HIV POLICY IN SCOTLAND:

A stocktake of relevant policy and law

EDITION 1: MARCH 2014
ABOUT THIS DOCUMENT

This stocktake aims to provide researchers, policy makers and stakeholders with an overview of HIV related policy in Scotland. It is accurate as at March 2014 and is intended as a reference guide, providing a situation report for legislation, guidelines and national policy documents on issues of key relevance to HIV. It also highlights a number of areas where no national policy exists or where it is unclear if a UK-level policy is adopted in Scotland.

This document may be particularly useful to those new to HIV policy or those unclear on specific areas of policy in Scotland. However, this stocktake should not be used as advice. It aims to provide information for initial reference only.

This document will be updated over time to reflect new developments. References to relevant policies, reports and legislation are provided throughout, with a comprehensive list of references also provided in the bibliography.
ABOUT HIV SCOTLAND

This report was produced by HIV Scotland. HIV Scotland is the national HIV policy charity for Scotland: we speak out for people living with HIV. We want a society which is well-informed about HIV and devoid of HIV-related stigma and discrimination.

HIV Scotland provides:

- Knowledge and expertise to help inform and deliver strong policies and effective strategies;
- Expert advice and a voice for HIV in Scotland;
- Information, training and resources;
- Signposting to evidence, expertise and community experience; and
- Opportunities to engage with others in shaping policy and practice.

**OUR VISION** is a society which is well informed about HIV, devoid of HIV related stigma and discrimination, and where everyone living with or affected by HIV has access to and helps shape excellent services.

**OUR MISSION** is to ensure that all HIV relevant policy and practice in Scotland is grounded in evidence and in the experience of people living with and affected by HIV.
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HIV is a major public health challenge for Scotland. Since 2001, the number of people currently living with HIV in Scotland who have been diagnosed has doubled, reaching an estimated 4,509 people as at September 2013. This figure takes into account those who have migrated to and from Scotland, those known to have died, and those deemed to have been ‘lost to follow up’ by services. It is also estimated that approximately 25% of people living with HIV in Scotland are yet undiagnosed. Combined, these figures suggest there are currently 5,591 people living with HIV in Scotland.

In 2012, there were 349 new HIV diagnoses in Scotland. The most common route of transmission in that year was sexual intercourse, including 146 new diagnoses from heterosexual intercourse and 171 between men who have sex with men (MSM). After averaging 160 new reports per year from 1988 to 2001, annual HIV reports showed a sustained increase from 2002 onwards, peaking at 441 in 2007. From 2010 to 2013, Health Protection Scotland recorded an average of 357 per annum. While transmissions between men who have sex with men appear to have levelled out in recent years, heterosexual transmissions have steadily fallen, from 220 in 2007 to 146 in 2012. During the 10 year period from 2003 to 2012, 61% of newly reported cases are presumed to have been exposed outwith Scotland. During the same period, transmissions between men who have sex with men accounted for 70% of diagnosed infections presumed to have occurred in Scotland.

Approximately 86% of people who have been diagnosed are accessing specialist healthcare, and 88% of those are on treatment. Since data reporting began, a cumulative total of 7,470 people have been diagnosed with HIV in Scotland, of whom 5,422 (73%) are male and 2,048 (27%) are female. At least 1,854 (25%) of the cumulative total are known to have died.

An estimated 38% of those diagnosed with HIV and living in Scotland are aged 50 or above (as of 30 September 2013). It is also estimated that there are currently 50 children living with HIV. The HIV Action Plan in Scotland identifies men who have sex with men and “persons originating from high prevalence, particularly African countries” as key populations in Scotland in relation to HIV.

The following NHS board areas have the highest prevalence of people diagnosed with HIV: NHS Lothian, NHS Greater Glasgow and Clyde, NHS Tayside and NHS Grampian.
HEALTH AND SOCIAL CARE: OVERARCHING POLICY AND STANDARDS

The health and social care landscape in Scotland is changing. The Scottish Government has stated it intends to reform public services to improve care and make better use of resources, and a broad range of policies have been created to drive up the quality of health and social care Scotland. There is also increasing emphasis on ensuring that all stakeholders (including the NHS, local authorities and third sector) work together with patients, carers and the public towards the shared goal of ‘world-leading healthcare’.

National Strategic Objectives, Outcomes and Indicators

As part of the 2007 Spending Review\(^1\), the Scottish Government introduced a new outcomes-based National Performance Framework (NPF)\(^1\) to underpin the delivery of its agenda. The NPF contains five levels:

> **Purpose**: setting out the direction and ambition for Scotland;

> **Purpose targets**: 11 high level targets that show progress towards the purpose;

> **Strategic objectives**: five objectives describing where action will be focused;

> **National outcomes**: 16 outcomes describing what the Scottish Government wishes to achieve over the years to 2017; and

> **National indicators**: 50 indicators for the Government to track its progress towards the purpose and national outcomes.

One of the five strategic objectives is to ‘create a Scotland that is healthier by helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care’. There is also a national outcome focusing on ensuring people in Scotland “live longer, healthier lives”, and a number of the national indicators relate specifically to health and social care. These include:

> Improve self-assessed general health;

> Improve support for people with care needs; and

> Improve the quality of healthcare experience.

Scottish Government Health and Social Care Directorate

The Scottish Government Health and Social Care Directorate is responsible for delivering the Healthier strategic objective, which aims to help people to sustain and improve their health and access to health care. The Directorate also allocates resources, sets the strategic direction for NHS Scotland and is responsible for the development and implementation of health and social care policy in Scotland.
2020 Vision for Health and Social Care

The Scottish Government set out its strategic vision for achieving quality in the delivery of healthcare services across Scotland in the 2020 Vision for Health and Social Care, published in 2011.15

This vision is that by 2020 everyone in Scotland will be able to live longer healthier lives at home or in a homely setting, and that Scotland will have a healthcare system where:

> health and social care are integrated;
> there is a focus on prevention, anticipation and supported self-management;
> if hospital treatment is required and cannot be provided in a community setting, day case treatment will be the norm;
> whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions; and
> there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

NHS Scotland Quality Strategy

The Quality Strategy is the approach and shared focus for all work led by the Scottish Government to realise the 2020 Vision.16 The Quality Strategy aims to deliver the highest quality healthcare to the people of Scotland and ensure that the NHS, local authorities and the third sector work together - and with patients, carers and the public - towards a shared goal of world-leading healthcare.

A route map has been designed to retain focus on improving quality and make measureable progress toward the 2020 Vision of quality, sustainable health and social care services.17 It describes 12 priority areas, across three domains:

- Quality of care;
- Health of the population; and
- Value and financial sustainability.

HIV is not specifically mentioned in the 2020 Vision, but priority areas in the route map do directly relate to HIV, such as: care for multiple and chronic illnesses; person-centred care, and health inequalities. The map also lists ‘prevention’ as a key area, although deliverables focus on early detection of cancer and restrictions on tobacco advertising.

In addition to the 12 priority areas for action, the 2020 Vision emphasises that the underpinning foundations of high quality health and care services must be maintained, including: performance (e.g. HEAT), governance, planning (services, workforce, finances and estate), IT and measurement.

Quality Ambitions

Three Quality Ambitions are set out within the Quality Strategy to provide focus for all activity.18 All healthcare policy in Scotland is being aligned to support the delivery of these ambitions.

Based on the Institute of Medicine’s six dimensions of quality (person-centred, safe, effective, efficient, equitable and timely), the ambitions are:

> Safe: There will be no avoidable injury or harm to people from healthcare, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.
> Person-centred: Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making.

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17 Scottish Government, Route Map to the 2020 Vision for Health and Social Care, 2013
19 Institute of Medicine, To Err is Human: Building a Safer Health System, 1999; and Institute of Medicine, Crossing the Quality Chasm: A New Health system for the 21st Century, 2001
Effective: The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

NHS Scotland
NHS Scotland consists of 14 regional NHS boards which are responsible for the protection and the improvement of their population’s health and for the delivery of healthcare services. These 14 health boards are:

> NHS Ayrshire and Arran
> NHS Borders
> NHS Dumfries and Galloway
> NHS Fife
> NHS Forth Valley
> NHS Grampian
> NHS Greater Glasgow and Clyde
> NHS Highland
> NHS Lanarkshire
> NHS Lothian
> NHS Orkney
> NHS Shetland
> NHS Tayside
> NHS Western Isles / Eileanan Siar

There are also seven special NHS boards, which support the regional boards by providing a range of specialist national services:

NHS Education for Scotland: Develops and delivers education and training for people who work in NHS Scotland.

NHS Health Scotland: Promotes ways to improve the health of the population and reduce health inequalities.


NHS24 / NHS Inform: Provides people across Scotland with access to health care information and advice online or over the phone.

Scottish Ambulance Service: Responds to almost 600,000 accident and emergency calls and takes 1.6 million patients to and from hospital each year.

The State Hospitals Board: Provides assessment, treatment and care in conditions of special security for people with a mental disorder.

NHS National Services Scotland: Supplies essential services including health protection, blood transfusion and information. It consists of the following five departments:

> Health Facilities Scotland: Provides NHS Scotland with technical guidance, support and advice on healthcare estates and facilities.

> Health Protection Scotland: Established in 2005 to strengthen and co-ordinate health protection in Scotland. They are organised into specialist groups: Healthcare Associated Infections and Infection Control; Blood Borne Viruses and Sexually Transmitted Infections, Immunisation, and Respiratory and Vaccine Preventable Diseases, and; Gastrointestinal and Zoonoses, Travel, and Environment and Health.

> Information Services Division: Produces information, analysis, and official statistics. Their products and services are used for a wide range of purposes, from monitoring waiting times to supporting patient safety initiatives.

> National Services Division: Commissions and manages national screening programmes and specialist clinical services on behalf of NHS Scotland.

> Scottish National Blood Transfusion Service: provides transfusion medicine in Scotland, supplying blood, tissues, products and services across the country. With transfusion centres in Inverness, Aberdeen, Dundee,
Edinburgh and Glasgow, the service works with communities, hospitals and professionals to ensure that the donor’s blood is used wisely and effectively for the benefit of patients.

NHS Scotland also includes the public health body:

**Healthcare Improvement Scotland:** formed on 1st April 2011 and subsumed the responsibilities of NHS Quality Improvement Scotland (QIS) to provide public assurance about the quality and safety of healthcare.

**HEAT targets and standards**

NHS performance is monitored against the four pillars of HEAT, standing for Health improvement, Efficiency, Access to services and Treatment. HEAT is a performance management system for the NHS in Scotland that includes specific, short to medium term targets supporting achievement of national outcomes across a range of health areas. NHS boards are accountable to the Scottish Government for achieving HEAT targets. They are reviewed annually and progress is published each November.20

There are currently no HEAT targets for sexual health or HIV.

**Patient Rights (Scotland) Act 2011**

The Patient Rights (Scotland) Act 2011 was passed by the Scottish Parliament in February 2011 and gained royal assent in March 2011. The Act aims to improve patients’ experiences of using health services and to support people to become more involved in their health and healthcare. The Schedule to the Act includes sections on patient focus; quality care and treatment; patient participation; communication; patient feedback; and waste of resources.

The Act also made provision for the introduction of a Charter of Patient Rights and Responsibilities which brings together, in one place in the Act, a summary of the rights and responsibilities that patients have when using NHS services.

**Public Health etc (Scotland) Act 2008**

The Public Health etc. (Scotland) Act 2008 provides a statutory framework for public health action to protect the people of Scotland from infectious disease, contamination and other such hazards.

It sets out the powers and responsibilities of individuals, public health professionals and organisations in relation to public health threats, including powers to quarantine an individual, to detain an individual in a hospital and to require a medical examination (from which the most appropriate course of action can be chosen to deal with a particular situation). The Act seeks to maintain and respect an appropriate balance between the goal of protecting public health in Scotland and the liberty and rights of individuals.

The Scottish Government produced guidance materials to support the implementation of the Act in 2011.21

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Social care

Social work legislation sets out the duties, responsibilities and powers of local authorities to promote social welfare and meet the social care needs of individuals and communities in Scotland. It also provides a framework of standards for the regulation of services and dictates what services must (or may) be put in place.

The Social Work (Scotland) Act 1968 is the primary piece of legislation regarding the social work functions of local authorities. The Act gives every local authority the duty to “promote social welfare” by making available advice and assistance and providing or securing facilities for people who are in need.

