The Sexual Health and Blood Borne Virus Framework

2011-15

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SCOTTISH GOVERNMENT

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
BBV	Blood Borne Virus
COSLA	Convention of Scottish Local Authorities (COSLA)
DASH	Data augmentation for sexual health
GP	General Practitioner
GUM	Genitourinary medicine
HAART	Highly Active Antiretroviral Therapy
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPS	Health Protection Scotland
IDU	Injecting Drug User
ISD	Information and Statistics Division
LARC	Longer Acting Reversible Contraception
LGBT	Lesbian, Gay, Bisexual, Transgender
MCN	Managed Care Network
MSM	Men who have Sex with Men
NaSH	National Sexual Health System
NES	NHS Education for Scotland
NESI	Needle Exchange Surveillance Initiative
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NSS	National Services Scotland
RSHP	Relationship, Sexual health and Parenthood education
SOA	Single Outcome Agreement
SIGN	Scottish Intercollegiate Guidelines Network
SNAP	Scottish Needs Assessment Programme
SSHI	Scotland's Sexual Health Information report
STI	Sexually Transmitted Infection

MINISTERIAL FOREWORD

Sexual health and blood borne viruses continue to be of high priority for the Scottish Government. The Sexual Health and Blood Borne Virus Framework represents an ambitious vision for these key public health challenges, bringing them together for the very first time.

The Framework is based on the solid foundations of existing policy, notably our sexual health strategy, *Respect and Responsibility*, and the *Hepatitis C Action Plan*. It continues our renewed focus on HIV, as signalled by the publication of the *HIV Action Plan* in 2009, and establishes a policy landscape in Scotland for hepatitis B. As we take this agenda forward, we intend to challenge inequalities; build on current achievements; and consider new priorities, new advances and new evidence.

It is important to recognise that improving sexual health and blood borne virus outcomes cannot be achieved in isolation. This Framework will establish real and active links with other national health concerns such as alcohol and drugs misuse as well as linkages to areas such as education, gender-based violence and the early years.

I acknowledge that these are challenging times for the public sector, and the Framework presents an ambitious agenda. It also, however, reflects the strength of enthusiasm and expertise that exists throughout Scotland for continuing improvement in sexual health and blood borne virus outcomes. The strategy reflects the key priorities of our colleagues throughout Scotland, priorities which I fully endorse.

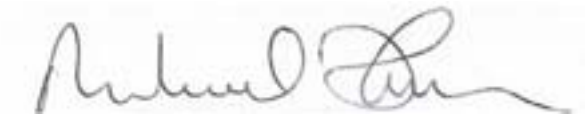
Improving sexual health and blood borne virus outcomes should be based on supporting those in our communities who are most vulnerable and ensuring that high quality treatment, care and support is accessible for all whenever, and wherever, they require it.

We want to live in a society where attitudes towards sexual health and wellbeing, to HIV, hepatitis C and hepatitis B are supportive and non-stigmatising. Where people of all ages and from all backgrounds feel enabled to seek the support they need without fear of discrimination or recrimination, whether that be from parents or carers; health and care professionals; or employers and work colleagues.

The portrayal of issues around sexual health and blood borne viruses in the media should be fair and balanced, so that we can all feel that we are equal and valued members of society in Scotland.

I believe that through the Framework we can harness the spectrum of skills and expertise that has seen such impressive advances in Scotland in sexual health and blood borne virus prevention, diagnosis, treatment and care and support to date.

Through working together we can see a healthy and more inclusive Scotland where sexual relationships are based on good communication and are free from harm; where life-affecting infection can be prevented and where people living with blood borne viruses can live healthier, fulfilling lives; and where no one is stigmatised for their health status, their life choices or lifestyle.



Michael Matheson MSP
Minister for Public Health

CHAPTER 1: INTRODUCTION

The *Sexual Health and Blood Borne Virus Framework* sets out the Scottish Government's agenda in relation to sexual health, HIV, hepatitis C and hepatitis B for the next four years.

For the first time, these four policy areas have been brought together into a single integrated strategy. Building on the solid foundations of proven and successful Scottish Government policy, notably *Respect and Responsibility* (Scottish Executive, 2005) and the *Hepatitis C Action Plan* (Scottish Executive, 2006a Scottish Government, 2008a*)*. The Framework reflects an ambitious vision for sexual health and blood borne viruses in Scotland. It adopts an outcomes based approach anchored by effective shared ownership and joint working with a strong focus on challenging inequalities.

The Scottish Government, NHS Boards, Local Authorities and Third Sector organisations all have essential roles to play in progressing the Framework Outcomes, both individually and in partnership, and all organisations have been fully involved in the development of this policy.

In progressing these outcomes, the Framework will also recognise the commonalities that exist across Scottish Government policy areas, including drug and alcohol policy, Early Years, child and maternal health, long-term conditions, Curriculum for Excellence and Equally Well. It will build on these going forward to support improvements in sexual health and wellbeing and to effectively tackle blood borne viruses in Scotland. These policy links are set out in **Appendix 3**.

Why a Sexual Health and Blood Borne Virus Framework?

Sexual health and blood borne virus policy is currently detailed in three major strategies: *the Hepatitis C Action Plan (Phase II)* (Scottish Government, 2008a), *Respect and Responsibility* (including the *National Outcomes 2008/11*) (Scottish Executive, 2005) and the *HIV Action Plan in Scotland* (Scottish Government, 2009a). Currently no overarching national policy exists for hepatitis B that encompasses diagnosis, treatment, care and prevention. The development of the *Sexual Health and Blood Borne Virus Framework* reflects the importance of building on our previous successes and continuing work across these policy areas.

The *Sexual Health and Blood Borne Virus Framework* advocates interventions and approaches to improve health and wellbeing in Scotland. It is informed by knowledge of the economic case for interventions in all of these policy areas. This includes the cost effectiveness of HIV and hepatitis C anti-viral treatment, which is well understood and notably, the annual UK cost of teenage pregnancies – £63 million to the NHS alone (Teenage Pregnancy Strategy Evaluation Team, 2003).

The costs to Scotland arising from blood borne virus infections and poor sexual health are significant. The economic impact is felt directly by the NHS, Local Authorities and the Third Sector, but also indirectly by other organisations. Costs to the public purse include, but are not limited to, the costs of clinical treatment (drug

treatments, psychological support and specialist care); social services and education.

In addition to the economic case for continuing to address the effects of blood borne viruses and seeking to improve sexual health and wellbeing, there is existing and emerging evidence of the need for and value of **joined-up working** in these areas. Specifically:

- the impact of inequalities: those most at risk across the Framework are amongst the most vulnerable members of our society and subject to both health and social inequalities;
- the importance of the Early Years agenda across the sexual health and blood borne virus policy areas;
- increasing evidence of cross-agenda working at practice and policy level by stakeholders and within Scottish Government;
- similar prevention, testing and treatment issues;
- the importance of providing a person-centred service, addressing all of an individual's health and wellbeing needs; and
- co-infection epidemiology.

While the Framework adopts an integrated approach to these policy areas, it also acknowledges that there are still areas where policy overlaps do not occur and where priorities differ. It is for this reason that the four policy strands are separately articulated in the body of the Framework.

This joined-up approach recognises the strategic links across sexual health and blood borne viruses nationally and locally but also acknowledges that operational distinctions exist.

The Framework does not mandate that structural change is necessarily required to deliver on outcomes. The need for structural change should be determined by local circumstances against consideration of the Framework Outcomes.

An Outcomes Based Approach

The Framework has been developed to promote an outcomes based approach. The Framework will support progress towards, and achievement of, a small number of high level sexual health and blood borne virus outcomes. These are outlined in more detail in **Chapter 2**.

Progress against the outcomes will be monitored nationally through a small set of indicators (**Appendix 1**) using, wherever possible, nationally generated data (these data will be broken down by local area when feasible and where appropriate) and by reviewing progress in the context of Local Authority Single Outcome Agreements.

The Scottish Government and other partners will work together to ensure progress is maintained and that challenges do not become barriers to delivery.

Recommendations

While the Framework takes an outcomes based approach, this document also provides a number of recommendations for NHS Boards, Local Authorities, Third Sector agencies and other partners which set out the key approaches or deliverables that will support achievement of the outcomes.

These recommendations are drawn from best practice and are in line with *Respect and Responsibility*, the *Hepatitis C Action Plan* and the *HIV Action Plan* where relevant. They outline key issues that service providers need to give consideration to, or key elements of service that providers who are delivering best practice should offer.

- **Throughout this document recommendations or suggested key-approaches are highlighted by indented bold text with a square bullet-point.**

A Quality Approach

The development of the Framework supports the ambitions of Scottish Government's *Healthcare Quality Strategy for NHSScotland* ('*the Quality Strategy'*), which was published in May 2010 (Scottish Government, 2010a). *The Quality Strategy* seeks to ensure that the highest quality NHS healthcare services are delivered in Scotland. Specifically, the Framework supports *the Quality Strategy* by:

- engaging with those most at risk of poor sexual health outcomes and/or blood borne viruses to ensure that they are able to benefit from our NHS services;

- ensuring that effective treatments, interventions, support and services are provided to people when they need them, whilst at all times working in partnership with our stakeholders to ensure that services provided are evidence based and appropriate and that unnecessary duplication is minimised; and

- ensuring that people are able to maintain high levels of health, good relationships and positive wellbeing; to live well through self management, improved health literacy and by supporting anticipatory and preventative responses through an assets-based approach to sexual health and blood borne viruses. (The asset model accentuates positive capability within individuals and supports them to identify problems for which they can activate their own solutions.)

CHAPTER 2: THE OUTCOMES

In line with the Scottish Government's *Quality Strategy*, this Framework is focussed on outcomes rather than inputs or processes. This approach will ensure that all partners, nationally and locally, are working to the same shared agenda while having the freedom to take different approaches in the way things are done. We want to foster innovation and imaginative solutions to delivery, while retaining a focus on what we ultimately want to achieve.

The Framework Outcomes are:

Outcome 1: Fewer newly acquired blood borne virus and sexually transmitted infections; fewer unintended pregnancies.

The Framework intends to improve public health through reducing the harm that can be caused through preventable infections and poor sexual and reproductive health. This will be achieved through strong health improvement prevention and education initiatives amongst professionals and the public (especially those at risk).

Outcome 2: A reduction in the health inequalities gap in sexual health and blood borne viruses.

Health inequalities remain a significant challenge in Scotland. This is clearly illustrated across sexual health and blood borne viruses, where the greatest impact is on those most vulnerable in society, from socio-economic inequality to the impact of sexual orientation, gender and race.

This outcome will support focussed improvement and targeted intervention locally and nationally in order to ensure that nobody is inappropriately disadvantaged in prevention, treatment and care.

Outcome 3: People affected by blood borne viruses lead longer, healthier lives.

More and better targeted testing, early diagnosis and effective treatment and care of blood borne virus infections underpinned by high quality personal and social support are essential in ensuring long-term health. Effective treatment, and curing of infections where this is possible, will help reduce onwards transmission. The Framework will seek to improve practice in these areas. Better partnership working, including closer links with sexual health and drug and alcohol misuse partners, will support people living with blood borne viruses.

Outcome 4. Sexual relationships are free from coercion and harm.

Holistic approaches to sexual wellbeing are central, not only to tackling sexual ill-health but to ensuring a positive approach to sex and sexual relationships for people of all ages. This includes tackling issues around gender-based violence, homophobia and racism.

This will be achieved through improvements in knowledge and awareness; promotion of positive sexual health and through targeted education, awareness raising and social marketing amongst the public and professionals.

Outcome 5: A society where 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.

Changing the culture in Scotland around sex, sexual relationships, sexual health and blood borne viruses is challenging, but vitally important.

We must support people living in Scotland to improve their health and wellbeing by encouraging communication and positive attitudes to sex, sexual health and blood borne viruses.

Changing the culture is also essential if we are to reduce onward transmission of infection and ensure that those people living with, and affected by, blood borne viruses are able to feel they are equal and valued members of our society. Many people living in Scotland have outdated knowledge about blood borne viruses, the way in which they are transmitted, life expectancy, quality of life for someone living with a blood borne virus and the realities of living on treatment for a lifetime.

Linking with these ambitions, there is a need to normalise attitudes towards the provision of HIV, viral hepatitis and sexual healthcare in Scotland, moving away from an exceptional approach and towards a more transparent and mainstream one.

The indicators which will measure progress against these outcomes are set out in more detail in **Appendix 1**.

CHAPTER 3: RESPECT AND RESPONSIBILITY: SEXUAL HEALTH AND WELLBEING

Introduction

Unlike the other three topic chapters in this Framework, each of which deals with a single disease, this chapter relates to a range of sexual health and wellbeing issues. The sexual health chapter of the Framework is, therefore, necessarily broader in scope.

Where we are now

Respect and Responsibility (Scottish Executive, 2005), the first national strategy for sexual health in Scotland, has been in place since 2005. Following a review in 2008, the Scottish Government, NHS Boards, Third Sector agencies, Local Authorities and other stakeholders worked towards the *Respect and Responsibility National Sexual Health Outcomes 2008-2011 (*Scottish Government, 2008b*)*.

Respect and Responsibility has three broad aims:

- to improve the quality, range, consistency, accessibility and cohesion of sexual health services from primary care to GUM services, in line with the principles of providing services that are safe, local and appropriate;

- to support everyone in Scotland, including those who face discrimination due to their life circumstances or their gender, race or ethnicity, religion or faith, sexual orientation, disability or age, to acquire and maintain the knowledge, skills and values necessary for good sexual health and wellbeing; and

- to positively influence the cultural and social factors that impact on sexual health.

The strategy recognised the diversity of lifestyles in the population of Scotland. Its approach, based on the principles of self respect, respect for others and strong relationships, continues to be relevant.

Much has been achieved through *Respect and Responsibility* and the National Outcomes. In particular, the majority of NHS Board areas now offer high quality integrated sexual health services. Quality Standards for sexual health services have been developed by NHS Quality Improvement Scotland (QIS) and NHS Boards are working to meet these standards with support from Healthcare Improvement Scotland (formerly QIS). The type of service provided in Primary Care, however, remains inconsistent.

In many areas of Scotland young people also now have access to general health advice, chlamydia testing, pregnancy testing and condoms in or within walking distance of schools. There is improved availability of sexual health and relationships education in schools and other settings, although this is not consistent throughout Scotland. The *Reducing Teenage Pregnancy Guidance and self-assessment tool* (LTS, 2010) has been produced but has not, as yet, been uniformly implemented.

In terms of communication the *Sexual Health Scotland* website (http://www.sexualhealthscotland.co.uk/) has been an important development. It provides non-judgemental advice and information about sexual health, relationships and service provision. There has also been the delivery of national social marketing campaigns *Sex: It's Healthy to Talk About It (*promoting communication); *Giving You More Choice* (raising awareness of Longer Acting Reversible Contraception (LARC); and *HIV Wake Up (*raising awareness of HIV testing, aimed at men who have sex with men).

Sound leadership and co-ordination has been provided through the Ministerial *National Sexual Health and HIV Advisory Committee (NSHHAC)* and, at local level, through multi-agency sexual health strategy groups and sexual health leads. Some areas have been more successful than others, however, in getting the necessary buy-in and support of non-NHS statutory organisations and agencies.

Where we want to be

The sexual health and wellbeing element of the Framework intends to support and promote ongoing delivery of the key elements of *Respect and Responsibility*. Specifically, for 2011-2015 the intention is that:

- the aims and principles of *Respect and Responsibility,* should continue to be delivered, taking into account the progress already made; and

- key areas for further action to improve sexual health and wellbeing in Scotland should be identified, informed by up to date evidence and, in particular, a focus on those who are considered to be most at risk of poorest sexual health and wellbeing.

The Framework translates this agenda into the high level Framework Outcomes:

Framework Outcomes: Sexual Health and Wellbeing

1. Fewer sexually transmitted infections; fewer unintended pregnancies
2. A reduction in the health inequalities gap in sexual health
3. People affected by blood borne viruses lead longer, healthier lives
4 Sexual relationships are free from coercion and harm
5. A society and culture whereby the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health are positive, non-stigmatising and supportive.

The Multi-Agency Approach

As highlighted throughout the Framework, improving sexual health and wellbeing is a multi-agency responsibility. It cannot be addressed through interventions delivered in specialist sexual health services alone. Each area has already established a multi-agency sexual health strategy group and these groups should continue their role in promoting and delivering partnership working to enable local progress and improvement in sexual health and wellbeing.

Primary Care has an important role to play, particularly in remote and rural areas where access to specialist services may be difficult and challenging. A well-informed, responsive and supported Primary Care sector can fulfil the essential sexual healthcare needs of the majority of the local population, enabling sexual health services to focus on the provision of specialist care. Universal women's, men's and children's health services also play their part. Importantly, Local Authorities have responsibility for key policy areas which impact on sexual health outcomes, including education and social work.

