HIVPA Bulletin | Autumn 2024

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Welcome to the Autumn bulletin!

Hello and welcome to the Autumn 2024 bulletin – this issue is packed with updates from the Darzi report, Mpox and a focus on health inequalities that people living with HIV face. Our spotlight series for this issue summarises UKHSA data, and we take a deep dive into an innovative project by a pharmacist who wanted to improve the information on HIV and sexual health in the South Asian community.

We would like to thank all those that have contributed and hope you enjoy the content. If you have any feedback or want us to include any of your amazing work in a future issue, please email: bhavna.halai@nhs.net

Dates for your diary

Click on the links to load the registration pages!

ID week – 16 - 19th October 2024, Los Angeles, USA – ID week

HIV Glasgow Congress – 10 - 13th November 2024, Glasgow – HIV Glasgow Congress

BHIVA Autumn Conference – 29th November 2024, London – BHIVA autumn conference

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Update: *Mpox – new variant*

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Mpox is a rare disease that is caused by infection with the monkeypox virus (MPXV). MPXV is related to but distinct from the viruses that cause smallpox and cowpox.

Spread of MPXV may occur when a person comes into close contact with lesions, body fluids (including during intimate sexual contact), or respiratory droplets from an animal or human with the infection; or from contact with material contaminated with the virus e.g. bedding. The virus enters the body through broken skin, the respiratory tract or the mucous membranes.

Sign and symptoms

The incubation period is 5 to 21 days, but typically 6 to 13 days following exposure. Most experience a mild, self-limiting illness, with spontaneous and complete recovery seen within 3 weeks of onset.

However, severe illness can occur and sometimes results in death. The risk of severe disease is higher in children, pregnant women and severely immunosuppressed individuals.

Common symptoms of mpox are a skin rash or mucosal lesions which can last 2–4 weeks accompanied by fever, headache, muscle aches, back pain, low energy and swollen lymph nodes.

Variants

There are two genetic groups of MPXV: Clade I (previously known as Central African or Congo basin Clade) and Clade II (previously known as West African Clade). These clades subdivide into multiple lineages.

Clade I is associated with more severe disease in humans and a reported case fatality rate of up to 10%. By contrast, Clade II is associated with milder disease, with a case fatality rate of 3-4%.

While Clade I MPXV has historically only been reported in a few countries in Central Africa, during 2024 cases were also reported from several countries surrounding DRC including: Republic of Congo, Central African Republic, Burundi, Rwanda, Uganda, Kenya, Cameroon and Gabon. In August 2024, the Africa Centre for Disease Control (CDC) declared a Public Health Emergency of Continental Security and WHO declared a Public Health Emergency of International Concern in view of the upsurge of cases in the DRC and neighbouring countries and the emergence of the new strain (Clade Ib). By August 2024, single cases of Clade Ib mpox had also been reported in Sweden and in Thailand after acquisition in an affected country in Africa.

What about the UK?

To date, there have been **no confirmed MPXV Clade I cases in the UK (19th September 2024)**; Clade II was implicated in the 2022 outbreak in the UK.

MPXV is included in the national list of High Consequence Infectious Diseases (HCID) in the UK. Following the 2022 MPXV Clade IIb outbreak, mainly affecting gay, bisexual and other men who have sex with men (GBMSM), the Advisory Committee on Dangerous Pathogens (ACDP) recommended that all of Clade II MPVX should no longer be classified as HCID; but all of Clade I should remain an HCID.

Update: *Mpox – new variant*

Joint statement from the British HIV Association (BHIVA) and the British Association for Sexual Health and HIV (BASHH) regarding the emergence of new mpox variant with links to UK Health Security Agency (UKHSA) guidance can be found here.

Management

Patients with confirmed or clinically suspected mpox but clade not yet known should be managed as a HCID mpox case whilst further information is pending, if either (or both):

- there is a travel history to the Democratic Republic of the Congo (DRC) or specified countries where there may be a risk of Clade I exposure, or a link to a suspected case from those countries (listed below), within 21 days of symptom onset

Or:

- there is an epidemiological link to a case of Clade I mpox within 21 days of symptom onset

Vaccination

In 2022, the Medicines and Healthcare Regulatory Agency (MHRA) approved the use of modified vaccinia Ankira (MVA-BN) (Imvanex®) for active immunisation against mpox. Imvanex® contains a replication-defective virus, therefore is considered as an inactivated vaccine. Vaccine effectiveness was estimated to be between 74% to 78% (one dose) and 82% to 83% (two doses) respectively across a few studies.

In one review, vaccine effectiveness estimates in immunocompromised individuals, people living with HIV or taking PrEP for prevention of HIV transmission were similar to overall vaccine estimates, although with wide confidence intervals.