Social care services are also developed and commissioned in Scotland within the wider national drive for improved outcomes and the Government’s strategic objectives. The third sector and private sector are recognised as providing significant levels of care and support and as crucial partners with statutory services. Policy also dictates that commissioning strategies, social care procurement, and service provision must all take account of key national policies for social care.

21st Century Social Work Review

In 2004, Scottish ministers initiated a review of social work in light of an increasing demand for services as well as repeated messages arising from case reviews. The national review resulted in the Changing Lives report, published in 2006. This set out a vision for the future direction of social work services in Scotland, with more personalised and sustainable services. Scottish ministers accepted the 13 recommendations made in the report.

National Care Standards

Scottish ministers have developed National Care Standards to ensure everyone in Scotland receives the same high quality of social care. The standards explain what people can expect from any social care and support service, written from the point of view of the person using the service. There are six main principles behind the standards: dignity; privacy; choice; safety; realising potential; and equality and diversity.

Community Care Outcomes Framework

The Community Care Outcomes Framework was published in 2008. It includes four national outcomes and 16 performance measures. The four national outcomes are: improved health; improved wellbeing; improved social inclusion; improved independence and responsibility. The 16 performance measures cover people’s satisfaction with services, waiting times, quality of assessment, shifting the balance of care, carers’ well-being, unscheduled care and identifying ‘people at risk’.

Self-directed support

Self-directed support gives people control over an individual budget and allows them to choose how it is spent to...
meet their agreed health and social care outcomes. It is most commonly used in the delivery of social care and support but it can cover a much wider range of services.

In November 2010, the Scottish Government published a 10-year strategy to grow self-directed support and in February 2012 it introduced a Bill on self-directed support into the Scottish Parliament\textsuperscript{26}. The Bill was passed in November 2012 and received royal assent soon after, becoming the \textit{Social Care (Self-directed Support) (Scotland) Act 2013}. Together, the Act and strategy aim to deliver a vision for social care where support is based around the person, not the service.

\textsuperscript{26} Scottish Government, Self-directed support: A National Strategy for Scotland, 2010
Community planning

Community planning is the process by which councils and other public bodies work together, with local communities, businesses and the third sector, to plan and deliver services. It was given a statutory basis by the Local Government in Scotland Act 2003, which sought to establish community planning as the key means of coordinating partnership working and initiatives at a local level.

As part of the Government's response to the Christie report, it agreed to undertake a review of community planning. In March 2012, following that review, the Scottish Government and COSLA published a shared Statement of Ambition. This aimed to put community planning at the heart of an outcome-based approach to public services in Scotland and make clear that effective community planning arrangements will be at the core of public service reform.

Community Planning Partnerships

Community planning is currently delivered by local Community Planning Partnerships (CPPs). There are 32 CPPs, one for each local authority area. As well as the statutory partners, a wide range of other organisations are involved in CPPs including those from the third and private sectors.

Community Health Partnerships

The NHS Reform (Scotland) Act 2004 abolished separate acute and primary care trusts in Scotland, requiring NHS boards to manage both primary and acute health services under a single system. As part of the Act, the Scottish Executive (as it was at that time) also introduced Community Health Partnerships as committees of NHS boards. They were intended to help bridge the gap between primary and secondary healthcare, and between health and social care. CHPs were also expected to coordinate the planning and provision of primary and community health services in their area.

There are 36 CHPs in Scotland, varying in size and structure. There are also two types of CHP: a health-only structure and an integrated health and social care structure.

The Public Bodies (Joint Working) (Scotland) Bill will remove CHPs from statute when it comes into force. See details regarding the Bill below.

Single Outcome Agreements

The 2007 Concordat between the Scottish Government and local authorities gave councils more local flexibility in the way they spend the money received from the Scottish Government. This was largely achieved through the removal of a substantial number of ring-fenced funding streams; including 'ring-fenced' funding for HIV prevention work.

As part of the new arrangement, councils were required to develop a Single Outcome Agreement (SOA).
outlining the strategic priorities, expressed as local outcomes, for the council area. From 2009/10 onwards, CPPs were required to be fully involved in developing and agreeing on the SOAs. This established SOAs as the main framework for aligning public sector activity towards agreed priorities.

Commissioning

Commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to desired outcomes, planning services and working in partnership to put them in place. Joint commissioning is where these actions are undertaken by several agencies working together, typically health and local government, often from a pooled or aligned budget.

The Scottish Government and the Joint Improvement Team in Scotland have produced a Joint Strategic Commissioning Learning Development Framework. It has a particular focus on the commissioning of older people’s services but is intended to be useful for work in relation to all populations, service users and patients.

Public procurement

Public procurement can be defined as the acquisition of goods and services from third parties by public bodies, ranging from the purchase of routine supplies to formal tendering for service contracts.

Public procurement in Scotland is governed by a legal framework which includes principles deriving from EU directives, as implemented in national legislation. The legal framework establishes procedures which must be followed by public bodies when they purchase services from external service providers.

The overarching policy framework is described in the Scottish Procurement Policy Handbook. The Handbook is supplemented by Scottish Procurement Policy Notes which provide updates on current procurement policy issues.

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Public Bodies (Joint Working) (Scotland) Bill

The Public Bodies (Joint Working) (Scotland) Bill was introduced to the Scottish Parliament on 28 May 2013. The Parliament debated and passed the Bill at Stage 3 on 25 February 2014. It provides a framework intended to support improvement in the quality and consistency of health and social care in Scotland, through the integration of health and social care services.

The aims of the Bill are focused on improving outcomes for people by providing consistency in the quality of services, ensuring people are not unnecessarily delayed in hospital and maintaining independence by creating services that allow people to stay safely at home for longer.

The Bill requires the 14 regional health boards and 32 local authorities to jointly submit an integration plan for each local authority area. The Bill would give local authorities and health boards the choice between 2 broad models for integration:

- The body corporate model – under this model local authorities and health boards will delegate functions to a joint board. This will be separate from local health boards and will be led by a chief officer.
- The lead agency/delegated function model – under this model, functions will be delegated from one body to another. This model would require the establishment of a joint monitoring committee to oversee delivery.

The Bill will remove Community Health Partnerships from statute. New national outcomes will be specified by ministers in regulations and these will be used to hold health boards and local authorities jointly accountable. Although health boards and local authorities have until April 2015 to put the new arrangements in place, many have already begun operating shadow boards to oversee the integration process.31

31 Provided by Health and Social Care Alliance, 2014
The main national policy documents for HIV in Scotland are:

- The Sexual Health and Blood Borne Virus Framework 2011-2015
- The HIV Action plan in Scotland 2009 – 2014

**Sexual Health and Blood Borne Virus Framework 2011-2015**

In 2011 the Scottish Government launched The Sexual Health and Blood Borne Virus Framework 2011 - 2015 which draws together five high level outcomes regarding sexual health, HIV and hepatitis C and hepatitis B:

> Fewer newly acquired blood borne viruses and STIs; fewer unintended pregnancies;
> A reduction in the health inequalities gap in sexual health and blood borne viruses;
> People affected by blood borne virus(es) lead longer, healthier lives;
> Sexual relationships are free from coercion and harm; and
> A society whereby the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and blood borne viruses are positive, non-stigmatising and supportive.

The framework brings together sexual health, HIV and viral hepatitis into one strategic policy. Prior to this there were three separate policy documents (there was no national policy for hepatitis B):

- Respect and Responsibility

The current framework is monitored by a series of indicators against each outcome and the National Monitoring and Assurance Group is responsible for measuring and monitoring these indicators.

Funding is provided to NHS boards towards delivering the outcomes in the framework and boards are assessed by local area visits carried out on an annual basis by sexual health and blood borne viruses national coordinators from the Scottish Government. Funding is provided as part of an Effective Prevention Bundle, meaning that funding is provided for sexual health, viral hepatitis, HIV, smoking cessation, smoking prevention, adult healthy weight and child healthy weight in bundled allocations and NHS boards are free to move funding between these streams. Funding is currently confirmed until the end of the framework in 2015.

During 2014/15, work is being carried out to evaluate the success of the framework and update any areas where changes have occurred. A refreshed framework will be published in 2015.

In 2009, the Scottish Government launched the HIV Action Plan in Scotland (December 2009 – March 2014). The HIV Action Plan aims to reduce transmission and undiagnosed infection, to address the health needs of people living with HIV and to effectively coordinate services across the health, social care and voluntary sectors.

According to the Sexual Health and Blood Borne Virus Framework, the HIV section of the 2011-2015 framework is not a replacement of the HIV Action Plan. It is intended that the framework approach will support organisations to continue to focus on the key aims of the action plan, while working towards the outcomes of the framework.

TB Action Plan for Scotland

Tuberculosis (TB) is a major global health challenge which the World Health Organization has ranked as the second leading cause of death from an infectious disease worldwide after HIV. In Scotland, there has been a mean increasing trend of TB rates from 2008 to 2012, and although there had been a slight decline in 2011 and 2012 it is too early to say that this is a downward trend.

In 2011 the Scottish Government published a TB Action Plan for Scotland with the goal “to eliminate, by 2050, TB as a public health problem (incidence <1 per million population)”. Since then NHS health boards, clinicians, laboratories and agencies have been working towards implementation of the 42 recommendations in the action plan.

When HIV and TB disease occur together they interact and treatment becomes very complicated, with several different drugs required. Those with such ‘co-infection’ may have a poorer outcome unless both conditions are identified early and treatment is very closely supervised. All boards report that they are aware of existing guidance on HIV screening of TB patients and that it is in force. All but one of the regional boards report that they meet the recommendation that co-infected patients are managed by an expert in both conditions (with two of these boards transferring patients elsewhere).

Health Protection Scotland have completed an initial analysis of a data linkage based study to improve Scotland’s evidence base around dual infection with TB and HIV. One key challenge identified is the integrated care for TB/HIV co-infection: data on HIV status of TB cases is not known at a national level in real time in Scotland. This information is likely to be known at a board level but is not collected by Health Protection Scotland.

In Scotland, the main risk factors for TB infection are being non-UK born, and problem alcohol use. However, cases are becoming increasingly complex as: individuals may have dual infection with TB and blood borne viruses (such as hepatitis B, HIV, hepatitis C); they may have underlying chronic conditions such as diabetes or coronary heart disease; they may be employed as care workers; they may share multiple occupancy accommodation, such as halls of residence or rural workers accommodation; and they may be mobile both internationally and internally, which can make identification and management of clusters of cases more difficult. In order to tackle TB, it is necessary to develop links to many other policy areas.
HIV PREVENTION

There are a range of HIV prevention methods used within Scotland and prevention is the first outcome in the Sexual Health and Blood Borne Virus Framework: ‘Fewer newly acquired blood borne viruses and STIs’\textsuperscript{38}. Government, NHS, local authorities and the third sector all have a significant role to play in the prevention of blood borne viruses.

**Condom provision**

There is no national strategy for the provision of free condoms across Scotland. Condoms in Scotland are provided by NHS boards, voluntary organisations and local authorities. As there is no national agreement on how or where this should be done, provision can vary across the country.

Respect and Responsibility stated that NHS boards should: “…explore the possibility of making a range of condoms and lubricants more extensively available free of charge to outlets and services, targeted at high risk groups and as part of outreach work.”\textsuperscript{39} And: “…sustain [their] commitment to health improvement and harm reduction enabling the availability of condoms for males and dental dams for females throughout the course of their detention in young offender institutions and adult prisons.”

There is however no legislation or national guidance mandating that free condoms should be provided or where they should be provided.

**Condom provision in schools**

There is no obligation for schools in Scotland to offer condoms. Some schools host sexual health drop-in centres or condom schemes such as the C:Card scheme. The Sexual Health and Blood Borne Virus Framework recommends: “the provision of drop-in services for young people in, or close to, schools, particularly in areas of greatest need (e.g. areas of high prevalence, remote/rural areas where there are fewer specialised sexual health services), which provide both general and sexual health advice, pregnancy testing and condoms.”\textsuperscript{40}

On 3 June 2013 the Health and Sport Committee inquiry into teenage pregnancy\textsuperscript{41} noted that: “The Committee believes that schemes such as the C:Card Scheme, which makes condoms available at a range of venues to 13-24 year olds at no cost, make an important contribution to ensuring contraception is easily accessible to young people…. the Committee recognises that responsibility for determining the nature of the provision of these services in schools lies with the local authority and head teacher”.

