

# HIV and AIDS

## in the North West of England 2000

by Penny A. Cook, Pauline Rimmer, Andy Towle, Qutub Syed and Mark A. Bellis

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## EXECUTIVE SUMMARY

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This report, the fifth 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. During 2000 a total of 1,632 individuals living with HIV or AIDS presented to statutory treatment centres in the North West Region, representing a 16% increase on the number reported in 1999 (1,410). This is the second year running that there has been an increase of this magnitude in the size of the HIV positive population seeking treatment. As was the case last year, the increase is much larger than national predictions of 11%. Over the six years since this level of monitoring began, the HIV positive population in treatment in the North West has grown by 73% (figure 1.12).

A total of 39 statutory centres within the North West provided treatment and care for HIV positive individuals resident throughout the region. The predominant mode of exposure to HIV for North West residents continues to be homosexual sex, accounting for 65% of all cases presenting to North West treatment centres in 2000 (table 3.1). There are, however, considerable variations across health authorities, with over 70% of the HIV positive residents of Manchester, North West Lancashire and Salford and Trafford having been infected by sex between men, compared to fewer than half the cases in Liverpool, Sefton, North Cheshire and South Lancashire (table 3.3). The relatively high proportion of individuals infected by homosexual sex is reflected in the gender distribution of HIV and AIDS cases, with males representing 87% of all cases (table 3.4). Heterosexual sex continues to be the second largest exposure group, accounting for one fifth of all cases in 2000 (table 3.3). This represents a slight increase on the proportion in 1999, reflecting trends for the United Kingdom as a whole. Manchester Health Authority continues to report the highest number of HIV positive individuals in the North West, accounting for over a quarter of all cases (table 3.2) and new cases presenting to statutory treatment centres (table 2.1).

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 2000 (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 2000 from an AIDS-related condition (6%) than are those younger than 55 years, of whom only 2% died. The proportion of AIDS related deaths has decreased over the years, from 9% in 1996 to under 2% in 2000.

A total of 335 new HIV and AIDS cases (HIV positive individuals who had not previously been seen in North West statutory treatment centres prior to the year 2000) were reported during the year. This is the largest number of new cases since regional monitoring of HIV and AIDS began, and represents a 16% increase on last year's figure of 288. New cases represented 21% of all cases, a similar proportion to previous years. The majority of new cases were infected via homosexual sex (56%), while heterosexual sex was reported to be the route of transmission for 27% of individuals (table 2.2). The proportion of new cases who were exposed through heterosexual sex continues to rise, reflecting national trends (figure 1.6). However, unlike the situation nationally, heterosexual sex has not overtaken homosexual sex as the predominant exposure route for new cases in the North West. 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. There was an increase in the number of babies born with HIV, from one in 1999 to six in 2000. Such a rise is to be expected as the proportion of HIV positive individuals who are women increases. While the largest proportion of new cases presenting for treatment and care were categorised as asymptomatic (45%), the seven new cases who died during 2000 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. Nearly a quarter (24%) 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 (53%), a significantly higher proportion than in those known to have been infected in the United Kingdom (11%). Of all the infections contracted outside the United Kingdom, 41% were in Africa, predominantly sub-Saharan Africa (figure 3.3). Europe accounted for a further quarter of the infections that were contracted abroad, with Spain being the most frequently reported country of exposure. The role of exposure abroad was even more pronounced for cases who were new in 2000, where a third were reported to have been infected abroad (figure 2.2).

Ethnicity was recorded for 98% of individuals accessing treatment and care in 2000, most of whom (88%) were self-classified as white (table 3.7). However, an increasing proportion of individuals with HIV were from black and ethnic minority communities (12%), a substantial over-representation when considering the proportion of North West residents who are from ethnic minority groups (3.8%). An even higher proportion (19%) of new cases were from ethnic minority groups, 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 ethnic minority 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), resulting in proportionally more females infected (table 2.8 and 3.8) and babies born with HIV infection (tables 2.7 and 3.9). Black Africans were considerably more likely to present to services for the first time already with an AIDS diagnosis than where white individuals. This later presentation is a cause for concern, since it may have a significant detrimental impact on their prognosis.

