EXPERT ADVISORY GROUP ON AIDS

Providing expert scientific advice on HIV

ANNUAL REPORT 2010

Introduction

1. This report from the Expert Advisory Group on AIDS (EAGA) covers the period 1 January 2010 to 31 December 2010.

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".

EAGA Membership

3. 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 2010 is attached at **Annex A**.

4. There were no changes to membership during 2010.

EAGA Observers

5. 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

6. EAGA works to a code of practice based on the Government Office for Science's Code of Practice for Scientific Advisory Committees (December 2007[under revision]) 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. EAGA's code can be found at: http://www.dh.gov.uk/ab/EAGA/DH_095303. The register of members' interests is attached at **Annex B**.

Epidemiology of HIV/AIDS

7. 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/

8. The key findings from surveillance in 2009[1] were presented to EAGA at their 87th meeting, as follows:

   - The number of people living with HIV in the UK reached an estimated 86,500. A quarter of these people were unaware of their infection.
   - New diagnoses among men who have sex with men (MSM) remained high (2,760); four out of five probably acquired their infection in the UK.
   - Of the people newly diagnosed in 2009, 1,130 probably acquired their infection heterosexually within the UK, accounting for a third of heterosexuals diagnosed.
   - One in six MSM, and one in sixteen heterosexuals newly diagnosed with HIV had acquired their infection within the previous 4-5 months before diagnosis.
   - A total of 6,630 people were newly diagnosed as HIV-infected. This represents a fourth year-on-year decline, largely due to fewer diagnoses among people infected heterosexually abroad, mostly in Sub-Saharan Africa.
   - Some 65,000 individuals accessed HIV care, of whom one in five were aged 50 years or over. Since 2000 there has been a three-fold increase in the number of individuals accessing care and a four-fold increase among older (greater than 50 years) individuals.
   - Half of adults were diagnosed with HIV at a late stage of infection in 2009 (CD4 counts less than 350 per mm^3 within three months of diagnosis), the stage at which treatment is recommended to begin.
   - Thirty-seven English primary care trusts (PCTs) had a prevalence of diagnosed HIV greater than 2 per 1,000 population, the threshold at which expanded HIV testing should be implemented.
   - Uptake of HIV testing was 95% in antenatal clinics and 77% among STI clinic attendees in England.

[1] From *HIV in the United Kingdom: 2010 Report*. Available from: http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1287145264558

- The quality of HIV care received is high. Based on London data, 80% of newly diagnosed patients were seen in an HIV clinic within one month of diagnosis; 90% had an undetectable viral load (less than 50 copies/ml) one year after starting therapy; and 93% of those in care for more than a year had a CD4 count above 200 cells per mm^3.

Main items of business

9. EAGA met on three occasions during the period of this report - on 3 February 2010 (85th meeting), 2 June 2010 (86th meeting) and 13 October 2010 (87th 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. The annual Work Plan can be found at **Annex C**.

85th meeting, February 2010

- Non-occupational post-exposure prophylaxis (PEP): EAGA had been invited as a stakeholder to be represented on the Writing Group revising the British Association for Sexual Health and HIV (BASHH) guidelines for PEP following sexual exposure. An early draft of the revised guidance was reviewed at EAGA and members suggested a number of areas where it could be strengthened. It was important to ensure consistency with EAGA's occupational PEP guidelines on issues common to both e.g. starter regimens and duration of follow-up. EAGA considered the document again in February 2011 prior to launch of the public consultation.

- HIV and infant feeding guidance: EAGA had discussed the results of breastfeeding transmission risk reduction trials conducted in African settings. WHO now recommended provision of antiretroviral therapy to either the mother or the infant during the breastfeeding period to reduce the risk of post-natal HIV transmission[2]. The consequences of not breastfeeding in developing countries differed substantially from those in the UK with respect to infant morbidity and mortality. These differences had to be considered in devising guidance for the UK that would also ensure the current low rates of mother-to-child HIV transmission were maintained. There was insufficient evidence at this time to conclude that breastfeeding on antiretrovirals was as safe as infant milk formula (i.e. breastfeeding avoidance) for preventing HIV transmission. Thus, feeding by infant milk formula continued to be recommended.

  EAGA members provided detailed feedback on 'rapid advice' produced by the British HIV Association (BHIVA) and Children's HIV Association (CHIVA) taking account of the latest research evidence. Breastfeeding avoidance was still advocated for HIV-positive mothers in the UK as the best and safest option for feeding their infants. However, referral to a child protection team should no longer be automatically considered as an option if a woman on antiretroviral therapy with an undetectable viral load made an informed decision to exclusively breastfeed her infant. A position statement was published in November 2010[3]. This effectively replaced EAGA's 2004 guidance and would be incorporated into broader guidelines from BHIVA on the management of HIV in pregnancy.

