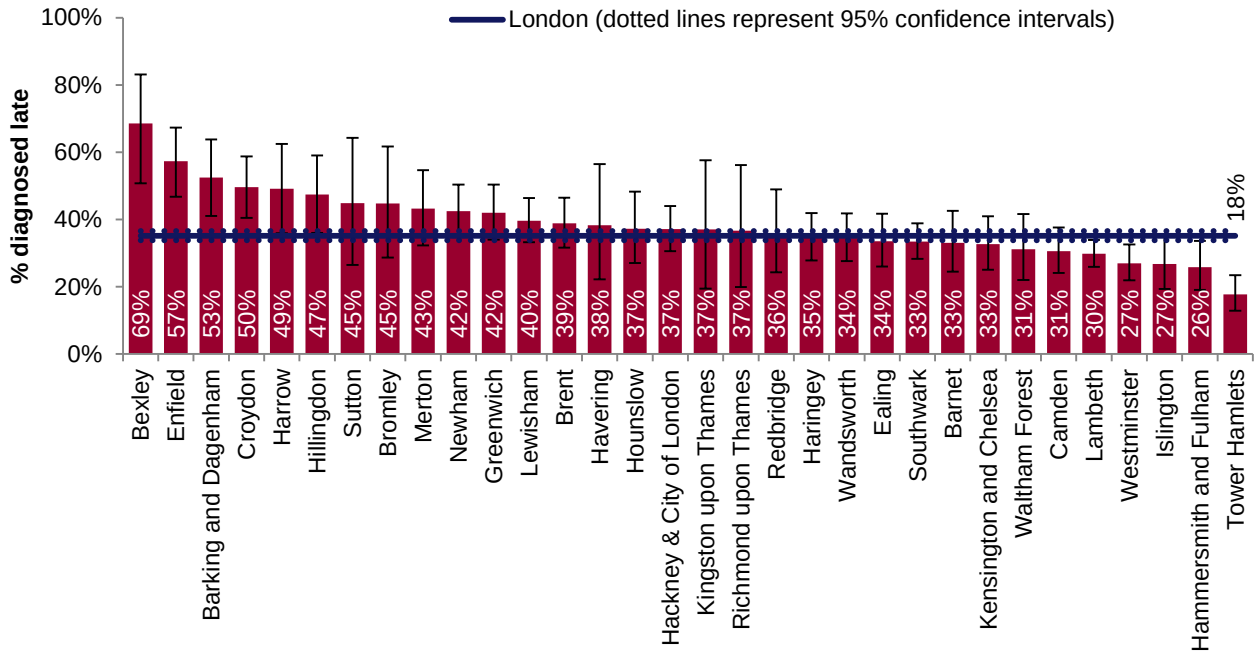
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.
*Numbers may rise as further reports are received and more information is obtained on area of residence of those diagnosed. This is more likely to affect more recent year, particularly 2017. Please see important note on data earlier in this report. This will impact on interpretation of trends in more recent years.

Figure 8: Number of MSM London residents diagnosed with HIV by place of birth: 2008-2017



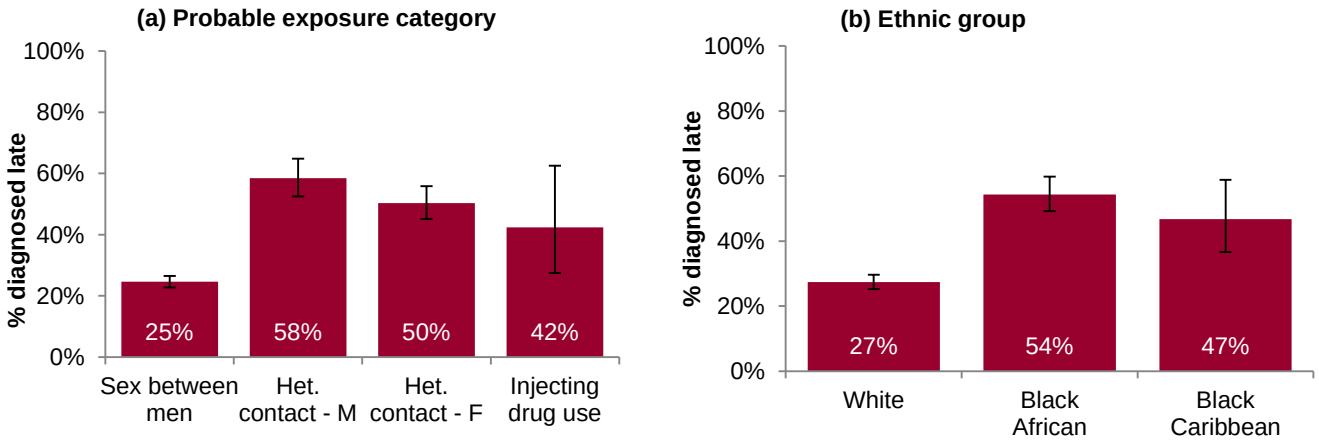
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.
*Numbers may rise as further reports are received and more information is obtained on area of residence of those diagnosed. This is more likely to affect more recent year, particularly 2017. Please see important note on data earlier in this report. This will impact on interpretation of trends in more recent years.

