HIV AIDS 2002

in the north west of england

PENNY A. COOK
JENNIFER DOWNING
GILLIAN HUNT
QUTUB SYED
MARK A. BELLIS

HIV & AIDS
in the North West of England 2002

by Penny A. Cook, Jennifer Downing, Gillian Hunt, Qutub Syed and Mark A. Bellis

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Centre for Public Health
Faculty of Health and Applied Social Sciences
70 Great Crosshall Street
Liverpool John Moores University
Liverpool L3 2AB

Tel: +44 (0)151 231 4315/4316
Fax: +44 (0)151 231 4320
e-mail: p.a.cook@livjm.ac.uk

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Penny A. Cook
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Tel: +44 (0)151 231 4315/4316
Fax: +44 (0)151 231 4320
e-mail: p.a.cook@livjm.ac.uk

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Executive Summary

During 2002 the North West Region has seen the largest recorded increase in numbers of HIV positive people in treatment since regional monitoring began. During 2002 a total of 2,429 individuals living with HIV or AIDS accessed HIV treatment and care from statutory treatment centres in the North West Region. This represents a 24% increase on the number reported in 2001 (1,964). Over the eight years since this level of monitoring began, the HIV positive population in treatment in the North West has increased by two and a half times (figure 1.12). This report, the seventh annual report of the North West HIV/AIDS Monitoring Unit, presents data on HIV positive individuals accessing treatment and care in the North West Region.

A total of 45 statutory centres within the North West provided treatment and care for HIV positive individuals resident throughout the region and beyond. We present analyses by treatment centre, as well as by primary care trust (PCT) and strategic health authority (SHA) of residence. It is not possible to present all possible breakdowns at PCT level, however, additional tables are available on the North West Public Health Observatory website (http://www.nwpho.org.uk/hiv2002).

The predominant mode of exposure to HIV for those accessing treatment in the North West continues to be homosexual sex, accounting for 59% of all cases presenting to North West treatment centres in 2002 (table 3.1). There is, however, considerable variation across the three strategic health authorities, with 63% of the HIV positive residents of Greater Manchester having been infected by sex between men, compared to 51% of Cheshire and Merseyside residents (table 3.3a). The relatively high proportion of individuals infected by homosexual sex is reflected in the gender distribution of HIV and AIDS cases, with males representing 82% of all cases (table 3.4). Heterosexual sex continues to be the second largest exposure group, accounting for over a quarter of all cases in 2002 (table 3.3a). This represents an increase on the proportion in 2001, reflecting trends for the United Kingdom as a whole. Greater Manchester SHA reports the highest number of HIV positive individuals in the North West, accounting for over half of all cases (table 3.2a) and new cases presenting to statutory treatment centres (table 2.1a).

The proportion of HIV positive people in the older age groups (50 years and over) continues to increase, from 7% in 1996 to 11% in 2002 (figure 3.1). This ageing cohort effect is likely to be due to the effectiveness of antiretroviral therapies and subsequent improved prognosis of many HIV positive individuals. However, those aged 55 years or over are more likely to have died during 2002 from an AIDS-related condition (2%) than are those younger than 55 years, of whom only 1% died. The proportion of the HIV positive population dying from AIDS related conditions has decreased over the years, from 10% in 1995 to 1.2% in 2002 (figure 1.12).

A total of 617 new HIV and AIDS cases (HIV positive individuals who had not previously been seen in North West statutory treatment centres prior to the year 2002) were reported during the year. This is the largest number of new cases since regional monitoring of HIV and AIDS began, and represents a 37% increase on last year's figure of 449. New cases represented 25% of all cases, a similar proportion to previous years. In the North West, heterosexual sex has overtaken homosexual sex as the predominant exposure route for new cases for the first time (41% and 37% respectively; table 2.2a), reflecting the trend that has been apparent nationally since 1999 (figure 1.6). The proportion of new cases exposed to HIV through homo/bisexual sex is higher in the North West (table 2.1a) than nationally (figure 1.6). The number of new cases who were exposed by other transmission routes (injecting drug use, blood or tissue and mother to child) remain relatively low. While the largest proportion of new cases presenting for treatment and care were categorised as asymptomatic (57%), the five new cases who died during 2002 all had an AIDS defining illness. This illustrates the continuing need to attract HIV positive people into services at an early stage of their HIV disease to maximise the efficacy of treatment and improve prognosis.

The global AIDS pandemic continues to influence the situation in the North West of England, as reflected in the number and pattern of HIV infections acquired abroad. Over a quarter of all HIV positive individuals accessing treatment and care in the North West were reported to have been infected outside the United Kingdom (figure 3.2). Heterosexual sex continues to be the major method of exposure to HIV in those infected abroad (64%), a significantly higher proportion than in those known to have been infected in the United Kingdom (13%). Of all the infections contracted outside the United Kingdom, 55% were in sub-Saharan Africa (figure 3.3). Western Europe accounted for a further 14% of the infections that were contracted abroad, with Spain being the most frequently reported western European country of exposure. The role of exposure abroad was even more pronounced for cases who were new in 2002, where 31% were reported to have been infected abroad (figure 2.2). The number of new cases exposed to HIV in Zimbabwe has increased by 70% on 2001, and this year accounts for 45% of new cases known to have been exposed abroad. This high number of cases reflects both the high prevalence of HIV and the political situation in Zimbabwe.

Ethnicity was recorded for 95% of individuals accessing treatment and care in 2002, most of whom (80%) were self-classified as white (table 3.7). However, an increasing proportion of individuals with HIV were from black and minority ethnic communities (20%), a substantial over-representation when considering the proportion of North West residents who are from ethnic minority groups (5.2%). An even higher proportion (33%) of new cases were from minority ethnic groups (table 2.6), which has increased from 29% of new cases in 2001, demonstrating the increasing burden of HIV on these communities and the need for continuing and strengthening HIV prevention activities. The characteristics of HIV positive individuals from black and minority ethnic groups, particularly black Africans, are different to those of the white HIV positive population. Whereas white individuals were more likely to have been infected by homosexual sex, heterosexual sex is the predominant method of exposure of black Africans (tables 2.7 and 3.9). This results in there being proportionally more females from black and minority ethnic groups with HIV compared to white females (table 2.8 and 3.8) and more babies born with HIV infection (tables 2.7 and 3.9). Whilst in previous years we have reported that those from ethnic minority groups presenting for the first time were more likely to already be at a more advanced stage of disease than were white individuals, in 2002 there was little difference between ethnic groups.

For the second year, we have collected information on asylum seeker status of HIV positive individuals accessing HIV related care. This is information that is not available nationally, despite growing concern over the health of this vulnerable population. During 2002, there were 153 individuals who were identified as being asylum seekers, an increase of 143% on last year's total of 63 (table 3.25). These individuals were more likely to be asymptomatic (64%) than were those who were known not to be asylum seekers (33%). The majority of those known to be asylum seekers resided in Greater Manchester Strategic Health Authority (68%) and most (93%) were black Africans (table 3.26).

During 2002, nearly two thirds of individuals received triple or more combination therapy, including 13% who were taking quadruple or more therapy when they last attended treatment centres in the year (table 3.13). The level of triple or more therapy rose to 89% when considering those with an AIDS diagnosis, while only 36% of asymptomatic individuals were taking this level of therapy (table 3.14). The improved prognosis of HIV positive individuals across all clinical categories of HIV disease, together with relatively low numbers of individuals at early stages of HIV disease receiving combination therapy, has implications for a potential increase in demand for combination therapies. This has both planning and financial implications for the care of HIV positive individuals across the region.

For the fourth year, we can provide information on the level of inpatient and outpatient care for the whole of the region. During 2002, North Manchester General Infectious Disease Unit, the treatment centre with the highest number of HIV positive attendees (table 3.17), provided the highest number of outpatient visits, day cases, inpatient episodes and inpatient days (table 3.23). Demand for outpatient care peaked for those with an AIDS diagnosis (table 3.24), while those who died during 2002 required the most inpatient care. Ongoing monitoring of HIV treatment and care requirements will allow detection of any alterations in the level of demand for services, for example due to further developments in therapies. Home visits also formed a significant part of the care of HIV positive individuals (table 3.23), with those individuals who died during the year receiving the highest mean number of home visits.

During 2002, eight voluntary agencies in the North West reported care of 1,121 HIV positive individuals. Of these, 17% were not seen in North West statutory treatment centres during 2002, illustrating the continuing contribution of the voluntary sector to the care of those HIV positive individuals for whom the voluntary agencies may be the sole provider of care. This also has particular significance for regional funding of HIV services, since individuals accessing voluntary agencies but not the statutory sector are not included in the regional statistics provided to the Department of Health, the basis of the formula for the national distribution of funds for the care of HIV positive people.

This year, for the first time, we requested information from social services departments in the North West on the social care of HIV positive people. Twelve social services departments were able to take part, and contributed data on 193 individuals. Most (85%) of social services clients were also seen in the statutory sector in 2002. The profile of individuals reported by social services departments differed from those accessing the statutory sector, being more likely to be heterosexual (37%: table 5.1). Services were provided for 17 individuals known to be asylum seekers.

Three hospices reported providing palliative care for HIV positive individuals during 2002. Three HIV positive individuals residing in three strategic health authorities received hospice care, accounting for 90 inpatient days (table 6.1). All three individuals also received care from the statutory sector during 2002. In addition, specialist drugs services contributed data on clients whom were known to be HIV positive (table 6.2). Thirteen individuals were reported by six drugs services, all of whom also received HIV treatment from the elsewhere in the statutory sector in 2002.

We hope that the tables and figures provided in this report, together with additional analyses at PCT level available on the North West Public Health Observatory website (http://www.nwpho.org.uk/hiv2002), address most of your HIV-related information requirements. However, additional analyses and further breakdown of the data can be provided on request. As ever, we value your suggestions as to any developments that would improve the usefulness of the report in future years.

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1. Introduction

1. Introduction

Monitoring HIV and AIDS in the North West Region

This is the seventh annual report of The North West HIV/AIDS Monitoring Unit. Over the past eight years, we have collected, collated and disseminated data on the treatment and care of HIV positive individuals in the North West. The NHS information strategy for 1998 to 2005 supports this level of clinical and public health monitoring. The strategy highlights the need for comprehensive, accurate information as an integral part of improving the public's health[1]. However, in view of the sensitive nature of the information collected, data are anonymised and the Caldicott principles and recommendations (relating to data confidentiality and security) applied[2].

Over the past eight years we have collected data from over 40 statutory treatment centres including genito-urinary medicine clinics, infectious disease units, haematology clinics and a number of other specialist units and clinics [3-8]. The data collected form part of the national dataset - Survey of Prevalent Diagnosed HIV Infections (SOPHID) - and have been used in the production of the AIDS Control Act treatment and care reports. In addition, data are used at both regional, strategic health authority (SHA) and primary care trust (PCT) level to assist in service planning, development and evaluation as well as providing analysis of the changing patterns of disease prevalence and characteristics.

In addition to data collected from statutory treatment centres, we also access data from a number of additional sources of HIV care within the North West. This year we have extended data collection to include information from social service departments. Twelve North West social service departments have participated, all of which have HIV positive service users. The Unit continues to collect data from HIV/AIDS voluntary organisations across the region. For the fourth year, we have gathered data relating to HIV positive individuals accessing specialist drug services in the North West. Six drug agencies provided information on clients known to be HIV positive. Hospices in the North West also continue to report care of HIV positive individuals to the Monitoring Unit.

The rest of this chapter gives an overview of the global and national epidemiology of HIV and AIDS, before discussing specific aspects in the North West Region. In chapter 2, we present analyses of new HIV cases in the North West, and in chapter 3 analyses of all HIV and AIDS cases presenting for treatment and care in the North West. Voluntary sector care and social service care is dealt with in chapters 4 and 5, followed by care from additional sources in chapter 6.

For reason of space not all analyses employing PCTs can be included here, but additional tables can be found on the North West Public Health Observatory website (.nwpho.org.uk/hiv2002). We hope that the tables and figures provided within the report, and the extra analyses on the website, answer most of your HIV-related information requirements. We would value your suggestions as to what additions would improve the usefulness of the report in future years.

Global perspectives on HIV and AIDS in 2002

The need for accurate surveillance for HIV/AIDS is critical: HIV infection remains incurable, is characterised by a high morbidity, is very expensive to treat and predominantly effects younger adults, often the most economically active individuals. A sophisticated understanding of the epidemiology is essential for the allocation of resources for both treatment and prevention programs[9]. Good surveillance is essential for measuring the success of prevention and treatment policies. In England and Wales, The National Strategy for Sexual Health and HIV emphasises the need for a sound evidence base for effective prevention campaigns[10;11]. The strategy for combating infectious diseases[12] places surveillance at the heart of tackling all infectious disease, including HIV/AIDS.

For many countries, accurate figures for the number of HIV positive individuals, AIDS cases and AIDS deaths are not available: the surveillance systems are not in place. The numbers employed here for countries outside the UK are drawn from the publications of UNAIDS/WHO. They provide estimates based on diverse sources and are widely recognized as being the best available figures[13;14].

In 2002, an estimated 42 million people were living with HIV (figure 1.1), 5 million of whom were newly infected (figure 1.2) and three million of whom died. The total number of lives claimed by the pandemic so far is estimated to be 27.9 million. Sub-Saharan Africa continues to bear the brunt of the AIDS epidemic: HIV/AIDS is now the leading cause of death in sub-Saharan Africa. It is estimated that 2.4 million Africans died of AIDS in 2002[15;16]. The situation is further complicated by the high rates of co-infection with Tuberculosis: about a third of all those living with HIV/AIDS worldwide are also infected with Tuberculosis[17]. While Africa currently has the biggest AIDS problem, the future global course of the epidemic depends on what happens in India, China and Indonesia. The apparently low national prevalence rates mask localised epidemics and there is a threat of major generalised outbreaks.

Figure 1.1: Number of adults and children estimated to be living with HIV/AIDS as of end 2002 Source: UNAIDS/WHO Report on the Global HIV/AIDS Epidemic – December 2002

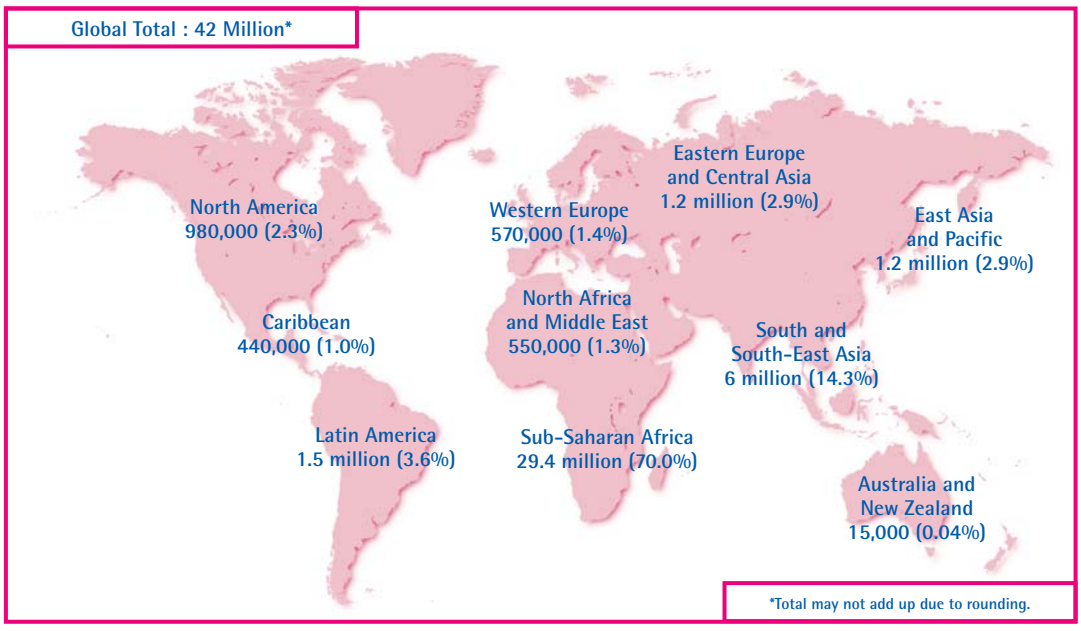
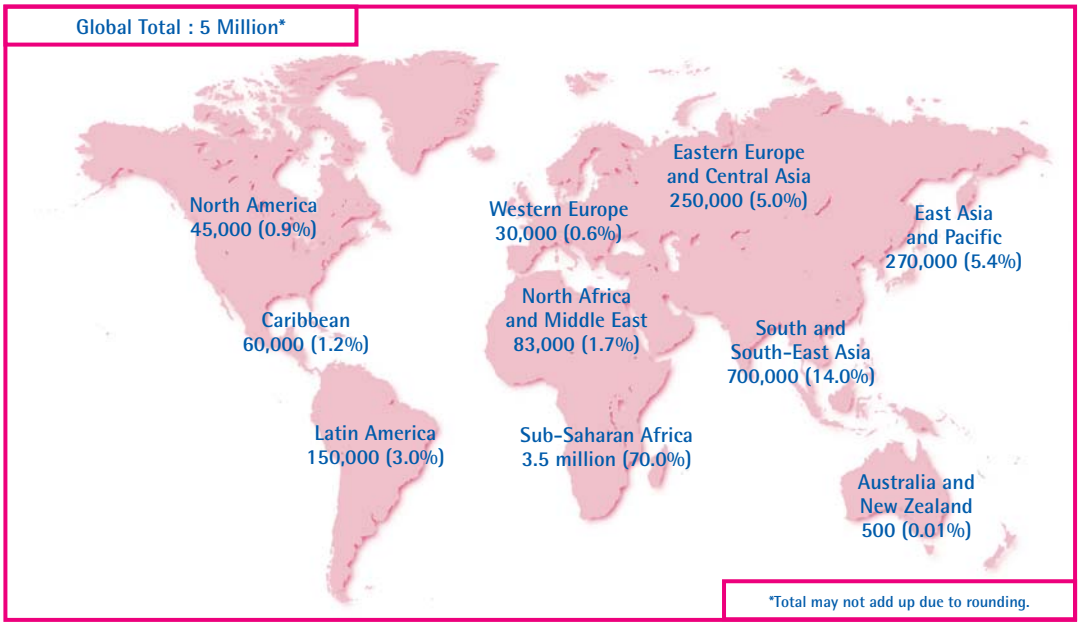


Figure 1.2: Number of adults and children estimated to be newly infected with HIV/AIDS during 2002 Source: UNAIDS/WHO Report on the Global HIV/AIDS Epidemic – December 2002



A global fund to fight AIDS, tuberculosis and malaria, became operational in January 2002[18]. To date the fund has received pledges of US$ 2.1 billion, significantly short of the annual target of US$10 billion. The fund states that its needs will grow to an additional $2 billion in 2003 in order to finance worthy proposals, rising to $4.6 billion in 2004 based on the growing capacity of countries to absorb the resources and expand effective programmes[19].

Access to antiretroviral drugs in the developing world

The World Health Organisation has recently placed antiretroviral drugs on its list of essential drugs[20], but this alone does not make access easier in resource-poor circumstances. Some progress has been made in the provision of antiretroviral drugs to prevent mother to child transmission; the manufacturers of Nevirapine have made the drug freely available in less developed countries[21]. If successful, this supply of drugs may address the commonly raised argument that even if the drugs were free the lack of an adequately resourced healthcare system and delivery system would continue to block access[22]. Positive developments have also been made in countries such as Argentina, Costa Rica, Cuba and Uruguay, where widespread access to antiretroviral drugs is currently provided free through the public sector[15].

Vaccine development

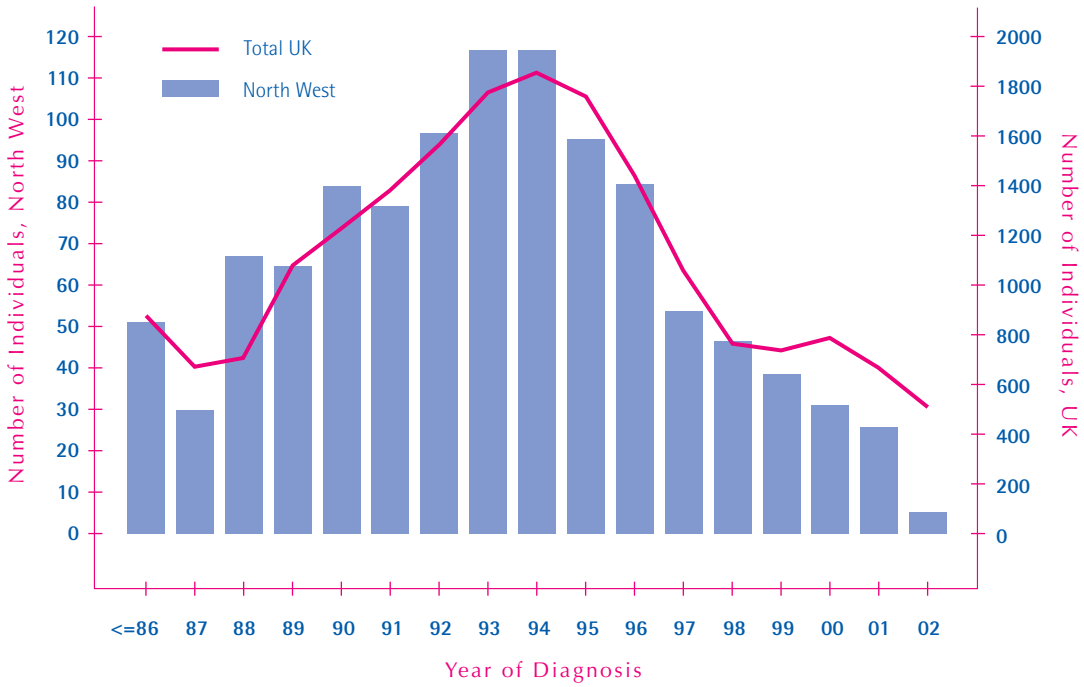
Twenty-two years on from the first cases of HIV, and a successful vaccine remains elusive. All studies to date show that traditional vaccine designs are ineffective in preventing HIV and AIDS. Many new vaccine designs are currently being developed and the greatest promise lies in the use of plasmid DNA. Studies on other primates have not resulted in immunity so far, but the vaccine may slow disease progression in an individual who is subsequently infected with HIV and, in addition, decrease levels of the virus in an HIV infected individual's secretions resulting in a reduced risk of transmission[23]. In addition to these developments, an HIV vaccine, made from genetically engineered proteins, has been in phase III trials for the last three years and has shown positive results in certain ethnic groups. The trial involved gay men and at risk women and has shown that black and Asian volunteers may have produced

higher levels of antibodies against HIV than white and Hispanic volunteers[24]. Major barriers to vaccine development remain the variability of the virus and the complexity of its interactions with the immune system. It is likely that any vaccine that is developed will have to be tailored to the local strain or strains in each geographical region[25] and may not work where new recombinant strains are formed[26].

The epidemic in the developed world

In richer countries, the epidemic continues to have a very different shape to that of the developing world, with the population living with HIV/AIDS growing as people have fewer opportunistic infections and live longer due to life-prolonging therapies[27]. Correspondingly, the number of people developing AIDS has decreased. This is demonstrated for the North West and UK in figure 1.3, where the number of AIDS cases begins to drop after 1994, while the number of people newly infected continues at approximately the same rate (figure 1.4). Data from the US show that even those who go on to develop AIDS can expect to live nearly three years longer than those diagnosed in the mid 1980s[28]. However, within the developed world, there are big differences in the prevalence of HIV between countries. For example, the USA has a rate eight times higher than that of the UK[29]. In the developed world HIV remains focussed in marginalised communities, for example injecting drug users, homosexual men and ethnic minority communities.

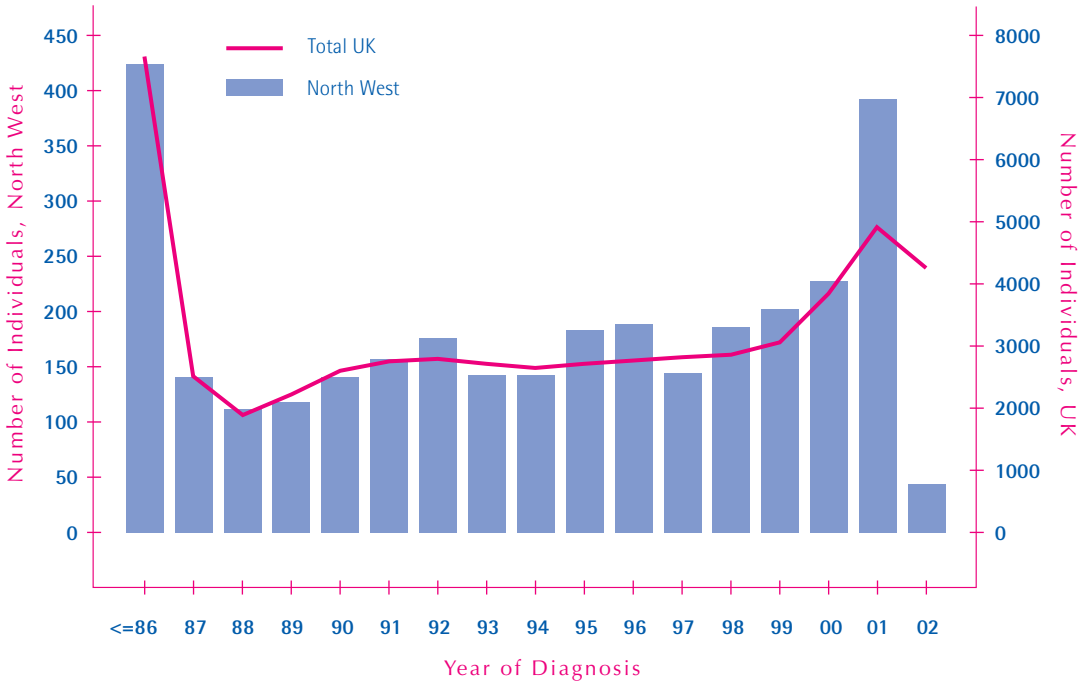
Figure 1.3: Number of new AIDS cases in the North West and the UK by year of diagnosis to December 2002 Source: AIDS/HIV Quarterly Surveillance Tables No 57, CDSC



	<=86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	Total
North West Region	51	30	68	65	84	79	97	117	117	95	84	53	47	29	21	16	5*	1058
Total UK	**882**	**680**	**905**	**1081**	**1244**	**1388**	**1577**	**1785**	**1854**	**1767**	**1432**	**1069**	**777**	**739**	**795**	**674**	**510**	**19159**

** revised figure at the end of March 2003 is 7 (AIDS/HIV Quarterly Surveillance Table No 58, CDSC)*

Figure 1.4: Number of new HIV cases in the North West and the UK by year of diagnosis to December 2002 Source: AIDS/HIV Quarterly Surveillance Tables No 57, CDSC



	<=86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	Total
North West Region	422	145	109	116	145	157	172	146	146	179	186	147	185	203	225	394	42*	3119
Total UK	**7614**	**2504**	**1940**	**2140**	**2540**	**2715**	**2739**	**2612**	**2566**	**2642**	**2681**	**2722**	**2801**	**3053**	**3818**	**4902**	**4204**	**54193**

** revised figure at the end of March 2003 is 334 (AIDS/HIV Quarterly Surveillance Table No 58, CDSC)*

Sub-Saharan Africa

Sub-Saharan Africa remains the region most severely affected by HIV/AIDS. In the year 2002 an estimated 3.5 million adults and children were newly infected (figure 1.2), bringing the total number of people living with HIV/AIDS to 30 million (figure 1.1). An estimated 2.4 million people (from a global figure of 3 million) died from HIV/AIDS in Sub-Saharan Africa.

The fact that the epidemic is centred on the heterosexual population in Africa, rather than a minority group, vastly increases the number of people at risk. In West Africa four countries have a national prevalence rate in excess of 5%: Cameroon (12%), Central African Republic (13%), Cote d'Ivoire (10%) and Nigeria (6%). However, Southern Africa continues to bear the brunt of the AIDS epidemic, with the national adult HIV prevalence exceeding 30% in four countries: Botswana (39%), Lesotho (31%), Swaziland (33%) and Zimbabwe (34%)[15]. At present there is evidence of some positive trends within the younger population of some countries: in South Africa, HIV prevalence in pregnant women under 20 years fell from 21% in 1998 to 15% in 2001. HIV prevalence has also declined among inner-city women aged 15-24 years attending antenatal clinics in Addis Ababa, Ethiopia from 24% in 1995 to 15% in 2001. In several parts of Uganda there has been a drop in HIV prevalence among pregnant women aged 15-19 years, with condom use by single women aged 15-24 years almost doubling between 1995 and 2000/01[15].

The high prevalence of HIV in sub-Saharan African countries, along with the political situation in some of these countries, accounts for large numbers of HIV positive individuals accessing care in the North West: of those newly reported in 2002 who were exposed abroad, nearly three quarters were exposed in Africa (see chapter 2, figure 2.3).

East Asia and the Pacific

In China the HIV surveillance data are weak: the country's health ministry estimated that approximately 600,000 Chinese were living with HIV/AIDS in 2000. The UNAIDS organization now puts that figure at 1.2 million, with official estimates predicting a manifold increase by the end of the decade[15]. Localised HIV epidemics have been observed in several parts of China. Nine provinces have reported outbreaks among their drug injecting population with the most recent in Hunan and Guizhou with prevalence rates of 8% and 14% respectively. Epidemics are also evident in the heterosexual populations of Yunnan, Guangxi and Guangdong province[15].

South and South East Asia

During the course of 2002, an estimated 700,000 people became infected with HIV in South and South East Asia (figure 1.2), bringing the total number of people living with HIV and AIDS in this area to 6 million (figure 1.1). Behaviours in the region that are associated with the highest risk are unprotected sex between sex workers and clients, injecting drug use and sex between men. Several countries have seen major epidemics grow out of relatively contained infection rates within these communities[30].

The national prevalence in India is 1% but this still equates to an estimated 3.97 million Indians living with HIV/AIDS, more people than anywhere else outside of South Africa[15]. Increasing HIV rates are also fuelling India's tuberculosis epidemic[31;32]. Without the implementation of a widespread prevention programme, the World Bank estimates that India could have 37 million infected individuals by 2005[31;33].

The world's fourth-most populous country, Indonesia has seen a ten fold increase in prevalence amongst blood donors between 1998 and 2000. HIV infection is rapidly increasing amongst both injecting drug users and sex workers[30]. It is estimated that Indonesia has between 124,000 and 196,000 injecting drug users, and, with 43,000 of them infected with HIV and sharing needles this figure is expected to double in 2003[15].

Prevention campaigns in Cambodia have proven successful: HIV prevalence amongst pregnant women fell from 3.2% in 1996 to 2.8% in 2002. HIV prevalence among sex workers has reduced from 42% in 1998 to 29% in 2002. However, the most positive progress has been in promoting consistent condom use in sex workers, which has risen from 37% in 1997 to 90% in 2001[15].

Latin America and the Caribbean

These regions account for almost 2 million people living with HIV (figure 1.1). Men who have sex with men, bisexual men, unsafe sexual practices and injecting drug use are the main contributors to the HIV rates of Latin America and the Caribbean. In seven central American countries HIV prevalence rates among men who have sex with men is between 8% and 18%, and six south American countries show HIV prevalence rates of between 14% to 28% for men who have sex with men. Recent research has shown that a significant proportion of this community also have sex with women, thus contributing to the spread of HIV through the female population[15].

Several Caribbean countries have the highest rates of HIV outside sub-Saharan Africa, with the worst effected country being Haiti where 6% of the population is infected with HIV and the Bahamas with 3.5% prevalence. Twelve countries in this region have a HIV prevalence of at least 1% among pregnant women; these countries include the Dominican Republic, Haiti, Belize, Guyana, Honduras and Suriname[15].

North America

An estimated 45,000 new infections occurred in the USA and Canada during 2002 (figure 1.2), and these contribute to an estimated total of 980,000 people living with HIV (figure 1.1). The group most affected by the HIV virus is African Americans, especially African American men who have sex with men and African American heterosexual women. African Americans constitute 54% of all new HIV infections and 75% of all heterosexual infections in the United States even though they represent only 12% of the population[34].

Eastern Europe and Central Asia

Eastern Europe and Central Asia is the region with the fastest growing epidemic. There are now an estimated 1.2 million people living with HIV (figure 1.1), 250,000 of whom were new cases (figure 1.2). The majority of people with HIV are injecting drug users, and a 2001 study of the drug injecting population in the Russian city of Togliatti revealed an HIV prevalence of 56%. The study also revealed that 40% of sex workers who injected drugs did not consistently use condoms with their partners, while 25% of the sex worker population failed to use them in their commercial sex work, thereby contributing to the heterosexual transmission of HIV[15]. The deepening economic crisis across the entire region has led to the collapse of public health systems, and prevention campaigns have been limited in number and impact.

Western Europe

At the end of 2002, the number of people living with HIV in Western Europe was estimated to be 570,000 (figure 1.1), of whom 30,000 were newly infected in 2002 (figure 1.2). The overall prevalence has increased slightly, mainly because effective therapies prolong the life expectancy of HIV positive people. The prevalence of HIV varies widely in Western Europe, and the nature of the epidemic differs between countries: in Portugal, Spain and Italy the epidemic is driven by injecting drug users, whilst in Germany and Greece sex between men remains the principle transmission route. It should be noted that there is also significant diversity within individual countries. The national prevalence rates also vary, from 0.1% of the adult population in the Scandinavian countries to an estimated 0.5% in Spain and Portugal[35]. However, the quality of data is poor in some of the countries that are most affected by HIV, particularly those with large injecting drug user epidemics (for example, France, Portugal, Italy and Spain)[36]. The heterosexually transmitted infections amongst Western European countries have distinct patterns. Over 50% of heterosexually exposed cases in Norway, Germany, Finland, Sweden, Denmark, Iceland, Greece and the UK are acquired in a country with a generalised epidemic (i.e. over 1% of the population infected, typically sub-Saharan Africa)[37].

Many Western European countries are popular holiday destinations for British tourists. Moreover, risk behaviour, particularly among young people, increases when on holiday[38]. In 2002, 8.8% of new HIV infections contracted abroad were infected in Western Europe (see chapter 2, figure 2.3).

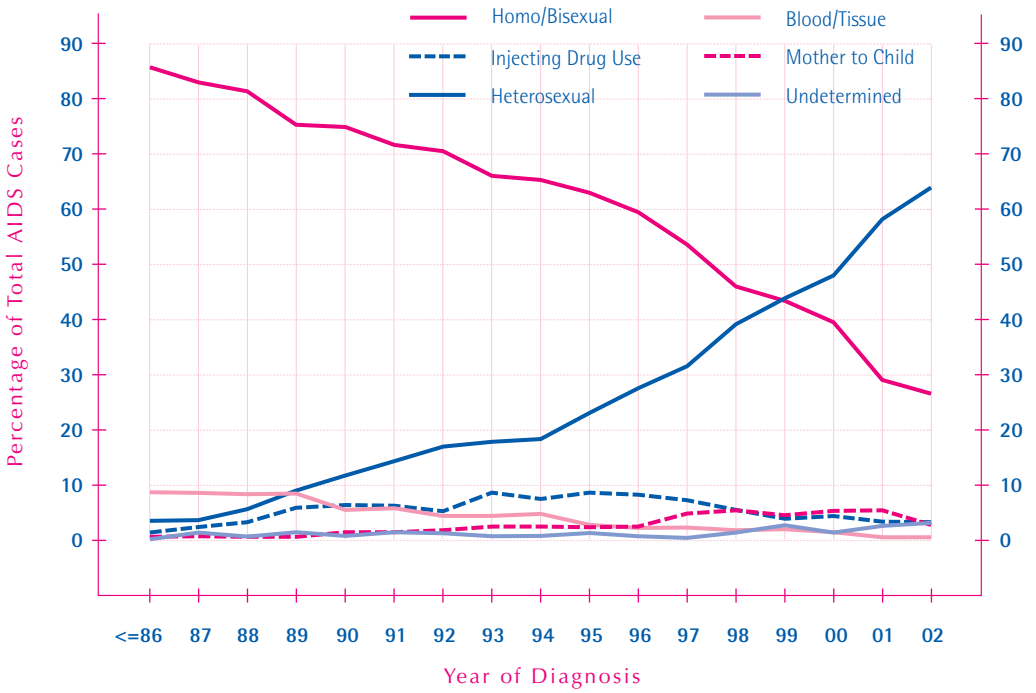
New diagnoses of HIV, development of AIDS and deaths of HIV positive people are reported to the Health Protection Agency (HIV, STD Division, Communicable Disease Surveillance Centre) and the Scottish Centre for Infection and Environmental Health, who compile the data into quarterly surveillance tables. Figures 1.3 to 1.7 and tables 1.1 and 1.2 in this chapter give an overview of trends in the UK using these data. Most people with HIV live in London. This means that national policy is shaped with a strong bias to the needs of London and the South East[39-42]. Additionally, the data under-represent some regions of the UK (notably the North West and Trent[39-42]). Chapters 2 to 5 of this report are based on monitoring of treatment and care of individuals with HIV or AIDS, and provide the most accurate and detailed information on HIV epidemiology available for the North West.

The number of people reported as being newly diagnosed with AIDS in the UK in 2002 alone was 510, bringing the cumulative total number of people with AIDS since notification began in 1982 to 19,159 (figure 1.3). The number of new AIDS cases represents a 77% decrease from 1994 when the number of AIDS diagnoses was at its highest. This decline in AIDS incidence in the UK is also observed across Europe and the USA and has been attributed to the success of antiretroviral therapies[27].

The cumulative total of reported HIV infections in the UK rose to 54,193 at the end of 2002 (figure 1.4). Of these, 4,204 cases were newly identified in 2002. The epidemiology of HIV in England, Wales and Northern Ireland is shifting as a result of changing patterns in the route of transmission of new infections (figures 1.5 and 1.6). The epidemiology of HIV differs in Scotland, as shown in figure 1.7.

An additional tool for monitoring the HIV epidemic in the UK is provided by the unlinked anonymous HIV seroprevalence programme conducted by CDSC and the Institute of Child Health. Part of the programme involves the testing of blood samples that have been taken for other purposes, for example antenatal screening, after having irreversibly removed patient identifying details. This allows estimations of the extent of undiagnosed HIV infection in high risk groups as well as in the general population. The monitoring programme has been operating throughout England and Wales since 1990 and provides low cost estimates of current HIV prevalence[43].