Condoms can be provided to those aged under 16 and national guidance has been provided by Scottish Government on identifying where there may be a child protection concern\textsuperscript{42}.

**Pre-Exposure Prophylaxis (PrEP)**

Pre-exposure prophylaxis (PrEP) is when HIV anti-retroviral medication is taken by a person who does not have HIV, to prevent HIV infection. PrEP is taken before the person is at risk of infection or when they may be at on-going risk, such as those in a serodiscordent relationship.

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\textsuperscript{38} Scottish Government, The Sexual Health and Blood Borne Virus Framework 2011-2015

\textsuperscript{39} Scottish Executive, Respect and Responsibility, 2005, p.18, p.22

\textsuperscript{40} Scottish Government, The Sexual Health and Blood Borne Virus Framework 2011-2015, p.10

\textsuperscript{41} The Health and Sport Committee, Report on Inquiry into Teenage Pregnancy, 2013, p.70

\textsuperscript{42} Scottish Government, Under-age Sexual Activity: Meeting the Needs of Children and Young People, 2010
A position statement on the use of PrEP was published by The British HIV Association (BHIVA) and British Association for Sexual Health and HIV (BASHH) in December 2011, which concluded that: “There are important concerns, and we recommend that ad hoc prescribing is avoided, and that PrEP is only prescribed in the context of a clinical research study in the UK”. They also noted that “validated behavioural interventions, regular HIV testing, the diagnosis and treatment of other sexually transmitted infections, and intensive health-promotion activities ... should be implemented in preference to PrEP”.

Guidance on the use of pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV was published by the World Health Organization (WHO) in July 2012.

**Post-Exposure Prophylaxis (PEP)**

Post-exposure prophylaxis (PEP) involves taking antiretroviral medication when someone has (or may have) been exposed to HIV, in order to reduce the risk of the virus becoming established and causing HIV infection. PEP must be started within 72 hours of the risk event and it is recommended that it started within 1 hour or as soon as possible.

PEP is predominantly used in two situations:

**Occupational post-exposure prophylaxis (oPEP)**

PEP following a risk event that has happened in an occupational setting, such as from a needlestick injury or other blood exposure, is sometimes known as occupational post-exposure prophylaxis or oPEP. The standard safety procedures adopted in the UK for the prevention of needlestick injuries are known as ‘standard’ or ‘universal’ precautions, whereby all blood and body fluids regardless of source are considered to contain infectious agents, and treated as such. Guidance for Clinical Health Care Workers: Protection against Infection with Blood-borne Viruses was published by the Department of Health in 1998.

In 2001, NHS Scotland published Needlestick Injuries: Sharpen your Awareness. This made a number of recommendations including:

“NHS Scotland employers must have in place health and safety policies and procedures, which include needlestick injuries, and cover the legislative and regulatory requirements. Such policies and procedures must be regularly audited and reviewed. NHS Scotland employers must also ensure that staff understand and follow good working practices at all times.”

**Post-exposure prophylaxis following sexual exposure (PEPse)**

Post-exposure prophylaxis can be used to prevent infection following sexual exposure (known as PEPse). Updated UK Guidelines for the use of post-exposure prophylaxis following sexual exposure were released by the British Association for Sexual Health and HIV (BASHH) in 2011. The use of PEPse following potential sexual exposure to HIV is only recommended within 72 hours of exposure. Within that timeframe, it is recommended that PEPse should be administered as early as possible. Each NHS board in Scotland has its own procedures for distribution of PEPse, with many making it available through accident and emergency departments.

**Treatment as prevention**

In 2011, a randomised clinical trial (HPTN 052) found conclusive evidence to suggest effective anti-retroviral treatment (ART) in serodiscordant heterosexual couples can reduce the transmission of HIV through vaginal sex by 96%. A joint position statement was published in 2013 by the British HIV Association (BHIVA) and Expert Advisory Group on AIDS (EAGA) in support of the findings.
Using treatment to reduce the likelihood of transmission is only possible if the following conditions are met:

> The person living with HIV is taking effective ART;

> Neither partner has any other STI, and frequent tests are taken every 3 - 6 months;

> Viral load of the HIV positive partner has been below 50 copies/mL for more than 6 months; and

> Regular viral load tests are undertaken every 3 - 4 months.

A further study on HIV serodiscordant partnerships has been funded by NIHR (National Institute for Health Research in the UK), and has been given the name PARTNER. The PARTNER Study presented data at the Conference on Retroviruses and Opportunistic Infections (CROI) 2014, reporting that no cases of HIV transmission were observed in mixed-status couples (both heterosexuals and MSM) when the HIV-positive partner was on treatment with a viral load below 200. The PARTNER study followed 767 mixed-status couples in 75 sites across 14 European countries.

The British Association of Sexual Health and HIV (BASHH) UK National Guidelines on safer sex advice called for treatment as prevention to be considered as part of safer sex advice for some people living with HIV. The BHIVA Guidelines for Treatment recommend the discussion of treatment as prevention with all patients, along with an assessment of transmission risk. For patients with a CD4 count above 350 who wish to begin treatment, ART should be started. The guidelines do advise, however, that treatment can only lower (rather than eliminate) the risk of transmission and that consistent and effective adherence to ART is vital.

### Partner notification

Partner notification (or ‘contact tracing’) is defined by the World Health Organization (WHO) as: “…the process of contacting the sexual partners of an individual with a sexually transmitted infection including HIV, and advising them that they have been exposed to infection. By this means, people who are at high risk of STI/HIV…are contacted and encouraged to attend for counselling, testing and other prevention and treatment services.”

In May 2012, the National AIDS Trust published the report HIV Partner Notification: A Missed Opportunity? which gives a number of recommendations on how partner notification can be improved and can be used to improve rates of HIV diagnoses.

In July 2012, the British Association of Sexual Health and HIV (BASHH) published a Partner Notification Statement for Sexually Transmissible Infections which outlines general principles on partner notification and provides a resource for quality improvement. It states that:

“An estimate, based on a risk assessment, of when infection is likely to have occurred should be made and partner notification provided to include all contacts since, and in the three months prior to, this estimate. If this is not possible, all previous partners should be contacted and offered HIV testing.”

### Safer injecting equipment programmes

The Misuse of Drugs Act 1971 provides the legislation for the provision of safer injecting equipment provision, further amendments to this Act and related regulations also allow for the provision of drug paraphernalia including spoons and filters through clean needle programmes and pharmacies. The provision of sterile water is made legal under the Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005.

On 4 July 2013 the Home Secretary Theresa May presented a written
ministerial statement to the House of Commons and the House of Lords accepting the Advisory Council on the Misuse of Drugs advice on the lawful provision of foil and stating that legislation would be introduced to allow for the lawful provision of foil by drug treatment providers. This legislation is reserved and therefore will also apply in Scotland.

In 2010, the Scottish Government published Guidelines for services providing injecting equipment: Best practice recommendations for commissioners and injecting equipment provision (IEP) services in Scotland. The development of these guidelines was an action from the Hepatitis C Action Plan for Scotland: Phase II: May 2008 - March 2011.

These guidelines contain best practice for the provision of needles, syringes and other injecting paraphernalia to people who inject opioids (including heroin and methadone), stimulants and other illicit substances.

Injecting equipment in Scottish prisons

There are currently no prison-based injecting equipment provision schemes in Scotland. Some prisons do offer sterile injecting equipment for people who inject drugs when they leave prison. Prison-based injecting equipment was recommended in the Hepatitis C Action Plan for Scotland.

On 1 November 2012 the University of the West of Scotland, University of Bristol and West of Scotland Specialist Virology Centre published Hepatitis C Prevalence and Incidence among Scottish Prisoners and Staff Views of its Management. This commented that harm reduction interventions provided by the Scottish Prison Service had been successful in achieving a low prevalence of injecting behaviour as well as low rates of hepatitis C incidents. However, it also commented that low prevalence of injecting was not present in all Scottish prisons, so consideration of what interventions can reduce risks in those prisons with a higher rate of injecting may need to include provision of sterile equipment.

The Scottish Government has stated that although it will continue to monitor this issue there are currently no plans to introduce a pilot prison-based needle exchange scheme.

Male circumcision

There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%.

The World Health Organization and UNAIDS have recommended that male circumcision be included as part of a comprehensive approach to HIV prevention.

The impact of male circumcision on HIV transmission among men who have sex with men (MSM) is not known. Research was carried out by the Medical Research Council in 2010 to explore the feasibility of research into circumcision for HIV prevention among this group in Scotland.

This research concluded that circumcision is unlikely to be a feasible HIV prevention strategy: “The lack of association between circumcision and HIV status, low levels of exclusive UIAI (that is men practising unprotected insertive anal intercourse), and low levels of willingness to take part in circumcision research studies suggest circumcision is unlikely to be a feasible HIV prevention strategy for MSM in the UK. Behaviour change should continue to be the focus of HIV prevention in this population.”
Health Improvement Scotland’s HIV Standards for Services provide guidelines for HIV testing\(^63\). The standards (in particular standards 6 and 7) require each NHS board to produce its own HIV testing policy, which should include guidance on: testing in GUM clinics; testing in non-clinical settings; testing for high risk populations; antenatal testing; and repeat testing for those at sustained risk of infection.

HIV testing is recommended for anyone testing positive for hepatitis B, hepatitis C, or syphilis. Sexual health clinics are expected to have a system in place for people who defer a HIV test. The guidelines call for increased recognition of HIV symptoms to reduce the likelihood of late testing. Late testing is defined as a CD4 count of 350 or less at the point of diagnosis.

The standards (standard 8 in particular) also provide guidelines for the testing procedure itself. These include providing those who test positive with their results within seven days, offering anonymous testing as required, and ensuring a referral pathway is in place to refer people who are newly diagnosed persons to a HIV specialist clinician within 14 days of diagnosis.

NHS Health Scotland, in partnership with the Scottish Government, published a briefing paper in support of the National Institute for Health and Care Excellence (NICE) guidelines on “increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England”\(^64,65\). These place an emphasis on linking patients to “appropriate HIV treatment and care” immediately following an HIV diagnosis.

These guidelines state that universal testing should be offered at:

- GUM or sexual health clinics;
- antenatal services;
- termination of pregnancy services;
- drug dependency programmes; and
- healthcare services.

The guidance also lists a number of people (adults and children) who should be offered testing, and states that an HIV test should be considered in the following settings where diagnosed HIV prevalence in the local population exceeds 2 in 1000 population:

- all men and women registering in general practice;
- all general medical admissions.

\(^{61}\) World Health Organization and UNAIDS, WHO and UNAIDS announce recommendations from expert consultation on male circumcision for HIV prevention, 2007

\(^{62}\) McDaid, Weiss, & Hart, Circumcision among men who have sex with men in Scotland: limited potential for HIV prevention, 2010

\(^{63}\) Healthcare Improvement Scotland, Standards for HIV Services, 2011

\(^{64}\) Health Scotland, Scottish Briefing on NICE public health guidance 33: Increasing the uptake of HIV testing to reduce undiagnosed infection and prevent transmission among black African communities living in England, 2011

\(^{65}\) NICE, Public health guidance 33, 2011

\(^{66}\) BHIVA, BASHH, British Infection Society, UK National Guidelines for HIV Testing 2008, p. 1
Avidity testing

HIV avidity testing distinguishes recent infections from established infections and is primarily used for monitoring at a population level. The term ‘HIV avidity testing’ is used in Scotland. Other nations use different names; in England the generic term RITA (Recent Infection Testing Algorithm) is used. Although the two names are different the tests are of the same type.

There is no requirement for individuals or health boards to undertake HIV avidity testing, however on a public health level the results may help address standards set out in the Healthcare Improvement Scotland Standards for HIV Services, particularly those standards addressing treatment and care, and recognition and diagnosis67.

The period of recency of infection depends on the test used by a lab and tends to range between four to six months. The test used in Scotland is accurate to within four months. Avidity testing techniques are not yet able to give an accurate or definitive date to an individual’s infection; they are only able to suggest rough timings68. In Scotland HIV avidity testing is undertaken on most new diagnoses and are analysed in Edinburgh or Glasgow using the same test type. The test results are provided to the individual and can be helpful for contact tracing. This practice has been well accepted by patients.