Figure 9: Percentage of new HIV diagnoses that were diagnosed late by upper tier local authority of residence, London, aged 15 years and over, 2015-2017 *



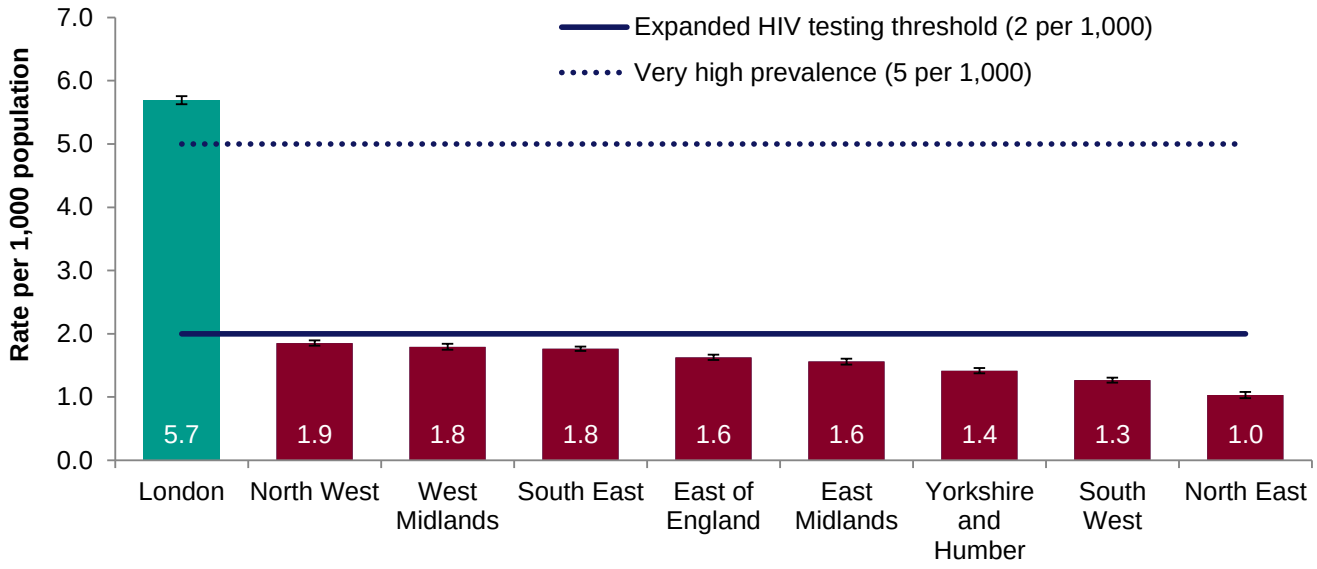
Source: Public Health England, HIV and AIDS New Diagnosis Database/System, HIV & AIDS Reporting System (HARS).
* Only includes new diagnoses for which CD4 count was reported within 91 days of diagnosis; late diagnosis defined as CD4 count <350 cells/mm3.Percentages for UTLAs with fewer than 5 late diagnoses are excluded as the denominator for this calculation is valid new HIV diagnoses which will always be lower than 10,000.
The underlying population will impact on the proportion diagnosed late, eg MSM are less likely to be diagnosed late.

Figure 10: Percentage of new HIV diagnoses that were diagnosed late by probable route of infection (A) and ethnic group (B), London residents, ages 15 years and over, 2015-2017*