[2] http://www.who.int/child_adolescent_health/documents/9789241599535/en/index.html
[3] http://www.bhiva.org/documents/Publications/InfantFeeding10.pdf

- HIV testing: Various aspects of HIV testing were addressed throughout 2010. The common thread running through these discussions was how to reduce the number of HIV infections remaining undiagnosed and/or being diagnosed late. In February, EAGA specifically discussed near-patient HIV testing technologies and their benefits for overcoming certain barriers to testing, such as anxiety about waiting for the result, needlephobia, unwanted pre-test discussion and failure to return for the result. Available tests used finger-stick blood or oral fluid, cost around £7-8 per unit and took between 60 seconds and 20 minutes to produce a result. Performance characteristics (sensitivity and specificity) were similar and all exceeded 99%.

  EAGA concluded that point-of-care tests (POCT) had the potential to reduce barriers to HIV testing and thereby increase uptake. However, they should not be used indiscriminately. The tests were best suited to screening populations at high risk of HIV infection, for whom the likelihood that a positive result was a true positive exceeded the likelihood that it was a false positive. Using two POCTs sequentially had successfully reduced the false positive rate. Evidence was still lacking to demonstrate that more people get diagnosed sooner as a result of POCT use. For individuals with a possible recent infection, a fourth-generation laboratory assay remained the best option to achieve an accurate diagnosis.

- Expansion of HIV testing: Considerable momentum had been generated by the publication, in 2008, of new UK National Guidelines for HIV Testing. This resulted in numerous pilot projects being undertaken across the country, including eight funded by the Department of Health (DH). The DH-funded projects were designed to assess the acceptability, feasibility and cost-effectiveness of implementing the national guidelines. Evaluation would also examine sustainability of the pilots and suitability for large-scale expansion. Their main focus was on testing in areas of the country where diagnosed HIV prevalence exceeded 2 cases per 1000 in the local population[4]. Preliminary results indicated that higher test volumes could be achieved for new registrants in general practice and general medical admissions than in community-based projects.

  EAGA was also updated on the HIV in Europe project, which was independently undertaking indicator disease-guided testing as an alternative strategy to reach those with undiagnosed HIV infection. Efforts to engage non-HIV specialists in testing and diagnosing HIV were continuing in parallel. A number of innovative strategies had been tried and evaluated. The results would inform future HIV testing policy.

- Remit and purpose: EAGA took a critical look at its remit and purpose and noted a number of strengths connected to its constitution and broad membership as well as possible weaknesses relating to its profile and sphere of influence. It provided a forum for in-depth discussion of topical and sometimes contentious issues and took a particular interest in HIV-related occupational health issues.

  Following the Arms Length Body review published by the Cabinet Office in October 2010, EAGA was informed that its status would change from an advisory

[4] This level was chosen as being equivalent to that identified in US studies as cost-effective to offer HIV testing universally.

non-departmental public body and be reconstituted as a Department of Health/Public Health Service Committee of Experts. There would be a continued need for high-quality expert advice on HIV on an ongoing basis.

- Testing incapacitated source patients for blood-borne viruses: Current law (Mental Capacity Act 2005) prohibits testing the infection status of an incapacitated patient solely for the benefit of a healthcare worker involved in the patient's care. This has important implications for providing PEP to workers following possible occupational exposure to HIV – if the source's status is unknown, the need for PEP is harder to assess.

  EAGA discussed audit evidence on the management of blood and body fluid exposures in an acute trust and in intensive care units. The audits identified a significant proportion of exposure incidents where the source patient lacked capacity to consent to serological testing. In view of the potential scale of the problem, EAGA encouraged the General Medical Council to develop practical guidance on the circumstances under which such testing might be ethically and legally acceptable.

- Evidence to assess behavioural interventions: Behaviour change is the mainstay of HIV prevention policy in the UK. Proving the link between a health promotion programme and a desirable health outcome is very difficult. Biomedical interventions such as male circumcision, microbicides, pre-exposure prophylaxis and HIV vaccines remain unproven or of little relevance in the UK context. Because of the complexity of behaviour change, few HIV prevention interventions have been tested in randomised controlled trials, and fewer still have demonstrated efficacy. Action research (an iterative process allowing multiple 'solutions' to be tested in parallel) was discussed as an alternative research method that might be more readily applied to HIV prevention.

86th meeting, June 2010

- Relationship between other sexually transmitted infections (STIs) and HIV transmission: EAGA reviewed the evidence on this topic and noted the following key points: (i) that the probable mechanism by which STIs increased susceptibility to HIV infection was by a general increase in genital tract inflammation and by making the genital tract more receptive to pathogens (e.g. ulcerative STIs increase susceptibility more than non-ulcerative ones); (ii) that treating STIs reduced the incidence of STIs but not HIV acquisition; (iii) that an HIV-positive person was more likely to transmit HIV if they had a concurrent STI; and (iv) that the presence of a concurrent STI appeared to have little effect on HIV progression or treatability of the STI. Using antiretroviral treatment to prevent HIV transmission appeared to be a better long-term strategy, when coupled with behaviour change and condom use, than large-scale prophylaxis against a range of bacterial and viral STIs.