When rates of HIV diagnoses go up, it is often not clear whether this increase is the result of a success in promoting HIV testing (which may identify people who have unknowingly lived with HIV for a longer period of time), or whether there is an increase in new infections. Knowing whether infections are recent or not provides a more accurate picture of who in the population is at increased risk of HIV infection; will help target resources to the populations in greatest need; contributes to the monitoring and evaluation of HIV prevention initiatives and HIV testing strategies; and helps predict how prevalence (the total number of people with HIV) will change. This information enhances understanding and planning regarding future human and economic costs of HIV69.

The principle of avidity testing is that in early infection antibodies have a weaker binding capacity to antigen (i.e. low avidity) compared to antibodies produced later in infection when the antigen binding capacity is strong (i.e. high avidity). In practice, this means carrying out a modified enzyme–linked immunoassay where a sample is treated with either a chemical agent which interferes with antibody binding (e.g. urea) or a wash solution. When the results of the two tests are compared, an avidity index (AI) can be calculated70.

Clinicians report that discussing avidity test results can be useful when a patient is diagnosed with a possible seroconversion illness or with a CD4 cell count which would indicate that antiretroviral treatment is necessary. Moreover, avidity test results can help with safer sex support and contact tracing – for example, by more confidently restricting contact tracing to a specific timeframe and by prioritising patients with a probable recent infection71.

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67 Healthcare Improvement Scotland, Human Immunodeficiency Virus (HIV) Services Standards, 2011
68 Guy R, Accuracy of serological assays for detection of recent infection with HIV and estimation of population incidence: a systematic review, 2009
69 NAM Website: http://www.aidsmap.com/RITA-Recent-Infection-Testing-Algorithm/
cpage/1323428/
70 Scottish Government Health Directorates Chief Scientist Office, Focus on Research, Developing Avidity Assays To Differentiate Acute And Chronic Infection, 2011
71 See note 69
Home testing kits

There are two types of HIV home testing kit:

> Instant result self-testing kits; and
> Home Sampling kits.

Instant result self-testing kits

An instant result self-testing kit for HIV is a kit that can be used by an individual to test a blood or saliva sample and instantly interpret the results themselves. They do not have to be used in a healthcare setting or involve a healthcare professional in any way, and can be used at home or any other location the individual prefers.

The distribution of such kits was made illegal by the HIV Testing Kits and Services Regulations in 1992. At that time there was no effective treatment for HIV, and as a result there were serious concerns about the impact of testing without any prior counselling, under duress or without consent72. There was also concern over the quality and regulation of HIV testing kits on the market at that time (testing kits available for home use were then unreliable and potentially misleading)73.

Although the 1992 regulations made it illegal to distribute self-testing kits, it has never been unlawful for an individual to buy or use them, and self-testing kits can easily be bought over the internet from illegal suppliers. In 2008, the UK Medicines and Healthcare products Regulatory Agency issued a warning to the public not to use HIV self-testing kits bought online; cautioning that these unregulated tests may not meet European safety and quality standards and that their reliability could not be guaranteed.

In 2011, a House of Lords select committee stated that the ban on home testing had become unnecessary and unsustainable, and should be repealed: “A plan should be drawn up, in consultation with clinicians, patients, voluntary organisations and professional associations, to license kits for sale with appropriate quality control procedures in place. The licensing regime must make sure that the tests are accurate, and that the process gives comprehensive advice on how to access clinical and support services in order that those who test positive get the care that they need.”74

In August 2013 the UK Department of Health publically announced that the ban on the sale of HIV self-testing kits will be lifted with effect from April 2014. All kits will be subject to strict regulatory control by the Medicines and Healthcare Regulatory Authority, and will be required to carry the European CE mark to confirm they meet minimum European standards.

Although health is a devolved matter in Scotland, the Scottish Government introduced a Scottish Statutory Instrument in March 2014 to revoke the HIV Testing Kits and Services Regulations 199275. This further confirms that the ban on the sale of instant result testing kits for HIV will also be lifted in Scotland with effect from 6 April 2014, with the same requirement that they meet European quality standards.

Home sampling kits

Home sampling kits do not give an instant result and can be used legally in the UK. Saliva or a small amount of blood is taken and sent by post to a laboratory who will give test results by phone or post. These kits are different from instant result home test kits in that the result is provided by a healthcare practitioner. Phone counselling and referrals may be offered. These tests are already available in the UK.
A range of standards and policies have been developed to help ensure that people living with HIV can access the best possible treatment and care possible. In Scotland HIV healthcare is the responsibility of NHS boards, and they may commission third sector and other services to deliver services as they deem necessary.

**Standards for HIV services**

Health Improvement Scotland’s Standards for HIV Services provide guidelines for NHS boards in HIV-related primary, secondary and tertiary care settings. A self-evaluation toolkit has also been developed for NHS boards to help them determine if the Standards for HIV Services have been met.

The Standards for HIV Services require all regional health boards to complete an HIV treatment and care network grid, identifying named individuals or services responsible for specific roles, such as an HIV consultant or alcohol addiction service. The standards set minimum access levels for each role, ranging from dedicated sessions within a specialist HIV unit to referral to a regional or national service.

**Integrated Care Pathways**

In accordance with Standard 9 of the Standards for HIV Services, NHS boards are expected to develop Integrated Care Pathways (ICPs). These should be developed in line with the patient and must address a number of criteria, including the roles of the HIV clinic and the primary care team, and how to contact HIV support. Individual ICPs should be updated regularly, and multidisciplinary meetings should be held every three months or more to review the ICPs in general.

The development of a national ICP is discussed in the Sexual Health and Blood Borne Virus Framework, where it is stated that a national HIV integrated care pathway will be developed which NHS boards and their partners will be able to utilise and adapt to local need.

**Standards of care for people living with HIV**

The British HIV Association (BHIVA), working in partnership with care providers, professional associations, commissioners and people living with HIV, have produced Standards of Care for People Living with HIV.

They cover 12 key themes, prioritised as being the most important issues for the care of people with HIV. The standards focus on aspects of care that have particular relevance for delivering equitable high-quality services that secure the best possible outcomes for people with HIV.

**HIV treatment for overseas visitors**

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 state that NHS boards in Scotland “may recover from any overseas visitor charges for the provision of treatment for Human Immunodeficiency Virus”.

In 2012 the UK Government took the decision, on the strength of the House of Lords report No Vaccine, No Cure: HIV and AIDS in the United Kingdom, that it would amend the English NHS Charges to Overseas Visitors Regulations to exempt overseas visitors, including asylum seekers, from charges for all HIV treatment.
Previously only testing and counselling was provided at no cost to overseas visitors. The introduction of the National Health Service (Charges to Overseas Visitors) Amendment Regulations 2012 meant that HIV treatment was no longer be chargeable to any overseas visitor in England.

In Scotland, asylum seekers were already exempt from all charges for NHS treatment, regardless of the status of their application for asylum, and the small cohort of patients to whom charges could apply receives HIV treatment without charge in the interest of public health. Nevertheless, in 2012 Scottish ministers agreed this arrangement should be formalised when appropriate opportunity arose.

As part of its preparation for the 2014 Commonwealth Games, the Scottish Government passed the National Health Service (Charges To Overseas Visitors) (Scotland) Amendment Regulations 2014 which exempted all HIV treatment from charges.

**Ageing**

There is currently no specific policy for HIV and ageing in Scotland. However, broader policies on ageing do exist which will have implications for the future care of people living with HIV. This includes Reshaping Care for Older People – A Programme for Change 2011-2021, which provides a national framework within which local partnerships are expected to develop joint strategies and commissioning plans.78

Reshaping Care aims to design a new model of health and social care in Scotland that is fair, affordable and sustainable into the future. The Reshaping Care programme is an important driver for implementing the NHS Quality Strategy (see section above) and the vision and aspirations it sets out are consistent with and give meaning to the three Quality Ambitions: partnerships between the NHS and those seeking care and support; care that is reliably safe; and appropriate, timely and efficient care and treatment. The Reshaping Care programme is equally a key driver for implementing existing policies within social care services.

In 2013, a follow up report, Reshaping Care for Older People ‘Getting On’79, was published, emphasising on community and home-based care as opposed to hospital or residential admission.

**Palliative and end of life care**

There are no HIV specific guidelines for palliative care. The national palliative care action plan for Scotland, Living and Dying Well80, advises NHS boards to adopt integrated care pathways, such as the Liverpool Care Pathway, and tools such as the Gold Standards Framework. Managed clinical networks for palliative care exist for some health boards. An electronic Palliative Care Summary (ePCS) exists to allow primary care GPs and nurses to access information on patients with palliative care needs at any time.

In 2011, the Scottish Government published Living and Dying Well: Building on Progress81. It advised all boards who do not have their own palliative care guidelines should use the NHS Lothian guidelines provided online. These cover:

- Symptom control
- Pain management
- Subcutaneous medicine
- Medication guidelines
- Non-cancer palliative care
- Care planning, including anticipatory care plans

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78 Scottish Government, Reshaping Care for Older People – A Programme for Change 2011-2021, 2011
79 Scottish Government, Reshaping Care for Older People ‘Getting On’, 2013
81 Scottish Government, Living and Dying Well: Building on Progress, 2011
The HIV epidemic has drastically changed the world in which children live. In Scotland, there are children who are living with HIV and many more who are affected as their parents and family members are HIV positive. The epidemic impacts on the daily life of children, and increases the victimisation and marginalisation of children.82

Children living with, or affected by, HIV
Specific UK guidelines exist for children, including testing, treatment, and standards of care. The National Study of HIV in Pregnancy and Childhood records all children diagnosed with HIV in the UK, and data is updated annually through clinicians reporting to the Collaborative HIV Paediatric Study (CHIPS).83

Further information is available on the Scottish Paediatric and Adolescent Infection and Immunology Network website.84

Testing
The British HIV Association (BHIVA) recommends testing for any infant, child, or young person thought to be at “significant risk” of HIV infection.85 It states that children who fall into the following categories should be considered for testing:

- Infants and children whatever their age where the mother has HIV, or may have died of an HIV-associated condition;
- Infants born to mothers known to have HIV in pregnancy;
- Infants born to mothers who have refused an HIV test in pregnancy;
- Infants and children who are presented for fostering/adoption where there is any risk of blood-borne infections;
- Infants and children newly arrived in the UK from high-prevalence areas (they may be unaccompanied minors);
- Infants and children with signs and symptoms consistent with an HIV diagnosis;
- Infants and children being screened for a congenital immunodeficiency;
- Infants and children in circumstances of post-exposure prophylaxis; and
- Infants and children in cases where there has been sexual abuse.

Young people under the age of 16 are expected to undergo assessment for “competency to consent” or consent should be given by a parent or guardian. In Scotland, if the young person refuses testing parents cannot override this decision. BHIVA encourages professionals ask for consent in children aged 11 or over.

Treatment
The Children’s HIV Association (CHIVA) reference the Paediatric European Network for Treatment of AIDS (PENTA) guidelines, which advise that all infants (children under 12 months) begin treatment urgently, “irrespective of clinical or immunological stage.”86 ART should be started for children aged 12 months or over with symptomatic disease (defined as CDC clinical stage B or C or WHO stage 3 or 4).

References:
82 UN, Convention on the Rights of the Child General Comment No. 3: HIV/AIDS and the rights of the child, 2003
83 http://www.chipscohort.ac.uk
84 http://www.spain.scot.nhs.uk/publications
85 BHIVA, BASHH, and British Infection Society, UK National Guidelines for HIV Testing, 2008
86 BHIVA, PENTA 2009 guidelines for the use of antiretroviral therapy in paediatric HIV-1 infection, 2009
Standards of care

The CHIVA Standards of Care for Children and Young People with HIV provide guidelines for clinical care pathways and multidisciplinary working, from antenatal care right through to the transition to adult care.

The standards are aimed at service providers, healthcare commissioners, and families and carers.

Guidelines are given for a total of 12 standards including testing, referral to services, inpatient and outpatient care, treatment, HIV education, sexual health, and transition to adult services. Standard 12 discusses “engagement and involvement of service users, non-HIV specialists, voluntary organisations and social care”, placing an emphasis on joint working and the involvement of children and young people living with HIV.