- **Multi-agency sexual health strategy groups should ensure that Primary Care is engaged and supported in the development and implementation of local sexual health strategies, including the development of cost-effective models of care, with clear care pathways for the individual.**

- **Those heading up multi-agency sexual health strategy groups should ensure that membership is relevant, pro-active and at a sufficiently senior level to ensure appropriate and timely decision making. Roles and responsibilities should be clear and explicit.**

- **There should be strong links between multi-agency sexual health strategy groups, Blood Borne Virus MCNs, Alcohol and Drug Partnerships and Community Health Partnerships which, in turn, will feed into the Community Planning process.**

- **Where relevant, Local Authorities should link progress against Framework Outcomes to Single Outcome Agreements, in conjunction with local partners.**

Delivering the Outcomes

The following section details the recommendations and strategies that multi-agency partners should adopt to contribute towards delivery of each of the Framework Outcomes. Progress against outcomes will be measured through the agreed set of national indicators (see **Appendix 1**).

<u>Outcome 1</u>: Fewer newly acquired blood borne virus and sexually transmitted infections; fewer unintended pregnancies.

<u>Outcome 2</u>: A reduction in the health inequalities gap in sexual health and blood borne viruses.

Children and Young People

Getting it Right for Every Child (Scottish Government, 2006) provides the methodology for delivering the *Early Years Framework* (Scottish Government and COSLA, 2008a,b), *Equally Well* and *Achieving our Potential: A Framework to tackle poverty and income inequality in Scotland* (Scottish Government 2008e). Strong partnership working should be taking place locally across all agencies, at both practitioner and strategic organisational level, to improve outcomes for all children and young people. This work should take an early intervention approach and deliver

streamlined and co-ordinated help that is appropriate, proportionate and timely. This work, combined with the other values, principles and core components of *Getting it Right for Every Child*, is key to addressing some of our most entrenched problems in society, including the need for improvement in sexual health and wellbeing.

- **Improving sexual health and wellbeing should be integrated into wider work streams at local level which aim to address health and social inequalities and risk taking behaviours and which focus on prevention, including building resilience, aspiration and self-esteem.**

Teenage Pregnancy

Whilst pregnancy and parenthood are positive choices for some young people, for others they are associated with negative social and psychological consequences.

Local Authorities have the lead role at local level in delivering national strategies which address disadvantage in Scotland and breaking the intergenerational cycle of inequalities. They are, therefore, best placed to assume a leadership role in delivering reduced teenage pregnancies in partnership with NHS, Third Sector and other local partners. Where relevant, Local Authorities should ensure the inclusion of a teenage pregnancy Single Outcome Agreement indicator.

In addition, Local Authorities and other statutory and Third Sector organisations are asked to work together to implement *Reducing teenage pregnancy – Guidance and self-assessment tool,* published by Learning Teaching Scotland (LTS) in 2010. This brings together the range of current evidence and advice on the partnerships, strategies and interventions that need to be in place locally if teenage pregnancy rates are to be reduced (LTS, 2010). By reviewing this evidence and using the self-assessment tool on an annual basis, Local Authorities and their partners can build on existing good practice to address teenage pregnancy in the long term.

- **Local authorities should take a leadership role in addressing teenage pregnancy and should play a key role in implementing the 'Reducing teenage pregnancy' self assessment tool (LTS, 2010).**

Targeted Interventions

It is more effective and cost effective to focus efforts on those known to be most at risk; this is supported by Healthcare Improvement Scotland Sexual Health Standard Criteria 3.6[1].

Local needs assessment will inform multi-agency sexual health strategies but high risk groups are likely to include young people aged under 25 and men who have sex with men (MSM). Within these groups, higher-risk populations include young people not in school, young offenders and those who are looked after or accommodated.

[1] Targeted interventions are demonstrated for young people at greater risk of teenage pregnancy and poor sexual health, including looked after children. (NHS Quality Improvement Scotland, 2008)

Those with alcohol and/or drugs problems are also at risk of poor sexual health outcomes.

Pregnancy and parenthood are positive choices for many; many unintended pregnancies lead to positive experiences for mother and child. However, some women may be at risk of harm due to unintended pregnancy and should therefore be targeted for supportive and preventative action. Those who are most at risk include women who have had a previous termination, young women who have had repeat pregnancies in adolescence and some women in areas of deprivation. They will also include other vulnerable women such as those who misuse substances and/or who are involved in prostitution.

- **In order to support a more targeted approach multi-agency partners should be working together to ensure:**
  - **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 heath services), which provide both general and sexual health advice, pregnancy testing and condoms;**
  - **that women who attend for termination are made aware of the availability of local sexual health services, where this is appropriate;**
  - **the provision of Longer Acting Reversible Contraception (LARC) to vulnerable women most at risk of unintended pregnancy, where appropriate, including in termination and maternity services, prior to discharge. This is supported through NHS Quality Improvement Scotland Sexual Health Standards 6[2] and 8[3];**
  - **targeted provision of sexual health and HIV prevention services to support MSM. This work should be delivered in partnership through both the statutory and Third Sector.**

Sexual Health and Drug or Alcohol Use

It is recognised that being under the influence of alcohol and drugs can affect an individual's judgement and make them vulnerable to engaging in risk-taking behaviour, such as unprotected sex. This includes both those who drink socially and those with a drug or alcohol problem. Work to encourage and support people to make responsible decisions around alcohol and drugs will therefore contribute to fewer poor sexual health outcomes, such as unintended pregnancies and STIs. It is therefore important that there are strong operational links between sexual health and alcohol and drug services and strong strategic links between Multi-Agency Sexual Health Strategy Groups and Alcohol and Drug Partnerships.

[2] Women receive safe termination of pregnancy with minimal delay, followed by contraceptive advice and psychological support. (NHS Quality Improvement Scotland, 2008)
[3] All individuals have access to intrauterine and implantable methods of contraception. (NHS Quality Improvement Scotland, 2008)

Providing drug and alcohol harm reduction, treatment and rehabilitation services should involve a sexual health assessment, with appropriate advice given and contraception needs met. This should be revisited when staff become aware that clients are in a relationship. Similarly, those undertaking needs assessment in sexual health services will need to take into account drug and alcohol use, without the individual being judged or stigmatised. Staff should also be aware of how and where to refer people on to appropriate local services. This has education and training implications to ensure that drug and alcohol staff feel confident and skilled to discuss sexual health issues and sexual health staff feel confident and skilled in specific issues for people with drug and alcohol problems. For those at particular risk of poor sexual health outcomes, contraception needs may include the provision of LARC. Particular support is required for pregnant women with a drug or alcohol problem, and their partners, throughout pregnancy and in bringing up their child in the future.

- **There should be strong partnership working between Multi-Agency Sexual Health Strategy Groups and Alcohol and Drug Partnerships.**

- **There should be clear links between sexual health and drug and alcohol services, with sexual health issues addressed as part of the assessment process, including advice on contraception for both men and women and, where appropriate, the provision of contraception including LARC.**

Relationships, Sexual Health and Parenthood (RSHP) Education

Local Authorities are responsible for ensuring that Relationships, Sexual Health and Parenthood Education (RSHP) is delivered to all young people, both in school and wherever learning takes place. Looked after and accommodated young people and young offenders are most at risk of poor sexual health outcomes and should therefore be prioritised for such education.

The delivery of RSHP within the Health and Wellbeing component of Curriculum for Excellence provides the opportunity for linkages with other health improvement issues and risk-taking behaviours such as blood borne viruses, alcohol and drug misuse, smoking and mental health. Local Authorities must ensure that the delivery of such education meets their equality and diversity legal obligations.

Parents and carers have an essential role to play in the provision of age appropriate RSHP. Local Authorities, in partnership with NHS Boards, must play a key role in supporting and facilitating parents and carers to discuss relationships and sexual health with children and young people.

- **Relationships, Sexual Health and Parenthood education should be provided to all young people, including those not in school, with delivery in line with equality and diversity legal obligations.**

Sexual Health Services

As highlighted throughout the Framework, the provision of sexual health services should be a multi-agency and multi-disciplinary responsibility, based on local epidemiology and need. All sexual health and blood borne virus consultations, whether carried out in primary or secondary care, should begin with a risk assessment. Critical issues to be addressed include the use of an effective method of contraception, STI and blood borne virus testing tailored to individual risk, as well as alcohol and drug use (see **page 10**). Specialist services should be set up in such a way that they can provide holistic care, based on the needs of the individual, including, for example, a focus on tackling non-sexual health issues such as drug and alcohol abuse or gender-based violence.

In addition, specialist services for those with specific sexual health needs (e.g. sexual dysfunction, transgender issues etc) should be accessible throughout Scotland. This is supported by NHS Quality Improvement Scotland Sexual Health Standard 1[4].

The Lead Clinicians for Sexual Health have been key in driving forward the agenda on sexual health locally and nationally. Every NHS Board should ensure that this role is fulfilled and recognised in job-planning processes. The Lead Clinician role is clearly set out in *Respect and Responsibility* (Scottish Executive, 2005).

- **Sexual health consultations, undertaken in primary or secondary care, should begin with a risk assessment, with testing and treatment and care tailored to individual needs.**

- **High quality, integrated sexual health services should be available throughout Scotland.**

Training and Education

Regular training, education and continuing professional development is vital to ensure the confidence and competence of the workforce.

- **Local multi-agency strategies should detail clear action to ensure a competent and confident workforce for both health and non-health staff through regular training, education and continuous professional development. In NHS Boards, this is supported by NHS Quality Improvement Scotland Sexual Health Standard 9[5].**

[4] Individuals who are diagnosed with a sexually transmitted infection see an appropriately trained member of staff to organise partner notification (partner tracing). (NHS QIS , 2008)
[5] All staff who deliver sexual health services are adequately and appropriately trained. (NHS QIS, 2008)

Sexual Health Improvement Interventions

In January 2011, the Chief Medical Officer for Scotland set up an Expert Advisory Group to review the evidence base underpinning opportunistic chlamydia testing, with a view to further advice being provided to the NHS in Scotland to augment *SIGN Guideline 109* (SIGN, 2009) on the management of genital chlamydia trachomatis infection. The Group are due to report in summer 2011. The Scottish Government will consider carefully the findings from the review and the potential impact on current policy and practice, taking forward work with stakeholders as part of the implementation of this Framework.

- **The Scottish Government will consider carefully the findings from the Report of the Expert Advisory Group on chlamydia testing and its impact on current policy and practice, working with stakeholders as part of the implementation of the Framework.**

A report on a systematic review of reviews on effective interventions to improve sexual health and wellbeing and three short evidence briefings covering *Children and Young People*, *Adults* and *Service Delivery* (NHS Health Scotland, 2010a,b,c) were published by NHS Health Scotland in September 2010. The findings, and the outcome of a service mapping exercise across Scotland, published in June 2011, will assist with the implementation of interventions which have a sound or promising evidence base.

Monitoring and evaluation should be integral to service provision, with findings shared to promote best value and to inform local priorities and future planning.

- **Sexual health improvement interventions should have a sound or promising evidence base and should be monitored and evaluated.**

Sexual Health and the Prison Service

In Scotland, some of those most vulnerable to poor sexual wellbeing are those who are, or have been, in prison or young offender services.

Sexual health work in prisons should prioritise those most in need. Young offenders, their partners and women are particularly vulnerable to poor sexual health and wellbeing and may also be perpetrators or victims of coercive and harmful sexual relationships.

Examples of good practice are already in evidence and the transfer of prison health services into the NHS in 2011 offers an opportunity to further support improvements in sexual health for these key populations.

Supporting these vulnerable populations requires input both during their time in prison and following release. Scottish Prison Service and NHS Boards have a duty of care to ensure that people are adequately signposted to services following release. It can be challenging for these populations to link with services. Many people leaving

prison will also have drug and alcohol problems. The linkage between sexual health and drug and alcohol services will again, therefore, be important.

- **The Scottish Prison Service and NHS Boards should work in partnership to ensure that:**
  - **the sexual health and wellbeing needs of prisoners, and their partners where possible, are addressed, including the provision of contraception, which may include LARC, where appropriate; and**
  - **sex and relationships education is prioritised; in the first instance to young offenders and women.**

<u>Outcome 3</u>: People affected by blood borne viruses lead longer, healthier lives.

Co-infection

There is evidence of the impact of STI and blood borne virus co-infection with a number of studies indicating a strong association between STIs and increased risk of HIV acquisition. Co-infection of HIV and other STIs is common, particularly amongst MSM; co-infection of hepatitis C and HIV accelerates the development of advanced liver disease and can create complications for those living with blood borne viruses. Services should therefore be alert to issues of co-infection, develop cross-condition measures to tackle the problem and, when appropriate, provide long-term care and support.

- **Sexual health services should be alert to issues of co-infection and, where possible, develop cross-condition measures to tackle the problem.**

Accessibility of Sexual Health Services

As set out in NHS Quality Improvement Scotland sexual health Criteria 1.4[6] and Standard 5[7], there should be targeted services for communities or individuals with specific needs. This includes not only people living with HIV and hepatitis B, but also those affected by hepatitis C, where new infection is being seen in some HIV positive MSM. Services should ensure that both men and women living with, or at risk of, blood borne viruses have access to sexual health care, including contraceptive advice and provision, where relevant.

Women involved in prostitution are extremely vulnerable to blood borne viruses, STIs and poor sexual and reproductive health. It is therefore important that these women are able to easily access high quality sexual health services.

[6] There are targeted services for communities or individuals with specific needs. (NHS Quality Improvement Scotland, 2008)

[7] Individuals attending for ongoing HIV care are offered high quality sexual and reproductive healthcare to improve personal wellbeing and to minimise the risk of transmitting infection to others. (NHS Quality Improvement Scotland, 2008)

NHS Quality Improvement Scotland Sexual Health Standard 5 supports the accessibility of high quality sexual healthcare to those attending services for ongoing HIV care, to improve their personal wellbeing and to minimise the risk of transmission.

- **High quality sexual health and support services should be accessible to all, including those affected by blood borne viruses, through both NHS and Third Sector services.**

<u>Outcome 4</u>: Sexual relationships are free from coercion and harm

Information for Young People and Other Vulnerable Groups

Self-esteem and aspiration have an important role to play in ensuring that sex takes place within a safe, respectful and mutually supportive environment and that sexual experiences are not coerced or regretted. It is important that all young people, but in particular young women and young MSM, should be supported through programmes of confidence, self-esteem and aspiration building.

Parents and carers also play an extremely important role in this area, for example through fostering openness and discussion opportunities with their children, looking at family cultural issues and supervision of young people. Their role should be acknowledged and facilitated, where it is considered appropriate.

People with learning disabilities can be vulnerable to coercion and harm, including sexual abuse. It is important that appropriate information explaining what sexual abuse is, how to protect oneself and where to get help if required, is made available to those with learning difficulties. Family carers and support workers also need information to address issues such as how to recognise, support and respond to abuse, legal issues and where to go for further information and help.

- **Local Authorities should work with partners to ensure that all young people, parents and carers, have access to high quality and consistent information on sexual health and wellbeing.**

- **Appropriate information should be available to those with learning difficulties, their carers and support workers.**

Promoting Communication

All services and professionals should be comfortable promoting good communication as central to better sexual health and wellbeing and better relationships.

- **There should be continued action to encourage good communication for better sex and better relationships, including same sex relationships, including action to**:

    - **encourage communication and confidence both before and during sexual relationships;**

- **provide support to ensure that no-one feels coerced into an unwanted sexual encounter whether through force, abuse of alcohol or drugs or through pressure from peers and/or the media;**

- **recognise that body image has a strong impact on individual's and society's perceptions of sexual relationships;**

- **support positive sexuality for people with physical disability; and**

- **challenge the negative assumptions attributed to the sexuality of people with learning disability.**

Gender-Based Violence

Gender-based violence comprises a range of abusive and controlling behaviours that can include sexual assault and forced sex, as well as more hidden forms of victimisation that interfere with a person's choices about sexual activities, contraception, safer sex practises, pregnancy and the ability to negotiate around these issues.

Whilst sexual abuse and coercion can happen to anyone, young people (particularly young women) and women and men involved in prostitution have heightened vulnerability. Evidence indicates that experience of gender-based violence is consistently associated with unplanned pregnancies, sexual risk taking, STIs, terminations of pregnancy and sexual dysfunction and can be a barrier to adults and young people accessing sexual health care.

The NHS has a pivotal role in the appropriate identification and management of gender-based violence, since virtually all survivors of abuse will interact with health services at some point, either on their own or on their children's behalf. The implementation of Routine Enquiry of Sexual Abuse is currently underway. This will lead to increased detection and will afford survivors the opportunity to access support and services, allowing for earlier intervention and improved health outcomes. It also necessitates strong partnership working between all relevant services.