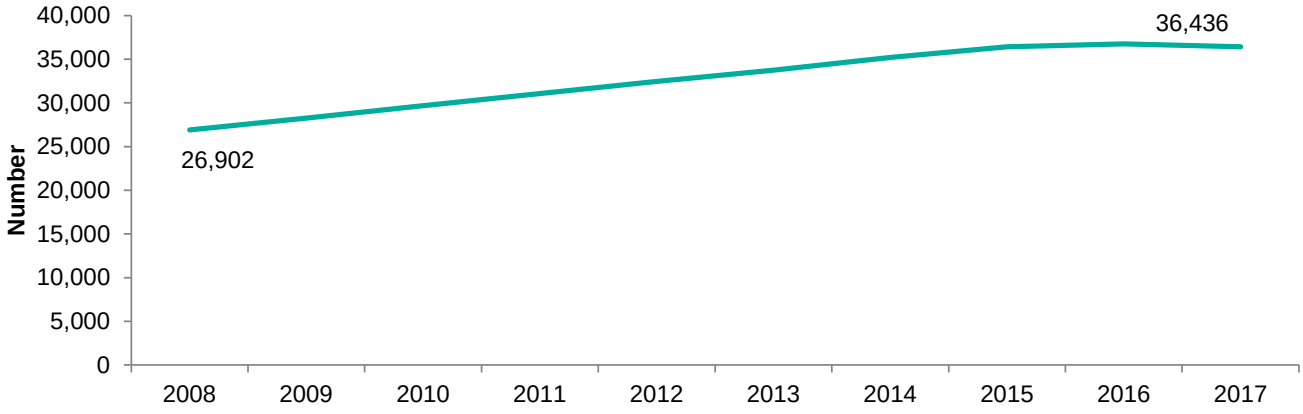
Source: Public Health England, HIV and AIDS New Diagnosis Database/System, HIV & AIDS Reporting System (HARS).
* Only includes new diagnoses for which CD4 count was reported within 91 days of diagnosis; late diagnosis defined as CD4 count <350 cells/mm3.

Figure 11: Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by PHE Centre, 2017



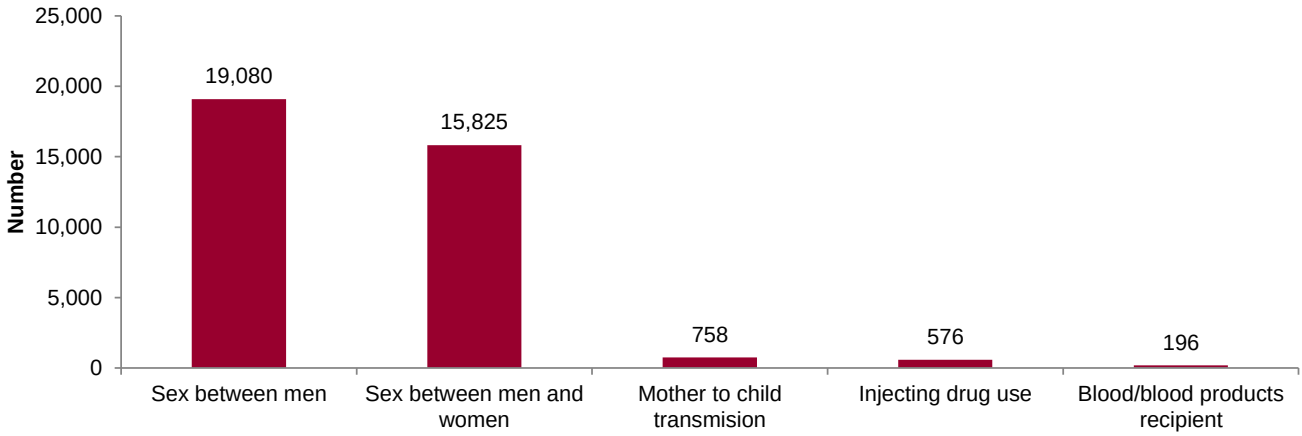
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 12: Number of residents living with diagnosed HIV and accessing care, London, 2008-2017



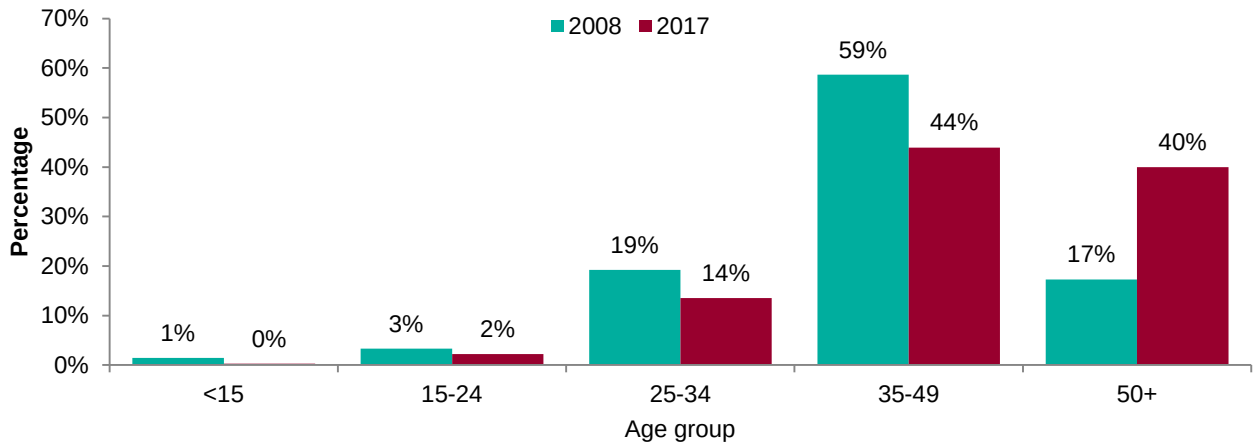
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 13: Number of residents living with diagnosed HIV and accessing care by probable route of transmission (adjusted for missing information), London, 2017