Children more than 12 months without symptomatic disease should begin treatment if the CD4 count falls below:

- 1 to < 3 years CD4 < 25%, or <1000 cells/mL
- 3 to < 5 years CD4 < 20%, or <500 cells/mL

Above 5 years CD4 count < 350 cells/mL. Once a child is taking ART, laboratory and clinical monitoring should be undertaken every 3-4 months. CHIVA also provides a Paediatric HIV Drug Dosing Chart, which provides dosage guides for clinicians, by ART type.

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87 BHIVA, PENTA 2009 guidelines for the use of antiretroviral therapy in paediatric HIV-1 infection in HIV Medicine Vol.10, p.591–613
88 CHIVA, Paediatric HIV Drug Dosing Chart 2012-13, 2012
89 CHIVA Standards of Care for Infants, Children, and Young People with HIV (including infants born to mothers with HIV), 2013
**Pregnancy and birth**

**Fertility treatment**

Fertility legislation is reserved to Westminster under the *Human Fertilisation and Embryology Act, 2008* and is regulated by the Human Fertilisation and Embryology Authority (HFEA). However, the delivery of fertility services is devolved to the Scottish Government.

National criteria for access to IVF guarantees a maximum of two full cycles of IVF, as well as unlimited frozen transfers (if available) for eligible couples until the woman's 40th birthday. NHS Scotland's HEAT target (see HEAT section earlier in this document) for IVF states that “eligible patients will commence IVF treatment within 12 months by 31 March 2015”.

In February, 2013 the National Institute for Health and Care Excellence (NICE) released updated guidelines for the assessment and treatment of people with fertility problems: *Fertility: Assessment and Treatment for people with Fertility Problems* clinical guidelines. This includes guidelines for people living with HIV (see section below on pregnancy in serodiscordant couples).

**Preventing vertical transmission**

In 2002, the National Screening Committee Antenatal Subgroup and Expert Advisory Group on AIDS recommended that antenatal screening for HIV should be *routinely offered to all pregnant women in Scotland*. Prior to this, since 1995, HIV testing had been offered to pregnant women who requested a test or whom were at high risk of HIV.

In 2012 BHIVA published *Guidelines for the management of HIV infection in pregnant women*. These guidelines focus on reducing the risk of mother-to-child transmission whilst maintaining the health of the mother. The scope includes guidance on the use of antiretroviral therapy (ART) to prevent vertical transmission.

The guidelines also state that pregnant women should be offered screening for HIV infection early in antenatal care because appropriate antenatal interventions can reduce mother-to-child transmission of HIV. A system of clear referral pathways should be established in each unit or department so that pregnant women who are diagnosed with an HIV infection are managed and treated by the appropriate specialist teams.

**Pregnancy in serodiscordant couples**

Section 6.5 of the NICE guidelines on assessment and treatment for people with fertility problems deals specifically with “additional investigations for viral infection and cancer”, and recommendations 66-72 specifically relate to HIV. The guidelines state: “For HIV the standard approach for female to male transmission is use of assisted reproductive techniques (ART), such as IUI or IVF. For male to female transmission the standard approach has been sperm washing. Sperm washing is used to reduce the viral load in prepared sperm to a very low or undetectable level. The washed sperm preparation can then be transferred to the women using IUI or used to fertilise eggs in IVF or ICSI. However, alternatives to sperm washing are now being proposed.”

Advances in antiretroviral therapy for serodiscordant couples may offer an alternative to ART/sperm washing (see below) which is equally effective, less invasive and more cost effective for a specific cohort of these patients.

**Sperm washing**

HIV is carried in seminal fluid. Sperm washing is the process of separating HIV infected seminal fluid from sperm by centrifugation and ‘washing’. The ‘washed’ sperm is then combined with nutritional fluid and tested for HIV. The ‘washed’ sample can then be...
inseminated into the female partner when she is ovulating or used for fertility treatments such as IVF.

**Labour and childbirth**

BHIVA Guidelines for the management of HIV infection in pregnant women recommend that:

> For women taking HAART, a decision regarding recommended mode of delivery should be made after review of plasma [viral load] VL results at 36 weeks [gestation].

> For women with a plasma VL <50 HIV RNA copies/mL at 36 weeks, and in the absence of obstetric contraindications, planned vaginal delivery is recommended.

> For women with a plasma VL of 50–399 HIV RNA copies/mL at 36 weeks, [planned caesarean section] PLCS should be considered, taking into account the actual VL, trajectory of the VL, length of time on treatment, adherence issues, obstetric factors and the woman's views.

> Where the VL is ≥400 HIV RNA copies/mL at 36 weeks, PLCS is recommended."

The guidance also recommends that “All mothers known to be HIV positive, regardless of ART, and infant PEP should be advised to exclusively formula feed from birth”.

**Looked after children: fostering and adoption**

There are a number of statutes that relate to looked after and accommodated children including:

> Children (Scotland) Act 1995

> Adoption and Children (Scotland) Act 2007

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93 BHIVA, Guidelines for the management of HIV infection in pregnant women, 2012
HIV information and education in schools

In August 2010, the Scottish Government introduced the Curriculum for Excellence (CfE). Under this curriculum there are three core subjects taught right through a child’s education from age 3 up to 18. These three subjects are: health and wellbeing; literacy; and numeracy.

The aim of CfE is to join up more subjects on topic-based learning using skills and knowledge from more than one subject within a project. Teachers decide what to study and schools are encouraged to adapt learning to local needs, using people and places in their local area, or the individual interests of classes and pupils to choose topics to focus on.

Within CfE there are eight curriculum areas:
- Expressive arts
- Health and wellbeing
- Languages
- Mathematics
- Religious and moral education
- Sciences
- Social studies
- Technologies

Relationships, sexual health and parenthood education is included under health and wellbeing. Learning about relationships, sexual health, and parenthood begins early on in primary school and continues to S4-S6.

However parents can withdraw their children from all or part of a planned sex education programme. They are expected to discuss with the head teacher how they intend to provide this education themselves. There is no legal requirement to teach sex and relationships education in schools.

The Scottish Government document, Partnership Matters, provides guidance on collaboration between NHS boards, local authorities, third sector organisations, and education providers for people living with disabilities or long term health conditions.

Sexual health and relationships education resources

SHARE is a teacher-led sexual health education programme which is available to all schools in Scotland and is aimed at S2-S4 pupils. SHARE was developed by Health Scotland and Learning Teaching Scotland in 2006 and updated in 2013. It includes information on sexually transmitted infections (STIs) and HIV. However, schools are not mandated to use SHARE or any other sexual health and relationships resource.

The Called to Love resource was created as a partnership between the Scottish Catholic Education Service (SCES) and Healthy Respect as an alternative to SHARE for use in Catholic Schools. It was funded by the Scottish Executive (as it was at that time) in 2006. Called to Love provides support materials and training opportunities, specific to the needs of Catholic schools and in accordance with Catholic beliefs. It does not contain information about sexually transmitted infections or HIV.

There is no requirement for schools to use any set resource when teaching sexual health and relationships education in schools and it is unknown how widely or effectively teaching on the subject takes place.

On 1 December 2012 Waverly Care launched Always Hear, a campaign to raise awareness of HIV and challenge HIV stigma in Scotland. Funded by the Scottish Government, this included the provision of detailed resources for schools and youth groups linked to Curriculum for Excellence and produced in association with Education Scotland.

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94 Education Scotland, Curriculum for Excellence, 2011
95 Scottish Government, Partnership Matters, 2009
96 NHS Health Scotland, SHARE Education Resource, 2011
97 Scottish Catholic Education Service, Called to Love, 2006
Scotland’s carers strategies were launched in July 2010 and outline support for carers and young carers in Scotland until 2015. The Scottish Government is also investing over £98 million in supporting carers and young carers between 2008 and 2015.

The Government states that through these measures it intends to include carers as equal partners in the planning and delivery of care and support and to focus on identifying, assessing and supporting carers in an outcome-focused and consistent way.


The Scottish Government and COSLA worked together to produce Caring Together[98]. This strategy sets out ten of the Government’s key headline actions to improve support to carers in Scotland by 2015. It states that the Scottish Government with partners will:

- Develop a Carers Rights Charter, consolidating existing legal rights and setting out key principles for carer support both now and in the future.
- Put in place measures to help professionals in the health and social care workforce identify carers.
- Take steps to improve the uptake and quality of carers assessments/carer support plans.
- Improve the provision of information and advice to carers through various means including workforce training and support for NHSInform.
- Ensure carer representation on Community Health Partnerships.
- Produce a bespoke resource on issues relating to stress and caring to complement the successful Steps for Stress; continue to work on carer identification and support, including promoting good health; ensure that carers aged 40-64 have access to health checks under plans to target groups of people, including carers, who may not live in the most deprived areas.
- Invest in carer (and workforce) training.
- Work with a range of partners to promote the further development of flexible, personalised short breaks.
- Encourage and promote carer-friendly employment practices.
- Work to ensure better strategic planning and collaborative working between health and social care services to ensure the delivery of co-ordinated services and supports.

Getting it Right for Young Carers

Getting it Right for Young Carers recognises that the demands of caring can be onerous and can have an adverse impact on young carers’ health and wellbeing[99]. It states that early intervention is necessary to prevent this. By identifying, assessing and supporting young carers, agencies and practitioners can relieve them of inappropriate caring roles and enable them to be children and

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[99] Scottish Government, Progress Report on implementation and related developments to support carers and young carers, 2013

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A STOCKTAKE OF HIV POLICY IN SCOTLAND 35
young people first and foremost.

The following are the key headline Government actions in this strategy to help improve outcomes for young carers:

> Continue to engage with young carers to identify their needs and priorities and to inform the development of policy.

> Put in place measures to help professionals in education, health and social care to identify young carers.

> Introduce a classification of ‘young carers’ in the 2011 school census, which will report on the numbers of young carers who have been

> Work with the Scottish Young Carers Services Alliance to produce a practice guide on young carers for teachers and schools.

> Improve the provision of information and advice to young carers

> Commission research into the characteristics of young carers being supported by dedicated young carers’ services.

> Work with a range of partners to promote the further development of flexible, personalised short breaks.

> Skills Development Scotland will design and develop suitable materials and training opportunities to support young carers’ services’ contact with young adult carers.

> Encourage young adult carers to plan to achieve their career aspirations,

> Progress a range of actions to improve support to young adult carers.
In the early years of the HIV epidemic, people receiving blood transfusions were at increased risk of HIV. However, the screening of all blood donations is now universal across the UK and blood collection procedures are highly regulated and safe. There are certain restrictions on who can be a blood or organ donors as well as guidelines related to the embalming of people with HIV.

Blood, organ and tissue donation

Blood donation

In Scotland blood donation is controlled by the Scottish National Blood Transfusion Service (SNBTS), part of the special NHS board NHS National Services Scotland, and responsible for supplying blood, tissue and products across Scotland. A wide range of exclusions apply to those who can give blood, as set out below100.

A person is permanently excluded from giving blood if:

> They think they need a HIV or hepatitis test.

> They are HIV, HTLV (human T cell lymphotropic virus), hepatitis B or hepatitis C positive.

> They have ever received money or drugs for sex.

> They have ever injected or been injected with drugs.

> They have ever had sex with a potentially high risk partner, (even if a condom was used). This includes:

> Anyone who has had sex with a partner who thinks or who they think may be: HIV or HTLV positive; a carrier for hepatitis B; a carrier for hepatitis C.

> Any man and has had oral or anal sex with another man.

> Any woman who has had sex with a man who has ever had sex with another man.

> Anyone who has had sex with a partner who has, or they think may have, been sexually active in parts of the world where HIV is highly prevalent.

> Anyone who has had sex with someone who has ever received money or drugs for sex.

> Anyone who has had sex with a partner who has ever injected or been injected with drugs.

The permanent exclusion of men who have had sex with men from donating blood was changed in 2011 to a 12 month fixed period deferral from the latest relevant sexual contact following an evidence based review by the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO)101.

The change (implemented from 7 November 2011) and means that in Scotland, England and Wales only men who have had anal or oral sex with another man in the past 12 months are prohibited from donating blood. Men whose last sexual contact with another man was more than 12 months ago are now eligible to donate, subject to meeting the other donor selection criteria.

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101 Advisory Committee on the Safety of Blood, Tissues and Organs, Donor Selection Criteria Review, 2011
Infected blood products

During the 1970s and early 1980s some blood and blood products supplied by the NHS, (mostly to haemophilia sufferers) were contaminated with HIV and hepatitis C. More than 1,200 people with haemophilia were infected with HIV through clotting factor treatments. Since then, more than 800 of those people have died. Since October 1985 all blood donations have been screened for HIV. Hepatitis C screening was introduced in 1991.