- **Those working in sexual health services should be sensitive to the impact of gender-based violence on sexual health and be aware of support services for individuals who have been abused and how to refer onwards.**

- **NHS Boards should review sexual health service provision for those who have suffered from sexual assault to identify how this can be improved or strengthened.**

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 and/or prostitution.

The Scottish Prison Service, and from November 2011 NHS Boards, have an important role in offering advice, education and support to such vulnerable women

to help empower them to remove themselves from coercive and harmful relationships. Many of these women may also have drug or alcohol problems associated with abusive sexual relationships and supporting recovery will be an important factor.

- **Scottish Prison Service and NHS Boards should work in partnership to provide advice, education, and support to women in prison who are, or who may be, subject to coercive and harmful relationships.**

<u>Outcome 5</u>: 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.

Relationships, Sexual Health and Parenthood (RSHP) Education

- **Relationships, Sexual Health and Parenthood education should be provided to all young people, with delivery in line with equality and diversity legal obligations.**

Promoting Sexual Health and Wellbeing

National and local awareness raising is key to promoting knowledge, understanding and communication around sexual health and wellbeing and in particular to a broader understanding beyond 'safer sex'.

Challenging cultural and commercial messages which reinforce negative stereotypes of gender identity and sexual orientation are essential to promoting positive sexual health and wellbeing. Gender stereotypes of both men and women perpetuate assumptions of male power and control over a sexual partner, are often founded on misinformation and can inhibit and limit both men and women in developing meaningful relationships and emotional maturity. These stereotypes can be reinforced by both written and electronic media and through, for example, advertising. These rapidly developing influences should be counteracted with positive local and national action.

- **Work to promote the positive and life enhancing aspects of sexual wellbeing and sexual relationships should continue locally, regionally and nationally.**

- **Efforts to promote a positive approach to sexual health and relationships in the media should continue, nationally and locally, through linking in with media groups such as the National Union of Journalists and national broadcasting regulators.**

Supporting Delivery

The Scottish Government will monitor progress on delivery of the outcomes through the Framework Indicators detailed in **Appendix 1**.

The Scottish Government, including the National Co-ordinators, Special Health Boards and other national organisations will have key roles in progressing the achievement of the Framework Outcomes and supporting multi-agency partners. These roles are set out in **Chapter 7**.

Evidence Tables

Table 3.1 – Outcome 1: Fewer newly acquired STIs; **Fewer unintended pregnancies**

Sexually Transmitted Infections

- The overall trends for the four main sexually transmitted infections (genital chlamydia, gonorrhoea, genital herpes and genital warts), show a general increase in diagnoses – although much of this increase is related to increased access to services and increased testing in recent years.
- Young people aged less than 25 and men who have sex with men are most at risk of infection.

Teenage Pregnancy

- The teenage pregnancy rate in Scotland has remained steady over the last ten years, but the most recent data has shown a very slight decrease across all age groups. (ISD, 2011a)
- There is a strong association between deprivation and rates of teenage pregnancy. Those living in Scotland's most deprived areas have approximately four times the rate of teenage pregnancy (91.3 per 1,000 compared with 22.2 per 1,000) and ten times the rate of delivery as the least deprived (65.3 per 1,000 compared with 7.6 per 1,000) (ISD, 2011a).

Termination of Pregnancy

- In 2009 and 2010, there was a reduction in the number of terminations of pregnancy performed. 28% of those women had had at least one previous termination. (ISD, 2011b)
- The rate of terminations in 2010 was highest in younger women 16-19 (21.4 per 1,000) and those aged 20-24 (22.4 per 1,000). (ISD, 2011b)
- Termination rates show a clear link with levels of deprivation. Rates in areas of high deprivation (16 per 1,000) are nearly double that seen in the most affluent areas of Scotland (9.2 per 1,000). (ISD, 2011b)

Table 3.2 – What the evidence tells us

- Evidence indicates that interventions in the early years of a child's life are most effective in supporting positive sexual health outcomes (NHS Health Scotland, 2010a). In particular, the Family Nurse Partnership and Abecedarian Projects have provided high quality evidence on the effectiveness of early intervention in achieving positive sexual health outcomes in young people, including reductions in unintended pregnancy.
- The evaluation of *Healthy Respect Phase Two* (NHS Health Scotland, 2010d) also highlighted that poor outcomes in teen years, including sexual risk-taking, are best tackled in the early years (pre-birth to age eight) of a child's life; that there is a need to work more intensely with young people to help them address underlying issues which shape sexual health; that the most vulnerable young people should be targeted for interventions; and that generic aspects of parenting are more important than communication about sexual matters.
- Sexual health and relationships education remains critically important. It is now well established that providing accurate age and stage appropriate information can support young people to avoid sexual activity until they are physically and emotionally ready (Currie et al, 2008).
- The availability of comprehensive and integrated sexual health services remains key to sexual health and wellbeing.
- Socio-economic influences have a clear impact on sexual health outcomes.
- Early evidence indicates the strong impact of the media on young people's approaches to sex and sexual relationships.
- Data suggests that healthy sexual attitudes are understood by a significant majority, but significantly fewer act on these healthy attitudes. (Progressive Partnership Ltd. 2008)
- Recent findings suggest that young people in alternative educational settings have poorer health-related behaviours compared with their peers in mainstream education and are more vulnerable than their mainstream peers in terms of sexual activity, condom and contraception use. (Henderson et al, 2011)

CHAPTER 4: HIV

Where we are now

HIV is a major public health challenge for Scotland. Recognising this, the Scottish Government published the *HIV Action Plan* in November 2009. (Scottish Government, 2009a).

Since 2001, the number of people diagnosed with HIV, known to be alive and currently living in Scotland has more than doubled (an estimated 5,100 by the end of 2010) (Health Protection Scotland, 2011). This increase is due to people with HIV coming to Scotland from areas of high prevalence; sustained new transmissions among MSM and effective drug regimens sustaining and improving the quality and length of life of people living with HIV.

Whilst HIV testing has been increasing year on year, a considerable proportion (around 25%) of individuals remain undiagnosed or are diagnosed at a late or very late stage of infection.

Currently, access to HIV specialist clinical care in Scotland is excellent, with only a small proportion of those living with HIV not accessing such care. Nevertheless, inconsistencies in access to, and provision of, optimal services are evident across NHS Boards (Johnman, 2009). Work being taking forward through the HIV Services Standards (Healthcare Improvement Scotland, 2011), along with the implementation of the Framework, will continue to drive forward improvements in this area.

The *HIV Action Plan* (Scottish Government, 2009a) set out the Scottish Government's key goals for HIV, including: a renewed commitment to tackle the virus through more focussed and effective prevention; increased uptake of testing; and by ensuring that people living with HIV receive high quality treatment, care and support.

Developed by a wide range of committed and expert stakeholders, the *HIV Action Plan* constitutes short- and medium-term actions to address HIV in Scotland.

Where we want to be

The HIV element of the Sexual Health and Blood Borne Virus Framework is not a replacement of the *HIV Action Plan*. It is intended that the Framework approach will support multi-agency organisations to continue to focus on the key aims of the Action Plan:

- reducing new transmissions;
- reducing undiagnosed HIV through increased testing and early diagnosis;
- ensuring universal access to high quality HIV treatment and care; and
- supporting those living with, and affected by, HIV in Scotland.

Underpinning these aims is the need to address the HIV-related stigma and discrimination experienced by people living with and affected by HIV and to enable a society and culture whereby the attitudes of individuals, the public, professionals and the media in Scotland towards HIV are positive, non-stigmatising and supportive.

Many of the actions within the *HIV Action Plan* remain integral and will be a key part of the delivery of this Framework, including:

- NHS Board needs assessment and planning for HIV;
- Healthcare Improvement Scotland Standards for HIV Services;
- educational and training needs in the HIV-related workforce;
- clinical IT developments;
- national procurement of HIV anti-retroviral therapy; and
- guidance on HIV prevention in key populations.

The Framework translates this agenda into the high level Framework Outcomes:

Framework Outcomes: HIV

1. Fewer newly acquired HIV infections
2. A reduction in health inequalities associated with HIV
3. People affected by HIV live longer, healthier lives
5. A society whereby the attitudes of individuals the public and professionals and the media in Scotland towards HIV are positive, non-stigmatising and supportive

The Multi-Agency Approach

A multi-agency, collaborative approach to the prevention, testing, treatment and care of HIV and the provision of support services is essential. In some areas, locally established Managed Care Networks (MCNs) for hepatitis C have been expanded to encompass blood borne viruses as a useful structure for multi-agency working, ensuring the participation of all partners, including people living with HIV.

- **There should be strong links between Multi-Agency Sexual Health Strategy Groups, Blood Borne Virus MCNs, Alcohol and Drug Partnerships and Community Health Partnerships which, in turn, will feed into the Community Planning process.**

All partners have a role in influencing behaviours, lifestyles and risk factors. They should help implement evidence-based prevention initiatives, support testing, strengthen early engagement with treatment services and should provide support services for those living with HIV.

In particular, it is essential that Local Authorities (e.g. education, community services, social work, housing) and the Third Sector both recognise and are recognised for the role and contribution they make to tackling all three blood borne viruses (HIV, HCV, HBV).

- **Where relevant, Local Authorities should link progress against Framework Outcomes to Single Outcome Agreements in conjunction with local partners.**

- **The multi-agency approach should centre on, and involve people living with, HIV to ensure effective responses to need and in the planning of HIV services either directly or through relevant advocacy and support groups**.

Regional Approaches and Sharing Expertise

Regional networking has been identified as having an important role in both HIV prevention and in meeting the needs of people living with HIV in Scotland (Johnman, 2009) in order to share expertise and best practice as well as clinical resource. Few Boards can offer all of the clinical resources that are required to support high quality HIV clinical care. Working regionally can help ensure that people living with HIV have equitable access to safe, effective and person-centred clinical services and enable effective prevention approaches that benefit from cross NHS Board and cross-partner working.

The National Co-ordinators will offer support to NHS Boards and other organisations to work together national and regionally, where required. This will include, for example, working in conjunction with the Convention of Scottish Local Authorities (COSLA), Scottish Government National ADP Support Co-ordinators, Scottish Prison Service and appropriate Local Authority national bodies (e.g. Association of Directors of Social Work).

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. An HIV Clinical Leads network will support the sharing of expertise, experience and advice.

Delivering the Outcomes

The following section details the recommendations and strategies multi-agency partners should adopt to contribute towards delivery of each of the Framework Outcomes. Progress against outcomes will be measured through the agreed set of national indicators (see **Appendix 1**).

Outcome 1: Fewer newly acquired blood borne viruses and STIs; fewer unintended pregnancies.[8]

Efforts to reduce new transmissions of HIV should focus on where they are likely to have the highest impact – all people living with HIV, MSM and those who have come from areas of high prevalence, notably African countries.

Transmission among people who inject drugs and between heterosexuals who do not fall into a clearly defined risk group is less common but the potential for such transmission exists. It is therefore important that all groups are considered in terms

[8] Links to Healthcare Improvement Scotland HIV Services Standards 3, 4 and 5.

of HIV risk and HIV related sexual health. Raising awareness of HIV is important for the prevention of infection in all ages, including those who may not consider themselves at risk.

For young people, the Health and Wellbeing component of Curriculum for Excellence should provide the opportunity to link HIV with other health improvement issues and risk taking behaviours. Parents and carers also have an essential role to play in increasing the awareness and understanding of HIV in young people.

- **Multi-agency partners should work together to ensure:**
  - **effective links between prevention, diagnosis, treatment and care services in the statutory and Third Sector. Prevention should be a key part of all treatment and care services;**
  - **the use of the most up to date evidence to inform prevention approaches within local NHS Board multi-agency HIV needs assessments and plans;**
  - **engagement, support and involvement of those most at risk of HIV transmission, notably MSM and those from areas of high prevalence, particularly African countries;**
  - **regular training, education and continuing professional development to ensure the competence of the health and non-health HIV-related workforce in relation to HIV prevention. Staff should be provided with the resources they require in order to feel confident in discussing issues, including sexual health, with people at risk of and living with HIV. This should include the implementation of HIV educational solutions as identified and developed through the NHS Education for Scotland (NES) HIV expert advisory group;**
  - **delivery of effective awareness raising and social marketing approaches, including the continued implementation of HIV Wake Up and local/regional social marketing activities;**
  - **that learning about HIV is built into Curriculum for Excellence experiences and outcomes, including Relationships, Sexual Health and Parenthood (RSHP) education. RSHP education should be provided to all young people, in all schools and wherever learning takes place, with delivery in line with equality and diversity legal obligations. This should include young people not in school, young offenders and those who are looked after and accommodated; and**
  - **the implementation of:**
    - **Healthcare Improvement Scotland Standards on HIV Prevention;**
    - **NHS Health Scotland HIV Prevention Guidance and Recommendations.**

Outcome 2: A reduction in the health inequalities gap in sexual health and blood borne viruses

Those most at risk of HIV in Scotland are MSM and those from areas of high prevalence, notably African countries. The inequality gap seen in HIV manifests in relation to race and sexual identity, more so than socio-economic status. This is, for example, pertinent to those living with HIV in Scotland in black and minority ethnic (BME), particularly African, communities, who may face race related stigma as well as discrimination relating to their HIV status.

People living with HIV may also face financial hardship, sometimes for reasons that are not related to their health status. Living in severe financial hardship can impact on someone's ability to live well with HIV. Those who were diagnosed before the emergence of effective drug therapy may not have prepared for older age and thus may require additional support. Third Sector organisations have a key role to play in supporting such vulnerable populations.

Many people living with HIV are capable of having a fulfilling working life and of obtaining the health, financial and social benefits of such. Some support may be required in order to enable people living with HIV to maintain a working life for as long as they can and wish to.

Strategies to reduce new transmissions of HIV (see outcome 1) and to ensure people living with HIV have longer, healthier lives (see outcome 3) will help to address HIV and thus to reduce inequalities.

- **Multi-agency partners should be proactive in working to prevent new transmissions of HIV and to provide support for those living with HIV in order to facilitate a reduction in the inequitable impact of HIV in Scotland.**

- **Multi-agency partners should work together to support people living with HIV who are facing financial hardship.**

- **Multi-agency partners should work together to support people living with HIV in maintaining a working life for as long as they can and wish to. Information should be made available to both employer and employee on the effect that living with HIV may (or may not) have on their working life and on the requirement for confidentiality, avoidance of stigma and discrimination and compliance with equality legislation.**

Outcome 3: People affected by blood borne viruses lead longer, healthier lives[9]

Living a longer and healthier life with HIV requires a holistic approach to health and wellbeing. Provision of, for example, specialist clinical, psychological, social and peer support is critical in maintaining contact and support from the moment of initial

[9] Links to Healthcare Improvement Scotland HIV Services Standards 6 - 11.

diagnosis through to management of HIV as a long-term chronic condition. For those who were diagnosed before the emergence of HAART this also includes adjustment to longer life expectancy and improved quality of life with HIV, which had not been anticipated before the availability of these highly effective drug treatments; this may include, for example, the provision of support to those who may have found difficulty in forming and/or maintaining relationships, following their diagnosis.

Diagnosis – Late Diagnosis and Undiagnosed HIV

It is critical that people living with HIV are diagnosed at the earliest opportunity. A considerable proportion, approximately 25%, of people infected with HIV in Scotland remain undiagnosed.

Undiagnosed infection risks further transmission and can result in extremely poor health outcomes and a reduction in the effectiveness of HAART for those living with HIV.

Testing for HIV has been increasing year on year; however, a notable proportion of individuals each year are diagnosed at a late (47% in 2010) or very late stage of infection. Missed opportunities within Primary Care and non-HIV related inpatient healthcare services can be a barrier for the early diagnosis and treatment of HIV.

Normalisation of attitudes amongst the public and professionals towards HIV testing is important in order to increase HIV testing rates and to enable HIV testing to be offered across a much wider variety of settings including primary and secondary care services (Burns and Martin, 2007).

Co-infection

Co-infection with other blood borne viruses or STIs can compromise the health of people living with HIV and can increase the risk of transmission, so testing of vulnerable populations (including those already diagnosed with hepatitis B, hepatitis C and/or syphilis) is key.

Treatment, Care and Support

People living with HIV require comprehensive treatment and care services. It is essential to ensure that all those who require specialist HIV treatment and care receive it regardless of transmission route, co-morbidities or any other factor irrelevant to good quality, safe, patient-centred and effective prevention, treatment and care and support.

There should be clear links and referral pathways between specialist HIV treatment and care and other services. This network of services which can enable joined-up clinical management and care, can be described as a ‘treatment and care network’ (Healthcare Improvement Scotland, 2011). Within this network, key services include primary care, sexual health, maternity, children’s, mental health, addictions, men’s health and older people’s services.

Women's health, particularly in terms of contraception and pre conception advice and assessment needs, should be considered.