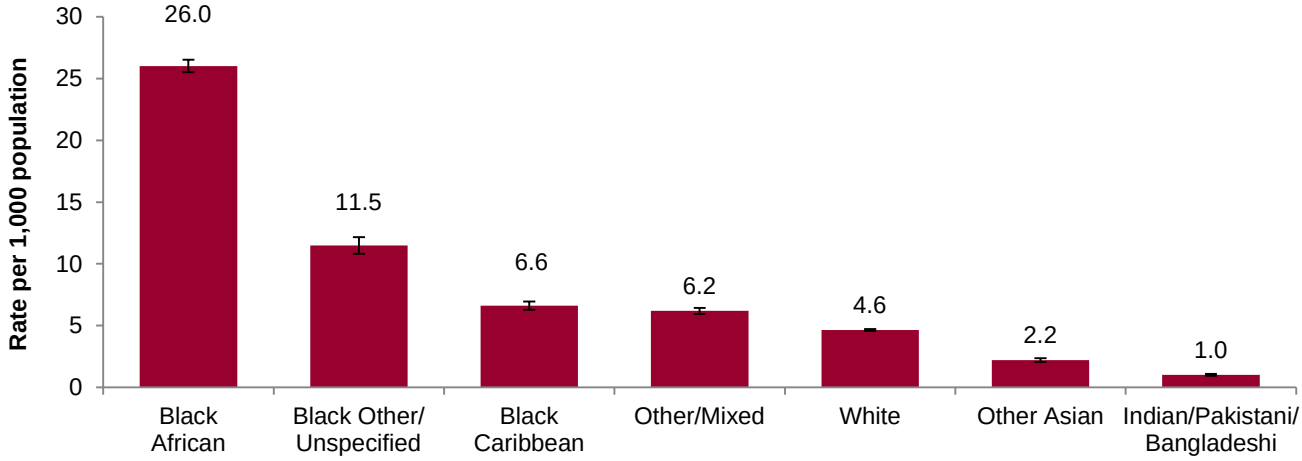
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 14: Percentage of residents with diagnosed HIV and accessing care by age group, London, 2008 and 2017



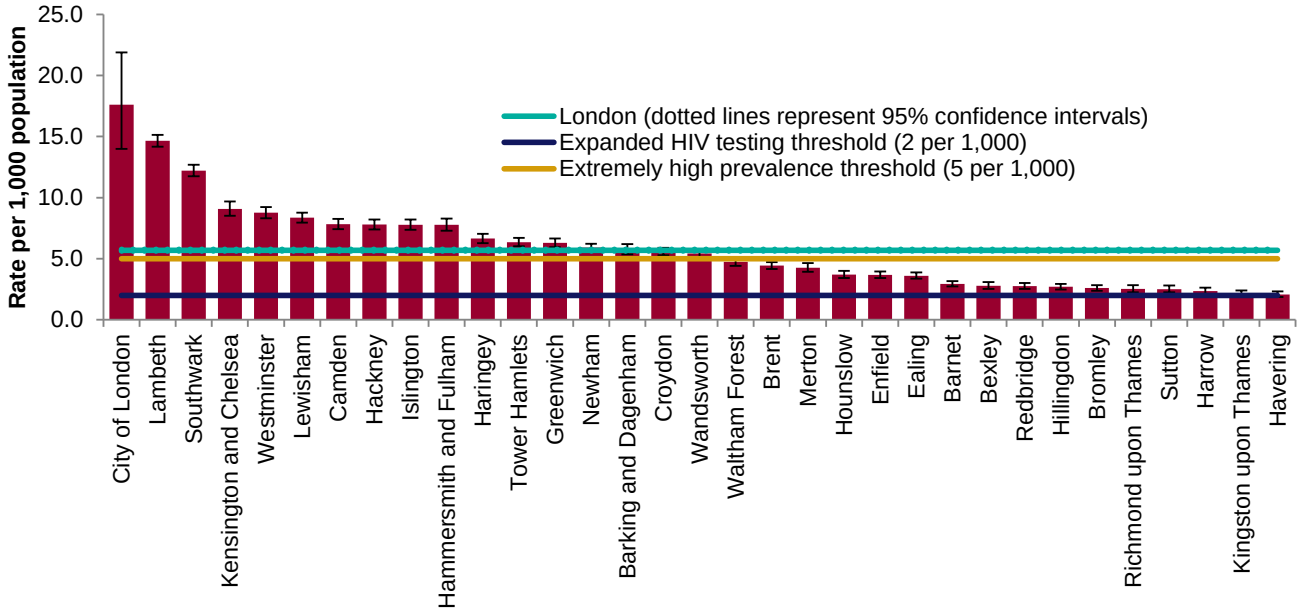
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 15: Diagnosed HIV prevalence per 1,000 residents by ethnic group aged 15-59 years, London, 2017



