NHS Shetland Sexual Health and Blood Borne Virus Strategy

2014-24

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Executive Lead | Dr Sarah Taylor

Proposed groups to present document to:
- SH & BBV Strategy Group
- Sexual Health Clinic Team
- CHCP Strategic Management Team
- Health Action Team

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<tr>
<td>June 2011</td>
<td>Initial draft version 1.0 produced by Wendy Hatrick incorporating draft National Framework and existing local Sexual Health Strategy and Hepatitis C Strategy</td>
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<td>May-August 2012</td>
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## Abbreviations and acronyms

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<tr>
<td>ADP</td>
<td>Alcohol and Drug Partnership</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
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<tr>
<td>BASHH</td>
<td>British Association of Sexual Health &amp; HIV</td>
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<tr>
<td>BBV</td>
<td>Blood Borne Virus</td>
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<tr>
<td>BHIVA</td>
<td>British Human Immunodeficiency Virus Association</td>
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<tr>
<td>CHCP</td>
<td>Community Health and Care Partnership</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer for Scotland</td>
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<td>COSLA</td>
<td>Coalition of Scottish Local Authorities</td>
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<tr>
<td>CPB</td>
<td>Community Planning Board</td>
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<tr>
<td>ESLD</td>
<td>End Stage Liver Disease</td>
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<tr>
<td>GPwSI</td>
<td>GP with a special interest</td>
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<tr>
<td>GUM</td>
<td>Genitourinary medicine</td>
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<td>HAT</td>
<td>Health Action Team</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>HPS</td>
<td>Health Protection Scotland</td>
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<tr>
<td>ID</td>
<td>Infectious diseases</td>
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<tr>
<td>IDU</td>
<td>Intravenous Drug User</td>
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<tr>
<td>ISD</td>
<td>Information Services Division (of NHS Scotland National Services Division)</td>
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<tr>
<td>Incidence</td>
<td>Number of new cases in the population over a given time</td>
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<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraception</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual, Transgender</td>
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<tr>
<td>MPCN</td>
<td>Managed Prevention and Care Network</td>
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<tr>
<td>MRC</td>
<td>Medical Research Council</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men, and including gay and bisexual men</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<tr>
<td>NSHAC (Now NSHHAC)</td>
<td>National Sexual Health (and HIV) Advisory Committee</td>
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<tr>
<td>OPEN</td>
<td>Our Peer Education Network (OPEN)</td>
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<tr>
<td>PEP(SE)</td>
<td>Post exposure prophylaxis (sexual exposure)</td>
</tr>
<tr>
<td>QIS (HIS)</td>
<td>Quality Improvement Scotland (Now Healthcare Improvement Scotland)</td>
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<tr>
<td>Prevalence</td>
<td>Total number of cases in the population at a given time</td>
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<tr>
<td>Respect &amp; Responsibility</td>
<td>Scottish Government’s action plan to improve sexual health</td>
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<td>ScotPHN</td>
<td>Scottish Public Health Network</td>
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<tr>
<td>SHIVAG</td>
<td>Scottish HIV and AIDS Group</td>
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<td>SHWB Clinic</td>
<td>Sexual Health and Wellbeing Clinic</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>Stonewall</td>
<td>A UK charity that works to achieve equality and justice for lesbians, gay men and bisexual people</td>
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<td>SYIS</td>
<td>Shetland Youth Information Clinic</td>
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<td>UAI</td>
<td>Unprotected Anal Intercourse</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV &amp; AIDS</td>
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Executive Summary

This Sexual Health and Blood Borne Virus (BBV) Strategy for Shetland brings together into a single integrated strategy, local work on sexual health, Human Immuno-deficiency Virus (HIV), hepatitis C and hepatitis B. This is in line with the Scottish Government’s single national Framework incorporating both sexual health and BBV policy that was published in August 2011. The national Framework for Sexual Health and Blood Borne Viruses builds on previous Scottish Government policy in these areas, including Respect and Responsibility (2005) and the Hepatitis C Action Plan (2006). It also incorporates the HIV Action Plan for Scotland (2009) and work on hepatitis B. This Strategy echoes the framework by linking different strands of the agenda and addressing health inequalities as a key theme throughout.

The overall aim of the Strategy is to ensure that all people in Shetland irrespective of age, gender, sexual orientation, lifestyle, ethnicity, faith, disability and BBV status have the right to positive sexual health and relationships, free of coercion and harm. This overarching aim incorporates the five national outcomes:

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

The seven local objectives aim to achieve these outcomes and tackle local issues:

- To ensure that the promotion and protection of sexual health and risk of BBVs is coordinated and comprehensive
- To support development of a culture which supports long-term improvements in Shetland’s sexual health; including reducing the risk of acquiring BBVs and maximising the health of those with BBVs
- To provide accurate, relevant and accessible information about sexual health and BBVs.
- To support provision of effective sexual health promotion and relationships education
- To target health promotion messages which meet the needs of the most vulnerable and disadvantaged individuals and communities
- To support provision of a range of accessible services to meet the needs of the population, run by appropriately trained staff
- To work with partners to tackle issues of general risk taking in a coordinated way, and the underlying determinants of risk-taking behaviour in all ages.

Although the Strategy adopts an integrated approach to Sexual Health and BBV there are areas where the main issues and priorities differ. In acknowledgement of this, four separate work streams are described in part 2 of this document, each setting out priorities for the coming years for the areas of sexual health; HIV; hepatitis B and hepatitis C. Whilst this document concentrates on the three currently most common and significant three BBVs, the general principles of BBV prevention would apply to other BBVs that have the same modes of transmission and may become more prominent in the future.
PART 1: Background

Chapter 1. Introduction

This Sexual Health and Blood Borne Virus (BBV) Strategy for Shetland brings together into a single integrated strategy, local work on sexual health, Human Immuno-deficiency Virus (HIV), hepatitis C and hepatitis B.

This is in line with the Scottish Government’s single national Framework incorporating both sexual health and BBV policy that was published in August 2011. Through the Framework, the Scottish Government is implementing an ambitious vision which strengthens joint working through adoption of an outcomes based approach. The national Framework for Sexual Health and Blood Borne Viruses builds on the solid foundations of proven and successful Scottish Government policy in these areas, notably Respect and Responsibility (2005) and the Hepatitis C Action Plan (2006). It also incorporates the more recently published HIV Action Plan for Scotland (2009) and work on hepatitis B. The Framework links the different strands of the agenda, but also strengthens links with other major health issues, such as alcohol and drugs misuse, and with other key policy areas such as education and the Early Years. Addressing health inequalities is a key theme that runs throughout the document.

1.1 Why a combined Sexual Health and BBV Strategy?

Bringing together sexual health together with BBVs in one action plan using the national Framework approach is in line with existing and emerging evidence of the effectiveness of joined-up working in these areas.

It reflects:

- the right of all to a longer, healthier life which includes healthy sexual relationships and wellbeing;
- increasing evidence of cross-agenda working at practice and policy level by stakeholders and within Scottish Government;
- overlaps in client groups;
- similar prevention, testing and treatment issues;
- that some of the clients groups are amongst the most vulnerable members of our society and are subject to health and social inequalities;
- the need to provide a person-centred service, addressing all of a client’s needs;
- co-infection epidemiology:
  - a number of studies indicate a strong association between sexually transmitted infection (STI) and increased risk of HIV acquisition.
  - co-infection of HIV and other STIs is common, particularly amongst men who have sex with men.
  - co-infection of hepatitis C and HIV significantly accelerates the development of advanced liver disease and can create complications for those living with BBVs.
Although the Strategy adopts an integrated approach to Sexual Health and BBV there are areas where the main issues and priorities differ. In acknowledgement of this, four separate work streams are described in part 2 of this document, each setting out priorities for the coming years for the areas of sexual health; HIV; hepatitis B and hepatitis C. Whilst this document concentrates on the three currently most common and significant three BBVs, the general principles of BBV prevention would apply to other BBVs that have the same modes of transmission and may become more prominent in the future.

The aim and objectives of this local Strategy, listed below, are based on our original Sexual Health Strategy and local Hepatitis C Action Plan, and link closely with the National Outcomes in the new Framework.

1.2 Aim

The overall aim of the Strategy is to ensure that all people in Shetland irrespective of age, gender, sexual orientation, lifestyle, ethnicity, faith, disability and BBV status have the right to positive sexual health and relationships, free of coercion and harm.

1.3 National Outcomes

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

1.4 Local Objectives

1.4.1 To ensure that the promotion and protection of sexual health and risk of BBVs is coordinated and comprehensive
1.4.2 To support development of a culture which supports long-term improvements in Shetland’s sexual health; including reducing the risk of acquiring BBVs and maximising the health of those with BBVs
1.4.3 To provide accurate, relevant and accessible information about sexual health and BBVs.
1.4.4 To support provision of effective sexual health promotion and relationships education
1.4.5 To target health promotion messages which meet the needs of the most vulnerable and disadvantaged individuals and communities
1.4.6 To support provision of a range of accessible services to meet the needs of the population, run by appropriately trained staff
1.4.7 To work with partners to tackle issues of general risk taking in a coordinated way, and the underlying determinants of risk-taking behaviour in all ages.
1.5 Performance Indicators and targets

There are a number of indicators and targets related to each outcome contained within the National Framework: these are listed in Appendix E and in each individual workstream chapter.

A number of these have been monitored over recent years as a set of Sexual Health Key Clinical Indictors for local performance management. Some of these were included in the National Standards for Sexual Health Services self assessment, and there are other indicators within the standards that were not included in the self assessment.

It should be noted that not all these indicators can be measured locally in Shetland, because the relevant service is currently provided in Grampian (e.g. termination of pregnancy, HIV specialist services). However, there is some further work required to understand how to monitor these indicators for Shetland patients who are accessing the service from elsewhere.

There are currently no national HEAT targets or local SOA indicators relating specifically to sexual health and BBVs.
Chapter 2. National context

2.1 Building on previous national policies
Prior to the publication of the National Framework, sexual health and blood borne virus national policy was guided by three major strategies; the Hepatitis C Action Plan (Phase II)\(^3\), Respect and Responsibility\(^2\) (including the National Outcomes 2008/11) and the HIV Action Plan\(^4\). There was no national policy for hepatitis B.

There are also close links with a number of other national polices and drivers including the Quality Strategy, launched in May 2010\(^5\).

2.2 Respect and Responsibility
*Respect and Responsibility: A Strategy and Action Plan for Improving Sexual Health* was published in January 2005 after extensive consultation and against a background of poor teenage pregnancy rates and rising incidence of sexually transmitted infections (STIs).

£15 million of additional funding was allocated over the three financial years from 2005 to 2008 to help implement the strategy, which was based on the principles of respect for self and for others, on strong relationships and on recognising the diversity of needs and lifestyles of people in Scotland.

2.3 Better Health Better Care
Commitments by the Scottish Government in the national policy document *Better Health Better Care Action Plan: (2007)*\(^6\) included:

- implement Scotland’s sexual health strategy
- increase the availability of independent sexual health information
- enhance treatment and testing services for Hepatitis C

2.4 National Sexual Health Outcomes 2008-11
The National Sexual Health Outcomes were published as the Scottish Government’s response to an independent stock taking review of ‘Respect and Responsibility’. The review made a number of recommendations but specifically suggested that, having achieved an initial goal of enhancing the provision and accessibility of sexual health services in Scotland, the focus should then shift towards achieving cultural change. The Scottish Government Sexual Health Team has been reviewing each NHS Boards’ progress against the Outcomes through an annual review visit.

The Outcomes cover the following areas:

2.4.1 Knowledge and awareness
- An increase in public awareness of sexual health issues and links to other risk taking behaviours such as alcohol use.
2.4.2 Reduced stigma and discrimination associated with sexual health and HIV.

- Increased access to sexual health information and advice, particularly amongst disadvantaged groups and those at higher risk of poor sexual health outcomes.

2.4.3 Leadership, co-ordination and performance management

- A co-ordinated approach to the delivery of evidence informed sexual health interventions across Scotland will be achieved through local and national leadership and performance management frameworks.

2.4.4 Standards and Service Provision

- NHS Quality Improvement Scotland Standards for Sexual Health achieved in all NHS Board and local authority areas by 2010 leading to high quality information and service provision across Scotland.
- Evidence informed health improvement interventions are a key part of local service delivery.

2.4.5 Young People

- All young people receive evidence based, age appropriate Sex and Relationships Education (SRE) and have access to a linked local drop-in service which provides as a minimum, general health advice, Chlamydia testing, pregnancy testing and free condoms.
- Increased confidence and competence of education, nursing, community learning, social work, voluntary and community sector staff leading to provision of relevant interventions which meet young people’s needs.

2.5 Key Clinical Indicators for Sexual Health

The National Sexual Health Advisory Committee produced a set of interim Key Clinical Indicators (KCIs) which could be used to measure impact as a result of service improvements until the full standards and targets developed by Quality Improvement Scotland are implemented. These indicators are used by all NHS Boards in Scotland to measure activity across all sexual health services. A number of the indicators are difficult to measure for Shetland as they relate to services provided on the mainland, primarily by NHS Grampian.

The KCIs are:

- The proportion of men who have sex with men attending a GUM clinic and eligible for hepatitis B vaccine who receive their first dose in this setting.
- The proportion of the population within each NHS Board having a chlamydia test and the proportion of those tests which are positive.
- The number of tubal ligation procedures and vasectomies (sterilisations) performed by each NHS Board and waiting times for these procedures.
- Percentage of termination of pregnancy procedures taking place at less than or equal to 9 weeks gestation per NHS Board.
• The proportion of HIV positive people in specialist care and eligible for anti-retroviral therapy (ART) who have been treated and the proportion of those treated who have an undetectable viral load

• The proportion of women of reproductive age with intrauterine and implantable contraceptives (LARC): target being 60 per 1000 women.

2.6 Quality Improvement Scotland (now Healthcare Improvement Scotland) Standards for Sexual Health Services

As proposed in Respect and Responsibility, NHS Quality Improvement Scotland (QIS) developed clinical standards in relation to sexual health services. These were published in 2009 and the first self assessments and peer review visits were held in 2010-11. The national report, and local reports, were published in 2011 and are available at: www.healthcareimprovementscotland.org/our_work/reproductive, maternal_child/sexual_health/national_overview.aspx

2.7 Hepatitis C Strategy

The growing problem of hepatitis C as a public health issue in this country was highlighted in 2000 with the publication of a report by the Scottish Needs Assessment Programme (SNAP)\(^8\), which brought together existing initiatives to tackle hepatitis C and made recommendations on how prevention, diagnosis and treatment could be improved. The report of a deliberative seminar: Preventing HCV in Scotland (2002)\(^9\) was resultant from the bringing together of multi-disciplinary professionals from across the country to discuss, debate and challenge the evidence and demonstrating the public health crisis brought about by the hepatitis C epidemic.

Locally, the NHS Shetland Hepatitis C Stakeholders Group was formed in 2004 comprising disciplines supporting individuals locally who inject drugs.

2.7.1 Hepatitis C Action Plan

The national Hepatitis C Action Plan was published in September 2006\(^10\), and drew on key messages in the Consensus Statement emerging from the Royal College of Physicians Conference (2004)\(^11\) which highlighted the increased HCV prevalence nationally and the need for formal procedures at Board level. NHS Boards subsequently developed local Strategy and Action Plans in response. The NHS Shetland Hepatitis C Strategy and Action Plan\(^12\) were developed by the multi-agency stakeholders group, which was strengthened to become the local Hepatitis C Managed Clinical Network in 2008.

The aims of the Hepatitis C Action Plan:

• To prevent the spread of Hepatitis C particularly among IDUs.
• To diagnose Hepatitis C infected persons, particularly those who would most benefit from treatment.
• To ensure that those infected receive optimal treatment, care and support.

