

The Unlinked Anonymous HIV Prevalence Monitoring Programme in N. Ireland 1992-1995

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Accepted 15 May 1997

SUMMARY

Previous evidence has suggested that Northern Ireland is a low seroprevalence area for HIV infection. The Unlinked Anonymous HIV Prevalence Monitoring Programme initiated in England and Wales in 1990 was extended to Northern Ireland in 1992. Patients attending the Genitourinary Medicine Clinic at the Royal Victoria Hospital have, with informed consent, been tested anonymously for HIV infection since that time. The results of the survey between 1992 and 1995 have shown an overall seroprevalence rate of 3.01% for homosexual/bisexual men, 0.08% for heterosexual men, and 0.05% for heterosexual women. These results confirm the previous impression of low HIV seroprevalence in Northern Ireland and the survey provides an excellent longitudinal study by which changes may be monitored.

INTRODUCTION

The Unlinked Anonymous HIV Prevalence Monitoring Programme was introduced in Northern Ireland in 1992 in the Department of Genitourinary medicine (GUM) in the Royal Victoria Hospital, Belfast, under the auspices of the Public Health Laboratory Service, having been initiated in England and Wales in 1990.¹

All data available prior to the introduction of the survey suggested a low HIV seroprevalence in Northern Ireland. Between January 1985 and December 1991 there was a total of 91 first ever UK notifications of HIV infections from Northern Ireland. The Northern Ireland Blood Transfusion Service which tests approximately 15,000 new donors annually for HIV infection identified four donors as HIV positive during this time. A study done in the GUM in 1989 testing 500 consecutive new attenders for HIV yielded no positive results.² In 1991 the Northern Ireland Regional Virus Laboratory tested 3,003 samples from sources other than GUM of which three were positive – all of whom had a clinical diagnosis of HIV infection at the time of testing. In 1991 11 out of 1,006 attenders at the GUM clinic tested positive for HIV.³ Our concern with these surveys was that there was the possibility of self-exclusion from testing by those at high risk of HIV infection.

The aims of the Programme nationwide are to ascertain the seroprevalence and to monitor the spread of HIV in sentinel groups of patients attending GUM Clinics, injecting-drug users attending specialist treatment and support agencies, and pregnant women proceeding to birth or having terminations.

Providing estimates of the prevalence of HIV infected people in these groups assists in

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TABLE

Anonymous HIV Test Results of patients attending the Genitourinary Medicine Clinic, Royal Victoria Hospital Belfast 1992-95.

<i>Sex</i>	<i>Sexual Orientation</i>	<i>Year</i>	<i>Objections</i>	<i>HIV Positive</i>	<i>Total Tested</i>	<i>Prevalence (%)</i>
M	Homo/ Bisexual	1992	0	3	147	2.04
		1993	1	3	116	2.59
		1994	1	6	142	4.23
		1995	1	4	126	3.17
		TOTAL	3	16	531	3.01
M	Heterosexual	1992	4	2	2047	0.10
		1993	4	0	1930	0.00
		1994	2	4	1911	0.21
		1995	6	0	1781	0.00
		TOTAL	16	6	7669	0.08
F	Heterosexual	1992	4	1	1567	0.06
		1993	5	2	1561	0.13
		1994	13	0	1536	0.00
		1995	10	0	1556	0.00
		TOTAL	32	3	6220	0.05

predicting the future numbers of people with HIV disease, enabling appropriate service planning. The Programme comprises six longitudinal surveys of six categories of persons - homosexual men, bisexual men, heterosexual men and heterosexual women attenders at GUM clinics, injecting drug users and pregnant women. In Northern Ireland only GUM clinic attenders in the first four categories have been studied.

METHODS

All patients attending the GUM Department from 1st January 1992 were given written information on the Unlinked Anonymous HIV Seroprevalence Monitoring Programme. Verbal consent for participation was obtained by the examining doctor.

Individuals eligible for inclusion were those who were having serum taken for a syphilis serology

test and not surveyed previously in that quarter of the year. They were also eligible for retesting in subsequent quarters. Demographic data on age group, gender and country of birth and epidemiological data on sexual orientation, past use of injecting drugs, known diagnosis of HIV infection and presence of acute or non-acute sexually transmitted diseases (STD) was recorded in the information sheet attached to the patient's chart. Data were also collected from persons not consenting to testing of their blood for HIV antibodies to ascertain any demographic or epidemiological trends by which self-excluders might bias survey results.