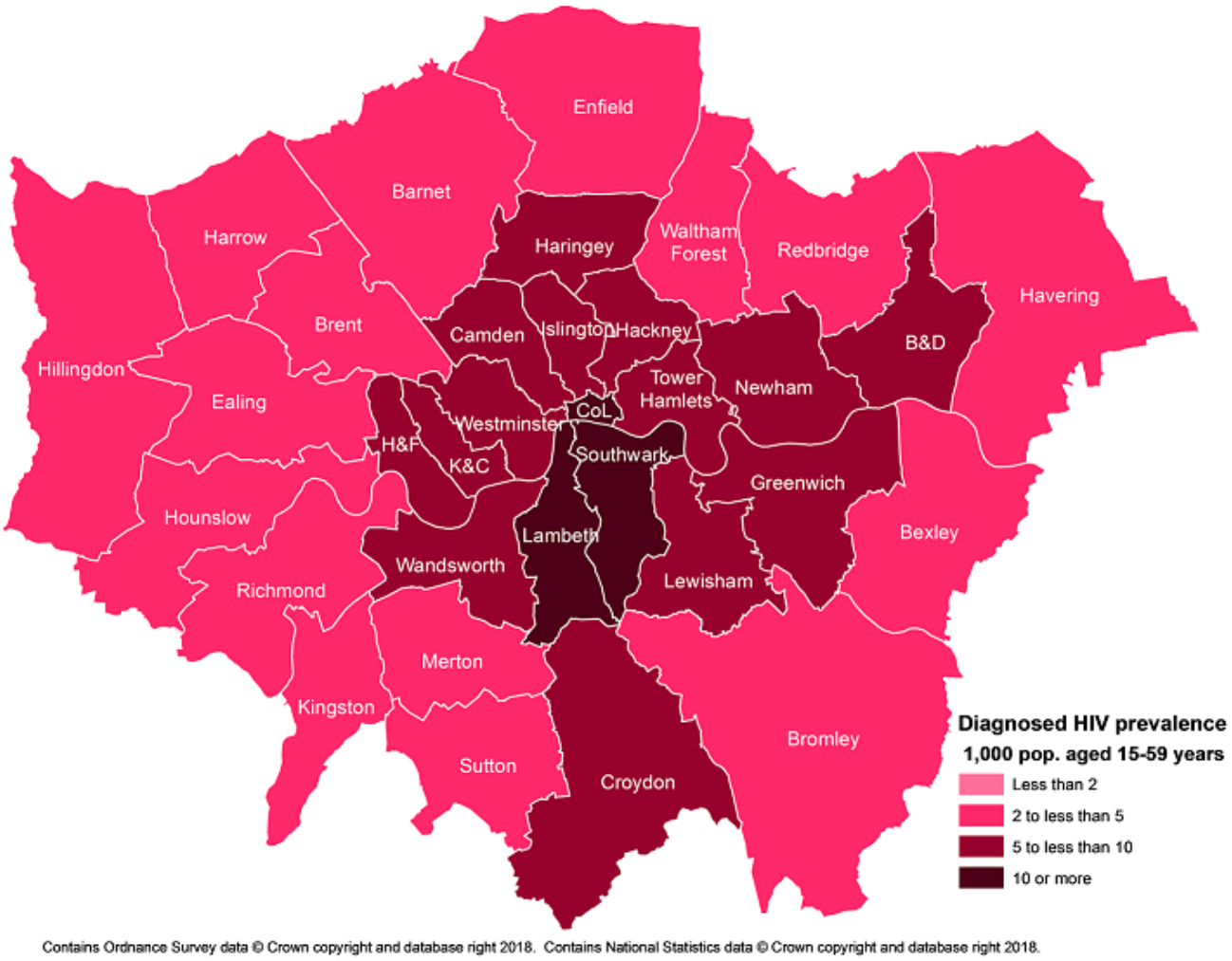
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 16: Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by local authority, London, 2017