The Plan was a two-phased one with Phase I (2006-2008) aiming to generate the evidence base for the Phase II (2008-2011): Improving services.
Phase II covered a three year span 2008/9, 2009/10 and 2010/11. With its specific actions categorised into:

i) Testing, Treatment, Care and Support,
ii) Prevention,
iii) Information Generating and
iv) Coordination activities.

Generally, the actions were high level in nature, to allow NHS Boards particularly, the freedom to develop services in the context of their particular circumstances regarding existing arrangements for Hepatitis C service provision and the epidemiology of infection in their area.

2.8 Healthcare Improvement Scotland: Quality Indicators for Hepatitis C Services

These indicators were published in April 2012. They focus on prevention; testing and assessment; treatment and support. The Indicators can be found at: www.healthcareimprovementscotland.org/our_work/long_term_conditions/hepatitis_c/hepatitis_c_quality_indicators.aspx

2.9 HIV Action Plan

The HIV Action Plan in Scotland 2009 -13 was published in December 2009. The Action Plan aims to reduce the number of transmissions taking place in Scotland through increased prevention, increasing early diagnosis and improving the treatment and care of those living with the virus. More people are living with HIV in Scotland than ever before and the numbers are expected to continue to rise. Whilst this reflects in part an increase in testing, leading to earlier diagnosis, it also reflects a true rise in transmission. The action plan’s aims are to:

- improve the effective co-ordination of prevention and treatment and care activities across health, social care and voluntary sectors
- reduce levels of HIV transmission and undiagnosed HIV
- develop appropriate accountability and reporting arrangements together with increased opportunities to evaluate and research practice

2.10 HIV Standards

These standards were published in 2011, along with a self evaluation tool and focus on prevention; testing and assessment; treatment and support. There is an accompanying self evaluation tool which has been used to shape to inform the Action Plan to implement this Strategy.

The standards can be found at: www.healthcareimprovementscotland.org/our_work/long_term_conditions/hiv_treatment_and_care/hiv_standards.aspx
2.11 Gender Based Violence Action Plan

Gender-based violence is a term that covers the range of violence and abuse aimed at individuals and groups based on their specific gender role in society. It is mostly experienced by women and mostly perpetrated by men, although men can be victims and women can be perpetrators. GBV includes all forms of violence against women including domestic abuse in both heterosexual and same sex relationships, sexual harassment, stalking, childhood sexual abuse, commercial sexual exploitation, harmful traditional practices such as female genital mutilation, forced marriage (this is not the same as an arranged marriage) and so-called ‘honour’ crimes. It affects health, safety and autonomy of the victims, and has far reaching effects on their families and wider society.

In 2008, the Government announced a three year action plan to tackle Gender Based Violence (CEL 41) with each NHS Board being required to:

- Implement routine enquiry about abuse within the priority settings of mental health, maternity, addictions, sexual & reproductive health, A&E, and primary care.
- Implement nationally produced revised guidance on abuse for NHS staff
- Implement an NHS employee policy on gender-based violence.
- Ensure multi-agency collaboration on gender-based violence particularly in relation to child protection and homelessness.

Locally the implementation of this plan is being closely linked with sexual health strategy work.

2.12 Health Promoting Health Service: Action in Hospitals

The Health Promotion Health Services programme identifies that, as well as treating illness, hospital services can help create a step change in health and wellbeing, while also contributing to a reduction in health inequalities, through promoting health and enabling wellbeing in patients, their families, visitors, and staff. Clinical teams and whole hospitals can incorporate health improvement into their day-to-day ethos and activities, taking advantage of opportunities to change behaviours, especially among people most at risk of poor health. The programme, as set out in the Scottish Government circular, CEL 2012 (01), includes actions that should be undertaken in maternity services to promote effective contraception after delivery or termination. This is with the aim of improving health and wellbeing through preventing unplanned pregnancy, especially amongst the most vulnerable women.

The performance measures for sexual health are: “Ensure that, prior to discharge from maternity services, all women aged 16-50 are advised of their contraception options. In particular, vulnerable women at risk of poor sexual health outcomes should be offered effective methods of contraception, including long-acting reversible contraception (LARC). Prior to discharge from termination services, all women should be provided with an effective method of contraception, including LARC, where appropriate”

2.13 Equally Well

Equally Well, the report of the Scottish Ministerial Task Force on Health Inequalities was launched in June 2008. Equally Well set an ambitious programme for change across the key priority areas of children's very early years; the big killer diseases of cardiovascular disease and cancer; drug and alcohol problems and links to violence; and mental health
and wellbeing. The report brought together thinking on poverty, lack of employment, children's lives and support for families and physical and social environments, as well as on health and wellbeing. A detailed implementation plan was launched in December 2008. This identified who is responsible for taking forward the recommendations contained in Equally Well. The plan described how the Scottish Government and community planning partnerships can turn Equally Well's recommendations into action in both the medium and short term. A number of Equally Well test sets were set up to progress specific recommendations. There were reviews of progress in 2010 and 2012.

2.14 The Quality Strategy

The Scottish Government published the Quality Strategy in May 2010, which aims to deliver the highest quality NHS healthcare services to people in Scotland and through this to ensure that NHSScotland is recognised by the people of Scotland as amongst the best in the world. The aims of the Sexual Health and BBV Framework link with those of the Quality Strategy.

- Firstly, to ensure that at all times those most at risk of poor sexual health outcomes and/or BBV are at the heart of our NHS services.
- Secondly, to provide the users of these services with effective treatments, interventions, support and services when they need them, whilst at all times working in partnership with our stakeholders to ensure that services provided are evidence based and appropriate.
- Thirdly, to enable people to maintain high levels of health, good relationships and wellbeing; to live well through self management, improved health literacy and by supporting anticipatory and preventative responses through an asset based approach to sexual health and BBV.

2.15 Equality and Diversity

Shetland’s Equality Outcomes 2013-17 has two specific outcomes related to Lesbian, Gay, Bisexual and Transgender issues which are relevant to this Strategy and incorporated within the action plans.

- LGBT people feel confident and included when accessing services
- Services meet the needs of LGBT people

The details of evidence and actions relating to these outcomes are noted below, in an extract from the local Equalities Outcomes Implementation Plan for 2013-17.
<table>
<thead>
<tr>
<th>Situation / problem</th>
<th>Evidence</th>
<th>Activities / outputs</th>
<th>Equality Outcome</th>
<th>General Equality Duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information relating to LGBT health outcomes and inequalities is unavailable. National evidence indicates links to mental health issues and LGBT people</td>
<td>Stonewall Gay &amp; Bisexual Men’s Health Survey Scotland. Stonewall Prescription for Change: Lesbian &amp; Bisexual Women’s Health Check 2008</td>
<td>Monitoring and analysis of sexual orientation – starting in the Sexual Health Clinic, once the national patient system is input. From there determine and act on any evident local health inequalities. Establish a local action group to signpost LGBT people to support when needed – to include youth services, education, school nursing service, CAMHS, social work. Use this group to explore and implement the concept of straight allies or an ally network. Utilise Stonewall online training to build awareness amongst healthcare professionals and third sector partners and to eliminate assumptions/prejudice from the provision of care to LGBT people e.g. end of life care, admissions, screening.</td>
<td>LGBT people feel confident and included when accessing services</td>
<td>Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.</td>
</tr>
<tr>
<td>Not clear whether universal sexual health clinic service meets the needs of LGBT people in Shetland</td>
<td>Review service data to identify any amendments which would make service more relevant, appropriate and easy to access</td>
<td>Services meet the needs of LGBT people</td>
<td>Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td>
<td></td>
</tr>
</tbody>
</table>

Extract from Shetland’s Equality Outcomes 2013-17

2.16 An Assets Based Approach

In his 2009 report, the Chief Medical Officer for Scotland described the benefits of taking an asset based approach to health and health improvement. Such an approach enables individuals to take control of their own health and wellbeing while also promoting self esteem and the coping abilities of individuals and communities.

Initiatives to support good sexual health and relationships, to reduce the incidence of BBVs and to empower people living with BBVs 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 BBV improvement through combining key prevention initiatives with social and cultural approaches which will support Shetland to positively influence sexual health, prevent new BBV infection and support those living with BBVs.
2.17 The Economic Case

Blood borne virus infection and poor sexual health outcomes have a huge financial impact in Scotland – not just to the NHS, but to local authorities and other statutory organisations. The costs include drug treatments, psychological support, costs to social services and education, and in societal costs. The Economic Case will be considered within this Strategy.

2.18 Supporting Delivery

The Scottish Government, Special Health Boards and other key national organisations will have key roles in progressing the achievement of the Framework Outcomes and supporting NHS Boards, Local Authorities and Voluntary Sector organisations.
Chapter 3. The National Framework Outcomes

In line with the Scottish Government’s Quality Strategy, this Strategy is focused 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 locally in the way things are done. Innovation and imaginative solutions to delivery need to be fostered, while retaining a focus on the ultimate aims.

Embedded in our NHS Shetland Sexual Health and BBV Strategy Work plan are the national framework outcomes:

**Outcome 1: Fewer newly acquired BBVs and STIs; fewer unintended pregnancies.**

The Framework intends to improve public health by reducing the harm that can be caused through the impact of preventable infections and poor sexual and reproductive health. This will be achieved through strong health improvement, prevention and education initiatives, tackling not only at-risk sexual activity, but also linking closely to work undertaken in drug and alcohol misuse.

**Outcome 2: A reduction in the health inequalities gap in sexual health and BBVs.**

Health inequalities remain a significant challenge in Scotland. (Scottish Government, 2010a). This is clearly illustrated across sexual health and BBV, 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 focused improvement and targeted intervention locally and nationally in order to ensure that nobody is disadvantaged in terms of care by virtue of irrelevant differences.

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

More and better targeted testing, early diagnosis and the effective treatment and care of BBV infections underpinned by good quality personal support are essential in ensuring long term health. Effective treatment and curing infections, where this is possible, will help reduce onwards transmissions. The Framework will seek to improve practice in these areas. Better partnership working will support people living with BBV.

**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.

**Outcome 5: A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs are positive, non-stigmatising and supportive.**

Changing the culture in Scotland around sex, sexual relationships, sexual health and BBVs is vitally important.

People living in Scotland can be supported to improve their health and wellbeing by encouraging communication and positive attitudes to sex, sexual health and BBVs.
Changing the culture is essential if onward transmission of infection is to be reduced and ensure that those people living with, and affected by, BBVs are able to feel equal and valued members of our society. Many people living in Scotland have outdated knowledge about BBVs, the way in which they are transmitted, life expectancy, quality of life for someone living with BBV and the realities of living on treatment for a lifetime.

Linking in 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.
PART 2: Work streams

Chapter 4. Sexual Health and Wellbeing

Framework Outcomes: Sexual Health

1. Fewer newly acquired STIs and fewer unintended pregnancies
2. A reduction in health inequalities associated with sexual health
3. People living with BBVs lead longer, healthier lives
4. Everyone in Scotland is able to exercise their right to fulfilling sexual relationships 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 and BBVs are positive, non-stigmatising and supportive.

The national intentions for the Sexual Health Workstream are to:

- continue to deliver the aims and principles of Respect and Responsibility, taking into account the progress already made; and
- identify key areas for further action to improve sexual health and wellbeing in Scotland, informed by up to date evidence and, in particular, focusing on those who are considered to be most at risk of poorest sexual health and wellbeing.

4.1 Epidemiology of Sexually Transmitted Infections in Scotland

- The overall trends for the four main sexually transmitted infections (genital chlamydia, gonorrhoea, genital herpes and genital warts), show a general increase in diagnoses.
- Nationally young people aged less than 25 and men who have sex with men are most at risk of infection.
- In the past Shetland statistics have been similar although the small numbers require analysis with caution. Some Shetland patients may attend mainland Scotland clinics for diagnosis and treatment. The most recent figures for Chlamydia show that there is a higher proportion in Shetland of people over the age of 25 who are testing positive.

4.2 Epidemiology of Unintended and Teenage Pregnancy in Scotland

- The teenage pregnancy rate in Scotland has remained steady over the last ten years for the under 16s, with the most recent data (for 2012) showing a very slight decrease. The rates for under 18s and under 20s have been decreasing in the past five years.
There is a strong association between deprivation and rates of teenage pregnancy. In the under 20 age group, those living in Scotland’s most deprived areas have approximately 12 times the rate of delivery as the least deprived. (53.8 per 1,000 and 4.6 per 1,000). Shetland’s rate in 2012 for this age group was 23.2 per 1,000.

Use of Scottish Index of Multiple Deprivation (SIMD) data as a measure of deprivation can be problematic for small populations; the very small numbers of teenage pregnancy locally requires that interpretation of the data is done with caution.

There has been a reduction in the number of terminations of pregnancy performed in Scotland since a peak in 2008, especially in younger age groups with a reduction of a third amongst the 16-19 year olds.

However the rate of terminations in Scotland in 2013 remained highest in younger women aged 16-19 (16.3 per 1,000) and those aged 20-24 (19.1 per 1,000).

Termination rates show a clear link with levels of deprivation. Rates in areas of high deprivation (14.4 per 1,000 in 2013) are nearly double that seen in the most affluent areas of Scotland (8.2 per 1,000).

Nearly a third of women (30.7%) having an abortion in Scotland in 2013 have had a previous termination. This varies across Boards, being lowest in the Island Boards at 18.8%.

In Shetland the actual number of teenage pregnancies is very low with often none or one each year and occasionally higher numbers, and so it is difficult to interpret trends. Termination rates for the small Island Boards are reported together as a result of the small numbers involved; local numbers are extrapolated for service planning purposes but not published here.

### 4.3 Key Research Evidence

- Evidence indicates that interventions in the early years of a child’s life are most effective in supporting positive sexual health outcomes.
- Sexual health and relationships education and widespread implementation of integrated sexual health services remain key to good 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.

### 4.4 Sexual Health Indicators and Targets

#### 4.4.1 STIs

- The proportion of the population within each NHS Board having a chlamydia test and the proportion of those tests which are positive.
• The proportion of chlamydia tests per year taken from males and females aged under 25 (TARGET 60%)
• The rate of chlamydia tests performed in the NHS Board area in males aged 15-24 (TARGET GREATER THAN 100 PER 1000)
• The rate of chlamydia tests performed in the NHS Board area in females aged 15-24 (TARGET GREATER THAN 300 PER 1000)
• For every 100 individuals diagnosed with chlamydia in a specialist sexual health setting, 64 contacts are verified as having attended within 90 days of the first partner notification interview.
• Proportion of individuals with priority sexual health conditions who are offered the opportunity to be seen within two working days of initial contact with a specialist sexual health services (TARGET 80%)

4.4.2 Contraception
• The proportion of women of reproductive age with intrauterine and implantable contraceptives (LARC): (TARGET 60 per 1000 women).
• The number of tubal ligation procedures and vasectomies (sterilisations) performed by each NHS Board and waiting times for these procedures.

4.4.3 Teenage pregnancy
• Teenage pregnancy (rate per 1000) for <16 year olds
• Teenage pregnancy (rate per 1000) for <20 year olds

4.4.4 Termination of pregnancy
• Percentage of termination of pregnancy procedures taking place at less than or equal to 9 weeks gestation per NHS Board. (TARGET 70%)
• Proportion of women who have had a termination, who leave the facility with one of the more effective methods of contraception (hormonal oral contraceptives, intrauterine devices or contraceptive implants). (TARGET 60%)

4.5 Nationally identified key approaches to achieving the five outcomes within the Sexual Health workstream

4.5.1 Multi-agency working
As highlighted throughout this Strategy, poor sexual health cannot be addressed through health interventions alone. The role of local authorities, including education and social work, is crucial. In Shetland this will be led through the Shetland Sexual Health and BBV Strategy Group.