Between 1987 and 2004 the UK Department of Health created and funded four organisations to provide financial support for those infected with HIV and hepatitis C via contaminated blood or blood products:

- The MacFarlane Trust provides support for haemophilia sufferers who contracted HIV from contaminated blood products prior to September 1991;
- The Eileen Trust provides support for non-haemophilia sufferers who contracted HIV from contaminated blood or blood products prior to September 1991;
- The Skipton Fund provides payments to those who developed chronic hepatitis C from blood or blood products prior to September 1991;
- The Caxton Foundation provides discretionary payments, in the form of alternative economic support, to those who developed chronic hepatitis C from blood or blood products prior to September 1991.

Since 2003, there have been no new HIV diagnoses resulting from UK blood donations. Infection from blood transfusions received abroad still occurs as not all countries screen blood, or do so effectively.

The Rt Hon Lord Ross established an expert group which published a report in March 2003. It looked at the compensation system for those harmed by NHS treatment and proposed alternatives, including with regard to the situation of patients who have contracted HIV and/or hepatitis C from blood transfusion or treatment with blood products.

In 2007, The Rt Hon Lord Archer chaired a privately financed investigation into “the circumstances surrounding the supply to patients of contaminated NHS blood and blood products; its consequences for the haemophilia community and others afflicted; and further steps to address both their problems and needs and those of bereaved families”. The Archer inquiry reported in February 2009.

In 2008 Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary for Health and Wellbeing for the Scottish Government announced that a Scottish public inquiry into hepatitis C/HIV acquired infection from NHS treatment in Scotland with blood and blood products would be set up by Scottish ministers.

The Penrose inquiry is currently drafting its final report and it is expected that it will report by the end of May 2014.

Organ and tissue donation

The Human Tissue (Scotland) Act 2006 sets out the legislation for the donation of organs or tissues. Blood is taken from all potential donors (after death) and tested to rule out transmissible diseases including HIV.
Persons infected with HIV are not able to donate their organs to HIV negative recipients; however selected donors with HIV may be suitable donors for recipients with HIV. People living with HIV are not excluded from being part of the organ donor register; the only absolute exclusion for organ donation is Creutzfeldt–Jakob disease (CJD).

The criteria for selection are internationally agreed by bodies such as the Council of Europe, Transplantation Societies around the world and in the UK and by the UK Committee on the Safety of Blood Tissues and Organs (SaBTO). However the criteria are always discussed by NHS Blood and Transplant (NHSBT) and clinicians and a determination is made on the balance of risks.

Guidance and legislation dealing with transplants to recipients with HIV is the same as for any type of transplant. HIV infection does not exclude a person from receiving a transplant and those requiring transplant will be added to the transplant list in accordance with transplant guidance\textsuperscript{107}.

**Burial and cremation**

After death people in Scotland can be buried or cremated as per the wishes of the deceased and their family, there is no special requirement for the method of disposal of a deceased HIV positive person.

The Health and Safety Executive (HSE) is the national independent watchdog for work-related health, safety and illness. HSE guidance on infection at work and human remains states that persons with HIV who have died should not be embalmed\textsuperscript{108}. Embalming involves removing the blood from the body and replacing it with embalming fluid. Due to an increased risk of needlestick injury and contact with blood to the embalmer, embalming is not recommended for people who have HIV. This guidance is not legally binding however health and safety inspectors may still choose to refer to it.

\textsuperscript{107} NHS Blood and Transplant, Organ donation and transplantation patient selection and organ allocation, 2012

\textsuperscript{108} Health and Safety Executive, Infection at work: controlling the risks from human remains, 2005
There have been some significant improvements in the general public’s awareness and understanding of HIV since the start of the epidemic. Unfortunately, HIV related stigma remains a problem in Scotland and can manifest itself in a variety of ways, including ostracism, discrimination and even violence against people living with HIV. Discrimination can occur within the workplace, educational settings, public services, and social situations. There are a range of rights and laws in place to help prevent discrimination and promote equality of opportunity.

**Equality Act 2010**

HIV is a disability from the point of diagnosis as defined in the Equality Act 2010. The Equality Act replaces previously existing anti-discrimination laws (such as the Disability Discrimination Act 1995) and prohibits discrimination against people with ‘protected characteristics’.

This means that it is unlawful to discriminate against someone on the grounds of: age; disability; gender reassignment; race; religion or belief; sex; sexual orientation; marriage and civil partnership; and pregnancy and maternity. The Equality Act applies to all organisations that provide a service to the public. It also applies to anyone who sells goods or provides facilities.

The Equality Act 2010 protects people from:

- Direct discrimination: treating someone less favourably because of a characteristic they have (such as being gay). Direct discrimination can also include less favourable treatment based on how someone appears (‘perceptual discrimination’) or who they associate with (‘associative discrimination’).

- Indirect discrimination: when rules and practices are applied equally to everyone but a particular group are disadvantaged by them.

- Harassment: creating an environment which is degrading, humiliating or offensive for someone because of their protected characteristic. This can be through name-calling, isolating them, pinning up pictures etc.

- Victimisation: treating someone less well because they have made a discrimination complaint.

- Discrimination arising from disability: treating an individual with disabilities less favourably because of something arising from their disability.

The Equality Act also places a duty on public bodies and others carrying out public functions to routinely consider how they can promote equality and eliminate discrimination when making decisions about policy and practice.

**Employment**

The Equality Act makes it illegal for an employer to:

- dismiss an employee because they are living with HIV;

- turn down someone for a job, based on their status;
> treat an employee unfairly in regards to redundancy, advancement and other opportunities on the basis of HIV status;
> fail to make reasonable adjustments to the workplace that would allow someone living with HIV to work there; or
> verbally or physically harass an employee on the basis of their HIV status.

The Equality Act requires employers to make ‘reasonable’ adjustments to working arrangements or premises, in order to prevent disabled employees or job applicants from being disadvantaged. For someone living with HIV this could include adjustments such as being offered flexible working hours to attend clinic appointments or extra breaks so medication can be taken privately.

The Act applies to all employees, including prison officers, fire fighters, the police and contract workers. It also applies to trade organisations (such as trade unions) and qualifying bodies (such as General Medical Council). However, the Act does not cover volunteers or people working for the armed forces.

Healthcare workers with HIV

Under previous guidance from the UK Department of Health, healthcare workers who had HIV were not permitted to carry out exposure-prone procedures which are defined as:

“Invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient’s open tissues to the blood of the worker (bleed-back). These include procedures where the worker’s gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (e.g. spicules of bone or teeth) inside a patient’s open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. However, other situations, such as pre-hospital trauma care Should be avoided by health care workers restricted from performing exposure prone procedures, as they could also result in the exposure of the patient’s open tissues to the blood of the worker”\textsuperscript{109}.

In 2007, the Expert Advisory Group on AIDS (EAGA) suggested that policy restricting the practice of HIV-infected primary care dentists should be reviewed. The UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses (UKAP) suggested that this should be undertaken as part of a wider review of restrictions on healthcare workers with blood borne viruses\textsuperscript{110}.

A Tripartite Working Group, consisting of chairs and members of UKAP, the Advisory Group on Hepatitis (AGH) and EAGA was set up to review blood borne virus policy. Following consideration of the scientific evidence presented, the Working Group published its report in April 2011 recommending that restrictions on healthcare workers with HIV be relaxed if certain conditions are met\textsuperscript{111}.

Following this report, a consultation was launched by both the Scottish and UK Governments on 1 December 2011\textsuperscript{112, 113}. On 15 August 2013 the Scottish, English and Welsh Governments announced that the restrictions on procedures undertaken by healthcare workers with HIV would be relaxed\textsuperscript{114}. Under the new rules, healthcare workers with HIV will be allowed to undertake exposure prone procedures if they are on effective combination anti-retroviral drug therapy, have an undetectable viral load and are regularly monitored.

Human rights

The term ‘human rights’ refers to the basic rights and freedoms to which all humans are entitled. Human rights law is a system of laws - both domestic and international - designed to promote and protect these rights. Examples of rights and freedoms which have come to be commonly thought of as human rights...
include civil and political rights (e.g. the right to life and liberty) and economic, social and cultural rights (e.g. the right to work and the right to education). The HIV epidemic has a number of human rights dimensions and in the 1980s, the HIV movement very quickly adopted a human rights-based approach. For example, the application of human rights can help to ensure that public health policies and practices do not violate the right people living with or at risk of HIV have to health provisions. Human rights can also help to ensure that people living with HIV do not experience unfair treatment and discrimination.

The Scottish Human Rights Commission has led the development of Scotland's first National Action Plan for Human Rights115. Launched in December 2013, Scotland's National Action Plan for Human Rights is a roadmap for the realisation of all internationally recognised human rights in Scotland. It is intended to coordinate action by a wide range of public bodies and voluntary organisations to progressively realise the potential of human rights in all areas of life.

Action plans can lead to improvements in human rights protection across a range of sectors such as health, education, welfare and justice. Experiences from other countries show the potential of this approach to deliver real and sustainable improvements in the realisation of human rights for all, particularly the most marginalised and vulnerable in society.

**International human rights law**

**Universal Declaration of Human Rights:**

The **Universal Declaration of Human Rights (UDHR)** is a non-binding declaration adopted by the United Nations General Assembly in 1948. It consists of 30 articles which have been elaborated in subsequent international treaties and national constitutions and laws. While not a treaty itself, the UDHR is a fundamental constitutive document of the United Nations. The UDHR is therefore a powerful tool in applying diplomatic and moral pressure to governments that violate any of its articles.

The declaration has served as the foundation for two binding UN human rights covenants - the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.

**European Convention on Human Rights:**

The **European Convention on Human Rights (ECHR)** was adopted in 1950 to protect human rights and fundamental freedoms in Europe. The convention established the European Court of Human Rights, allowing any person who feels his or her rights have been violated to take a case to the court in Strasbourg. The European Convention is still the only international human rights agreement providing such a high degree of individual protection.

Fundamental rights and freedoms set out in the ECHR include: the right to life, right to liberty and security, right to a fair trial, right to respect for private and family life, and prohibition of discrimination.

**United Nations treaties and conventions:**

A ‘treaty’, ‘convention’ or a ‘covenant’ lays out legally binding obligations for the governments that sign on to them. Unlike the ECHR, these are not yet domestically enforceable in the UK.

However, when the UK ratifies (agrees to) UN conventions it is bound to deliver these internationally agreed minimum standards. The current seven international human rights treaties that have been ratified by the UK are:

> International Covenant on the Elimination of All Forms of Racial Discrimination
> International Covenant on Economic, Social and Cultural Rights
International Covenant on Civil and Political Rights

Convention on the Elimination of All Forms of Discrimination against Women

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Convention on the Rights of the Child

Convention on the Rights of Persons with Disabilities

Health and government responsibility for health in the context of the HIV epidemic is set out in these documents in several ways. In almost all of them, the right to the highest attainable standard of physical and mental health appears in some form. Furthermore everything from the right to information and to education - to the right to social security or to the benefits of scientific progress - has clear implications for HIV.

The UN Convention on the Rights of Persons with Disabilities (CRPD) was ratified by the UK in 2009. Governments agreeing to this convention must amend national laws and policies to give greater protection to the human rights of people with disabilities, including protecting them against disability-based discrimination. The CRPD addresses issues faced by people living with HIV but does not explicitly include HIV within its open-ended definition of ‘disability’.

International Guidelines on HIV/AIDS and Human Rights

Produced by the Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV and AIDS, the purpose of the International Guidelines is to assist states in creating a positive, rights-based response to HIV that reduces the transmission and impact of HIV and AIDS and is consistent with human rights and fundamental freedoms.

The guidelines make clear that the protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards.

As the guidelines address many difficult and complex issues, some of which may or may not be relevant to the situation in a particular country, it is intended that governments and communities should carefully consider how they are relevant, assess priority issues and devise effective ways to implement the guidelines in their respective contexts.