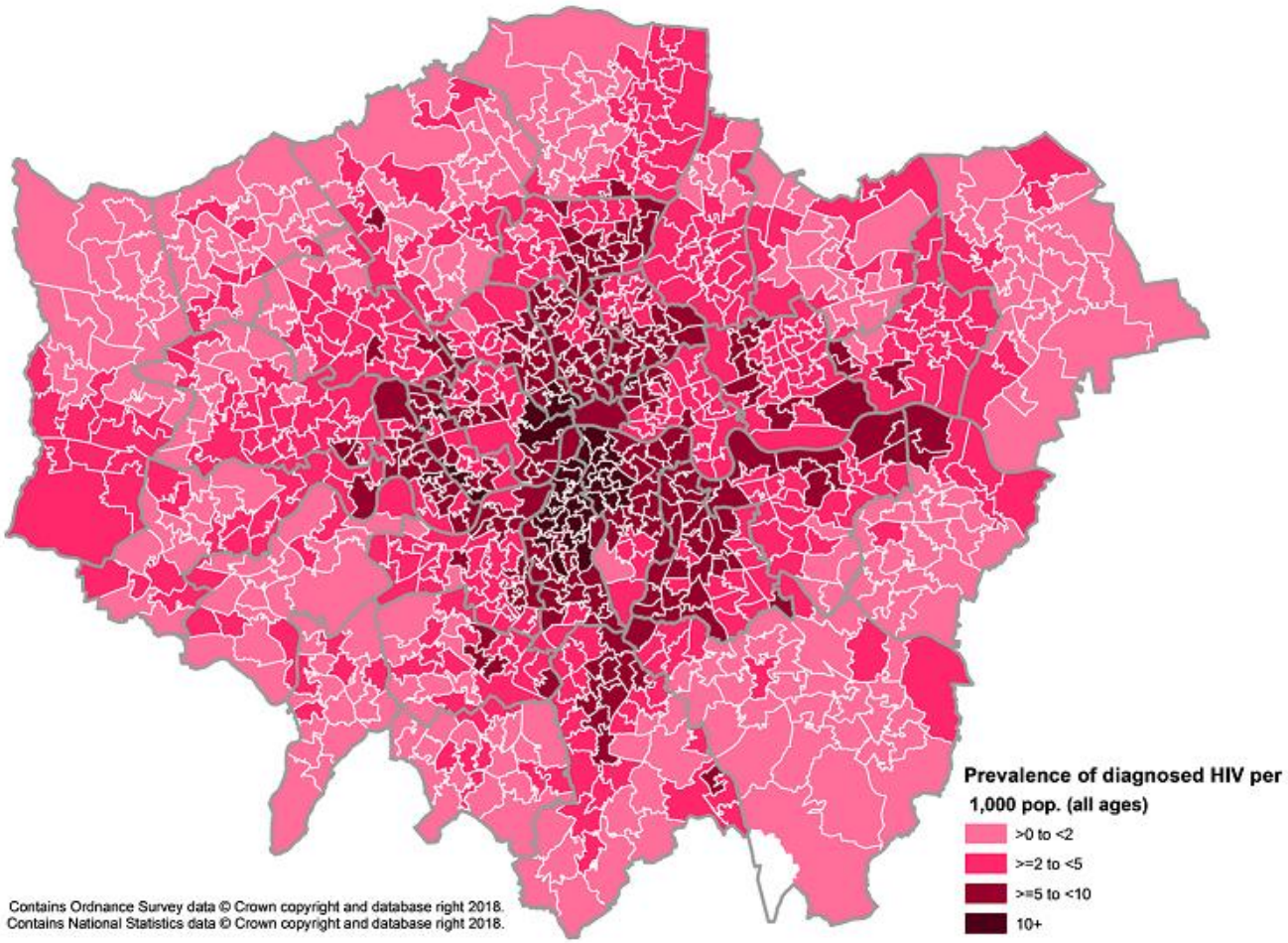
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 17: Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by local authority, London, 2017



Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 18: Diagnosed HIV prevalence per 1,000 residents (all ages) by middle super output area of residence, London, 2017



Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 19: The continuum of HIV care, London, 2017