4.5.2 Outcome 1: Fewer newly acquired BBVs and STIs; fewer unintended pregnancies.
Outcome 2: A reduction in the health inequalities gap in sexual health and BBVs.
### Key approach

<table>
<thead>
<tr>
<th>Early intervention and addressing wider risk taking behaviours</th>
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<tbody>
<tr>
<td>• Strengthening partnership working across statutory and non-statutory organisations and the involvement of the Community Planning Board.</td>
</tr>
<tr>
<td>• Close working with the Health Action Team, which reports through Health Improvement Updates to the Community Health Partnership Committee, to address risk taking behaviour.</td>
</tr>
<tr>
<td>• Include sexual health in the work being carried out through local Anti-social Behaviour Strategy to identify and work with young people engaging in risky behaviour</td>
</tr>
<tr>
<td>• Further strengthening of links with other relevant strategies and Strategy Groups.</td>
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</table>

### Local action

<table>
<thead>
<tr>
<th>Interventions are targeted toward those most at risk.</th>
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<tbody>
<tr>
<td>• Development of a needs led approach to delivering targeted messages to specific groups who may be vulnerable or who may not access ‘mainstream’ initiatives.</td>
</tr>
<tr>
<td>• Development of specific health improvement work with vulnerable young people including those who are looked after and those with learning disabilities</td>
</tr>
<tr>
<td>• Continuation of specific health improvement work with young people not in education, employment or training and those excluded from mainstream school, including staff training, in conjunction with projects such as The Bridges</td>
</tr>
<tr>
<td>• Further development of specific health improvement work with the LGBT community, building on the work of the LGBT Working Group and NHS Shetland Diversity Taskforce and working with Stonewall. Also linking with the work on Shetland’s Equality Outcomes for 2013-17.</td>
</tr>
<tr>
<td>• Further work to ensure that those most at risk have access to information and advice, free condoms and emergency contraception in particular eg through use of ‘Confidentiality cards’ and revision of condom distribution scheme.</td>
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</table>

<table>
<thead>
<tr>
<th>Local authorities should take leadership on addressing teenage pregnancy particularly with those aged under 16</th>
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</thead>
<tbody>
<tr>
<td>The Shetland Single Outcome Agreement previously included a Teenage Pregnancy indicator. However as this has remained at a lower in Shetland over many years, it is currently not in the SOA.</td>
</tr>
<tr>
<td>• The Teenage Pregnancy Audit Toolkit will be used to review current work in this area.</td>
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</tbody>
</table>
### High quality integrated sexual health services

- Further work to improve the efficiency and quality of the local Sexual Health and Wellbeing Clinic is ongoing.
- Further work on increasing primary care capacity and linking with the Clinic is ongoing.

### Regular training, education and CPD to ensure the confidence and competence of the workforce

Continuation and formalisation of the local training programme which includes a combination of:

- multi-agency training sessions on sexual health and/or BBVs;
- training sessions for youth workers (both council and voluntary sector);
- SHARE training for teachers, health visitors and others;
- Clinical training for sexual health clinic and primary care staff eg LARC fitting; use of PGDs;
- Ensuring clinical staff maintain relevant competencies, eg LARC fitting.

### Sexual health improvement interventions should have a sound or promising evidence base

This is achieved through links with national groups and networks; use of national guidelines and training.

### 4.5.3 Outcome 3: People affected by BBVs lead longer, healthier lives

#### Key approach

Support for people living with BBV to ensure good sexual health should be accessible to all, through both NHS and Third Sector services.

Services should ensure that women living with BBV are offered advice and care on both contraception and pregnancy.

#### Local action

- The numbers of people with BBVs in Shetland are very small and most will be managed through mainland health boards. However the SHWB clinic will continue to promote access for everyone and staff training and awareness raising of the particularly high risk and vulnerable groups will continue.

- This approach is to be further developed in primary care.

- The numbers of women in this situation in Shetland are very small, so dedicated services cannot be developed. However the SHWB clinic will continue to promote access for everyone and staff training and awareness raising of the particularly high risk and vulnerable groups will continue.
This approach is to be further developed in primary care.

Development of links between the Sexual Health Clinic and the new Pre-conceptual Care Clinic.

Women who sell sex are extremely vulnerable to HCV infection and sexual ill health. It is therefore important that these women are able to access good sexual and reproductive health services.

Although there is no overt sex worker trade in Shetland, anecdotally it is known that there are people who ‘sell’ sex for money or other forms of ‘payment’. However the numbers are too small to develop dedicated services.

The SHWB clinic will continue to promote access for everyone and staff training and awareness raising of the particularly high risk and vulnerable groups will continue. (this links in with GBV work)

4.5.4 Outcome 4: Everyone in Scotland is able to exercise their right to fulfilling sexual relationships free from coercion and harm

<table>
<thead>
<tr>
<th>Key approach</th>
<th>Local action</th>
</tr>
</thead>
</table>
| Local Authorities should ensure that all young people have access to high quality, consistent information on sexual health | • Continue to provide up to date information about sexual health and current services that is easily and readily accessible to all target groups, including through ‘Help yourself to health’ project which is a joint project between the Council’s Library Service and the NHS Health Improvement Department.
• Continue to raise awareness and disseminate information amongst with young people through participating in events such as Youth Worker Conference and Youth Voice meetings
• Further development of drop in sessions in schools, working in partnership with health and voluntary sector
• Roll out of raining for staff working with young people to recognise healthy sexual development and where behaviour maybe harmful or risky (Brook Traffic Light Training)

| Sexual Health, Relationships and Parenthood education should be provided | • Continuation of SHARE programme in junior high / high schools
• Implementation of recommendations following SRE audit in schools
• Review current local methods for involving parents in SRE and look at further development on a locality basis. |
### Outcome 5: A society and culture 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

<table>
<thead>
<tr>
<th>Key approach</th>
<th>Local action</th>
</tr>
</thead>
</table>
| Work to promote positive and life enhancing aspects of sex and sexual relationships should continue locally, regionally and nationally | • Continue with the theme of ‘everyone has a right to healthy relationships’ for local awareness raising campaigns, tying in with national campaigns  
• Support for voluntary sector work in peer education |
| Efforts to promote a positive approach to sex, sexual health and relationships in the media should continue, nationally and locally, through linking in with groups such as the National Union of Journalists. | Continue to participate in local and national media and publicity campaigns, and work proactively with the local media, Annual campaigns may include:  
• Men’s Health Week  
• Sexual Health Week  
• World Aids Day |
Chapter 5. Human Immunodeficiency Virus (HIV)

Framework Outcomes: HIV

1. Fewer newly acquired infections
2. People living with HIV lead longer, healthier lives
3. People living with HIV lead longer, healthier lives
4. 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.

The HIV workstream of this Sexual Health and BBV Strategy incorporates our local response to the national HIV Action Plan 2009-14. The local figures for newly acquired HIV infections are very small and the pattern of transmission locally is different to the national picture with heterosexual transmission accounting for half of the numbers reported.

The overarching aims of the national HIV Action Plan are to:

- reduce new transmissions;
- reduce undiagnosed HIV;
- support those living with and affected by HIV in Scotland.

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

5.1 Epidemiology of HIV infection in Scotland

- During 2013, NHS Scotland laboratories reported positive HIV-antibody test results for 354 individuals not previously recorded as HIV-positive, similar to previous years.
- The cumulative total of known HIV-positive individuals in Scotland was 7647 by the end 2013, of whom 5562 (73%) are male and 2085 (27%) are female.
- Of the 354 people diagnosed with HIV in 2013:
  - 235 (66%) are aged 25-44
  - 83 (23%) are presumed to have acquired their infection outwith Scotland
  - 127 (36%) acquired through MSM route
  - 112 (32%) acquired through heterosexual intercourse
  - 22 (6%) acquired through injecting drug use
  - 87 (26%) acquired through other route or undetermined
- At least 1900 (25%) of people diagnosed are known to have died. Allowing for known and presumed migration of cases, it is estimated that there are currently 4600 persons living in Scotland who have been diagnosed HIV-positive.
• It is estimated that only 75% of the people with HIV have been diagnosed.
• 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)
• **In Shetland:** between the early 1980s and 2013, 10 people in Shetland have been diagnosed with HIV with the most recent being in 2013. However, small numbers do not mean that there is no issue, there are likely to continue to be new HIV diagnoses, and as already noted transmission amongst heterosexuals and anecdotal evidence of co-infection with Hepatitis C mean there needs to be continued vigilance and pro-active health promotion of these population groups.

5.2 Risk factors
• 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 IDU respectively; the rate in MSM has remained unchanged since the late 1980s.
• Among MSM attending gay bars in Glasgow and Edinburgh 2008, 40% reported practicing unprotected anal intercourse in the previous 12 months. This rate was similar to that reported in 2005.
• In 2008, the prevalence among heterosexual men and women whose geographical region of exposure was sub-Saharan Africa was 7.3%; this compares with 0.1% in those whose region of exposure is the UK.
• A major decline in the transmission of HIV among IDUs 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 Shetland** it is very relevant to note that heterosexual transmission accounts for half of the reported HIV cases.

5.3 Management of HIV
• At end December 2013, 3895 (86%) HIV infected individuals in Scotland were attending specialist services for monitoring and treatment.
• 88% of these patients were receiving anti-retroviral therapy.

5.4 HIV indicators and Targets
• The proportion of HIV positive people in specialist care and eligible for anti-retroviral therapy (ART) who have been treated and the proportion of those treated who have an undetectable viral load
• The proportion of HIV+ adults presenting for the first time in Scotland who have their sexual and reproductive history documented within 4 weeks of their initial HIV diagnosis, and are given advice to prevent onward HIV transmission, backed by the availability of condoms. **(TARGET 70%)**
• The proportion of adults receiving ongoing HIV care who have the result of syphilis serology taken within the preceding 6 months recorded in their HIV records, or documentation why this is not required updated at 6 monthly intervals (TARGET 90%)

• The proportion of adults receiving ongoing HIV care who have an offer of a sexual health screen at least once every 12 months. If a sexual health screen is not required or if the offer is declined, this information is documented at 12 monthly intervals. (TARGET 90%)

5.5 Nationally identified key approaches to achieving the outcomes within the HIV workstream

5.5.1 Multi Agency Approach

A multi agency, collaborative approach to the prevention of HIV, treatment and care of those living with HIV and the provision of support services is essential. The already locally established managed care network for Hepatitis C is well placed and adopted a BBV approach at the outset.

Partners outwith the NHS have an essential role in influencing behaviours, lifestyles and risk factors. They can help prevent transmission, support testing, strengthen engagement with treatment services and can provide support services for those living with HIV. It is essential that local authorities and the voluntary sector are recognised for the role which they can, and must, play. This approach should centre on and involve people living with HIV to ensure effective responsiveness to need.

The National Co-ordinators will offer support to NHS Boards and other organisations to work regionally, where required.

5.5.2 Outcome 1: The prevention of newly acquired HIV infection

Work to reduce new transmissions of HIV should focus on where they are likely to have the highest impact – in Shetland this includes all people living with HIV, heterosexuals, MSM and those who have come from areas of high prevalence, notably African countries. Transmission among IDUs and the indigenous heterosexual population is uncommon nationally but locally as noted, heterosexual transmission accounts for half of those reported locally with a diagnosis of HIV. It is important that all groups are considered in terms of HIV risk and HIV related sexual health.

<table>
<thead>
<tr>
<th>Key approach</th>
<th>Local action</th>
</tr>
</thead>
</table>
| Effective links between prevention, diagnosis, treatment and care services. Prevention should be a key part of all treatment and care services. | • Development of care pathways linking Shetland services and the mainland services.  
• Continuation of prevention work locally in all settings |
<p>| The use of the most up to date evidence to inform prevention approaches within local needs assessments. | This is achieved through links with national groups and networks; use of national guidelines and training. |</p>
<table>
<thead>
<tr>
<th>Engagement, support and involvement of those most at risk of HIV transmission notably, MSM and those from areas of high prevalence.</th>
<th>Further work is required to engage with this relatively small community locally. This is being developed through working with national groups such as Terrence Higgins Trust and through linking with the NHS Shetland Diversity taskforce which is working with Stonewall on LGBT issues.</th>
</tr>
</thead>
</table>
| Regular training, education and CPD to guarantee the competence of the HIV-related workforce in relation to HIV prevention. | - Local training needs analysis to understand training needs related to BBV, including HIV, for different groups of staff (including clinical staff, social care, youth workers, voluntary sector)  
- Development of a training framework, which is likely to include continuation of locally delivered programmes:  
  - multi-agency training sessions on sexual health and/or BBVs;  
  - training sessions for youth workers (both council and voluntary sector)  
  - SHARE training for teachers, health visitors and others  
- Along with to with NHS Grampian training courses and other course outwith Shetland. |
| The inclusion of HIV within RSHP education as part of Curriculum for Excellence in all educational settings | - Further work to ensure that HIV is included within SHARE lessons, or in additional sessions provided, for example, by OPEN Peer Education workshops (Voluntary sector) |
| Effective awareness raising and social marketing approaches, including HIV Wake Up and local/regional social marketing activities. | - OPEN (Voluntary sector) is running a peer education programme, incorporating HIV and AIDS as a theme.  
- The North of Scotland Boards are considering a proposal for a localised approach to the HIV Wake Up Campaign including the use of social networking applications to raise awareness of HIV amongst MSM, and to signpost to services. |
| The implementation of: NHS QIS HIV Standards (Prevention)\(^\text{14}\) | - Use self evaluation tool to assess NHS Shetland against the HIV Standards |
5.5.3 **Outcome 3: People affected by HIV lead longer, healthier lives**

**Outcome 5: 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.**

It is important that people living with HIV are diagnosed at the earliest opportunity. Undiagnosed infection risks further transmission, can result in extremely poor health outcomes and reduced effectiveness of HAART for those living with HIV. HIV-related stigma can be a barrier for the testing and diagnosis of HIV as can missed opportunities within non-HIV related primary care and in patient healthcare services. It essential to ensure 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 treatment and care.

<table>
<thead>
<tr>
<th>Key approach</th>
<th>Local action</th>
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</thead>
<tbody>
<tr>
<td>Increased knowledge and awareness of HIV in all populations;</td>
<td>Continued awareness raising and publicity across different groups in the community eg</td>
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<tr>
<td></td>
<td>• World Aids Day events</td>
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<td></td>
<td>• The OPEN Peer Education project</td>
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<td></td>
<td>• HIV Wake Up campaign</td>
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<td></td>
<td>• Through Healthy Working Lives</td>
</tr>
<tr>
<td>Continued engagement with, and testing of, at risk populations and normalising of testing within 'not at risk' populations to reduce late diagnoses and issues of stigma around HIV testing and diagnoses;</td>
<td>• All patients attending sexual health clinic are offered HIV testing, in an ‘opt out’ model.</td>
</tr>
<tr>
<td>Routine testing for those with early sentinel conditions;</td>
<td>• Work with clinicians to understand how this can be addressed locally</td>
</tr>
<tr>
<td>Regular training, education and CPD to ensure the competence of the HIV-related workforce;</td>
<td>• As above</td>
</tr>
<tr>
<td>Ensuring all those who require specialist treatment and care, and support, are receiving it;</td>
<td>• Review current treatment and care pathways for people with HIV, noting that in Shetland there are very small numbers and pathways tend to be tailored towards the individual. Also note that currently not all patients are cared for by NHS Grampian.</td>
</tr>
<tr>
<td>The inclusion of HIV within RSHP education as part of Curriculum for Excellence.</td>
<td>• As above</td>
</tr>
</tbody>
</table>
Ensuring that support services for those living with HIV are available throughout Scotland, particularly in remote and rural areas, via NHS Boards, Local Authorities and Third Sector organisations.