During 2000, 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 90% when considering those living with AIDS, while only 31% of asymptomatic individuals were taking this level of therapy (table 3.14). Compared to 1999, the number of individuals receiving triple or more therapy increased by 16%; this increase is the same as that of the HIV positive population as a whole. 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.

Manchester Health Authority provided treatment and care for the highest number of HIV and AIDS cases in the North West. However, not all individuals resident in a particular district receive their treatment from within that health authority. Around half (48%) of the individuals presenting for treatment and care in Manchester were residents of that health authority, and a similar situation was apparent for Stockport (34%), Liverpool (44%) and Sefton (17%) health authorities (table 3.16). The majority (80%) of individuals attended only one treatment centre in the North West during 2000 (table 3.23). However, there was considerable variation across health authorities, with 35% of HIV positive residents of Manchester having attended more than one treatment centre.

For the second year, we can provide information on the level of inpatient and outpatient care for the whole of the region. During 2000, North Manchester General Infectious Disease Unit, the treatment centre with the highest number of HIV positive attendees (table 3.19), provided the highest number of outpatient visits, day cases, inpatient episodes and inpatient days (table 3.25). Demand for outpatient care peaked for those with an AIDS diagnosis (table 3.26), while those who died during 2000 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.

During 2000, seven voluntary agencies in the North West reported care of 1,004 HIV positive individuals. Of these, 20% were not seen in North West statutory treatment centres during 2000, 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 new funding formula.

Five hospices reported providing palliative care for HIV positive individuals during 2000. Six HIV positive individuals residing in five health authorities across the region received hospice care, accounting for 94 inpatient days (table 5.1). All six individuals also received care from the statutory sector during 2000. In addition, specialist drugs services contributed data on clients whom were known to be HIV positive (table 5.2). Twenty individuals were reported by seven drugs services, 90% of whom also received HIV treatment from the statutory sector in 2000.

We hope that the tables and figures provided in this report answer 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

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# 1. INTRODUCTION

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## MONITORING HIV AND AIDS IN THE NORTH WEST REGION

The North West HIV/AIDS Monitoring Unit, at the Public Health Sector, Liverpool John Moores University is responsible for the collection, collation and dissemination of data regarding the number of individuals with HIV infection presenting in the North West for treatment and care. 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<sup>1</sup>. 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)<sup>2</sup> applied.

Over the past seven 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<sup>3-6</sup>. The data collected form part of the national dataset - Survey of Prevalent Diagnosed HIV Infections (SOPHID) and are used in the production of the AIDS Control Act treatment and care reports. In addition, data are utilised at both regional and health authority 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. The Unit continues to collect data from HIV/AIDS voluntary organisations across the region, and, for the second year, we have gathered data relating to HIV positive individuals accessing specialist drug services in the North West during 1999. Seven drug agencies from six health authorities 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.

In addition to data reported to the regional HIV/AIDS Monitoring Unit, in the past laboratories have reported HIV test results directly to the Public Health Laboratory Service (PHLS), and new AIDS diagnoses have also been reported (also directly to PHLS) on an ad hoc basis. In future years all these systems will report to the North West HIV/AIDS Monitoring Unit. This will make the Unit the single point for HIV reporting, and enable more rapid detection of any changes in the epidemiology of HIV/AIDS in the North West Region. We hope to be able to report on these data in future years.

The rest of this section gives an overview of the global and national epidemiology of HIV and AIDS. In section 2, we present analyses of new cases of HIV infection in the North West, and in section 3 analyses of all HIV and AIDS cases presenting for treatment and care in the North West. Voluntary sector care and care from additional sources are dealt with in Chapters 4 and 5. Due to the complexity of the North West treatment and care dataset, not all the analyses that are possible can be produced in this annual report. Further breakdown of the data can be provided on request. Later this year you will also be able to download aggregated data on HIV and AIDS in the North West directly from the North West Public Health Observatory website at [www.nwpho.org.uk](http://www.nwpho.org.uk). However, we hope that the tables and figures provided within the report answer most of your HIV-related information requirements, and would value your suggestions as to what additions would improve the usefulness of the report in future years.