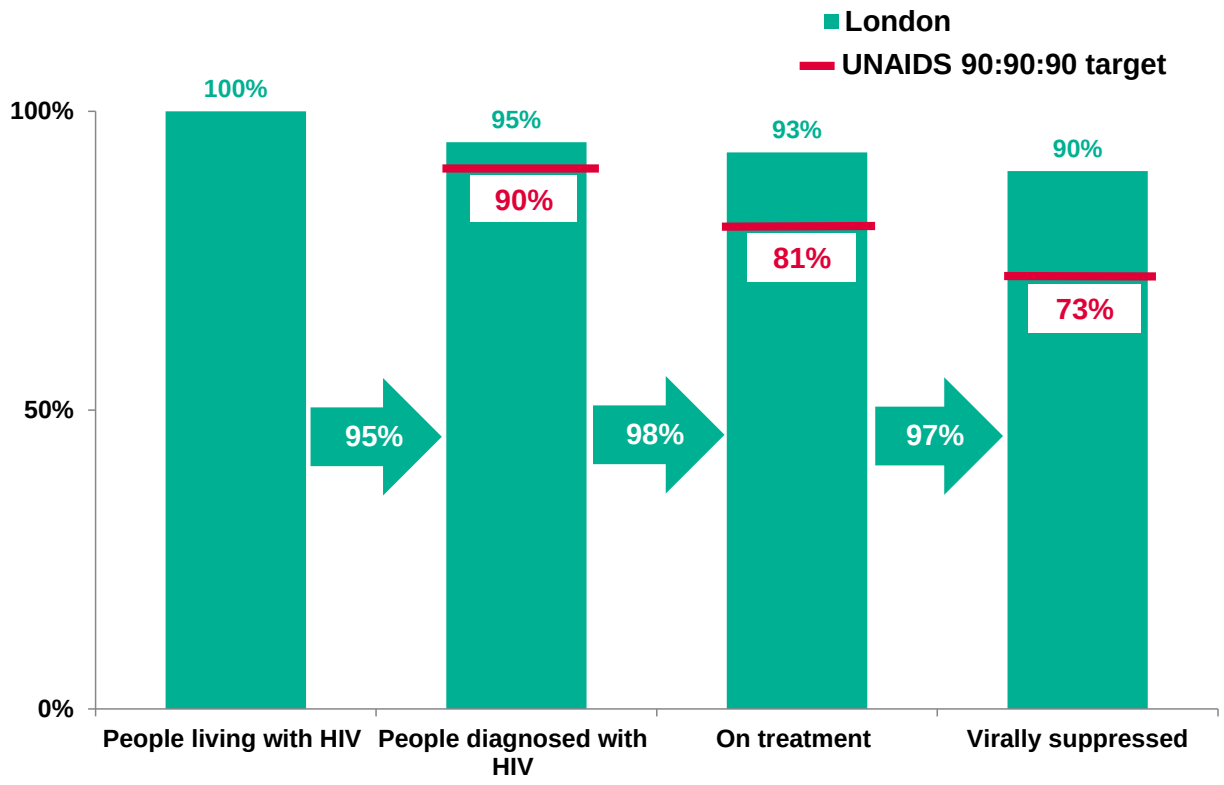


Table 1: Proportion of diagnosed HIV patients on ART and proportion of those on ART virally suppressed, by borough, 2017

	All		MSM		All heterosexuals	
Local Authority	Proportion on ART	Proportion virally suppressed (of those on ART)	Proportion on ART	Proportion virally suppressed (of those on ART)	Proportion on ART	Proportion virally suppressed (of those on ART)
Barking and Dagenham	98%	95%	95%	92%	98%	96%
Barnet	99%	98%	98%	99%	98%	98%
Bexley	99%	98%	99%	97%	99%	98%
Brent	98%	97%	98%	99%	98%	97%
Bromley	98%	98%	98%	99%	98%	97%
Camden	98%	97%	98%	98%	99%	95%
Croydon	98%	96%	99%	98%	98%	96%
Ealing	99%	97%	98%	98%	99%	97%
Enfield	98%	94%	98%	97%	98%	95%
Greenwich	98%	97%	98%	98%	98%	98%
Hackney and City of London	98%	96%	99%	97%	98%	95%
Hammersmith and Fulham	98%	98%	98%	99%	99%	97%
Haringey	97%	95%	98%	96%	97%	94%
Harrow	98%	96%	95%	97%	99%	98%
Havering	98%	94%	99%	99%	98%	95%
Hillingdon	97%	97%	97%	99%	97%	98%
Hounslow	99%	95%	100%	97%	99%	94%
Islington	98%	97%	99%	98%	97%	95%
Kensington and Chelsea	99%	98%	99%	98%	100%	97%
Kingston upon Thames	99%	98%	99%	98%	99%	98%
Lambeth	99%	97%	99%	98%	99%	97%
Lewisham	99%	97%	99%	98%	98%	96%
Merton	99%	96%	99%	98%	99%	97%
Newham	97%	94%	98%	96%	97%	94%
Redbridge	97%	96%	99%	98%	98%	95%
Richmond upon Thames	99%	98%	100%	99%	99%	98%
Southwark	99%	97%	99%	98%	99%	96%
Sutton	98%	98%	99%	98%	98%	98%
Tower Hamlets	96%	95%	98%	97%	94%	93%
Waltham Forest	96%	95%	96%	97%	97%	93%
Wandsworth	98%	97%	99%	98%	98%	96%
Westminster	98%	98%	99%	98%	98%	96%