HIV is now considered to be a long-term chronic condition. As such, primary care services are an important part of the care pathway for people living with HIV and, for example, can have an important role in monitoring and minimising co-morbidities of HIV and its treatment.

- **Multi-agency partners should work together to ensure people living with HIV can live longer, healthier lives through:**
  - **continued engagement with, and testing of, at risk populations with repeat testing being offered every 6-12 months for those who remain at ongoing risk;**
  - **increased knowledge and awareness of HIV in all populations;**
  - **the normalisation[10] of testing within all populations to encourage testing and to reduce late diagnoses and issues of stigma around HIV testing and diagnosis;**
  - **routinely offering HIV testing to individuals who present with clinical indicator conditions that could point to underlying HIV infection (BHIVA, BASHH and BIS, 2008);**
  - **the recommendation of HIV testing to individuals who test positive for hepatitis C, hepatitis B and/or syphilis in order to address potential complications of co-infection;**
  - **regular training, education and continuing professional development to ensure the competence of health and non-health HIV-related workforce; staff should be provided with the resources they require in order to feel confident in the discussion and provision of HIV testing, diagnosis and treatment in addition to those issues which affect people living with HIV such as social and emotional needs and sexual and reproductive health. This should include the implementation of HIV educational solutions as identified and developed through the NHS Education for Scotland (NES) HIV expert advisory group;**
  - **ensuring that all those who require specialist treatment and care and support are able to receive it; this may include consideration of HIV Home Delivery, where appropriate;**
  - **ensuring the provision of high quality HIV specialist treatment and care in order that all people living with HIV, including those living in remote and rural areas, have access to the full range of HIV-related**

[10] HIV testing should be considered normal and routine, not difficult, special or requiring specialist training. (Baggaley, 2008) (BHIVA, BASHH and BIS, 2008)

services through national and regional, as well as local, care pathways;

- **ensuring that primary care is engaged in the development and implementation of local HIV strategies, including the development of cost effective models of care, with clear pathways of care for the individual;**

- **ensuring that people living with HIV have access to specialist sexual healthcare and preconception advice/assessment;**

- **ensuring that support services for those living with HIV are available throughout Scotland, including for those living in remote and rural areas. Key to ensuring a holistic approach to wellbeing for people living with HIV, these should be offered via NHS Boards, Local Authorities and Third Sector organisations; and**

- **implementation of:**
  - **Healthcare Improvement Scotland HIV Service Standards;**
  - **NHS Quality Improvement Scotland Sexual Health Standard 5 to ensure high quality sexual and reproductive healthcare for people living with HIV; and**
  - **NHS Health Scotland recommendations on the retention of people living with HIV in clinical services.**

<u>Outcome 5</u>: 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.

It is acknowledged that HIV-related stigma and discrimination can be a barrier to testing. Those at risk of, or living with, HIV may be wary of accessing services or being open about their condition or risk behaviours because of (real or perceived) attitudes toward HIV, or due to fear of discrimination.

Changing the culture in Scotland around HIV is essential not only to increase awareness and reduce onward transmission of infection, but to ensure that those people living with, and affected by, HIV are able to feel that they are equal and valued members of our society.

Many people living in Scotland have outdated knowledge about HIV and the way in which it is transmitted, life expectancy and quality of life and the realities of living on HIV treatment for a lifetime.

Through this outcome we aim to see real change in attitudes toward HIV in Scotland.

- **Efforts to promote a positive approach to HIV in the media should continue nationally and locally through linking in with media groups, such as the National Union of Journalists and national broadcasting regulators.**

- **Multi-agency partners should work together to ensure:**
  - **that work to promote awareness and understanding of HIV continues locally, regionally and nationally;**
  - **the building of learning about HIV into appropriate Curriculum for Excellence experiences and outcomes, including Relationships, Sexual Health and Parenthood (RSHP) education, which should be provided to all young people, in all schools and wherever learning takes place, with delivery in line with equality and diversity legal obligations. This should tackle issues around stigma and discrimination in addition to awareness raising and prevention and should address HIV in Scotland as well as internationally; and**
  - **regular training, education and continuing professional development to ensure the competence of the health and non-health HIV-related workforce; ensuring an understanding and knowledge of issues around stigma and discrimination and demonstrating commitment to equality and diversity. This should include the implementation of HIV educational solutions as identified and developed through the NHS Education for Scotland (NES) HIV expert advisory group.**

Supporting Delivery

The Scottish Government will monitor progress in respect of delivery of the outcomes through the Framework Indicators detailed in **Appendix 1**.

The Scottish Government, including the National Co-ordinators, Special Health Boards and other national organisations will have key roles in progressing the achievement of the Framework Outcomes and supporting multi-agency partners. These roles are set out in **Chapter 7**.

Evidence Tables

Table 4.1 – Outcome 1: Fewer newly acquired HIV infections

Prevention

- Among people undergoing repeat HIV antibody testing between 2005-2009, the incidence of infection rates (new transmissions) were 15, 1.5 and 1.5 per 1000 person years for MSM, heterosexual men and women and people who inject drugs respectively; the rate in MSM has remained unchanged since the late 1980s.
- Among MSM attending gay bars in Glasgow and Edinburgh 2008, 40% reported practising unprotected anal intercourse in the previous 12 months. This rate was similar to that reported in 2005.
- Although a decline in infectious syphilis among MSM was observed between 2008 and 2009, the incidence of rectal gonorrhoea increased during this time.
- The annual prevalence of HIV among MSM undergoing testing in Scotland has remained constant at around 3-4% in recent years.
- The average annual number of HIV diagnoses and average prevalence of HIV among people who inject drugs having a named test during 2004-2008 was 19% and 0.6%, respectively. These figures are considerably lower than those recorded prior to this period. A major decline in the transmission of HIV among people who inject drugs in Scotland occurred contemporaneously with the implementation of harm reduction measures, namely needle exchange and methadone maintenance therapy in the late 1980s and early 1990s.
- In 2008, the prevalence among heterosexual men and women whose geographical region of exposure is sub-Saharan Africa was 7.3%; this compares with 0.1% in those whose region of exposure is the UK.
- Prevalence of HIV among UK-born women giving birth in Scotland has remained constant at around 0.04% between 2004 and 2008.

Table 4.2 – Outcome 3: People affected by HIV lead longer, healthier lives

- At the end of 2010, an estimated 5100 individuals were living with HIV in Scotland; of these, an estimated 3803 (75%) had been diagnosed and 1300 (25%) were estimated to remain undiagnosed.
- There were 360 new reports of HIV diagnoses made in Scotland during 2010; this compares to an average of 394 new diagnoses made each year between 2004 and 2008 and 429 reported in 2009.
- There has been a two-and-a-half-fold rise in testing since 2003 with 43,726 individuals tested in Greater Glasgow & Clyde, Lothian, Tayside, and Grampian NHS Boards combined during 2008. The majority of testing (80%) is performed in the genitourinary medicine (GUM) clinic setting.
- Of 357 individuals enrolling for the first time in HIV specialist care in 2010, 169 (47%) had a diagnosis of late infection (CD4 count <350) with 99 (59%) of this group of patients with evidence of a very late diagnosis (CD4 count <200) of HIV infection. The proportion diagnosed late was 46% and 48% among MSM and heterosexual men and women, respectively. Among the heterosexual group, those most likely to be diagnosed late comprise those born outwith Scotland. (52% versus 47% of those who are born in Scotland).
- Of 3339 individuals attending for HIV treatment and care in the 12 months up to

31st December 2010, 80% were on antiretroviral therapy (at levels of triple therapy or higher).

- Of 2616 individuals receiving antiretroviral treatment (at levels of triple therapy or higher) and attending for viral load monitoring in the 12 months up to the 31st December 2010, 96% achieved viral suppression (as indicated by a viral load of <400 copies per ml at their latest visit).
- The number of diagnoses of AIDS and deaths among HIV-infected individuals has remained stable at around 41 and 49, respectively between 2005 and 2009. An average of 15 deaths each year are among those with an AIDS diagnoses.
- Thanks to effective treatment, the over-50s are the fastest growing group of people with HIV in the UK (Power et al, 2010).
- Evidence shows that people living with HIV are less likely to be in paid employment and one in three people diagnosed with HIV in the UK have experienced severe economic hardship (National Aids Trust, 2008).

CHAPTER 5: HEPATITIS C

Where we are now

In 2004, the Scottish Government recognised that "*hepatitis C is one of the most serious and significant public health risks of our generation*" (Chisholm, 2004). This followed the Royal College of Physicians of Edinburgh (RCPE) *Consensus Conference and Consensus Statement on Hepatitis C* in 2004 (RCPE, 2004), and the *Scottish Needs Assessment Programme (SNAP) Report* in 2000 (SNAP, 2000)

An estimated 39,000 people are currently living in Scotland with chronic (long-term) hepatitis C. More than half remain undiagnosed and 75% of those chronically infected are not currently in specialist care. Chronically infected people are at increased risk of serious liver disease and cancer. Yet treatment for hepatitis C, a combination antiviral therapy, is deemed highly cost effective by both the National Institute for Health and Clinical Excellence (NICE) (NICE, 2006) and Quality Improvement Scotland (SIGN, 2006).

Accordingly, following extensive consultation with stakeholders, the Scottish Government launched the *Hepatitis C Action Plan* in 2006. The plan was completed in two phases. Phase I operated from September 2006 to March 2008 (Scottish Executive, 2006a). It focussed on increasing awareness and establishing the evidence base for hepatitis C, both in terms of the disease burden and the quality and quantity of services in Scotland, to inform proposals for future delivery. Phase II was published in May 2008 (Scottish Government 2008a) and was supported by significant Government investment for the period 2008-2011. It included 34 Actions which sought to significantly develop the quality and capacity of hepatitis C testing, treatment, care and prevention services in Scotland.

The Framework will continue to progress the key aims of the *Hepatitis C Action Plan*.

Where we want to be

The Sexual Health and Blood Borne Virus Framework recognises the need for ongoing and long term investment in hepatitis C to improve public health and wellbeing in Scotland. The Framework will build on the foundations established by the *Hepatitis C Action Plan* in 2008-2011 and, specifically, will continue to progress the key aims of that policy:

- to prevent the spread of hepatitis C, particularly among people who inject drugs;
- to diagnose hepatitis C infected persons, particularly those who would most benefit from treatment; and
- to ensure that those infected receive optimal treatment, care and support.

The Framework translates these aims into the high level Framework Outcomes:

Framework Outcomes: Hepatitis C

1. Fewer newly acquired hepatitis C infections
2. A reduction in health inequalities associated with hepatitis C
3. People affected by hepatitis C lead longer, healthier lives
5. A society whereby the attitudes of individuals, the public, professionals and the media in Scotland towards hepatitis C are positive, non-stigmatising and supportive.

The Multi-Agency Approach

Holistic Delivery

Delivery of the Framework Outcomes will be underpinned by holistic pathways, person centred services and collaborative partnerships for hepatitis C prevention, treatment and care. These will operate in conjunction with care pathways to help people overcome drug or alcohol addiction through relevant harm reduction, treatment and rehabilitation services, referred to as “recovery orientated systems of care”. Drug injecting remains the main transmission route for hepatitis C in Scotland and alcohol is a significant co-morbidity factor, accelerating the rate of liver disease in infected individuals.

The Framework acknowledges that although a significant proportion of those infected have recovered from drug and/or alcohol misuse, many are at different stages in their recovery. This is often associated with complex social care, medical and support needs that require to be addressed through partnership working across sectors if hepatitis C treatment is to be effective.

Local Managed Care Networks (MCNs) and Prevention Networks

The infrastructure and initiatives established by the *Hepatitis C Action Plan* to improve capacity, consistency and the quality of service delivery in Scotland will continue and remain integral to the delivery of the Framework. These include: the national procurement of hepatitis C medicines and injecting equipment; local Managed Care Networks (MCNs); *Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b); local Prevention Networks encompassing hepatitis C; national workforce development; education and competency frameworks (NHS Education for Scotland, 2010a,b,c); national information generating initiatives; and Healthcare Improvement Scotland Indicators (previously NHS Quality Improvement Scotland Standards) for hepatitis C.

A multi-agency approach to the prevention, testing, treatment, care and support of those living with hepatitis C remains essential. Local MCNs for hepatitis C and Prevention Networks encompassing hepatitis C (or equivalent for smaller NHS Boards) provide a forum for all partners (NHS, Local Authority, Third Sector and those living with hepatitis C) to plan, design and implement the services which this Framework seeks to continue. Where appropriate, these networks have expanded to

adopt a blood borne virus remit and have linked to their local planning structures (e.g. Community Planning Partnerships, Alcohol and Drug Partnerships and Community Health Partnerships) in line with need and circumstance.

- **The accreditation of local MCNs and the publication of Healthcare Improvement Scotland Indicators (previously NHS Quality Improvement Scotland Standards) for hepatitis C are expected within the first year of the Framework (2011/12).**

Enhanced Links with Local Authorities and the Third Sector

It is essential that NHS (including Primary Care), Local Authorities (e.g. education, community services, social work, housing), Scottish Prison Service and the Third Sector recognise and are acknowledged for the role and contribution they make to tackling all three blood borne viruses (HIV, HCV, HBV).

- **There should be strong links between Blood Borne Virus MCNs, Multi-Agency Sexual Health Strategy Groups, Alcohol and Drug Partnerships and Community Health Partnerships which, in turn, will feed into the Community Planning process.**

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- **Where relevant, Local Authorities should link progress against Framework Outcomes to Single Outcome Agreements in conjunction with local partners.**

- **The Third Sector contribution should be further supported nationally through a Third Sector lead organisation for Viral Hepatitis, encompassing both hepatitis B and hepatitis C for Scotland.**

The *Sexual Health and Blood Borne Virus Framework* National Co-ordinators will support this approach nationally, for example working in conjunction with the Convention of Scottish Local Authorities (COSLA), Scottish Government National ADP Support Coordinators, the Third Sector Lead for Viral Hepatitis, Scottish Prison Service and appropriate Local Authority national bodies (e.g. Association of Directors of Social Work).

Delivering the Outcomes

The following section details recommendations and strategies multi-agency partners should adopt to contribute towards delivery of each of the Framework Outcomes. Progress against Outcomes will be measured through the agreed set of national indicators (see **Appendix 1**).

<u>Outcome 1</u>: Fewer newly acquired blood borne virus infections.

The great majority of hepatitis C transmissions in Scotland occur within the Injecting Drug User (IDU) population with approximately 90% of the infected population in Scotland having ever injected (refer to **Evidence Table 5.1**). Large numbers of people who inject drugs continue to be infected annually (estimated 1000-1500 in

2008/9). In comparison, transmission amongst people who do not inject drugs and other routes of transmission, including sexual transmission, occurs very infrequently.

Reducing transmission of hepatitis C amongst people who inject drugs remains the major focus of prevention activity in Scotland. The establishment of needle exchange in Scotland in the late 1980s was instrumental in curtailing the transmission of HIV in the injecting drug user population. Since 2008, additional monies have been provided to NHS Boards for injecting equipment and the *Scottish Government National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b) were published, through the *Hepatitis C Action Plan*. These improved the provision of injecting equipment (particularly paraphernalia) alongside education initiatives to reduce the sharing of injecting equipment during drug use preparation. A decline in needle/syringe sharing has been observed in recent years (see **Evidence Table 5.1**). However, although significant progress has been made, there remains a considerable shortfall in the amount of injecting equipment provided to people who inject drugs compared with the number of injecting events taking place (refer to **Evidence Table 5.1**).

- **In line with *Road to Recovery* (Scottish Government, 2008f), the Scottish Government's strategy on tackling problem drug use, an ethos of recovery should be central to:**
  - **the optimal uptake of sterile injecting equipment and safer injecting practises for those who currently inject; and**
  - **access to optimal opiate substitution therapy, as part of a range of interventions available to help people recover from problem drug and/or alcohol use.**

- **Multi-agency partners should work together to continue to deliver effective local strategies, including:**
  - **early diagnosis and treatment of those already chronically infected with hepatitis C;**
  - **provision of an increasing range and number of needles, syringes and injecting paraphernalia to people who inject drugs in line with Scottish Government *National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b), utilising innovative approaches (including outreach) to enhance provision in a range of community settings (e.g. community pharmacies, NHS, Local Authority and Third Sector services/facilities);**
  - **education of people who inject drugs in the use of sterile injecting equipment for each injecting episode to promote a culture whereby, if someone is going to inject drugs, they do so using sterile equipment (needle/syringe, spoon, filter and water) on each occasion;**
  - **delivery of peer-to-peer educational interventions to reduce initiation into injecting drug use and to highlight how onward transmission**

(spread) of the virus can be prevented. These should be aimed at vulnerable individuals, people who inject drugs, those at risk of starting to inject and people who inject that have been newly diagnosed with hepatitis C;

- **provision of regular training, education and continuing professional development to ensure the competence of the health and non-health hepatitis C-related workforce, particularly those working with vulnerable groups, in the context of blood borne virus prevention. This should be provided in line with existing national frameworks for hepatitis C workforce development, education and competency (NHS Education for Scotland, 2010a,b,c) and Recommendation 9 of the *Scottish Government National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b); and**

- **incorporating hepatitis C education into Curriculum for Excellence for all young people, particularly those most vulnerable, wherever learning takes place (in and out of school). This should be provided in line with Learning Teaching Scotland *Hepatitis C Guidance for Educational Settings* (LTS, 2011) and equality and diversity legal obligations.**

<u>Outcome 2</u>: A reduction in the health inequalities gap in sexual health and blood borne viruses.