Figure 1.5: Number of AIDS cases in the UK by year of diagnosis and infection route of HIV to December 2002 Source: AIDS/HIV Quarterly Surveillance Tables No 57, CDSC

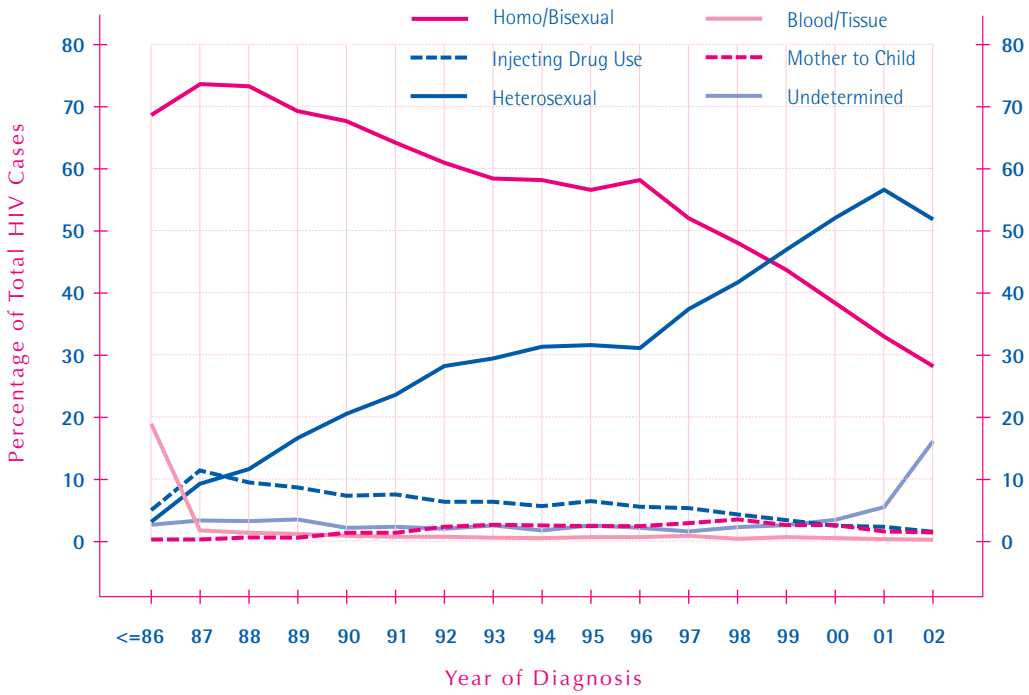


YEAR OF DIAGNOSIS	Infection Route						Total
	Homo/ Bisexual*	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
<=1986	755	10	30	76	7	4	882
1987	567	16	26	58	6	8	681
1988	738	28	52	75	7	8	908
1989	809	64	98	91	8	12	1082
1990	926	82	140	69	17	10	1244
1991	988	88	193	82	18	19	1388
1992	1108	84	268	70	30	17	1577
1993	1193	154	308	79	41	11	1786
1994	1230	140	335	90	43	16	1854
1995	1109	153	394	51	40	20	1767
1996	850	118	388	31	34	12	1433
1997	574	77	337	24	52	5	1069
1998	361	44	303	15	42	12	777
1999	318	29	323	15	33	21	739
2000	314	35	381	12	42	11	795
2001	198	23	395	4	36	18	674
2002	139	17	320	3	15	16	510
Total	**12177**	**1162**	**4291**	**845**	**471**	**220**	**19166**

** includes 317 men who had also injected drugs*

Figure 1.6: Number of HIV cases in England, Wales and Northern Ireland by year of diagnosis and infection route of HIV to December 2002

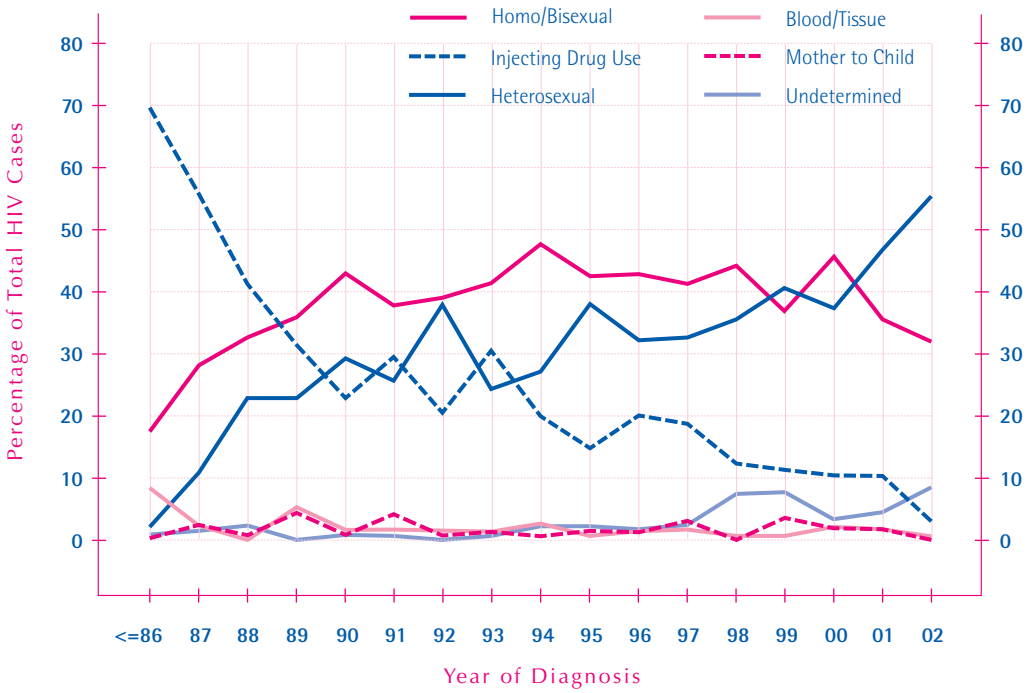
Source: AIDS/HIV Quarterly Surveillance Tables No 57, CDSC



YEAR OF DIAGNOSIS	Infection Route						Total**
	Homo/ Bisexual*	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
<=1986	4625	403	206	1267	12	181	6709
1987	1686	256	211	44	5	73	2283
1988	1337	174	210	25	12	57	1817
1989	1411	177	334	22	11	68	2027
1990	1647	172	499	22	28	51	2424
1991	1648	190	602	21	29	55	2545
1992	1587	160	729	22	56	53	2608
1993	1428	153	725	15	64	61	2447
1994	1414	138	757	13	62	45	2429
1995	1405	159	794	19	58	60	2497
1996	1473	140	785	18	59	53	2528
1997	1330	136	952	24	76	45	2564
1998	1281	111	1102	9	93	56	2653
1999	1284	95	1363	18	77	70	2910
2000	1416	91	1920	20	98	127	3672
2001	1606	107	2676	21	78	263	4751
2002	1129	58	2087	9	57	662	4002
Total* **	**27707**	**2720**	**15952**	**1589**	**875**	**1980**	**50866**

** includes 655 men who had also injected drugs*
*** includes 43 with sex not stated on report*
**** includes 68 patients who were first reported from the Channel Islands*

Figure 1.7: Number of HIV cases in Scotland by year of diagnosis and infection route of HIV to December 2002 Source: AIDS/HIV Quarterly Surveillance Tables No 57, CDSC



YEAR OF DIAGNOSIS	Infection Route						Total
	Homo/ Bisexual*	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
<=1986	162	635	28	76	1	7	909
1987	62	126	25	5	5	3	226
1988	44	56	31	0	1	3	135
1989	42	36	26	6	5	0	115
1990	52	28	35	2	1	1	119
1991	66	51	44	3	7	1	172
1992	52	27	50	2	1	0	132
1993	69	52	41	2	2	1	167
1994	69	29	39	4	1	3	145
1995	62	22	56	1	2	3	146
1996	69	32	51	2	2	3	159
1997	69	31	54	3	5	4	166
1998	68	19	54	1	0	11	153
1999	53	16	58	1	5	11	144
2000	67	15	54	3	3	5	147
2001	56	16	73	3	3	7	158
2002	66	6	112	1	0	17	202
Total	**1128**	**1197**	**831**	**115**	**44**	**80**	**3395**

** includes 39 men who had also injected drugs*

Men who have sex with men

The category of homosexual exposure accounts for 64% of all AIDS cases so far reported in the UK (figure 1.5) and 54% of all HIV cases (figure 1.6). However, the shape of the epidemic is changing, and the proportion of new HIV diagnoses attributed to sex between men has decreased from a high of 74% in 1987 to 28% in 2002. The pattern is different in Scotland, where men who have sex with men account for only 33% of the total number of people who have been diagnosed with HIV (figure 1.7). From anonymous testing of blood samples, the prevalence of HIV among gay men in London is estimated to be 15%, significantly higher than that outside London (2%)[44].

The 1980s saw substantial reductions in risk behaviour among gay men in response to the AIDS crisis. Following several years of stable levels of risk behaviour[45], more recent annual surveys[46] show that gay men in London appear to be following a trend for a reduction in safer sex behaviour. This change in self-reported risk behaviour is mirrored by increasing levels of homosexually acquired syphilis (by 186% between 2000 and 2001) in the UK[47]. As well as indicating increases in risk behaviour, sexually transmitted infections may also act as a co-factor in the transmission of HIV[48].

A national survey of homosexual men found that more than two thirds of men agreed that they would expect a man with HIV to disclose his status prior to sex and one third would assume someone to be negative unless told otherwise[49]. Assessments of HIV status can have important ramifications upon the decision to have unprotected sex[50]. However, a previous negative test does not guarantee continued HIV negative status, and non-disclosure by a potential partner could be the result of having not been tested (46% men)[49], as opposed to the certainty of being free of HIV.

Heterosexual sex

Sex between men and women now accounts for 31% of the total number of HIV diagnoses in England, Wales and Northern Ireland. However, for the third year running, heterosexual sex has accounted for the largest number of new cases, at 52% in 2002 (figure 1.6). Heterosexual cases are categorised as to whether they were exposed through sex with high risk partners, were exposed abroad or exposed in the UK (figure 1.8). In 2002, 72% cases of heterosexually acquired HIV were contracted abroad. The prevalence of HIV in the general heterosexual population is also monitored by anonymous testing of pregnant women. These data reveal that the prevalence of HIV in the heterosexual population is more than fifteen times higher in London than the North West (350 per 100,000 compared to 22 per 100,000: figure 1.9). For those HIV positive individuals infected through heterosexual sex, the majority (63%) are female[51].

Sub-Saharan Africa is the predominant global region of transmission for those HIV cases acquired abroad[51]. This is also reflected in the epidemiology of HIV in the North West, where, of those newly reported in 2002 and infected abroad, nearly three quarters were exposed in Sub-Saharan Africa (see chapter 2, figure 2.3). Individuals from black and minority ethnic communities form the majority of heterosexually transmitted AIDS cases in the UK with black Africans constituting the largest group[51]. These communities have close connections with sub-Saharan societies, the region in which 70% of the global total of adults and children estimated to be living with HIV/AIDS at the end of 2002 reside (figure 1.1). However, HIV is often stigmatised within African communities, which can prevent individuals from accessing services[52].

Figure 1.8: Number of heterosexually acquired HIV cases in the UK by year of diagnosis to December 2002 Source: AIDS/HIV Quarterly Surveillance Tables No 57, CDSC

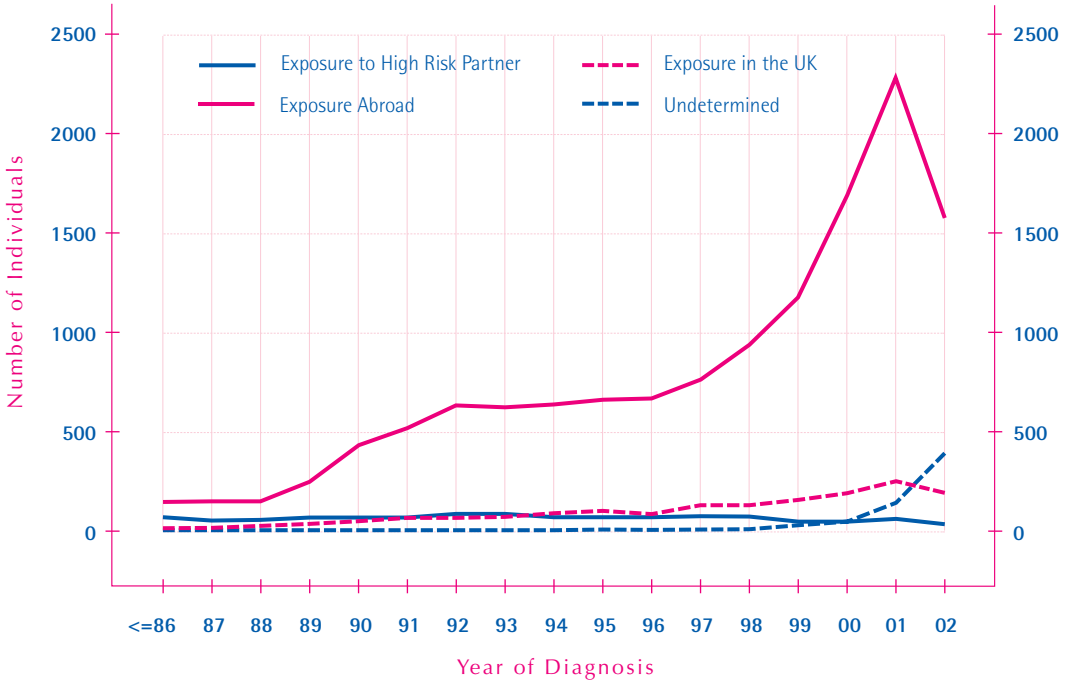
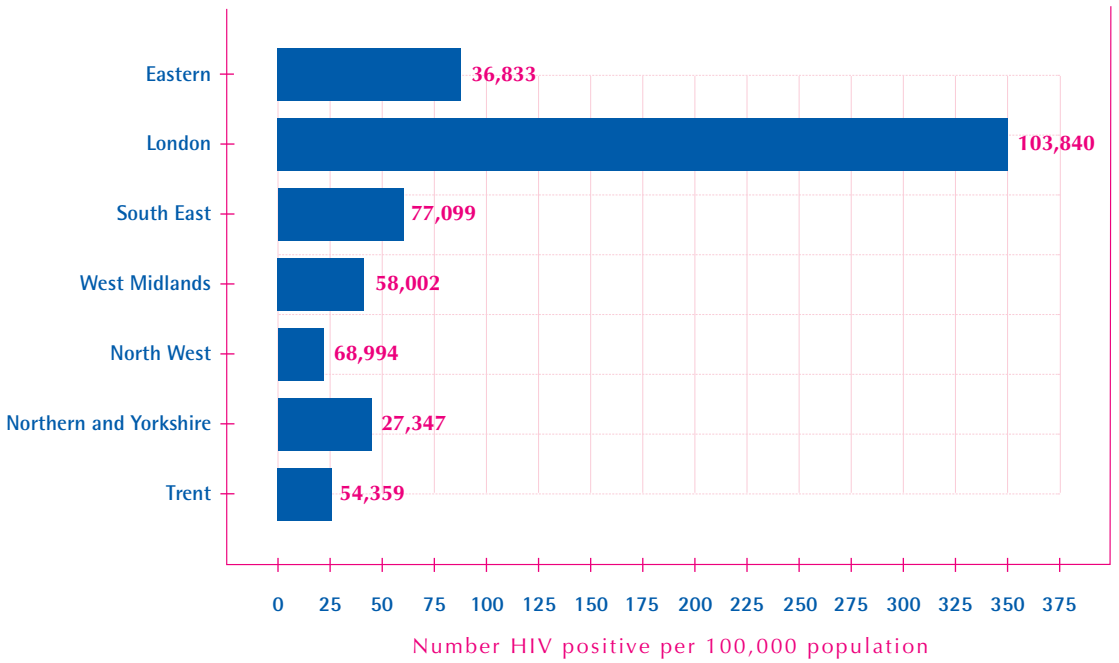


Figure 1.9: HIV prevalence among pregnant women in England, 2001 (newborn infant dried blood spots collected for metabolic screening)

Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 2001)



Numbers by each bar represent sample sizes

Injecting drug users

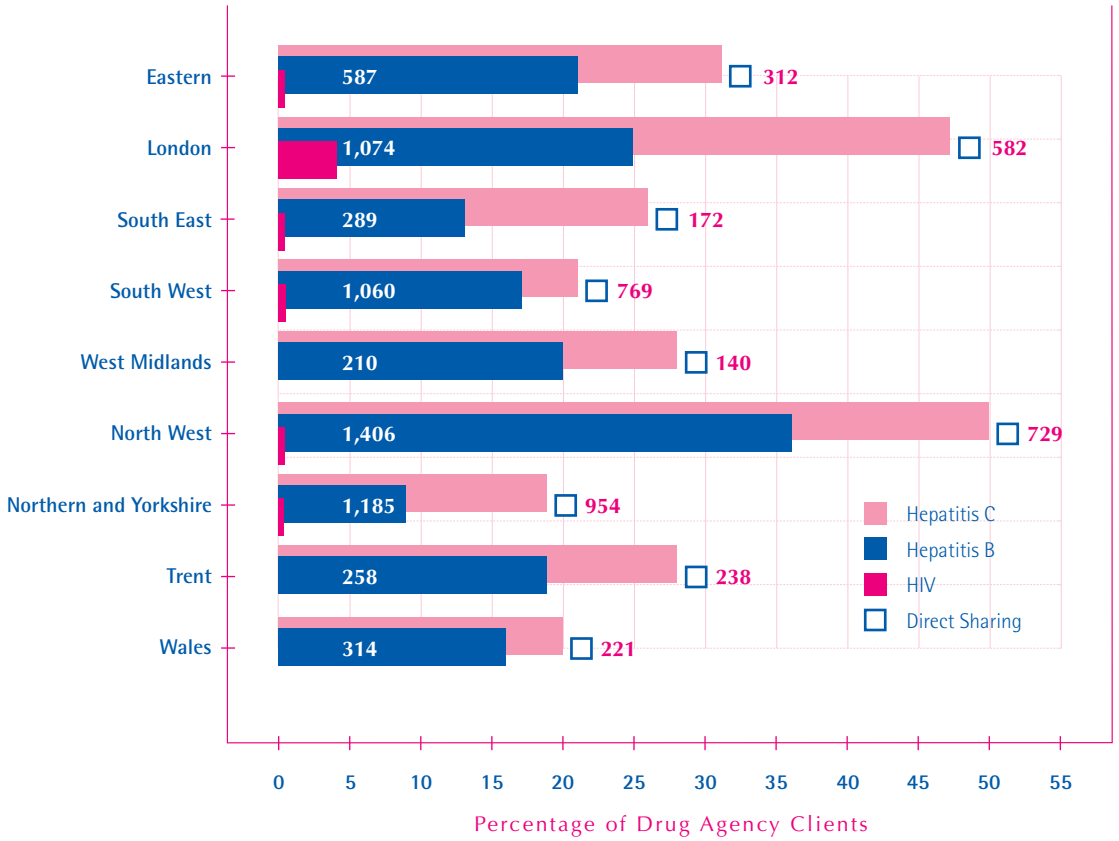
Injecting drug use accounts for 5% of the total diagnosed HIV infections in England, Wales and Northern Ireland to date (figure 1.6). The proportion newly diagnosed by this route in 2002 has dropped to just 1.4%, the lowest since reporting started. In Scotland, the epidemic has historically been centred on injecting drug use, which accounted for 70% of infections up to and including 1986. This proportion has steadily decreased, and in 2002 only 3% of new infections were attributed to this route (figure 1.7). Anonymous testing of injecting drug users attending services reveals that, outside London, the prevalence of HIV among injectors is low, at 0.21% in the North West. In London, an estimated 4% have HIV (figure 1.10). The pioneering harm reduction strategies, such as needle exchanges, in Liverpool during the 1980s have helped keep the prevalence low in the North West[9].

Other blood borne infections, such as hepatitis B and C, are more infectious than HIV and are transmitted during episodes of indirect sharing (for example sharing of filters, spoons or water when preparing drugs). Figure 1.10 shows the prevalence of HIV, hepatitis B and hepatitis C amongst injecting drug users by region. While the prevalence of HIV remains fairly low, hepatitis B and C are highly prevalent. London and the North West in particular have the highest prevalences of hepatitis infections amongst clients of drugs services. A recent survey of injecting drug users from a range of drugs service and community settings in the North West found the prevalence of hepatitis C to be yet higher, at 53%[53;54]. Because HIV is less infectious than hepatitis C, those individuals who have had sufficient high risk exposure via injecting drug use to acquire HIV are also likely to have been infected with hepatitis C. Having both infections makes the treatment of each more difficult to manage, increases the progression of hepatitis disease and, for women, increases the probability of transmission of HIV to an infant during pregnancy or birth (see review in the recent North West report[53]).

An area of particular concern for the transmission of HIV (and hepatitis B and C) is within prisons. Prisoners are particularly at risk due to the high levels of intravenous drug use and sharing of injecting equipment within the prison environment. Tattooing and unprotected sex between men are also high risk activities known to be widespread. The Prison Service has been slow to incorporate harm reduction measures, such as condom distribution and needle exchange, over the concern about condoning illegal activity[55]. An initiative aimed at preventing the transmission of hepatitis in prisons was the provision of hepatitis B vaccines to all individuals entering prison, in a number of facilities within England and Wales[44].

Figure 1.10: Prevalence of HIV, hepatitis B and hepatitis C antibodies and direct sharing of injecting equipment among injecting drug users attending drugs agencies, 2000/01 (voluntary saliva samples)

Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 2001)



Numbers at the base of each bar represent the sample sizes for blood tests. Direct Sharing refers to receiving or passing on used needles or syringes in the previous four weeks and the numbers represent the sample size for the direct sharing question.

Blood or tissue

Since the introduction of screening of donated blood for HIV in 1985, infection by blood transfusion has been rare. This is clearly indicated by the abrupt decline from 19% of all infections reported before and during 1986 to just 0.2% in 2002 (figure 1.6).

The relatively rare instances of HIV infection via this route tend to be a result of donations collected during the window period of HIV infection (i.e. before antibodies had developed in the donor's blood) or people infected prior to screening who have only recently developed HIV-related disease[56]. When 5,579 transfusion recipients were followed up, none had been infected with HIV as a result, suggesting that the current risk of transmission from a transfusion in the UK is very low: at less than one in 5,000[57].

Mother to child

During 2002, 57 infants were reported to have contracted HIV from their mothers (figure 1.6). Although this is an apparent decline on last year's figure of 78, there is an inevitable delay in reporting vertically transmitted HIV. This is because maternal antibodies are present for up to 18 months after birth, which confounds the diagnosis. The equivalent figure published for 2001 was 18; however, by December 2002 this 2001 figure had been adjusted to 78. Thus it is likely that several more diagnoses for the year 2002 will be reported during coming months.

Interventions of anti-HIV therapy for the mother, caesarean section and avoidance of breast feeding have been successful at reducing the rates of vertical transmission from around 32% to 4%[58]. Currently, the main obstacle that prevents successful intervention is lack of knowledge by the mother of her HIV status. It has recently become policy to offer an HIV test to all pregnant women with the aim of increasing the uptake of the test to 90% of all pregnant women[59;60]. In 2002, 82% of pregnant HIV positive women in London were diagnosed before delivery. There was a noticeable improvement in diagnosis prior to delivery outside the London area: from 55% in 2000 to an estimated 64% in 2001[44]. Over three quarters of all HIV positive women who gave birth in 2001, for whom country of birth was known, were born in Sub-Saharan Africa[44].

HIV and AIDS in the North West of England - 2002

Figures 1.3 and 1.4 and Tables 1.1 and 1.2 are taken from the CDSC Quarterly Surveillance Tables to illustrate the status of the HIV/AIDS epidemic in the North West by comparison to the rest of the UK. While these data underestimate the number of cases in the North West[39-42], the information is useful for monitoring trends both nationally and regionally. For the most accurate and detailed information about people living with HIV and AIDS in the North West, see the comprehensive overview in chapters 2 to 5 of this report.

By the end of 2002, a cumulative total of 3,119 HIV infections in the North West had been reported to the Communicable Disease Surveillance Centre at the Health Protection Agency, including 42 new cases during 2002 (Figure 1.4). By the end of March 2003, the processing of late reports brought the total number of new cases during 2002 to 334[61]. There were five newly diagnosed AIDS cases in the North West, bringing the cumulative total to 1,058, 6% of the total number of AIDS cases reported in the UK (Figure 1.3).

The pattern of exposure to HIV among people with AIDS in the North West is broadly similar to that of the UK, with the majority of people who have had an AIDS diagnosis reported as having been infected by homosexual sex (table 1.1). However, the North West has a lower proportion of people infected with HIV via heterosexual sex (21% compared to 31%) and a correspondingly higher proportion of men who were infected by having sex with men (63% compared to 53%) (table 1.2). As in previous years, the proportion of individuals exposed through the receipt of contaminated blood or blood products is approximately twice the national average for both HIV and AIDS cases. At least part of this is likely to be due to patients from other areas attending specialist haematology units in the North West Region and in some cases moving residence for convenience.

The data in figure 1.11 are derived from the anonymous seroprevalence survey conducted by the CDSC, and show the level of HIV infection in pregnant women; a sample intended to represent the general population of the North West. The data for 2001 show an increase in the prevalence of HIV from 17 per 100,000 in 2000 to 22 per 100,000 pregnant women.

Table 1.1: Cumulative number of AIDS cases in the North West and the UK by infection route of HIV to December 2002 Source: AIDS/HIV Quarterly Surveillance Tables No 57, CDSC

	Infection Route					Total
	Homo/ Bisexual*	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Other/ Undetermined**	
North West Region	703 (66.4%)	58 (5.5%)	158 (14.9%)	104 (9.8%)	35 (3.3%)	1058 (100.0%)
Total UK	**12173 (63.5%)**	**1162 (6.1%)**	**4291 (22.4%)**	**844 (4.4%)**	**689 (3.6%)**	**19159 (100.0%)**

** includes 317 men who had also injected drugs*
*** includes 471 children of HIV infected mothers*

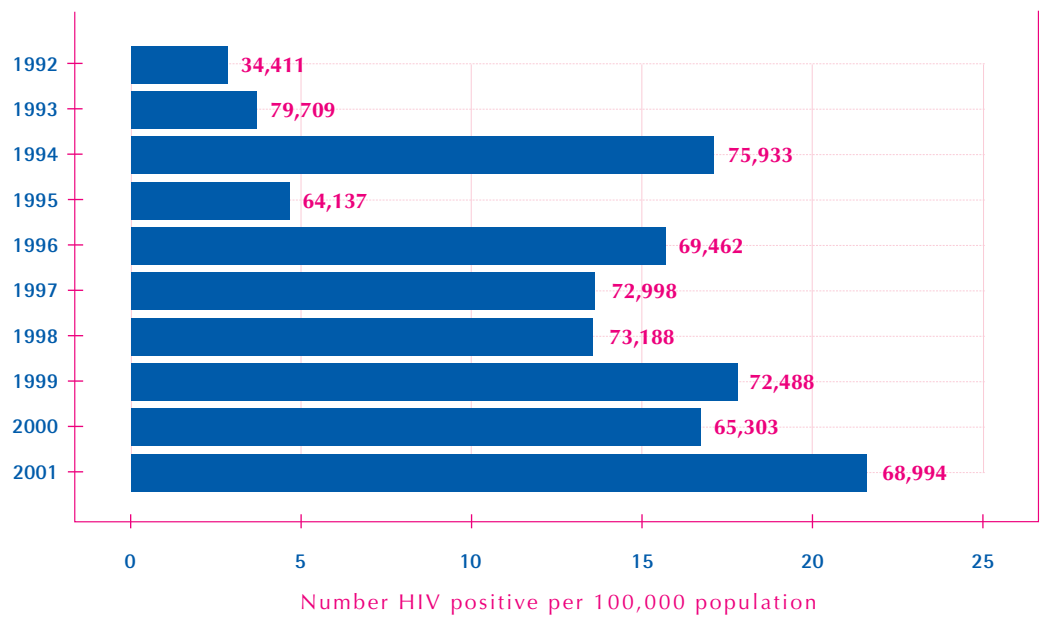
Table 1.2: Cumulative number of HIV cases in the North West and the UK by infection route of HIV to December 2002 Source: AIDS/HIV Quarterly Surveillance Tables No 57, CDSC

	Infection Route					Total***
	Homo/ Bisexual*	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Other/ Undetermined**	
North West Region	1956 (62.7%)	179 (5.7%)	668 (21.4%)	196 (6.3%)	120 (3.8%)	3119 (100.0%)
Total UK	**28805 (53.2%)**	**3908 (7.2%)**	**16760 (30.9%)**	**1701 (3.1%)**	**2976 (5.5%)**	**54193 (100.0%)**

** includes 694 men who had also injected drugs*
*** includes 920 children of HIV infected mothers*
**** includes 43 with sex not stated on report*

Figure 1.11: HIV prevalence among pregnant women in the North West, 1992-2001 (newborn infant dried blood spots collected for metabolic screening)

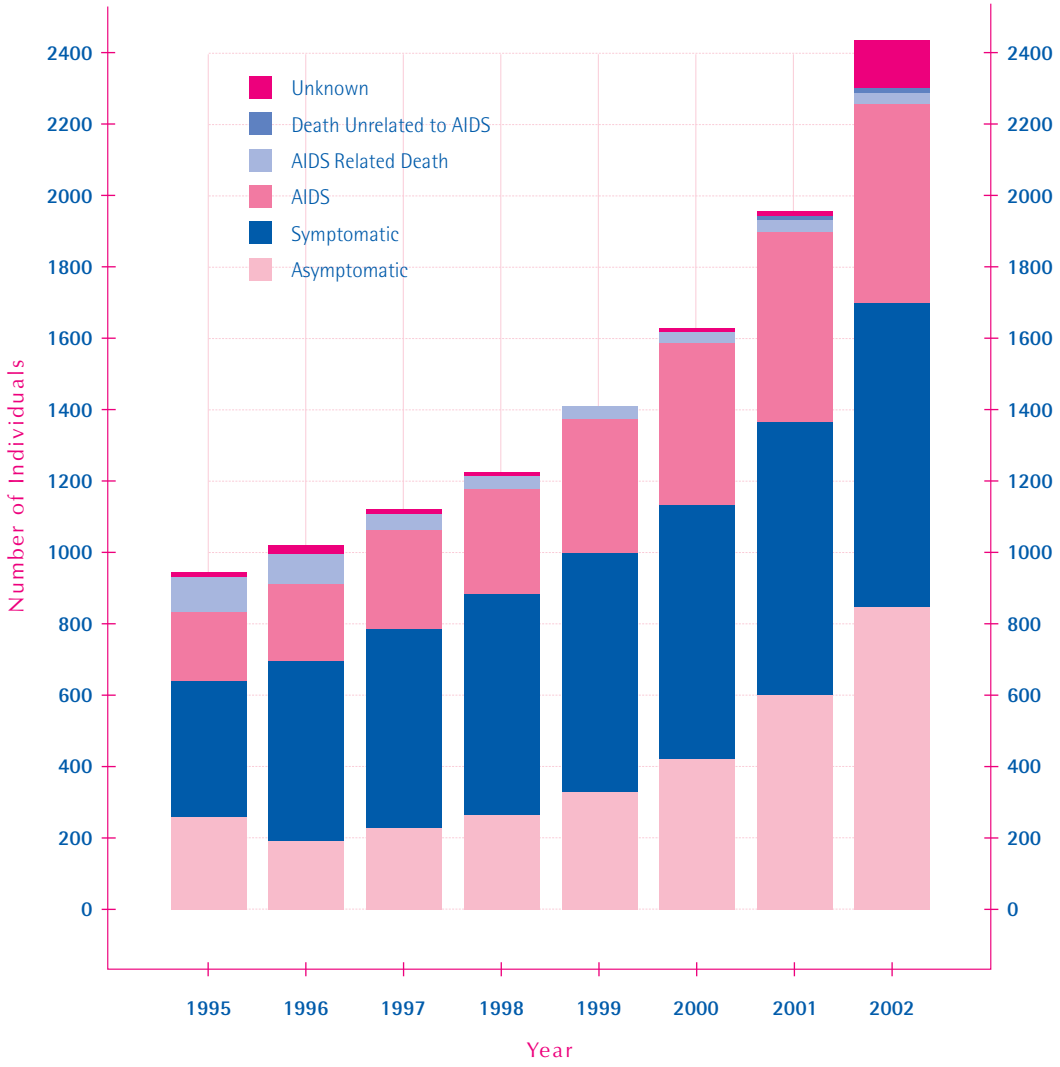
Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 2001)



Numbers by each bar represent sample sizes

Figure 1.12: Number of AIDS cases and HIV positive individuals presenting to treatment centres in the North West Region by year and stage of HIV disease

(All cases including those that died during each year)



STAGE OF HIV DISEASE	Year							
	1995	1996	1997	1998	1999	2000	2001	2002
Asymptomatic	260 (27.6%)	192 (18.9%)	228 (20.5%)	266 (21.8%)	337 (23.9%)	423 (25.9%)	606 (30.9%)	844 (34.7%)
Symptomatic	370 (39.3%)	498 (49.1%)	552 (49.6%)	610 (50.1%)	660 (46.8%)	715 (43.8%)	774 (39.4%)	848 (34.9%)
AIDS	198 (21.0%)	213 (21.0%)	278 (25.0%)	297 (24.4%)	376 (26.7%)	458 (28.1%)	534 (27.2%)	562 (23.1%)
AIDS Related Death*	98 (10.4%)	87 (8.6%)	43 (3.9%)	38 (3.1%)	37 (2.6%)	30 (1.8%)	30 (1.5%)	28 (1.2%)
Death Unrelated to AIDS							6 (0.3%)	8 (0.3%)
Unknown	15 (1.6%)	24 (2.4%)	12 (1.1%)	7 (0.6%)		6 (0.4%)	14 (0.7%)	139 (5.7%)
Total (100%)	**941**	**1014**	**1113**	**1218**	**1410**	**1632**	**1964**	**2429**

**Prior to 2001, no distinction was made been AIDS related deaths and deaths from other causes*

Figure 1.12 shows the number of people with HIV and AIDS who contacted statutory treatment centres in the North West of England. These data represent the most accurate and comprehensive source of information related to HIV and AIDS in the North West of England. The data collected by the North West HIV and AIDS Monitoring Unit, from across the region over the last eight years, illustrate the increasing number of people accessing HIV services. For the fourth year running, there has been a large increase (24%) in the number of HIV positive individuals attending treatment centres. The continuing increase in the size of the HIV positive population is partly due to the decrease in the number of people dying from AIDS related illnesses, but also due to an increasing number of new cases (which this year has increased by 37% on last year's total: see chapter 2). A full description of the epidemiology of HIV and AIDS in the North West is given in chapters 2 and 3 of this report.

The sexual health of the North West

There is particular concern about the sexual health of the North West population, where rates of sexually transmitted infections such as chlamydia, gonorrhoea and syphilis amongst males are the highest in England outside London[62]. The presence of sexually transmitted infections in the population not only serve as an indicator of sexual risk-taking behaviour, but also increase the probability of HIV transmission, probably by weakening the defences of the genital tract[63]. Of the recent outbreaks of syphilis in the UK, the outbreak in Manchester continues to be the largest. Between January 1999 and February 2003, there have been a total of 435 cases, with 220 of these being diagnosed during the year 2002[64]. Prior to the outbreak, only about seven cases would have been expected per year in Greater Manchester[65]. Most of the people who contracted syphilis in the Manchester outbreak have been homosexual men[12;66;67].

Asylum seekers and HIV

Globally, migrants are often at greater risk of HIV infection than are resident populations, irrespective of their country of origin[68]. During 2002 the UK received 85,865 asylum applications, 20% more than in 2001[69]. Although not all asylum seekers are from high HIV prevalent countries, 35% of all applications were from Africa in 2002, and Zimbabwe (a country with high prevalence of HIV) was the second most common nationality of asylum seekers[69]. Since April 2000 asylum seekers have been dispersed away from the traditional ports of entry and established screening systems for infectious diseases. Both statutory and voluntary sectors have responded with services aimed at asylum seekers and refugees, but this group nonetheless remains very vulnerable. As a consequence of the stigma and discrimination associated with HIV, refugees are often reluctant to test for HIV, reveal their status or access HIV care. Some asylum applicants have experienced difficulty accessing primary healthcare, despite being entitled to full registration and free healthcare[70].

Asylum seekers in the North West are principally located in Liverpool and Manchester. No precise figures exist for the numbers relocated into the region, or those arriving and applying for asylum in the area. There are an estimated 3,500 to 5,000 asylum seekers and refugees in Liverpool[71], and Manchester City Council estimates that there are currently 3,500 asylum seekers in Manchester alone, with a larger refugee and asylum seeker community of 10,000[72]. According to Home Office statistics, there are currently 11,250 new asylum applicants residing in the North West receiving support from the National Asylum Support Service[69]. For the second year, the North West HIV/AIDS Monitoring Unit has requested information about HIV positive individuals' asylum seeker status. Since last year, the number of such individuals has increased by 143%, from 63 to 153. Information about those known to be asylum seekers is presented in tables 3.25 and 3.26.