  Patient-level data on STI diagnoses among genito-urinary medicine clinics attenders in England allowed the first estimates to be made of the proportion of HIV-positive patients with concurrent STI(s). Overall, 3.7% of HIV-positive patients were diagnosed within a year with an acute STI compared with 7.7% of HIV-negative or untested patients. The significance of this finding for onward HIV

transmission was uncertain; there may be a degree of sero-sorting, whereby HIV-positive patients are acquiring STIs without putting others at risk of HIV infection.

- Life expectancy in the HAART era: Encouraging data discussed by EAGA indicated that HIV-positive individuals were now expected to lead a near-normal lifespan (within 10 years of the uninfected matched population) if they had access to free healthcare, were diagnosed promptly after infection, began therapy at the optimal time and looked after their health.

87th meeting, October 2010

- Tripartite Working Group Report: The 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 focussed 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, and a comparison of international policies on restriction of HIV-infected HCWs. The TWG report was subsequently submitted to the Health Departments for consideration at the end of April 2011.

- NICE draft public health guidance on increasing the uptake of HIV testing among men who have sex with men and black Africans: EAGA welcomed the opportunity to comment on these documents which addressed testing strategies for the two population subgroups at highest risk of HIV infection in the UK. As a registered stakeholder, EAGA submitted formal responses to the consultations. Two reservations were highlighted concerning the impact of the guidance: firstly, major gaps in the evidence base relating to the influence of sexual behaviour had limited the scope of the guidance; and secondly, experience showed that recommendations made in previous NICE guidance in the sexual health field had not been implemented or monitored effectively, i.e. recommendations made in NICE technology appraisals are mandated by the NHS Constitution, but this does not extend to public health guidance.

- *Equity and Excellence: Liberating the NHS*: EAGA discussed the NHS White Paper and the potential threats and opportunities it presented for commissioning and provision of prevention, testing, diagnosis, treatment and support services for HIV.

- Exclusion of HIV-positive healthcare workers from working with patients with tuberculosis (TB): EAGA was asked to consider the validity of the occupational health practise of restricting HIV-positive HCWs from contact with TB patients. This was primarily to protect the workers from being infected with TB but there was also a risk of reactivation of latent TB disease and subsequent transmission to patients.

  Since this practise was last reviewed, antiretroviral treatments had improved significantly, restoring immune systems and keeping HIV-positive individuals in good health. Infection control measures generally had also improved. The scientific evidence showed that there was no excess risk of acquisition of TB by HIV-positive HCWs compared with other HCWs unless they were

immunosuppressed and that HIV-positive individuals with TB were no more infectious than those without HIV co-infection. EAGA advised that HIV-positive HCWs who were well on antiretroviral treatment (viral load undetectable and CD4 >500 cells/μl), who had been screened for TB by occupational health and taken chemoprophylaxis if indicated, no longer needed to be restricted from working with TB patients.

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

Consultations

EAGA submitted formal responses to the consultations listed below in 2010. Full details can be found on the website at: http://www.dh.gov.uk/ab/EAGA/DH_094975

- *January 2010*: Infectious Diseases in Pregnancy Screening Programme Standards. Link to EAGA's response
- *June 2010*: BHIVA/BASHH HIV transmission, the law and the work of the clinical team. Link to EAGA's response
- *November 2010*: NICE Public Health Intervention Guidance: Increasing the uptake of testing among men who have sex with men. Link to EAGA's response
- *November 2010*: NICE Public Health Intervention Guidance: Increasing the uptake of testing among black African communities living in England. Link to EAGA's response

In addition, EAGA provided informal input to consultations on:

- BHIVA consultation: Investigations in the newly diagnosed patient and routine monitoring
- SaBTO consultation: Guidance on the microbiological safety of human organs, tissues and cells used in transplantation

EAGA Subgroups

10. There were no subgroup meetings in 2010. EAGA members participated in the scientific subgroup of the Tripartite Working Group in June 2010 and the Tripartite Working Group in September 2010. EAGA was also formally represented on the BASHH Writing Group on guidelines for PEP following sexual exposure and a BHIVA/CHIVA Writing Group convened to provide updated advice on feeding for infants born to HIV-positive women.