Hepatitis C infection in Scotland is associated with deprivation and health inequality as a consequence of drug injecting, which remains the main transmission route in this country. Strategies adopted to reduce new transmissions amongst people who inject drugs (see **Outcome 1**) and to improve access to antiviral treatment to clear the virus (see **Outcome 3**) will help to reduce the pool of infection within the injecting drug user population in Scotland.

Inequality of access to services by people who inject drugs may result from lifestyle and environmental barriers (e.g. prison, homelessness) and will be dependent on the strength of local MCNs, care pathways, relationships with alcohol and drugs partnerships (ADPs), prison and Local Authority partners (e.g. social work, community services, housing) to overcome these effectively.

- **Multi-agency partners should work together to progress strategies to reduce health inequality associated with hepatitis C, including:**

  - **local MCNs and care pathways for hepatitis C working closely and effectively with harm reduction, drug treatment and rehabilitation services to more effectively support people to access and complete antiviral treatment for their hepatitis C infection as part of their progress in overcoming and recovering from drug or alcohol misuse; and**

- **local MCNs and care pathways for hepatitis C which encompass service provision in a range of community and prison settings to optimise uptake, access and retention by people who inject drugs as part of an integrated person-centred approach.**

<u>Outcome 3</u>: People affected by blood borne viruses lead longer, healthier lives.

Diagnosis

Raising awareness of hepatitis C amongst professionals and the public is a significant challenge. An estimated 39,000 people are currently living in Scotland with chronic (long-term) hepatitis C infection. At present, 50-60% of people chronically infected with hepatitis C remain undiagnosed (approximately 22,500). Of the 16,500 who are diagnosed, around 75% are not currently in specialist care. Nationally, a twofold increase in the annual number of diagnosed persons developing end-stage liver disease has been observed between 1999 and 2009 (see **Evidence Table 5.2**).

Through the *Hepatitis C Action Plan*, local MCNs for hepatitis C have been established and the capacity of testing, treatment, care and support services have increased significantly. This has affected a more than twofold rise in the number of people initiated onto antiviral treatment in Scotland from 468 in 2007/08 to 1,043 in 2010/11, as well as a increase in annual hepatitis C diagnoses (see **Evidence Table 5.2**) which the Framework will build upon.

- **NHS Boards and their partners should work towards early intervention in order to reduce the number of hepatitis C infected people developing end-stage liver disease.**

- **NHS Boards and their partners should adopt approaches that ensure the great majority of people living with chronic hepatitis C are diagnosed and referred into specialist care. All partners are asked to work together with individuals living with or affected by hepatitis C to implement effective strategies that encompass:**

  - **innovative approaches to improve access to hepatitis C testing, such as dry blood spot testing, in settings attended regularly by people who inject drugs (e.g. drug treatment services, community pharmacies);**

  - **case finding initiatives in conjunction with laboratories, GPs and specialist services to identify individuals who should be offered or recommend a test in line with *SIGN Guideline 92: Management of Hepatitis C* (SIGN, 2006), or encouraged to re-engage with services where a diagnosis has been made;**

  - **sensitive and informed communication of test results and the provision of support throughout the testing and diagnosis process;**

- **awareness raising and peer to peer initiatives to promote the importance of hepatitis C testing and the availability and effectiveness of antiviral treatment in order to encourage test uptake among at risk populations, particularly current injectors and people who formerly injected drugs (noting past risk behaviour may be 10-20 years ago);**

- **awareness raising and other initiatives among migrant populations to encourage test uptake among people who have come from areas of high prevalence for hepatitis C such as Pakistan and other South Asian countries (Khokhar, Gill and Malik, 2004) (Khattak et al, 2002) (Parker, Khan and Cubitt 1999); and**

- **incorporation of annual hepatitis C testing into recovery plans of people attending drug and alcohol services, normalising testing as part of a person's recovery in line with Recommendation 14 of Scottish Government *National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b).**

Treatment Care and Support

A holistic approach to treatment and care is essential in order to effectively support people living with hepatitis C to lead longer healthier lives. Provision of, for example, specialist clinical, mental health (psychological/psychiatric), drug, alcohol, social care, welfare and peer support services, are essential components of integrated care pathways. Together, these support and sustain people from the point of diagnosis to completion of their antiviral treatment and contribute to improved personal wellbeing.

The *Hepatitis C Action Plan Phase II* established local MCNs and care pathways for hepatitis C across Scotland, increasing treatment and care capacity to double the number of people receiving antiviral therapy. In doing so, NHS Boards improved the integration of their primary care, specialist addiction, prison and social care services through the locally established MCNs. However, not all NHS Boards have reached the same level of maturity in terms of service design and delivery following delays and challenges in recruitment.

The Framework will maintain and build on these foundations with multi-agency partners, linking to Community Planning, Alcohol and Drug Partnerships and Community Health Partnerships as appropriate to strengthen relationships between NHS, Local Authority (e.g. social work, community services, housing) and harm reduction, drug treatment and rehabilitation services for those affected by substance misuse.

- **All partners should further develop testing, treatment, care and support services to increase the numbers of people initiated onto therapy in Scotland each year to 1100 in 2011/12, 1150 in 2012/13, 1200 in 2013/14 and 1250 in 2014/15.**

- **A proportion (10%) of those initiated onto treatment each year will be prisoners.**

- **Thereafter, the numbers of people initiated onto therapy should continue to rise to at least 2000 each year, subject to review and in accordance with research on the impact of treatment on the chronic hepatitis C population and associated burden of disease.**

- **Work should be undertaken to further develop and locally accredit managed care networks and care pathways for people living with hepatitis C. This includes cooperative arrangements between the NHS and prisons, Third Sector and Local Authority partners to provide a continuum of treatment, care and support for those infected and living in the community and prison environments.**

- **NHS Boards and other partners should explore the feasibility and benefits of specialist treatment services that outreach into the community and prisons, led by specialist nurses, consultants or GP shared care (e.g. in rural areas) to enhance referrals, attendance and clinical capacity. Notably, new medicines for hepatitis C (e.g. protease inhibitors) are likely to render treatment more complex in future.**

- **The potential for the further procurement of hepatitis C medicines (e.g. home delivery/joint purchasing/new medicines) to reduce costs to NHSScotland will be explored**

- **NHS Boards should explore the feasibility and strengths in establishing shared care arrangements with GPs, Local Authority (e.g. social work, housing, community services) and Third Sector partners to provide a broader range of support in relation to lifestyle changes, welfare needs, mental health and treatment side effects to improve access to specialist services, retention and completion of antiviral treatment**.

- **NHS Boards should review and refine treatment provision to take cognisance of changing health care arrangements in prisons and new hepatitis C medicines, recognising that although hepatitis C treatment is highly cost effective (NICE, 2006. SIGN 2006), it is evolving and new medicines (e.g. protease inhibitors for particular strains of hepatitis C) are in development and due to enter the pharmaceutical market later in the lifetime of the Framework.**

<u>Outcome 5</u>: 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.

Stigma and discrimination related to hepatitis C reflects public attitudes towards viral hepatitis, drug injecting and substance misuse generally. Such stigma and

discrimination can present a barrier both to testing and access to services that provide treatment, care and support. Changing the culture in Scotland around viral hepatitis and drugs and alcohol is essential to ensure people living with or at risk of hepatitis C are able to feel that they are equal and valued members of our society.

Many people living in Scotland have a poor understanding of hepatitis C including how it is transmitted, the availability of treatment, life expectancy and the quality of life for someone living with the virus long term.

These are not easy issues to address and no single strategy or policy can successfully change beliefs or prejudices that may exist across a country. Through this outcome we aim to progress aspects within our control that may contribute to understanding and attitudes towards hepatitis C in Scotland including how it is portrayed in the media through local and national strategies.

- **Efforts to promote a positive approach to viral hepatitis and substance misuse in the media should continue nationally and locally through linking in with media groups such as the National Union of Journalists and national broadcasting regulators.**

- **Hepatitis C education for all young people, particularly those most vulnerable, should be incorporated into Curriculum for Excellence wherever learning takes place (in and out of school). This should be provided in line with Learning Teaching Scotland *Hepatitis C Guidance for Educational Settings* (LTS, 2011) and equality and diversity legal obligations.**

- **Work to promote awareness and understanding of hepatitis C should continue locally, regionally and nationally including:**

    - **regular training, education and continuing professional development to ensure the competence of the workforce, encompassing anyone working with individuals or communities affected by hepatitis C, to improve knowledge and understanding of stigma and discrimination and promoting commitment to equality and diversity; and**

    - **awareness raising and peer to peer initiatives to promote and normalise testing and treatment for hepatitis C as part of a persons journey and care pathway in recovering from drug misuse.**

Supporting Delivery

The Scottish Government will monitor progress on delivery of the outcomes through the Framework Indicators detailed in **Appendix 1**.

The Scottish Government including the National Co-ordinators, Special Health Boards and other national organisations will have key roles in progressing the achievement of the Framework Outcomes and supporting multi-agency partners. These roles are set out in **Chapter 7**.

Evidence Tables

Table 5.1 – Outcome 1: Fewer newly acquired blood borne virus infections

- It is estimated that 90% of Scotland's hepatitis C virus (HCV) infected population has injected drugs.
- In 2006, the estimated number of current IDUs in mainland Scotland was 23,900, which compares to an estimated 18,700 current IDUs in 2003.
- In 2008-2009, the prevalence of HCV infection was 55% among IDUs who were interviewed at services providing injection equipment in Scotland and the incidence was estimated at 10-15 infections per 100 person years. This incidence rate translates to an estimated 1000–1500 IDUs having become infected with HCV.
- Among current IDUs in Scotland in contact with drug treatment services, a decline in needle/syringe sharing (either borrowing or lending a used needle/syringe) in the past month was observed from 27%-35% during 1995–2005 to 18%-22% during 2006–2009; further, a decline in only borrowing used needles/syringes in the past month was observed from 16% in 2006/07 to 11% in 2009/10. These findings are consistent with data obtained through surveys of IDUs in needle exchange settings
- Among current IDUs interviewed at services providing injection equipment in Scotland during 2008-2009, 15% reported having recently (last six months) injected with a needle/syringe previously used by someone else, while 48% reported having recently used other injecting paraphernalia (filters, spoons and water) that had previously been used by someone else.
- At least 4.1 million needles/syringes were distributed to IDUs in Scotland during 2008/09, which compares to the distribution of 3.6 million in 2005 and 4.3 million in 2007/08.
- Information on recent transmission, in the context of prevention initiatives implemented during the Hepatitis C Action Plan, is currently being obtained.
- There is a considerable shortfall in the amount of injecting equipment provided to IDUs. The estimated number of needles/syringes distributed to each IDU in Scotland during 2008/09 was approximately 170, and ranged from 110 to 360 across NHS Boards. The shortfall in sets of needles/syringes that need to be distributed to IDUs in Scotland, if the number of such sets is to correspond with the number of injecting events (estimated at around 500 per year), is approximately 8 million per year.
- Between 2008/09 and 2009/10, a several-fold increase in the number of sets of injection paraphernalia (filters and spoons/cookers) distributed to IDUs was observed in Scotland. This observation is related to the implementation of *National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b). and the provision of additional monies to NHS Boards, through the *Hepatitis C Action Plan*, to improve the provision of injecting equipment, particularly paraphernalia for drug use preparation.
- Data from IDUs surveyed in Amsterdam (Van Den Berg et al, 2007) indicate that the optimal intervention to prevent HCV transmission amongst this population involves a combination of opiate substitution therapy together with high levels of injection equipment provision (i.e. a sterile needle/syringe for each injection); recent findings from the UK, including Scotland, are consistent with this observation.

- The incidence of HCV infection amongst persons who do not inject drugs is low and the scope for prevention of HCV infection among non-IDUs is limited.

Table 5.2 – Outcome 3: People affected by blood borne viruses lead longer, healthier lives

Diagnosis

- In 2009, an estimated 39,000 people living in Scotland were chronically infected with the Hepatitis C Virus (HCV); of these, 16,500 (42%) were estimated to have been diagnosed by the end of 2009, and 22,500 (58%) were estimated to remain undiagnosed.
- In 2009, approximately 2000 new HCV diagnoses were made in Scotland, which compares to approximately 1500 new diagnoses made each year in 2006 and 2007; this represents a 33% increase in the annual number of persons newly diagnosed with HCV between 2006-2007 and 2009. This relates to an increase in testing (and therefore diagnosis) over this period and does not equate to an increase in transmission of HCV.
- Among IDUs who were interviewed at services providing injection equipment in Scotland during 2008-2009, only 46% of those who were found to be infected with HCV (through anonymous testing) reported that they had been diagnosed with HCV.
- In 2009, 61 people in Scotland had developed end-stage liver disease (i.e. were first hospitalised (58) or had died (3)) within one year of their HCV diagnosis. This figure compares to 41 people who had developed end-stage liver disease within one year of their HCV diagnosis in 1999. Among all HCV diagnosed people who had developed end-stage liver disease, the proportion of those who had developed end-stage liver disease within one year of their HCV diagnosis reduced from 46% (41/90) in 1999 to 33% (61/183) in 2009.

Treatment and Care

- Compared to an estimated 16,500 chronically infected people living in Scotland during 2009 who had ever been diagnosed with HCV, an estimated total of between 3500 and 4000 individuals had ever received antiviral therapy.
- Of the estimated 16,500 chronically infected people living in Scotland during 2009 who had ever been diagnosed with HCV, approximately 4000 (24%) had attended a specialist centre in 2009.
- The number of chronically infected people initiated on HCV antiviral therapy in Scotland increased from 468 in the financial year 2007/08 to 591 in 2008/09, 904 in 2009/10 and a provisional total of 1043 in 2010/11. The numbers initiated on antiviral therapy are in excess of the Hepatitis C Action Plan targets of 500 in 2008/09, 750 in 2009/10 and 1000 in 2010/11.
- Among patients (with either genotype 1, 2 or 3) initiated on pegylated interferon and ribavirin across nine clinics in Scotland during 2000-2007, 58% were known to have achieved a sustained viral response; this rate ranged from 39% among those with genotype 1 to 70% among those with genotype 2 or 3.
- In 2009, 183 people diagnosed with HCV in Scotland had developed end-stage liver disease (i.e. were first hospitalised (176) or had died (7)), which compares to 90 HCV diagnosed people who had developed end-stage liver disease in 1999; this represents a twofold increase in the annual number of HCV diagnosed

persons developing end-stage liver disease between 1999 and 2009.

NB: Whilst the document refers to 'people who inject drugs', the Framework data tables and indicators tables refer to IDU (intravenous drug user/s) population(s) as a recognised epidemiological term.

CHAPTER 6: HEPATITIS B

Where we are now

Scotland has historically been a country of very low prevalence of hepatitis B. The actual and potential burden of disease associated with HIV and hepatitis C were previously considered to be much greater. Consequently, systems and initiatives were established to generate comprehensive information on the burden of HIV and hepatitis C in Scotland while those for hepatitis B, until very recently, have been either absent or rudimentary.

In recent years, however, it has become evident that the number of people living in Scotland with chronic hepatitis B infection has increased considerably, as a consequence of a rise in the number of immigrants coming to Scotland from countries in the world where the prevalence of hepatitis B infection is high (particularly East Asia) (Hahne et al, 2004). In response, Health Protection Scotland, in association with laboratory and clinical colleagues, has embarked on a programme of information generating activity which will provide ongoing high quality information on the burden of hepatitis B infection and disease in Scotland.

The development of information systems and the use of statistical modelling techniques for hepatitis B, while well underway, are incomplete and will be unable to provide robust data until 2012. The following evidence cited in this chapter should, therefore, be considered in this context.

Where we want to be

Due to the historically low prevalence of hepatitis B, there has been no overarching national policy for hepatitis B in Scotland encompassing diagnosis, treatment and care as well as prevention. The inclusion of hepatitis B within the *Sexual Health and Blood Borne Virus Framework* demonstrates that hepatitis B has become a priority area for Scottish Government to progress two fundamental aims:

- to establish an understanding of the epidemiology and burden of hepatitis B-related disease in Scotland; and
- to ensure optimal prevention, treatment, care and support for hepatitis B across Scotland for those at risk or living with the infection.