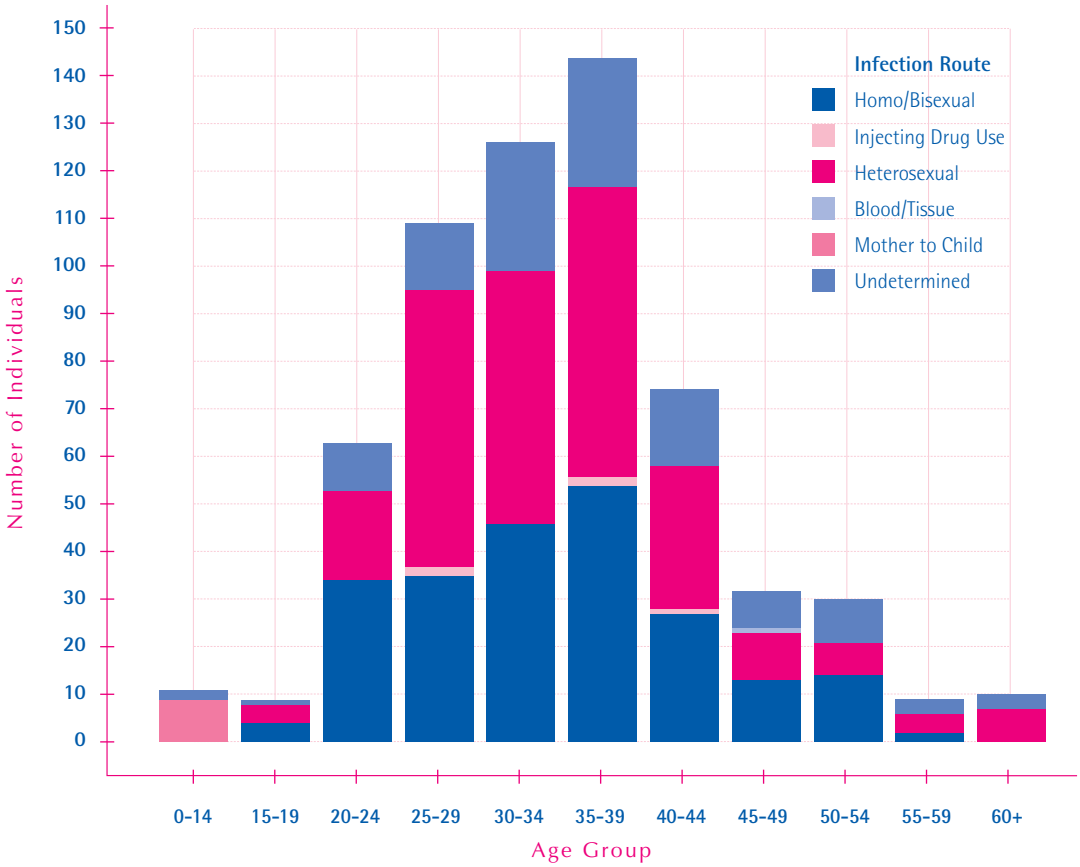
2. New Cases 2002

During 2002, 617 new HIV and AIDS cases presented to statutory treatment centres in the North West Region. New cases are defined as individuals seen in the North West Region in 2002 but not during the years 1995 to 2001 and include new HIV positive individuals who died during the year. The number of new cases has increased by 37% on the number of new cases reported in 2001 (449)[8]. This figure is higher than last year's increase of 34% and much higher than the year 2000's increase of 16%.

Data regarding newly reported cases of HIV infections assist in the identification of trends in incidence and represent the most up to date information on the characteristics of HIV infection and transmission. Such information is valuable not only for planning and evaluating the success of preventive activities, but also for predicting the future incidence of HIV and AIDS and its impact on treatment and care services in the North West of England. The aim of this chapter is to present information relating to new cases and, where appropriate, references are made to corresponding data from previous North West reports[3-8].

Analyses are given by strategic health authorities (SHAs) and primary care trusts (PCTs). PCTs have been allocated on the basis of postcode data, and reflect the boundaries provided by the North West Public Health Observatory as of December 2002. It is not possible to present all analyses by PCT; further PCT data are available from the North West Public Health Observatory website (http://www.nwpho.org.uk/hiv2002).

Figure 2.1: Age distribution of new HIV and AIDS cases by infection route of HIV, January-December 2002 (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)



AGE GROUP	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
0-14					9 (81.8%)	2 (18.2%)	11
15-19	4 (44.4%)		4 (44.4%)			1 (11.1%)	9
20-24	34 (54.0%)		19 (30.2%)			10 (15.9%)	63
25-29	35 (32.1%)	2 (1.8%)	58 (53.2%)			14 (12.8%)	109
30-34	46 (36.5%)		53 (42.1%)			27 (21.4%)	126
35-39	54 (37.5%)	2 (1.4%)	61 (42.4%)			27 (18.8%)	144
40-44	27 (36.5%)	1 (1.4%)	30 (40.5%)			16 (21.6%)	74
45-49	13 (40.6%)		10 (31.3%)	1 (3.1%)		8 (25%)	32
50-54	14 (46.7%)		7 (23.3%)			9 (30%)	30
55-59	2 (22.2%)		4 (44.4%)			3 (33.3%)	9
60+			7 (70%)			3 (30%)	10
Total	**229 (37.1%)**	**5 (0.8%)**	**253 (41%)**	**1 (0.2%)**	**9 (1.5%)**	**120 (19.4%)**	**617**

Age ranges refer to the age of individuals at end of December 2002, or at death. Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Figure 2.1 illustrates the age distribution and infection route of new HIV and AIDS cases presenting in the North West for treatment in 2002. A quarter of all reported cases in 2002 were seen for the first time during this year. The majority of newly reported cases fall between the ages of 25 and 39 (61%), with incidence being highest in those aged 35-39 years (23%). For the first time in the North West, exposure by heterosexual sex accounts for more new cases (41%) than does homosexual sex (37%). Thus the North West now follows the trend that has been apparent in England, Wales and Northern Ireland since 1999 (see chapter 1, figure 1.6). All the young people aged 15 to 24 years for whom route of exposure is known were infected with HIV during sex (either homosexual or heterosexual).

After a decline in recent years (from 8% in 1997 to 3% in 2001), the proportion of new HIV positive individuals infected through injecting drug has decreased further, to just 1% in 2002. During the year nine new cases of vertical transmission were reported from North West treatment centres. One new case was reported as being attributed to having received contaminated blood or tissue. The infection route for 120 new cases (19%) has not yet been determined. It is anticipated that the infection route for some of these new cases will be resolved in future years. The proportion undetermined for all cases is only 7% (chapter 3, table 3.1).

Table 2.1a: Residential distribution of new HIV and AIDS cases by stage of HIV disease, January-December 2002: strategic health authority (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

SHA OF RESIDENCE	Stage of HIV Disease					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
Cumbria and Lancashire	34 (35.4%)	33 (34.4%)	14 (14.6%)		15 (15.6%)	96
Cheshire and Merseyside	87 (70.2%)	27 (21.8%)	8 (6.5%)		2 (1.6%)	124
Greater Manchester	205 (57.3%)	78 (21.8%)	51 (14.2%)	5 (1.4%)	19 (5.3%)	358
Isle of Man	2 (100%)					2
London	3 (60%)	2 (40%)				5
Scotland		1 (100%)				1
South West		1 (100%)				1
Wales	4 (100%)					4
West Midlands	2 (50%)	1 (25%)	1 (25%)			4
Yorkshire and The Humber	1 (33.3%)	1 (33.3%)	1 (33.3%)			3
Unknown	13 (68.4%)	1 (5.3%)	2 (10.5%)		3 (15.8%)	19
Total	**351 (56.9%)**	**145 (23.5%)**	**77 (12.5%)**	**5 (0.8%)**	**39 (6.3%)**	**617**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category.

Table 2.1b: Residential distribution of new HIV and AIDS cases by stage of HIV disease, January-December 2002: Cumbria and Lancashire primary care trusts

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

PCT OF RESIDENCE	Stage of HIV Disease				Total (100%)
	Asymptomatic	Symptomatic	AIDS	Unknown	
Carlisle and District	3 (50%)	2 (33.3%)		1 (16.7%)	6
Eden Valley	1 (50%)		1 (50%)		2
West Cumbria	1 (100%)				1
Morecambe Bay			1 (100%)		1
Blackpool	5 (20%)	8 (32%)	2 (8%)	10 (40%)	25
Wyre	1 (14.3%)	2 (28.6%)	1 (14.3%)	3 (42.9%)	7
Preston	5 (38.5%)	4 (30.8%)	4 (30.8%)		13
Hyndburn and Ribble Valley	3 (50%)	2 (33.3%)	1 (16.7%)		6
Burnley, Pendle, Rossendale	4 (40%)	4 (40%)	2 (20%)		10
Blackburn with Darwen	6 (42.9%)	8 (57.1%)			14
Chorley and South Ribble	1 (20%)	2 (40%)	1 (20%)	1 (20%)	5
West Lancashire	4 (66.7%)	1 (16.7%)	1 (16.7%)		6
Total	**34 (35.4%)**	**33 (34.4%)**	**14 (14.6%)**	**15 (15.6%)**	**96**

Table 2.1c: Residential distribution of new HIV and AIDS cases by stage of HIV disease, January-December 2002: Cheshire and Merseyside primary care trusts

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

PCT OF RESIDENCE	Stage of HIV Disease				Total (100%)
	Asymptomatic	Symptomatic	AIDS	Unknown	
Southport and Formby	2 (50%)	1 (25%)	1 (25%)		4
South Sefton	2 (66.7%)	1 (33.3%)			3
North Liverpool	3 (100%)				3
Central Liverpool	30 (76.9%)	8 (20.5%)	1 (2.6%)		39
South Liverpool	13 (100%)				13
Knowsley	1 (33.3%)	2 (66.7%)			3
St Helens	5 (71.4%)	2 (28.6%)			7
Halton	1 (50%)	1 (50%)			2
Warrington	6 (100%)				6
Birkenhead and Wallasey	4 (40%)	4 (40%)	2 (20%)		10
Bebington and West Wirral		1 (100%)			1
Ellesmere Port and Neston	4 (80%)	1 (20%)			5
Cheshire West	7 (63.6%)	2 (18.2%)	2 (18.2%)		11
Central Cheshire	6 (54.5%)	3 (27.3%)		2 (18.2%)	11
Eastern Cheshire	3 (50%)	1 (16.7%)	2 (33.3%)		6
Total	**87 (70.2%)**	**27 (21.8%)**	**8 (6.5%)**	**2 (1.6%)**	**124**

Table 2.1d: Residential distribution of new HIV and AIDS cases by stage of HIV disease, January-December 2002: Greater Manchester primary care trusts

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

PCT OF RESIDENCE	Stage of Disease					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
Ashton, Leigh and Wigan	7 (70%)	2 (20%)	1 (10%)			10
Bolton	16 (57.1%)	8 (28.6%)	1 (3.6%)	3 (10.7%)		28
Bury	9 (64.3%)	3 (21.4%)	2 (14.3%)			14
Heywood and Middleton	4 (44.4%)	2 (22.2%)	2 (22.2%)		1 (11.1%)	9
Rochdale	4 (40%)	4 (40%)	2 (20%)			10
Salford	35 (57.4%)	13 (21.3%)	10 (16.4%)		3 (4.9%)	61
Trafford North	5 (71.4%)		1 (14.3%)		1 (14.3%)	7
Trafford South	2 (50%)	1 (25%)			1 (25%)	4
North Manchester	32 (46.4%)	18 (26.1%)	13 (18.8%)	1 (1.4%)	5 (7.2%)	69
Central Manchester	67 (69.8%)	12 (12.5%)	12 (12.5%)		5 (5.2%)	96
South Manchester	6 (42.9%)	6 (42.9%)	2 (14.3%)			14
Oldham	7 (58.3%)	2 (16.7%)	1 (8.3%)	1 (8.3%)	1 (8.3%)	12
Tameside and Glossop	6 (46.2%)	3 (23.1%)	2 (15.4%)		2 (15.4%)	13
Stockport	5 (45.5%)	4 (36.4%)	2 (18.2%)			11
Total	**205 (57.3%)**	**78 (21.8%)**	**51 (14.2%)**	**5 (1.4%)**	**19 (5.3%)**	**358**

Table 2.1a illustrates the clinical stage of HIV disease and of new HIV and AIDS cases presenting in the North West for treatment in 2002, broken down by strategic health authority of residence. The figures refer to the clinical condition of individuals when last seen in the year 2002; individuals who died from AIDS related illnesses are presented in a separate category to other AIDS cases.

HIV positive individuals categorised as asymptomatic continue to represent the largest proportion of new cases (57%), with the proportion in each category being comparable to the 2001 data. This maintains the observation that HIV positive individuals are contacting services at a relatively early stage of their HIV disease. Of the five new individuals who died during the year all had been first diagnosed as having had AIDS defining illnesses. This suggests that despite continuing media attention some individuals present too late to benefit from life-prolonging treatment.

Tables 2.1b, c and **d** present the breakdown of stage of disease by primary care trust within each of the three strategic health authorities (Cumbria and Lancashire, table 2.1b; Cheshire and Merseyside, table 2.1c; and Greater Manchester, table 2.1d). The widespread distribution of new HIV positive individuals demonstrates the importance of HIV prevention initiatives in every primary care trust.

Residents of Greater Manchester SHA accounted for over half (58%) of new HIV and AIDS cases presenting for treatment and care in the North West. However, at 70%, it was Cheshire and Merseyside SHA that saw the biggest increase on last years' figures, compared to a 46% increase in Greater Manchester SHA and only a 10% increase in Cumbria and Lancashire. The vast majority of new cases receiving care in the North West during 2002 were resident within the region (94%). Of the 20 individuals known to live outside the region, 25% were reported as residing in London.

Table 2.2a: Residential distribution of new HIV and AIDS cases by infection route of HIV, January-December 2002: strategic health authority

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

SHA OF RESIDENCE	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria and Lancashire	29 (30.2%)	3 (3.1%)	39 (40.6%)			25 (26%)	96
Merseyside and Cheshire	41 (33.1%)	2 (1.6%)	58 (46.8%)		1 (0.8%)	22 (17.7%)	124
Greater Manchester	145 (40.5%)		146 (40.8%)	1 (0.3%)	8 (2.2%)	58 (16.2%)	358
Isle of Man	1 (50%)		1 (50%)				2
London			1 (20%)			4 (80%)	5
Scotland						1 (100%)	1
South West	1 (100%)						1
Wales	3 (75%)		1 (25%)				4
West Midlands						4 (100%)	4
Yorkshire and The Humber	2 (66.7%)					1 (33.3%)	3
Unknown	7 (36.8%)		7 (36.8%)			5 (26.3%)	19
Total	**229 (37.1%)**	**5 (0.8%)**	**253 (41%)**	**1 (0.2%)**	**9 (1.5%)**	**120 (19.4%)**	**617**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category

Table 2.2b: Residential distribution of new HIV and AIDS cases by infection route of HIV, January-December 2002: Cumbria and Lancashire primary care trusts

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

PCT OF RESIDENCE	Infection Route				Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Undeter-mined	
Carlisle and District	3 (50%)	1 (16.7%)	2 (33.3%)		6
Eden Valley			2 (100%)		2
West Cumbria	1 (100%)				1
Morecambe Bay			1 (100%)		1
Blackpool	8 (32%)		2 (8%)	15 (60%)	25
Wyre	1 (14.3%)		2 (28.6%)	4 (57.1%)	7
Preston	6 (46.2%)		4 (30.8%)	3 (23.1%)	13
Hyndburn and Ribble Valley			6 (100%)		6
Burnley, Pendle and Rossendale	7 (70%)	1 (10%)	2 (20%)		10
Blackburn with Darwen	2 (14.3%)	1 (7.1%)	11 (78.6%)		14
Chorley and South Ribble			2 (40%)	3 (60%)	5
West Lancashire	1 (16.7%)		5 (83.3%)		6
Total	**29 (30.2%)**	**3 (3.1%)**	**39 (40.6%)**	**25 (26%)**	**96**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category

Table 2.2c: Residential distribution of new HIV and AIDS cases by infection route of HIV, January-December 2002: Cheshire and Merseyside primary care trusts

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

PCT OF RESIDENCE	Infection Route					Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Mother to Child	Undeter-mined	
Southport and Formby	1 (25%)		3 (75%)			4
South Sefton			1 (33.3%)		2 (66.7%)	3
North Liverpool	1 (33.3%)		2 (66.7%)			3
Central Liverpool	4 (10.3%)		28 (71.8%)	1 (2.6%)	6 (15.4%)	39
South Liverpool	1 (7.7%)		9 (69.2%)		3 (23.1%)	13
Knowsley	1 (33.3%)				2 (66.7%)	3
St Helens	4 (57.1%)		2 (28.6%)		1 (14.3%)	7
Halton			1 (50%)		1 (50%)	2
Warrington	4 (66.7%)		1 (16.7%)		1 (16.7%)	6
Birkenhead and Wallasey	4 (40%)		5 (50%)		1 (10%)	10
Bebington and West Wirral	1 (100%)					1
Ellesmere Port and Neston	3 (60%)		1 (20%)		1 (20%)	5
Cheshire West	6 (54.5%)	2 (18.2%)	2 (18.2%)		1 (9.1%)	11
Central Cheshire	8 (72.7%)		2 (18.2%)		1 (9.1%)	11
Eastern Cheshire	3 (50%)		1 (16.7%)		2 (33.3%)	6
Total	**41 (33.1%)**	**2 (1.6%)**	**58 (46.8%)**	**1 (0.8%)**	**22 (17.7%)**	**124**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 2.2d: Residential distribution of new HIV and AIDS cases by infection route of HIV, January-December 2002: Greater Manchester primary care trusts

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

PCT OF RESIDENCE	Infection Route					Total (100%)
	Homo/ Bisexual	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Ashton, Leigh and Wigan		7 (70%)		1 (10%)	2 (20%)	10
Bolton	3 (10.7%)	25 (89.3%)				28
Bury	8 (57.1%)	4 (28.6%)			2 (14.3%)	14
Heywood and Middleton	4 (44.4%)	4 (44.4%)			1 (11.1%)	9
Rochdale	3 (30%)	6 (60%)			1 (10%)	10
Salford	37 (60.7%)	14 (23%)			10 (16.4%)	61
Trafford North	5 (71.4%)	1 (14.3%)			1 (14.3%)	7
Trafford South	2 (50%)	1 (25%)			1 (25%)	4
North Manchester	28 (40.6%)	21 (30.4%)		2 (2.9%)	18 (26.1%)	69
Central Manchester	38 (39.6%)	44 (45.8%)		3 (3.1%)	11 (11.5%)	96
South Manchester	5 (35.7%)	7 (50%)			2 (14.3%)	14
Oldham	1 (8.3%)	6 (50%)			5 (41.7%)	12
Tameside and Glossop	4 (30.8%)	3 (23.1%)	1 (7.7%)	1 (7.7%)	4 (30.8%)	13
Stockport	7 (63.6%)	3 (27.3%)		1 (9.1%)		11
Total	**145 (40.5%)**	**146 (40.8%)**	**1 (0.3%)**	**8 (2.2%)**	**58 (16.2%)**	**358**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 2.2a shows the strategic health authority of residence and the route of transmission of new HIV and AIDS cases presenting in the North West for treatment in 2002. Although the infection route for 59% of all HIV positive individuals seen in 2002 was attributed to sex between men (chapter 3, table 3.1), this proportion was lower for new cases, where 37% were infected through homosexual/bisexual sex. Tables 2.2b, c and d show route of infection of new HIV and AIDS cases and the PCT of residence for each of the strategic health authorities. Manchester has a large gay community[73], and correspondingly, North Manchester and Central Manchester PCTs account for 31% of new cases exposed via homosexual sex who reside within the region.

The proportion of new cases exposed to HIV via heterosexual transmission (41%) represents a large increase when compared to previous years data (17% in 1997 and 38% in 2001) and is also higher than the 27% of all cases exposed via this route of infection (chapter 3, table 3.1). The proportion of heterosexually infected new cases is highest in Cheshire and Merseyside (47%).

Table 2.3: Residential distribution of total HIV and AIDS cases by age category, January-December 2002 (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

SHA OF RESIDENCE	Age Group											Total (100%)
	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	
Cumbria and Lancashire			9 (9.4%)	15 (15.6%)	17 (17.7%)	27 (28.1%)	10 (10.4%)	4 (4.2%)	9 (9.4%)	3 (3.1%)	2 (2.1%)	96
Cheshire and Merseyside	3 (2.4%)	5 (4%)	16 (12.9%)	20 (16.1%)	24 (19.4%)	27 (21.8%)	13 (10.5%)	8 (6.5%)	5 (4%)	2 (1.6%)	1 (0.8%)	124
Greater Manchester	8 (2.2%)	3 (0.8%)	35 (9.8%)	73 (20.4%)	74 (20.7%)	80 (22.3%)	45 (12.6%)	19 (5.3%)	14 (3.9%)	2 (0.6%)	5 (1.4%)	358
Isle of Man				1 (50%)		1 (50%)						2
London					2 (40%)	1 (20%)	1 (20%)			1 (20%)		5
Scotland											1 (100%)	1
South West						1 (100%)						1
Wales						1 (25%)	1 (25%)		1 (25%)	1 (25%)		4
West Midlands					1 (25%)	1 (25%)	1 (25%)	1 (25%)				4
Yorkshire and The Humber					2 (66.7%)		1 (33.3%)					3
Unknown		1 (5.3%)	3 (15.8%)		6 (31.6%)	5 (26.3%)	2 (10.5%)		1 (5.3%)		1 (5.3%)	19
Total	**11 (1.8%)**	**9 (1.5%)**	**63 (10.2%)**	**109 (17.7%)**	**126 (20.4%)**	**144 (23.3%)**	**74 (12%)**	**32 (5.2%)**	**30 (4.9%)**	**9 (1.5%)**	**10 (1.6%)**	**617**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. Age ranges refer to the age of individuals at end of December 2002, or at death. For a breakdown of age category by primary care trust, please see the North West Public Health Observatory website: http://www.nwpho.org.uk/hiv2002/table2-3.htm

Table 2.3 illustrates the residential distribution of all HIV and AIDS cases presenting in the North West for treatment in 2002, categorised by age group. Individuals aged 35-39 represent the largest group of new cases accessing treatment and care (23%). As would be expected, new cases tend to be younger (median age of 34 years, with 90% aged between 21 and 53 years) than the age distribution of all cases (median age 38 years, 90% aged between 24 and 56 years). Thus, individuals under the age of 25 represent a larger proportion of new cases (13%) than all cases (6%: chapter 3, table 3.6), demonstrating the continuing need to encourage young people at risk of HIV exposure to access services. Individuals aged 50 years or older represent 8% of all new cases seen during 2002, the same proportion as in 2001.

Table 2.4: Residential distribution of new HIV and AIDS cases by sex, January-December 2002

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

SHA OF RESIDENCE	Sex		Total (100%)
	Male	Female	
Cumbria and Lancashire	70 (72.9%)	26 (27.1%)	96
Merseyside and Cheshire	88 (71%)	36 (29%)	124
Greater Manchester	253 (70.7%)	105 (29.3%)	358
Isle of Man	1 (50%)	1 (50%)	2
London	4 (80%)	1 (20%)	5
Scotland	1 (100%)		1
South West	1 (100%)		1
Wales	4 (100%)		4
West Midlands	4 (100%)		4
Yorkshire and The Humber	3 (100%)		3
Unknown	16 (84.2%)	3 (15.8%)	19
Total	**445 (72.1%)**	**172 (27.9%)**	**617**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category.
For a breakdown of sex by primary care trust, please see the North West Public Health Observatory website:
http://www.nwpho.org.uk/hiv2002/table2-4.htm

Table 2.4 illustrates the residential distribution of new HIV and AIDS cases presenting in the North West for treatment in 2002, categorised by sex. As in previous years, the majority of new cases in 2002 were men (72%). This is largely due to the relatively high proportion of homo/bisexual sex as a method of exposure to HIV. Although more men were newly infected in 2002 (445 individuals) compared to 2001 (344 individuals), the proportion of individuals who are male has decreased from 77% reflecting the increasing numbers of new cases who are heterosexually infected. The breakdown by sex is similar across the three SHAs.

The number of female new cases has tripled from 57 in 2000 to 172 in 2002, and the proportion of new HIV cases that are female has increased from 17% to 28% in the same time period. This may have a knock-on effect on the number of mother to child infections, especially in ethnic minority communities, since 62% of females are self-defined as being from an ethnic minority (table 2.8).

Table 2.5: Infection route of new HIV and AIDS cases by sex, January-December 2002

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

SEX	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Male	229 (51.5%)	3 (0.7%)	102 (22.9%)		2 (0.4%)	109 (24.5%)	445
Female		2 (1.2%)	151 (87.8%)	1 (0.6%)	7 (4.1%)	11 (6.4%)	172
Total	**229 (37.1%)**	**5 (0.8%)**	**253 (41%)**	**1 (0.2%)**	**9 (1.5%)**	**120 (19.4%)**	**617**

Men who have had homo/bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 2.5 illustrates the route of transmission of new HIV and AIDS cases presenting in the North West Region for treatment in 2002, categorised by sex. This year, for the first time, heterosexual sex has overtaken homosexual sex as the predominant mode of HIV exposure. The proportion of individuals infected by sex between men has declined by 27% from 51% in 2001 to 37% in 2002, while the proportion of heterosexually acquired HIV has increased by 8% (from 38% in 2001 to 41% in 2002). The predominant method of exposure to HIV amongst women continues to be heterosexual sex (88%). Of those HIV positive individuals whose route of infection has been identified, 51% of new cases presenting in the North West had their infection attributed to heterosexual sex. This compares to 29% of all cases seen during 2002 (chapter 3, table 3.5) and 40% of new cases seen during 2001, reflecting the growing issue of heterosexual transmission of HIV in the North West and in the United Kingdom as a whole (chapter 1, figure 1.6). Five new cases were identified as having been infected via injecting drug use, (three men and two women), this represents a decrease on last years' figure.[13]

Table 2.6: Residential distribution of new HIV and AIDS cases by ethnic group, January-December 2002

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

SHA OF RESIDENCE	Ethnicity								Total (100%)
	White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Cumbria and Lancashire	66 (68.8%)		14 (14.6%)			1 (1%)	1 (1%)	14 (14.6%)	96
Merseyside and Cheshire	75 (60.5%)	1 (0.8%)	35 (28.2%)		1 (0.8%)	3 (2.4%)	2 (1.6%)	7 (5.6%)	124
Greater Manchester	138 (38.5%)	3 (0.8%)	123 (34.4%)	1 (0.3%)	6 (1.7%)	4 (1.1%)	4 (1.1%)	79 (22.1%)	358
Isle of Man	1 (50%)		1 (50%)						2
London	1 (20%)		1 (20%)					3 (60%)	5
Scotland	1 (100%)								1
South West	1 (100%)								1
Wales	4 (100%)								4
West Midlands								4 (100%)	4
Yorkshire and The Humber								3 (100%)	3
Unknown	13 (68.4%)	2 (10.5%)	1 (5.3%)					3 (15.8%)	19
Total	**300 (48.6%)**	**6 (1%)**	**175 (28.4%)**	**1 (0.2%)**	**7 (1.1%)**	**8 (1.3%)**	**7 (1.1%)**	**113 (18.3%)**	**617**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of ethnicity by primary care trust, please see the North West Public Health Observatory website: http://www.nwpho.org.uk/hiv2002/table2-6.htm

Table 2.6 illustrates the residential distribution of new HIV and AIDS cases presenting in the North West for treatment in 2002, categorised by ethnic group. Ethnic group classifications are adapted from the 1991 Census Questionnaire and are those used by the Health Protection Agency AIDS and STD Centre, for the Survey Of Prevalent Diagnosed HIV Infections (SOPHID).

The majority of new cases in 2002 whose ethnicity was known were self-defined as white (60%), a lower figure than the corresponding data for all cases (80%) (chapter 3, table 3.7). Of those HIV positive individuals whose ethnicity was known, 40% are self-defined as being from an ethnic minority, compared to 29% in 2001. This indicates a substantial over representation of new HIV cases within black and minority ethnic communities, when compared to their overall proportion within the North West population (5.2%)[74]. Thus, the incidence of diagnosed HIV is over ten times higher in black and minority ethnic groups than in the white population in the North West. However, there are substantial differences across the North West in terms of the proportion of new HIV cases that are from black and minority ethnic populations, ranging from 20% in Cumbria and Lancashire (up from 16% last year) to 51% in Greater Manchester (up from 36% last year). The proportion of new cases who are from black and minority ethnic communities (40%) is higher than the 20% identified within all cases, in particular those self-defined as black African (35% for new cases, 15% for all cases) (chapter 3, table 3.7). This illustrates the change in the ethnic distribution of HIV and AIDS cases and the need for specialist services such as The Black Health Agency (BHA) and specialist projects within the voluntary sector to provide care and support for communities which have already been identified as having shorter life expectancies, together with poorer physical and mental health[75].

Table 2.7: Ethnic distribution of new HIV and AIDS cases by infection route of HIV, January-December 2002

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

ETHNICITY	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
White	184 (61.3%)	5 (1.7%)	68 (22.7%)		1 (0.3%)	42 (14%)	300
Black Caribbean	3 (50%)		3 (50%)				6
Black African	11 (6.3%)		149 (85.1%)	1 (0.6%)	7 (4%)	7 (4%)	175
Black (other)			1 (100%)				1
Indian/Pakistani/Bangladeshi	2 (28.6%)		5 (71.4%)				7
Other Asian/Oriental	2 (25%)		4 (50%)			2 (25%)	8
Other/mixed	5 (71.4%)		1 (14.3%)			1 (14.3%)	7
Unknown	22 (19.5%)		22 (19.5%)		1 (0.9%)	68 (60.2%)	113
Total	**229 (37.1%)**	**5 (0.8%)**	**253 (41%)**	**1 (0.2%)**	**9 (1.5%)**	**120 (19.4%)**	**617**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 2.7 illustrates the ethnic group and HIV exposure category of new HIV and AIDS cases presenting in the North West for treatment in 2002. Whilst heterosexual sex accounts for the largest number of new cases over all, there are differences between ethnic groups. Of the 204 individuals self-classified as being from a black or ethnic minority group, most (80%) were infected heterosexually while only 11% were infected by sex between men. In contrast, amongst white individuals, most (61%) were infected by sex between men, with only 23% infected heterosexually. Of the nine children infected by mother to child transmission, seven were from the black African community. A decisive factor influencing the dissimilar distribution of infection route across ethnicity of new cases of HIV and AIDS may be the role of exposure abroad (table 2.10).

Table 2.8: Ethnic distribution of new HIV and AIDS cases by sex, January-December 2002 (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

SEX	Ethnicity								Total
	White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Male	259 (86.3%)	4 (66.7%)	78 (44.6%)		5 (71.4%)	4 (50%)	7 (100%)	88 (77.9%)	445 (72.1%)
Female	41 (13.7%)	2 (33.3%)	97 (55.4%)	1 (100%)	2 (28.6%)	4 (50%)		25 (22.1%)	172 (27.9%)
Total (100%)	**300**	**6**	**175**	**1**	**7**	**8**	**7**	**113**	**617**

Table 2.8 illustrates the ethnic group and sex of new HIV and AIDS cases presenting in the North West for treatment in 2002. As in previous years the majority of new HIV and AIDS cases are male (72%) with 58% of these being self-defined as white, down from 82% last year. The majority of women seen in the region for the first time in 2002 are self-defined as being from an ethnic minority (63%). Black Africans account for 66% of all female new cases for whom ethnicity is known. Whilst in the white population the gender distribution is highly biased towards males (86%), 52% of the new black and minority ethnic cases are female. This is predominately due to the lower proportion of homosexual exposure in black and minority ethnic groups and higher levels of heterosexual exposure to HIV (table 2.7).

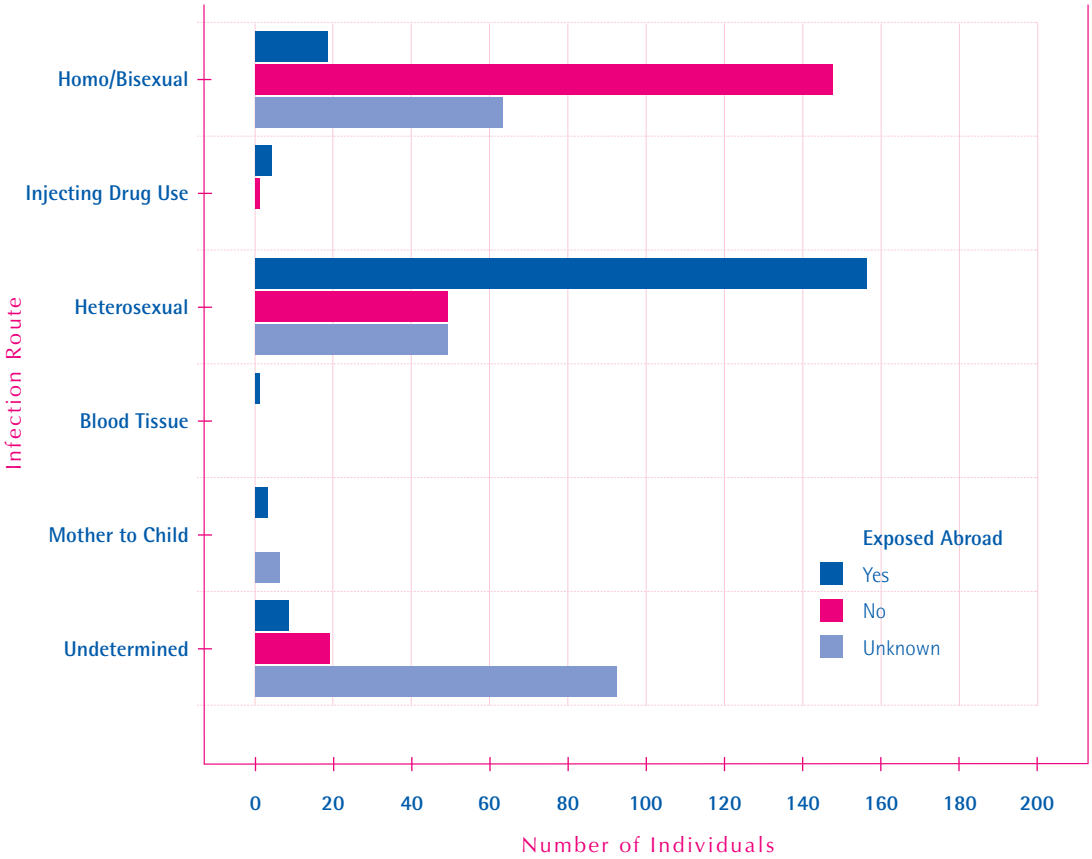
Table 2.9: Ethnic distribution of new HIV and AIDS cases by clinical stage of HIV disease January-December 2002 (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

ETHNICITY	Stage of HIV Disease					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
White	186 (62%)	71 (23.7%)	30 (10%)	2 (0.7%)	11 (3.7%)	300
Black Caribbean	5 (83.3%)	1 (16.7%)				6
Black African	106 (60.6%)	32 (18.3%)	30 (17.1%)		7 (4%)	175
Black (other)		1 (100%)				1
Indian/Pakistani/Bangladeshi	4 (57.1%)	1 (14.3%)		2 (28.6%)		7
Other Asian/Oriental	5 (62.5%)	2 (25%)	1 (12.5%)			8
Other/mixed	6 (85.7%)	1 (14.3%)				7
Unknown	39 (34.5%)	36 (31.9%)	16 (14.2%)	1 (0.9%)	21 (18.6%)	113
Total	**351 (56.9%)**	**145 (23.5%)**	**77 (12.5%)**	**5 (0.8%)**	**39 (6.3%)**	**617**

Table 2.9 illustrates the ethnic group and clinical stage of new HIV and AIDS cases presenting in the North West for treatment in 2002. The figures refer to the clinical condition of individuals when last seen in the year 2002; individuals who died from AIDS related illnesses are presented in a separate category to other AIDS cases.

Overall, 57% of new HIV and AIDS cases presented while still asymptomatic, 13% were categorised as AIDS and 1% died during the year. In previous years we reported considerable differences among ethnic groups. However, this year, when considering those whose stage of disease was known, individuals from black and minority ethnic groups were just as likely to present while still asymptomatic (64%) as were white individuals (64%) and no more likely to be symptomatic (19% compared to 25% of white individuals), to have AIDS (15% compared to 10%) or die (1% for both white and non-white). This contrasts with last year, when 28% of new cases from black and minority ethnic communities presented already with an AIDS defining illness, while only 17% of white new cases presented at this stage. This suggests that those from black and minority ethnic groups are becoming more likely to access care at an early stage of their disease, and hopefully prolong their life expectancy.