The data sheet was removed from the patient's chart and sent to the Public Health Laboratory Service to be matched with the HIV test results. The information could not be linked to patient identity thus ensuring anonymity.

RESULTS

There was a total of 531 samples tested from the homosexual/bisexual male group between 1992 and 1995. Sixteen were positive for HIV, giving an overall prevalence rate of 3.09% (Table). Only two HIV infected men were aware of their diagnosis at the time of testing. Of the 16, five presented with an acute STD at the time of testing. Those homosexual/bisexual men testing positive for HIV were in the 25-45 age bracket except one who was in the 20-24 age group.

A total of 7,669 samples was tested from the heterosexual male group. Six were positive for HIV (2 in 1992, 0 in 1993 and 4 in 1994) giving a prevalence rate of 0.08%. (Table). Only two HIV infected men were aware of their diagnosis at the time of testing. Of these six, four presented with an acute STD.

There was a total of 6,220 samples from heterosexual women taken between 1992-95. Three tested positive for HIV, giving an infection rate of 0.05% (Table). Of these three, none was aware of her HIV status. None presented with an acute STD.

CONCLUSIONS

Seroprevalence reporting of the data collected from GUM Departments in England and Wales has been on a geographical basis. These have been attenders at Central London Clinics, Greater London and the South East, and other regions inclusive of England, Wales, and Northern Ireland. The Northern Ireland figures have to date not been identified separately in published reports. It is interesting to compare the seroprevalence in Northern Ireland with these other areas. The prevalence in London clinics involved in the survey between 1992 and 1995 was 15.1% in homosexual and bisexual males (with a range in clinic prevalences from 23.1% to 5.9%), 1.0% for heterosexual males, and 0.6% in heterosexual females. In the areas outside London and S.E. England, a prevalence of 4.0% was detected in homosexual and bisexual males, 0.1% in heterosexual males, and 0.1% in heterosexual females. In all areas the group with the highest prevalence is the homosexual/bisexual male group.⁴ Northern Ireland is seen to have a very much lower prevalence of HIV than the London and S.E. England regions but the overall figures for the areas outside London and S.E. England are not substantially different.

Attenders at a GUM Clinic are likely to be among those at greatest risk of HIV infection in our community. If there were a significant or increasing prevalence of undetected HIV infection in our population this would be one of the first places where this would be detected.

Previous information on seroprevalence could have been biased by persons not wishing to be identified as HIV positive excluding themselves from testing. By ensuring anonymity in the Unlinked Anonymous Screening Programme few persons have self-excluded themselves from testing. This has enabled us to be confident that GUM clinic attenders provide a good sentinel population for HIV seroprevalence in Northern Ireland.

The information obtained confirms our impression that Northern Ireland is a low seroprevalence area, although not so different from areas outside London and the South East of England. This may be due to several factors including cultural hostility to expression of homosexuality, resulting in homosexual men going to more cosmopolitan cities such as London or Dublin, the presence of a small injecting drug community and a small commercial sex industry. Church influence and the relatively intact family structure along with geographic isolation and civil disorder may also be strong contributory factors.⁵ As elsewhere in the UK, homosexual/bisexual men are found to be the population with the highest seroprevalence. It is a matter of concern that few of those testing positive for HIV were aware of their HIV status. It is also alarming that a high proportion of those infected with HIV continue to present with acute STDs thus indicating the absence of "safe sex" practices and illustrating the potential for HIV transmission to people unaware of their HIV status. Large numbers of homosexual/ bisexual men, heterosexual men and heterosexual women continue to acquire new episodes of STDs,⁶ and risk of acquiring another STD is a powerful predictor for HIV infection.⁷ This indicates the need for continued targeting of all groups but perhaps especially homosexual/bisexual men for preventative intervention.

ACKNOWLEDGEMENT

The Survey is co-ordinated by the Public Health Laboratory Service AIDS Centre at the Communicable Disease Surveillance Centre, as part of the Unlinked Anonymous HIV Prevalence Monitoring Programme in England and Wales.

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