There is also evidence that pre-exposure vaccination may modify disease and thus reduce more severe presentations. Vaccine effectiveness against hospitalisation was estimated to be 67% in a meta-analysis of any dose of MVA-BN

Recommended schedule for pre-exposure vaccination of individuals not vaccinated against smallpox:

Immunocompetent (includes PLHIV who are virally suppressed and CD4 count >200 cells/mm^3)

- 1st dose: 0.5mL SC/IM injection
- 2nd dose: 0.5mL SC/IM injection any time from 28 days
- Can have 0.1mL intradermal injection during supply constraints.

Immunosuppressed (includes people living with HIV with persistent viraemia or CD4 count <200 cells/mm^3)

- 1st dose: 0.5mL SC/IM injection only
- 2nd dose: 0.5mL SC/IM injection only; at any time from 28 days

More information on pre- and post-exposure vaccination, dosage, schedule and storage can be found under the Green Book, Chapter 29.

Spotlight Series: UKHSA data

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In October 2023, UKHSA published its annual report relating to the HIV statistics across the UK. This annual report shines a light on the areas in which the UK has improved with regards to HIV care and prevention, but also exposes areas in which care needs are not being met. Earlier in the year, we saw the HIV Action Plan published as a roadmap to helping tackle the issues unearthed from the data below and commit to reducing HIV infection by 2025.

HIV testing

HIV testing is crucial to prevention, a negative result can prompt access to PrEP and safe sex advice, whilst a positive test can lead to initiation of effective treatment.

2022 saw the number of people having a HIV test in sexual health services rise by 10% to a total of 1,155,551 – however this is still 16% lower in comparison to 2019, prior to the pandemic. Half of all HIV tests undertaken in 2022 were via test kits ordered online.
HIV test uptake was highest among eligible GBMSM (74% tested, 23% not offered a test, 3% declined a test) and lowest amongst eligible heterosexual and bisexual women (38% tested, 40% not offered a test, 22% declined a test).

HIV diagnoses

The number of HIV diagnoses in England rose by 22% to 3,802 in 2022. Approximately a third of these (1,361) were previously diagnosed outside of the UK, with the majority already established on ART and undetectable when coming to the UK.
Within England new first-diagnoses increased by 6%, however when looking at specific sub groups first diagnoses in GBMSM fell by 8% (with 3% drop in London and 10% decline amongst GBMSM living outside of London).
In regards to sub-ethnic groups, there was a steep fall of 17% (508 to 420) in the number of first diagnoses in men of white ethnicity between 2021 and 2022, however a 17% rise was seen in men of Asian and mixed or other ethnicities.
Amongst the heterosexual men and women in London, first diagnoses rates rose by 14% and 11% outside of the capital. The rise in rates were 31% in women living outside London who were exposed through sex with men. Given that 77% of these women were born abroad and 31% arrived in England in 2022 (where this information was provided), there is a suggestion that most transmissions were likely to have been abroad versus previous years.

Late and very late diagnosis

The report highlights that 44% of new diagnoses in England were late in accordance with a CD4 count of <350cells/mm3 – however this is based on only 865 people diagnoses who had not previously been diagnosed in another country.

Want to read more?
Scan the QR code below to load the UKHSA report

Lord Darzi's report: The state of the NHS

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In July 2024, the Secretary of State for Health and Social Care commissioned Lord Darzi to conduct an immediate and independent investigation of the NHS. The report provides an expert understanding of the current performance of the NHS across England and the challenges facing the healthcare system.

Lord Ara Darzi
Baron Darzi of Denham

Introduction

- Public satisfaction with the NHS is now at its lowest ever
- Social determinants of health, e.g. poor-quality housing, low income, insecure employment have moved in the wrong direction over the past 15 years, leading to rising demand for healthcare
- Surge in multiple long-term conditions, e.g. mental health in children and young adults, immunisations and key screening programmes
- The public health grant has been slashed by more than 25% in real terms since 2015

Performance

- There has been a surge in waiting list times to access GPs, community and mental health services, A&E, routine surgery and cancer and cardiac services
  - Apr 2024: ~1 million people waiting for mental health services
  - May 2024: 60% people attending A&E were seen within 4 hours (vs. 94% in 2010); nearly 10% of all patients waiting 12 hours or more
  - June 2024: More than 300,000 people waited for over a year for hospital procedures
- NHS budget is not being spent where it should be – too great a share is being spent in hospitals, too little in the community, and productivity is too low. 13% of NHS beds are occupied by people waiting for social care support

Want to read more?
Scan the QR code below to load the Lord Darzi report

Lord Darzi's report: The state of the NHS

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The response to independent report *from Lord Ara Darzi on the state of the NHS* ***from the British HIV Association (BHIVA) can be found here***