Figure 2.2: The role of contact abroad in exposure to HIV of new HIV and AIDS cases by infection route, January-December 2002 (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

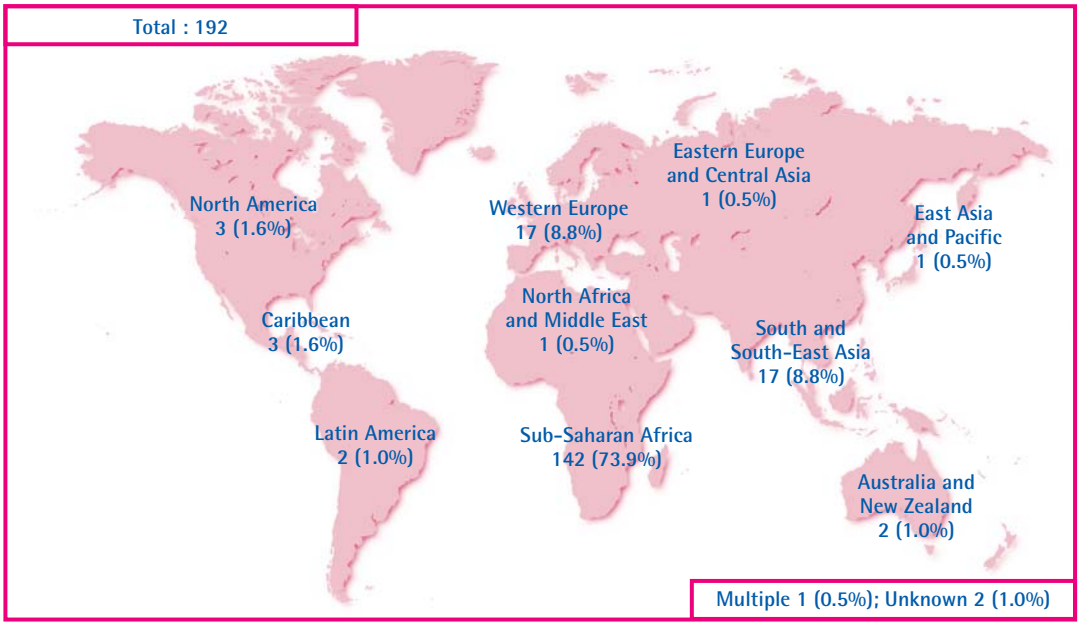


EXPOSED ABROAD	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Yes	19 (9.9%)	4 (2.1%)	157 (81.8%)	1 (0.5%)	3 (1.6%)	8 (4.2%)	192
No	147 (68.4%)	1 (0.5%)	48 (22.3%)			19 (8.8%)	215
Unknown	63 (30%)		48 (22.9%)		6 (2.9%)	93 (44.3%)	210
Total	**229 (37.1%)**	**5 (0.8%)**	**253 (41%)**	**1 (0.2%)**	**9 (1.5%)**	**120 (19.4%)**	**617**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

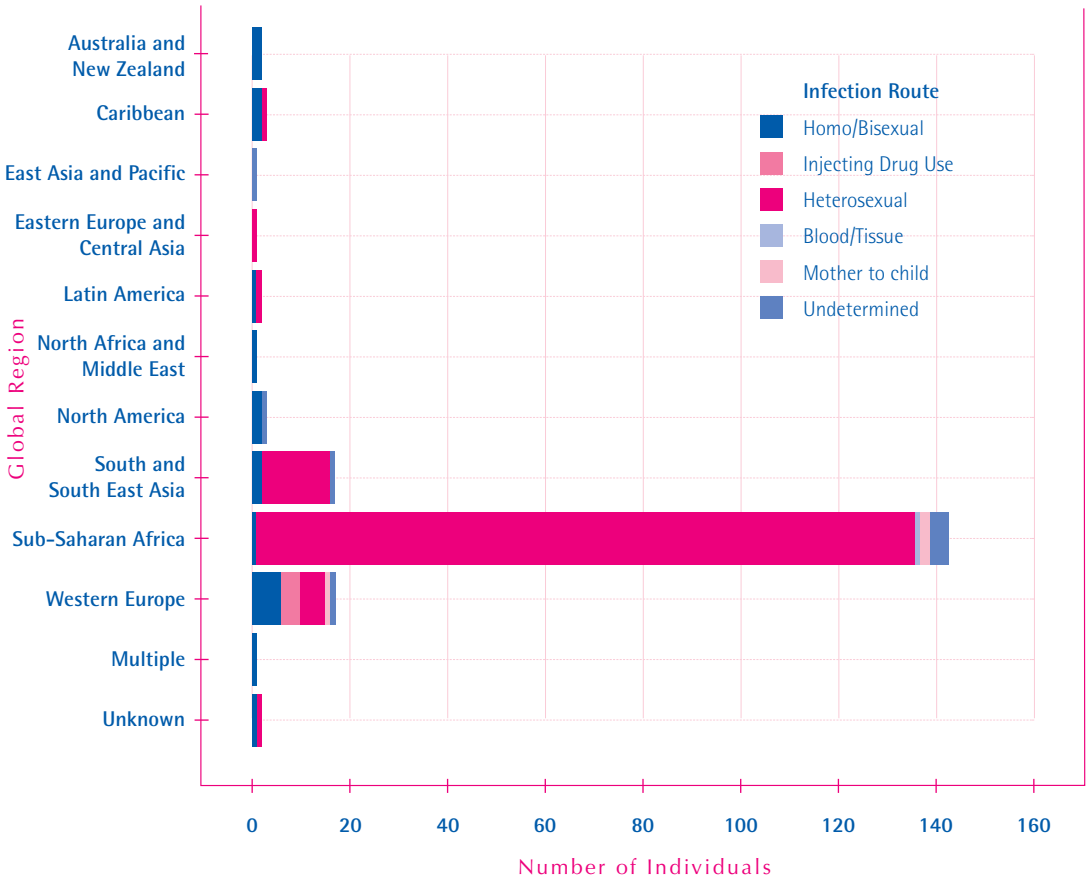
Figure 2.2 illustrates route of infection of new cases and whether or not exposure to HIV occurred abroad. Thirty one percent of all new cases of HIV and AIDS were reported to have been contracted outside the UK. As in previous years heterosexual sex continues to be the major method of exposure to HIV in those infected abroad with over three quarters of those individuals infected via this route. Of those infected abroad, the proportion who were infected via homosexual sex has decreased in 2002 to 10%, from 14% in 2001. For those new individuals reported to have been infected with HIV in the UK, sex between men is the predominant mode of exposure (68%).

Figure 2.3: Global region and country of new HIV and AIDS cases who probably acquired their infection outside the UK, January-December 2002 (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)



Sub-Saharan Africa	**142 (73.9%)**	Tanzania	2 (1%)	Greece	1 (0.5%)
Angola	1 (0.5%)	Uganda	2 (1%)	Italy	5 (2.6%)
Botswana	4 (2.1%)	Zambia	4 (2.1%)	Netherlands	1 (0.5%)
Burundi	2 (1%)	Zimbabwe	86 (44.8%)	Portugal	5 (2.6%)
Cameroon	1 (0.5%)	Unknown	6 (3.1%)	Spain	1 (0.5%)
Congo	5 (2.6%)	**East Asia and the Pacific**	**1 (0.5%)**	**North Africa and Middle East**	**1 (0.5%)**
Dem. Republic of Congo	2 (1%)	China	1 (0.5%)	Egypt	1 (0.5%)
Gambia	2 (1%)	**Australia and New Zealand**	**2 (1%)**	**North America**	**3 (1.6%)**
Ghana	1 (0.5%)	Australia	2 (1%)	Canada	1 (0.5%)
Kenya	1 (0.5%)	**South and South East Asia**	**17 (8.8%)**	United States of America	2 (1%)
Liberia	1 (0.5%)	India	2 (1%)	**Caribbean**	**3 (1.6%)**
Malawi	5 (2.6%)	Pakistan	1 (0.5%)	Jamaica	3 (1.6%)
Namibia	1 (0.5%)	Philippines	1 (0.5%)	**Latin America**	**2 (1%)**
Nigeria	5 (2.6%)	Thailand	13 (6.8%)	Brazil	1 (0.5%)
Rwanda	3 (1.6%)	**Eastern Europe and Central Asia**	**1 (0.5%)**	Guyana	1 (0.5%)
Sierra Leone	1 (0.5%)	Russian Federation	1 (0.5%)	**Multiple**	**1 (0.5%)**
Somalia	2 (1%)	**Western Europe**	**17 (8.8%)**	**Unknown**	**2 (1%)**
South Africa	5 (2.6%)	Germany	4 (2.1%)	**Total**	**192 (100%)**

Figure 2.4: Global region and infection route of HIV of new cases who probably acquired their infection outside the UK, January-December 2002 (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)



GLOBAL REGION	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Australia and New Zealand	2 (100%)						2
Caribbean	2 (66.7%)		1 (33.3%)				3
East Asia and Pacific						1 (100%)	1
Eastern Europe and Central Asia			1 (100%)				1
Latin America	1 (50%)		1 (50%)				2
North Africa and Middle East	1 (100%)						1
North America	2 (66.7%)					1 (33.3%)	3
South and South-East Asia	2 (11.8%)		14 (82.4%)			1 (5.9%)	17
Sub-Saharan Africa	1 (0.7%)		134 (94.4%)	1 (0.7%)	2 (1.4%)	4 (2.8%)	142
Western Europe	6 (35.3%)	4 (23.5%)	5 (29.4%)		1 (5.9%)	1 (5.9%)	17
Multiple	1 (100%)						1
Unknown	1 (50%)		1 (50%)				2
Total	**19 (9.9%)**	**4 (2.1%)**	**157 (81.8%)**	**1 (0.5%)**	**3 (1.6%)**	**8 (4.2%)**	**192**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Figure 2.3 shows the global region and country of HIV transmission for new cases acquired outside the UK presenting in the North West for treatment in 2002. Almost three quarters of all HIV infections contracted abroad were acquired in sub-Saharan Africa, with a further 9% in each of South and South East Asia and Western Europe.

Of the 192 new cases who probably acquired their infection abroad, the country of probable exposure is available for 183 individuals (95%). This year, individuals reported to have been infected in Zimbabwe dominate the statistics, accounting for 45% of all infections thought to have been acquired abroad (86 individuals). Last year, the equivalent figure was 16% (26 individuals). This increase is likely to be related to both the high prevalence of HIV in Zimbabwe and the current political situation in that country. Although fewer infections occurred in the other sub-Saharan African countries compared to previous years, exposure continues to be spread across 21 different countries, illustrating the impact of the current epidemic in Africa[13] and its influence on the situation in the UK. Thailand accounts for the second highest number of infections attributed to a single country (13 individuals). Infections acquired in Western Europe were most likely to be from between Germany, Italy or Portugal.

Figure 2.4 shows the global region of HIV transmission by infection route of HIV for new HIV and AIDS cases acquired outside the UK who presented in the North West for treatment in 2002. The vast majority (85%) of individuals with heterosexually acquired HIV whose infections were probably contracted abroad were acquired in sub-Saharan Africa, with a further 9% contracted in South and South East Asia. Heterosexually acquired HIV in sub-Saharan Africa accounts for 53% of all new cases attributed to this mode of infection (table 2.2a). Heterosexual exposure in sub-Saharan Africa is spread across 21 different countries, reflecting the extent of the epidemic in that continent[13].

Western Europe accounted for the largest number of new cases acquired via homosexual sex (32%). This could reflect the reported tendency of gay men to take risks while on holiday[76]. Four out of the five new cases that were infected by injecting drug use were thought to be infected abroad, and all of these were in Western Europe (Portugal and Italy). The predominant mode of HIV transmission in many European countries is injecting drug use[13;36;77]. Although the risk of contracting HIV is relatively low in the UK due to the low prevalence of HIV among this group (chapter 1 figure 1.10) sharing injecting equipment abroad remains a significant risk.

Table 2.10: The role of contact abroad in exposure to HIV of new HIV and AIDS cases by ethnicity, January-December 2002

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

HIV EXPOSURE ABROAD	Ethnicity								Total
	White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Yes	35 (11.7%)	3 (50%)	138 (78.9%)	1 (100%)	4 (57.1%)	4 (50%)	4 (57.1%)	3 (2.7%)	192 (31.1%)
No	192 (64%)	1 (16.7%)	13 (7.4%)		2 (28.6%)		1 (14.3%)	6 (5.3%)	215 (34.8%)
Unknown	73 (24.3%)	2 (33.3%)	24 (13.7%)		1 (14.3%)	4 (50%)	2 (28.6%)	104 (92%)	210 (34%)
Total (100%)	**300**	**6**	**175**	**1**	**7**	**8**	**7**	**113**	**617**

Table 2.10 shows exposure to HIV abroad by ethnic group of new HIV and AIDS cases who presented in the North West for treatment in 2002. Of those self-defined as white, 12% were reported as having probably been infected with HIV whilst abroad. This is not the case for those from black and ethnic communities where 75% are reported as being exposed to HIV whilst abroad, with this figure rising to 79% amongst individuals self-defined as black African. The role of contact abroad to HIV has not been identified in 24% of white HIV positive individuals accessing treatment in 2002, compared to 16% for black and ethnic minorities. Although this may represent individuals where the significance of potential exposure abroad is ambiguous, it may also reflect a reluctance to ascertain whether white HIV positive individuals had been exposed to HIV abroad and to presume ethnic minorities have been infected outside the UK[78].

Table 2.11: Stage of HIV disease of new HIV and AIDS cases by level of antiretrovival therapy, January-December 2002

(New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

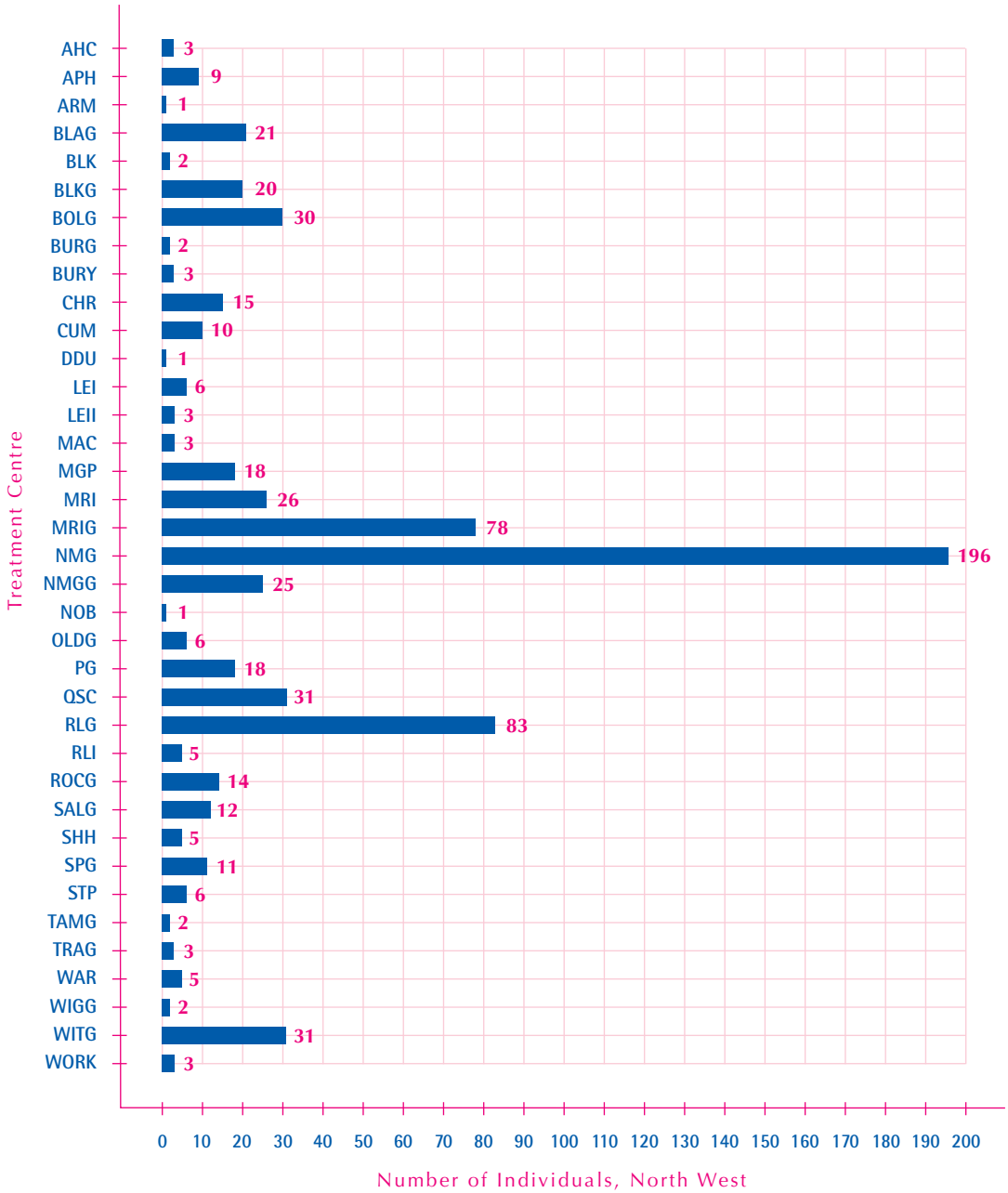
STAGE OF HIV DISEASE	Level of Antiretroviral Therapy					Total (100%)
	No ART	Mono Therapy	Dual Therapy	Triple Therapy	Quad (or more) Therapy	
Asymptomatic	255 (75.9%)	2 (0.6%)	2 (0.6%)	72 (21.4%)	5 (1.5%)	336
Symptomatic	48 (36.6%)			72 (55%)	11 (8.4%)	131
AIDS	22 (31%)		1 (1.4%)	45 (63.4%)	3 (4.2%)	71
AIDS related death	5 (100%)					5
Unknown	49 (66.2%)			19 (25.7%)	6 (8.1%)	74
Total	**379 (61.4%)**	**2 (0.3%)**	**3 (0.5%)**	**208 (33.7%)**	**25 (4.1%)**	**617**

Table 2.11 refers to the clinical condition of individuals when last seen in the year 2002; individuals who died from AIDS related illnesses are presented in a separate category to other AIDS cases. Individuals are categorised by the highest level of combination therapy they received from any treatment centre in the North West during 2002.

As illustrated, 38% of new HIV and AIDS cases presenting in the North West received triple or more combination therapy when last seen during 2002. The number of new individuals receiving quadruple or more therapy has increased from 14 (3%) in 2001 to 25 (4%) in 2002. While antiretroviral therapy was not prescribed for 61% of new cases, less than 1% of new cases were prescribed mono or dual therapy. This low level of mono and dual therapy is consistent with the current British HIV Association (BHIVA) guidelines on the treatment of HIV disease, which recommends the use of a triple or more regime[79].

The majority (68%) of new cases categorised as AIDS received triple or more combination therapy, while 63% of those classed as symptomatic received this level of therapy. The data also illustrate that 76% of new cases categorised as asymptomatic were not receiving any antiretroviral therapy at the end of 2002. The latest BHIVA guidelines advocate the initiation of therapy in the following circumstances: immediately, if HIV infection is detected within first six months of seroconversion; if the CD4 count is falling rapidly; when the CD4 count falls below 200; or in the event of HIV related symptoms[78]. There are, therefore, implications for a continued increase in demand and supply of combination antiretroviral therapy.

Figure 2.5: Distribution of new HIV and AIDS cases by treatment centre, January-December 2002 (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)



For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report.

Figure 2.5 illustrates the distribution of new HIV and AIDS cases between treatment centres located in the North West. The treatment centre with the largest number of new cases in 2002 was the Infectious Disease Unit at North Manchester General Hospital (NMG), with 28% of new cases. As in previous years, large numbers of new cases were also seen at Manchester Royal Infirmary Department of Genito-Urinary Medicine (MRIG) and Royal Liverpool University Hospital Department of Genito-Urinary Medicine (RLG). Whilst these larger centres report substantial increases on last year's figures (NMG: 31%, MRIG: 59%, RLG: 69%), several smaller treatment centres have seen substantial increases in the number of new cases seen in 2002 compared to 2001, notably the Blackburn Royal Infirmary GUM (BLKG) (from one to 20) and the GUM at the Countess of Chester Hospital (CHR) has seen over twice as many new patients (from seven to 15).

Although the larger hospitals reported the most new cases it is the smaller ones that have the higher proportion of all new cases relative to their total case load. (For example, Royal Albert Edward Infirmary GUM 67%, Warrington Hospital GUM 56%, St Helen's General Hospital GUM 56%; see chapter 3, table 3.15). This illustrates the importance these smaller treatment centres have in attracting individuals who think they have contracted HIV or other sexually transmitted diseases.

Figure 2.6: Population prevalence of new HIV and AIDS cases by primary care trust, January-December 2002 (New cases are defined as individuals seen in the North West Region in 2002 but not between 1995 and 2001 and include new cases who died during the year)

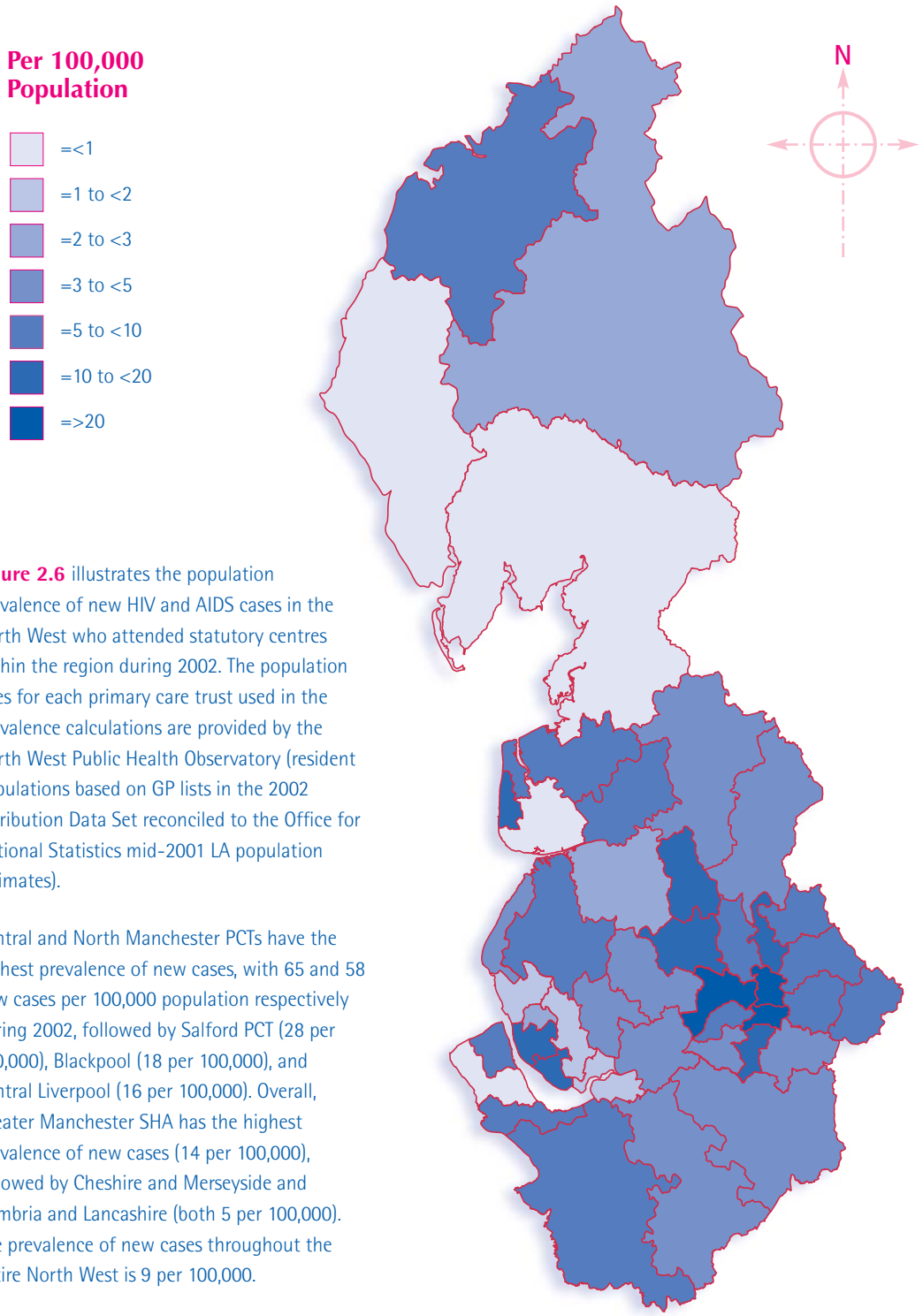


Figure 2.6 illustrates the population prevalence of new HIV and AIDS cases in the North West who attended statutory centres within the region during 2002. The population sizes for each primary care trust used in the prevalence calculations are provided by the North West Public Health Observatory (resident populations based on GP lists in the 2002 Attribution Data Set reconciled to the Office for National Statistics mid-2001 LA population estimates).

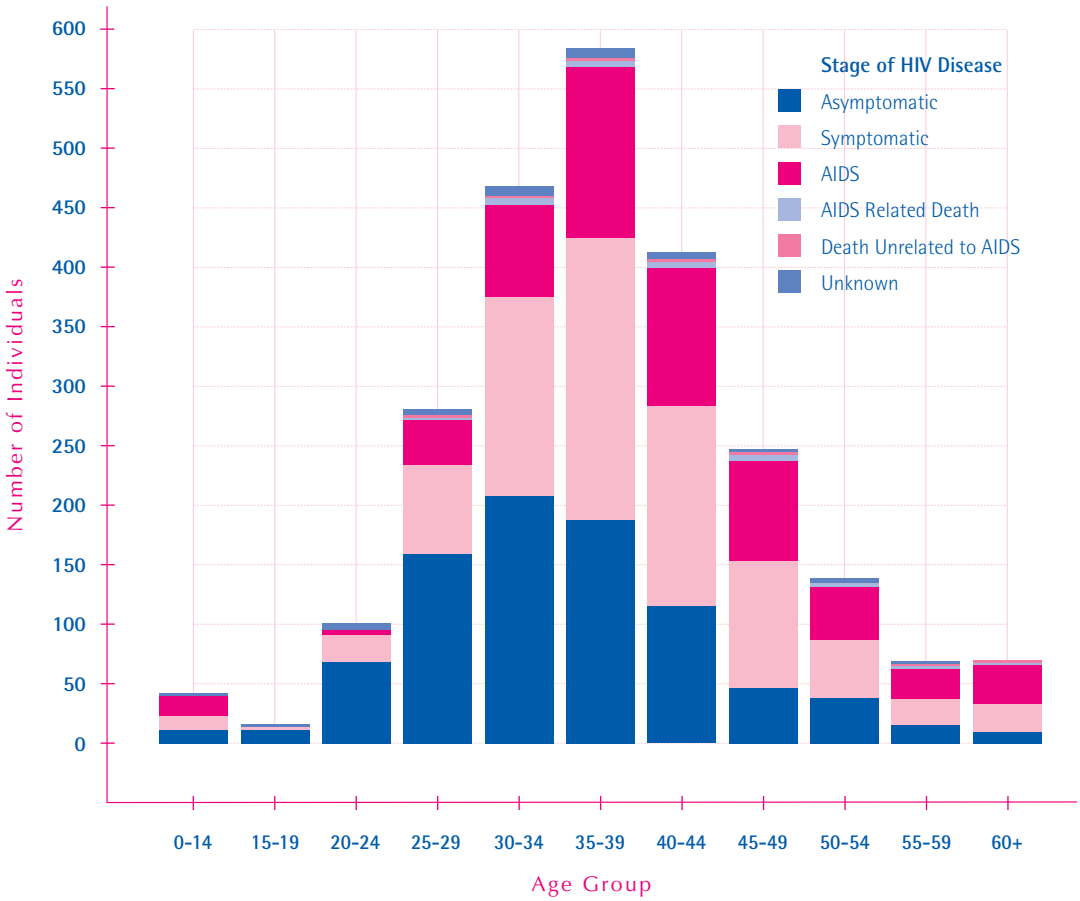
Central and North Manchester PCTs have the highest prevalence of new cases, with 65 and 58 new cases per 100,000 population respectively during 2002, followed by Salford PCT (28 per 100,000), Blackpool (18 per 100,000), and Central Liverpool (16 per 100,000). Overall, Greater Manchester SHA has the highest prevalence of new cases (14 per 100,000), followed by Cheshire and Merseyside and Cumbria and Lancashire (both 5 per 100,000). The prevalence of new cases throughout the entire North West is 9 per 100,000.

3. All Cases 2002

During 2002, a total of 2,429 individuals living with HIV or AIDS accessed treatment and care from statutory treatment centres in the North West, representing a 24% increase in the size of the HIV positive population (from 1,964 individuals in 2001). This is the largest increase since regional monitoring of HIV began in 1995, compared to last year's increase of 18% and the two previous years of 16%, and is in line with national predictions[80]. The size of the population has doubled in the last five years, and is two and a half times the size of that when regional monitoring began (see chapter 1, figure 1.12). The aim of this chapter is to provide information on the demographics and characteristics of these 2,429 individuals and, where appropriate, references are made to corresponding data from previous North West reports[3-8].

Analyses are given by strategic health authorities (SHAs) and primary care trusts (PCTs). PCTs have been allocated on the basis of postcode data, and reflect the boundaries provided by the North West Public Health Observatory as of December 2002. It is not possible to present all analyses by PCT; further PCT data are available from the North West Public Health Observatory website (http://www.nwpho.org.uk/hiv2002).

Figure 3.1: Age distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2002 (All cases seen during 2002 including those who died during the year)



AGE GROUP	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
0-14	12 (29.3%)	12 (29.3%)	16 (39%)			1 (2.4%)	41
15-19	12 (80%)	2 (13.3%)				1 (6.7%)	15
20-24	69 (68.3%)	22 (21.8%)	5 (5%)			5 (5%)	101
25-29	159 (56.6%)	75 (26.7%)	38 (13.5%)	2 (0.7%)	1 (0.4%)	6 (2.1%)	281
30-34	207 (44.1%)	166 (35.4%)	80 (17.1%)	5 (1.1%)	1 (0.2%)	10 (2.1%)	469
35-39	189 (32.3%)	236 (40.3%)	144 (24.6%)	5 (0.9%)	1 (0.2%)	10 (1.7%)	585
40-44	116 (28.1%)	168 (40.7%)	116 (28.1%)	5 (1.2%)	2 (0.5%)	6 (1.5%)	413
45-49	47 (19.1%)	107 (43.5%)	85 (34.6%)	5 (2%)	1 (0.4%)	1 (0.4%)	246
50-54	37 (26.6%)	49 (35.3%)	47 (33.8%)	3 (2.2%)		3 (2.2%)	139
55-59	16 (23.2%)	23 (33.3%)	26 (37.7%)	2 (2.9%)	1 (1.4%)	1 (1.4%)	69
60+	10 (14.3%)	25 (35.7%)	33 (47.1%)	1 (1.4%)	1 (1.4%)		70
Total	**874 (36%)**	**885 (36.4%)**	**590 (24.3%)**	**28 (1.2%)**	**8 (0.3%)**	**44 (1.8%)**	**2429**

Age ranges refer to the age of individuals at end of December 2002, or at death.

Figure 3.1 shows a breakdown of the age and clinical stage of disease of HIV positive individuals attending for treatment and care in 2002. The figures refer to the clinical condition of individuals when last seen in 2002; individuals who died are presented in separate categories. The age distribution remained concentrated in the 30-44 year age range, accounting for more than half of all cases (60%) and, as would be expected, shows little deviation from previous years. The entire population of HIV positive individuals in treatment was older (median age of 38 years, with 90% aged between 24 and 56 years) than the cases that were new to treatment in 2002 (median age of 34 years, with 90% aged between 21 and 53 years). New cases were more likely to be under 25 years (13%, see chapter 2, figure 2.1) when compared to all cases (6%).

The proportion of HIV positive people in the older age groups (50 years and over) continues to increase, from 7% in 1996 to 11% in 2002. This ageing cohort effect is likely to be due to the effectiveness of anti-HIV treatment and subsequent improved prognosis of many HIV positive individuals. However, those aged 55 years or over are more likely to have died during 2002 (4%) than are those younger than 55 years, of whom only 1% died. Those in the age range 15 to 24 years were the most likely to be classed as asymptomatic.

The proportion of individuals with HIV who died during the year decreased from 9% in 1996 to 2% in 2000. In 2001, we modified data collection to distinguish between death related to AIDS and death unrelated to AIDS. In 2002, 1.2% of individuals died of AIDS related death. Of the 36 individuals who died in 2002, 78% died of an AIDS related condition and eight (22%) died of other causes. Two of the eight and had been classed as asymptomatic, and the remaining six as symptomatic.

Table 3.1: Age distribution of total HIV and AIDS cases by infection route of HIV, January-December 2002 (All cases seen during 2002 including those who died during the year)

AGE GROUP	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
0-14				1 (2.4%)	38 (92.7%)	2 (4.9%)	41
15-19	7 (46.7%)		5 (33.3%)	1 (6.7%)	1 (6.7%)	1 (6.7%)	15
20-24	59 (58.4%)	1 (1%)	27 (26.7%)	3 (3%)		11 (10.9%)	101
25-29	155 (55.2%)	7 (2.5%)	100 (35.6%)	5 (1.8%)		14 (5%)	281
30-34	268 (57.1%)	7 (1.5%)	150 (32%)	12 (2.6%)		32 (6.8%)	469
35-39	357 (61%)	26 (4.4%)	151 (25.8%)	14 (2.4%)		37 (6.3%)	585
40-44	270 (65.4%)	22 (5.3%)	87 (21.1%)	11 (2.7%)		23 (5.6%)	413
45-49	163 (66.3%)	6 (2.4%)	55 (22.4%)	9 (3.7%)		13 (5.3%)	246
50-54	81 (58.3%)	5 (3.6%)	37 (26.6%)	2 (1.4%)		14 (10.1%)	139
55-59	37 (53.6%)	2 (2.9%)	24 (34.8%)	2 (2.9%)		4 (5.8%)	69
60+	35 (50%)		26 (37.1%)	2 (2.9%)		7 (10%)	70
Total	**1432 (59%)**	**76 (3.1%)**	**662 (27.3%)**	**62 (2.6%)**	**39 (1.6%)**	**158 (6.5%)**	**2429**

Age ranges refer to the age of individuals at end of December 2002, or at death. Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 3.1 shows the age distribution of all HIV and AIDS cases presenting in the North West for treatment in 2002, categorised by infection route of HIV. Sex between men remains the most common route of infection among people with HIV in the North West (59% of all cases). The proportion of people infected through heterosexual sex continues to increase, from 15% in 1996 to 27% in 2002. It is anticipated that the proportion of individuals infected by heterosexual sex will continue to increase in view of the increasing proportion of new cases who have been heterosexually infected (41% in 2002: chapter 2, figure 2.1). Correspondingly, there is likely to be an increase in the number of babies born with HIV: infants newly reported in 2002 represent 23% of all children infected by mother to child transmission. Conversely, the proportion of all homosexually infected people who are newly reported in 2002 is lower, at 16%.

The number of individuals exposed to HIV via injecting drug use remains low at 3%, with the most common age groups being 35 to 44 years (63% of cases). The proportion of people infected by contaminated blood or tissue and vertical transmission remains also relatively low (4%).

Table 3.2a: Residential distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2002: strategic health authority

(All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	Infection Route						Total (100%)
	Asympto-matic	Sympto-matic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria and Lancashire	127 (27.5%)	184 (39.9%)	126 (27.3%)	4 (0.9%)	2 (0.4%)	18 (3.9)	461
Cheshire and Merseyside	193 (41.3%)	159 (34%)	105 (22.5%)	8 (1.7%)		2 (0.4%)	467
Greater Manchester	495 (36.1%)	507 (37%)	327 (23.9%)	15 (1.1%)	6 (0.4%)	21 (1.5%)	1371
Isle of Man	6 (46.2%)	4 (30.8%)	3 (23.1%)				13
East Midlands	3 (75%)	1 (25%)					4
East of England			1 (100%)				1
London	4 (50%)	3 (37.5%)	1 (12.5%)				8
Scotland		1 (100%)					1
South East			2 (100%)				2
South West		2 (100%)					2
Wales	9 (37.5%)	3 (12.5%)	11 (45.8%)	1 (4.2%)			24
West Midlands	6 (42.9%)	5 (35.7%)	3 (21.4%)				14
Yorkshire and The Humber	11 (39.3%)	10 (35.7%)	7 (25%)				28
Abroad		1 (100%)					1
Unknown	20 (62.5%)	5 (15.6%)	4 (12.5%)			3 (9.4%)	32
Total	**874 (36%)**	**885 (36.4%)**	**590 (24.3%)**	**28 (1.2%)**	**8 (0.3%)**	**44 (1.8%)**	**2429**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category.

Table 3.2b: Residential distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2002: Cumbria and Lancashire primary care trusts

(All cases seen during 2002 including those who died during the year)

PCT OF RESIDENCE	Stage of Disease						Total (100%)
	Asympto-matic	Sympto-matic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Carlisle and District	9 (50%)	5 (27.8%)	3 (16.7%)			1 (5.6%)	18
Eden Valley	6 (85.7%)		1 (14.3%)				7
West Cumbria	8 (61.5%)	2 (15.4%)	3 (23.1%)				13
Morecambe Bay	9 (36%)	7 (28%)	7 (28%)	2 (8%)			25
Blackpool	28 (18.1%)	67 (43.2%)	47 (30.3%)		1 (0.6%)	12 (7.7%)	155
Fylde	2 (10.5%)	8 (42.1%)	8 (42.1%)			1 (5.3%)	19
Wyre	9 (30%)	9 (30%)	9 (30%)			3 (10%)	30
Preston	18 (28.1%)	25 (39.1%)	20 (31.3%)		1 (1.6%)		64
Hyndburn and Ribble Valley	7 (31.8%)	10 (45.5%)	5 (22.7%)				22
Burnley, Pendle and Rossendale	8 (22.9%)	20 (57.1%)	7 (20%)				35
Blackburn with Darwen	11 (39.3%)	14 (50%)	3 (10.7%)				28
Chorley and South Ribble	3 (12%)	10 (40%)	10 (40%)	1 (4%)		1 (4%)	25
West Lancashire	9 (45%)	7 (35%)	3 (15%)	1 (5%)			20
Total	**127 (27.5%)**	**184 (39.9%)**	**126 (27.3%)**	**4 (0.9%)**	**2 (0.4%)**	**18 (3.9%)**	**461**

Table 3.2c: Residential distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2002: Cheshire and Merseyside primary care trusts

(All cases seen during 2002 including those who died during the year)

PCT OF RESIDENCE	Stage of Disease						Total (100%)
	Asympto-matic	Sympto-matic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Southport and Formby	7 (35%)	8 (40%)	4 (20%)	1 (5%)			20
South Sefton	4 (21.1%)	8 (42.1%)	6 (31.6%)	1 (5.3%)			19
North Liverpool	4 (50%)	3 (37.5%)	1 (12.5%)				8
Central Liverpool	53 (46.9%)	36 (31.9%)	22 (19.5%)	2 (1.8%)			113
South Liverpool	14 (48.3%)	8 (27.6%)	7 (24.1%)				29
Knowsley	3 (21.4%)	9 (64.3%)	2 (14.3%)				14
St Helens	8 (34.8%)	8 (34.8%)	7 (30.4%)				23
Halton	4 (23.5%)	6 (35.3%)	6 (35.3%)	1 (5.9%)			17
Warrington	17 (54.8%)	10 (32.3%)	4 (12.9%)				31
Birkenhead and Wallasey	16 (28.1%)	24 (42.1%)	16 (28.1%)	1 (1.8%)			57
Bebington and West Wirral	3 (30%)	5 (50%)	2 (20%)				10
Ellesmere Port and Neston	15 (83.3%)	2 (11.1%)	1 (5.6%)				18
Cheshire West	20 (57.1%)	8 (22.9%)	6 (17.1%)	1 (2.9%)			35
Central Cheshire	14 (36.8%)	12 (31.6%)	10 (26.3%)			2 (5.3%)	38
Eastern Cheshire	11 (31.4%)	12 (34.3%)	11 (31.4%)	1 (2.9%)			35
Total	**193 (41.3%)**	**159 (34%)**	**105 (22.5%)**	**8 (1.7%)**		**2 (0.4%)**	**467**

Table 3.2d: Residential distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2002: Greater Manchester primary care trusts

(All cases seen during 2002 including those who died during the year)

PCT OF RESIDENCE	Stage of Disease						Total (100%)
	Asympto-matic	Sympto-matic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Ashton, Leigh and Wigan	13 (39.4%)	15 (45.5%)	5 (15.2%)				33
Bolton	37 (39.4%)	31 (33%)	23 (24.5%)	3 (3.2%)			94
Bury	18 (28.1%)	28 (43.8%)	17 (26.6%)	1 (1.6%)			64
Heywood and Middleton	7 (29.2%)	7 (29.2%)	8 (33.3%)		1 (4.2%)	1 (4.2%)	24
Rochdale	7 (18.9%)	16 (43.2%)	12 (32.4%)	2 (5.4%)			37
Salford	82 (43.4%)	67 (35.4%)	34 (18%)	1 (0.5%)	1 (0.5%)	4 (2.1%)	189
Trafford North	12 (35.3%)	12 (35.3%)	9 (26.5%)			1 (2.9%)	34
Trafford South	10 (24.4%)	21 (51.2%)	8 (19.5%)		1 (2.4%)	1 (2.4%)	41
North Manchester	90 (31.8%)	121 (42.8%)	62 (21.9%)	4 (1.4%)		6 (2.1%)	283
Central Manchester	148 (43.3%)	103 (30.1%)	83 (24.3%)	1 (0.3%)	2 (0.6%)	5 (1.5%)	342
South Manchester	14 (25%)	21 (37.5%)	21 (37.5%)				56
Oldham	12 (26.7%)	13 (28.9%)	16 (35.6%)	3 (6.7%)		1 (2.2%)	45
Tameside and Glossop	17 (29.8%)	25 (43.9%)	12 (21.1%)		1 (1.8%)	2 (3.5%)	57
Stockport	28 (38.9%)	27 (37.5%)	17 (23.6%)				72
Total	**495 (36.1%)**	**507 (37%)**	**327 (23.9%)**	**15 (1.1%)**	**6 (0.4%)**	**21 (1.5%)**	**1371**

Table 3.2a illustrates the strategic health authority of residence and clinical stage of HIV disease for all HIV positive and AIDS cases presenting to a North West treatment centre in 2002. The figures refer to the clinical condition of individuals when last seen in 2002; individuals who died are presented in separate categories. The highest number of people with HIV live in Greater Manchester SHA (56% of the total number of people). As in previous years, the vast majority of people treated in the North West were also resident in the North West (95%).