This requires some further work to ensure that people with HIV living in Shetland can access appropriate support. Because of our small population, and small number of people with HIV, any local support will be generic and specialist support for HIV and AIDS will need to be sought from mainland organisations.

| Implementation of: NHS QIS HIV Service Standards | Use self evaluation tool to assess NHS Shetland against the HIV Standards. |
Chapter 6.  Hepatitis C

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

The Sexual Health and BBV Framework recognises the need for ongoing and long term investment in Hepatitis C to improve public health and wellbeing in Scotland. The Framework builds on the foundations established by the Hepatitis C Action Plan in 2008-2011 and, specifically, continues to progress the key aims of that policy:

- To prevent the spread of Hepatitis C particularly among intravenous drug users (IDUs).
- To diagnose Hepatitis C infected persons, particularly those who would most benefit from treatment.
- To ensure that those infected receive optimal treatment, care and support.

Local research in Shetland exploring ethical issues and effect of knowledge of HCV status in IDUs has run concurrently with development of this Strategy. Collection of local data, collation, analysis and reporting of findings has informed the strategy development.

6.1 Epidemiology of Hepatitis C in Scotland

- In 2013, 1903 new cases of hepatitis C antibody-positivity were diagnosed in Scotland, slightly lower than in 2011 and 2012.
- 432 (23%) of these are known to have injected drugs and 300 (19%) were diagnosed in drug services.
- A total of 35,500 people have been diagnosed with Hepatitis C in Scotland, and of these, 5522 (16%) have died.
- 55% of the total number are known to have injected drugs; 1% of infections were associated with receipt of blood factor.
- It is thought that about 50% of people chronically infected with hepatitis C remain undiagnosed.
- By end 2013, approximately 0.9% of Scotland’s population aged 15-59 had been diagnosed hepatitis C antibody positive.
- In Shetland there are approximately 45 patients diagnosed with Hepatitis C; suggesting that there could be a further 40 – 50 people who remain undiagnosed.
6.2 Risk Factors

- The majority of hepatitis C transmissions in Scotland occur amongst injecting drug users with approximately 90% of the infected population in Scotland having ever injected.
- Large numbers of IDUs continue to be infected annually (estimated 1000-1500 in Scotland in 2008/9) whilst transmission among non IDUs occurs very infrequently.
- Although significant progress has been made, there remains a considerable shortfall in the amount of injecting equipment provided to IDUs if this is to correspond with the number of injecting events to reduce Hepatitis C transmission.
- Hepatitis C infection in Scotland is associated with deprivation and health inequality as a consequence of drug injecting.

6.3 Management

- Through the Hepatitis C Action Plan Phase II, local Managed Care Networks for Hepatitis C have been established and the capacity of testing, treatment, care and support services have increased significantly.
- This has affected a 220% rise in the number of people initiated onto antiviral treatment in Scotland to 1024 (projected) in 2010/11 and an increase in Hepatitis C diagnoses which the Framework will build upon.

6.4 Hepatitis C Indicators and Targets

The following are all taken from the Hepatitis C Quality Indicators, published in 2012:

- Proportion of people who have had a named hepatitis C test with recently acquired hepatitis C infection
- Proportion of recently at risk drug users who have had an anonymous hepatitis C test which indicates recently acquired hepatitis C infection
- Proportion of injecting drug users sharing injecting equipment
- Proportion of injection episodes undertaken with sterile injecting equipment
- Proportion of hepatitis C testing by deprivation index
- Proportion of positive hepatitis C antibody tests by referral source
- Proportion of injecting drug users with chronic hepatitis C who are unaware of their infection
- Proportion of people diagnosed with current hepatitis C infection attending a hepatitis C service
- Proportion of people diagnosed with current hepatitis C infection assessed for genotype and liver disease fibrosis
- Proportion of antiviral therapy initiations suggested nationally that took place
- Proportion of treatment-naïve patients achieving sustained viral response to antiviral therapy
- Proportion of treatment-experienced patients achieving sustained viral response to antiviral therapy
- Proportion of patients not receiving antiviral therapy who are under review in secondary care or equivalent

6.5 Nationally identified key approaches to achieving the outcomes within the HIV workstream

The infrastructure and initiatives established by the Hepatitis C Action Plan to improve capacity, consistency and the quality of service delivery in Scotland remain integral to the delivery of the Framework. These include the national procurement of Hepatitis C medicines and injecting equipment, local Managed Care Networks, Guidelines for Services Providing Injecting Equipment, local Prevention Networks encompassing Hepatitis C, Frameworks for Workforce Development and Education, national information generating initiatives and NHS HIS Quality Performance Indicators (previously Standards) for Hepatitis C Services.

It is essential that NHS, local authorities and the third sector recognise the role and contribution they make to tackling all three BBVs focusing on involving people living with these viruses to ensure that the approach in Scotland remains effective and responsive to need. Better links between MCNs, Prevention Networks and local Community Planning Partnerships (CPP), through local Alcohol and Drug Partnerships (ADPs), are required.

6.5.1 Outcome 1 Fewer newly acquired infections

<table>
<thead>
<tr>
<th>Key approach</th>
<th>Local action</th>
</tr>
</thead>
</table>
| The optimal uptake of clean injecting equipment and safer injecting practises for those who are currently injecting | • Continuing provision and monitoring of the needle exchange service and harm minimisation work delivered by CADSS and, in the future, the redesigned Addictions Service  
• Updating the needle exchange service delivered through Community Pharmacy to reflect the needs of the client group. This includes exploring the provision of ‘one hit kits’ to ensure safer injecting behaviours.  
• Input of local data into the in the National Injecting Equipment Database |
| Access to opiate substitution therapy as part of a range of interventions available to support recovery from substance misuse. | • Continuing provision and monitoring of the substitute prescribing service delivered by the Substance Misuse Clinic                                                                                                                                 |
| The implementation of NHS HIS Hepatitis C Indicators (published April 2012) | • Local services to be reviewed against the indicators to inform future development of services                                                                                                                  |
6.5.2 Outcome 2 A reduction in the health inequalities gap in sexual health and BBVs

<table>
<thead>
<tr>
<th>Key approach</th>
<th>Local action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-agency partners should work together to progress strategies to reduce health inequality associated with Hepatitis C</td>
<td>• This will be incorporated into the health inequalities work led by the Health Action Team and Fairer Shetland Group</td>
</tr>
</tbody>
</table>

6.5.3 Outcome 3: People affected by BBVs lead longer, healthier lives

Drug injecting remains the main transmission route for Hepatitis C in Scotland and in Shetland, 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 what is recognised as a spectrum of recovery. This is often associated with complex social care, medical and support needs to be addressed through partnership working across sectors. Infection with Hepatitis C and a lifestyle which includes the practice of injecting drug use are sensitive. Confidentiality and anonymity can be very important for individuals on the recovery journey. It is crucial that partners across all sectors recognise the often subtle issues which may make or break the recovery cycle.

<table>
<thead>
<tr>
<th>Key approach</th>
<th>Local action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approaches should be adopted to ensure the great majority of people living with chronic Hepatitis C are diagnosed and in specialist care</td>
<td>• The further development of local pathways in collaboration with colleagues in NHS Grampian through the MCN, focusing on increasing support that can be provided in Shetland.</td>
</tr>
</tbody>
</table>
| Earlier intervention is required to reduce the number of Hepatitis C infected people developing end-stage liver disease. | • Through the further development of pathways as above  
• Through awareness raising with the at risk population and primary care eg through further training events. |
<p>| Innovative approaches to improve access to Hepatitis C testing, such as dry blood spot testing, in settings attended regularly by IDUs; | • Participation in pilot projects as appropriate( eg near patient testing) |
| Case finding initiatives in conjunction with laboratories, GPs and specialist services to identify individuals who should be offered or recommend a test in line SIGN Guideline 92 or encouraged to re-engage with services where a diagnosis has been made; | • To be developed |</p>
<table>
<thead>
<tr>
<th>Awareness raising concerning the importance of Hepatitis C testing and the availability and effectiveness of antiviral treatment to encourage test uptake among at risk populations.</th>
<th>• Through local awareness raising and work with addictions services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorporation of annual hepatitis C testing into care plans for those progressing through recovery orientated systems of care for drug misuse in line with recommendations to encourage annual BBV testing within the Scottish Government Guidelines for Services Providing Injecting equipment</td>
<td>• To be delivered through the substitute prescribing service as part of a client’s recovery plan</td>
</tr>
<tr>
<td>Multi-agency partners should continue to support Hepatitis C testing, treatment, care and support services within hospital, community and prison settings in Scotland in line with initiating 1000 people onto antiviral treatment each year as a minimum national target within prisons and the community;</td>
<td>• Continue offering Hep C testing (along with HIV and Hep b testing) as routine in Sexual Health Clinic and Substitute prescribing clinic</td>
</tr>
<tr>
<td>Work should be undertaken to further develop and accredit locally managed care networks and care pathways for Hepatitis C. This includes cooperative arrangements between NHS and prisons, third sector and local authority partners to provide a continuum of treatment, care and support for those infected living in the community and prison environments;</td>
<td>• Further work required for other clinical settings</td>
</tr>
<tr>
<td>NHS Boards and other partners should explore the feasibility and benefits of nurse or GP led clinics and nurse prescribing in community or prison settings to enhance referrals, attendance ad clinical capacity where appropriate;</td>
<td>• (No prison in Shetland)</td>
</tr>
<tr>
<td>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, it is evolving and new</td>
<td>This work is primarily through NHS Grampian as all treatment is initiated there. Local work is required to understand the needs of people with hepatitis C in relation to new therapies / drugs and develop local protocols in conjunction with Grampian.</td>
</tr>
</tbody>
</table>
medicines (e.g. protease inhibitors for particular strains of Hepatitis C) are in development and due to enter the pharmaceutical market later in the Framework.

The implementation of NHS HIS Hepatitis C Indicators

- As above

### 6.5.4 Outcome 5: A society and culture whereby the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs are positive, non-stigmatising and supportive.

Stigma and discrimination of 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 due. Changing the culture in Scotland around viral hepatitis and substance misuse 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.

<table>
<thead>
<tr>
<th>Actions for Health Boards /partners</th>
<th>Local action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efforts to promote a positive approach to viral hepatitis and substance misuse and relationships in the media should continue nationally and locally through linking in with groups such as the National Union of Journalists</td>
<td>- Continue to promote positive stories through local media outlets</td>
</tr>
<tr>
<td>Incorporation of Hepatitis C education into Curriculum for Excellence (CfE) for all schools and educational settings</td>
<td>- Work with Education and local schools through local CoE lead for Health and Wellbeing (member of the Strategy Group) and other organisations that provide input to schools and other educational settings including Youth Services and OPEN.</td>
</tr>
<tr>
<td>Work to promote awareness and understanding of Hepatitis C will continue locally, regionally and nationally.</td>
<td>- Continuation of local awareness raising and linking in with national campaigns: including through workplaces; schools; healthcare and community settings.</td>
</tr>
</tbody>
</table>
Chapter 7. Hepatitis B

Framework Outcomes: Hepatitis B

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

Due to the historically low prevalence of hepatitis B, there has been no national policy for hepatitis B in Scotland to date. 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 the landscape and burden of disease for hepatitis B in Scotland
- To ensure optimal prevention, treatment, care and support for hepatitis B across Scotland for those at risk or living with the infection.

Once the landscape for hepatitis B has been fully established in Scotland, these aims will be translated into high level Framework Outcomes for hepatitis B for delivery late in the Framework and beyond:

7.1 Epidemiology of Hepatitis B in Scotland

- Scotland has historically been a country of very low prevalence for hepatitis B. The actual and potential burden of disease associated with HIV and hepatitis C were previously considered much greater.

- 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 to Scotland from countries in the world where the prevalence of hepatitis B infection is high (particularly East Asia).

- 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.

- **Incidence:** It is likely that the actual number of new transmissions occurring annually in Scotland is between 200 and 400

- **Prevalence:** Precise estimates on the number of people living in Scotland with chronic Hepatitis B infection are unavailable but preliminary work indicates that there are 5000-15000 people affected and the majority of infected individuals are likely to have originated from countries with a high prevalence of hepatitis B infection, particularly south-east Asia.
Around 50% of infected persons in Scotland remain undiagnosed

In Shetland whilst numbers of individuals newly infected with Hepatitis B are known to be small, local work is necessary to establish and map the picture to ensure a robust service and in order that those living with chronic infection are known to be receiving the best care, treatment and support.

7.2 Risk Factors

- There are many risk factors for hepatitis B infection
- A vaccine against hepatitis B has been available since 1982 and is 95% effective in preventing infection

7.3 Management

- 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 (e.g. HIS Standards, SIGN Guidance).

7.4 Hepatitis B Indicators and Targets

The proportion of men who have sex with men attending a GUM clinic and eligible for hepatitis B vaccine who receive their first dose in this setting. (TARGET 70%)

7.5 Nationally identified key approaches to achieving the outcomes within the Hepatitis B workstream

A range of infrastructure and initiatives have been established for hepatitis C during 2008-2011 to improve capacity, consistency and the quality of service delivery as part of the Hepatitis C Action Plan for Scotland. Where feasible, these can be expanded to encompass hepatitis B but only where this is appropriate to local circumstance and need. Similarly, hepatitis B can be encompassed and/or linked with local sexual health infrastructures and initiatives where feasible and appropriate to do so.

7.5.1 Multi Agency Approach

A multi agency, collaborative approach to the prevention of Hepatitis B, treatment and care of those living with hepatitis B and the provision of support services is required. The already locally established managed care networks for Hepatitis C is well placed and adopted a BBV approach at the outset, the Framework is a useful structure for multi agency working to ensure inclusion of hepatitis B.

Partners outwith the NHS have an essential role in influencing behaviours, lifestyles and risk factors. They can help prevent transmission, support testing, strengthen engagement with treatment services and can provide support services for those living with hepatitis B.
7.5.2  **Outcome 1: Fewer newly acquired BBVs**

**Hepatitis B vaccination**

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 Scottish Prison inmates in 1999. There is also a selective programme in place which offers the vaccine to a number of groups considered to be at higher risk (see section 4.3.5).

Many countries provide universal hepatitis B immunisation programmes, either as part of an infant or adolescent schedule. Unlike most other western countries, Scotland (and the rest of the UK) does not currently provide universal vaccination against hepatitis B. This position is based on previous advice from the Joint Committee on Vaccination and Immunisation (JCVI) who provide UK Health Departments with recommendations on all vaccination and immunisation issues. However, that advice is now changing and it is going to be recommended that a universal infant programme should be implemented in the UK, subject to procurement of a cost effective vaccine. It is recommended that the vaccine to be used will be a hexavalent Hep B containing vaccine to replace the current 5 in 1 infant vaccine.\(^2^2\)

Until a new programme is implemented, the selective vaccination programme will continue, recommending that those at particular risk of infection are vaccinated.

<table>
<thead>
<tr>
<th><strong>Actions for Health Boards / partners</strong></th>
<th><strong>Local action</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue delivery of the selective vaccination programme for hepatitis B in line with JCVI recommendations:</td>
<td>To be delivered through Vaccination and Immunisation Group Work Plan; including:</td>
</tr>
<tr>
<td>• NHS Board vaccination plans should updated regularly in respect of local needs, population, epidemiology and national guidance to ensure optimal uptake of hepatitis B vaccine by those most at risk of infection</td>
<td>• Training for staff (primary care, sexual health clinic, maternity, health visiting, Alcohol and Drugs services)</td>
</tr>
<tr>
<td>• Work should be done to increase the proportion of babies born to hepatitis B infected mothers who are vaccinated and immunised</td>
<td>• Local awareness raising with at risk groups: particularly those at risk through sexual activity and injecting drug use</td>
</tr>
<tr>
<td>• Hepatitis B vaccination should be incorporated into care plans for those progressing through recovery orientated systems of care for drug misuse in line with recommendations to encourage uptake of Hepatitis B vaccination within the Scottish Government Guidelines for Services Providing Injecting equipment</td>
<td>• Ensuring use of SIRS to record neonatal Hep B vaccination and call/recall for subsequent doses.</td>
</tr>
</tbody>
</table>
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

- Pathways to be developed through multiagency Sexual Health and BBV Strategy Group working with partners in NHS Grampian.