Domestic human rights law

Human Rights Act 1998

The Human Rights Act 1998 is an act of the UK Parliament which aims to ‘give further effect’ to the rights contained in the European Convention on Human Rights (ECHR). The Act requires that all legislation in the UK is compatible with the ECHR and that cases can be brought to UK courts instead of the European Court of Human Rights. It also makes it unlawful for any public body to act in a way incompatible with the ECHR.

The ECHR contains the following articles:

- Article 2: The right to life
- Article 3: The prohibition of torture and inhuman treatment
- Article 4: Protection against slavery and forced labour
- Article 5: The right to liberty and security
- Article 6: The right to a fair trial


The European Convention on Human Rights (formally the Convention for the Protection of Human Rights and Fundamental Freedoms)
Scotland Act 1998

The Scotland Act 1998 sets out the Scottish Government’s compliance with the ECHR on devolved human rights issues such as health, education, social policy, justice and housing.

The Scotland Act provides that the Scottish Executive (now publicly known as the Scottish Government) and the Scottish Parliament have no power to act contrary to the ECHR. It also provides that:

- legislation from the Scottish Parliament is only competent if it is ECHR compliant (s 29 (2) (d)); and that
- all actions of Scottish ministers must be ECHR compliant (s 57 (2)).

These sections will become particularly powerful if any future UK government abolishes the Human Rights Act 1998.

> Article 7: No punishment without law
> Article 8: Right to respect for private and family life
> Article 9: Freedom of thought, conscience and religion
> Articles 10 and 11: Free speech and peaceful protest
> Article 12: The right to marry
> Article 14: Prohibition of discrimination
> Article 16: Restrictions on political activity of aliens
> Articles 17 and 18: Prohibition on abuse of rights and restrictions on rights
> Article 19: Protection of property, the right to an education and the right to free elections
Immigration and asylum

While immigration is a reserved issue, healthcare is devolved - please see section on HIV treatment for overseas visitors for more detailed information on access to treatment in Scotland.

Current immigration legislation has its roots in the Immigration Act 1971, but has been regularly updated. While the legislation does not directly reference HIV issues, regulations and guidelines produced by the UK Home Office and the Department for Health have implications for applications by people who are living with HIV.

Rules around entry to the UK

The Home Office publishes the Immigration Rules, which are regularly updated through the Statement of Changes to Immigration Rules (last update April 2014)\textsuperscript{118}. These are the rules that govern entry process to the UK so will be relevant to any migrant or asylum seeker living with HIV. There is also guidance on how medical issues will be considered during the visa application process\textsuperscript{119}. The medical component of entry clearance is intended to “prevent the entry of, or bring to notice, persons who if admitted to the UK might:

- endanger the health of other persons in the UK, or
- be unable for medical reasons to support themselves and or dependants in the UK; or
- require major medical treatment (for which an entry clearance application has not been made).”

The Medical Issues guidance does not include any formal restrictions on people living with HIV, but does state the following: “If an applicant for entry clearance has a serious illness, for example HIV / AIDS, the entry clearance officer should decide on the application under the provisions of the Rules or, if in doubt, refer it…”

The guidance continues to describe the Medical Officer’s role in assessing whether the applicant is able to provide for herself or himself and any dependants during the course of their stay, “for instance, although a person who is HIV positive may be well enough to work, study or undertake a visit, a person with full blown AIDS may not be capable”

There are specific rules relating to TB:

“Applicants from participant countries…. applying for entry clearance for more than six months are required to produce a certificate issued by a UK Visas and Immigration approved provider either, usually the International Organisation for Migration (IOM) or a clinic already approved by the Five Country Conference (FCC) showing that they are free from active pulmonary TB.”

The asylum pathway

Sometimes people who enter the UK on a visa will go on to claim asylum, related to persecution in their home country. This might happen at the port of entry (e.g. the airport), or after they have been in the UK for some time.

Once asylum has been formally claimed, the asylum seeker enters the ‘asylum pathway’, as described in Figure 1 below, produced by the National AIDS Trust.

If an asylum seeker has their claim accepted they are normally recognised as a ‘refugee’. In some cases they may also receive ‘humanitarian protection’, which also allows them to remain in the UK for a specific period of time.

\textsuperscript{118} UK Border Agency, Immigration Rules, 2013

\textsuperscript{119} UK Border Agency, Medical issues (MED), 2013
Dispersal

People with an open asylum claim who are ‘destitute’ (without housing and/or income) can get support from the Home Office. Dispersal is the process by which the Home Office moves an asylum seeker to accommodation outside London and the south east. They are first moved to initial accommodation while their application for asylum support is processed. Once the application has been processed and approved they are moved to dispersal accommodation elsewhere in the UK.

The UK Border Agency Healthcare Needs and Pregnancy Dispersal Guidance makes a number of specific recommendations concerning asylum seekers who are living with HIV. It details the need for asylum seekers living with HIV to be dispersed from their ‘initial accommodation’ at the earliest opportunity so that treatment can be started as soon as possible.

The guidance also specifies that great care should be taken when finding accommodation for families with children and that case workers are required to satisfy themselves that any accommodation is located near appropriate facilities. Section 55 of the Borders, Citizenship and Immigration Act 2009 must also be taken into account. The need for case workers to be aware of issues around children in HIV affected families and disclosure is also highlighted.

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120 NAT, HIV and the UK Asylum Pathway, 2008

121 UK Border Agency, Healthcare needs and pregnancy dispersal guidance, 2012
Detention and removal

The detention and removal of an asylum seeker occurs when his or her asylum claim has been denied and appeals have been rejected. A failed asylum seeker who is not offering to voluntarily return to their country of origin can be detained at an immigration removal centre (IRC) before their deportation and for an indefinite time period, however failed asylum seekers can opt to voluntarily return to their country of origin and are offered support while they take steps to do so.

If an asylum seeker is detained they will be held at one of ten IRCs, nine in England and one in Scotland (Dungavel, South Lanarkshire). They will be detained until there is a change in circumstance concerning their failed application or they are deported. Detention can create a range of problems for asylum seekers living with HIV including access to treatment and other related issues including problems with nutrition and mental health. NAT and BHIVA have published agreed guidance on the management of HIV in IRCs, with NAT also publishing research into how this guidance is being implemented.

Irregular migration

An irregular migrant is defined as someone who does not comply with immigration law requirements. This applies to variety of situations for example a refugee whose status has been revoked or an asylum seeker whose application has been denied and whose appeals have failed. It also includes migrants who have never been part of the formal immigration process, for example people who have been trafficked or who have successfully entered the country undetected. Sometimes these migrants are called ‘illegal migrants’ and this group may be charged for accessing NHS secondary care services. However, primary care services are currently provided for free to all, regardless of immigration status, and all will get free HIV treatment.

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122 NAT, HIV and the UK Asylum Pathway, 2008
123 UNAIDS, HIV-related restrictions on entry, stay and residence, 2013
124 NAT and BHIVA, Detention, Removal and People Living with HIV. Advice for healthcare and voluntary sector professionals, 2009
125 NAT, HIV Care in Immigration Removal Centres, Survey Report, December 2013
Welfare and social security

The Welfare Reform Act 2012 and the Welfare Reform act (further provision), Scotland Act 2012 have introduced significant changes to the welfare system and will continue to do so as the changes are implemented. Although welfare is a reserved matter for UK Government, the reforms impact on people and services across Scotland. The Act provides for the introduction of a ‘Universal Credit’ to replace a range of existing means-tested benefits and tax credits for people of working age.

The progressive roll out of Universal Credit has begun and replaces six main benefits with a single monthly payment for people in work or out of work. Universal Credit also requires that claimants sign a claimant commitment, which began rolling out to Jobcentres across the country from October 2013. Claimants of Jobseekers Allowance will be expected to take all reasonable steps to give themselves the best prospects of finding work. If they do not meet this requirement they risk losing benefits.

The Welfare Reform Act 2012 gave the UK Government the power to cap the total benefits to which a single person or couple is entitled. In 2013 a benefit cap was rolled out to all local authorities across the country. Household benefit payments will be capped at £350 per week for a single adult with no children and £500 per week for couples, with or without children, and lone parent households.

The Welfare Reform Act 2012 introduced a new benefit called Personal Independence Payment (PIP) that will eventually replace Disability Living Allowance for people aged 16 to 64. PIP is intended to help towards some of the extra costs incurred as a result of a long term ill-health condition or disability. It is based on how a person’s condition affects them, not the condition they have.

The UK Government has also used powers contained in the Welfare Reform Act 2012 to provide that, since 1 April 2013, working-age social tenants in receipt of Housing Benefit will experience a reduction in their benefit entitlement if they live in housing that is deemed to be too large for their needs. This is more commonly known as ‘the bedroom tax’. Although there are certain exemptions from the charges, for example people who use a spare bedroom for a non-resident carer who provides overnight care most people will lose 14% for one extra bedroom and 25% for two.
Criminal justice
Criminalisation for transmission and exposure

There have been a small number of high-profile cases in the last decade that have resulted in individuals being found guilty of passing on HIV (transmission) or putting another person at risk of HIV (exposure) and given substantial prison sentences. These cases are not the result of a government decision to prosecute people for passing on HIV; they began in Scotland in 2001 because prosecutors tested existing laws to see if they could be applied to HIV.

The Global Commission on HIV and the Law was an independent body, convened by the United Nations Development Programme (UNDP) on behalf of the Joint United Nations Programme on HIV/AIDS (UNAIDS). The Commission undertook extensive research, consultation, analysis and deliberation over a period of two years to examine links between legal environments and HIV responses. The conclusions and recommendations of the Commission are included in its final report HIV and the Law: Risks, Rights and Health. The commission disbanded following the release of its report. UNDP, working in partnership with the UNAIDS Secretariat, UN agencies, governments, civil society and donors, monitors and participants in activities to implement the findings and recommendations of the report.

The objectives of the Commission were to:

- Analyse existing evidence and generate new evidence on rights and law in the context of HIV and develop rights-based and evidence-informed recommendations;
- Increase awareness amongst key constituencies on issues of rights and law in the context of HIV and engage with civil society and strengthen their ability to campaign, advocate and lobby.

The outcomes of the Commission included:

- Consolidated, coherent and compelling evidence base on human rights and legal issues relating to HIV;
- Greater awareness among key stakeholders and leadership of law- and policy-makers;
- Public dialogue and civil society engagement on social attitudes, human rights and legal issues relating to HIV.

The Crown Office and Procurator Fiscal Service (COPFS) of Scotland is Scotland's prosecution service: they receive reports about crimes from the police and other reporting agencies and then decide what action to take, including whether to prosecute someone. They act as independent prosecutors. They also look into deaths that need further explanation and investigate allegations of criminal conduct against police officers.

The COPFS developed a policy, Intentional or Reckless Sexual Transmission of, or Exposure to, Infection which sets out how prosecutors should deal with cases involving an allegation of intentional or reckless sexual transmission of, or exposure to, infection which has serious, potentially life threatening consequences for the person infected. Differences in the criminal law and evidential requirements between Scotland compared with England and Wales mean that it was not possible to adopt an identical policy across the UK.

In developing this guidance, the COPFS consulted with the public health sector including HIV Scotland, the National AIDS Trust (NAT) and Terrence Higgins Trust (THT). An initial policy was published in July 2012 and HIV Scotland, THT and NAT jointly published a community resource to explain the policy. There was considerable concern amongst people living with HIV about the potential for HIV related prosecutions to violate their human rights. HIV Scotland have met with the COPFS.
annually as part of monitoring the application and content of the policy.

In 2012 the Scottish Government published the 'Strategy for Justice in Scotland' to set out the vision and outcomes for justice in Scotland. It uses an outcomes-focused and evidence-based approach. It sets out each of the priority areas and the programmes and activities that are addressing them. It concludes by describing how the strategy will be monitored and taken forward by leaders across the justice system.

The COPFS plays a pivotal part in the justice system, working with others to make Scotland safe from crime, disorder and danger. Their strategic focus is the public interest and their aim is to take into account the diverse needs of victims, witnesses, communities and the rights of those accused of crime. They support the Strategy for Justice in Scotland and, in particular, its priorities of:

> Reducing crime, particularly violent and serious organised crime
> Tackling hate crime and sectarianism
> Supporting victims and witnesses
> Increasing public confidence and reducing fear of crime

**Sex work and sexual health for sex workers**

In Scotland selling sex is legal as long as it is between consenting adults. Certain practices that relate to sex work however are illegal. There are several acts that describe these. The term ‘prostitution’ is used below only where the specific Act has done so.