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Prepared by EAGA Secretariat: April 2011

Annex A

MEMBERSHIP OF THE EXPERT ADVISORY GROUP ON AIDS IN 2010

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 July 2008
Members			
Dr Christopher Conlon	Consultant in Infectious Diseases, John Radcliffe Hospital, Oxford	Infectious disease	Appointed 14 February 2007
Mr David Crundwell	Communications Consultant	Lay member	Appointed 1 July 2005; re-appointed 1 July 2008
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 2008
Professor Geoffrey Garnett	Professor of Microparasite Epidemiology, Department of Infectious Disease Epidemiology, Imperial College, London	Epidemiology	Appointed 1 April 2006; re-appointed 1 July 2008
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 July 2008
Dr Jeremy Hawker	Regional Epidemiologist, Health Protection Agency	Public health	First appointed 1 March 2001; re-appointed 1 January 2007
Professor Clifford Leen	Consultant Physician, Regional Infection Unit, Western General Hospital, Edinburgh	Infectious disease	Appointed 14 February 2007

Annex A

MEMBERSHIP OF THE EXPERT ADVISORY GROUP ON AIDS IN 2010 (cont.)

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 2008
Dr Helen McIlveen	Clinical Manager Sexual Health and HIV for Newcastle and North Tyneside Community Health Services	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 January 2007. 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 2008
Dr Anton Pozniak	Consultant Physician in GUM/HIV, Chelsea & Westminster Hospital, London	HIV medicine	Appointed 1 July 2005; re-appointed 1 July 2008
Dr Keith Radcliffe	Consultant in HIV/GUM, Whittall Street Clinic, Birmingham	HIV/GUM	Appointed 14 February 2007
Dr Alison Rimmer	Consultant Occupational Physician, Sheffield Occupational Health Service, Northern General Hospital, Sheffield	Occupational medicine	First Appointed 1 March 2001; re-appointed 1 January 2007
Miss Susan Sellers	Consultant Obstetrician, St Michael's Hospital, Bristol	Perinatal HIV	Appointed 1 April 2006; re-appointed 1 July 2008
Dr Ewen Stewart	General Practitioner, Edinburgh	General practice	Appointed 1 July 2005; re-appointed 1 July 2008

Annex B

EXPERT ADVISORY GROUP ON AIDS (EAGA): REGISTER OF MEMBERS' INTERESTS 2010

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
Dr Matthew Donati		None	Bristol-Myers Squibb, Sanofi Pasteur MSD	Conference/Lecture fees		None
Ms Ceri Evans		None		None		None
Professor Geoffrey Garnett	GlaxoSmithKline, Merck, Sanofi Pasteur, Sanofi Pasteur MSD	Consultant	GlaxoSmithKline	Research grants		None
Dr John Green		None		None		None
Dr Jeremy Hawker		None		None	Health Protection Agency	Employee
Professor Clifford Leen	Boehringer Ingelheim, Bristol-Myers Squibb, Merck, ViiV, Tibotec	Consultant (ad hoc)	Bristol-Myers Squibb, ViiV, Tibotec Abbott, Gilead, Bristol-Myers Squibb MRC, Abbott, Pfizer, Janssen	Travel grants Lecture fees Research grants	BHIVA Executive Committee BHIVA Education and Scientific Sub-committee	Member Chair
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

EXPERT ADVISORY GROUP ON AIDS (EAGA): REGISTER OF MEMBERS' INTERESTS 2010 (cont.)

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
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
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 2010-11

Topics	Lead	Timescale
➢ Continuing work on reviewing policy on restricting practice of blood-borne virus infected healthcare workers and development of advice for consideration by the tripartite group	Joint work with UKAP and AGH. UKAP to lead	Scientific subgroup meeting June 2010. Tripartite Working Group meeting September 2010.
➢ Life expectancy in the HAART era	Valerie Delpech	June 2010
➢ Examination of relationship between other STIs and HIV transmission ➢ STIs among HIV-infected individuals and MSM in particular	Chris Conlon Alison Brown	June 2010
➢ Submit response to BHIVA/BASHH guidelines on HIV transmission, the law and the work of the clinical team, 2010	Brian Gazzard	June 2010
➢ Consider BHIVA consultation on 'Investigations in the newly diagnosed patient and routine monitoring'	Brian Gazzard	June 2010
➢ Contribute to the consultation on revised PEPSE guidance	Keith Radcliffe	February 2011
➢ HIV and infant feeding guidance: provide input to the BHIVA/CHIVA writing group	Sue Sellers, Beatrice Osoro, Brian Gazzard	July 2010
➢ Ongoing review of surveillance data (including novel ways to target HIV testing)	HPA	October 2010
➢ HIV testing policy: consideration of who, when and where to test in light of recent pilot projects	Brian Gazzard	October 2010
➢ Horizon scanning for emerging HIV issues	All	ongoing
➢ Contribute to NICE, BASHH, BHIVA consultations/reviews of guidance	As required	As required