### 7.5.3 Outcome 2: A reduction in the health inequalities gap in sexual health and BBVs

Health inequality associated with hepatitis B infection in Scotland is currently unproven but there is potential for this to manifest in relation to race given the association of hepatitis B infection in Scotland with migrant populations, particularly south-east Asians. 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.

<table>
<thead>
<tr>
<th>Actions for Health Boards /partners</th>
<th>Local action</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>This will be addressed in the development of pathways as above. including working with the local Adult Learning Service.</td>
</tr>
</tbody>
</table>

### 7.5.4 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.

<table>
<thead>
<tr>
<th>Actions for Health Boards / partners</th>
<th>Local action</th>
</tr>
</thead>
<tbody>
<tr>
<td>National guidance, standards and/or recommendations on the diagnosis, treatment and care for hepatitis B should be developed</td>
<td>Ensure that a remote &amp; rural / small board perspective is included in the development of such guidance</td>
</tr>
<tr>
<td>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:</td>
<td>Through development of pathways as above</td>
</tr>
<tr>
<td>- The use of innovative and targeted approaches to test, diagnose and case find for Hepatitis B</td>
<td></td>
</tr>
<tr>
<td>- Establishment of care pathways for Hepatitis B to ensure that those</td>
<td></td>
</tr>
</tbody>
</table>
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.

7.5.5 **Outcome 5: A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs 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 less likely 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 experienced by populations within our society including immigrants, ethnic minorities, injecting drug users and those from deprived areas.

<table>
<thead>
<tr>
<th>Actions for Health Boards / partners</th>
<th>Local action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efforts to promote a positive approach to hepatitis B and relationships in the media should continue nationally and locally through linking in with groups such as the National Union of Journalists.</td>
<td>• Included within local work on awareness raising and reducing stigma of all BBVs</td>
</tr>
<tr>
<td>Work to promote awareness and understanding of Hepatitis B will continue locally, regionally and nationally</td>
<td>• Included within local work on awareness raising and reducing stigma of all BBVs</td>
</tr>
</tbody>
</table>
REFERENCES


8 SNAP 2000, Scottish Needs Assessment Programme.

9 HEBS 2002,


11 Royal College of Physicians Consensus Statement


17 Equally Well documents available at: www.scotland.gov.uk/Topics/Health/Healthy-Living/Health-Inequalities/Equally-Well


21 Hatrick, W., Bond, C., Matheson, C., and Taylor, S., (2011), Minimising the Spread of Hepatitis C in Intravenous Drug Users (IDUs) in a Remote Island Community, Scottish Government Health Directorates Chief Scientist Office

22 Joint Committee on Vaccination and Immunisation. Draft minutes of meeting on 1st October 2014. JCVI 2014. Available at: https://app.box.com/s/iddfb4ppwkmtjusir2tc#/s/iddfb4ppwkmtjusir2tc/1/2199012147/22846051967/1?_suid=142116272889006672137237759306
Appendix A

Organisational Structure 2014

(Will be subject to change with implementation of Health and Social Care Integration and potential changes to Community Planning partnership groups)

Scottish Government

Via Community Plan & SOA

Voluntary sector

Via annual review meeting

Shetland Islands Council

NHS Shetland: primary and secondary care

Children & Family Services

Sexual Health & BBV Strategy Group

Short term working groups eg for training

Sexual Health and Wellbeing Clinic

NHS Grampian & visiting services

Links with other strategy groups etc. including

- Child Health Strategy Group
- Integrated children’s services
- Child Protection Committee
- Shetland Alcohol and Drug Partnership (SADP)
- Shetland Domestic Abuse Partnership (SDAP)
- Diversity Taskforce (NHS Shetland)
- Implementation of CEL 41 (Gender based violence)
- LGBT Working Group
Appendix B

**Membership of Sexual Health Strategy Group during 2013-14**  
(involved in developing strategy)

Dr Susan Laidlaw  
Consultant in Public Health Medicine, NHS Shetland (Chair)

Wendy Hatrick  
Public Health Specialist, NHS Shetland

Melanie Smith / Elsbeth Clark  
Health Improvement Practitioner, NHS Shetland

Aimee Barclay / Lesley Gray  
Youth Development Workers SIC

Una Murray  
Our Peer Education Network

Maggie Sandison / Patti Dinsdale  
Environmental Health Services Manager, SIC / Environmental Health Services Team Leader, SIC

Edna Mary Watson  
Assistant Director of Nursing (Community) NHS Shetland

Andrea Melville  
School Nurse

Bernadette Dunne  
Senior Occupational Health Nurse, NHS Shetland

Dr Aileen Brown / Dr Alison Chandler  
GPs / Sexual Health Clinic doctors

Sheila Fraser  
PHN Development Manager, NHS Shetland

Linda Gray  
Community Alcohol and Drugs Support Shetland

Clive Harper  
Substance Misuse Social worker, SIC

Elaine McCover  
Midwife / Sexual Health Clinic

Kate Kenmure  
Consultant Midwife, NHS Shetland

Stephen Renwick  
Officer with responsibility for HWB, Education Dept. SIC.
Appendix C

The Shetland Perspective, Local Epidemiology and Current Sexual Health and Bloodborne Virus Services

The Shetland Perspective

Shetland is the most northerly part of Scotland, being as close to Norway as it is to Aberdeen. It consists of over 100 islands of which 15 are inhabited. Over 80% of the 23,000 population live on the largest island with approximately 7,000 living in the main town of Lerwick. Outside Lerwick, communities are small and scattered, and include several island communities. The whole of Shetland is remote from mainland Scotland and is a considered a rural area; and within Shetland, some parts, particularly the outlying islands, are remote from the main inhabited areas. Travel to Shetland from mainland Scotland involves either an overnight ferry crossing from Aberdeen or a 60-90 minute flight from a mainland Scotland airport.

At the beginning of the 20th century the population of Shetland was 28,000. This had declined to 17,000 by the beginning of the 1970s. However, the discovery of North Sea oil then led to significant influx of people to Shetland, with a population of 22,000 in recent years. The introduction of the oil and gas industries to Shetland and the development of the fishing industry are two factors that have helped to guard against migration out of Shetland, to retain a stable population and a low rate of unemployment compared to other parts of Scotland. In 2012/13 the employment rate was 82.9% with 1.5% of people on out of work benefits (such as job seekers allowance). Although Shetland has had a strong economy in the recent past, it is reliant on industries such as fishing, oil production, farming (crofting) and tourism which are subject to external influences.

The positive aspects of living and working in Shetland include high quality of life and the excellent education system which is inclusive and consistently achieves high standards in inspections. The natural environment, cultural and sporting facilities are other factors with a generally positive impact on life in Shetland.

1. The Shetland population

The 2011 census showed that 18.0% of the population were aged 14 or under; 11.9% aged 15-24; 47% aged 25-59 and 23% aged 60 and over. In Shetland, there is a high rate of GP registration and so GP practice figures are used to give a more up to date estimate of the size of the population. The age profile in April 2014 is shown below:

<table>
<thead>
<tr>
<th></th>
<th>0-4</th>
<th>5-14</th>
<th>15-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65-84</th>
<th>85+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people registered with a GP</td>
<td>1303</td>
<td>2592</td>
<td>2615</td>
<td>5659</td>
<td>6533</td>
<td>3710</td>
<td>474</td>
<td>22886</td>
</tr>
<tr>
<td>Percentage of population</td>
<td>5.7%</td>
<td>11.3%</td>
<td>11.4%</td>
<td>24.7%</td>
<td>28.5%</td>
<td>16.4%</td>
<td>2.0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: GPASS

Shetland’s population can fluctuate significantly in various seasons, for example, in summer there is an influx of tourists as well as migratory workers from Eastern Europe. All through the year there is constant flow of transient workers to the oil
Appendix C

terminal at Sullom Voe. There is currently, in 2014, several thousand additional workers in Shetland to support the building of a new gas plant.

2. Equality and diversity

2.1 Poverty, social exclusion and deprivation

Shetland is a relatively prosperous community, and we have, for the most part, a good quality of life. But there are people living in Shetland in poverty, families who are not able to access services, or get the help and support they need, and people who suffer from discrimination and exclusion. For some people who have mental health problems, problems with addiction or who live with long term conditions and disabilities, stigma and exclusion can worsen health and limit access to services.

In 2005 there was a local piece of qualitative research to better understand the nature of deprivation and exclusion in Shetland.1 Nationally in Scotland there are a range of programmes that tackle poverty and deprivation, but these are difficult to implement in Shetland because it is relatively well off compared to other areas – there is not have high unemployment, or large geographical areas of poor quality housing and people living in poverty. But there are individuals and households who live in poverty, often hidden within an otherwise affluent community. And there are things about living in very remote and rural areas that can exacerbate the exclusion that some people feel, from coming from another culture, not sharing the language, from having a disability or health problems that add to isolation. This research was updated in 2011, focusing on young people. The project (‘Poverty is bad: let’s fix it!) took a youth led peer research approach to identifying the issues young people in Shetland face around poverty, exclusion and inequalities, and initiate actions to tackle the identified problems.

Transport difficulties are a particular issue: not only is Shetland remote from the mainland, but many parts of Shetland are remote from Lerwick, and many services. Public transport is limited and access to a car is essential for many people. The cost of transport is rising, with fuel prices around 10p a litre higher than the mainland. For island communities there are the additional costs of ferry or plane, both within Shetland and from Shetland to mainland Scotland.

2.2 Ethnicity and nationality

There is a relatively small Black and minority ethnic population. The 2011 Census showed that there were just over 350 people in Shetland who described themselves as an ethnicity other than white. Of these, 234 were Asian including 73 of Chinese background; and 31 were of African or Caribbean background. Nearly 100 people described themselves as of mixed ethnicity or from other ethnic groups. Of the almost 22,800 people who described themselves as white, nearly 22,000 were British, 199 were Irish, 164 were Polish, and 457 from another background. In total 95% of the population were white British, 3.5% other white and 1.5% Black, Asian, Arab or mixed ethnicity.

In terms of language, the Census also showed that 80% of the population (aged three and over) only used English at home. A further 16% also used ‘Scots’ or Gaelic; 0.3% British Sign Language; 0.7% Polish and 3% other languages. Just over 370 people described not speaking English well, or not at all. Information from the
Appendix C

school roll in 2008 showed that there were 114 children from minority ethnics groups in school, and 55 children whose first language was not English.

A race equality mapping exercise conducted in 2009 by NHS Shetland showed that of the 558 new national insurance numbers issued between 2006 and 2008 in Shetland; 178 were for people from Poland, 101 for people for Hungary and 100 for people from Latvia, Lithuania and Czech Republic.

2.3 Lesbian, gay, bisexual and transgendered people

It is hard to estimate the number of lesbian, gay, bisexual and transgendered people in Shetland, although there is no reason to believe that it is any different from other rural areas of Scotland: there are a small number of people who are openly LGBT.

2.4 Other vulnerable and potentially disadvantaged groups

For most other vulnerable or potentially disadvantaged groups, there are similar rates in Shetland as any other part of Scotland, although the absolute numbers of people involved will be small. For example, there expected to be similar rates of people with disabilities and long term conditions in Shetland as anywhere else in Scotland.

There are a number of groups who may be at increased risk of poor sexual health, or who may be ‘hard to reach’ or have particular difficulty in accessing services. There are currently no travelling communities in Shetland and there is no prison on Shetland, but there are have ex-prisoners who return to Shetland for resettlement.

Although there is no overt sex worker trade in Shetland, anecdotally it is known that there are people who ‘sell’ sex for money or other forms of ‘payment’.

3. General Health services

3.1 Hospital Services

NHS Shetland provides general hospital services in the Gilbert Bain Hospital (GBH) in Lerwick and community services throughout the islands. GBH is a small general (remote and rural) hospital providing consultant led surgical and medical services; midwife led and GP supported maternity services, day surgery and accident and emergency services. A number of services are provided by NHS Grampian (including, in the context of BBV and sexual health services: gynaecology; female sterilisation; termination of pregnancy and treatment for blood borne viruses). Visiting consultants from mainland Scotland provide some specialist services locally, but for many services patients travel outwith Shetland, principally to Aberdeen.

3.2 Community Health and Care Partnership

There is currently one Community Health and Care Partnership (CHCP) which incorporates community services including a community mental health team; community nursing (covering health visiting, school nursing, district nursing and specialist nurses) and podiatry along with social care services. Community nurses and health visitors cover geographical areas and are based in health centres. The
school nursing service is delivered by one dedicated school nurse along with health visitors in the rural locations. There are also three salaried GP practices managed through the CHCP.

Delivery of all these services, along with planning of sexual health services and health improvement, are included as part of the new Integrated Health and Social Care model which is currently being progressed in Shetland.

3.3 Child and Family Services
This is a newly developed structure which incorporates both hospital and community services including maternity; the child health department; health visiting; school nursing; and the sexual health clinic.

3.4 Primary care
The majority of healthcare contact in Shetland is delivered in primary care. There are ten general practices, based in individual health centres, which deliver a full range of primary care services. The biggest practice is in Lerwick. This has a list size of 9000 and is a salaried practice with 6.5 WTE GPs. The other nine practices are in rural locations, and one is salaried. The size of the rural practices ranges from around 700 - 3000 patients. Each practice generally has one or two GP principals working with associate GPs, and one or more practice nurses. All the rural practices are dispensing practices. There are five community pharmacies, three in Lerwick; one in Scalloway and one at the Health Centre in Brae.

3.5 Non-doctor islands
Most services are provide on the main island (‘mainland’). Of the other inhabited islands; three have a Health Centre with resident GPs and other practice staff and there are five ‘non doctor’ islands (NDI). A NDI is smaller, remote, inhabited islands where healthcare is provided by a resident island-based community nurse attached to a GP practice. Four of these islands are remote, linked to the main island by ferry and plane, and one (Bressay) is close to Lerwick, linked by a ferry. Papa Stour is an island with a population of 20-30 but no resident health staff. The other inhabited islands are either linked by bridge or have just one or two residents.

3.6 Clinical Strategy
In 2011 NHS Shetland launched a Clinical Strategy which is driving forward changes in the organisation and provision of healthcare. In respect of sexual health and blood borne viruses, there is a move to bring more services back to Shetland and streamline patient pathways. Sexual health services have been brought together with child health, health visiting, school nursing and maternity into ‘Child and Family Health’ Services which will strengthen links across these areas.

Further detail on Sexual Health and BBV services is in Chapter 5.

3.7 Joint working
Joint working within Shetland with the co-terminus local authority (Shetland Islands Council) and other community planning partners is primarily delivered through the Community Plan and monitored through the Single Outcome Agreement (SOA).
Appendix C

There are a number of strategic partnerships and groups to deliver and monitor the outcomes under each of the SOA priority headings; including the Fairer Shetland group and Community Safety Partnership. ‘Healthier’ outcomes are delivered through the Health Action Team (which oversees health improvement strategies and action plans) and the Community Health and Care Partnership. Planning of sexual health services and delivery of all primary care and community based health services are included as part of the new Integrated Health and Social Care model which is currently being progressed in Shetland. There is also joint work with other NHS Boards. Primarily this involves delivery of services that cannot be provided by NHS Shetland, being provided through NHS Grampian.

4. Challenges in a remote and rural area

4.1 Access to services

There are specific challenges in providing healthcare and health promotion services in a remote and rural population. Transport is a particular issue that affects all aspects of life in Shetland, including access to health care. The cost of travel, the time it takes and disruption due to the weather influence links between islands and with mainland Scotland and beyond. Within Shetland, there is a reliance on car use, to the disadvantage of people who do not have access to a car. Services tend to be seen as centralised in Lerwick and public transport is limited tending to focus on getting people to and from the main town of Lerwick rather than to more local services such as the shop or GP practice. There are some very remote, isolated communities, including a number of small islands that rely on ferry or air links to mainland Shetland. As mentioned, socio-economic deprivation is often hidden, difficult to measure and different in its causes and effects compared to other areas of Scotland.