## EPIDEMIOLOGY OF HIV

HIV is a rapidly evolving virus and exists as many different subtypes and strains. If an infected individual is infected by more than one subtype or strain, the viruses can recombine to form a virus population with a combination of characteristics from each<sup>7</sup>. This rapid evolution, and ability of the virus to share genetic material, both confound the search for a vaccine and is the cause of resistance to anti-HIV drugs<sup>8</sup>. For example, exactly the same mutation (on three different parts of genome) occurred at the same time in different parts of the world and rendered the first anti-HIV drug unusable<sup>7</sup>. The transmission of drug resistant HIV strains limits the therapeutic options of newly infected patients. The proportion of people that have been recently infected with resistant strains is increasing, both in the USA<sup>9</sup> and the UK<sup>10</sup>. Of people newly infected in the UK in 2000, it is estimated that around 30% have been infected by resistant viruses<sup>10</sup>.

In addition to the various strains and subtypes of HIV, there are two major types of the virus known as HIV-1 and HIV-2. These are effectively two different species of virus, since people infected with both HIV-1 and HIV-2 do not go on to host viruses with new combinations of the genetic material. The two species appear to have entered the human population on separate occasions, and they also have rather different epidemiology. HIV-2 occurs mostly in West Africa, is less pathogenic<sup>11,12</sup> and has not turned into a pandemic<sup>13</sup>, while HIV-1 occurs in the rest of Africa and the world and is responsible for the pandemic. Very few people in the UK are infected with HIV-2.

### Surveillance of the epidemic

Surveillance of the epidemic in the developed world has become more difficult with the advent of successful treatment. Reliable estimations of the number of people with HIV used to be back-calculated from the number of AIDS cases. Now, because current therapies keep HIV positive people healthier for longer, the time until onset of an AIDS defining illness is less predictable. Instead, the epidemic is tracked by improved reporting of new HIV infections. However, this method is more prone to bias, since it detects fewer cases in marginalised groups, such as ethnic minority communities<sup>14</sup>. Some countries, such as the USA, are yet to fully establish monitoring of HIV diagnoses, thus diminishing the quality of the estimations produced.

There are problems with making estimations of the incidence of HIV infection using the number of new diagnoses of HIV. This is because there is large variation in how soon HIV infection is detected, and newly detected cases cannot be treated as having recently occurred. It is now possible to detect whether an individual has recently been infected with HIV using a new test, and if this were to come into widespread use in surveillance the quality of information on the epidemic would be much improved<sup>15</sup>. The test now has been introduced as part of HIV surveillance in Canada<sup>15</sup>.

As HIV disease progresses, the cells of the immune system that are most severely affected by the virus, the CD4 T lymphocytes, are progressively lost. This results in immunosuppression and increased susceptibility to opportunistic infections. CD4 counts are routinely monitored in individuals with HIV to monitor the course of the disease. The profile of the CD4 count of the population can also be monitored. For example, CD4 at diagnosis may indicate whether certain groups of infected people are less likely to be identified until much later after infection<sup>16</sup>.

### Vaccine development

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<sup>17</sup> and may not work where new recombinant strains are formed<sup>8</sup>.

There are several vaccines currently under development. One of the further advanced is targeted at the site at which the virus enters the CD4 cell (the gp120 molecule). Currently, a large-scale trial of this vaccine is underway among a large group of Thai injecting drug users<sup>18</sup>. A trial of a similar vaccine is also underway in the USA, this time targeted towards strains prevalent in that area<sup>19</sup>. The other main approach for designing a vaccine focuses on the cellular component of the immune response<sup>20</sup>. This is based on studies of the immune system of a group of sex workers in Kenya, who, despite repeated exposure to the virus, remained HIV negative. A trial of this vaccine is underway in Oxford, and another is due to begin in Kenya soon. A vaccine would also influence epidemiology of HIV even if transmission was only modestly reduced but if individuals who did get infected had lower viral loads<sup>21</sup>.