Applicable legislation:

> **Civic Government (Scotland) Act 1982 Section 46:**

This Act states that it is an offence for any sex worker, be they female or male, to engage in a number of activities for the purposes of prostitution, including: ‘Loitering in a public place’; ‘Soliciting in a public place or any other place so as to be seen from a public place’; or which ‘importunes any person who is in a public place’.

The maximum penalty for a conviction under section 46 of the 1982 Act is a fine not exceeding £500.

> **Prostitution (Public Places) (Scotland) Act 2007:**

This sets out specific offences that criminalise the purchase of sex in public. It makes it illegal, for the purposes of obtaining the services of someone engaged in prostitution, to: ‘Loiter in a public place in a manner from which it may be reasonably inferred that the loitering is for the purposes of obtaining the services of someone engaged in prostitution’; or ‘Solicit in a public place or any other place so as to be seen from a public place’.

The maximum penalty under section 1 of the 2007 Act is a fine not exceeding £1000.

> **Criminal Law (Consolidation) (Scotland) Act 1995:**

Sections 7 to 13 of this Act contain a number of provisions on the procurement of prostitution, abduction and detention, unlawful intercourse, trading in prostitution, brothel keeping, allowing children to be in a brothel, and living off the earning of another from male prostitution.

> **Criminal Justice and Licensing (Scotland) Act 2010:**

Section 45 of this Act contains provisions to increase the maximum penalties in sections 11 and 13 of the Criminal Law (Consolidation) (Scotland) Act 1995 which deal with the offences of ‘brothel-keeping’ and ‘living on the earnings of prostitution’ to a maximum penalty of 7 years imprisonment and an unlimited fine. The Act also contains a provision in relation to prostitution (Section 99) to assist the police by providing powers for the closure of premises associated with...
human exploitation which includes prostitution.

* > **Criminal Justice (Scotland) Act 2003:**

This Act contains offences that relate to the trafficking of human beings for the purposes of exploitation through prostitution. The maximum penalty after conviction is 14 years imprisonment or a fine or both.

* > **Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005:**

Sections 9 through 14 create a number of offences related to paying for the sexual services of a child (a person under the age of 18) and causing, inciting, controlling, arranging of facilitating the providing of sexual services by a child. The maximum penalty for these crimes is 14 years imprisonment.

**Sexual health for sex workers:**

While the HIV Action Plan for Scotland does not directly address sexual health issues for sex workers, the Sexual Health and Blood Borne Virus Framework does. In chapter 3 of the framework the value of targeted interventions is presented and the need to focus efforts on those known to be at risk is discussed. Sex work is explicitly mentioned in the context of an increased risk of harm for women with unintended pregnancies and the increased vulnerability of women who misuse substances or are involved in sex work.

Sex work is also mentioned in the context of gender-based violence and again referring to the increased vulnerability that sex workers, both male and female, have to this kind of violence. The framework also shows that this is an issue that concerns the Scottish Prison Service: “many women who are, or have been, within the prison service are victims of coercive, harmful or abusive relationships, whether through their partner, childhood sexual abuse or prostitution”.

**Hate crime**

The Offences (Aggravation by Prejudice) (Scotland) Act 2009 created new statutory offences in Scotland to protect victims of crime who are targeted because of their disability, sexual orientation or transgender identity. The definition of disability contained in the Act includes any medical condition which may have in the future a substantial or long term effect, such as HIV.

The Act states that if a crime is motivated by malice and ill-will towards a victim because of his or her actual or presumed disability, sexual orientation or transgender identity, then it constitutes an offence ‘aggravated by prejudice’. Where offences are proven to be as a result of such malice or ill-will, the court must take that into account when determining sentence. This can lead to a longer custodial sentence or higher fine or a different type of disposal.

This legislation built upon pre-existing protections from hate crime in relation to race and religion or belief; bringing Scotland into line with the rest of the United Kingdom, which already protected against crimes motivated by prejudice based on disability, sexual orientation or transgender identity.

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HIV is a global issue and the response to the epidemic has been global in its scope, entailing international institutions, national governments, regional bodies, and networks of community advocates. As well as domestic policy, there are a range of international guidelines and standards which seek to ensure universal access to HIV prevention, treatment care and support.

**EU policy**

The European Union published the *Bremen Declaration on Responsibility and Partnership - Together Against HIV/AIDS*[^133], pledging its support for the UN Declaration of Commitment on HIV/AIDS[^134] and the UN Political Declaration on HIV/AIDS[^135]. The Bremen declaration draws particular attention to Eastern Europe and Central Asia and recognises challenges exist in accessing universal treatment across Europe.

The EU’s HIV agenda was supported by the action plan, *Combating HIV/AIDS in the European Union and Neighbouring Countries*[^136]. This identified sexual transmission and injecting drug use as the primary methods of transmission and, while recognising the growing rate of heterosexual transmissions, it identifies the following priority groups: men who have sex with men, injecting drug users, and migrants from countries with a high rate of HIV infections.

The action plan’s main objectives included scaling up prevention strategies, supporting priority EU member states and neighbouring countries, and developing methods to reach vulnerable and at risk populations.

The World Health Organization (WHO) has a UN organisation that concerns itself with global and public health matters. It provides technical support to UN member countries as well as setting norms and standards for responding to health issues such as HIV and AIDS.

The WHO Global health sector strategy on HIV/AIDS, 2011–2015 is intended to guide the health sector response to the HIV epidemic in order to achieve universal access to HIV prevention, diagnosis, treatment, care and support. The strategy reaffirms global goals and targets for the health sector response to HIV, identifies four strategic directions to guide national responses, and outlines recommended country actions and WHO’s contributions. The strategy promotes a long-term, sustainable HIV response through strengthening health and community systems, tackling the social determinants of health that both drive the epidemic and hinder the response, and protecting and promoting human rights and promoting gender equity as essential elements of the health sector response.

WHO guidelines

As set out above, the World Health Organization (WHO) is a UN organisation that concerns itself with global and public health matters. It provides technical support to UN member countries as well as setting norms and standards for responding to health issues such as HIV and AIDS.

WHO has published guidelines on a variety of issues including ARV therapy for adults and adolescents, and children and infants. In July 2013 they published their first consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. They cover the following topics:

Antiretroviral therapy for adults and adolescents:

These new guidelines describe the WHO’s recommendations for the treatment of HIV infection in adults and adolescents. The most important change from the 2010 guidelines concerns the stage of HIV infection at which age treatment should be initiated. This differs depending on the target population.

A priority should be to initiate ART in all individuals with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) or individuals with a CD4 count equal to, or lower than 350. However ART should be initiated in all individuals living with HIV with a CD4 count greater than 350 and equal to, or lower than 500 regardless of WHO clinical stage.

In the following situations ART should be initiated regardless of WHO clinical stage or CD4 count:

- Individuals living with HIV and active TB disease
- Individuals co-infected with HIV and HBV with evidence of severe, chronic liver disease.
- Partners with HIV in serodiscordant couples should be offered ART to reduce HIV transmission to uninfected partners.

Antiretroviral therapy for children and infants and pregnant and breastfeeding women:

The consolidated guidelines include the recommendations for the treatment of adults and adolescents living with HIV but also treatment guidelines relating to children and infants and pregnant and breastfeeding women. These sections of the consolidated guideline are an update to an earlier 2010 guideline document that focussed exclusively on children and infants. The guidelines state that:

- ART should be initiated in all children infected with HIV below five years of age, regardless of WHO clinical stage or CD4 cell count.
- ART should be initiated in all children infected with HIV who are five years of age or older with a CD4 cell count equal to or lower than 500.
ART should be initiated in all children infected with HIV with severe or advanced, symptomatic disease (WHO clinical stages 3 or 4) regardless of age or CD4 cell count.

Finally, ART should be initiated in any child younger than 18 months of age who has a presumptive clinical diagnosis of HIV.

It is important to initiate ART in pregnant women, and women who are breastfeeding and living with HIV, to prevent vertical transmission.

The guidelines make these main recommendations:

> All pregnant and breastfeeding women living with HIV should initiate ART, and this should be maintained at least for the duration of mother to child transmission risk\(^1\). Women meeting treatment eligibility criteria for adults (see above) should continue lifelong ART.

> Particularly in generalised epidemics, all pregnant and breastfeeding women living with HIV should initiate ART as lifelong treatment.

The guidelines go into far more detail about specific drug regimens for different target populations and these are specified all the way to third line ART as well as clinical diagnosis. WHO clinical stages are also described. The guidelines also provide extensive recommendations for the delivery of services, guidance for programme managers and monitoring and evaluation.

**UNAIDS Strategy 2011-2015**

The UNAIDS strategy aims to advance global progress in achieving: set targets for universal access to HIV prevention, treatment, care and support; to halt and reverse the spread of HIV, and contribute to the achievement of the Millennium Development goals by 2015\(^2\).

Adopted by the Programme Coordinating Board in December 2010, the strategy works to position the HIV response in the new global environment. It recognises that the HIV response is a long term investment and the intent of the strategy is to revolutionise HIV prevention, catalyse the next phase of treatment, care and support, and advance human rights and gender equality.

The strategy is underpinned by a unified budget and accountability framework. The framework is intended to operationalise the strategy, mobilise and allocate resources for its implementation, measure progress and report on results.

**Travel**

Some countries have entry and visa restrictions for people living with HIV. The World Health Organization has stated that there is no public health justification for entry restrictions that discriminate solely on the basis of an individual’s HIV status\(^3\). There are no restrictions on travel to or from Scotland or the UK based on HIV status.

A number of countries restrict entry for people living with HIV, consequently foreigners living with HIV may be denied entry, denied permission to work and immigrate, or even be deported. The rules differ from country to country and often change, some countries deny entry to anyone living with HIV others have no restrictions on entry for tourists but require you to take a test if applying for a work or residence permits.

The way these laws are enforced also varies. Compulsory testing may be used on entry, or in certain areas of a country, alternatively proof of a negative HIV status may be required to remain.

Not all countries have laws or policy specifically relating to immigration or tourism and HIV. However this does not mean that declaring one’s HIV status would not cause problems.

\(^1\) While the term ‘mother to child’ is used in the referenced guidelines, HIV Scotland prefers to use the term ‘vertical transmission’.


\(^3\) Cited on World Health Organization website: http://www.who.int/ith/diseases/hivaids/en/
TABLE 1: Countries, territories and areas with restrictions on entry, stay or residence of people living with HIV\textsuperscript{146}

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It is important to note that if the law in a given country is unclear, or information cannot be found, declaring a HIV positive status may still effect the granting or extension of a visa, residence permit, or entry into a country.

There are also countries that have laws that explicitly state that entry and permission to live or work will not be affected by the applicants HIV status. Particularly for those with a right to live in the EU there should be no restrictions relating to HIV for travel or residence in other EU member states, though access to care may vary. The overwhelming majority of countries worldwide have rejected restrictions on the entry, stay and residence of people living with HIV, and there is a clear international trend towards repeal of such discriminatory laws.

From 2000 to mid-2013, the number of countries, territories and areas with HIV-related travel restrictions fell by more than half – from 96 to 43\textsuperscript{147}.

For people planning on travelling, up to date information should always be sought from www.namlife.org.uk.

\textsuperscript{146} UNAIDS, Report on the global AIDS epidemic, 2013

\textsuperscript{147} See note 146
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ABBREVIATIONS

> HIV: Human Immunodeficiency Virus
> AIDS: Acquired Immune Deficiency Syndrome
> NPF: National Performance Framework
> HEAT: Health Improvement, Efficiency, Access to Services and Treatment
> SDS: Self-directed support
> CPPs: Community Planning Partnerships
> CHPs: Community Health Partnerships
> SOAs: Single Outcome Agreements
> PrEP: Pre-exposure prophylaxis
> PEP: Post-exposure Prophylaxis
> oPEP: Occupational Post Exposure Prophylaxis
> PEPse: Post-Exposure Prophylaxis following sexual exposure
> ART: Antiretroviral therapy
> HAART: Highly active antiretroviral therapy
> MSM: Men who have sex with men
> ICPs: Integrated Care Pathways
> IVF: In vitro fertilisation
> STI: Sexually transmitted infection
> CfE: Curriculum for Excellence
> LGBT: Lesbian, gay, bisexual, and transgender
> BBV: Blood-borne virus
> TB: Tuberculosis