4.2 Anonymity and confidentiality

One of the particular concerns expressed by people who may wish to access sexual health and wellbeing information or services, or indeed any health related service, is the perceived lack of confidentiality in such small close knit communities. This perception is not confined to young people and does have a bearing on the very small numbers of people who are openly out as lesbian, gay or bisexual.

4.3 Small teams and competing priorities

It can be difficult to maintain sexual health and wellbeing as a priority amongst organisations and service providers in Shetland. The small number of people who are able to champion BBV and sexual health also have other areas of responsibility which compete with their time and commitment.

4.4 Training for staff and maintaining competencies

Accessing training for staff can be particularly difficult in a remote and rural area. Whilst many courses can be accessed on-line, there is still the need for clinical training and experience which can require time spent ‘off island’. The expense of travelling to mainland Scotland and often needing to spend one or more nights away from Shetland can be prohibitive. Similarly the time away from work and home is far greater than for our colleagues on the mainland, and particularly affects those who
work part-time, who are in small departments (possibly single handed) and who have family commitments. Where possible, trainers are brought to Shetland where this is more cost effective and practical, although sometimes this is not possible because of the relatively small number of people here who require the particular training being offered.

1 www.shetland.gov.uk/communityplanning/SocialExclusion.asp

Local Epidemiology

Information on the population, geography, socio-economic status and culture of Shetland is contained in Appendix C.

Shetland experiences the same sorts of sexual health issues as the rest of Scotland, although there do tend to be very small numbers and generally lower rates of STIs and BBVs, and teenage pregnancy.

- There is a low level of teenage (girls under 16) pregnancies.
- There are small numbers of people with HIV and hepatitis C, although probably comparable with other remote and rural areas
- The number of people diagnosed with HIV has remained relatively stable: the number with diagnosed hepatitis C is increasing probably as a result of increased awareness and testing.
- There have been a small number of cases of genital herpes each year for several years; after many years with no cases of gonorrhoea, there were a small number in 2013; there have been no cases of syphilis in recent years.
- The number of chlamydia infections has been rising, probably in part due to increased testing.

7.6 Sexually transmitted infections (STIs)

Figures collected by Health Protection Scotland and reported in the weekly surveillance report gives us an indication of the incidence and prevalence of genital chlamydia, gonorrhoea and genital herpes simplex virus (HSV1&2) in Shetland. The 2013 data is the most recent published data.

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</tr>
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<tbody>
<tr>
<td>Genital chlamydia</td>
<td>8</td>
<td>24</td>
<td>&lt;5</td>
<td>41</td>
<td>50</td>
<td>53</td>
<td>37</td>
<td>23</td>
<td>26</td>
<td>52*</td>
<td>42</td>
<td>69</td>
<td>60</td>
<td>62</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Genital Herpes Simplex (HSV)</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
</tr>
</tbody>
</table>

7.6.1 Chlamydia

Of the 60 chlamydia diagnoses in 2012, 19 (31%) were male and 40 (65%) female (with three unknown). This is slightly different to the national picture, where 38% of the positive diagnoses were in men. 6 (32%) of the men and 23 (58%) of the women in Shetland were under 25. Again this was different to national figures, where 61% of the positive results in men where in men aged under 25, and 77% of the results in women where in those aged under 25. This is showing that in 2013 there were proportionately more people over the age of 25 in Shetland testing positive for Chlamydia, this was the same in 2011 and 2012.

Our overall rates for Chlamydia are lower than the rest of Scotland for men of all ages (379 / 100,000 in Scotland; 246 per 100,000 in Shetland). For women of all ages, the rate is slightly lower in Shetland (598 in Scotland, 546 in Shetland). The rates in Shetland were higher in 2013 than in Orkney (217/100,000 for men and 368 for women) and higher higher than in the Western Isles where the male: female trend is reversed (222 and 167 / 100,000 respectively).

The rates for under 25s are much lower in Shetland compared to the rest of Scotland. The rate amongst young women is 2422/ 100,000 in Scotland and 1173 in Shetland. And for young men it is 1166/100,000 for Scotland and 429 in Shetland. In Orkney, the rates for under 25s are higher than in Shetland ( for men it is 642/100,000 and for women 1932). In the Western Isles the rates are higher than Shetland for men (697/100,000) and lower for women (916 per 100,000) and there is less of a difference between male and female rates here.

Looking at trends over time, the number of positive Chlamydia results in Shetland appears to be increasing, however there is more testing, and contact tracing, done in the Sexual Health Clinic, so the increase may be a result of this rather than a true increase in prevalence.

7.6.2 Gonorrhoea

There had been no positive diagnoses of gonorrhoea since at least 2000, until 2013, when there were a small number. These were diagnosed in the Sexual Health Clinic, but not thought to be linked. Again this may reflect increased numbers of people being tested in Shetland (patients previously may have travelled to the mainland and been tested anonymously).

7.6.3 Herpes simplex

There has usually been a small number of cases of herpes simplex each year since 1999. (Noting that since 2009, if the number is smaller than 10 then it is not published by Health Protection Scotland). The rate in 2013 was too low to be reported, but in 2012, it was 13/100,000 for men and 14/100,000 for women. These are much lower that the Scottish average rates of 39/100,000 for men and 109/100,000 for women. And in Shetland, in contrast to the rest of Scotland, the rate is almost the same for men and women, although these are small numbers. The rates are also generally lower than those in the other two island Boards (in 2012
Appendix C

Orkney rates per 100,000 were 31 for men and 46 for women and Western Isles rates were 12 for men and 75 for women) where the male to female ratio is also closer to the Scottish picture.
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7.7 Pregnancy

7.7.1 Unintended pregnancy

It is difficult to know the true rate of unintended pregnancy because many women will go on to have their baby even if their pregnancy had not been planned. There are a small number of women who have terminations of pregnancy, but for the purposes of national reporting the figures are included in with the other island boards because they are so small. Below are the figures for the three island Boards combined (Orkney, Shetland and Western Isles):

<table>
<thead>
<tr>
<th>Year</th>
<th>Isles - number</th>
<th>Islands – rate per 1000 women aged 15-44</th>
<th>Scotland - rate per 1000 women aged 15-44</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>91</td>
<td>7.5</td>
<td>11.1</td>
</tr>
<tr>
<td>2003</td>
<td>87</td>
<td>7.3</td>
<td>11.6</td>
</tr>
<tr>
<td>2004</td>
<td>82</td>
<td>6.8</td>
<td>11.8</td>
</tr>
<tr>
<td>2005</td>
<td>66</td>
<td>5.5</td>
<td>12.0</td>
</tr>
<tr>
<td>2006</td>
<td>73</td>
<td>6.1</td>
<td>12.5</td>
</tr>
<tr>
<td>2007</td>
<td>73</td>
<td>6.2</td>
<td>13.1</td>
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<tr>
<td>2008</td>
<td>67</td>
<td>5.7</td>
<td>13.3</td>
</tr>
<tr>
<td>2009</td>
<td>81</td>
<td>6.6</td>
<td>12.4</td>
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<tr>
<td>2010</td>
<td>50</td>
<td>4.0</td>
<td>12.2</td>
</tr>
<tr>
<td>2011</td>
<td>63</td>
<td>5.1</td>
<td>11.9</td>
</tr>
<tr>
<td>2012</td>
<td>68</td>
<td>5.6</td>
<td>11.9</td>
</tr>
<tr>
<td>2013</td>
<td>64</td>
<td>5.2</td>
<td>11.2</td>
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</tbody>
</table>


As can been seen from the table above, the rate of terminations of pregnancy is much lower in the islands compare to the rest of Scotland.

A number of women will also choose to take emergency contraception (emergency hormonal contraception or intra-uterine methods) after unprotected sex to prevent an unplanned pregnancy. Emergency contraception is available from a number of services in Shetland including the community pharmacies; GP practices; Sexual Health and Wellbeing Clinic and A&E. At present figures are not collected on the usage of emergency contraception in Shetland, however this is being investigated to see if this information can be collated to allow us to monitor patterns of usage.

7.7.2 Teenage pregnancy

Reducing the rate of teenage pregnancy is a national priority as demonstrated by the Scottish Executive’s previous target to reduce the incidence of pregnancy amongst girls aged 13-15 by 20% from a baseline of 8.5 per 1000 in 1995 to 6.8 in 2010.

The number of teenage pregnancies amongst 13-15 year olds in Shetland is very low with often none or one each year and occasionally higher numbers. There is sensitivity around publishing data relating to teenage pregnancies because the numbers are so small – and in recent years figures have only been reported nationally if there are 10 or more pregnancies in a particular population (e.g. Shetland). There is some data from previous years, which shows that there was a total of 14 pregnancies in the ten year period 1996-2006, and average of 1.4 each
Appendix C

year with the rate per 1000 girls aged 13-15 fluctuating between 0.0 and 8.0. Currently information on rates, but not numbers, is included in the Board’s Performance Monitoring Report. The figures are reported as a three year rolling average to smooth out the large changes in rate caused by just one or two more or less pregnancies each year. However, this does mean that there is always a time lag in the reporting.

Because the numbers are so small, a 20% reduction in the annual rate is not a useful target for Shetland. A more realistic aim is to maintain the low rate: the Shetland Single Outcome Agreement target for 2011-12 was to maintain the rate at below 4.0 per 1000 and it is now to maintain it at less than 2.0 per 1000.

**Pregnancies in girls aged 13-15 (3 year rolling average)**

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</thead>
<tbody>
<tr>
<td>Shetland - number in 3 year period</td>
<td>&lt;10</td>
<td>0</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>0</td>
<td>&lt;10</td>
<td>&lt;10</td>
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<tr>
<td>Shetland –rate per 1000 girls aged 13-15</td>
<td>2.8</td>
<td>0.7</td>
<td>3.3</td>
<td>3.3</td>
<td>4.1</td>
<td>2.2</td>
<td>2.1</td>
<td>1.5</td>
<td>1.5</td>
<td>2.2</td>
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<tr>
<td>Scotland–rate per 1000 girls aged 13-15</td>
<td>6.9</td>
<td>7.3</td>
<td>7.0</td>
<td>8.0</td>
<td>7.8</td>
<td>7.7</td>
<td>7.0</td>
<td>6.9</td>
<td>5.6</td>
<td>5.6</td>
</tr>
</tbody>
</table>

**Source** NHS Shetland Performance Monitoring Reports

There are also data published on the number and rates of pregnancy amongst women under 18 and under 20. Although there are no targets to reduce the pregnancies in these age groups they are useful to monitor trends. It can be seen from the tables below that the rate of pregnancy in these ages groups is consistently lower than the Scottish average. Amongst the under 20s, there has been a steady decrease in past ten years. However in Shetland there has been little if any decrease over time with the numbers remaining fairly stable.

**Pregnancies in girls under 18 (per year)**

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</thead>
<tbody>
<tr>
<td>Shetland – number</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>&lt;10</td>
<td>13</td>
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<td>&lt;10</td>
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<tr>
<td>Shetland –rate per 1000 women aged 15-17</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>27.0</td>
<td>22.1</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Scotland– rate per 1000 women aged 15-17</td>
<td>40.2</td>
<td>41.1</td>
<td>41.6</td>
<td>41.2</td>
<td>41.9</td>
<td>40.0</td>
<td>36.2</td>
<td>35.2</td>
<td>30.0</td>
<td>27.9</td>
</tr>
</tbody>
</table>
Appendix C

**Pregnancies in women aged under 20 (per year)**

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Shetland - number</strong></td>
<td>18</td>
<td>21</td>
<td>28</td>
<td>19</td>
<td>21</td>
<td>26</td>
<td>20</td>
<td>20</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td><strong>Shetland – rate per 1000 women aged 15-19</strong></td>
<td>28.8</td>
<td>31.1</td>
<td>40.8</td>
<td>26.4</td>
<td>29.1</td>
<td>36.6</td>
<td>28.2</td>
<td>28.6</td>
<td>37.0</td>
<td>23.2</td>
</tr>
<tr>
<td><strong>Scotland – rate per 1000 women aged 15-19</strong></td>
<td>54.3</td>
<td>55.8</td>
<td>56.9</td>
<td>57.6</td>
<td>57.7</td>
<td>54.6</td>
<td>51.3</td>
<td>48.5</td>
<td>43.8</td>
<td>41.5</td>
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</table>


(Original source, GROS registered births and stillbirths & Notifications (to the Chief Medical Officer for Scotland) of abortions performed under the Abortion Act 1967)

In should be noted that the tables above show the numbers of pregnancies: not all these pregnancies will go to term. A small number of young women may have a miscarriage and some will choose to have a termination. Across Scotland between two thirds and a half of the pregnancies in the under 20 age group are terminated. Because the figures are small for Shetland, the number of terminations is often not reported because it is less than 10. In 2008, when there were 26 pregnancies, 12 resulted in a termination.

### 7.7.3 Prevention of pregnancy: Long Acting Reversible Contraception

The most recent figures on the use of long acting reversible contraception (LARC) show that the rate of usage has increased, and is higher than the average for Scotland, exceeding the target of 60/1000 women.

Previously most of the LARC has been dispensed / fitted in primary care with nearly all the rest being provided in the sexual health clinic. However, as can be seen for the most recent figures, there is now more LARC prescribed through the hospital pharmacy compared to primary care, and this is most likely to be because there is increased service provision in the Sexual Health Clinic, due to nurses being trained to insert implants.
## Appendix C

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th></th>
<th>2012/13</th>
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<th>2013/14</th>
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<tr>
<td></td>
<td>Quantity dispensed</td>
<td>Rate / 1000 women aged 15-49</td>
<td>Quantity dispensed</td>
<td>Rate / 1000 women aged 15-49</td>
<td>Quantity dispensed</td>
<td>Rate / 1000 women aged 15-49</td>
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<tr>
<td><strong>Implants</strong></td>
<td></td>
<td></td>
<td></td>
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<td>Primary care</td>
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<td>43</td>
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<td><strong>Total</strong></td>
<td>157</td>
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<td>137</td>
<td>27.2</td>
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<tr>
<td></td>
<td>27.4</td>
<td></td>
<td>31.5</td>
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<tr>
<td><strong>IUD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>22</td>
<td>4.3</td>
<td>32</td>
<td>6.4</td>
<td>13</td>
<td>2.6</td>
</tr>
<tr>
<td>Hospital pharmacy</td>
<td>12</td>
<td>2.4</td>
<td>5</td>
<td>1.0</td>
<td>19</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>34</td>
<td>6.7</td>
<td>37</td>
<td>7.4</td>
<td>32</td>
<td>6.4</td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
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<td></td>
<td>5.7</td>
<td></td>
<td>7.4</td>
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<tr>
<td><strong>IUS</strong></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Primary care</td>
<td>140</td>
<td>27.5</td>
<td>136</td>
<td>27.0</td>
<td>122</td>
<td>24.5</td>
</tr>
<tr>
<td>Hospital pharmacy</td>
<td>23</td>
<td>4.5</td>
<td>26</td>
<td>5.2</td>
<td>160</td>
<td>32.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>163</td>
<td>32.1</td>
<td>163</td>
<td>32.2</td>
<td>282</td>
<td>56.6</td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22.3</td>
<td></td>
<td>23.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All very long acting LARC:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Shetland</td>
<td>354</td>
<td>69.6</td>
<td>336</td>
<td>66.8</td>
<td>542</td>
<td>108.8</td>
</tr>
<tr>
<td><strong>Total Scotland</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>54.5</td>
<td></td>
<td>61.0</td>
<td></td>
<td>62.1</td>
<td></td>
</tr>
<tr>
<td>*<em>Depo-provera</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>421</td>
<td>-</td>
<td>507</td>
<td>-</td>
<td>464</td>
<td></td>
</tr>
<tr>
<td>Hospital pharmacy</td>
<td>30</td>
<td>21</td>
<td>528</td>
<td>316</td>
<td>780</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>451</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Not possible to calculate rates because one woman may have up to 4 injections a year.