Once our knowledge and understanding of hepatitis B in Scotland has developed, these aims will be translated into high level Framework Outcomes for hepatitis B to be progressed in future years:

Framework Outcomes: Hepatitis B

1. Fewer newly acquired hepatitis B infections
2. A reduction in health inequalities associated with hepatitis B
3. People affected by hepatitis B lead longer, healthier lives
5. A society whereby the attitudes of individuals, the public, professionals and the media in Scotland towards hepatitis B are positive, non-stigmatising and supportive.

The Multi-Agency Approach

Holistic Delivery

If we are to be successful in our attempts to improve public and individual health in respect of hepatitis B, a more holistic, integrated and cross sector approach is required. The NHS, Local Authority, Scottish Prison Service and Third Sector are all essential to progress Framework Outcomes in relation to hepatitis B. The NHS has a critical role in preventing, diagnosing and treating infections, but it operates in a context where many other partners can influence service uptake and the behaviours, lifestyles and risk factors that put individuals at risk of infection. Consequently, the Framework also recognises the vital role of Local Authorities (e.g. through education, social work, community services, addiction services) and the Third Sector for hepatitis B.

Local Infrastructure

A range of infrastructure developments and new initiatives have been developed for hepatitis C during 2008-2011, through the *Hepatitis C Action Plan for Scotland*. Where feasible, these should be expanded to encompass hepatitis B but only where this is appropriate to local circumstance and need. Similarly, hepatitis B should be encompassed and/or linked with local sexual health infrastructures and initiatives where it is feasible and appropriate to do so.

Delivering the Outcomes

The following section details the recommendations and strategies multi-agency partners should adopt to contribute towards the delivery of each of the Framework Outcomes. Progress against Outcomes will be measured through the agreed set of national indicators (see **Appendix 1**).

Outcome 1: Fewer newly acquired blood borne virus infections.

The Scottish Government is committed to reducing the transmission of serious infections, including hepatitis B. While prevalence of hepatitis B in Scotland remains low, we cannot be complacent. During the 1990s, several hundred new transmissions of hepatitis B infection were diagnosed annually in Scotland, during a time when outbreaks of infection among injecting drug users were relatively frequent. The numbers of new transmissions started to decline in the early 2000s and in recent years between 50 and 100 new transmissions have been diagnosed annually.

However, it is likely that the actual number of new transmissions occurring annually in Scotland lie within the 200-400 range (see **Evidence Table 6.1**).

The decline in new transmissions, particularly among injecting drug users, coincided with concerted efforts to vaccinate injecting drug users against hepatitis B. Of particular importance was the implementation of the offer of vaccination to prison inmates in Scotland in 1999.

A vaccine against hepatitis B has been available since 1982 and is 95% effective in preventing infection (Plotkin and Orenstein, 2004). Many countries provide universal hepatitis B immunisation, as part of either an infant or adolescent schedule. However, unlike most other western countries, Scotland, and the rest of the UK, does not provide universal vaccination against hepatitis B. This position is based on advice from the Joint Committee on Vaccination and Immunisation (JCVI) who provide UK Health Departments with recommendations on all vaccination and immunisation issues. Currently, universal hepatitis B vaccination is not considered cost effective in the UK. Instead, a selective vaccination programme is in place which recommends that those at particular risk of infection are vaccinated.

- **NHS Boards should continue delivery of the selective vaccination programme for hepatitis B in line with national immunisation policy, and specifically:**
  - **NHS Board vaccination plans should be updated regularly in respect of local needs, population, epidemiology and national guidance to ensure the optimal uptake of hepatitis B vaccine by those most at risk of infection. These plans should reflect, promote and support the responsibilities of local community partners, including GPs, in offering hepatitis B vaccination for clinical reasons, to those at risk of infection in line with immunisation policy (Department of Health, 2006) and national and local best practice guidance;**
  - **work should be done to increase the proportion of babies born to hepatitis B infected mothers, or to mothers who are otherwise identified as being at risk of infection, that receive a full course of vaccine in line with national immunisation policy (Department of Health, 2006) and national best practice guidance for neonatal immunisation (Department of Health, 2011); and**
  - **hepatitis B vaccination should be incorporated into care plans for those in harm reduction, drug treatment and rehabilitation services progressing through 'recovery orientated systems of care' (care pathways) for drug misuse in line with recommendations to encourage the uptake and availability of hepatitis B vaccination within the *Scottish Government National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b).**

- **Multi-agency partners should work together to:**
  - **develop effective local strategies that support and promote early diagnosis and treatment of those already chronically infected with hepatitis B; and**
  - **deliver regular training, education and continuing professional development to ensure the competence of the health and non-health hepatitis B related workforce in the context of blood borne virus prevention. Provision should be in line with existing NHS Education for Scotland national frameworks for workforce development, education and competency and Recommendation 9 of the *Scottish Government National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b). This should include the implementation of hepatitis B educational solutions (or blood borne virus/sexual health solutions encompassing hepatitis B) recommended by NHS Education for Scotland Advisory Group(s).**

Outcome 2: A reduction in the health inequalities gap in sexual health and blood borne viruses.

Health inequality associated with hepatitis B infection in Scotland is currently unproven but there is potential for this to manifest in relation to affected migrant populations.

Strategies to reduce new transmissions of hepatitis B (see **Outcome 1**) and to improve the earlier diagnosis of those infected to enable access to specialist care and treatment (see **Outcome 3**) will help to reduce the pool and spread of infection within risk populations in Scotland to reduce inequality.

- **Multi-agency partners should work together to ensure that prevention, treatment and care pathways for hepatitis B consider the language, literacy and/or cultural challenges to risk populations accessing these services in Scotland to optimise their uptake.**

Outcome 3: People affected by blood borne viruses lead longer, healthier lives.

Hepatitis B is a condition where effective and timely intervention can minimise adverse health outcomes for the individual and the burden of resource on NHS and other services. Precise estimates on the number of people living in Scotland with chronic hepatitis B infection are unavailable but preliminary work indicates that the number lies within the 5000-15,000 range and the majority of infected individuals will be of Asian, African or East European ethnicity, areas with a high prevalence of hepatitis B infection.

A considerable proportion, possibly around 50%, of infected persons in Scotland remain undiagnosed (refer to **Evidence Table 6.2**). Undiagnosed infections present a transmission risk and can lead to further spread of disease. It is vital that undiagnosed infections are reduced to ensure the maximum individual and public health benefit.

Hepatitis B cannot currently be cured and is a complex condition, but it can be managed through appropriate treatment, care and support. Antiviral treatment can also contribute to efforts to prevent onward transmission. Unlike hepatitis C, there is no national guidance document or standards for the management of hepatitis B in Scotland. At present, only 1000-1500 chronically infected individuals are estimated to have attended a specialist for hepatitis B infection management and care during 2009/10 (refer to **Evidence Table 6.2**).

- **National guidance, standards and/or recommendations on the diagnosis, treatment and care for hepatitis B should be developed.**

- **The potential for procurement of hepatitis B medicines (e.g. home delivery/joint purchasing) to reduce costs to NHSScotland will be explored.**

- **Multi-agency partners should work together to reduce the pool of undiagnosed hepatitis B infection in Scotland and to optimise available treatment, care and support through effective local strategies to ensure:**

    - **the use of innovative and targeted approaches to test, diagnose and case find for hepatitis B;**

    - **establishment of care pathways for hepatitis B to ensure that those diagnosed are effectively signposted to services and referred to specialist care for assessment, even where clinical treatment is not immediately appropriate or necessary;**

    - **delivery of diagnosis, treatment and care for hepatitis B in line with national guidance, standards and/or recommendations; and**

    - **regular training, education and continuing professional development to ensure the competence of the health and non-health hepatitis B-related workforce, particularly those working with vulnerable groups. Provision should be in line with existing NHS Education for Scotland national frameworks for workforce development, education and competency and Recommendation 9 of the *Scottish Government National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b).**

<u>Outcome 5</u>: 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.

Stigma and discrimination can be major determinants of health outcomes. Those infected or at risk of hepatitis B, may be disinclined to access services or be open about their infection and risk behaviours as a result of public perceptions of the infection or fear of discrimination.

If we are to successfully reduce the burden of disease associated with viral hepatitis we need to foster a culture in Scotland that is non-stigmatising and non-discriminatory to those infected or at risk. Education and awareness raising needs to be increased and misinformation in the media, if it exists, needs to be reduced. These are not easy issues to address and no single strategy or policy can successfully change beliefs or prejudices that may be common across the country, however we believe that there are things within our control that may contribute to the broader outcome.

Through this outcome we aim to progress understanding and attitudes towards hepatitis B in Scotland including how it is portrayed in the media through local and national strategies, encompassing:

- **Efforts to promote a positive approach to hepatitis B in the media should continue nationally and locally through linking in with media groups such as the National Union of Journalists and national broadcasting regulators.**

- **Work to promote awareness and understanding of hepatitis B will continue locally, regionally and nationally.**

Supporting Delivery

The Scottish Government will monitor progress on delivery of the outcomes through the Framework Indicators detailed in **Appendix 1**.

The Scottish Government, including the national coordinators, Special Health Boards and other national organisations, will have key roles in progressing the achievement of the Framework Outcomes and supporting multi-agency partners. These roles are set out in **Chapter 7**.

Evidence Tables

Table 6.1 – Outcome 1: Fewer newly acquired blood borne virus infections

- In recent years between 50 and 100 new transmissions have been diagnosed annually.
- Since it is common for hepatitis B infection not to result in an acute symptomatic illness and, since not all individuals with acute symptomatic illness seek medical treatment and thus diagnosis, it is likely that the actual number of new transmissions occurring annually in Scotland lie within the 200-400 range.
- All pregnant women in Scotland are offered a hepatitis B test to allow babies of infected mothers to be vaccinated. In recent years, the numbers of hepatitis B infected pregnant women have increased considerably as a consequence of immigration; accordingly, the opportunity for hepatitis B transmission from mother-to-child has increased. Vaccination at the time of birth dramatically reduces the chances of such transmission.

Table 6.2 – Outcome 3: People affected by blood borne viruses lead longer, healthier lives

Diagnosis

- While precise estimates of the number of people living in Scotland with chronic hepatitis B infection are unavailable, preliminary work indicates that the number lies within the 5000-15,000 range and the majority of infected individuals will be of Asian, African or East European ethnicity, areas with a high prevalence of hepatitis B infection.
- A considerable proportion – possibly around 50% – of infected persons in Scotland remain undiagnosed.

Treatment and Care

- During 2009-2010, it is estimated that between 1000 and 1500 chronically infected individuals attended a specialist for hepatitis B infection management/care.
- Antiviral therapy was being administered to between 10 and 20% of those attending for management and/or care. It should be noted, however, that only a proportion of chronically infected individuals in specialist care would be eligible for antiviral therapy.

CHAPTER 7: SUPPORTING DELIVERY: SCOTTISH GOVERNMENT AND NATIONAL ORGANISATIONS

The *Sexual Health and Blood Borne Virus Framework* affects a broad range of stakeholders, both professional and public. Successful delivery will be underpinned by the breadth of knowledge, skills, services and systems in place across Scotland.

The Scottish Government

The Scottish Government will support the delivery of the *Sexual Health and Blood Borne Virus Framework* through the following national activity:

- **Governance:** Performance Management and leadership nationally across the Framework, including Ministerial leadership through the National Sexual Health and BBV Advisory Committee.

- **Multi-Agency approach:** The National Co-ordinators will work with local, regional and national structures and groups to support multi-agency cross sector working and communication in relation to the Framework across Scotland.

- **Surveys:** The Scottish Government will examine options for regular surveys to determine a) public satisfaction with sexual health and blood borne virus related services in Scotland and b) awareness and competency of staff and the extent of stigma and discrimination in sexual health and blood borne virus services.

- **Awareness raising:** The maintenance of awareness raising around sexual health, relationships and sexual wellbeing through the national 'Sexual Health Scotland' website (www.sexualhealthscotland.co.uk). This will continue to promote positive sexual health and wellbeing, including the delivery of sexual health and wellbeing improvement messages through the website and other national communication initiatives.

- **National media:** Monitoring how sexual health and blood borne virus related issues are portrayed in the media, in Scotland, to determine the extent of unduly negative, inaccurate or biased portrayal and that which is positive and supportive. Options will be explored to work with media groups such as the National Union of Journalists, national broadcasting regulators and other key stakeholders, to agree a protocol on the way in which issues around sexual health and blood borne viruses are portrayed.

- **Guidance/guidelines:**
  - the provision of national guidance on chlamydia testing and treatment, to augment *SIGN Guideline 109* (SIGN, 2009); and
  - to review and, if necessary, update, the *National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b) to support HIV, hepatitis B and C initiatives to reduce the transmission of infection occurring from the reuse of injecting equipment.

- **Supporting Improvements in Effective Contraception**
  - increased emphasis within the new *Refreshed Framework for Maternity Care in Scotland*, published in January 2011 (Scottish Government, 2011a), that the contraceptive needs of women (including LARC, where appropriate) should be addressed prior to discharge. This is included as a Key Quality Indicator in the Maternity Services Framework;

  - the setting of performance measures for the provision of contraceptive advice and contraception (including LARC) in termination and maternity services as part of the Health Promoting Health Service;

  - the promotion of improved uptake of LARC following discussion by the National Planning Forum; and

  - the examination of cost effective service models for LARC in primary care, sexual health and maternity services by the Quality and Efficiency Support Team, Directorate for Healthcare Delivery.

- **National Pharmacy Contract:** To consider the role of community pharmacy in the provision of sexual health and blood borne virus services including the continuation of Emergency Hormonal Contraception in the national Community Pharmacy Contract.

- **Primary Care Advice:** The provision of regular advice (e.g. via CMO letters) to primary care professionals to ensure consistency in the provision of sexual health and blood borne virus services including prevention advice, support and treatment and care.

- **Integrated Care Pathway:** the development, with stakeholders, of an integrated care pathway and care plan for HIV with associated documentation.

National Organisations will be accountable to the Scottish Government for the deliverables specified below.

<u>NHS Education for Scotland (NES)</u>

Provision of strategic support in order to progress an integrated and cohesive approach to sexual health and blood borne virus workforce education and development:

- Establish NES facilitated expert advisory group(s) in relation to both blood borne virus and sexual health workforce education and development;
- Consolidate and progress, where appropriate, existing work undertaken as part of the *Hepatitis C Action Plan, HIV Action Plan* and *Respect and Responsibility National Sexual health Outcomes*;
- Carry out further workforce education development in line with the *Sexual Health and Blood Borne Virus Framework*, with guidance from NES expert groups, including:

  - identifying and developing educational solutions (individual/combination as appropriate);
  - identify the training needs of the hepatitis B and sexual health related workforce;
  - developing a Sexual and Reproductive Health Nursing Competencies Portfolio; and
  - identifying leadership opportunities for Sexual Health and Blood Borne Virus Leads within the existing NHSScotland National Leadership Framework.

- Support NHS Health Scotland in their work to examine sexual health and blood borne virus contextualisation for the generic Health Behaviour Change Competency Framework in order to support NHS and non-NHS staff (health/non-health).

NHS Health Scotland

Provision of strategic support work to build knowledge and capacity and offer specific evidence informed guidance, in relation to health improvement, to NHS Boards in support of the Framework including:

- The provision of deliverables carried over from the *HIV Action Plan* (Actions 6, 8, 9 and 10) and the *Hepatitis C Action Plan Phase II* (Action 16) including support to NHS Boards and local partners. Also, a supporting role carried over in relation to *HIV Action Plan* Actions 2, 7 and 11.
- To review, revise and update the SHARE educational resource and support potential development of exemplar materials in line with Curriculum for Excellence .
- The evaluation and maintenance of the Teenage Pregnancy Guidance and provision of support to Local Authorities and NHS Boards in implementing this Guidance (including the provision of a briefing note and practice sharing event).
- Production of guidance for NHS Boards and Local Authorities on addressing termination of pregnancy; with a focus on repeat terminations
- The development and maintenance of the Wellbeing in Sexual Health (WiSH) Network; to include HIV and HBV and to enable the sharing of best practice, current issues and evidence via regular eCommunications and local, regional and national events.
- Substance misuse activities and partnership working extended to incorporate HCV where appropriate.
- To examine sexual health and blood borne virus contextualisation for generic Health Behaviour Change Competency Framework to support NHS and non-NHS staff.

NHS National Services Scotland Health Protection Scotland (HPS)

The provision of strategic leadership, advice and programme support to the *Sexual Health and Blood Borne Virus Framework*, including:

- The provision of expertise and guidance to agencies associated with the *Sexual Health and Blood Borne Virus Framework*.