The proportion of people at different stages of HIV disease has consequences for the funding of HIV treatment and care, since those at a more advanced stage require more hospital care (see table 3.24)[41]. Overall, 36% were asymptomatic, 36% were symptomatic and 24% were classified as having AIDS.

Tables 3.2b, c and **d** present the breakdown of stage of disease by PCT within each of the three SHAs (Cumbria and Lancashire, table 3.2b; Cheshire and Merseyside, table 3.2c; and Greater Manchester, table 3.2d). There is variation among primary care trusts as to the proportion of individuals with AIDS, from only 6% in Ellesmere Port and Neston PCT to 38% in South Manchester PCT.

Table 3.3a displays the route of transmission of HIV for all HIV positive and AIDS cases presenting in the North West for treatment in 2002, by strategic health authority of residence. Homosexual sex continues to be the dominant mode of HIV transmission (59%). However, there are considerable variations within the North West, with 63% of the HIV positive residents of Greater Manchester SHA compared to only 51% of Cheshire and Merseyside SHA residents having been infected by sex between men.

Tables 3.3b, c and **d** present the breakdown of route of infection by PCT within each of the three SHAs (Cumbria and Lancashire, table 3.3b; Cheshire and Merseyside, table 3.3c; and Greater Manchester, table 3.3d). Considerable variation in the proportions of residents infected by homosexual sex can be seen across primary care trusts, for example from only 31% in South Liverpool PCT to 79% in Central Cheshire and Blackpool PCTs. Greater Manchester continues to report by far the highest number of HIV positive injecting drug users, accounting for 61% of all residents of the North West infected by this route.

Table 3.3a: Residential distribution of total HIV and AIDS cases by infection route of HIV, January-December 2002: strategic health authority

(All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria and Lancashire	267 (57.9%)	15 (3.3%)	121 (26.2%)	13 (2.8%)	10 (2.2%)	35 (7.6%)	461
Cheshire and Merseyside	238 (51%)	15 (3.2%)	159 (34%)	21 (4.5%)	4 (0.9%)	30 (6.4%)	467
Greater Manchester	866 (63.2%)	46 (3.4%)	340 (24.8%)	24 (1.8%)	21 (1.5%)	74 (5.4%)	1371
Isle of Man	3 (23.1%)		10 (76.9%)				13
East Midlands	2 (50%)		2 (50%)				4
East of England	1 (100%)						1
London	2 (25%)		2 (25%)			4 (50%)	8
Scotland						1 (100%)	1
South East	1 (50%)		1 (50%)				2
South West	1 (50%)		1 (50%)				2
Wales	9 (37.5%)		7 (29.2%)	3 (12.5%)	4 (16.7%)	1 (4.2%)	24
West Midlands	4 (28.6%)		5 (35.7%)	1 (7.1%)		4 (28.6%)	14
Yorkshire and The Humber	22 (78.6%)		5 (17.9%)			1 (3.6%)	28
Abroad	1 (100%)						1
Unknown	15 (46.9%)		9 (28.1%)			8 (25%)	32
Total	**1432 (59%)**	**76 (3.1%)**	**662 (27.3%)**	**62 (2.6%)**	**39 (1.6%)**	**158 (6.5%)**	**2429**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 3.3b: Residential distribution of total HIV and AIDS cases by infection route of HIV, January-December 2002: Cumbria and Lancashire primary care trusts

(All cases seen during 2002 including those who died during the year)

PCT OF RESIDENCE	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Carlisle and District	10 (55.6%)	1 (5.6%)	7 (38.9%)				18
Eden Valley	3 (42.9%)		4 (57.1%)				7
West Cumbria	6 (46.2%)		4 (30.8%)	1 (7.7%)	1 (7.7%)	1 (7.7%)	13
Morecambe Bay	11 (44%)	4 (16%)	9 (36%)			1 (4%)	25
Blackpool	122 (78.7%)	1 (0.6%)	10 (6.5%)	4 (2.6%)	1 (0.6%)	17 (11%)	155
Fylde	13 (68.4%)		4 (21.1%)		1 (5.3%)	1 (5.3%)	19
Wyre	20 (66.7%)	1 (3.3%)	5 (16.7%)			4 (13.3%)	30
Preston	23 (35.9%)	1 (1.6%)	28 (43.8%)	2 (3.1%)	6 (9.4%)	4 (6.3%)	64
Hyndburn and Ribble Valley	8 (36.4%)	1 (4.5%)	12 (54.5%)	1 (4.5%)			22
Burnley, Pendle and Rossendale	21 (60%)	4 (11.4%)	6 (17.1%)	3 (8.6%)		1 (2.9%)	35
Blackburn with Darwen	11 (39.3%)	1 (3.6%)	15 (53.6%)			1 (3.6%)	28
Chorley and South Ribble	10 (40%)	1 (4%)	8 (32%)	1 (4%)	1 (4%)	4 (16%)	25
West Lancashire	9 (45%)		9 (45%)	1 (5%)		1 (5%)	20
Total	**267 (57.9%)**	**15 (3.3%)**	**121 (26.2%)**	**13 (2.8%)**	**10 (2.2%)**	**35 (7.6%)**	**461**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 3.3c: Residential distribution of total HIV and AIDS cases by infection route of HIV, January-December 2002: Cheshire and Merseyside primary care trusts

(All cases seen during 2002 including those who died during the year)

PCT OF RESIDENCE	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Southport and Formby	9 (45%)	1 (5%)	8 (40%)	1 (5%)		1 (5%)	20
South Sefton	6 (31.6%)		6 (31.6%)	4 (21.1%)		3 (15.8%)	19
North Liverpool	4 (50%)		4 (50%)				8
Central Liverpool	44 (38.9%)	2 (1.8%)	55 (48.7%)	4 (3.5%)	1 (0.9%)	7 (6.2%)	113
South Liverpool	9 (31%)	1 (3.4%)	14 (48.3%)	2 (6.9%)		3 (10.3%)	29
Knowsley	8 (57.1%)	1 (7.1%)	2 (14.3%)			3 (21.4%)	14
St Helens	15 (65.2%)		6 (26.1%)	1 (4.3%)		1 (4.3%)	23
Halton	7 (41.2%)	1 (5.9%)	5 (29.4%)	1 (5.9%)	1 (5.9%)	2 (11.8%)	17
Warrington	19 (61.3%)		10 (32.3%)	1 (3.2%)		1 (3.2%)	31
Birkenhead and Wallasey	31 (54.4%)	5 (8.8%)	16 (28.1%)	1 (1.8%)	1 (1.8%)	3 (5.3%)	57
Bebington and West Wirral	7 (70%)		3 (30%)				10
Ellesmere Port and Neston	6 (33.3%)		10 (55.6%)		1 (5.6%)	1 (5.6%)	18
Cheshire West	25 (71.4%)	2 (5.7%)	5 (14.3%)	2 (5.7%)		1 (2.9%)	35
Central Cheshire	30 (78.9%)		6 (15.8%)	1 (2.6%)		1 (2.6%)	38
Eastern Cheshire	18 (51.4%)	2 (5.7%)	9 (25.7%)	3 (8.6%)		3 (8.6%)	35
Total	**238 (51%)**	**15 (3.2%)**	**159 (34%)**	**21 (4.5%)**	**4 (0.9%)**	**30 (6.4%)**	**467**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 3.3d: Residential distribution of total HIV and AIDS cases by infection route of HIV, January-December 2002: Greater Manchester primary care trusts

(All cases seen during 2002 including those who died during the year)

PCT OF RESIDENCE	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Ashton, Leigh and Wigan	14 (42.4%)		14 (42.4%)	2 (6.1%)	1 (3%)	2 (6.1%)	33
Bolton	39 (41.5%)	3 (3.2%)	47 (50%)	2 (2.1%)	3 (3.2%)		94
Bury	37 (57.8%)	1 (1.6%)	18 (28.1%)	4 (6.3%)	1 (1.6%)	3 (4.7%)	64
Heywood and Middleton	16 (66.7%)	1 (4.2%)	4 (16.7%)	2 (8.3%)		1 (4.2%)	24
Rochdale	15 (40.5%)	4 (10.8%)	12 (32.4%)	2 (5.4%)	3 (8.1%)	1 (2.7%)	37
Salford	145 (76.7%)	5 (2.6%)	27 (14.3%)	1 (0.5%)		11 (5.8%)	189
Trafford North	26 (76.5%)	1 (2.9%)	5 (14.7%)		1 (2.9%)	1 (2.9%)	34
Trafford South	28 (68.3%)	5 (12.2%)	4 (9.8%)	2 (4.9%)		2 (4.9%)	41
North Manchester	195 (68.9%)	8 (2.8%)	53 (18.7%)	1 (0.4%)	3 (1.1%)	23 (8.1%)	283
Central Manchester	218 (63.7%)	7 (2%)	95 (27.8%)	2 (0.6%)	6 (1.8%)	14 (4.1%)	342
South Manchester	35 (62.5%)	4 (7.1%)	14 (25%)			3 (5.4%)	56
Oldham	19 (42.2%)	4 (8.9%)	14 (31.1%)	2 (4.4%)		6 (13.3%)	45
Tameside and Glossop	35 (61.4%)	1 (1.8%)	14 (24.6%)	1 (1.8%)	1 (1.8%)	5 (8.8%)	57
Stockport	44 (61.1%)	2 (2.8%)	19 (26.4%)	3 (4.2%)	2 (2.8%)	2 (2.8%)	72
Total	**866 (63.2%)**	**46 (3.4%)**	**340 (24.8%)**	**24 (1.8%)**	**21 (1.5%)**	**74 (5.4%)**	**1371**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 3.4: Residential distribution of total HIV and AIDS cases by sex, January-December 2002 (All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	Sex		Total (100%)
	Male	Female	
Cumbria and Lancashire	378 (82%)	83 (18%)	461
Cheshire and Merseyside	373 (79.9%)	94 (20.1%)	467
Greater Manchester	1130 (82.4%)	241 (17.6%)	1371
Isle of Man	8 (61.5%)	5 (38.5%)	13
East Midlands	3 (75%)	1 (25%)	4
East of England	1 (100%)		1
London	6 (75%)	2 (25%)	8
Scotland	1 (100%)		1
South East	2 (100%)		2
South West	2 (100%)		2
Wales	21 (87.5%)	3 (12.5%)	24
West Midlands	12 (85.7%)	2 (14.3%)	14
Yorkshire and The Humber	23 (82.1%)	5 (17.9%)	28
Abroad	1 (100%)		1
Unknown	29 (90.6%)	3 (9.4%)	32
Total	**1990 (81.9%)**	**439 (18.1%)**	**2429**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category.
For a breakdown of sex by primary care trust, please see the North West Public Health Observatory website:
http://www.nwpho.org.uk/hiv2002/table3-4.htm

Table 3.4 shows the sex and strategic health authority of residence of all HIV and AIDS cases presenting in the North West for treatment in 2002. As in previous years, the vast majority of all cases are male (82%), primarily due to the relatively high number of individuals exposed to HIV via homosexual or bisexual sex (table 3.3a). The proportion of women has increased steadily from 11% in 1996 to 18% this year. As would be expected, the highest proportion of females is found in Cheshire and Merseyside SHA (20%), the SHA with the highest number of heterosexual HIV infections.

Table 3.5: Infection route of HIV of total HIV and AIDS cases by sex, January-December 2002 (All cases and new cases seen during 2002 including those who died during the year)

INFECTION ROUTE	Sex		Total (100%)
	Male	Female	
Homo/Bisexual	1432 (72%)		1432 (59%)
Injecting drug use	52 (2.6%)	24 (5.5%)	76 (3.1%)
Heterosexual	291 (14.6%)	371 (84.5%)	662 (27.3%)
Blood/Tissue	54 (2.7%)	8 (1.8%)	62 (2.6%)
Mother to child	18 (0.9%)	21 (4.8%)	39 (1.6%)
Undetermined	143 (7.2%)	15 (3.4%)	158 (6.5%)
Total	**1990**	**439**	**2429**

Men who have had homo/bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 3.5 illustrates the sex and route of transmission of all HIV and AIDS cases presenting for treatment in the North West in 2002. Amongst men, the largest category of individuals living with HIV was those infected by sex between men (72%), while most women had been infected by heterosexual sex (85%). An even greater proportion of female new cases (88%) were infected by this route (chapter 2, table 2.5), highlighting the growing issue of heterosexual transmission of HIV. Less than half (44%) of those infected by heterosexual sex are male. As in previous years, the majority of injecting drug users are male (68%).

Table 3.6: Residential distribution of total HIV and AIDS cases by age category, January-December 2002 (All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	Age Group											Total (100%)
	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	
Cumbria and Lancashire	10 (2.2%)	1 (0.2%)	16 (3.5%)	39 (8.5%)	75 (16.3%)	116 (25.2%)	84 (18.2%)	47 (10.2%)	36 (7.8%)	17 (3.7%)	20 (4.3%)	461
Cheshire and Merseyside	6 (1.3%)	7 (1.5%)	26 (5.6%)	51 (10.9%)	89 (19.1%)	110 (23.6%)	73 (15.6%)	43 (9.2%)	26 (5.6%)	19 (4.1%)	17 (3.6%)	467
Greater Manchester	21 (1.5%)	6 (0.4%)	55 (4%)	182 (13.3%)	279 (20.4%)	326 (23.8%)	236 (17.2%)	144 (10.5%)	70 (5.1%)	26 (1.9%)	26 (1.9%)	1371
Isle of Man				1 (7.7%)		5 (38.5%)	5 (38.5%)	1 (7.7%)	1 (7.7%)			13
East Midlands						1 (25%)		1 (25%)	1 (25%)	1 (25%)		4
East of England											1 (100%)	1
London					2 (25%)	2 (25%)	1 (12.5%)	2 (25%)		1 (12.5%)		8
Scotland											1 (100%)	1
South East					1 (50%)			1 (50%)				2
South West						2 (100%)						2
Wales	4 (16.7%)		1 (4.2%)	1 (4.2%)	3 (12.5%)	5 (20.8%)	3 (12.5%)	1 (4.2%)	1 (4.2%)	4 (16.7%)	1 (4.2%)	24
West Midlands				3 (21.4%)	4 (28.6%)	3 (21.4%)	2 (14.3%)	1 (7.1%)			1 (7.1%)	14
Yorkshire and The Humber				1 (3.6%)	7 (25%)	5 (17.9%)	6 (21.4%)	4 (14.3%)	2 (7.1%)	1 (3.6%)	2 (7.1%)	28
Abroad								1 (100%)				1
Unknown		1 (3.1%)	3 (9.4%)	3 (9.4%)	9 (28.1%)	10 (31.3%)	3 (9.4%)		2 (6.3%)		1 (3.1%)	32
Total	**41 (1.7%)**	**15 (0.6%)**	**101 (4.2%)**	**281 (11.6%)**	**469 (19.3%)**	**585 (24.1%)**	**413 (17%)**	**246 (10.1%)**	**139 (5.7%)**	**69 (2.8%)**	**70 (2.9%)**	**2429**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. Age ranges refer to the age of individuals at end of December 2002, or at death. For a breakdown of age by primary care trust, please see the North West Public Health Observatory website: http://www.nwpho.org.uk/hiv2002/table3-6.htm

Table 3.6 shows the strategic health authority of residence of all HIV and AIDS cases presenting for treatment in the North West in 2002, categorised by age group. The proportion of HIV positive individuals who are under 25 years of age has remained relatively static over the last four years and was 6% in 2002. During 2002 the age group with the largest number of individuals is 35 to 39 years (585). The proportion of HIV positive people in the older age groups (50 years and over), which had increased between 1996 and 2001 (from 7% to 12%), now appears to have stabilised at 11% in 2002. As for new cases, Cumbria and Lancashire SHA has the highest proportion of individuals aged over 50 years (16%) compared to Cheshire and Merseyside SHA (13%) and Greater Manchester SHA (9%).

Table 3.7: Residential distribution of total HIV and AIDS cases by ethnic group, January-December 2002 (All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	Ethnicity								Total (100%)
	White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Cumbria and Lancashire	385 (83.5%)	4 (0.9%)	36 (7.8%)		7 (1.5%)	4 (0.9%)	9 (2%)	16 (3.5%)	461
Cheshire and Merseyside	379 (81.2%)	2 (0.4%)	62 (13.3%)		2 (0.4%)	3 (0.6%)	10 (2.1%)	9 (1.9%)	467
Greater Manchester	970 (70.8%)	9 (0.7%)	233 (17%)	6 (0.4%)	24 (1.8%)	16 (1.2%)	18 (1.3%)	95 (6.9%)	1371
Isle of Man	11 (84.6%)		2 (15.4%)						13
East Midlands	4 (100%)								4
East of England	1 (100%)								1
London	3 (37.5%)		2 (25%)					3 (37.5%)	8
Scotland	1 (100%)								1
South East			1 (50%)			1 (50%)			2
South West	1 (50%)		1 (50%)						2
Wales	21 (87.5%)					1 (4.2%)	1 (4.2%)	1 (4.2%)	24
West Midlands	8 (57.1%)		2 (14.3%)					4 (28.6%)	14
Yorkshire and The Humber	20 (71.4%)	1 (3.6%)	2 (7.1%)			1 (3.6%)	1 (3.6%)	3 (10.7%)	28
Abroad						1 (100%)			1
Unknown	24 (75%)	3 (9.4%)	1 (3.1%)		1 (3.1%)			3 (9.4%)	32
Total	**1828 (75.3%)**	**19 (0.8%)**	**342 (14.1%)**	**6 (0.2%)**	**34 (1.4%)**	**27 (1.1%)**	**39 (1.6%)**	**134 (5.5%)**	**2429**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of ethnicity by primary care trust, please see the North West Public Health Observatory website: http://www.nwpho.org.uk/hiv2002/table3-7.htm

Table 3.7 shows a breakdown of ethnicity by strategic health authority for all those individuals with HIV or AIDS who attended statutory treatment centres in the North West in 2002. Ethnic group classifications are adapted from the 1991 census questionnaire and are those utilised by the Health Protection Agency AIDS and STD Centre, for the Survey of Prevalent Diagnosed HIV Infections (SOPHID).

The self-classification of ethnicity was recorded for 95% of cases, most of whom (80%) were white. The remaining 20% were from black and minority ethnic communities, and this proportion has increased from 15% last year. This is a reflection of the increasing proportion of new cases from black and minority ethnic communities (from 29% in 2000 to 40% in 2002: chapter 2, table 2.6). These data show an increase in the number of individuals from black and minority ethnic groups presenting for treatment and care in the North West of England. Moreover, individuals from black and minority ethnic communities are substantially over represented among the HIV positive population when compared to their proportion in the North West population as a whole (5.2%)[74]. Thus, individuals from black and minority ethnic groups in the North West are 4.7 times more likely to be HIV positive than are their white counterparts.

HIV positive individuals classified as black African comprise the largest ethnic minority group, at 14% of all cases and 73% of non-white individuals. This proportion from black African communities has been increasing over the years, from 3% in 1998, to 6% in 2000. These data highlight the need for specific HIV prevention initiatives within black and minority ethnic communities. However, the black African community is not homogenous and requires a culturally sensitive and diverse approach[81]. Of the three North West SHAs, Greater Manchester has the highest proportion of black and ethnic minorities (22%) compared to Cumbria and Lancaster (13%) and Cheshire and Merseyside (17%).

Table 3.8: Ethnic distribution of total HIV and AIDS cases by sex, January-December 2002 (All cases seen during 2002 including those who died during the year)

ETHNICITY	Sex		Total (100%)
	Male	Female	
White	1652 (90.4%)	176 (9.6%)	1828
Black Caribbean	15 (78.9%)	4 (21.1%)	19
Black African	143 (41.8%)	199 (58.2%)	342
Black (other)	4 (66.7%)	2 (33.3%)	6
Indian/Pakistani/Bangladeshi	22 (64.7%)	12 (35.3%)	34
Other Asian/Oriental	17 (63%)	10 (37%)	27
Other/mixed	30 (76.9%)	9 (23.1%)	39
Unknown	107 (79.9%)	27 (20.1%)	134
Total (100%)	**1990 (81.9%)**	**439 (18.1%)**	**2429**

Table 3.8 shows the ethnic group and sex of all individuals with HIV presenting in the North West for treatment in 2002. The vast majority of HIV and AIDS cases were male (82%). However, this is not the case for members of black and minority ethnic communities, where cases are much more evenly distributed between the sexes. Just over half of all HIV positive individuals from ethnic minorities were female (51%). This higher proportion of females with HIV is largely due to the predominance of heterosexual sex, rather than sex between men, as the route of transmission in black and minority ethnic groups (table 3.9). Fifty eight percent of diagnosed HIV positive black Africans are female. This female bias may be explained if females are more at risk of acquiring HIV through heterosexual sex, or more likely to present to treatment centres for diagnosis and treatment, or both.

Table 3.9: Ethnic distribution of total HIV and AIDS cases by infection route of HIV, January-December 2002 (All cases seen during 2002 including those who died during the year)

ETHNICITY	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
White	1333 (72.9%)	73 (4%)	281 (15.4%)	56 (3.1%)	12 (0.7%)	73 (4%)	1828
Black Caribbean	9 (47.4%)		9 (47.4%)	1 (5.3%)			19
Black African	17 (5%)		299 (87.4%)	2 (0.6%)	17 (5%)	7 (2%)	342
Black (other)	2 (33.3%)		4 (66.7%)				6
Indian/Pakistani/Bangladeshi	10 (29.4%)	1 (2.9%)	17 (50%)	3 (8.8%)	1 (2.9%)	2 (5.9%)	34
Other Asian/Oriental	7 (25.9%)		16 (59.3%)			4 (14.8%)	27
Other/mixed	20 (51.3%)	1 (2.6%)	10 (25.6%)		7 (17.9%)	1 (2.6%)	39
Unknown	34 (25.4%)	1 (0.7%)	26 (19.4%)		2 (1.5%)	71 (53%)	134
Total	**1432 (59%)**	**76 (3.1%)**	**662 (27.3%)**	**62 (2.6%)**	**39 (1.6%)**	**158 (6.5%)**	**2429**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category

Table 3.9 illustrates the ethnic group and route of transmission of HIV and AIDS cases presenting in the North West in 2002. Although most individuals with HIV were infected by sex between men (59%), this is not the case among black and minority ethnic communities where homosexual sex accounted for only 14% of cases and heterosexual sex was the main route of transmission (76% of cases). Within black African communities, this situation is even more apparent, with heterosexual sex accounting for 87% of cases. Because of the high proportion of HIV positive black Africans who are female (table 3.8) there is a correspondingly high proportion of HIV cases that were acquired by mother to child transmission (5%).

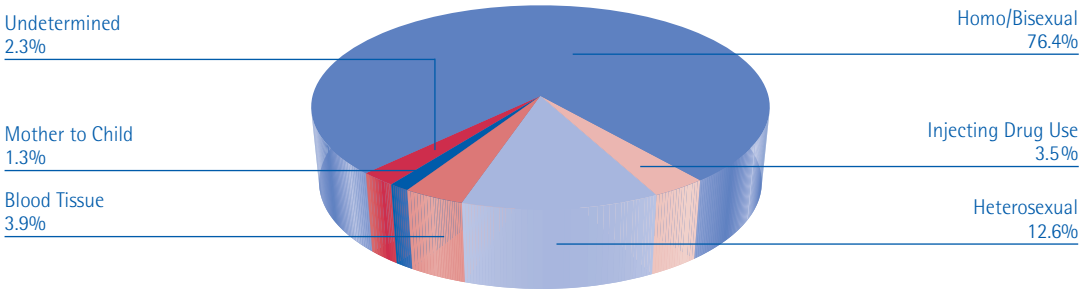
Table 3.10: Ethnic distribution of total HIV and AIDS cases by age group, January-December 2002 (All cases seen during 2002 including those who died during the year)

ETHNICITY	Age Group											Total (100%)
	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	
White	11 (0.6%)	9 (0.5%)	70 (3.8%)	176 (9.6%)	320 (17.5%)	456 (24.9%)	342 (18.7%)	201 (11%)	119 (6.5%)	61 (3.3%)	63 (3.4%)	1828
Black Caribbean		3 (15.8%)	2 (10.5%)	1 (5.3%)	3 (15.8%)	6 (31.6%)	1 (5.3%)	2 (10.5%)	1 (5.3%)			19
Black African	18 (5.3%)	1 (0.3%)	13 (3.8%)	71 (20.8%)	87 (25.4%)	75 (21.9%)	35 (10.2%)	22 (6.4%)	10 (2.9%)	5 (1.5%)	5 (1.5%)	342
Black (other)				1 (16.7%)	1 (16.7%)	1 (16.7%)	3 (50%)					6
Indian/Pakistani/ Bangladeshi	1 (2.9%)	1 (2.9%)	4 (11.8%)	4 (11.8%)	7 (20.6%)	8 (23.5%)	5 (14.7%)	3 (8.8%)			1 (2.9%)	34
Other Asian/Oriental	1 (3.7%)		2 (7.4%)	5 (18.5%)	6 (22.2%)	3 (11.1%)	3 (11.1%)	7 (25.9%)				27
Other/mixed	7 (17.9%)		2 (5.1%)	8 (20.5%)	6 (15.4%)	6 (15.4%)	8 (20.5%)	2 (5.1%)				39
Unknown	3 (2.2%)	1 (0.7%)	8 (6%)	15 (11.2%)	39 (29.1%)	30 (22.4%)	16 (11.9%)	9 (6.7%)	9 (6.7%)	3 (2.2%)	1 (0.7%)	134
Total	**41 (1.7%)**	**15 (0.6%)**	**101 (4.2%)**	**281 (11.6%)**	**469 (19.3%)**	**585 (24.1%)**	**413 (17%)**	**246 (10.1%)**	**139 (5.7%)**	**69 (2.8%)**	**70 (2.9%)**	**2429**

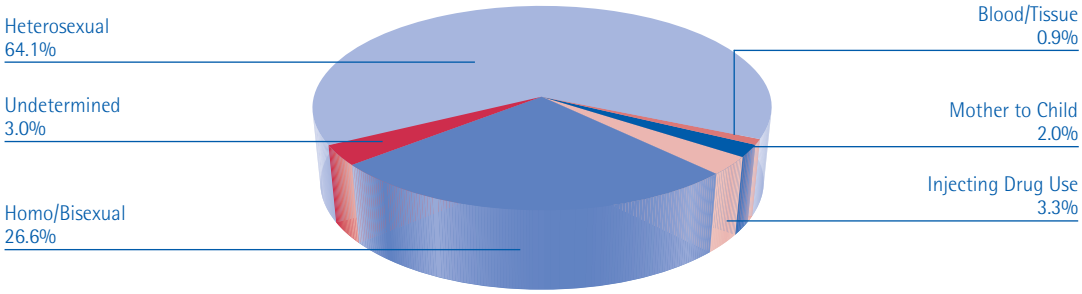
Table 3.10 displays the ethnicity and age group of HIV and AIDS cases presenting for treatment in the North West in 2002. White individuals tended to be older, with a median age of 39 years (with 90% of the population lying between the range 25 to 57 years) while black Africans had a median age of 34 (90% in the range 14 to 53 years). The fact that those from black and minority ethnic groups tend to be younger and infected by heterosexual sex suggests that in the future the rates of mother to child transmission may increase. The higher proportion of black Africans and those self-classified as 'Other/mixed' in the 0-14 year age group (5% and 18% respectively) compared to white individuals (1%) are a reflection of the higher rates of mother to child transmission in these groups (table 3.9).

Figure 3.2: The role of contact abroad in exposure to HIV of total HIV and AIDS cases, January-December 2002 (All cases seen during 2002 including those who died during the year)

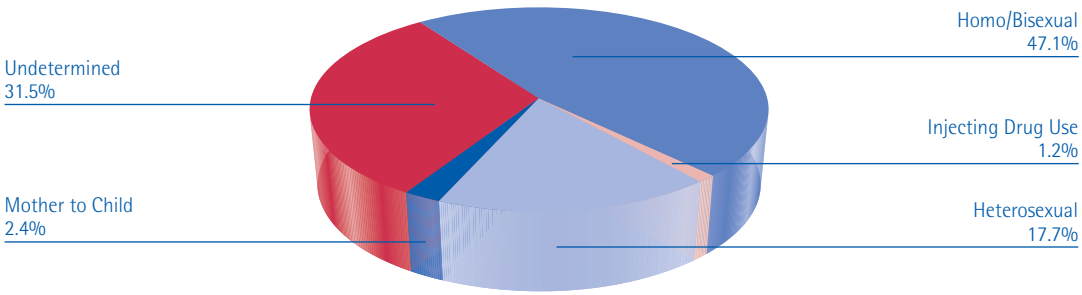
Exposed in UK



Exposed Abroad



Undetermined

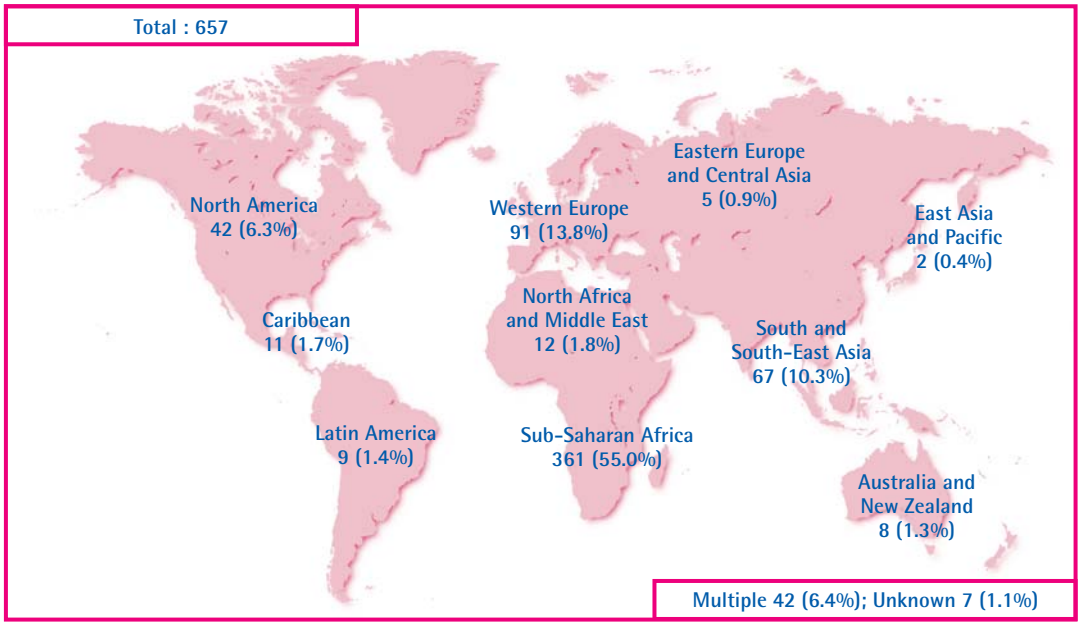


HIV EXPOSURE ABROAD	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Yes	175 (26.6%)	22 (3.3%)	421 (64.1%)	6 (0.9%)	13 (2%)	20 (3%)	657
No	1100 (76.4%)	50 (3.5%)	182 (12.6%)	56 (3.9%)	18 (1.3%)	33 (2.3%)	1439
Undetermined	157 (47.1%)	4 (1.2%)	59 (17.7%)		8 (2.4%)	105 (31.5%)	333
Total	**1432 (59%)**	**76 (3.1%)**	**662 (27.3%)**	**62 (2.6%)**	**39 (1.6%)**	**158 (6.5%)**	**2429**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Figure 3.3: Global region and country of total HIV and AIDS cases who probably acquired their infection outside the UK, January-December 2002

(All cases seen during 2002 including those who died during the year)



Sub-Saharan Africa	**361 (55%)**	Taiwan	1 (0.2%)	Portugal	9 (1.4%)
Angola	2 (0.3%)	**Australia and New Zealand**	**8 (1.3%)**	Spain	22 (3.3%)
Botswana	10 (1.5%)	Australia	7 (1.1%)	Sweden	1 (0.2%)
Burundi	4 (0.6%)	New Zealand	1 (0.2%)	Unknown	6 (0.9%)
Cameroon	2 (0.3%)	**South and South-East Asia**	**67 (10.3%)**	**North Africa and Middle East**	**12 (1.8%)**
Congo	19 (2.9%)	India	5 (0.8%)	Egypt	3 (0.5%)
Dem. Republic of Congo	4 (0.6%)	Iran	1 (0.2%)	Israel	1 (0.2%)
Eritrea	1 (0.2%)	Malaysia	1 (0.2%)	Morocco	1 (0.2%)
Ethiopia	3 (0.5%)	Pakistan	12 (1.8%)	Saudi Arabia	1 (0.2%)
Gambia	4 (0.6%)	Philippines	3 (0.5%)	Sudan	5 (0.8%)
Ghana	6 (0.9%)	Thailand	41 (6.2%)	United Arab Emirates	1 (0.2%)
Guinea	1 (0.2%)	Unknown	4 (0.6%)	**North America**	**42 (6.3%)**
Kenya	18 (2.7%)	**Eastern Europe and Central Asia**	**5 (0.9%)**	Canada	4 (0.6%)
Liberia	1 (0.2%)	Croatia	1 (0.2%)	United States of America	37 (5.6%)
Malawi	14 (2.1%)	Russian Federation	1 (0.2%)	Unknown	1 (0.2%)
Namibia	1 (0.2%)	Unknown	3 (0.5%)	**Caribbean**	**11 (1.7%)**
Nigeria	14 (2.1%)	**Western Europe**	**91 (13.8%)**	Jamaica	9 (1.4%)
Rwanda	4 (0.6%)	Balearics	1 (0.2%)	Unknown	2 (0.3%)
Sierra Leone	3 (0.5%)	Belgium	2 (0.3%)	**Latin America**	**9 (1.4%)**
Somalia	12 (1.8%)	Canary Islands	6 (0.9%)	Argentina	1 (0.2%)
South Africa	33 (5%)	Denmark	1 (0.2%)	Brazil	3 (0.5%)
Swaziland	3 (0.5%)	Eire	5 (0.8%)	Colombia	1 (0.2%)
Tanzania	9 (1.4%)	France	5 (0.8%)	Guyana	2 (0.3%)
Uganda	19 (2.9%)	Germany	11 (1.7%)	Mexico	1 (0.2%)
Zambia	26 (4%)	Gibraltar	1 (0.2%)	Peru	1 (0.2%)
Zimbabwe	120 (18.3%)	Greece	3 (0.5%)	**Multiple**	**42 (6.4%)**
Unknown	28 (4.3%)	Italy	11 (1.7%)	**Unknown**	**7 (1.1%)**
East Asia and Pacific	**2 (0.4%)**	Malta	1 (0.2%)	**Total**	**657**
China	1 (0.2%)	Netherlands	6 (0.9%)		

Figure 3.2 illustrates exposure abroad and the route of infection of all HIV and AIDS cases who presented for treatment and care in the North West in 2002. These data show the significant influence of global trends of the pandemic on the epidemiology of HIV in the North West Region. Over a quarter (27%) of all cases were reported have been exposed to HIV abroad. The role that exposure abroad plays in the epidemiology of HIV in the North West appears to be increasing in importance, with the proportion of people infected abroad having increased from 19% in 1998. However, part of this increase may be due to the fact that there has also been an improved level of reporting, with the proportion of cases for whom data on exposure abroad are available increasing from 48% in1997, 91% in 2001, to 86% in 2002. Heterosexual sex continued to be the predominant mode of transmission of those HIV positive individuals who were infected abroad (64%) compared to only 13% of those known to be infected in the UK.

Figure 3.3 illustrates the global region and country of infection for those 657 HIV positive individuals presenting for treatment in the North West in 2002 who were probably infected abroad. Of all the infections contracted outside the United Kingdom, 55% were exposed in sub-Saharan Africa. This high proportion reflects the impact of the pandemic in sub-Saharan Africa, where the prevalence of HIV is extremely high[13]. A further 14% of people who were infected abroad were infected in Western Europe and 10% in South and South East Asia.

Of the 657 individuals who were probably infected abroad, the country of infection is known for 564 individuals (86%). A total of 67 different countries have been named for those HIV positive people infected abroad, with Zimbabwe representing the country where the largest number of infections were contracted, at 21% of those where the country is known, up from 9% last year. Exposure in sub-Saharan Africa was spread across 25 countries. Of those exposed in Western Europe, 24% were infected in Spain, reflecting the extent of the epidemic in that country[36], the large number of people that travel between the United Kingdom and Spain, and the increased propensity to take risks when on holiday[38;76].