### 7.8 Blood Borne viruses

#### 7.8.1 HIV and AIDS

The latest available figures show there have been a total of ten people in Shetland who are or were known to have HIV. Two people have died of AIDS, both over ten years ago.
Appendix C

Because the figures for Shetland are so small, it is very difficult to interpret any information about trends including how the HIV has been transmitted, which is important to understand for future prevention work. However, it can be seen that for the people in Shetland, half of them acquired HIV through heterosexual contact, whereas the figure nationally is about a third. Half the people in Shetland with HIV are female and half are male, and the majority are aged over 35.

In Scotland, the cumulative total for people known to have HIV is now 7800, 73% are male and 27% are female. A quarter of these individuals are known to have died. It is estimated that there are currently 4705 persons living in Scotland who have been diagnosed HIV-positive. The majority of infections in Scotland are acquired by men who have sex with men (71% since 2004), followed by heterosexual sexual contact, with a small and decreasing proportion of people acquiring HIV through intravenous drug use. There are also very small number of people who acquired HIV through contaminated blood products in the past, and a small number of babies who have acquired HIV from their mothers. These are usually babies born outwith the UK. The number of people with HIV in Scotland is increasing due to a number of factors including people from high risk areas who are already infected moving into Scotland; an increase in the number of HIVs tests being done and people living longer with the infection.

7.8.2 Hepatitis C

Latest available figures show that in Shetland approximately 45 people have been diagnosed with Hepatitis C. This is an increase from 11 in 1997, with 2-3 new diagnoses each year.

The table below shows the number of people in Shetland reported to be hepatitis C positive and the rate per 100,000 population by year of earliest positive result from 1998 up to 2008. Since then the figures reported nationally have combined the figures for the three islands boards rather than reporting separately.

<table>
<thead>
<tr>
<th>Year</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate</td>
<td>13.1</td>
<td>4.4</td>
<td>13.4</td>
<td>13.7</td>
<td>13.7</td>
<td>9.1</td>
<td>9.1</td>
<td>9.1</td>
<td>13.7</td>
<td>13.8</td>
<td>13.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scottish rate</td>
<td>38.8</td>
<td>38.4</td>
<td>36.7</td>
<td>33.4</td>
<td>35.5</td>
<td>32.7</td>
<td>32.6</td>
<td>31.7</td>
<td>30.1</td>
<td>30.1</td>
<td>33.4</td>
<td></td>
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</tr>
</tbody>
</table>


However, local figures show that the rate of new diagnoses appears to have remained relatively stable with between 1-3 new diagnoses in from 2009 - 2013. There was an increase in 2011 which was undoubtedly due to increased awareness and testing in local services.

Although the rate of new cases is much lower than the national rate for Scotland, it is comparable to other remote and rural areas, for example Highland.

It is relevant to note for prevention services that within these small numbers there is anecdotal evidence that co-infection with HIV and Hepatitis C may exist.
Appendix C

7.8.3 Hepatitis B

There are very few new diagnoses of acute hepatitis B each year in Shetland (1 each year in 2010 and 2011).

There are an unknown number of people with chronic hepatitis B in Shetland, although there do appear to be a number of cases picked up through the routine testing at the Sexual Health Clinic.

Further work needs to be done on understanding the epidemiology of hepatitis B in Shetland.

7.8.4 Prevention of BBV amongst intravenous drug users

Most recent published information from the Scottish Drug Misuse Database\(^3\) shows that 40 people in Shetland received a new assessment for drug misuse during 2012/13, of these 25 reported injecting drugs. However, less than 5% reported sharing equipment. Out of these 25, 24 were tested for HIV; Hepatitis B and Hepatitis C.

Information from the Injecting Equipment Provision in Scotland survey 2012/13\(^4\) shows that attendances have dropped, which follows the pattern for Scotland as a whole. The numbers of needles / syringes issues has also dropped along with the rate per person in Shetland. However, the rate per person in Scotland has remained stable, with a slight upward trend.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>No. of attendances at</td>
<td>903</td>
<td>1029</td>
<td>783</td>
<td>461</td>
<td>660</td>
</tr>
<tr>
<td>the two needle exchanges</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in Shetland</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of needles /</td>
<td>21,154</td>
<td>26,312</td>
<td>24,279</td>
<td>10,289</td>
<td>9,812</td>
</tr>
<tr>
<td>syringes distributed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of needle /</td>
<td>1.2</td>
<td>1.4</td>
<td>1.3</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>syringe distribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>per person aged over 16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in Shetland</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of needle /</td>
<td>1.0</td>
<td>0.9</td>
<td>1.0</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>syringe distribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>over person aged over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 in Scotland</td>
<td></td>
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</tr>
</tbody>
</table>


Of the 660 attendances in 2012/13, nearly 500 were at the community pharmacy and 160 were at CADSS.

7.8.5 Prevention of BBV: Hepatitis B vaccination

Hepatitis B can be prevented by vaccination. It is not currently part of the universal immunisation programme in the UK, but is likely to be in the future. It is given routinely in a number of other countries. At present it is recommended for a number of groups who are at increased risk of being exposed to Hepatitis B. These include:
Appendix C

- Babies born to mothers who are hepatitis B positive, or at high risk themselves
- Intravenous drug users and close contacts, and some other drug users
- People who change sexual partners frequently, especially sex workers and men who have sex with men
- Close contacts of people with hepatitis B
- Travellers to intermediate and high risk countries
- Healthcare staff and some other workers at occupational risk
- Some prisoners, and prison staff
- People in learning disability residential care and other settings, and staff
- Foster carers
- People with chronic renal and liver disease; and those who receive regular blood or blood products and their carers.

Hepatitis B vaccination may be given in a number of settings in including primary care, the sexual health clinic, substance misuse service prescribing clinic, secondary care, maternity (first dose for high risk babies) and occupational health services.

There is some limited information of the amount of hepatitis B vaccination dispensed in primary care and by the hospital pharmacy. This not does correlate exactly with the number of patients vaccinated because they may have a full course of three or four doses, or a single dose booster, for example. However this does give a crude estimate of the amount of vaccine being used in Shetland. Further work is to be done on auditing the use of hepatitis B vaccine, in particular for neonates at high risk.

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</thead>
<tbody>
<tr>
<td>Prescribed in primary care</td>
<td>201</td>
<td>276</td>
<td>151</td>
<td>82</td>
<td>66</td>
<td>60</td>
<td>27</td>
<td>59</td>
<td>42</td>
<td>72</td>
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<tr>
<td>Occupational health</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>126</td>
<td>133</td>
<td>107</td>
<td>226</td>
<td>254</td>
<td>177</td>
<td>215</td>
</tr>
<tr>
<td>Sexual Health Clinic</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other hospital setting</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>25</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Other primary care (dispensed by hospital pharmacy)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
<td>12</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: local data from the hospital pharmacy and National Prescribing Database
Current Sexual Health and BBV services

7.9 Strategic planning and co-ordination of services
A local multi-agency Sexual Health and Blood Borne Virus Strategy group oversees the co-ordination of this area of work in Shetland, including developing the Strategy and workplans and monitoring progress.

The organisational structure and accountability routes is shown in Appendix A. The membership of the group is in Appendix B.

The Sexual Health and Blood Borne Virus Strategy Group links with the Shetland Drug and Alcohol Partnership, which has primary responsibility for Addictions Services and prevention work. The Strategy Group also links with the local LGBT Working Group and a number of other related groups including the Shetland Domestic Abuse Strategy Group and the Child Protection Committee.

7.10 Health Services

7.10.1 Sexual Health and Wellbeing (SHWB) Clinic
Specialist sexual health services are provided in Shetland through the Sexual Health and Wellbeing Clinic (SHWB clinic) which commenced in its current format in September 2009 (there had been a clinic running previously for a six month period in 2006-07 but this had to close due to a number of staffing and organisational issues).

The clinic runs once a week (on a Monday evening) in the out-patients department of the Gilbert Bain Hospital and provides both family planning and genitourinary medicine services with health promotion as a key element. It is managed through the Children and Families Service, with the team being led by a midwife with responsibility for sexual health, early pregnancy and gynaecology. Services include:

- Information, advice and counselling on family planning and contraception.
- Full range of contraceptive services including barrier methods, intra-uterine device / system (IUD/S) fitting and removal, contraceptive implants and removal, oral contraceptives and emergency contraception.
- Information and advice on sexual health and sexually transmitted infections, both prevention and treatment.
- Testing for blood borne viruses (HIV, Hepatitis B &C) and Hepatitis B vaccination when indicated.
- Information on other relevant services and referral in certain circumstances.

The clinic is staffed on a rota basis by GPs (every other week) and nurses (every week) from a range of backgrounds (both primary and secondary care).

7.10.2 Primary Care
- There are ten general practices in Shetland. Each offers access to some contraceptive services for their patients and a number also see non-registered patients for contraceptive services.
Appendix C

- Not all practices currently offer long acting reversible contraception (LARC) but those that do not have arrangements with other practices to ensure the service is provided.
- All the practices can offer screening for STIs via the local laboratory services and those in Grampian.
- Partner notification may be undertaken by the practice nurse or GP, but this is limited in practice. GPs can request the SHWB clinic or the specialist GUM services in Aberdeen to undertake partner notification.
- Emergency contraception is available out of hours: five of the GP practices provide their own out of hours services, the other practices use NHS24. There is also a walk-in primary care service at weekends in the Gilbert Bain Hospital.
- The five Community Pharmacies in Shetland can all provide emergency hormonal contraception free of charge to the patient.

7.10.3 Health Visiting and School Nursing

Health visitors and public health nurses provide a universal service for families, especially those with young children and also provide input to schools as part of the school nursing service. There is one dedicated full time school nurse who provides a school nursing service to all the schools in Shetland. Sexual health is one part of their overall health remit and activities include:

- Support for schools including delivering some of the Sexual Health and Relationships Education (SRE) curriculum.
- Delivery of the SHARE programme to specific groups such as the Bridges Project, for young people who are not in mainstream education, training or employment.
- Provision of drop in services in schools, although this is currently patchy across Shetland
- Input to SHARE training.
- Health visitors advise new mothers about contraception after the birth.

7.10.4 Secondary Care / Hospital services

There are some secondary care sexual health and BBV services provided in the Gilbert Bain Hospital in Lerwick, but most specialist services, particularly for the management of BBVs, are provided in Grampian. However there is scope to share the management of patients with BBVs between Grampian and Shetland

- Specialist services for the management of hepatitis C and HIV are provided by mainland NHS Boards; usually NHS Grampian, but occasionally NHS Lothian and other Boards. Management plans for individual patients include input from primary care locally in Shetland, and there may be scope to develop this further.
- Currently visiting consultants from Grampian hold a gynaecology outpatient clinic in Shetland every two months and also perform some operative procedures locally.
In 2009 a local post for a GP with a Special Interest (GPwSI) in Gynaecology was developed. The GP runs local gynaecological clinics alongside the visiting team.

In 2013 a new Shetland based Consultant in Obstetrician and Gynaecology post was developed, however, to date this has not yet been appointed to. They will provide locally based out-patient services and some operative procedures currently delivered in Grampian.

Patients are referred to NHS Grampian for sexual health services not available in Shetland such as termination of pregnancy and psycho-sexual counselling.

Emergency contraception is available through the Accident and Emergency Department 24 hours a day.

Antenatal testing for BBVs is carried out in the midwife led antenatal clinics (in the maternity unit and in primary care).

### 7.10.5 Substance Misuse services

Drug and Alcohol services in Shetland were reviewed during 2013-14. Previously there had been two service providers: Community Alcohol and Drug Services Shetland (CADSS), a voluntary sector organisation and the prescribing clinic which was part of the local mental health services. There was also a specialist social worker within the Shetland Islands Council Social Care department, for people with drug and alcohol problems and a needle exchange service in one of the local community pharmacies.

During 2014 a redesigned single Substance Misuse Service is being implemented. This service will include:

- Assessment and treatment planning
- Substitute prescribing
- Harm minimisation, including needle exchange
- Counselling and support
- BBV testing
- Work with families
- Work in schools

The community pharmacy needle exchange will continue.

### 7.10.6 Health Improvement / Public Health

In addition to delivering health promotion / health improvement activities in educational, workplace and community settings, the Health Improvement and Public Health teams led on the development of the new clinical service. This has resulted in a strong health promotion emphasis within the SHWB Clinic.

Health Improvement activities include:

- Provision of resources, including patient information leaflets and training materials, from the Health Improvement Resource Centre.
Appendix C

- **Help Yourself to Health** which is a joint project with local Library services to increase access to health information resources including sexual health information.
- Distribution of free condoms and lubricant in the community, usually at appropriate events and for specific projects
- Organisation and delivery of training programmes, including specific training for youth workers and multi-agency training
- Work with youth services on projects such as World Aids Day (WAD) activities
- Awareness raising, particularly using national campaigns
- Audit of Sexual Health and Relationship Education (SRE) in schools

Public Health activities include:

- Leadership and strategic planning for sexual health and BBVs
- Surveillance of BBV, STIs, teenage pregnancy and other sexual health indicators.

**7.10.7 NHS Occupational Health Services**

There is a specific role for Occupational Health Services in both protecting staff from exposure to and contracting BBVs, and also protecting patients from staff who may have BBVs. Staff may be at risk of BBV if they have a sharps injury from a piece of equipment contaminated with infected blood (for example a needlestick injury) or are otherwise exposed to contaminated body fluids. The risk is very low, but there are a number of steps that can be taken to prevent exposure and manage the risk of contracting an infection if there is exposure to a BBV.

Similarly, there is the potential for staff who have BBVs to put patients at risk, again for example through a sharps injury to the patient. Again the risk is very low and can be minimised further through safe practice.

Functions include:

- Occupational health screening to identify staff who have BBVs and ensure that they do not put patients at risk (for example sometimes staff members may be restricted from doing certain exposure prone procedures).
- Ensuring relevant staff have hepatitis B vaccination; including checking post vaccination immunity
- Training staff in the prevention of sharps injury and other exposure to BBVs
- Identifying, managing and following up staff who are exposed to BBVs.
- Development and implementation of relevant policies

**7.11 Services for Children and Young People**

**7.11.1 ‘OPEN’ (Our Peer Education Network)**

OPEN was set up in 2011 to train young people as peer educators in sexual health and alcohol. It is a third sector project that was originally part of Shetland Youth Information Services (SYIS). When SYIS folded in 2013, OPEN joined other
voluntary sector organisations under the umbrella of Voluntary Action Shetland (VAS). Trained peer educators deliver workshops in schools and other settings across Shetland. The project won the Shetland Youth Volunteering Award in 2012, and received the Volunteer Friendly Award in 2013.

Shetland Islands Council Youth Services

Youth Services have in the past undertaken a range of activities through youth clubs, schools and other settings. These have included:

- Provision of information and publicity around sexual health issues in settings such as youth clubs
- Educational session and workshops in schools (e.g. LGBT workshop)
- Events for World Aids Day including in the past Battle of the Bands; Disco and workshops.
- Awareness raising, often working in partnership with health and other services

However, as resources for Youth Services have been reduced, it is likely that there will be less formally organised activities on a Shetland wide basis, but potentially more local based activities in Youth Clubs. Youth Club workers are offered training by the Health Improvement Team.

7.11.2 Shetland Islands Council Children’s Services / Schools

All schools deliver some Sexual and Relationships Education, although it does vary particularly in the primary schools. The junior high and high schools mostly use SHARE as the basis for their teaching and there are teachers from nearly every school trained in SHARE.