Drivers of Performance

- Austerity: until 2018, spending grew at around 1% per year in real terms, against a long-term average of 3.4%
- Capital: the NHS has been starved of capital with a backlog maintenance bill standing at more than £11.6 billion; £4.3 billion raided from capital budgets in 2014/15 and 2018/19 to cover deficits
- The pandemic: a bigger backlog than other health systems as an impact of the Covid-19 pandemic
- Staff disengagement post-pandemic and distressingly high levels of sickness absence
- Management structures and systems: reformation of the NHS management line into an integrated care system; costly and distracting process of constant reorganisation of the 'headquarters' and 'regulatory' functions of the NHS

Conclusion

- The NHS is in critical condition, but its vital signs are strong
- Some of the major themes that have emerged for how to repair the NHS:
  - Re-engage staff and re-empower patients
  - Lock in the shift of care closer to home by hardwiring financial flows – GP, mental health and community services expansion to adapt to the needs of local population
  - Simplify and innovate care delivery for a neighbourhood NHS – embrace new multidisciplinary models of care
  - Drive productivity in hospitals – fixing flow through better operational management, capital investment in modern buildings and equipment
  - Tilt towards technology to unlock productivity
  - Reform to make the structure deliver – clarify roles and accountabilities, ensure the right balance of management resources in different parts of the structure

Want to read more?
Scan the QR code below to load the Lord Darzi report

Spotlight Series: Hasan Mirza – creator of Desi POV

Hasan Mirza
Advanced Practitioner / Lead Pharmacist GUM & 56 Dean St

Today's spotlight series is focusing on Hasan Mirza! Hasan has been working as a HIV and sexual health pharmacist since 2016. He leads on GUM at Chelsea and Westminster Hospital NHS Trust, home to one the busiest sexual health services in the UK. As an Advanced Pharmacist Practitioner, he provides holistic care to people living with HIV. Hasan also provides expertise nationally through his roles as BASHH Trustee and member of the BHIVA conference subcommittee.

Tell us about your career journey

I started off in HIV/GUM in Brighton, before moving to Chelsea & Westminster in 2017. Little did I know at the time, it was the biggest HIV centre in the UK! Working here with amazing colleagues has brought so many great opportunities. Dean Street is a centre for innovation and I've been honoured to be part of the team. From 2022, I undertook more of a practitioner role which has been very rewarding and feels like the direction of travel for the HIV Pharmacist workforce.

Desi POV is a digital campaign which aims to improve knowledge and awareness of HIV as well as key sexual health topics, amongst the South Asian community. We achieved this through creation of videos in English and commonly spoken SA languages.

How did the Desi POV project start?

It started very organically, through the shared experience of myself and two other South Asian (SA) doctor colleagues. We recognised the lack of campaigns serving our community, so put our heads together and got in a grant application for the project.
The key to the project's success was the collaboration we had with primary care and a digital marketing team. I thought I was social media savvy, but the marketing team were able to engage with our audience so much better than we would know how to! We also utilised a SA video animator who did a great job with the content.

Spotlight Series: Hasan Mirza – creator of Desi POV

What challenges have you experienced with the project and how were they overcome?

It was hard not being able to get together due to COVID restrictions. That definitely slowed the project down. Then there was the Mpox outbreak which meant many team members had no spare time. The other difficulty was bringing together people from different sectors and disciplines, as we're all working to different schedules. We mostly met on Teams but had a few in person meetings which definitely helped maintain morale.

How has the Desi community responded to the project?

The feedback has really exceeded our expectations. There was a sense that a campaign like this was really needed, and I think as a community it helps us feel seen and our needs recognised. We really wanted to tackle some of those topics typically considered taboo within the community (such as gender, sexuality and consent), so to create videos about these topics in SA languages felt quite ground-breaking.

Do you foresee any pharmacist specific roles in the Desi POV?

The campaign is winding down but it would be great if pharmacists could promote this resource within their workplace. I've had some conversations with pharmacists who want to create similar content for other underserved populations. As pharmacists we often get put into a box and are only approached about medication-related things, but we have the relevant skills and experience to do so much more.

Its undeniable that this has been a huge project, what advice would you give to others wanting to undertake such expansive projects?

You need funding and time! We do so much in the NHS and then take on additional projects which have to fit in around our day job, so often end up being done outside of work. We are fortunate in HIV/sexual health in that we have access to different funding streams, so definitely utilise these to ensure your project is well supported.

How can other HIV and sexual health teams get the most from the Desi POV?

Share our work with patients and colleagues! Send patients the link to our YouTube channel via SMS so they can watch in their own time. The biggest value of our videos is that topics are explained in a culturally sensitive manner. For non-English speakers, things can get lost in translation, even when using an interpreter. We know that these nuances are vital when navigating sensitive subjects, so getting the translation right was a priority for us.

Want to find out more? Check out the icons below for the Desi POV YouTube channel and Instagram page!