Table 3.11: Global region and infection route of HIV cases who probably acquired their infection outside the UK, January-December 2002

(All cases seen during 2002 including those who died during the year)

GLOBAL REGION	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Australia and New Zealand	8 (100%)						8
Caribbean	3 (27.3%)		8 (72.7%)				11
East Asia and Pacific	1 (50%)					1 (50%)	2
Eastern Europe and Central Asia	3 (60%)		2 (40%)				5
Latin America	5 (55.6%)	1 (11.1%)	3 (33.3%)				9
North Africa and Middle East	3 (25%)		9 (75%)				12
North America	33 (78.6%)	2 (4.8%)	4 (9.5%)	1 (2.4%)		2 (4.8%)	42
South and South-East Asia	17 (25.4%)		44 (65.7%)	1 (1.5%)		5 (7.5%)	67
Sub-Saharan Africa	12 (3.3%)	1 (0.3%)	325 (90%)	3 (0.8%)	12 (3.3%)	8 (2.2%)	361
Western Europe	50 (54.9%)	17 (18.7%)	19 (20.9%)	1 (1.1%)	1 (1.1%)	3 (3.3%)	91
Multiple	36 (85.7%)	1 (2.4%)	5 (11.9%)				42
Unknown	4 (57.1%)		2 (28.6%)			1 (14.3%)	7
Total	**175 (26.6%)**	**22 (3.3%)**	**421 (64.1%)**	**6 (0.9%)**	**13 (2%)**	**20 (3%)**	**657**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Table 3.11 shows the route of infection of those infected abroad categorised by the global region of their exposure. Of all HIV infections acquired abroad, most were exposed via heterosexual sex (64%). For those exposed in sub-Saharan Africa (55% of all those infected abroad), the proportion infected by this route is much higher, at 90%. Fourteen percent of those infected abroad were infected in Western Europe, nearly a fifth of whom were infected by sharing injecting equipment. Seventy seven percent of all injecting drug users who were exposed abroad were infected in Western Europe, with the largest numbers of these having been exposed in Spain (five individuals) and Portugal (four). This is a reflection of the fact that the drug using community remains the focus of the HIV epidemic in much of the rest of Western Europe (in particular Mediterranean Europe)[36].

Table 3.12: The role of contact abroad in exposure to HIV of total HIV and AIDS cases by ethnicity, January-December 2002 (All cases seen during 2002 including those who died during the year)

HIV EXPOSURE ABROAD	Ethnicity								Total
	White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Yes	289 (44%)	10 (1.5%)	290 (44.1%)	4 (0.6%)	19 (2.9%)	20 (3%)	19 (2.9%)	6 (0.9%)	657
No	1354 (94.1%)	6 (0.4%)	25 (1.7%)	2 (0.1%)	14 (1%)	2 (0.1%)	18 (1.3%)	18 (1.3%)	1439
Unknown	185 (55.6%)	3 (0.9%)	27 (8.1%)		1 (0.3%)	5 (1.5%)	2 (0.6%)	110 (33%)	333
Total	**1828 (75.3%)**	**19 (0.8%)**	**342 (14.1%)**	**6 (0.2%)**	**34 (1.4%)**	**27 (1.1%)**	**39 (1.6%)**	**134 (5.5%)**	**2429**

Table 3.13: Residential distribution of total HIV and AIDS cases by level of antiretroviral therapy, January-December 2002

(All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or More	
Cumbria and Lancashire	137 (29.7%)		8 (1.7%)	258 (55.9%)	58 (12.6%)	461
Cheshire and Merseyside	153 (32.8%)	2 (0.4%)	2 (0.4%)	237 (50.7%)	73 (15.6%)	467
Greater Manchester	542 (39.5%)	1 (0.1%)	6 (0.4%)	663 (48.4%)	159 (11.6%)	1371
Isle of Man	7 (53.8%)			5 (38.5%)	1 (7.7%)	13
East Midlands	1 (25%)			3 (75%)		4
East of England				1 (100%)		1
London	6 (75%)			2 (25%)		8
Scotland	1 (100%)					1
South East				1 (50%)	1 (50%)	2
South West	1 (50%)			1 (50%)		2
Wales	7 (29.2%)			11 (45.8%)	6 (25%)	24
West Midlands	5 (35.7%)			7 (50%)	2 (14.3%)	14
Yorkshire and The Humber	3 (10.7%)		2 (7.1%)	19 (67.9%)	4 (14.3%)	28
Abroad	1 (100%)					1
Unknown	21 (65.6%)			11 (34.4%)		32
Total	**885 (36.4%)**	**3 (0.1%)**	**18 (0.7%)**	**1219 (50.1%)**	**304 (12.5%)**	**2429**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of level of antiretroviral therapy by primary care trust, please see the North West Public Health Observatory website: http://www.nwpho.org.uk/hiv2002/table3-13.htm

Table 3.12 displays ethnicity and whether or not individuals were exposed to HIV abroad for all HIV and AIDS cases presenting for treatment in the North West in 2002. Twenty seven percent of all cases were reported to have been exposed abroad. However, there were considerable differences between ethnic groups. While the majority of white HIV positive individuals (74%) were thought to have been exposed in the United Kingdom, this was only true for 7% of black Africans. The higher proportion of white individuals for whom exposure abroad is unknown (10%, compared to 8% for ethnic minority groups) may reflect reluctance to pursue this topic with white individuals and make presumptions about those from black and minority ethnic populations.

Table 3.13 shows the level of antiretroviral therapy received by HIV positive individuals attending for treatment for treatment and care in the North West during 2002, broken down by strategic health authority of residence. Individuals are categorised by the highest level of combination therapy they received from any treatment centre in the North West during 2002. Nearly two thirds (63%) of HIV positive individuals were receiving triple or more combination therapy in the year 2002. The proportion of people receiving four or more drugs remains about the same (13%) as 2001. Around a third (36%) of HIV positive individuals were not on any antiretroviral therapy, a comparable proportion to 2001. Of those known to be resident outside the region, but who accessed treatment in the North West, 67% received antiretroviral therapy. In line with British HIV Association Guidelines[79], use of mono or dual therapy was rare (less than 1%).

Table 3.14: Stage of HIV disease of total HIV and AIDS cases by level of antiretrovival therapy, January-December 2002

(All cases seen during 2002 including those who died during the year)

STAGE OF DISEASE	Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or More	
Asymptomatic	537 (63.6%)	3 (0.4%)	3 (0.4%)	277 (32.8%)	24 (2.8%)	844
Symptomatic	201 (23.7%)		10 (1.2%)	506 (59.7%)	131 (15.4%)	848
AIDS	59 (10.5%)		4 (0.7%)	368 (65.5%)	131 (23.3%)	562
AIDS related death	11 (39.3%)			13 (46.4%)	4 (14.3%)	28
Death unrelated to AIDS	6 (75%)			2 (25%)		8
Unknown	71 (51.1%)		1 (0.7%)	53 (38.1%)	14 (10.1%)	139
Total	**885 (36.4%)**	**3 (0.1%)**	**18 (0.7%)**	**1219 (50.1%)**	**304 (12.5%)**	**2429**

Table 3.14 refers to the clinical condition of individuals when last seen in 2002; individuals who died are presented in separate categories. Individuals are categorised by the highest level of antiretroviral therapy they received from any treatment centre in the North West during 2002. The vast majority (89%) of those categorised as having had an AIDS defining illness received triple or more combination therapy, whilst three quarters of those who were symptomatic received this level of therapy. In contrast, most asymptomatic individuals (64%) were not receiving any antiretroviral therapy. This has implications for the future demand for drug therapy, since many of these individuals will require drug treatment when their HIV disease progresses.

Table 3.15 refers to the level of antiretroviral therapy prescribed by specific treatment centres when HIV positive individuals last presented for treatment and care in the North West during 2002. The infectious disease unit at North Manchester General Hospital (NMG), the treatment centre that sees the most individuals in the North West, prescribed triple or more antiretroviral therapy to 68% of their patients. The data illustrate a variation in the level of antiretroviral therapy prescribed across treatment centres in the region. For those receiving antiretroviral therapy, the most common level was triple therapy. Patients newly commencing treatment are more likely to be prescribed triple or more therapy (see chapter 2, table 2.11).

Table 3.15: Distribution of treatment for total HIV and AIDS cases by level of antiretrovival therapy, January-December 2002

(All cases seen during 2002 including those who died during the year)

TREATMENT CENTRE	Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or More	
AHC	1 (10%)			4 (40%)	5 (50%)	10
APH	14 (41.2%)			18 (52.9%)	2 (5.9%)	34
ARM	7 (100%)					7
BLAG	55 (31.8%)		4 (2.3%)	93 (53.8%)	21 (12.1%)	173
BLK			1 (20%)	2 (40%)	2 (40%)	5
BLKG	6 (18.8%)			24 (75%)	2 (6.3%)	32
BOLG	28 (28.3%)	1 (1%)	1 (1%)	55 (55.6%)	14 (14.1%)	99
BURG	4 (26.7%)			9 (60%)	2 (13.3%)	15
BURY	10 (71.4%)			4 (28.6%)		14
CHR	26 (47.3%)			26 (47.3%)	3 (5.5%)	55
CPED				1 (100%)		1
CUM	11 (39.3%)			14 (50%)	3 (10.7%)	28
DDU	5 (100%)					5
FGH	2 (66.7%)			1 (33.3%)		3
LEI	4 (33.3%)			8 (66.7%)		12
LEII	3 (30%)	1 (10%)		6 (60%)		10
MAC	7 (31.8%)			10 (45.5%)	5 (22.7%)	22
MGP	150 (100%)					150
MRI	45 (31.9%)		1 (0.7%)	66 (46.8%)	29 (20.6%)	141
MRIG	123 (67.6%)		1 (0.5%)	49 (26.9%)	9 (4.9%)	182
MRIH	6 (15%)		1 (2.5%)	29 (72.5%)	4 (10%)	40
NMG	296 (32%)		2 (0.2%)	529 (57.2%)	98 (10.6%)	925
NMGG	55 (73.3%)			17 (22.7%)	3 (4%)	75
NOB	4 (66.7%)			2 (33.3%)		6
OLDG	18 (100%)					18
PG	27 (30.7%)		3 (3.4%)	39 (44.3%)	19 (21.6%)	88
PP	3 (50%)			2 (33.3%)	1 (16.7%)	6
QSC	132 (100%)					132
RLG	104 (33.7%)	1 (0.3%)	2 (0.6%)	152 (49.2%)	50 (16.2%)	309
RLH	2 (13.3%)			12 (80%)	1 (6.7%)	15
RLI	5 (33.3%)			10 (66.7%)		15
ROCG	13 (37.1%)			12 (34.3%)	10 (28.6%)	35
SALG	16 (45.7%)			19 (54.3%)		35
SHH	2 (22.2%)		1 (11.1%)	5 (55.6%)	1 (11.1%)	9
SPG	16 (61.5%)			5 (19.2%)	5 (19.2%)	26
STP	24 (41.4%)			28 (48.3%)	6 (10.3%)	58
TAMG	2 (100%)					2
TRAG	3 (75%)			1 (25%)		4
WAR	5 (55.6%)		2 (22.2%)	2 (22.2%)		9
WGH	1 (16.7%)			5 (83.3%)		6
WHIT				3 (75%)	1 (25%)	4
WIGG	3 (100%)					3
WITG	66 (60.6%)			35 (32.1%)	8 (7.3%)	109
WORK	4 (44.4%)			5 (55.6%)		9

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. Rows cannot be totalled horizontally as some individuals may appear in more than one column (i.e. those attending two or more treatment locations), thus exaggerating the totals.

Table 3.16: Residential distribution of total HIV and AIDS cases by treatment centre, January to December 2002 (All cases seen during 2002 including those who died during the year)

SHA	PCT of Residence	AHC	APH	ARM	BLAG	BLK	BLKG	BOLG	BURG	BURY	CHR	CPED	CUM	DDU	FGH	LEI	LEII	MAC	MGP
Cumbria and Lancashire	Carlisle and District												18						
	Eden Valley												7						
	West Cumbria											1	1						
	Morecambe Bay														2				
	Blackpool				129														
	Fylde				12			2											
	Wyre				22														
	Preston				1														
	Hyndburn and Ribble Valley				1	4	9	3	1										
	Burnley, Pendle and Rossendale						1	1	11	1									
	Blackburn with Darwen						20		1										
	Chorley and South Ribble							2	1										
	West Lancashire			1															
Cheshire and Merseyside	Southport and Formby																		
	South Sefton																		
	North Liverpool																		
	Central Liverpool	2		3										3					
	South Liverpool			2										1					
	Knowsley																		
	St Helens																		
	Halton	1									1								
	Warrington										3								
	Birkenhead and Wallasey	1	22								5			1					
	Bebington and West Wirral		4	1							1								
	Ellesmere Port and Neston	2	3								10								
	Cheshire West		1								25					2			
	Central Cheshire												1			9	10	3	
	Eastern Cheshire																	14	
	Unknown Cheshire and Merseyside		1																
Greater Manchester	Ashton, Leigh and Wigan							5											
	Bolton							65								1			
	Bury							3		11									1
	Heywood and Middleton									1	1								
	Rochdale																		1
	Salford							2										1	40
	Trafford North																		2
	Trafford South																		
	North Manchester				1			2											51
	Central Manchester						1	1		1									52
	South Manchester		1																1
	Oldham				1			1											
	Tameside and Glossop				1														
	Stockport										1							1	1
	Out of Region	4				1		12			8				1			3	1
	Abroad																		
	Unknown		2		5		1		1				1						
	Total	**10**	**34**	**7**	**173**	**5**	**32**	**99**	**15**	**14**	**55**	**1**	**28**	**5**	**3**	**12**	**10**	**22**	**150**

MRI	MRIG	MRIH	NMG	NMGG	NOB	OLDG	PG	PP	QSC	RLG	RLH	RLI	ROCG	SALG	SHH	SPG	STP	TAMG	TRAG	WAR	WGH	WHIT	WIGG	WITG	WORK
																									1
										1												4			7
1			5				2					10									6				
		3	8				4		102																
			2				3		8																
			5				4		15																
	1	2	10				47	5	1																
		2	5	2																					
1	3	2	16										3											1	
	2		4				2																		
		1	3				18	1																	
				1			4			7	1			1	1	6									
1		1								5						14									
		1								17	2														
										8															
			2	1			1			106	4				1	2									
										28	1														
										14															
2			3	1						15	1				5										
		1	1							11						1				1					
	3		9							8	1			1	1		1			6				4	
1	1		2							32	1									2					
			1							6						1									
										4															
		2	3							7															
1			13	1						5			1		1									2	1
1	1	2	12														5							4	
4		2	14	3						3						1							3	1	
	1	2	27							1															
1	3	4	46	3										1					2					1	
		2	16										5												
		3	19			1							18												
15	20	1	114	13						1			1	27			2							7	
3	7		16																2					11	
5	1	1	23	1							1													11	
19	28	1	208	28		1			1	3		1	2	1			4							8	
70	86	1	162	15		1				2			1	3			4							33	
5	4		35				1						1				2							20	
1	2	2	35			14			1				2												
2	8		42	3									1				3	2						1	
6	4	3	28											1			33							4	
	2	1	34	3	6		1			22	3						3								
			1																						
2	5		1			1	1		4	3		4				1	1							1	
141	**182**	**40**	**925**	**75**	**6**	**18**	**88**	**6**	**132**	**309**	**15**	**15**	**35**	**35**	**9**	**26**	**58**	**2**	**4**	**9**	**6**	**4**	**3**	**109**	**9**

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. Rows cannot be totalled horizontally as some individuals may appear in more than one column (i.e. those attending two or more treatment locations), thus exaggerating the totals.

Table 3.17: Distribution of treatment for total HIV and AIDS cases by stage of HIV disease, January-December 2002 (All cases seen during 2002 including those who died during the year)

TREATMENT CENTRE	Stage of HIV Disease						Total (100%)
	Asympto-matic	Sympto-matic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
AHC	4 (40%)	1 (10%)	5 (50%)				10
APH	11 (32.4%)	11 (32.4%)	10 (29.4%)	2 (5.9%)			34
ARM	3 (42.9%)	1 (14.3%)	3 (42.9%)				7
BLAG	38 (22%)	76 (43.9%)	57 (32.9%)		1 (0.6%)	1 (0.6%)	173
BLK		3 (60%)	2 (40%)				5
BLKG	14 (43.8%)	18 (56.3%)					32
BOLG	46 (46.5%)	27 (27.3%)	24 (24.2%)	2 (2%)			99
BURG	2 (13.3%)	10 (66.7%)	3 (20%)				15
BURY	4 (28.6%)	5 (35.7%)	4 (28.6%)		1 (7.1%)		14
CHR	38 (69.1%)	8 (14.5%)	9 (16.4%)				55
CPED	1 (100%)						1
CUM	16 (57.1%)	6 (21.4%)	5 (17.9%)			1 (3.6%)	28
DDU	2 (40%)	3 (60%)					5
FGH			2 (66.7%)	1 (33.3%)			3
LEI	5 (41.7%)	1 (8.3%)	4 (33.3%)			2 (16.7%)	12
LEII	5 (50%)	1 (10%)	4 (40%)				10
MAC	13 (59.1%)	4 (18.2%)	5 (22.7%)				22
MGP	42 (28%)	74 (49.3%)	23 (15.3%)	1 (0.7%)		10 (6.7%)	150
MRI	44 (31.2%)	62 (44%)	34 (24.1%)	1 (0.7%)			141
MRIG	131 (72%)	35 (19.2%)	16 (8.8%)				182
MRIH	4 (10%)	28 (70%)	8 (20%)				40
NMG	187 (20.2%)	421 (45.5%)	299 (32.3%)	14 (1.5%)	4 (0.4%)		925
NMGG	38 (50.7%)	21 (28%)	9 (12%)	1 (1.3%)		6 (8%)	75
NOB	4 (66.7%)	1 (16.7%)	1 (16.7%)				6
OLDG	3 (16.7%)	2 (11.1%)	9 (50%)	2 (11.1%)		2 (11.1%)	18
PG	22 (25%)	36 (40.9%)	26 (29.5%)	2 (2.3%)	1 (1.1%)	1 (1.1%)	88
PP	3 (50%)	2 (33.3%)	1 (16.7%)				6
QSC	27 (20.5%)	42 (31.8%)	45 (34.1%)		1 (0.8%)	17 (12.9%)	132
RLG	117 (37.9%)	117 (37.9%)	70 (22.7%)	5 (1.6%)			309
RLH	4 (26.7%)	7 (46.7%)	3 (20%)	1 (6.7%)			15
RLI	10 (66.7%)	2 (13.3%)	3 (20%)				15
ROCG	6 (17.1%)	18 (51.4%)	8 (22.9%)	1 (2.9%)	1 (2.9%)	1 (2.9%)	35
SALG	27 (77.1%)	6 (17.1%)	1 (2.9%)		1 (2.9%)		35
SHH	5 (55.6%)	3 (33.3%)	1 (11.1%)				9
SPG	13 (50%)	6 (23.1%)	6 (23.1%)	1 (3.8%)			26
STP	21 (36.2%)	18 (31%)	19 (32.8%)				58
TAMG	1 (50%)					1 (50%)	2
TRAG	2 (50%)	1 (25%)	1 (25%)				4
WAR	5 (55.6%)	3 (33.3%)	1 (11.1%)				9
WGH	1 (16.7%)	2 (33.3%)	3 (50%)				6
WHIT	2 (50%)		2 (50%)				4
WIGG	2 (66.7%)	1 (33.3%)					3
WITG	55 (50.5%)	34 (31.2%)	18 (16.5%)			2 (1.8%)	109
WORK	6 (66.7%)	2 (22.2%)	1 (11.1%)				9

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. Columns cannot be totalled vertically as some individuals may appear in more than one row (i.e. those attending two or more treatment locations), thus exaggerating the totals.

Table 3.16 illustrates the residential distribution of all HIV and AIDS cases presenting to treatment centres in the North West in 2002. Most individuals with HIV or AIDS present to treatment centres close to where they live. The Infectious Disease Unit at North Manchester General Hospital (NMG) saw the largest number of people (925), and the largest number of residents outside the North West Region (34, 4% of its patients). However, some of the other treatment centres had higher proportions of residents from outside the region, for example the haematology department at Alder Hey Children's Hospital (AHC) because it is a specialist unit at 40% and the Countess of Chester Hospital GUM (CHR) at 15%.

Table 3.17 illustrates the clinical stage of all HIV and AIDS cases presenting for treatment in the North West during 2002, by treatment centre. The figures refer to the clinical condition of individuals when last seen in the year 2002; HIV positive individuals who died are presented in separate categories to other cases. In the North West, the treatment of HIV and AIDS cases is divided primarily between the large infectious disease unit, genitourinary medicine clinics and haematology clinics. Care is also provided by a number of other hospital units and a specialist general practice.

Thirty six percent of all HIV and AIDS individuals presenting for treatment in the North West during 2002 were categorised as symptomatic, with 24% classed as AIDS (table 3.2a). The largest HIV and AIDS treatment centre in the North West, the Infectious Disease Unit at North Manchester General Hospital (NMG), provides care for 38% of all HIV positive individuals presenting in the North West, including 50% of those individuals who died during the year.

There are significant differences between treatment centres in the proportion of individuals categorised as asymptomatic, symptomatic and AIDS. Although this variation may represent real differences, the distinction between stages of disease can be unclear, particularly in the light of developments in combination antiretroviral therapy.

Table 3.18 illustrates the infection route of all HIV and AIDS cases presenting for treatment in the North West in 2002, by treatment centre. There are considerable variations in the proportions of method of exposure to HIV between different treatment centres. Ninety six percent of individuals attending a specialist general practice in Manchester (MGP) had been exposed to HIV via homosexual sex compared to an overall rate of 59% of all HIV and AIDS cases within the region (table 3.3a). Treatment of individuals exposed through contaminated blood or blood products is primarily undertaken by specialist haematology units at Manchester Royal Infirmary (MRIH) and Royal Liverpool University Hospital (RLH).

The Infectious Disease Unit at North Manchester General Hospital (NMG) provides care for the highest number of HIV positive individuals in the North West (925), representing a 21% increase on the previous year. A number of other treatment centres have seen sharper increases: Blackburn GUM (BLKG) with 190%, Alder Hey Children's Hospital with 67%, and Royal Bolton Hospital GUM seeing a 36% increase. The main provider of HIV treatment and care in Cheshire and Merseyside, The Royal Liverpool University Hospital Department of Genito-Urinary Medicine (RLG) has also seen a large increase (by 44%, from 214 in 2001 to 309 in 2002).

Table 3.19 illustrates the age distribution of all HIV and AIDS cases presenting for treatment in the North West during 2002, by treatment centre. The age distribution of HIV cases remains (as in previous years) concentrated in the 30-44 age range, accounting for 60% of all cases (table 3.1). Age ranges are proportionally represented throughout most treatment sites, with the exception of centres specialising in paediatric care, in particular Alder Hey Children's Hospital (AHC) and the paediatric department at the Royal Preston Hospital (PP), where all individuals are under 15 years of age.

Table 3.18: Distribution of treatment for total HIV and AIDS cases by infection route of HIV, January-December 2002 (All cases seen during 2002 including those who died during the year)

TREATMENT CENTRE	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
AHC					8 (80%)	2 (20%)	10
APH	20 (58.8%)		13 (38.2%)			1 (2.9%)	34
ARM	6 (85.7%)		1 (14.3%)				7
BLAG	140 (80.9%)	3 (1.7%)	17 (9.8%)	1 (0.6%)	1 (0.6%)	11 (6.4%)	173
BLK	3 (60%)		2 (40%)				5
BLKG	10 (31.3%)	2 (6.3%)	20 (62.5%)				32
BOLG	48 (48.5%)	2 (2%)	49 (49.5%)				99
BURG	8 (53.3%)	2 (13.3%)	4 (26.7%)			1 (6.7%)	15
BURY	8 (57.1%)	1 (7.1%)	4 (28.6%)		1 (7.1%)		14
CHR	35 (63.6%)	2 (3.6%)	18 (32.7%)				55
CPED					1 (100%)		1
CUM	15 (53.6%)	1 (3.6%)	12 (42.9%)				28
DDU		4 (80%)				1 (20%)	5
FGH	2 (66.7%)	1 (33.3%)					3
LEI	9 (75%)		2 (16.7%)	1 (8.3%)			12
LEII	7 (70%)		3 (30%)				10
MAC	13 (59.1%)	1 (4.5%)	6 (27.3%)	1 (4.5%)		1 (4.5%)	22
MGP	144 (96%)	1 (0.7%)	3 (2%)			2 (1.3%)	150
MRI	110 (78%)	4 (2.8%)	26 (18.4%)			1 (0.7%)	141
MRIG	125 (68.7%)	1 (0.5%)	51 (28%)			5 (2.7%)	182
MRIH			2 (5%)	38 (95%)			40
NMG	558 (60.3%)	41 (4.4%)	215 (23.2%)	7 (0.8%)	23 (2.5%)	81 (8.8%)	925
NMGG	63 (84%)		7 (9.3%)			5 (6.7%)	75
NOB	2 (33.3%)		4 (66.7%)				6
OLDG	9 (50%)	3 (16.7%)	6 (33.3%)				18
PG	33 (37.5%)	3 (3.4%)	39 (44.3%)		2 (2.3%)	11 (12.5%)	88
PP					6 (100%)		6
QSC	96 (72.7%)	2 (1.5%)	10 (7.6%)		3 (2.3%)	21 (15.9%)	132
RLG	135 (43.7%)	12 (3.9%)	128 (41.4%)	7 (2.3%)		27 (8.7%)	309
RLH				15 (100%)			15
RLI	7 (46.7%)	1 (6.7%)	7 (46.7%)				15
ROCG	23 (65.7%)	2 (5.7%)	10 (28.6%)				35
SALG	27 (77.1%)		8 (22.9%)				35
SHH	7 (77.8%)		2 (22.2%)				9
SPG	11 (42.3%)		14 (53.8%)			1 (3.8%)	26
STP	42 (72.4%)	1 (1.7%)	14 (24.1%)			1 (1.7%)	58
TAMG	1 (50%)		1 (50%)				2
TRAG	4 (100%)						4
WAR	7 (77.8%)		2 (22.2%)				9
WGH	2 (33.3%)	1 (16.7%)	2 (33.3%)			1 (16.7%)	6
WHIT			2 (50%)	1 (25%)		1 (25%)	4
WIGG			3 (100%)				3
WITG	89 (81.7%)	4 (3.7%)	16 (14.7%)				109
WORK	6 (66.7%)		3 (33.3%)				9

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category. Columns cannot be totalled vertically as some individuals may appear in more than one row (i.e. those attending two or more treatment locations), thus exaggerating the totals.

Table 3.19: Distribution of treatment for total HIV and AIDS cases by age category, January-December 2002 (All cases seen during 2002 including those who died during the year)

TREATMENT CENTRE	Age Group											Total (100%)
	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	
AHC	10 (100%)											10
APH			2 (5.9%)	2 (5.9%)	11 (32.4%)	7 (20.6%)	3 (8.8%)	2 (5.9%)	2 (5.9%)	3 (8.8%)	2 (5.9%)	34
ARM		1 (14.3%)	1 (14.3%)		1 (14.3%)		2 (28.6%)		1 (14.3%)	1 (14.3%)		7
BLAG	1 (0.6%)	1 (0.6%)	8 (4.6%)	14 (8.1%)	30 (17.3%)	44 (25.4%)	32 (18.5%)	21 (12.1%)	11 (6.4%)	4 (2.3%)	7 (4%)	173
BLK						1 (20%)	1 (20%)		1 (20%)	1 (20%)	1 (20%)	5
BLKG			1 (3.1%)	9 (28.1%)	3 (9.4%)	7 (21.9%)	6 (18.8%)	1 (3.1%)	3 (9.4%)	1 (3.1%)	1 (3.1%)	32
BOLG		2 (2%)	5 (5.1%)	13 (13.1%)	15 (15.2%)	19 (19.2%)	18 (18.2%)	13 (13.1%)	7 (7.1%)	3 (3%)	4 (4%)	99
BURG					4 (26.7%)	2 (13.3%)	3 (20%)	1 (6.7%)	4 (26.7%)	1 (6.7%)		15
BURY	1 (7.1%)		1 (7.1%)	3 (21.4%)	3 (21.4%)	3 (21.4%)	2 (14.3%)	1 (7.1%)				14
CHR			3 (5.5%)	11 (20%)	10 (18.2%)	16 (29.1%)	6 (10.9%)	3 (5.5%)	2 (3.6%)	4 (7.3%)		55
CPED	1 (100%)											1
CUM			2 (7.1%)	3 (10.7%)	6 (21.4%)	3 (10.7%)	3 (10.7%)	6 (21.4%)	2 (7.1%)	1 (3.6%)	2 (7.1%)	28
DDU				1 (20%)		1 (20%)	1 (20%)	1 (20%)	1 (20%)			5
FGH						2 (66.7%)		1 (33.3%)				3
LEI		1 (8.3%)	1 (8.3%)	2 (16.7%)		3 (25%)	1 (8.3%)	1 (8.3%)	2 (16.7%)		1 (8.3%)	12
LEII				2 (20%)	2 (20%)	1 (10%)	1 (10%)		2 (20%)	2 (20%)		10
MAC				4 (18.2%)	3 (13.6%)	9 (40.9%)	2 (9.1%)	2 (9.1%)	1 (4.5%)	1 (4.5%)		22
MGP			3 (2%)	17 (11.3%)	37 (24.7%)	41 (27.3%)	30 (20%)	14 (9.3%)	6 (4%)	1 (0.7%)	1 (0.7%)	150
MRI			2 (1.4%)	26 (18.4%)	24 (17%)	29 (20.6%)	33 (23.4%)	15 (10.6%)	5 (3.5%)	5 (3.5%)	2 (1.4%)	141
MRIG		3 (1.6%)	18 (9.9%)	35 (19.2%)	46 (25.3%)	33 (18.1%)	28 (15.4%)	9 (4.9%)	8 (4.4%)	2 (1.1%)		182
MRIH				3 (7.5%)	8 (20%)	12 (30%)	6 (15%)	9 (22.5%)		2 (5%)		40
NMG	23 (2.5%)	3 (0.3%)	23 (2.5%)	82 (8.9%)	179 (19.4%)	237 (25.6%)	169 (18.3%)	115 (12.4%)	49 (5.3%)	16 (1.7%)	29 (3.1%)	925
NMGG			3 (4%)	9 (12%)	22 (29.3%)	21 (28%)	14 (18.7%)	4 (5.3%)	2 (2.7%)			75
NOB				1 (16.7%)		2 (33.3%)	2 (33.3%)	1 (16.7%)				6
OLDG			1 (5.6%)	1 (5.6%)	6 (33.3%)	4 (22.2%)	3 (16.7%)	2 (11.1%)	1 (5.6%)			18
PG	2 (2.3%)		2 (2.3%)	7 (8%)	18 (20.5%)	21 (23.9%)	17 (19.3%)	8 (9.1%)	5 (5.7%)	3 (3.4%)	5 (5.7%)	88
PP	6 (100%)											6
QSC	3 (2.3%)	1 (0.8%)	7 (5.3%)	10 (7.6%)	27 (20.5%)	32 (24.2%)	21 (15.9%)	14 (10.6%)	9 (6.8%)	3 (2.3%)	5 (3.8%)	132
RLG		3 (1%)	17 (5.5%)	33 (10.7%)	54 (17.5%)	74 (23.9%)	56 (18.1%)	29 (9.4%)	18 (5.8%)	14 (4.5%)	11 (3.6%)	309
RLH		1 (6.7%)	2 (13.3%)	2 (13.3%)	4 (26.7%)	2 (13.3%)	3 (20%)		1 (6.7%)			15
RLI			1 (6.7%)	1 (6.7%)	2 (13.3%)	4 (26.7%)		2 (13.3%)	3 (20%)	2 (13.3%)		15
ROCG			1 (2.9%)	5 (14.3%)	8 (22.9%)	7 (20%)	6 (17.1%)	4 (11.4%)	3 (8.6%)	1 (2.9%)		35
SALG		1 (2.9%)	3 (8.6%)	4 (11.4%)	10 (28.6%)	8 (22.9%)	6 (17.1%)	1 (2.9%)	1 (2.9%)		1 (2.9%)	35
SHH			1 (11.1%)	2 (22.2%)	2 (22.2%)	4 (44.4%)						9
SPG			2 (7.7%)	3 (11.5%)	6 (23.1%)	8 (30.8%)	2 (7.7%)	3 (11.5%)		1 (3.8%)	1 (3.8%)	26
STP			5 (8.6%)	8 (13.8%)	5 (8.6%)	15 (25.9%)	7 (12.1%)	5 (8.6%)	7 (12.1%)	3 (5.2%)	3 (5.2%)	58
TAMG					1 (50%)	1 (50%)						2
TRAG				1 (25%)			1 (25%)	1 (25%)	1 (25%)			4
WAR		1 (11.1%)		1 (11.1%)	3 (33.3%)		1 (11.1%)	1 (11.1%)	1 (11.1%)		1 (11.1%)	9
WGH					1 (16.7%)	2 (33.3%)		1 (16.7%)	1 (16.7%)	1 (16.7%)		6
WHIT					1 (25%)	2 (50%)	1 (25%)					4
WIGG						1 (33.3%)	1 (33.3%)		1 (33.3%)			3
WITG			5 (4.6%)	18 (16.5%)	22 (20.2%)	28 (25.7%)	19 (17.4%)	8 (7.3%)	4 (3.7%)	1 (0.9%)	4 (3.7%)	109
WORK				2 (22.2%)	2 (22.2%)	4 (44.4%)	1 (11.1%)					9

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. Columns cannot be totalled vertically as some individuals may appear in more than one row (i.e. those attending two or more treatment locations), thus exaggerating the totals.

Table 3.20: Distribution of treatment for total HIV and AIDS cases by sex, January-December 2002 (All cases seen during 2002 including those who died during the year)

TREATMENT CENTRE	Sex		Total (100%)
	Male	Female	
AHC	6 (60%)	4 (40%)	10
APH	32 (94.1%)	2 (5.9%)	34
ARM	7 (100%)		7
BLAG	164 (94.8%)	9 (5.2%)	173
BLK	5 (100%)		5
BLKG	21 (65.6%)	11 (34.4%)	32
BOLG	70 (70.7%)	29 (29.3%)	99
BURG	13 (86.7%)	2 (13.3%)	15
BURY	9 (64.3%)	5 (35.7%)	14
CHR	44 (80%)	11 (20%)	55
CPED		1 (100%)	1
CUM	20 (71.4%)	8 (28.6%)	28
DDU	3 (60%)	2 (40%)	5
FGH	2 (66.7%)	1 (33.3%)	3
LEI	12 (100%)		12
LEII	9 (90%)	1 (10%)	10
MAC	21 (95.5%)	1 (4.5%)	22
MGP	148 (98.7%)	2 (1.3%)	150
MRI	119 (84.4%)	22 (15.6%)	141
MRIG	148 (81.3%)	34 (18.7%)	182
MRIH	35 (87.5%)	5 (12.5%)	40
NMG	761 (82.3%)	164 (17.7%)	925
NMGG	70 (93.3%)	5 (6.7%)	75
NOB	4 (66.7%)	2 (33.3%)	6
OLDG	13 (72.2%)	5 (27.8%)	18
PG	65 (73.9%)	23 (26.1%)	88
PP	2 (33.3%)	4 (66.7%)	6
QSC	124 (93.9%)	8 (6.1%)	132
RLG	227 (73.5%)	82 (26.5%)	309
RLH	15 (100%)		15
RLI	12 (80%)	3 (20%)	15
ROCG	30 (85.7%)	5 (14.3%)	35
SALG	29 (82.9%)	6 (17.1%)	35
SHH	8 (88.9%)	1 (11.1%)	9
SPG	21 (80.8%)	5 (19.2%)	26
STP	51 (87.9%)	7 (12.1%)	58
TAMG	2 (100%)		2
TRAG	4 (100%)		4
WAR	7 (77.8%)	2 (22.2%)	9
WGH	5 (83.3%)	1 (16.7%)	6
WHIT	2 (50%)	2 (50%)	4
WIGG	2 (66.7%)	1 (33.3%)	3
WITG	100 (91.7%)	9 (8.3%)	109
WORK	6 (66.7%)	3 (33.3%)	9

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. Columns cannot be totalled vertically as some individuals may appear in more than one row (i.e. those attending two or more treatment locations), thus exaggerating the totals.

Table 3.20 illustrates the number of male and female HIV and AIDS cases presenting for treatment in the North West in 2002, by treatment centre. The vast majority of all HIV and AIDS cases treated in the North West were male (82%; table 3.4), with this trend illustrated to varying degrees at most treatment centres. The gender distribution at treatment centres is influenced primarily by the proportion of individuals whose infection route was classed as homosexual sex. This is most clearly illustrated at a specialist Manchester general practice (MGP) where homosexual exposure accounted for 96% of cases (table 3.18) and 99% of individuals were male. Similarly, the Armistead Project in Liverpool (ARM) caters specifically for gay men. The Haematology Units in Manchester Royal Infirmary (MRIH) and Royal Liverpool University (RLH) also see more males because conditions such as haemophilia are more common among males, and many haemophiliacs were infected with HIV prior to screening of blood products. Exceptions to this male biased gender distribution occur at treatment centres specialising in paediatric care such as Alder Hey Children's Hospital (AHC) and the Paediatric Department at Royal Preston Hospital (PP) where males and females are equally likely to be affected.

Table 3.21: Residential distribution of total HIV and AIDS cases by number of treatment centres attended, January-December 2002

(All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	Treatment Centres Attended			Total (100%)
	One	Two	Three	
Cumbria and Lancashire	332 (72%)	123 (26.7%)	6 (1.3%)	461
Cheshire and Merseyside	410 (87.8%)	52 (11.1%)	5 (1.1%)	467
Greater Manchester	1094 (79.8%)	255 (18.6%)	22 (1.6%)	1371
Isle of Man	11 (84.6%)	2 (15.4%)		13
East Midlands	4 (100%)			4
East of England	1 (100%)			1
London	8 (100%)			8
Scotland	1 (100%)			1
South East	2 (100%)			2
South West	2 (100%)			2
Wales	21 (87.5%)	3 (12.5%)		24
West Midlands	13 (92.9%)	1 (7.1%)		14
Yorkshire and The Humber	26 (92.9%)	2 (7.1%)		28
Abroad	1 (100%)			1
Unknown	29 (90.6%)	3 (9.4%)		32
Total	**1955 (80.5%)**	**441 (18.2%)**	**33 (1.4%)**	**2429**

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of number of treatment centres by primary care trust, please see the North West Public Health Observatory website: http://www.nwpho.org.uk/hiv2002/table3-21.htm

Table 3.21 illustrates the residential distribution of all HIV and AIDS cases presenting in the North West for treatment in 2002 by the number of statutory treatment centres attended. The majority (81%) attended only one treatment centre, a comparable proportion to 2001. However, this varied across strategic health authorities, with residents of Cheshire and Merseyside being more likely to attend only one centre (88%) than those of Cumbria and Lancashire (72%) or Greater Manchester (80%). It should be noted that these numbers refer only to treatment centres within the North West.