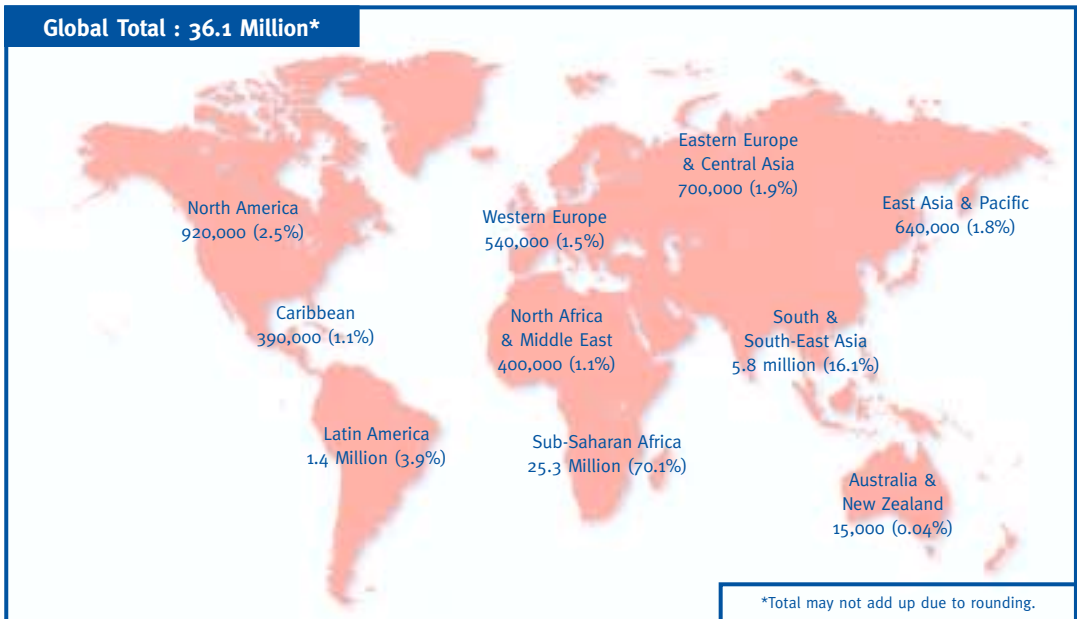
## GLOBAL PERSPECTIVES ON HIV AND AIDS IN 2000

In 2000, an estimated 36.1 million people were living with HIV, 5.3 million of whom were newly infected and 3.0 million of whom died<sup>22</sup>. The total number of lives claimed by the pandemic so far is estimated to be 21.8 million. Sub-Saharan Africa continues to bear the brunt of the AIDS epidemic, with 70% of the global total of people living with HIV and AIDS (figure 1.1), 80% of AIDS-related deaths to date and 72% of new infections during 2000 (figure 1.2)<sup>22</sup>.

In some southern African countries the prevalence of HIV among the adult population is estimated to be over 20%<sup>23</sup>. Such high prevalences mean that the probability of an individual becoming infected with HIV is very high. For example, in Botswana, the country with the highest prevalence (36%), the lifetime probability of a 15-year-old boy contracting HIV is over 80%. The fact that the epidemic is centred on the heterosexual population, rather than a minority group, vastly increases the number of people at risk. While Africa currently has the biggest AIDS problem, the future global course of the epidemic depends on what happens in India and China, since their combined populations account for more than one third of the world's population. In China, the prevalence of sexually transmitted infections has risen steeply since the early 1980s, and a recent survey of sex workers found very high prevalence of syphilis (14%) and other infections indicating the potential for the rapid spread of HIV<sup>24</sup>. However, HIV surveillance data from these areas are weak<sup>25</sup>.