- The further development and maintenance of a range of information systems, including providing data and reports on:
  - blood borne virus and STI prevalence, incidence and diagnoses; and
  - blood borne virus treatment and care in relation to the specified Framework Outcomes and Indicators.
- The development and maintenance of National Networks and online resources (e.g. Framework portal) to enable the sharing of best practice, current issues and evidence.
- The production of annual reports in association with ISD and other partners.
- The provision of strategic leadership and advice to Scottish Government and national agencies in the development and effective delivery of the Framework.

NHS National Services Scotland Information Services Division (ISD)

Provision of statistical and analytical expertise and guidance to the *Sexual Health and Blood Borne Virus Framework*, including:

- The implementation and maintenance of a national data collection system to monitor the provision of injecting equipment across Scotland in line with the *Scottish Government National Guidelines for Services Providing Injecting Equipment* (Scottish Government, 2010b).
- Production of an annual report on the provision of injecting equipment across all NHS Boards in Scotland in line with the *Scottish Government National Guidelines for Services Providing Injecting Equipment.*
- To maintain information systems providing annual data on teenage pregnancy, termination of pregnancy and births; to make data available by CHP and Local Authority, where appropriate.
- To maintain the development of new sexual health data through the DASH Project, including the reporting of the Key Clinical Indicators for sexual health. The DASH Project will be central in supporting sexual health indicator monitoring.
- To facilitate the extraction of data from the National Sexual Health (NaSH) system for regular national reporting; reports to be defined.
- The production of annual reports in association with HPS and other partners (e.g. SSHI).

Education Scotland

In order to support the education profession to deliver sexual health and blood borne virus education within Curriculum for Excellence.

- Raise awareness of, and signpost, the *Sexual Health and Blood Borne Virus Framework* document across the education profession.
- Provide educational advice to support national and local partners in developing materials which underpin sexual health and blood borne virus education.
- Further develop the health and wellbeing and GLOW areas of the LTS website to support the education profession and partners who are delivering Health and Wellbeing outcomes.

Healthcare Improvement Scotland (formerly NHS Quality Improvement Scotland)

- While Scottish Government develop, monitor and performance manage the delivery of national policy for sexual health and blood borne viruses in Scotland (through the outcomes and indicators in **Appendix 1**), Healthcare Improvement Scotland assure the quality, safety and effectiveness of the underpinning NHS services.

- As part of the Healthcare Improvement Scotland Work Programme:

    - To develop, publish, implement and maintain standards/indicators for HIV and hepatitis C.
    - To support implementation and maintenance of standards for sexual health.
    - To maintain SIGN Guidelines 92 (Management of Hepatitis C) and 109 (Management of Genital Chlamydia Trachomatis Infection), taking further advice into account as required.
    - To assess the need for clinical advice, guidance or standards/indicators in relation to hepatitis B and to develop and implement accordingly.

- Provision of information on the implementation of Healthcare Improvement Scotland standards/indicators by NHS Boards to Scottish Government to support NHS boards progression against Framework outcomes.

NHS National Services Scotland National Procurement

- To explore the potential for the joint purchasing of HIV, HCV and HBV medicines to further reduce costs to NHSScotland.
- To explore the potential to extend the procurement of HIV Home Delivery to reduce costs to NHSScotland.
- To explore the potential for procurement of hepatitis B and/or hepatitis C Home Delivery to reduce costs to NHSScotland.
- To update and maintain the national contract for injecting equipment to further reduce costs to NHSScotland.
- To explore the potential for new block purchasing arrangements and other potential savings that may benefit the Sexual Health and Blood Borne Virus Framework e.g. oral contraceptives.

Scottish Prison Service

- Effective partnership with NHS Boards, Local Authorities and Third Sector partners to take proportionate measures and host support services that deliver the aims of this Strategy.
- To seek routes to continuous improvement of through-care that supports people with blood-borne virus infections to begin, and continue to receive, appropriate treatment.
- Sustain health promotion programmes that promote sexual health and relationships and to reduce risk behaviour that is capable of transmitting blood borne viruses.

CHAPTER 8: GOVERNANCE AND ACCOUNTABILITY

Advice and Expertise

Advice and expertise will be provided to support the Framework through the following mechanisms:

- **National Sexual Health and Blood Borne Virus Advisory Committee (NSHBAC): A Ministerial led, multi-agency Committee will provide national Ministerial leadership.**

- **Professional Support: A small number of national networks will support the effective delivery of Framework Outcomes by providing and facilitating:**

  - **Professional advice and guidance to the Scottish Government;**
  - **Peer support, the sharing of expertise and best practice across national and local partners;**
  - **National and local clinical, prevention and executive leadership and expertise; and**
  - **Third Sector and service-user involvement nationally.**

National Networks will be developed during the initial implementation of the Framework in Autumn 2011. Each network will nominate a Chair who will be a member of the Sexual Health and Blood Borne Virus Advisory Committee.

Governance and Performance Management

The Scottish Government will performance manage the Framework through:

- **the multi-agency outcomes and indicators, in conjunction with supporting contextual information;**
- **multi-agency local visits, which will seek to explore how agencies have taken forward work to support the delivery of outcomes and how Framework recommendations have been progressed; and**
- **Local Authority Single Outcome Agreements (SOAs) and indicators.**

A **Sexual Health and Blood Borne Virus Governance Board**, Chaired by the Scottish Government, will review progress against outcomes and address high-level risks, issues and challenges affecting Framework delivery. The Governance Board will comprise representatives of the Lead Organisations, notably NHS Board Sexual Health and Blood Borne Virus Executive Leads and national organisation leads.

Monitoring and Reporting

Information and data required to monitor outcomes will be generated nationally and broken down by local area when feasible and where appropriate.

A **National Sexual Health and Blood Borne Virus Monitoring and Assurance Group** will support the Scottish Government in monitoring outcomes by providing an independent view of the effectiveness of delivery and underpinning interventions. This will include developing, refining or adapting national data systems to support the Framework. The Chair(s) of the National Monitoring and Assurance Group will report to the Governance Board and be represented on the Advisory Committee.

Executive Leads

NHS Boards will be asked to identify an Executive Lead for sexual health and an Executive Lead for blood borne viruses, jointly or individually, in line with local circumstance. The lead(s) will be accountable for the co-ordination, planning and monitoring of Framework delivery and spend at a local level.

National Organisations with specific Framework responsibilities will be asked to nominate a lead representative. Representation from National Local Authority Associations encompassing disciplines key to Framework delivery (e.g. education, social care) will be sought.

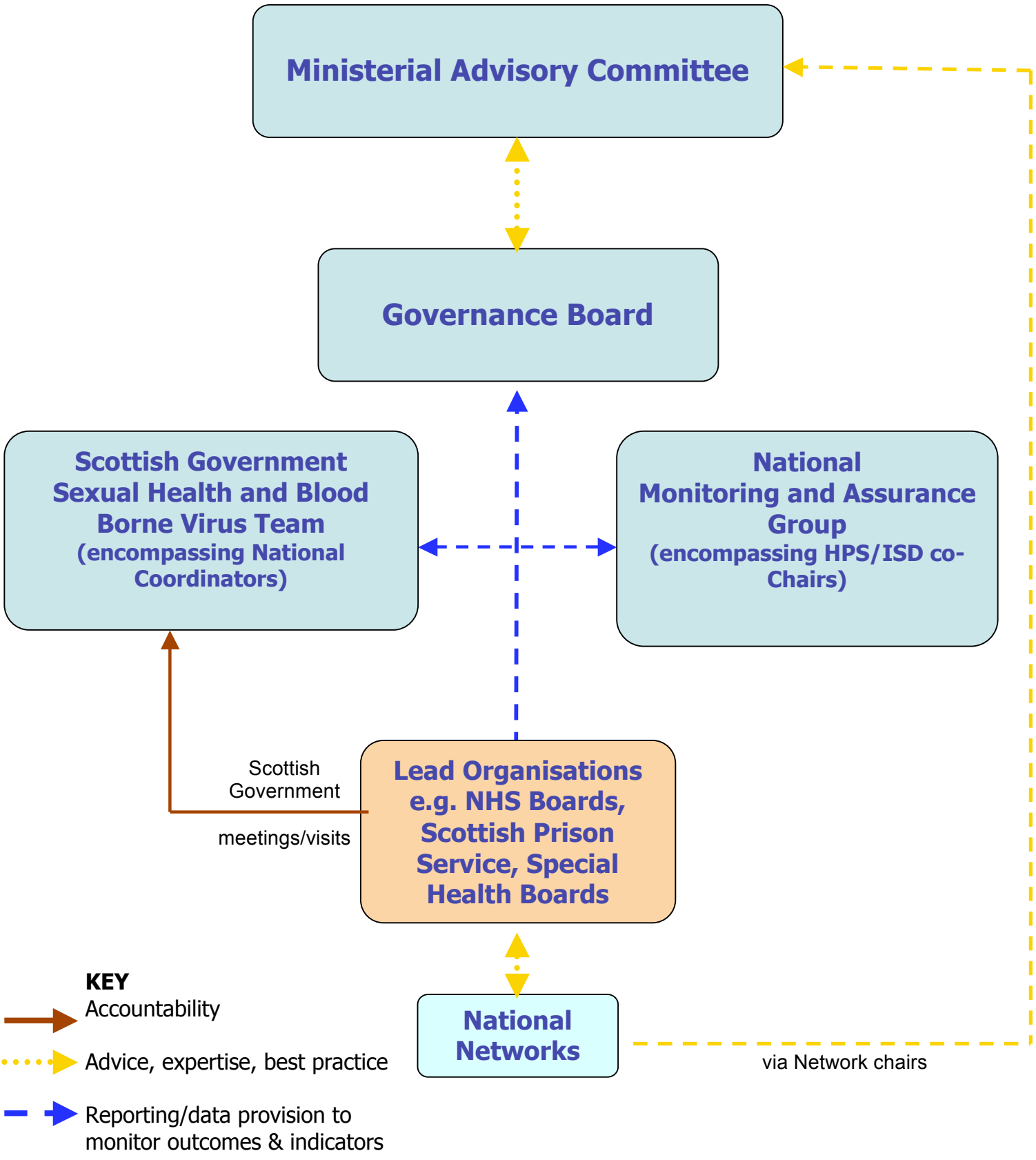
Executive Leads and Lead Representatives will represent their organisations and associations on the Framework Governance Board.

National Co-ordinators

The Scottish Government will appoint, a 'National Co-ordinator for Sexual Health and HIV' and a 'National Co-ordinator for Viral Hepatitis' to support the implementation of the Framework as part of its Sexual Health and Blood Borne Virus Policy Team.

The National Co-ordinators will:
- co-ordinate and oversee the Framework nationally;
- support the implementation of the strategy;
- act as key link between Ministers, NHS Boards, Local Authorities, Third Sector Organisations and other partners; and
- gather and retain knowledge and understanding on organisations' progress through Framework multi-agency visits and regular discussion and communication with stakeholders.

FRAMEWORK GOVERNANCE STRUCTURE



APPENDIX 1: OUTCOMES AND INDICATORS

<table>
<tr><th rowspan="2">Framework Outcome</th><th colspan="4">Indicators</th></tr>
<tr><th>Sexual Health</th><th>HIV</th><th>Hepatitis C</th><th>Hepatitis B</th></tr>
<tr><td rowspan="5">1. Fewer newly acquired blood borne viruses and STIs; fewer unintended pregnancies</td><td>SH 1.1 Diagnoses of genital Gonorrhoea in heterosexual men and women
Acc: NHS Boards/ Local Authorities
Mon: HPS</td><td rowspan="4">HIV 1.1 Rates of transmission of HIV acquired by residents in Scotland; overall and by risk group

Acc: NHS Boards/Local Authorities/Third Sector
Mon: HPS in association with BBV Specialist Laboratories</td><td rowspan="4">HCV 1.1 Rates of transmission of HCV acquired by residents in Scotland; overall and by risk group

Acc: NHS Boards/ Local Authorities / Third Sector
Mon: HPS in association with BBV Specialist Laboratories</td><td>HBV 1.1 Rates of transmission of HBV acquired by residents in Scotland; overall and by risk group
Acc: NHS Boards/ Local Authorities / Third Sector
Mon: HPS in association with BBV Specialist Laboratories</td></tr>
<tr><td>SH 1.2 Diagnoses of rectal gonorrhoea in MSM
Acc: NHS Boards/ Local Authorities
Mon: ISD</td><td rowspan="3">HBV 1.2 Proportion of babies born to HBV infected mothers vaccinated and immunised

Acc: NHS Boards
Mon: HPS</td></tr>
<tr><td>SH 1.3 The rate of terminations of pregnancy
Acc: NHS Boards/ Local Authorities
Mon: ISD</td></tr>
<tr><td>SH 1.4 The rate of repeat terminations of pregnancy
Acc: NHS Boards/ Local Authorities
Mon: ISD</td></tr>
<tr><td colspan="4">SH/BBV1.5 The delivery of evidence-informed Relationships, Sexual Health and Parenthood education and blood borne virus education in line with Curriculum for Excellence in all schools and wherever learning takes place.
Acc: Local Authorities
Mon: Scottish Government* in association with Education Scotland</td></tr>
</table>

Acc: Accountability for delivery Mon: Accountability for monitoring

*The Scottish Government will work with key stakeholders to examine and develop options for collecting national survey data

Framework Outcome	Indicators			
	Sexual Health	**HIV**	**Hepatitis C**	**Hepatitis B**
2. A reduction in the health inequalities gap in sexual health and blood borne viruses	**SH 2.1** The rate of teenage pregnancy in areas of highest deprivation *Acc: Local Authorities/NHS Boards* *Mon: ISD*	**HIV 2.1** Rate of HIV diagnosed population accessing specialist services by population* group *Acc: NHS Boards/ Local Authorities/ Third Sector* *Mon: HPS in association with BBV Specialist Laboratories*	**HCV 2.1** Rate of HCV diagnosed population accessing specialist services by population* group *Acc: NHS Boards/ Local Authorities/ Third Sector* *Mon: HPS in association with BBV Specialist Laboratories*	**HBV 2.1** Rate of HBV diagnosed population accessing specialist services by population* group *Acc: NHS Boards/ Local Authorities / Third Sector* *Mon: HPS in association with BBV Specialist Laboratories*
	SH 2.2 The rate of termination of pregnancy in areas of highest deprivation *Acc: NHS Board/ Local Authorities* *Mon: ISD*			
	SH 2.3 Chlamydia indicator [awaits recommendations of Chlamydia working group]			
	SH 2.4 The uptake of contraception amongst female IDUs**, where appropriate *Acc : NHS Board/ Local Authorities* *Mon: HPS in association with the University of the West of Scotland*			

Acc: Accountability for delivery *Mon: Accountability for monitoring* *to be defined by the Data Monitoring and Assurance Group

** Whilst the document refers to 'people who inject drugs', the Framework data tables and indicators tables refer to IDU population(s) as a recognised epidemiological term.