Table 3.22 illustrates the overlap of treatment of HIV and AIDS cases between treatment centres in the North West during 2002. The diagonal (in bold) represents the number of individuals who used each treatment centre as their sole provider of care during 2002, and the right hand column shows the total numbers accessing each treatment centre. For example, although 925 individuals accessed care from North Manchester General Infectious Disease Unit (NMG), only 71% (661) used NMG as their sole provider of care. North Manchester General patients also attended Manchester Royal Infirmary Outpatient Department (MRI, 37 individuals) and a specialist general practice in Manchester (MGP, 84 individuals). Involvement and specialism by GPs in the area of sexual health and HIV is promoted in the National Strategy for Sexual Health and HIV[82]. The crossover of treatment may reflect individuals' simultaneously accessing treatment and care from more than one centre or may represent individuals who have transferred their care between treatment centres during 2002.

Table 3.22: Overlap of total HIV and AIDS cases between different centres of treatment, January-December 2002 (All cases seen during 2002 including those who died during the year)

	AHC	APH	ARM	BLAG	BLK	BLKG	BOLG	BURG	BURY	CHR	CPED	CUM	DDU	FGH	LEI	LEII	MAC	MGP	MRI	MRIG	MRIH	NMG
AHC	**10**																					
APH		**25**								1										1		
ARM			**1**																			
BLAG				**63**																		4
BLK					**3**	1	1															
BLKG					1	**29**																2
BOLG					1		**95**															3
BURG								**13**														2
BURY									**5**													8
CHR		1								**43**												6
CPED											**1**											
CUM												**25**				1						
DDU													**1**									
FGH														**3**								
LEI															**10**	2						
LEII												1			2	**7**						
MAC																	**17**					4
MGP																		**29**	24	14		84
MRI																		24	**82**	5		37
MRIG		1																14	5	**138**		22
MRIH																					**36**	4
NMG				4		2	3	2	8	6							4	84	37	22	4	**661**
NMGG																		7				31
NOB																				1		
OLDG																			1			15
PG				4																		3
PP																						
QSC				107																		7
RLG		7	4							4		1	4					1	1	1		6
RLH																						
RLI																						
ROCG									1													5
SALG																		1				4
SHH																						1
SPG			2																			
STP				1						1							1	2		2		13
TAMG																						1
TRAG																						2
WAR										2												3
WGH																						
WHIT																						
WIGG																						2
WITG																		7	1	1		24
WORK												2				1						

NMGG	NOB	OLDG	PG	PP	QSC	RLG	RLH	RLI	ROCG	SALG	SHH	SPG	STP	TAMG	TRAG	WAR	WGH	WHIT	WIGG	WITG	WORK	TOTAL
																						10
						7																**34**
						4						2										**7**
			4		107								1									**173**
																						5
																						32
																						99
																						15
									1													**14**
						4							1			2						**55**
																						1
						1															2	**28**
						4																**5**
																						3
																						12
																					1	**10**
													1									**22**
7						1				1			2							7		**150**
		1				1														1		**141**
	1					1							2							1		**182**
																						40
31		15	3		7	6			5	4	1		13	1	2	3			2	24		**925**
39						2			1										1			**75**
	4					1																**6**
		3																				**18**
			76	2	2	1											1			1		**88**
			2	**3**	1																	**6**
			2	1	**21**																	**132**
2	1		1			**265**	5				6	2				1						**309**
						5	**10**															**15**
								15														**15**
1									**28**													**35**
										29						1						**35**
						6					**3**											**9**
						2						**22**										**26**
													40									**58**
														1								**2**
															2					1		**4**
						1				1						**4**						**9**
			1														**5**					**6**
																		4				**4**
1																			**0**			**3**
			1												1					**77**		**109**
																					7	**9**

The diagonal (in bold) represents the number of individuals who solely used each treatment centre in 2002. The total column represents the total number of individuals attending each treatment centre (excluding double counting of individuals attending more than two treatment centres). Individuals attending three or more treatment centres are counted more than once in the body of the table. For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report.

Table 3.23: Distribution of total and mean number of outpatient visits, day cases, inpatient episodes, inpatient days and home visits by treatment centre, January-December 2002 (All cases seen during 2002 including those who died during the year)

TREATMENT CENTRE	Outpatient Visits		Day Cases		Inpatient Episodes		Inpatient Days		Home Visits	
	Total	Mean	Total	Mean	Total	Mean	Total	Mean	Total	Mean
AHC	87	8.7	0	0	5	0.5	23	2.3	32	3.2
APH	414	12.2	115	3.4	22	0.6	350	10.3	2	0.1
ARM	120	17.1	0	0	0	0	0	0	0	0
BLAG	1039	6	17	0.1	8	0	56	0.3	3	0
BLK	26	5.2	0	0	0	0	0	0	0	0
BLKG	193	6	2	0.1	8	0.3	92	2.9	3	0.1
BOLG	867	8.8	0	0	7	0.1	98	1	17	0.2
BURG	123	8.2	0	0	5	0.3	150	10	81	5.4
BURY	58	4.1	0	0	0	0	0	0	32	2.3
CHR	338	6.1	7	0.1	12	0.2	141	2.6	7	0.1
CPED	3	3	0	0	0	0	0	0	0	0
CUM	127	4.5	0	0	2	0.1	20	0.7	0	0
DDU	40	8	0	0	0	0	0	0	14	2.8
FGH	4	1.3	0	0	0	0	0	0	2	0.7
LEI	85	7.1	0	0	0	0	0	0	1	0.1
LEII	41	4.1	1	0.1	2	0.2	12	1.2	0	0
MAC	200	9.1	0	0	1	0	7	0.3	23	1
MGP	854	5.7	0	0	0	0	0	0	11	0.1
MRI	1098	7.8	1	0	4	0	26	0.2	0	0
MRIG	1568	8.6	0	0	7	0	160	0.9	2	0
MRIH	245	6.1	2	0.1	12	0.3	133	3.3	0	0
NMG	6052	6.5	314	0.3	294	0.3	3492	3.8	1908	2.1
NMGG	400	5.3	1	0	3	0	10	0.1	59	0.8
NOB	58	9.7	0	0	1	0.2	1	0.2	1	0.2
OLDG	13	0.7	0	0	0	0	0	0	166	9.2
PG	550	6.3	9	0.1	11	0.1	334	3.8	32	0.4
PP	32	5.3	2	0.3	0	0	0	0	0	0
QSC	1132	8.6	0	0	0	0	0	0	348	2.6
RLG	2475	8	46	0.1	135	0.4	1488	4.8	0	0
RLH	84	5.6	2	0.1	13	0.9	116	7.7	0	0
RLI	55	3.7	0	0	0	0	0	0	29	1.9
ROCG	308	8.8	1	0	5	0.1	25	0.7	0	0
SALG	130	3.7	0	0	0	0	0	0	41	1.2
SHH	127	14.1	0	0	1	0.1	91	10.1	0	0
SPG	287	11	1	0	4	0.2	62	2.4	0	0
STP	405	7	1	0	1	0	49	0.8	5	0.1
TAMG	4	2	0	0	0	0	0	0	0	0
TRAG	46	11.5	0	0	0	0	0	0	0	0
WAR	49	5.4	0	0	1	0.1	63	7	0	0
WGH	19	3.2	0	0	0	0	0	0	15	2.5
WHIT	20	5	0	0	1	0.3	2	0.5	9	2.3
WIGG	19	6.3	0	0	0	0	0	0	10	3.3
WITG	808	7.4	1	0	0	0	0	0	261	2.4
WORK	83	9.2	2	0.2	7	0.8	11	1.2	19	2.1
Total	**20686**	**7**	**525**	**0.2**	**572**	**0.2**	**7012**	**2.4**	**3133**	**1.1**

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. The means are calculated as the number of outpatient visits / day cases / inpatient episodes / inpatient days / home visits divided by the total number of HIV positive individuals accessing the treatment centre.

Table 3.23 displays the amount of outpatient days, day cases, inpatient days, inpatient episodes and home visits attributed to HIV and AIDS cases accessing care from the statutory sector during 2002. The data are displayed as the total number of days, episodes or visits and the mean number of days, episodes or visits per HIV positive individual treated by that centre. This is the fourth year that information on inpatient and outpatient care for the whole of the North West Region has been collected, allowing comparisons to be made with the data from 1999 to 2001.

As was the case in the years 1999 to 2001, in the year 2002 North Manchester General Infectious Disease Unit (NMG) provided the highest number of outpatient visits. Outpatient visits at NMG accounted for 29% of all attendances across the region, with the Department of Genito-Urinary Medicine at the Royal Liverpool University Hospital (RLG) reporting the second highest number of visits, and a higher mean number of outpatient visits per HIV positive person. The Armistead Project (ARM) and St Helen's General Hospital (SHH) provided mean outpatient visits of 17.1 and 14.1 respectively, which is more than double the average of 7 visits per patient.

North Manchester General Infectious Disease Unit (NMG) also provided the highest number of day cases (60% of the total), inpatient episodes (51% of the total) and inpatient days, with the Department of Genito-Urinary Medicine at the Royal Liverpool University Hospital (RLG) providing the next highest numbers of inpatient episodes at 24% of the total.

Some of the treatment centres provided a significant number of home visits, with North Manchester General ID unit (NMG) providing the most at 1908 (61% of the total). This is the second year that we have collected data on home visits. The mean number per patient has increased from none in 2001 to 2.1 this year, reflecting improvements in data reporting and collection. Burnley GUM (BURG) and Royal Oldham Hospital GUM (OLDG) provided the highest number of home visits per HIV positive person, at 5.4 and 9.2 respectively. Oldham is the only hospital to see more people at home than in the outpatient department and it is the only treatment centre with mean outpatient visits less than one.

Table 3.24: Distribution of total and mean number of outpatient episodes, day cases, inpatient episodes, inpatient days and home visits by stage of HIV disease, January-December 2002 (All cases seen during 2002 including those who died during the year)

STAGE OF HIV DISEASE	Outpatient Visits		Day Cases		Inpatient Episodes		Inpatient Days		Home Visits	
	Sum	Mean	Sum	Mean	Sum	Mean	Sum	Mean	Sum	Mean
Asymptomatic	6383	7.3	80	0.1	77	0.1	602	0.7	597	0.7
Symptomatic	8015	9.1	183	0.2	210	0.2	2423	2.7	1011	1.1
AIDS	5858	9.9	245	0.4	227	0.4	3175	5.4	1270	2.2
AIDS related death	176	6.3	17	0.6	49	1.8	766	27.4	136	4.9
Death unrelated to AIDS	52	6.5	0	0	9	1.1	46	5.8	61	7.6
Unknown	202	4.6	0	0	0	0	0	0	58	1.3
Total	**20686**	**8.5**	**525**	**0.2**	**572**	**0.2**	**7012**	**2.9**	**3133**	**1.3**

The means are calculated as the number of outpatient visits / day cases / inpatient episodes / inpatient days / home visits divided by the total number of HIV positive individuals in the clinical category.

Table 3.24 illustrates the distribution of patient care by clinical stage for all those HIV positive individuals accessing treatment and care in the North West during 2002. The data show the increasing level and different type of care required as HIV disease progresses. While asymptomatic individuals required on average 7.3 outpatient visits per patient, 9.1 visits were required per symptomatic patient rising to 9.9 visits for each patient with an AIDS diagnosis. Those who died of an AIDS related illness during the year had on average of only 6.3 outpatient visits during 2002 but required by far the largest amount of inpatient care, at an average of 27.4 days each. In contrast, asymptomatic, symptomatic and AIDS patients required only 0.7, 2.7 and 5.4 days of inpatient care respectively. Levels of care were similar in 2002 compared to 2000 and 2001, with the overall mean number of outpatient visits dropping slightly (from 9.5 to 9.3 to 8.5 visits per HIV positive individual) and the number of inpatient days decreasing slightly from 3.8 in 2000 and 2001 to 2.9 in 2002.

Table 3.25 presents a breakdown of asylum seeker status by stage of HIV disease for all those individuals who presented for treatment in the North West in 2002. A total of 153 individuals were known to be asylum seekers (6% of the total HIV positive population). The proportion of individuals who are asylum seekers has doubled since last year (from 3%). Asylum seeker status for 7% was unknown.

The majority (64%) of asylum seekers were reported to be still asymptomatic, suggesting that individuals usually access treatment while still healthy and thus may benefit by life-prolonging treatment. This compares to the non-asylum seeking population, where only 33% are classified as asymptomatic. Of the known 153 asylum seekers 12% had an AIDS diagnosis, compared to 25% of non-asylum seekers. No asylum seekers died during the year 2002.

Table 3.26 shows the strategic health authority of residence by sex, age group, infection route and ethnicity of those individuals known to be asylum seekers who accessed treatment and care in the North West in 2002. Most of the known HIV positive asylum seekers (68%) were resident in Greater Manchester SHA, with a further 24% residing in Cheshire and Merseyside SHA and 6% in Cumbria and Lancashire. There were more females (58%) than males (42%), and the vast majority (92%) were infected via heterosexual sex. Asylum seekers were younger than the general HIV positive population (see chapter 3, figure 3.1), with most (55%) being aged between 25 and 34 years. The majority of (93%) asylum seekers were self-defined as black African.

Table 3.25: Asylum seeker status by stage of HIV disease, January-December 2002

ASYLUM SEEKER STATUS	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Yes	98 (64.1%)	33 (21.6%)	19 (12.4%)			3 (2%)	153
No	706 (33.4%)	810 (38.3%)	535 (25.3%)	27 (1.3%)	8 (0.4%)	30 (1.4%)	2116
Unknown	70 (43.8%)	42 (26.3%)	36 (22.5%)	1 (0.6%)		11 (6.9%)	160
Total	**874 (36%)**	**885 (36.4%)**	**590 (24.3%)**	**28 (1.2%)**	**8 (0.3%)**	**44 (1.8%)**	**2429**

Table 3.26: Residential distribution of individuals known to be asylum seekers by sex, age group, infection route, ethnicity, January-December 2002

SEX	SHA of Residence					Total (100%)
	Cumbria and Lancashire	Cheshire and Merseyside	Greater Manchester	Out of Region	Unknown	
Male	5 (7.7%)	15 (23.1%)	44 (67.7%)		1 (1.5%)	65
Female	4 (4.5%)	21 (23.9%)	60 (68.2%)	2 (2.3%)	1 (1.1%)	88
AGE GROUP						
0-14		1 (20%)	4 (80%)			5
15-19			1 (100%)			1
20-24	2 (16.7%)	5 (41.7%)	4 (33.3%)		1 (8.3%)	12
25-29	3 (7.3%)	10 (24.4%)	28 (68.3%)			41
30-34		9 (20.9%)	32 (74.4%)	1 (2.3%)	1 (2.3%)	43
35-39	3 (10.3%)	7 (24.1%)	18 (62.1%)	1 (3.4%)		29
40-44	1 (7.7%)	2 (15.4%)	10 (76.9%)			13
45-49			4 (100%)			4
50-54		2 (50%)	2 (50%)			4
55-59			1 (100%)			1
INFECTION ROUTE						
Homo/Bisexual			3 (75%)		1 (25%)	4
Heterosexual	9 (6.4%)	35 (25%)	93 (66.4%)	2 (1.4%)	1 (0.7%)	140
Mother to child			4 (100%)			4
Other/Unknown		1 (20%)	4 (80%)			5
ETHNICITY						
White		1 (100%)				1
Black Caribbean			2 (100%)			2
Black African	8 (5.6%)	32 (22.5%)	99 (69.7%)	2 (1.4%)	1 (0.7%)	142
Indian/Pakistani/Bangladeshi		1 (100%)				1
Other Asian/Oriental	1 (33.3%)		2 (66.7%)			3
Other/mixed		1 (100%)				1
Unknown		1 (33.3%)	1 (33.3%)		1 (33.3%)	3
Total	**9 (5.9%)**	**36 (23.5%)**	**104 (68%)**	**2 (1.3%)**	**2 (1.3%)**	**153**

Figure 3.4: Population prevalence of total HIV and AIDS cases by primary care trust, January-December 2002 (All cases seen during 2002 including those who died during the year)

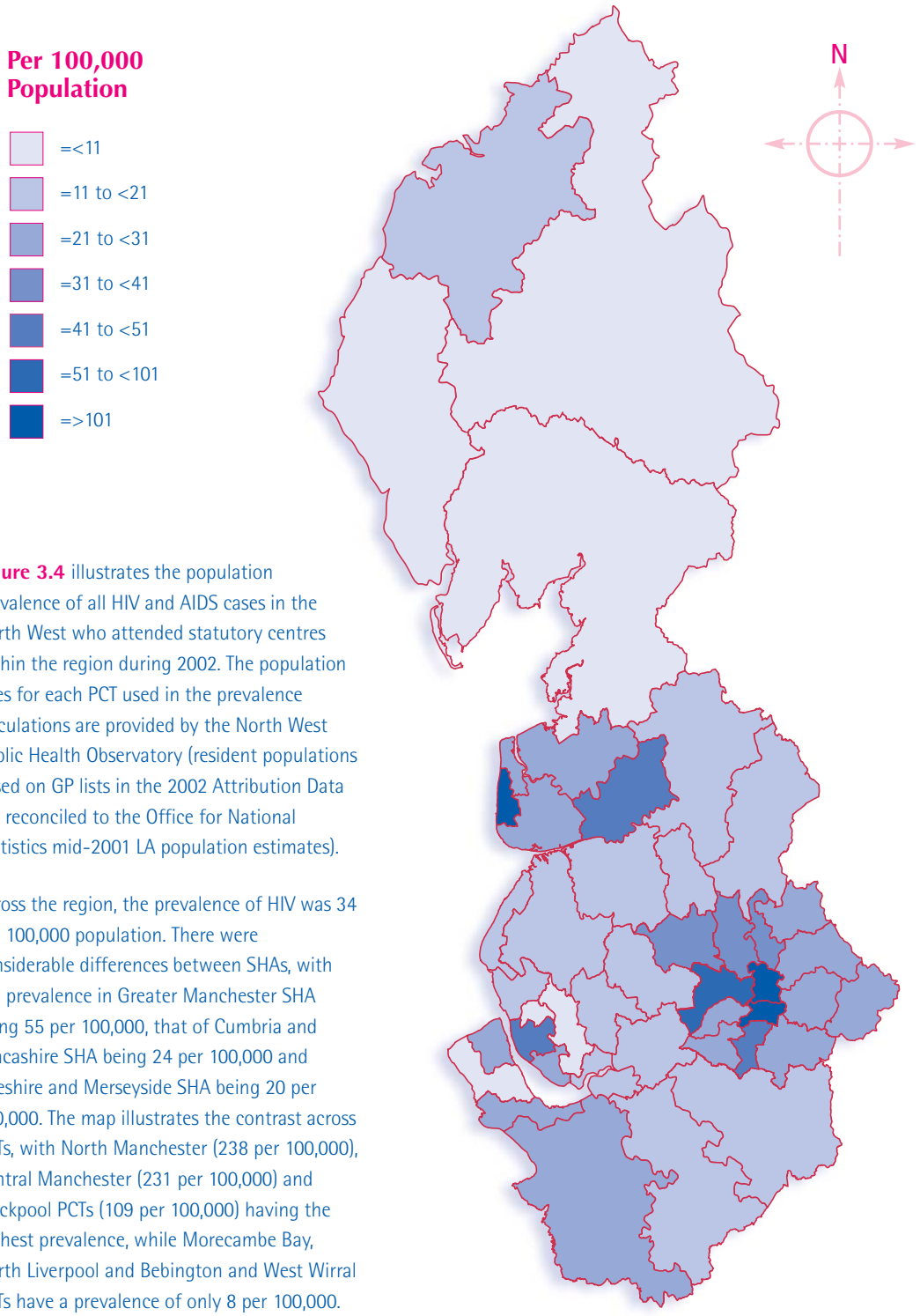


Figure 3.4 illustrates the population prevalence of all HIV and AIDS cases in the North West who attended statutory centres within the region during 2002. The population sizes for each PCT used in the prevalence calculations are provided by the North West Public Health Observatory (resident populations based on GP lists in the 2002 Attribution Data Set reconciled to the Office for National Statistics mid-2001 LA population estimates).

Across the region, the prevalence of HIV was 34 per 100,000 population. There were considerable differences between SHAs, with the prevalence in Greater Manchester SHA being 55 per 100,000, that of Cumbria and Lancashire SHA being 24 per 100,000 and Cheshire and Merseyside SHA being 20 per 100,000. The map illustrates the contrast across PCTs, with North Manchester (238 per 100,000), Central Manchester (231 per 100,000) and Blackpool PCTs (109 per 100,000) having the highest prevalence, while Morecambe Bay, North Liverpool and Bebington and West Wirral PCTs have a prevalence of only 8 per 100,000.

4. Voluntary Agencies 2002

Voluntary organisations have long played a fundamental role in the recognition of HIV/AIDS and in addressing the needs of HIV positive individuals[9;83]. In the North West Region, voluntary agencies continue to provide a wide range of services to HIV positive individuals and their families. Research into the economics of HIV in the North West of England has established that seven voluntary agencies annually contribute £1 million pounds worth of services over and above those purchased by the statutory sector[41]. During 2002, 1,121 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by eight voluntary organisations in the North West.

Voluntary agencies have contributed data to the North West HIV/AIDS Monitoring Unit since 1995, and have been consistently shown to have provided services to a broader constituency than the statutory sector alone[3-8]. The year 2002 was no exception, and 17% of individuals seen by voluntary organisations did not access care in the statutory sector, and 8% have never been known to the statutory sector in the North West.

This year we are pleased to include data from Barnardo's in Manchester for the first time. Barnardo's has developed HIV services to focus on the needs of young people affected by HIV, having recognised that most services were principally adult orientated. Barnardo's HIV services are available across the UK (in Leeds, Liverpool, Manchester, Newcastle, Edinburgh, Dundee and Glasgow). The Barnardo's Health Through Action Project in Manchester provides therapeutic care to children, young people and parents affected or infected by HIV. Other voluntary agencies in the region such as George House Trust and Body Positive North West have undertaken joint work with Barnardo's to address the needs of children.

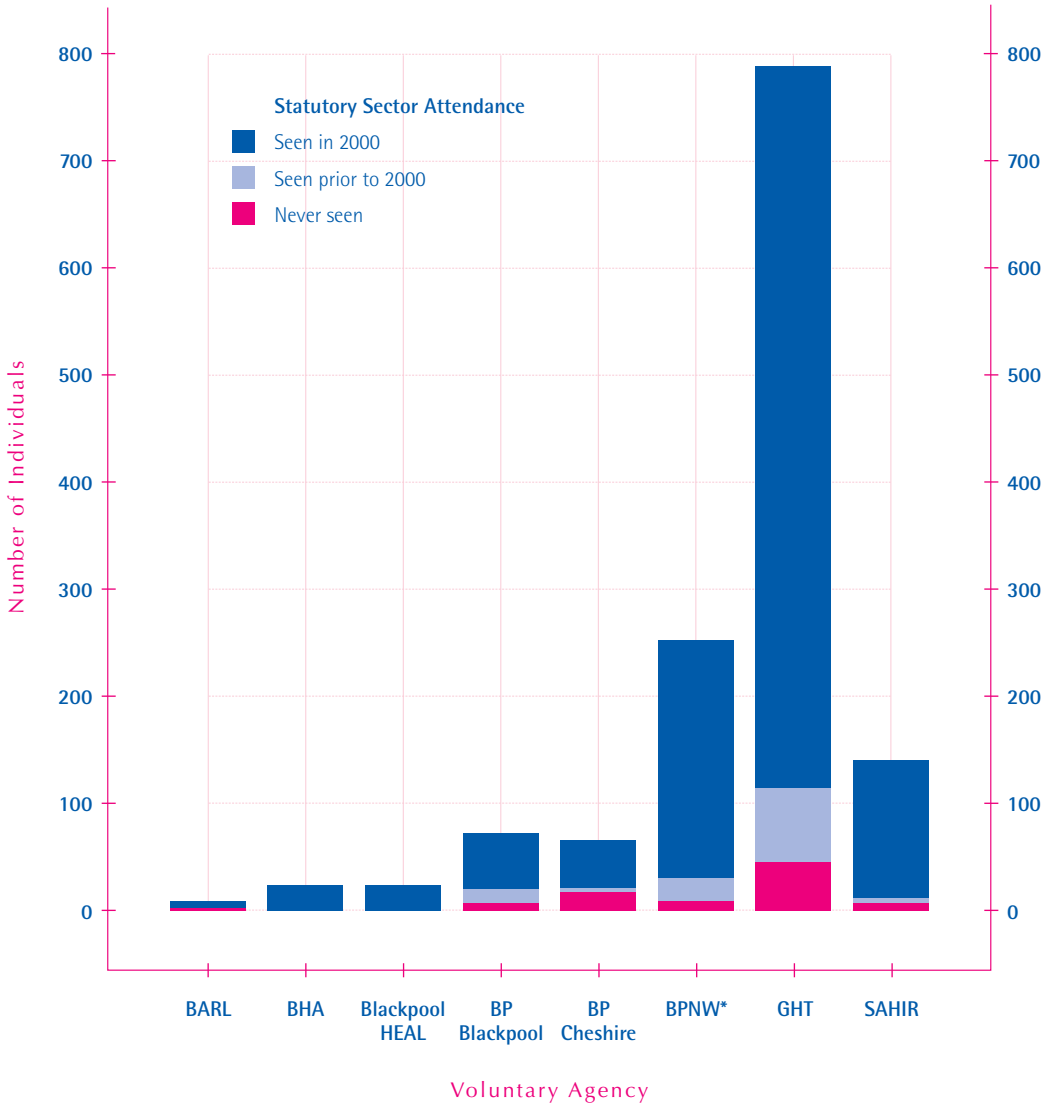
It is important to note that not all HIV/AIDS voluntary organisations are able to provide attributable data for the report. Organisations such as South Lancashire HEAL and Blackpool HEAL are not included in the tables, but nonetheless make a valuable contribution to the provision of care. Similarly, the amount of attributable data provided by each voluntary organisation does not necessarily reflect the overall service provision of that agency. Unfortunately Body Positive North West (BPNW) was only able to give a partial dataset, therefore the figures in figure 4.1 and tables 4.1 to 4.5 do not represent the total number of HIV positive individuals who were in contact with BPNW. For all organisations, where information relating to infection route and ethnicity was not available from the voluntary sector, data have been updated from that provided from the statutory care providers (where available). Figure 4.1 and tables 4.1 to 4.5 illustrate key characteristics of individuals accessing care from individual voluntary agencies, whilst figure 4.2 and table 4.6 are concerned with those HIV positive individuals accessing voluntary care as a whole. Where appropriate, references are made to corresponding data from previous North West reports[3-8].

Figure 4.1 illustrates the proportion of HIV positive individuals presenting to voluntary agencies in the North West during 2002, who had and had not presented at statutory agencies in the North West, either during 2002 or prior to 2002. Four out of the seven agencies who reported last year recorded an increase in their client base during 2002 compared with 2001 figures: Black Health Agency (BHA) increased by 155%, Sahir House by 35%, George House Trust (GHT) by 19% and Body Positive Cheshire and North Wales by 57%. Three organisations have reduced numbers compared with 2001: Barnardo's Liverpool (BARL) decreased by 36% and Body Positive Blackpool by 13%. The 27% reduction in the numbers seen by Body Positive North West are due to them only being able to provide a partial dataset this year. The overall number of individuals seen by the voluntary sector in 2002 is 8% higher than in 2001 (1,121 compared with 1,037).

There is variation in the proportion of voluntary sector clients also seen within the statutory sector in 2002, ranging from 68% and 72% at Body Positive Cheshire and North Wales and Body Positive Blackpool respectively, to all of those seen by the Black Health Agency (BHA) and Barnardo's in Manchester (BARM). The low level of North West statutory sector contact with Body Positive Cheshire and North Wales' clients may be explained by the geographical location of the organisation. Seventeen out of the 18 Body Positive Cheshire clients not in contact with the North West statutory sector during 2002 were reported to reside in Wales or the West Midlands. Sahir House also reports 9% of its clients as either living outside the North West or at an unknown residence, which could account for their statutory sector non-attendees. However, the situation is different at other voluntary agencies, where the vast majority of clients not in contact with statutory treatment centres in 2002 (or at any time since this level of monitoring began in 1995), reside in the North West of England (98% for Barnardo's in Manchester, 97% for Body Positive Blackpool and George House Trust, 93% for Body Positive North West and 100% for the remaining agencies). A significant number of individuals have never been seen at statutory centres: up to 46 individuals at George House Trust. The data suggest that the voluntary sector may be the sole provider of care and support for a substantial number of these HIV positive individuals who do not access statutory care.

Figure 4.1: The proportion of HIV and AIDS cases presenting to voluntary organisations and the statutory sector in the North West, January-December 2002

(All cases seen during 2002 including those who died during the year).



STATUTORY SECTOR ATTENDANCE	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	BPNW*	GHT	SAHIR
Never seen	2 (22.2%)			8 (11.3%)	18 (27.3%)	9 (3.6%)	46 (5.8%)	7 (5%)
Seen prior to 2002				12 (16.9%)	3 (4.5%)	21 (8.3%)	68 (8.6%)	5 (3.6%)
Seen in 2002	7 (77.8%)	23 (100%)	23 (100%)	51 (71.8%)	45 (68.2%)	222 (88.1%)	676 (85.6%)	128 (91.4%)
Total (100%)	**9**	**23**	**23**	**71**	**66**	**252**	**790**	**140**

*For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Rows cannot be totalled as some individuals may attend more than one voluntary organisation thus exaggerating the totals. * BPNW were only able to provide a partial dataset, therefore these numbers to not represent the total number of HIV positive individuals accessing this voluntary agency.*

Table 4.1. Distribution of voluntary sector care for HIV and AIDS cases by infection route of HIV and sex, January-December 2002

(All cases seen during 2002 including those who died during the year).

INFECTION ROUTE	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	BPNW*	GHT	SAHIR
Homo/Bisexual	2 (22.2%)	1 (4.3%)	1 (4.3%)	68 (95.8%)	34 (51.5%)	199 (79%)	524 (66.3%)	68 (48.6%)
Injecting Drug Use	1 (11.1%)	4 (17.4%)		1 (1.4%)	3 (4.5%)	13 (5.2%)	42 (5.3%)	4 (2.9%)
Heterosexual	3 (33.3%)	13 (56.5%)	22 (95.7%)	2 (2.8%)	9 (13.6%)	33 (13.1%)	197 (24.9%)	51 (36.4%)
Blood/Tissue						5 (2%)	8 (1%)	5 (3.6%)
Mother to Child	1 (11.1%)	5 (21.7%)			2 (3%)	2 (0.8%)	12 (1.5%)	
Undetermined	2 (22.2%)				18 (27.3%)		7 (0.9%)	12 (8.6%)
SEX								
Male	3 (33.3%)	10 (43.5%)	5 (21.7%)	71 (100%)	54 (81.8%)	226 (89.7%)	639 (80.9%)	107 (76.4%)
Female	6 (66.7%)	13 (56.5%)	18 (78.3%)		12 (18.2%)	26 (10.3%)	151 (19.1%)	33 (23.6%)
Total (100%)	**9**	**23**	**23**	**71**	**66**	**252**	**790**	**140**

*For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Men who have had homosexual or bisexual exposure and are also injecting drug users are included in the homo/bisexual category. Rows cannot be totalled as some individuals may attend more than one voluntary organisation, thus exaggerating the totals. * BPNW were only able to provide a partial dataset, therefore these numbers to not represent the total number of HIV positive individuals accessing this voluntary agency.*

Table 4.1 categorises individuals accessing voluntary care in 2002 according to infection route and sex. Apart from those attending BHA and Barnardo's in Manchester (BARM), the majority of individuals presenting to voluntary agencies were exposed to infection by homosexual sex, ranging from 4% at BHA and BARM to 95% at Body Positive Blackpool. The main route of infection for Barnardo's Liverpool, Barnardo's Manchester and BHA clients was heterosexual sex (33%, 57% and 96% respectively), with a high proportion of female service users (67%, 57% and 78% respectively). Barnardo's provides support for families with children affected by HIV. In some cases the HIV positive client is a parent, in other cases the child. Individuals accessing care from Sahir House in Liverpool also included a large group of individuals exposed through heterosexual sex (36%) and a correspondingly relatively high proportion of females (24%). A relatively high proportion of BP Cheshire and Merseyside, GHT and BPNW clients were injecting drug users (each at 5%); a higher proportion than those infected by this route attending statutory services (3%: chapter 3, table 3.1).

Table 4.2 refers to HIV positive individuals accessing voluntary care during 2002, categorised according to age group. As was the case for individuals presenting to the statutory sector during 2002, the majority of clients at all voluntary organisations were aged between 30 and 44 years. The organisation that saw the highest proportion of children is Barnardo's Manchester (17% of clients were aged 14 years or under), as would be expected for an organisation specialising in the needs of children. The numbers of service users aged 14 years or under has increased in four voluntary organisations since 2001. The organisation that sees the most children with HIV is George House Trust (17 HIV positive children aged 14 years or under). The differing profiles and characteristics of HIV positive clients accessing North West Voluntary agencies may in part reflect the different range of services provided and the varying strategies used to attract HIV positive clients.

Table 4.3 illustrates HIV positive individuals accessing North West based voluntary agencies during 2002, categorised by ethnic group. Ethnic group classifications are adapted from the 1991 Census Questionnaire and are those used by the Health Protection Agency AIDS and STD Centre, for the Survey of Prevalent Diagnosed HIV Infections (SOPHID).

With the exception of BHA, a specialist service for black and minority ethnic communities, the vast majority of presentations to voluntary sector organisations were by individuals self-defined as white, ranging from 99% at Body Positive Blackpool to 78% at George House Trust. However, both Barnardo's Liverpool and Manchester provided care for high proportions of HIV positive individuals from black African communities (33% and 44% respectively), with George House Trust providing care for the largest number of HIV positive black Africans (141 individuals).

Table 4.2: Distribution of voluntary sector care for HIV and AIDS cases by age group, January-December 2002 (All cases seen during 2002 including those who died during the year).