### FIGURE 1.1: NUMBER OF ADULTS AND CHILDREN ESTIMATED TO BE LIVING WITH HIV/AIDS AS END OF 2000

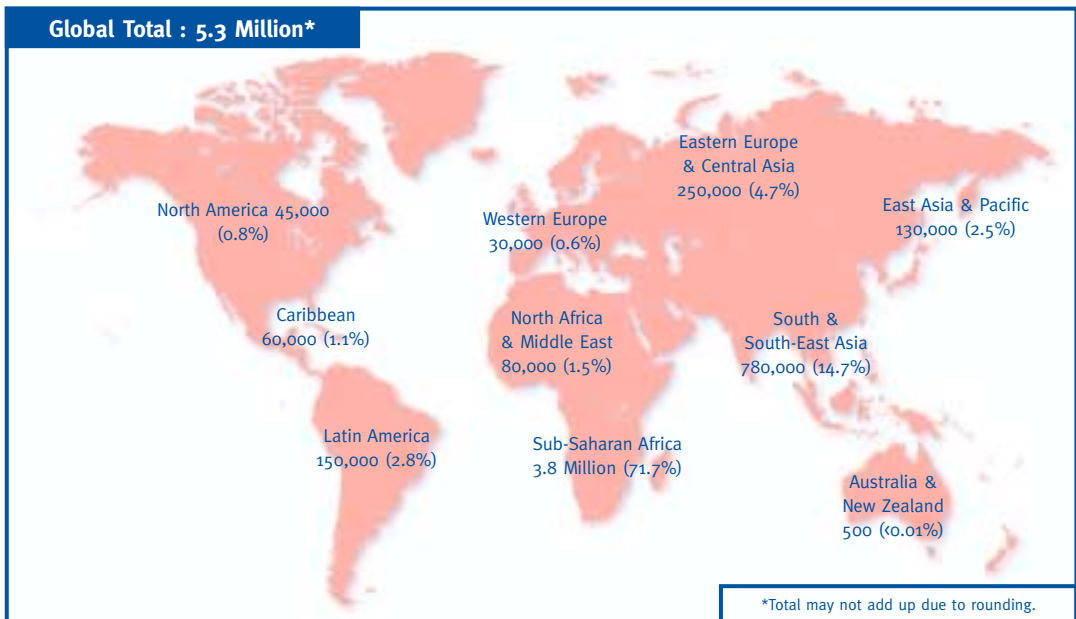
(Source: UNAIDS/WHO Report on the Global HIV/AIDS Epidemic - December 2000)



For the first time, a major international conference on HIV/AIDS was held in Africa, the continent most affected by the AIDS crisis. Over thirteen thousand delegates attended the Thirteenth International AIDS conference in Durban, South Africa in July 2000. The conference, whose theme was ‘Break the Silence’, aimed to bring AIDS to the top of the agenda in countries that have been slow to act to reduce the spread of the epidemic. In the opening ceremony the President of South Africa, Thabo Mbeki, emphasised the importance of poverty as a determinant of AIDS. Whilst the strength of the association between AIDS and poverty cannot be denied, the president attracted much criticism for not acknowledging that HIV is the causal agent of AIDS. In response, over 5,000 scientists and physicians from around the world signed a declaration stating that HIV is the cause of AIDS<sup>26</sup>. The South African Government recently regained favour in the press when it changed its law to enable the production of cheap generic anti-HIV drugs. In response, five major pharmaceutical companies have now dramatically cut the price of seven major drugs for the developing world. However, concerns remain that even at this lower price, anti-HIV drugs would be out of reach of most African countries<sup>27</sup>.