3 Information on data sources

HIV & AIDS New Diagnoses and Deaths (HANDD) collects information on new HIV diagnoses, AIDS at diagnosis and deaths among people diagnosed with HIV. Information is received from laboratories, specialist SHSs, GPs and other services where HIV testing takes place in England, Wales and Northern Ireland. The Recent Infection Testing Algorithm (RITA) and CD4 surveillance scheme are linked to HANDD to assess trends in recent and late diagnoses. Data is deduplicated across regions and therefore figures may differ from country-specific data.

The Survey of Prevalent HIV Infections Diagnosed (SOPHID) began in 1995 and was a cross-sectional survey of all adults living with diagnosed HIV infection who attend for HIV care in England, Wales and Northern Ireland. SOPHID collected information about the individual's place of residence along with epidemiological data including clinical stage and antiretroviral therapy (ART). In 2015, SOPHID reporting in England was replaced by the HIV & AIDS Reporting System (HARS) which captures information at every attendance for HIV care.

Date of data extract: September 2018. Updates to HANDD and SOPHID/HARS made after this date will not be reflected in this report.

Confidence intervals for rates in the figures have been calculated to the 95% level using the Byar's method; confidence intervals for percentages have been calculated to the 95% level using the Wilson Score method (see www.apho.org.uk/resource/item.aspx?RID=48457). Confidence intervals presented in the text are produced by Bayesian analysis.

ONS mid-year estimates for 2017 were used as a denominator for rates for 2017.

The data behind charts showing absolute numbers has been adjusted for missing information; however, unless stated otherwise, the numbers in the summary section are the numbers as reported, ie unadjusted counts. Where charts are displaying adjusted data this is indicated in the chart title.

The denominators for all percentages exclude records for which information was unknown, ie the proportion of new diagnoses where probable route of infection was sex between men would be calculated using new diagnoses for which route of infection was known as the denominator.

With the exception of Figure 3, all analyses in this report are residence-based. Information about a patient's place of residence is not collected by HANDD. Reports to

this database are cross-linked to the database of people accessing care for HIV, HARS.

If a report could not be linked to a corresponding HARS report, the patient's PHEC of residence (but not their LA of residence) was imputed using the location of the centre at which they were diagnosed where sufficient information about the latter was available.

Imputation was not used to supplement the linkage process in the HIV Spotlight report produced in 2014. This means that the numbers in the new diagnosis section of the report for that year cannot be compared directly with the numbers in this report.

Numbers may change as more information becomes available to assign area of residence to cases and historical data is refreshed accordingly.

4 Further information

Please access the online ‘Sexual and Reproductive Health Profiles’ for further information on a whole range of sexual health indicators: fingertips.phe.org.uk/profile/sexualhealth

For more information on local sexual health data sources please access the PHE guide: www.gov.uk/government/uploads/system/uploads/attachment_data/file/576052/PHE_SH_data_guide_December_2016_FINALNB081216.pdf

For the annual epidemiological spotlight on STIs in London: 2017 data please access: www.gov.uk/government/publications/sexually-transmitted-infections-london-data

Local authorities have access to LA HIV, sexual and reproductive health epidemiology reports (LASERs) and other HIV and STI intelligence via the HIV and STI portal. They should contact: josh.forde@phe.gov.uk if they do not have access to this information.

5 About the PHE Field Service

The Field Service was established as a national service comprising geographically dispersed multi-disciplinary teams integrating Field Epidemiology, Real-time Syndromic Surveillance, Lead Public Health Microbiology and Food, Water and Environment Microbiology to strengthen our surveillance, intelligence and response functions. The Field Service also leads and coordinates the Global Health work of the National Infection Service (NIS) working with the Global Public Health Team and will lead and coordinate the national aspects of our port health functions.

You can contact your local FS team at: fes.seal@phe.gov.uk

If you have any comments or feedback regarding this report or the FS, please contact: josh.forde@phe.gov.uk

6 Acknowledgements

We would like to thank the following:

- Local sexual health and HIV clinics for supplying the HIV data
- Institute of Child Health
- PHE Centre for Infectious Disease Surveillance and Control (CIDSC) HIV and STI surveillance teams for collection, analysis and distribution of data