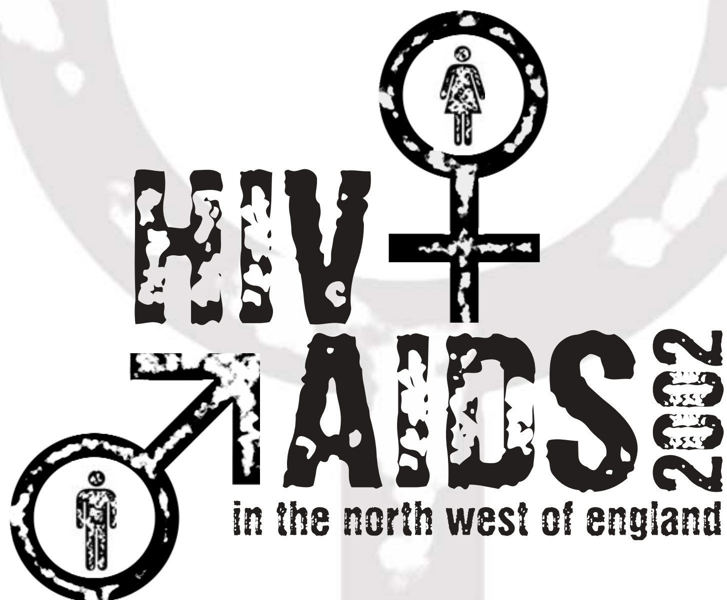

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HIV & AIDS
in the North West of England 2002

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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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