Framework Outcome	Indicators			
	Sexual Health	**HIV**	**HCV**	**HBV**
3. People affected by blood borne virus(es) lead longer, healthier lives	Refer to NHS Quality Improvement Scotland Sexual Health Criteria 1.4 and Standard 5	**Diagnosis** HIV 3.1 Number of people diagnosed and this number as a proportion of the estimated infected population *Acc: NHS Boards* *Mon: HPS in association with BBV Specialist Laboratories*	**Diagnosis** HCV 3.1 Number of people diagnosed and this number as a proportion of the estimated infected population *Acc: NHS Boards* *Mon: HPS in association with BBV Specialist Laboratories*	**Diagnosis** HBV 3.1 Number of people diagnosed and this number as a proportion of the estimated infected population *Acc: NHS Boards* *Mon: HPS in association with BBV Specialist Laboratories*
		Late Diagnosis: HIV 3.2 Number of people newly diagnosed with late HIV disease (indicated by a CD4 count less than 350). *Acc: NHS Boards* *Mon: HPS*		

		Late Diagnosis / Burden of Disease: HIV 3.3 Annual number of people hospitalised, or having died, with advanced HIV-related disease; total and within 1 year of diagnosis *Acc: NHS Boards* *Mon: HPS*	**Late Diagnosis / Burden of Disease:** HCV 3.3 Annual number of hepatitis C diagnosed persons hospitalised, or having died with end-stage liver disease; total and within 1 year of diagnosis *Acc: NHS Boards* *Mon: HPS*	**Late Diagnosis / Burden of Disease:** HBV 3.3 Annual number of hepatitis B diagnosed persons hospitalised, or having died with end-stage liver disease; total and within 1 year of diagnosis *Acc: For national purposes to establish baseline.* *Mon: HPS* *(Subject to epidemiological findings and the current HBV landscape, yet to be determined*).
		Treatment: HIV 3.4 Proportion of diagnosed HIV infected people, for whom treatment is clinically indicated*, receiving treatment *Acc: NHS Boards* *Mon: HPS*	**Treatment:** HCV 3.4 Ratio of the diagnosed HCV chronically infected population to the annual and total number of people initiated onto antiviral therapy *Acc: NHS Boards* *Mon: HPS*	**Treatment:** HBV 3.4 Proportion of diagnosed highly infectious (eAntigen positive/high viral load) HBV chronically infected persons, who are receiving antiviral therapy *Acc: NHS Boards* *Mon: HPS*

* To be defined by National Monitoring and Assurance Group

		Treatment: HIV 3.5 The proportion of the treated HIV population achieving an 'optimal treatment response' (viral load <50 copies per ml within 12 months of commencing treatment) *Acc: NHS Boards* *Mon: HPS*	**Treatment:** HCV 3.5 The proportion of the treated HCV population that completes treatment and the proportion achieving a sustained viral response *Acc: NHS Boards* *Mon: HPS*	**Treatment:** HBV 3.5 The proportion of the treated HBV population achieving an 'optimal treatment response' *Acc: NHS Boards* *Mon: HPS*

Framework Outcome	Sexual Health Indicators
4. Sexual relationships are free from coercion and harm.	SH 4.1 Levels of sexual regret (nationally) *Acc: Local Authorities/NHS Boards* *Mon: Scottish Government**
	SH 4.2 Levels of sexual wellbeing (nationally) *Mon: Scottish Government**
	SH 4.3 Levels of gender based violence, as recorded within specialist sexual health services *Mon: ISD (via NaSH)*

Acc: Accountability for delivery Mon: Accountability for monitoring

* The Scottish Government will work with key stakeholders to examine and develop options for collecting national survey data

<table>
<tr><th rowspan="2">Framework Outcome</th><th colspan="4">Indicators</th></tr>
<tr><th>Sexual Health</th><th>HIV</th><th>Hepatitis C</th><th>Hepatitis B</th></tr>
<tr><td rowspan="3">5. 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</td><td colspan="4">5.1 Acceptability of services to those living with, or vulnerable to, poor sexual health and/or blood borne viruses (including prevention, treatment, care and support services)

Acc: NHS Boards, Third Sector, Local Authorities
Mon: Scottish Government*</td></tr>
<tr><td>SH 5.2 Awareness and understanding in the general population of the positive and life enhancing aspects of sex and good sexual health

Acc: NHS Boards, Third Sector, Local Authorities, Scottish Government
Mon: Scottish Government*</td><td colspan="3">BBV 5.2 Awareness and understanding in the general population of blood borne viruses including transmission, treatment and complex long-term health issues of living with blood borne viruses, to support those living with and at risk of blood borne viruses to feel a sense of inclusion and equality in society

Acc: NHS Boards, Third Sector, Local Authorities, Scottish Government.
Mon: Scottish Government *</td></tr>
<tr><td colspan="4">SH/BBV 5.3 Positive portrayal of sexual health and blood borne virus issues in the media, including the portrayal of gender stereotypes, nationally and locally

Mon: Scottish Government</td></tr>
</table>

Acc: Accountability for delivery Mon: Accountability for monitoring

*The Scottish Government will work with key stakeholders to examine and develop options for collecting national survey data

APPENDIX 2: DATA SOURCES AND SUPPORTING CONTEXTUAL INFORMATION

Framework Outcome	Data Source for Indicator and National Lead	Examples of Supporting Contextual Information and National Leads
1. Fewer newly acquired blood borne viruses and STIs; fewer unintended pregnancies	• Laboratory Data Blood Borne Virus Avidity Testing - *HPS in association with Blood Borne Virus Specialist Laboratories (due to come online in 2012/13)* • Needle Exchange Surveillance Initiative (NESI) – *HPS in association with the University of the West of Scotland* • Substance Misuse Database – *ISD* • HIV treatment data – *HPS* • NaSH/STISS – *ISD* • Termination of pregnancy data – *ISD* • Laboratory data (gonorrhoea) – *HPS in association with Microbiology Laboratories including the Scottish Bacterial STI Reference Laboratory*	• Scottish Government Guidelines for Services Providing Injecting Equipment (2010) – *Scottish Government* • National Data Collection System on Injecting Equipment and associated reports – *ISD* • National guidance for HBV vaccination (e.g. Immunisation Against Infectious Disease – '*The Green Book' (2006), Dept of Health)* • HBV vaccination data and information - HPS/ISD • Sexual health key clinical indicators (KCIs) - *ISD* • Maternity data – *ISD* • Blood borne virus / sexual health education initiatives – *Scottish Government* / *Education Scotland*
2. A reduction in the health inequalities gap in sexual health and blood borne viruses	• Teenage pregnancy data – *ISD* • Termination of pregnancy data – *ISD* • Access to specialist services – *HPS (e.g. via HCV clinical system)* • Needle Exchange Surveillance Initiative (NESI) – *HPS in association with the University of the West of Scotland*	• NaSH – *ISD*

3. People affected by blood borne virus(es) lead longer, healthier lives	• National surveillance systems, test and diagnoses databases for hepatitis B and C and data linkage – Hepatitis B systems are in development as part of Framework delivery - *HPS* • National Hepatitis C Clinical Database. This is being expanded to encompass hepatitis B; redeveloped (for ease of use from an information gathering perspective) and maintained throughout the Framework - *HPS* • National HIV surveillance systems – *HPS (note: some aspects of these systems are under redevelopment)* • NaSH - *ISD*	• National provision of information on the implementation of Healthcare Improvement Scotland standards/indicators by NHS Board to Scottish Government (Sexual Health Services Standards, HIV Service standards/indicators (2011/12), Hepatitis C indicators (2011/12)) – *Healthcare Improvement Scotland* • Rate of blood borne virus testing in population groups – *HPS (note: some aspects of these systems are under development)* • Positivity of blood borne virus testing – *HPS (note: some aspects of these systems are under development)* • Local Hepatitis C MCN accreditation – *Scottish Government in conjunction with Healthcare Improvement Scotland* • Local and national audit (e.g. BASHH)
4. Sexual relationships are free from coercion and harm.	• National Survey Data – *Scottish Government*	• Local survey data – *where collected*
5. 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.	• National Survey Data – *Scottish Government* • Patient Experience Surveys – *Scottish Government* • Media monitoring data – *Scottish Government*	

NB: Whilst the document refers to 'people who inject drugs', the Framework data tables and indicators tables refer to IDU population(s) as a recognised epidemiological term.

APPENDIX 3: POLICY LINKS

As detailed elsewhere in the Framework, the links between the issues addressed in this document and other government, national and local policies are many, varied and complex. This appendix is intended to provide an overview of the key policy areas where there is an overlap with the content of this Framework and to provide signposting to where further information can be found.

Multi-agency partners involved in planning or delivering services under the Framework should ensure they are familiar with these links and that appropriate connections are made locally. The Scottish Government will endeavour to promote this approach, where possible, at the national level.

This section is not intended to be exhaustive and there will be many other policy links between the work of this Framework that are not explicitly noted here.

An Assets-Based Approach to Health Improvement

In his 2009 report, the Chief Medical Officer for Scotland described the benefits of taking an assets-based approach to health and health improvement. The asset model accentuates positive capability within individuals and supports them to identify problems for which they can activate their own solutions. This enables individuals to take control of their own health and wellbeing, promoting self esteem and increasing the coping abilities of individuals and communities through, for example, self-management approaches to long-term conditions such as HIV or viral hepatitis.

Initiatives to support good sexual health and relationships, to reduce the incidence of blood borne viruses and to empower people living with blood borne viruses to strive for better health and wellbeing can create positive attitudes, enabling individuals to develop the resources that they require in order to be resilient in the face of challenging circumstances.

The assets-based approach is relevant to sexual health and blood borne virus improvement through combining key prevention initiatives with social and cultural approaches which will support Scotland to positively influence sexual health, prevent new blood borne virus infection, reduce undiagnosed infection and support those with blood borne viruses to live longer, healthier lives. (Scottish Government, 2010e).

Early Years

Improving the early years experience in Scotland is key to enabling us to address some of our most entrenched problems in terms of poverty, poor health, poor attainment, risk taking and anti social behaviour. This is backed up by a large body of research evidence from a variety of academic fields, including sexual health. That is why the Scottish Government and COSLA published the *Early Years Framework* in December 2008 (Scottish Government and COSLA, 2008a,b). The *Early Years Framework* sets the strategic policy direction for all early years' services.

Investing in children and supporting their parents to be the best parents they can be for their children helps to develop resilience and life skills that have implications far beyond the early years of life. It is in our very earliest years that we develop skills such as empathy, communication with others and co-operation with others.

The *Early Years Framework* makes clear that improving the early years experience is not only about what have been traditionally viewed as early years services, such as preschool education and childcare. Improving the early years experience begins preconception, but ensuring that young people are prepared for parenthood and our work with the Health and Wellbeing strand of Curriculum for Excellence plays a key role in this. The work being done by the *More Choices More Chances* teams around Scotland, helping young people into positive post school destinations, also contributes to this.

There are a number of specific initiatives that seek to support first time teenage parents in developing their parenting skills. These include the Family Nurse Partnership projects in Edinburgh and Dundee and the, the Barnardo's You First projects in West, East and Midlothian. All of these seek to build parenting capacity in order to break the cycles of inequalities that can be passed down from generation to generation (for further information see the following: http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family).

Getting It Right for Every Child (GIRFEC)

The aim of *Getting it right for every child* (Scottish Government, 2006) is to ensure that we get it right for Scotland's children and young people by providing a framework for all services and agencies working with children and families to deliver a co-ordinated approach which is appropriate, proportionate and timely.

Getting it right for every child provides the how for positive change within children's services and adult services that have an impact on children and young people: how we can adapt and streamline systems to deliver the *Early Years Framework* (Scottish Government and COSLA, 2008a,b), Child Protection, *Equally Well, Achieving our Potential* (Scottish Government, 2008e), *More Choices More Chances* (Scottish Executive, 2006b) and many more. It is crucial to supporting the delivery of improved outcomes for children and young people, from the highest strategic decision-making to the smallest practical actions.

Getting it right for every child provides mechanisms for identifying and planning how we help children and young people, set out in the 10 Core Components. It seeks to improve services and measure the impact they have on a child's wellbeing as expressed through the eight Wellbeing Indicators (Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible and Included). This includes wellbeing with regard to sexual health.

Inequalities

The Scottish Government firmly believes that there is no place in Scotland for prejudice or discrimination and that everyone deserves to be treated fairly, regardless of age, disability, gender, gender identity/reassignment, race, religion or

sexual orientation. In one of a number of initiatives in this field, the Scottish Government has committed significant funding to support projects Scotland-wide that increase the visibility of LGBT communities, to build the capacity of these communities and work with public services to develop high quality practice for LGBT inclusion into society.

The introduction of the *Equality Act 2010* has been a positive step to reduce prejudice and discrimination in our society. In addition, the NHSScotland's "Fair for All" programme aims to ensue that whatever the individual circumstances of people's lives, including gender and sexual orientation, they have access to the right health services for their needs.

Equally Well

Intervention in children's early years, in addition to continued support for early intervention at different stages over the lifecourse, are at the heart of the Government's continued work to address inequalities – as set out in the *Equally Well Review 2010* (Scottish Government, 2010c). The latest review of *Equally Well* recommends a collaborative approach across different public services, with a key focus on early intervention.

Equally Well recommends that local agencies should provide high quality, consistent information to young people in a wide range of settings, including easily accessible drop-in services, staffed by health professionals and youth workers.

Reducing Antenatal Health Inequalities

Outcome-focussed evidence into action, *Guidance for NHS Boards* (Scottish Government, 2011b) has been developed to support NHS Boards increase their capacity to reach women in high risk groups as per recommendation 4 of *Equally Well.*

A recommended action for NHS Boards is to promote LARC to teenagers, women with substance misuse problems and women involved in prostitution prior to discharge from postnatal care. This guidance is a sub-set of the *Refreshed Framework for Maternity Care* (Scottish Government, 2011a). A national implementation support group is being developed to commission support tools for NHS Boards to enable them to carry out the specific actions in the guidance and to implement the refreshed framework.

Curriculum for Excellence

Education is a key tool in promoting positive sexual health and relationships and an understanding and awareness of blood borne viruses. Through the Health and Wellbeing outcomes of Curriculum for Excellence, sexual health and blood borne virus education will become part of the wider educational experience whilst also ensuring that young people, importantly including those who are more challenging to engage with, receive high quality education that equips them with the skills they require to maintain positive sexual health and wellbeing and prevent blood borne virus infection.

Drugs Policy

The Road to Recovery (Scottish Government, 2008f) strategy sets out the Government's approach to tackling Scotland's long-standing and serious drug problem based on the concept of recovery. Recovery is a process through which an individual is enabled to move on from their problem drug use towards a drug-free life and become an active and contributing member of society. Core to this is the reform of the way that drug services are planned, commissioned and delivered to place a stronger emphasis on outcomes and on recovery.

Alcohol Misuse

The Scottish Government Alcohol Framework: *Changing Scotland's Relationship with Alcohol* (Scottish Government, 2008c) sets out the Scottish Government's approach to tackling alcohol misuse. Taking a whole population approach, this includes supporting and encouraging people to make more positive choices about alcohol which will help them to maximise their potential both individually and collectively. The Framework links to work in other related fields, including on early years, poverty and health inequalities.

Refreshed Framework for Maternity Care in Scotland

There is increased emphasis within the new *Refreshed Framework for Maternity Care in Scotland* (Scottish Government, 2011a) on ensuring that the contraceptive needs of women, including Longer Acting Reversible Contraception (LARC), where appropriate, should be addressed prior to discharge. This is included as a Key Quality Indicator in the Maternity Services Framework.

Health Promoting Health Service and Quality Strategy

Performance measures on the promotion and, where relevant, the provision of LARC in maternity and termination services have been developed as part of plans for an extended suite of Health Promoting Health Service performance measures. The intention is to embed the revised Health Promoting Health Service measures within one of the strands of the Quality Strategy.

Long-term conditions

HIV, hepatitis C and hepatitis B are considered to be 'long-term conditions'. A great deal of work is being progressed across the long-term conditions agenda within the Scottish Government which will provide support for people living with blood borne viruses.

Gender Based Violence

Addressing gender-based violence falls within our legislative obligations to promote gender equality as detailed in the Equality Act (2006) and within our responsibility to implement both the cross governmental *Safer Lives: Changed lives: A Shared Approach to Tackling Violence Against Women in Scotland* (Scottish Government, 2009c) and the *Strategic Approach for Survivors of Childhood Sexual Abuse*

(Survivor Scotland, 2005). *The National Domestic Abuse Delivery Plan for Children and Young People* (Scottish Government, 2008d) developed under the auspices of *Getting It Right for Every Child* (Scottish Government, 2006) also includes a range of actions that have implications for the NHS, in particular the inclusion of a programme of routine enquiry of domestic abuse.

***The Sexual Offences (Scotland) Act 2009*.**

The Sexual Offences (Scotland) Act 2009 came into force on 1 December 2010 and reforms the law concerning sexual offences, replacing a complex patchwork of common law and statutory provision with a single statutory framework which reflects the values of modern society.

The Scottish Government has developed National guidance on under-age sexual activity: *Under-age sexual Activity: Meeting the need of Children and Young People and Identifying Child Protection* (Scottish Government, 2010d) as a consequence of the new legislation. It seeks to supplement Scotland's National Child Protection guidance and the *Getting it right for every child* approach. The guidance advises on how protocols can be developed locally to ensure the early identification and support for such children and young people and also, importantly to help ensure that in cases where there is no child protection issue, their needs are still met appropriately.

Mental Health

Through *Towards a Mentally Flourishing Scotland* (Scottish Government, 2009b), Scotland's national policy and action plan, the Scottish Government is committed to:

- promoting and protecting good mental wellbeing, both how we feel (emotions and life satisfaction), and how we function (self-acceptance, personal control over our environments, purpose in life and positive relations with others);
- preventing common mental health problems, suicide and self-harm; and
- improving the quality of life of those experiencing mental health problems, e.g. by improving physical health and social inclusion.

The approach taken is based upon a social model of health which recognises that our mental state is shaped by our social, economic, physical, and cultural environment. Many of our more vulnerable members of society, such as those with addiction problems, with a blood borne virus infection, or with other poor sexual health outcomes may have associated mental health problems which need to be recognised and addressed. This requires a combined effort on the part of Local Authorities, the NHS, Third Sector organisations, the individuals themselves and their communities.

The health of gay and bisexual men, in general, is poorer than average. Levels of depression, self-harm and suicide are also higher in this community, with many facing discrimination because of their sexual orientation. In order to begin to address this, the Scottish Government is funding LGBT Scotland to deliver an effective specialist LGBT Mental Health Service in Lothian as part of the Demonstration Project, which is also assisting with building an evidence base around mental health intervention with LGBT people.

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