There has been ad hoc training for staff involved with Looked After Children in the past; this is being further developed.

There has also been some limited training for staff working with children and adults with learning disabilities.

7.12 Training

This includes both clinical training, training for specific groups (eg youth workers) and multi-agency training.

7.12.1 Clinical training

A range of training is available for health staff working in the clinic and other settings including primary care. This includes locally delivered training by clinical staff; access to training events and shadowing in Aberdeen and distance learning or internet based BBV/sexual health courses.

7.12.2 SHARE training

Training for teachers, health visitors and youth workers on SHARE (Sexual Health and Relationships Education) is provided every two to three years. This is a national programme to deliver SRE in schools, which has been under review. There are
Appendix C

currently three SHARE trainers in Shetland: a guidance teacher; a health improvement advisor and a voluntary sector worker. There is also a version of the SHARE programme for children with learning disabilities.

7.12.3 Other training

A number of multi-agency training events have been held over the past few years, and these have always been oversubscribed. However, these do tend to be ad hoc, and often dependant on the availability of visiting speakers. Topics in the past have included hepatitis C; HIV and stigma; update on contraception; HIV and Hepatitis C and employment. Trainers have come from NHS Grampian, the Terrance Higgins Trust and Positive Scotland.

In 2014, the Brook ‘Sexual Behaviours Traffic Light Tool’ training was brought to Shetland and a number of staff from a variety of organisations were trained to deliver this programme that looks at helping those working with young people to distinguish between healthy sexual development and harmful or risky behaviour.

Training for specific groups tends to be on request, and needs led. In the past this has included training for youth workers; staff from Looked After Children’s services and supported accommodation.

7.13 Assessment against National Standards for Sexual Health

In 2011, NHS Shetland completed a self assessment and had a peer review to assess progress against the National Standards for Sexual Health, developed by NHS Quality Improvement Scotland (now Healthcare Improvement Scotland). The full local report is available at:

www.healthcareimprovementscotland.org/programmes/reproductive,_maternal__child/sexual_health/sexual_health_reviews.aspx

The standards focus on clinical and preventative services, but also cover training, information and multi-agency work with young people. The peer review team recognised the following strengths in NHS Shetland:

- a resilient service that is responsive to individual need
- good levels of promotional activity and publicity for the sexual health and wellbeing clinic
- strong partnership working arrangements
- a workforce that is committed to service improvement.

There were also some gaps and challenges noted, and there will be some criteria that NHS Shetland will never be able to fully meet because of our small size and geography. Taking this into account, the following recommendations were made:

- to ensure the service is sustainable
- to engage with partners at strategic level, particularly with education and social work partners
- to invest in structured and accredited training programmes, particularly for sexual health nurses, and
- to monitor the effectiveness of commissioned services.
Appendix C

These have been incorporated into this strategy and the annual work plans. A full list of the assessment criteria is included in Appendix D.

7.14 Funding for sexual health and BBV work in Shetland

Some specific funding for sexual health and BBV work is provided through an allocation from the Scottish Government as part of the Health Improvement Bundle for NHS Shetland. There are three elements to this: Sexual Health Service; Hepatitis C and BBV prevention.

The Sexual Health Services funding is used directly towards funding the clinic. The other finding elements are included in the general budgets for a number of areas including Health Improvement and Public Health.

__________________________


5 CMO (2014)02 *Practice of Exposure-prone medical procedures by healthcare workers living with HIV or hepatitis B*. Available at: www.sehd.scot.nhs.uk/cmo/CMO(2014)02.pdf
### Appendix D

Results of NHS Shetland Assessment against the Sexual Health Standards (June 2011)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Criteria</th>
<th>Met</th>
<th>Not met</th>
<th>KCI (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Comprehensive provision of specialist sexual health services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>The NHS board has integrated local specialist sexual health services, which as a minimum, deliver a full range of contraception options, facilities for the diagnosis and treatment of all sexually transmitted infections in both men and women, and HIV testing and counselling.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>There is a minimum of 2 full days per week of integrated local specialist sexual health service provision available within 30 minutes travel time from each settlement of over 10,000 people.</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>80% of individuals with priority sexual health conditions are offered the opportunity to be seen within 2 working days of initial contact with a specialist sexual health service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>There are targeted services for communities or individuals with specific needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Sexual health information provision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>The NHS board has a system in place to identify the diverse sexual health information needs of its population and to respond to those needs appropriately using relevant information formats.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>There are clear and effective arrangements to ensure accurate information describing sexual health conditions and local service provision arrangements. The information details links with partner organisations outside the NHS, such as local authorities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Services for young people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td>There is evidence of active engagement of local key partners including health, education, social work, youth services and the voluntary sector, to improve sexual health for young people and reduce teenage pregnancy.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix C

<table>
<thead>
<tr>
<th>3.6</th>
<th>Targeted interventions are demonstrated for young people at greatest risk of teenage pregnancy and poor sexual health, including looked-after children.</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.7</td>
<td>The NHS board supports the delivery of sex and relationship education training for professionals in partner organisations such as youth workers and social workers, who work with the most vulnerable young people</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4</th>
<th>Partner notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>A sexual health adviser, or a professional trained and supported by a sexual health adviser (eg a practice nurse), is available to all individuals diagnosed with chlamydia or gonorrhoea.</td>
</tr>
<tr>
<td>4.2</td>
<td>Individuals are offered partner notification in all settings delivering sexual healthcare, including in primary care, youth services and community pharmacies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>Sexual healthcare for people living with HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>90% of adults receiving ongoing HIV care have the result of syphilis serology taken within the preceding 6 months recorded in their HIV records, or documentation why this is not required updated at 6 monthly intervals</td>
</tr>
<tr>
<td>5.2</td>
<td>80% of HIV+ adults presenting for the first time in Scotland have their sexual and reproductive history documented within 4 weeks of their initial HIV diagnosis, and are given advice to prevent onward HIV transmission, backed by the availability of condoms.</td>
</tr>
<tr>
<td>5.3</td>
<td>80% of adults receiving ongoing HIV care have an offer of a sexual health screen at least once every 12 months. If a sexual health screen is not required or if the offer is declined, this information is documented at 12 monthly intervals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6</th>
<th>Termination of pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>70% of women seeking termination of pregnancy undergo the procedure at 9 weeks gestation or earlier</td>
</tr>
<tr>
<td>6.2</td>
<td>There is a mechanism to ensure that all women are offered, at the time of termination of pregnancy, a range of contraceptives in addition to condoms, including implants or intrauterine methods where appropriate.</td>
</tr>
<tr>
<td>6.3</td>
<td>60% of women leave the facility with one of the more effective methods of contraception (hormonal oral contraceptives, intrauterine devices or contraceptive implants).</td>
</tr>
<tr>
<td>6.4</td>
<td>Post termination of pregnancy counselling to provide psychological support is available within 4 weeks for women (and their partners) who request it.</td>
</tr>
</tbody>
</table>

### 7  Hepatitis B vaccination for men who have sex with men

7.2  MSM have a choice of where hepatitis B vaccination is available, with a protocol to promote hepatitis B vaccination of all individuals at risk outside specialist sexual health services. Information on other health promoting activities such as risk reduction and sexually transmitted infection testing is also available in that setting. |  |

7.3  70% of all MSM attending specialist sexual health services and not known to be immune to hepatitis B receive at least one dose of hepatitis B vaccine. 100% (≥70) |

### 8  Intrauterine and implantable methods of contraception

8.2  60 or more females per 1,000 females of reproductive age per year are prescribed intrauterine and implantable contraceptives. 60.8 per 1000 (≥60) |

8.3  Contraceptive service providers who do not provide intrauterine and implantable contraceptives within their own practice or service have an agreed mechanism in place for referring women for intrauterine and implantable contraceptives. |

8.4  A consultation appointment with a service providing intrauterine and implantable contraceptives is available within 5 working days. |

### 9  Appropriately trained staff providing sexual health services

9.3  All health professionals providing sexual health interventions in both generic and specialist services demonstrate knowledge gained from post registration courses in sexual health and provide evidence of relevant continuing professional development. |
### National Framework for Sexual Health and Bloodborne viruses: Outcomes and indicators

(Appendix 1 of the Framework document)

<table>
<thead>
<tr>
<th>Framework Outcome</th>
<th>Sexual Health</th>
<th>HIV</th>
<th>Hepatitis C</th>
<th>Hepatitis B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Fewer newly acquired blood borne viruses and STIs; fewer unintended pregnancies</strong></td>
<td><strong>SH 1.1 Diagnoses of genital Gonorrhoea in heterosexual men and women</strong>&lt;br&gt;Acc: NHS Boards/Local Authorities&lt;br&gt;Mon: HPS</td>
<td>HIV 1.1 Rates of transmission of HIV acquired by residents in Scotland; overall and by risk group</td>
<td>HCV 1.1 Rates of transmission of HCV acquired by residents in Scotland; overall and by risk group</td>
<td>HBV 1.1 Rates of transmission of HBV acquired by residents in Scotland; overall and by risk group&lt;br&gt;Acc: NHS Boards/Local Authorities / Third Sector&lt;br&gt;Mon: HPS in association with BBV Specialist Laboratories</td>
</tr>
<tr>
<td></td>
<td><strong>SH 1.2 Diagnoses of rectal gonorrhoea in MSM</strong>&lt;br&gt;Acc: NHS Boards/Local Authorities&lt;br&gt;Mon: ISD</td>
<td>Acc: NHS Boards/Local Authorities/Third Sector&lt;br&gt;Mon: HPS in association with BBV Specialist Laboratories</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>SH 1.3 The rate of terminations of pregnancy</strong>&lt;br&gt;Acc: NHS Boards/Local Authorities&lt;br&gt;Mon: ISD</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>SH 1.4 The rate of repeat terminations of pregnancy</strong>&lt;br&gt;Acc: NHS Boards/Local Authorities&lt;br&gt;Mon: ISD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>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.</strong>&lt;br&gt;Acc: Local Authorities&lt;br&gt;Mon: Scottish Government* in association with Education Scotland</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The Scottish Government will work with key stakeholders to examine and develop options for collecting national survey data*
# National Framework for Sexual Health and Bloodborne viruses: Outcomes and indicators

## Appendix 1 of the Framework document

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<th>Hepatitis C</th>
<th>Hepatitis B</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. A reduction in the health inequalities gap in sexual health and blood borne viruses</td>
<td>SH 2.1 The rate of teenage pregnancy in areas of highest deprivation</td>
<td>HIV 2.1 Rate of HIV diagnosed population accessing specialist services by population* group</td>
<td>HCV 2.1 Rate of HCV diagnosed population accessing specialist services by population* group</td>
<td>HBV 2.1 Rate of HBV diagnosed population accessing specialist services by population* group</td>
</tr>
<tr>
<td></td>
<td>Acc: Local Authorities/NHS Boards Mon: ISD</td>
<td>Acc: NHS Boards/ Local Authorities/ Third Sector Mon: HPS in association with BBV Specialist Laboratories</td>
<td>Acc: NHS Boards/ Local Authorities/ Third Sector Mon: HPS in association with BBV Specialist Laboratories</td>
<td>Acc: NHS Boards/ Local Authorities / Third Sector Mon: HPS in association with BBV Specialist Laboratories</td>
</tr>
<tr>
<td></td>
<td>SH 2.2 The rate of termination of pregnancy in areas of highest deprivation Acc: NHS Board/ Local Authorities Mon: ISD</td>
<td></td>
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<tr>
<td></td>
<td>SH 2.3 Chlamydia indicator [awaits recommendations of Chlamydia working group]</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>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</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
### National Framework for Sexual Health and Bloodborne viruses: Outcomes and indicators
(Appendix 1 of the Framework document)

<table>
<thead>
<tr>
<th>Framework Outcome</th>
<th>Sexual Health</th>
<th>Indicators</th>
<th>HIV</th>
<th>HCV</th>
<th>HBV</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. People affected by blood borne virus(es) lead longer, healthier lives</td>
<td>Refer to NHS Quality Improvement Scotland Sexual Health Criteria 1.4 and Standard 5</td>
<td>Diagnosis</td>
<td>Diagnosis</td>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV 3.1 Number of people diagnosed and this number as a proportion of the estimated infected population</td>
<td>HCV 3.1 Number of people diagnosed and this number as a proportion of the estimated infected population</td>
<td>HBV 3.1 Number of people diagnosed and this number as a proportion of the estimated infected population</td>
<td></td>
</tr>
<tr>
<td>Late Diagnosis: HIV 3.2 Number of people newly diagnosed with late HIV disease (indicated by a CD4 count less than 350).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acc: NHS Boards Mon: HPS</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
## National Framework for Sexual Health and Bloodborne viruses: Outcomes and indicators
(Appendix 1 of the Framework document)

<table>
<thead>
<tr>
<th>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</th>
<th>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</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acc: NHS Boards Mon: HPS</td>
<td>Acc: NHS Boards Mon: HPS</td>
<td>Acc: For national purposes to establish baseline. Mon. HPS (Subject to epidemiological findings and the current HBV landscape, yet to be determined).</td>
</tr>
</tbody>
</table>

### Treatment:

<table>
<thead>
<tr>
<th>HIV 3.4 Proportion of diagnosed HIV infected people, for whom treatment is clinically indicated*, receiving treatment</th>
<th>HCV 3.4 Ratio of the diagnosed HCV chronically infected population to the annual and total number of people initiated onto antiviral therapy</th>
<th>HBV 3.4 Proportion of diagnosed highly infectious (eAntigen positive/high viral load) HBV chronically infected persons, who are receiving antiviral therapy</th>
</tr>
</thead>
</table>

*To be defined by National Monitoring and Assurance Group
### Appendix E

National Framework for Sexual Health and Bloodborne viruses: Outcomes and indicators
(Appendix 1 of the Framework document)

<table>
<thead>
<tr>
<th>Treatment: HIV 3.5</th>
<th>The proportion of the treated HIV population achieving an ‘optimal treatment response’ (viral load &lt;50 copies per ml within 12 months of commencing treatment)</th>
<th>Treatment: HCV 3.5</th>
<th>The proportion of the treated HCV population that completes treatment and the proportion achieving a sustained viral response</th>
<th>Treatment: HBV 3.5</th>
<th>The proportion of the treated HBV population achieving an ‘optimal treatment response’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acc:</strong> NHS Boards</td>
<td><strong>Mon.:</strong> HPS</td>
<td><strong>Acc:</strong> NHS Boards</td>
<td><strong>Mon.:</strong> HPS</td>
<td><strong>Acc:</strong> NHS Boards</td>
<td><strong>Mon.:</strong> HPS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Framework Outcome</strong></th>
<th><strong>Sexual Health Indicators</strong></th>
</tr>
</thead>
</table>
| 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) |

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

**National Framework for Sexual Health and Bloodborne viruses: Outcomes and indicators**

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<tr>
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<th>Hepatitis B</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>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)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Acc:</strong> NHS Boards, Third Sector, Local Authorities</td>
<td><strong>Mon:</strong> Scottish Government*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>SH 5.2</strong> Awareness and understanding in the general population of the positive and life enhancing aspects of sex and good sexual health</td>
<td><strong>BBV 5.2</strong> 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</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Acc:</strong> NHS Boards, Third Sector, Local Authorities, Scottish Government</td>
<td><strong>Acc:</strong> NHS Boards, Third Sector, Local Authorities, Scottish Government</td>
<td><strong>Mon:</strong> Scottish Government</td>
<td><strong>Mon:</strong> Scottish Government*</td>
</tr>
<tr>
<td></td>
<td><strong>SH/BBV 5.3</strong> Positive portrayal of sexual health and blood borne virus issues in the media, including the portrayal of gender stereotypes, nationally and locally</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Mon:</strong> Scottish Government</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Acc: Accountability for delivery  Mon: Accountability for monitoring

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