AGE GROUPS	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	BPNW*	GHT	SAHIR
0-14	1 (11.1%)	4 (17.4%)		2 (2.8%)	3 (4.5%)	3 (1.2%)	17 (2.2%)	
15-19	1 (11.1%)	1 (4.3%)					3 (0.4%)	
20-24				3 (4.2%)	2 (3%)	6 (2.4%)	24 (3%)	5 (3.6%)
25-29	2 (22.2%)		5 (21.7%)	9 (12.7%)	14 (21.2%)	20 (7.9%)	74 (9.4%)	15 (10.7%)
30-34	1 (11.1%)	6 (26.1%)	8 (34.8%)	6 (8.5%)	11 (16.7%)	42 (16.7%)	158 (20%)	34 (24.3%)
35-39	2 (22.2%)	3 (13%)	2 (8.7%)	18 (25.4%)	14 (21.2%)	72 (28.6%)	197 (24.9%)	34 (24.3%)
40-44	2 (22.2%)	7 (30.4%)	4 (17.4%)	18 (25.4%)	9 (13.6%)	52 (20.6%)	160 (20.3%)	28 (20%)
45-49		2 (8.7%)	2 (8.7%)	10 (14.1%)	5 (7.6%)	31 (12.3%)	84 (10.6%)	12 (8.6%)
50-54			1 (4.3%)	2 (2.8%)	4 (6.1%)	18 (7.1%)	47 (5.9%)	8 (5.7%)
55-59				1 (1.4%)	2 (3%)	3 (1.2%)	14 (1.8%)	2 (1.4%)
60+			1 (4.3%)	2 (2.8%)	2 (3%)	5 (2%)	12 (1.5%)	2 (1.4%)
Total (100%)	**9**	**23**	**23**	**71**	**66**	**252**	**790**	**140**

*For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Rows cannot be totalled as some individuals may attend more than one voluntary organisation, thus exaggerating the totals. Age ranges refer to the age of individuals at end December 2002, or at death. * BPNW were only able to provide a partial dataset, therefore these numbers to not represent the total number of HIV positive individuals accessing this voluntary agency.*

Table 4.3: Distribution of voluntary sector care for HIV and AIDS cases by ethnic group, January-December 2002 (All cases seen during 2002 including those who died during the year)

ETHNICITY	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	BPNW*	GHT	SAHIR
White	5 (55.6%)	10 (43.5%)		70 (98.6%)	63 (95.5%)	227 (90.1%)	617 (78.1%)	114 (81.4%)
Black Caribbean			1 (4.3%)				3 (0.4%)	
Black African	3 (33.3%)	10 (43.5%)	21 (91.3%)	1 (1.4%)	2 (3%)	22 (8.7%)	141 (17.8%)	22 (15.7%)
Black Other						1 (0.4%)	3 (0.4%)	1 (0.7%)
Indian/Pakistani/Bangladeshi		2 (8.7%)				2 (0.8%)	7 (0.9%)	1 (0.7%)
Other Asian/Oriental							10 (1.3%)	
Other/Mixed	1 (11.1%)	1 (4.3%)	1 (4.3%)		1 (1.5%)		9 (1.1%)	2 (1.4%)
Total (100%)	**9**	**23**	**23**	**71**	**66**	**252**	**790**	**140**

*For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Rows cannot be totalled as some individuals may attend more than one voluntary organisation, thus exaggerating the totals. * BPNW were only able to provide a partial dataset, therefore these numbers to not represent the total number of HIV positive individuals accessing this voluntary agency.*

Table 4.4a: Residential distribution of voluntary sector care for HIV and AIDS cases, January-December 2002: strategic health authority

(All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	BPNW*	GHT	SAHIR
Cumbria and Lancashire		3 (13%)	2 (8.7%)	64 (90.1%)		15 (6%)	80 (10.1%)	2 (1.4%)
Cheshire and Merseyside	9 (100%)				44 (66.7%)	12 (4.8%)	35 (4.4%)	123 (87.9%)
Greater Manchester		18 (78.3%)	21 (91.3%)	5 (7%)		218 (86.5%)	649 (82.2%)	6 (4.3%)
Isle of Man								1 (0.7%)
East Midlands							4 (0.5%)	
London				1 (1.4%)		1 (0.4%)	1 (0.1%)	
Scotland							1 (0.1%)	1 (0.7%)
South West		2 (8.7%)					2 (0.3%)	
Wales					14 (21.2%)	3 (1.2%)	4 (0.5%)	3 (2.1%)
West Midlands				1 (1.4%)	3 (4.5%)	1 (0.4%)	3 (0.4%)	
Yorkshire and The Humber						2 (0.8%)	3 (0.4%)	
Unknown					5 (7.6%)		8 (1%)	4 (2.9%)
Total (100%)	**9**	**23**	**23**	**71**	**66**	**252**	**790**	**140**

*For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Rows cannot be totalled as some individuals may attend more than one voluntary organisation, thus exaggerating the totals. Individuals living outside of the North West Region are grouped by region. * BPNW were only able to provide a partial dataset, therefore these numbers to not represent the total number of HIV positive individuals accessing this voluntary agency.*

Table 4.4b: Distribution of voluntary sector care for HIV and AIDS cases, January-December 2002: Cumbria and Lancashire primary care trusts

(All cases seen during 2002 including those who died during the year)

PCT OF RESIDENCE	Voluntary Agency					
	BARM	BHA	BP Blackpool	BPNW*	GHT	SAHIR
Morecambe Bay			2 (3.1%)	3 (20%)	3 (3.8%)	
Blackpool			53 (82.8%)	3 (20%)	26 (32.5%)	
Fylde			4 (6.3%)		4 (5%)	
Wyre			2 (3.1%)		2 (2.5%)	
Preston			3 (4.7%)	3 (20%)	17 (21.3%)	
Hyndburn and Ribble Valley					3 (3.8%)	
Burnley, Pendle and Rossendale	1 (33.3%)	2 (100%)		3 (20%)	14 (17.5%)	
Blackburn with Darwen				1 (6.7%)	6 (7.5%)	
Chorley and South Ribble	2 (66.7%)			2 (13.3%)	5 (6.3%)	
West Lancashire						2 (100%)
Total (100%)	**3**	**2**	**64**	**15**	**80**	**2**

*For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Rows cannot be totalled as some individuals may attend more than one voluntary organisation, thus exaggerating the totals. * BPNW were only able to provide a partial dataset, therefore these numbers to not represent the total number of HIV positive individuals accessing this voluntary agency.*

Table 4.4c: Distribution of voluntary sector care for HIV and AIDS cases, January-December 2002: Cheshire and Merseyside primary care trusts

(All cases seen during 2002 including those who died during the year)

PCT OF RESIDENCE	Voluntary Agency				
	BARL	BP Cheshire	BPNW*	GHT	SAHIR
Southport and Formby					3 (2.4%)
South Sefton				3 (8.6%)	8 (6.5%)
North Liverpool				1 (2.9%)	3 (2.4%)
Central Liverpool	5 (55.6%)			9 (25.7%)	67 (54.5%)
South Liverpool			1 (8.3%)	2 (5.7%)	6 (4.9%)
Knowsley					3 (2.4%)
St Helens		1 (2.3%)	2 (16.7%)	4 (11.4%)	10 (8.1%)
Halton		1 (2.3%)			4 (3.3%)
Warrington		7 (15.9%)	2 (16.7%)	4 (11.4%)	1 (0.8%)
Birkenhead and Wallasey	3 (33.3%)	2 (4.5%)	1 (8.3%)		10 (8.1%)
Bebington and West Wirral				1 (2.9%)	3 (2.4%)
Ellesmere Port and Neston	1 (11.1%)	3 (6.8%)			
Cheshire West		20 (45.5%)		2 (5.7%)	
Central Cheshire		9 (20.5%)	3 (25%)	1 (2.9%)	2 (1.6%)
Eastern Cheshire		1 (2.3%)	3 (25%)	8 (22.9%)	3 (2.4%)
Total (100%)	**9**	**44**	**12**	**35**	**123**

*For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Rows cannot be totalled as some individuals may attend more than one voluntary organisation, thus exaggerating the totals. * BPNW were only able to provide a partial dataset, therefore these numbers to not represent the total number of HIV positive individuals accessing this voluntary agency.*

Table 4.4a illustrates the residential distribution of HIV positive individuals accessing North West based voluntary agencies during 2002. Presentations at most North West voluntary agencies were predominantly by residents of the North West Region. The proportion of clients known to be resident within the North West range from 67% of Body Positive Cheshire clients, to 100% at BHA and Barnardo's Liverpool. Body Positive Cheshire and North Wales was the only voluntary organisation with a significant proportion of HIV positive clients from outside the region: 25% of their clients lived in Wales and the West Midlands, reflecting the geographical location of this agency and its catchment area.

Tables 4.4b, c and **d** present the primary care trust of residence of individuals attending voluntary agencies within each of the three strategic health authorities (Cumbria and Lancashire, table 4.4b; Cheshire and Merseyside, table 4.4c and Greater Manchester, table 4.4d). It is important to note that the data relate to voluntary sector clients for whom full attributable data have been provided (soundex code, date of birth and sex). Therefore, the number of individuals from each primary care trust attending voluntary agencies does not necessarily reflect the overall service activity of that organisation within a specific primary care trust.

Table 4.4d: Distribution of voluntary sector care for HIV and AIDS cases, January-December 2002: Greater Manchester primary care trusts

(All cases seen during 2002 including those who died during the year)

PCT OF RESIDENCE	Voluntary Agency					
	BARM	BHA	BP Blackpool	BPNW*	GHT	SAHIR
Ashton, Leigh and Wigan			1 (20%)	3 (1.4%)	11 (1.7%)	1 (16.7%)
Bolton	1 (5.6%)	1 (4.8%)		5 (2.3%)	24 (3.7%)	
Bury	1 (5.6%)	2 (9.5%)		6 (2.8%)	16 (2.5%)	
Heywood and Middleton				2 (0.9%)	11 (1.7%)	
Rochdale		1 (4.8%)		3 (1.4%)	13 (2%)	
Salford	1 (5.6%)	4 (19%)	1 (20%)	35 (16.1%)	91 (14%)	2 (33.3%)
Trafford North	4 (22.2%)			11 (5%)	18 (2.8%)	
Trafford South				12 (5.5%)	14 (2.2%)	2 (33.3%)
North Manchester	1 (5.6%)	3 (14.3%)	2 (40%)	47 (21.6%)	151 (23.3%)	1 (16.7%)
Central Manchester	7 (38.9%)	9 (42.9%)	1 (20%)	65 (29.8%)	187 (28.8%)	
South Manchester	2 (11.1%)			8 (3.7%)	26 (4%)	
Oldham	1 (5.6%)	1 (4.8%)		5 (2.3%)	28 (4.3%)	
Tameside and Glossop				8 (3.7%)	32 (4.9%)	
Stockport				8 (3.7%)	27 (4.2%)	
Total (100%)	**18**	**21**	**5**	**218**	**649**	**6**

*For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Rows cannot be totalled as some individuals may attend more than one voluntary organisation, thus exaggerating the totals. * BPNW were only able to provide a partial dataset, therefore these numbers to not represent the total number of HIV positive individuals accessing this voluntary agency.*

Table 4.5 illustrates the crossover of care of HIV positive individuals between North West based voluntary agencies and the statutory organisations during 2002. The distribution of statutory treatment and care of voluntary agency clients reflects the geographical location of the voluntary agencies. However, the Infectious Disease Unit at North Manchester General Hospital (NMG), the largest HIV and AIDS treatment centre in the North West (chapter 3, table 3.15), accounts for a significant number of presentations by individuals accessing voluntary organisations across the whole region.

Table 4.5: Distribution of statutory treatment for HIV and AIDS cases presenting to voluntary organisations, January-December 2002

(All cases seen during 2002 including those who died during the year)

TREATMENT CENTRE	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	BPNW*	GHT	SAHIR
AHC	1				2			
APH								5
ARM	1						2	4
BLAG				35		2	21	1
BLKG						1	3	
BOLG			1	2		4	18	
BURG		1	1			1	6	
BURY			2			1	11	
CHR	1				24		3	2
DDU	1							2
LEI					1			
LEII					4			1
MAC					1	1	3	1
MGP				1		33	66	
MRI		1				23	57	1
MRIG		2	4	2	1	16	74	
MRIH						3	6	1
NMG		16	15	11	9	154	434	8
NMGG					1	10	23	1
NOB								1
OLDG		1	1			2	8	
PG		4		2		2	17	1
PP		2					1	
QSC				26		3	21	1
RLG	5		1		8	2	18	109
RLH						1		3
RLI						1	3	
ROCG			2	1		3	14	
SALG						4	13	
SHH						1	1	2
SPG							1	5
STP						5	20	1
TRAG							1	
WAR					3		1	1
WIGG							1	
WITG		3	1		1	20	31	

*For a definition of the abbreviated voluntary agencies and statutory treatment centres please refer to the glossary at the back of the report. Numbers cannot be totalled as some individuals may attend more than one treatment centre or voluntary agency thus exaggerating the totals. * BPNW were only able to provide a partial dataset, therefore these numbers to not represent the total number of HIV positive individuals accessing this voluntary agency.*

Figure 4.2: The proportion of HIV and AIDS cases presenting to the voluntary sector and statutory sector in the North West, January-December 2002

(All cases seen during 2002 including those who died during the year)

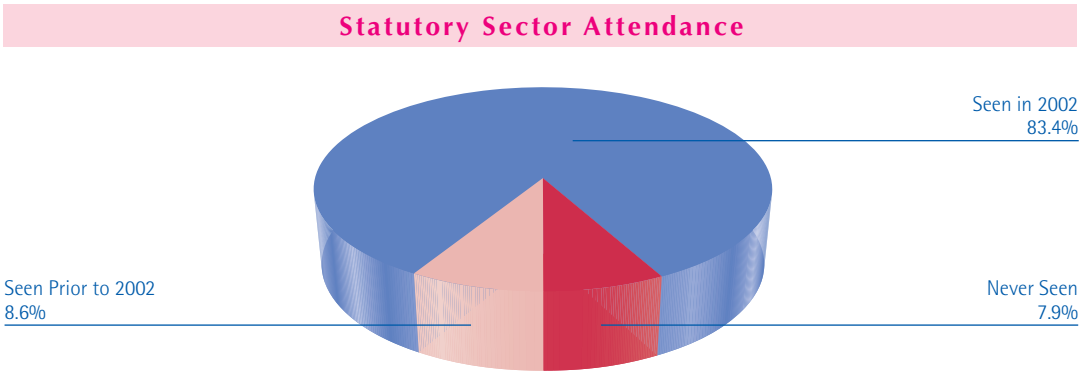


Figure 4.2 illustrates the proportion of HIV positive individuals presenting to voluntary agencies in the North West during 2002 who had and had not presented at statutory agencies in the North West, either during 2002 or prior to 2002. During 2002, 1,121 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by eight voluntary organisations in the North West. Of these individuals, 935 (83%) also attended statutory treatment centres during the year. Therefore, 186 (17%) of voluntary sector clients were unknown to statutory treatment centres within the North West during 2002 and are not, therefore, included in the regional statistics provided to the Department of Health. This may be partly explained by the fact that 21% of those individuals not accessing the statutory sector during 2002 reside outside the North West and may be receiving treatment and care from centres further afield.

Of the 186 HIV positive individuals not in contact with the statutory sector in 2002, 52% (97 individuals) had attended statutory treatment centres in the North West between 1995 and 2001. A total of 89 (8% of voluntary sector clients) had no contact with the statutory sector since North West regional monitoring began in 1995. These data highlight the importance of collecting epidemiological information from the voluntary sector and demonstrate the vital contribution of HIV/AIDS voluntary agencies in the North West.

Table 4.6 illustrates the infection route, sex, ethnicity and asylum seeker status of HIV positive individuals accessing the voluntary sector in the North West in 2002 by attendance at the statutory sector during the year. Because of the relatively high proportion of individuals for whom infection route and refugee status are unknown (particularly among those who have never attended the statutory sector), the percentages in the table are calculated as percentages of those individuals for whom the information is known. The predominant method of exposure to HIV amongst voluntary sector clients during 2002 was homosexual sex, accounting for 67% of cases where infection route has been determined. This represents a higher proportion than the 59% of individuals accessing the statutory sector for whom method of exposure has been determined (chapter 3, table 3.1). The year 2002 has seen a higher proportion of HIV positive clients from the voluntary sector who were exposed to HIV through injecting drug use (5%) than in the statutory sector (3%). A lower proportion of heterosexually exposed clients (24%) were seen at the voluntary sector compared to the statutory sector (27%: chapter 3, table 3.1). However, this has increased since 2001 when only 19% of voluntary sector clients were heterosexual. The vast majority of voluntary sector clients were male (81%), primarily due to the relatively high rates of HIV infection via homosexual sex (67%). As in those HIV positive individuals accessing the statutory sector (chapter 3, table 3.7), the majority of voluntary sector clients are self-defined as white (81%).

Table 4.6 also shows that 17% of individuals (186 out of 1,121) using voluntary services did not attend a statutory sector service during 2002. Of those where route of infection is known, a higher proportion of individuals exclusive to the voluntary sector in 2002 were exposed to HIV via homosexual sex (73%) than any other exposure category. Those HIV positive individuals accessing the voluntary sector but not the statutory sector in the North West during 2002 may represent a significant number of people for whom the voluntary sector is the sole provider of care. The overall ethnic (81% white) and sex distribution (81% male) of those exclusively attending voluntary agencies was similar to those attending both types of service (80% white and 82% male). Caution is required when interpreting these results, due to the relatively high proportion of missing data relating to those who have never had contact with the statutory sector (e.g. data on infection route were unavailable for 36% of those who had only ever been seen by the voluntary sector).

This year we have expanded our analysis to incorporate the asylum seeker status of voluntary services users. This is the first year we have collected these data, thus subsequent years will produce trends for analysis. In 2002, 7% (83 individuals) of all voluntary sector attendees were asylum seekers, a similar proportion to that of the statutory sector (6%, 153 individuals). Over half (52%) of asylum seekers who access statutory services also access voluntary services (chapter 3, table 3.25).

Table 4.6: HIV and AIDS cases presenting to the voluntary sector and statutory sector by infection route, sex, ethnicity and asylum seeker status, January-December 2002

(All cases seen during 2002 including those who died during the year)

INFECTION ROUTE	Statutory Sector Attendance			Total
	Never Seen	Seen prior to 2002	Seen in 2002	
Homo/Bisexual	40 (70.2%)	72 (75%)	617 (66.3%)	729 (67.3%)
Injecting Drug Use		5 (5.2%)	51 (5.5%)	56 (5.2%)
Heterosexual	17 (29.8%)	15 (15.6%)	232 (24.9%)	264 (24.4%)
Blood/Tissue		2 (2.1%)	14 (1.5%)	16 (1.5%)
Mother to Child		2 (2.1%)	16 (1.7%)	18 (1.7%)
Sub Total (100%)	**57**	**96**	**930**	**1083**
Undetermined	32	1	5	38
ETHNICITY				
White	67 (75.3%)	90 (92.8%)	752 (80.4%)	909 (81.1%)
Black Caribbean			3 (0.3%)	3 (0.3%)
Black African	18 (20.2%)	5 (5.2%)	150 (16%)	173 (15.4%)
Black Other	1 (1.1%)	1 (1%)	2 (0.2%)	4 (0.4%)
Indian/Pakistani/Bangladeshi			9 (1%)	9 (0.8%)
Other Asian/Oriental		1 (1%)	8 (0.9%)	9 (0.8%)
Other/Mixed	3 (3.4%)		11 (1.2%)	14 (1.2%)
Total (100%)	**89**	**97**	**935**	**1121**
SEX				
Male	61 (68.5%)	87 (89.7%)	764 (81.7%)	912 (81.4%)
Female	28 (31.5%)	10 (10.3%)	171 (18.3%)	209 (18.6%)
Total (100%)	**89**	**97**	**935**	**1121**
ASYLUM SEEKER STATUS				
Yes	3 (8.3%)	2 (3.3%)	78 (8.6%)	83 (8.3%)
No	33 (91.7%)	59 (96.7%)	828 (91.4%)	920 (91.7%)
Sub Total (100%)	**36**	**61**	**906**	**1003**
Undetermined	53	36	29	118
Total (100%)	**89**	**97**	**935**	**1121**

Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

5. Social Services 2002

This is the first year that the North West HIV/AIDS monitoring Unit has collected data related to the care and support of HIV positive individuals who access social service departments in the North West. All social service departments in the North West were contacted. Out of 40 social service departments 39 provided care to HIV positive individuals in 2002 and one department saw no HIV positive people in 2002. Twelve social service departments were able to participate, and between them contributed data on a total of 193 individuals. Of the 27 who were unable to participate this year 19 have expressed their wish to participate in the future.

2001/02 saw a £16.5 million allocation of funds to North West social services to provide HIV/AIDS care and support which constitutes 7.55% of the national allocation[41]. Social services provide essential care to HIV positive people by ensuring that their needs are assessed and met with respect to welfare, benefits, housing, advocacy and other necessary, community based practical support. This is a crucial service to those affected and infected with HIV and may be the only source of care to a number of HIV positive individuals (table 5.1).

Table 5.1: HIV and AIDS cases presenting to social service departments by sex, infection route, ethnicity, asylum seeker status and statutory sector attendance, January-December 2002 (All cases during 2002 including those who died during the year).

SEX	Social service department												Total*
	Barrow -in- Furness	Blackburn with Darwen	Bury	Lancaster	Oldham	Preston	Sefton	St Helens	Tameside	Trafford	Warrington	Wirral	
Male	4 (50%)	15 (65.2%)	7 (53.8%)	5 (71.4%)	5 (71.4%)	17 (47.2%)	10 (76.9%)	3 (75%)	26 (81.3%)	19 (76%)	1 (50%)	19 (76%)	130 (67.4%)
Female	4 (50%)	8 (34.8%)	6 (46.2%)	2 (28.6%)	2 (28.6%)	19 (52.8%)	3 (23.1%)	1 (25%)	6 (18.8%)	6 (24%)	1 (50%)	6 (24%)	63 (32.6%)
INFECTION ROUTE													
Homo/ Bisexual	2 (25%)	9 (39.1%)	6 (46.2%)	5 (71.4%)	4 (57.1%)	7 (19.4%)	6 (46.2%)	2 (50%)	22 (68.8%)	13 (52%)	1 (50%)	16 (64%)	92 (47.7%)
Injecting Drug Use	5 (62.5%)				2 (28.6%)	4 (11.1%)	1 (7.7%)			3 (12%)		1 (4%)	16 (8.3%)
Heterosexual		14 (60.9%)	5 (38.5%)	2 (28.6%)	1 (14.3%)	21 (58.3%)	6 (46.2%)	2 (50%)	7 (21.9%)	7 (28%)	1 (50%)	7 (28%)	72 (37.3%)
Blood/Tissue	1 (12.5%)		2 (15.4%)						2 (6.3%)	2 (8%)			7 (3.6%)
Mother to Child						4 (11.1%)							4 (2.1%)
Undetermined									1 (3.1%)			1 (4%)	2 (1.0%)
ETHNICITY													
White	8 (100%)	16 (69.6%)	8 (61.5%)	6 (85.7%)	6 (85.7%)	21 (58.3%)	12 (92.3%)	3 (75%)	29 (90.6%)	20 (80%)		19 (76%)	147 (76.2%)
Black Caribbean						2 (5.6%)							2 (1.0%)
Black African		7 (30.4%)	4 (30.8%)	1 (14.3%)	1 (14.3%)	8 (22.2%)	1 (7.7%)		3 (9.4%)	3 (12%)	1 (50%)	4 (16%)	32 (16.6%)
Indian/ Pakistani/ Bangladeshi			1 (7.7%)			4 (11.1%)				1 (4%)		1 (4%)	7 (3.6%)
Other Asian/ Oriental										1 (4%)			1 (0.5%)
Other/ Mixed						1 (2.8%)		1 (25%)			1 (50%)		3 (1.6%)
Unknown												1 (4%)	1 (0.5%)
ASYLUM SEEKER STATUS													
Yes		7 (30.4%)	2 (15.4%)		1 (14.3%)	1 (2.8%)			2 (6.3%)	3 (12%)		1 (4%)	17 (8.8%)
No	8 (100%)	16 (69.6%)	11 (84.6%)	7 (100%)	6 (85.7%)	30 (83.3%)	13 (100%)	4 (100%)	30 (93.8%)	22 (88%)	2 (100%)	22 (88%)	169 (87.6%)
Unknown						5 (13.9%)						2 (8%)	7 (3.6%)
STATUTORY SECTOR ATTENDANCE													
Never seen	8 (100%)	4 (17.4%)				3 (8.3%)			3 (9.4%)	4 (16%)	1 (50%)	1 (4%)	24 (12.4%)
Seen prior to 2002		1 (4.3%)				2 (5.6%)			2 (6.3%)			1 (4%)	6 (3.1%)
Seen 2002		18 (78.3%)	13 (100%)	7 (100%)	7 (100%)	31 (86.1%)	13 (100%)	4 (100%)	27 (84.4%)	21 (84%)	1 (50%)	23 (92%)	163 (84.5%)
Total (100%)	**8**	**23**	**13**	**7**	**7**	**36**	**13**	**4**	**32**	**25**	**2**	**25**	**193**

**Total excludes double counting of individuals who accessed care from more than one social services department.*

Table 5.1 illustrates the number of HIV positive individuals presenting to each social service department by sex, infection route, ethnicity, refugee status and statutory sector attendance. More men were reported by social services than women (67%, ranging from 50% at Barrow-in-Furness, South Lakeland and Warrington to 81% at Tameside). However, the proportion of men reported was lower than that accessing the statutory sector for care (82%: chapter 3, table 3.4). This difference between social services data and statutory sector was also reflected in the exposure route and ethnicity of social service clients: there was a higher proportion exposed via heterosexual sex (37% compared to 27% of statutory sector attendees) and a higher proportion from ethnic minority groups (23% of those whose ethnicity was known, compared to 20%).

A total of 17 individuals known to be asylum seekers received care from social service departments. Blackburn with Darwen had the highest proportion (7 individuals, 30% in total). However, five social service departments claim that no refugees accessed their services in 2002. Table 5.1 also shows that almost 12% of individuals had not been seen in the statutory sector since monitoring began in 1995. This indicates that social service departments may be the sole provider of care and support to those individuals who do not access statutory services.

Table 5.2: Distribution of social service care for HIV and AIDS cases presenting to voluntary organisations, January-December 2002

(All cases seen during 2002 including those who died during the year).

SOCIAL SERVICE DEPARTMENT	Voluntary Agency							
	BARL	ARM	BHA	BP B'Pool	BP Chesh	BPNW	GHT	SAHIR
Blackburn with Darwen						1	4	
Bury		1	2			1	11	
Lancaster				1		1	2	
Oldham		1	1				6	
Preston		4		1		2	15	1
Sefton	1						3	6
St Helens							1	2
Tameside				1		2	23	
Trafford						8	12	2
Wirral					1		1	12

Numbers cannot be totalled as some individuals may attend more than one social services department or voluntary organisation thus exaggerating the totals.

Table 5.2 illustrates those social service attendees who also accessed North West voluntary organisations in 2002. There is no crossover of care between Barrow-in-Furness, South Lakeland and Warrington and the voluntary sector. Therefore nine HIV positive individuals received care from only their social service department in 2002.

Every voluntary organisation was accessed by at least one individual who also presented to social services. All social service departments with a crossover of care had HIV positive individuals who have accessed George House Trust in 2002.

6. Additional providers of HIV treatment and care 2002

This is the fourth year that the North West HIV/AIDS Monitoring Unit has collected data relating to the care of HIV positive individuals attending hospices across the whole of the North West. All North West hospices that provide inpatient care were contacted. Out of 34 hospices contacted, 29 (85%) replied and 26 (90%) of these had not provided care for any HIV positive individuals during 2002. Palliative care, defined as the total (physical, emotional, social and spiritual) care of patients with life threatening disease and care of their families[84] was reported by three hospices in the North West during 2002. Information relating to HIV positive individuals receiving hospice care is presented in table 6.1. Due to the relatively small number of individuals (three in total), the hospices have not been named to ensure client confidentiality.

Data relating to HIV positive individuals accessing specialist drug services in the North West, have also been included in the North West HIV/AIDS annual report for the fourth year. Community drug teams and drug dependency units in the North West were asked to provide brief attributable data (soundex, date of birth, sex) on individuals they knew to be HIV positive who had accessed their services during 2002. Numbers of known HIV positive injecting drug users accessing specialist drug services in the North West are relatively low, as demonstrated in data from statutory treatment centres (chapter 3, table 3.1), reflecting the successful implementation of harm reduction strategies in the 1980s[85]. Information on HIV positive injecting drug users accessing specialist drug services is presented in table 6.2.

Table 6.1: HIV and AIDS care provided by North West hospices by strategic health authority (SHA) of residence, sex, age group, stage of HIV disease and level of inpatient care, January-December 2002 (All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	SHA of Hospice			Total (100%)
	Cumbria Lancashire	Cheshire and Merseyside	Greater Manchester	
Cumbria and Lancashire	1			1 (33.3%)
Cheshire and Merseyside		1		1 (33.3%)
Greater Manchester			1	1 (33.3%)
SEX				
Male	1		1	2 (66.7%)
Female		1		1 (33.3%)
AGE GROUP				
40-44	1			1 (33.3%)
45-49			1	1 (33.3%)
50-54		1		1 (33.3%)
CLINICAL STAGE				
Symptomatic			1	1 (33.3%)
AIDS	1	1		2 (66.7%)
Total (100%)	**1**	**1**	**1**	**3**

INPATIENT CARE	SHA of Hospice			Total (100%)
	Cumbria Lancashire	Cheshire and Merseyside	Greater Manchester	
Episodes	1	5		6
Days	15	75		90

Age ranges refer to the age of individuals at end of December 2002, or at death.

Table 6.1 illustrates the care provided by North West Hospices for HIV positive individuals, categorised by strategic health authority of residence, sex, age group, clinical stage of HIV disease and level of inpatient care provided. Three hospices (one in Merseyside, one in Greater Manchester and another in Lancashire) provided palliative care for HIV positive individuals resident in the North West during 2002. All the individuals receiving hospice care also attended North West statutory treatment centres during the year.

As identified in a previous study, the age group of HIV positive people accessing care from hospices is often younger than other groups presenting at these services[86], in this instance the mean age was 45 years (range 40 to 49 years). Of the three individuals who received hospice care in 2002, one individual was classed as being symptomatic and two had an AIDS defining illness. One of the three hospices provided respite, as opposed to inpatient care. Two hospices provided 90 inpatient days during 2002, an average of 45 days per HIV positive individual who received inpatient care.

Table 6.2: HIV and AIDS care provided by North West drug services by strategic health authority (SHA) of residence, sex and age group, January-December 2002

(All cases seen during 2002 including those who died during the year)

SHA OF RESIDENCE	SHA of Drug Service			Total (100%)
	Cumbria Lancashire	Cheshire and Merseyside	Greater Manchester	
Cumbria and Lancashire	1 (100%)			1 (7.7%)
Cheshire and Merseyside		10 (100%)		10 (76.9%)
Greater Manchester			2 (100%)	2 (15.4%)
SEX				
Male	1 (100%)	8 (80%)	2 (100%)	11 (84.6%)
Female		2 (20%)		2 (15.4%)
AGE GROUP				
25-29		1 (10%)		1 (7.7%)
30-34		1 (10%)		1 (7.7%)
35-39		3 (30%)	1 (50%)	4 (30.8%)
40-44		1 (10%)	1 (50%)	2 (15.4%)
45-49		2 (20%)		2 (15.4%)
50-54	1 (100%)			1 (7.7%)
55-59		2 (20%)		2 (15.4%)
Total (100%)	**1**	**10**	**2**	**13**

Age ranges refer to the age of individuals at end of December 2002, or at death.

Table 6.2 illustrates the care provided by North West specialist drug agencies for HIV positive individuals, categorised by strategic health authority of residence, sex and age group. Data relating to drug service clients who are known to be HIV positive were provided by six agencies, based in Cheshire, Merseyside, Greater Manchester and Lancashire (contributing drugs services are listed at the end of this report). A total of 13 HIV positive individuals were reported by drug services, all of whom attended statutory treatment centres during 2002.

Individuals only attended drug services in the same strategic health authority that they were resident in. The majority of individuals that were reported lived within Cheshire and Merseyside (77%). A lower proportion of HIV positive females attended drugs services than statutory treatment centres (15% compared to 32%, table 3.5). The mean age of HIV positive people accessing North West drug services was 41 years (range 28 to 56 years) compared to 39 years (range 22 to 59 years) for HIV positive injecting drug users accessing North West statutory treatment centres during 2002 (table 3.1).

Statutory treatment centres

AHC Alder Hey Children's Hospital, Haematology Treatment Centre, Eaton Road, Liverpool, L12 2AP, Tel: (0151) 228 4811

APH Arrowe Park Hospital, Department of GUM, Arrowe Park Road, Upton, Wirral, Merseyside, CH49 5PE, Tel: (0151) 678 5111

ARM The Armistead Project, 36 Bolton Street, Liverpool, L3 5LX, Tel: (0151) 708 7366

BLAG Victoria Hospital, Department of GUM, Whinney Heys Road, Blackpool, Lancashire, FY3 8NR, Tel: (01253) 300 000

BLK Blackburn Royal Infirmary, Bolton Road, Blackburn, BB2 3LR, Tel: (0154) 263 555

BLKG Blackburn Royal Infirmary, Department of GUM, Bolton Road, Blackburn, BB2 3LR, Tel: (0154) 263 555

BOLG Royal Bolton Hospital, Department of GUM, Minerva Road, Farnworth, Bolton, BL4 0JR, Tel: (01204) 390 390

BOOT Booth Hall Children's Hospital, Charlestown Road, Blackley, Manchseter, M9 7AA, Tel: (0161) 220 5095

BURG Burnley General Hospital, Department of GUM, Casterton Avenue, Burnley, Lancashire, BB10 2PQ, Tel: (01282) 425 071

BURY Fairfield General Hospital, Rochdale Old Road, Bury, BL9 7TD, Tel: (0161) 764 6081

CHR The Countess of Chester Hospital, Department of GUM, Liverpool Road, Chester, Cheshire, CH2 1UL, Tel: (01244) 365 000

CPED West Cumberland Hospital, Department of Paediatrics, Hensingham, Whitehaven, Cumbria, CA28 8JG, Tel: (01900) 68737

CUM Cumberland Infirmary, Department of GUM, Newtown Road, Carlisle, CA2 7HY, Tel: (01228) 814 814

DDU Liverpool Drug Dependency Unit, Hope House, 26 Rodney Street, Liverpool, L1 2TQ, Tel: (0151) 709 0516

FGH Furness General Hospital, Dalton Lane, Barrow in Furness, Cumbria, LA14 4LF, Tel: (01229) 870 870

LEI Leighton Hospital, Department of GUM, Middlewich Road, Crewe, Cheshire, CW1 4QJ, Tel: (01270) 255 141

LEII Leighton Hospital, Middlewich Road, Crewe, Cheshire, CW1 4QJ, Tel: (01270) 255 141

MAC Macclesfield District General Hospital, Department of GUM, Victoria Road, Macclesfield, Cheshire, SK10 3BL, Tel: (01625) 421 000

MGP 'The Docs' General Practice, Manchester, 55-59 Bloom Street, Manchester, M1 3LY, Tel: (0161) 237 9490

MRI Manchester Royal Infirmary, Outpatients Department, Oxford Road, Manchester, M13 9WL, Tel: (0161) 276 1234

MRIG Manchester Royal Infirmary, Department of GUM, Oxford Road, Manchester, M13 9WL, Tel: (0161) 276 1234

MRIH Manchester Royal Infirmary, Department of Haematology, Oxford Road, Manchester, M13 9WL, Tel: (0161) 276 1234

NOB Noble's Isle of Man Hospital, Department of GUM, Westmoreland Road, Douglas, Isle of Man, IM1 4QA, Tel: (01624) 642 479

NMG North Manchester General Hospital, Infectious Disease Unit, Delaunays Road, Crumpsall, Manchester, M8 5RB, Tel: (0161) 795 4567

NMGG North Manchester General Hospital, Department of GUM, Delaunays Road, Crumpsall, Manchester, M8 5RB, Tel: (0161) 795 4567

OLDG Royal Oldham Hospital, Department of GUM, Rochdale Road, Oldham, Lancashire, OL1 2JH, Tel: (0161) 624 0420

PG Royal Preston Hospital, Department of GUM, Sharoe Green Lane North, Fulwood, Preston, PR2 9HT, Tel: (01772) 716 565

PP Royal Preston Hospital, Paediatric Department, Sharoe Green Lane North, Fulwood, Preston, PR2 9HT, Tel: (01772) 716 565

QSC Queen Street Clinic, HIV Community Nursing Team, 18a Queen Street, Blackpool, FY1 1PD, Tel: (01253) 751 144

RLG Royal Liverpool University Hospital, Department of GUM, Prescot Street, Liverpool, L7 8XP, Tel: (0151) 706 2000

RLH Royal Liverpool University Hospital, Department of Haematology, Prescot Street, Liverpool, L7 8XP, Tel: (0151) 706 2000

RLI Royal Lancaster Infirmary, Ashton Road, Lancaster, LA1 4RP, Tel: (01524) 65944

ROCG Baillie Street Health Centre, Department of GUM, Baillie Street, Rochdale, OL16 1XS Tel: (01706) 517 655

SALG Hope Hospital, Department of GUM, Stott Lane, Salford, M6 8HD, Tel: (0161) 789 7373

SHH St Helens General Hospital, Department of GUM, Marshalls Cross Road, St Helens, WA9 3DA, Tel: (01744) 26633

SPG Southport and Formby District General Hospital, Department of GUM, Town Lane, Kew, Southport, Merseyside, PR8 6PN, Tel: (01704) 547 471

STP Stepping Hill Hospital, Department of GUM, Poplar Grove, Stockport, Cheshire SK2 7JE, Tel: (0161) 483 1010

TAMG Tameside General Hospital, Department of GUM, Fountain Street, Ashton-under-Lyne, Lancashire, OL6 9RW, Tel: (0161) 331 5151

TRAG Trafford General Hospital, Department of GUM, Moorside Road, Urmston, Manchester, M41 5SL, Tel: (0161) 748 4022

WAR Warrington Hospital, Department of GUM, Lovely Lane, Warrington, Cheshire, WA5 1QG, Tel: (01925) 635 911

WGH Westmorland General Hospital, Outpatients Department, Burton Road, Kendal, Cumbria, LA9 7RG, Tel: (01539) 732 288

WHIT West Cumberland Hospital, Department of Haematology, Hensingham, Whitehaven, Cumbria, CA28 8JG, Tel: (01946) 523 426

WIGG Royal Albert Edward Infirmary, Department of GUM, Wigan Lane, Wigan, WN1 2NN, Tel: (01942) 244 000

WITG Withington Hospital, Department of GUM, Nell Lane, Manchester, M20 2LR, Tel: (0161) 445 8111

WORK Workington Infirmary, Department of GUM, Infirmary Road, Workington, Cumbria, CA14 2UN, Tel: (01900) 68737

Voluntary agencies

BARL	Barnado's (Liverpool)	Tel: (0151) 708 7323
BARM	Barnardo's (Manchester)	Tel: (0161) 273 2901
BHA	Black Health Agency	Tel: (0161) 226 9145
BP B'pool	Body Positive Blackpool	Tel: (01253) 296 887
BP Chesh.	Body Positive Cheshire and North Wales	Tel: (01270) 653 150
BP NW	Body Positive North West	Tel: (0161) 873 8100
GHT	George House Trust	Tel: (0161) 274 4499
SAHIR	Sahir House (Mersey Body Positive and Merseyside AIDS Support Group),	Tel: (0151) 708 9080

Social Service Departments

Barrow-in-Furness and South Lakeland	Tel: (01229) 894 345
Blackburn with Darwen	Tel: (01254) 587 887
Bury	Tel: (0161) 778 2586
Lancaster	Tel: (01524) 583 630
Oldham	Tel: (0161) 911 4800
Preston	Tel: (01772) 263 689
Sefton	Tel: (0151) 529 3761
St Helens	Tel: (01744) 456 672
Tameside	Tel: (0161) 304 9725
Trafford	Tel: (0161) 912 1213
Warrington	Tel: (01942) 444 138
Wirral	Tel: (0151) 606 6900

Drug services

Drugs North West	Tel: (0161) 772 3537
Lancaster and District CDT	Tel: (01524) 389 851
Liverpool DDU	Tel: (0151) 709 0516
Oldham CDT	Tel: (0161) 624 9595
Tameside CDT	Tel: (0161) 344 5365
Warrington CDT	Tel: (01925) 415 176
Wirral Drug Service	Tel: (0151) 653 3871

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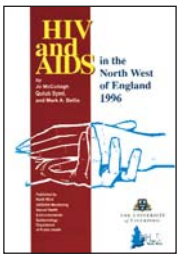

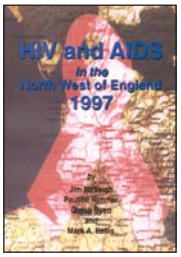

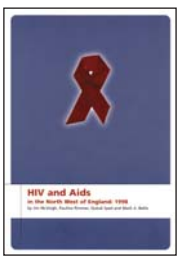

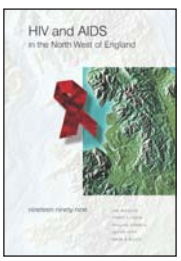

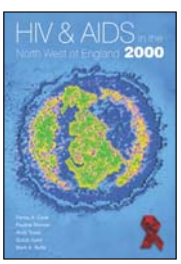

HIV + AIDS 2002 in the north west of england

PENNY A. COOK JENNIFER DOWNING GILLIAN HUNT
QUTUB SYED MARK A. BELLIS

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Liverpool John Moores University,
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