## FIGURE 1.2: NUMBER OF ADULTS AND CHILDREN ESTIMATED TO BE NEWLY INFECTED WITH HIV/AIDS DURING 2000

(Source: UNAIDS/WHO Report on the Global HIV/AIDS Epidemic - December 2000)



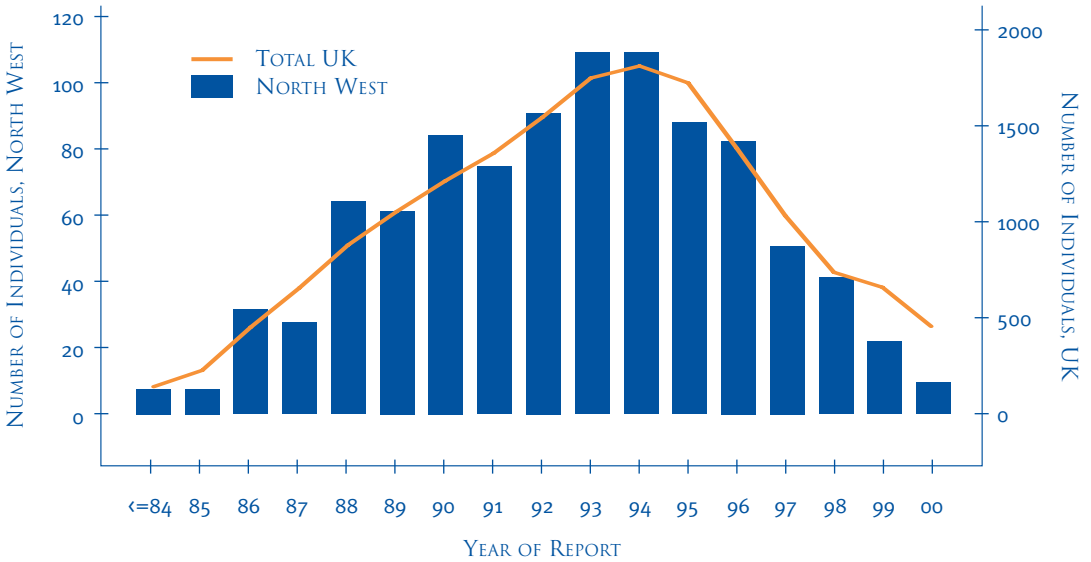
The challenge for poorer countries remains the development of basic health care infrastructure and effective prevention when a significant proportion of the population is infected. One area where interventions could be particularly effective and relatively cheap is preventing mother to child transmission. Infections in infants occur whilst in the womb, during delivery and during breastfeeding. The majority of infections can be prevented by the mother taking anti-HIV drugs during pregnancy, delivery by caesarean section and avoidance of breastfeeding. Breastfeeding is estimated to be responsible for 30-50% of the estimated 600,000 paediatric infections worldwide<sup>28</sup>. However, discouraging breastfeeding when artificial milk is not affordable is not appropriate, particularly in view of the fact that breastfeeding is strongly associated with a reduction in infant mortality and morbidity from all other causes in developing countries<sup>28</sup>. Recently this view has been vindicated, as the first study to separate the effects of breast feeding alone and mixed feeding (breast feeding an artificial feeding) has found that breastfeeding alone conferred no additional risk of HIV transmission in South African mothers<sup>29</sup>. It is hypothesised that the artificial food in mixed feeding may damage the bowel and allow HIV from the breast milk to enter the infant's circulatory system.

Another intervention that may reduce HIV incidence is male circumcision, although this has been controversial. However, a recent meta-analysis has supported the protective effect of circumcision and suggests that is more likely to have a role where ulcerative sexually transmitted infections (e.g. syphilis) are important cofactors in HIV transmission<sup>30</sup>.

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<sup>31</sup>. 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). Recent data from the USA 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<sup>32</sup>. 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<sup>33</sup>. In the developed world HIV remains focussed in marginalised communities, for example 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 REPORT TO DECEMBER 2000**

(Source: AIDS/HIV Quarterly Surveillance Tables No.49, CDSC)



	<=84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	Total
North West Region	8	8	33	29	67	64	84	78	95	114	114	92	82	53	43	23	10	997
Total UK	161	247	474	680	905	1081	1242	1388	1576	1783	1846	1757	1414	1059	762	683	478	17538*

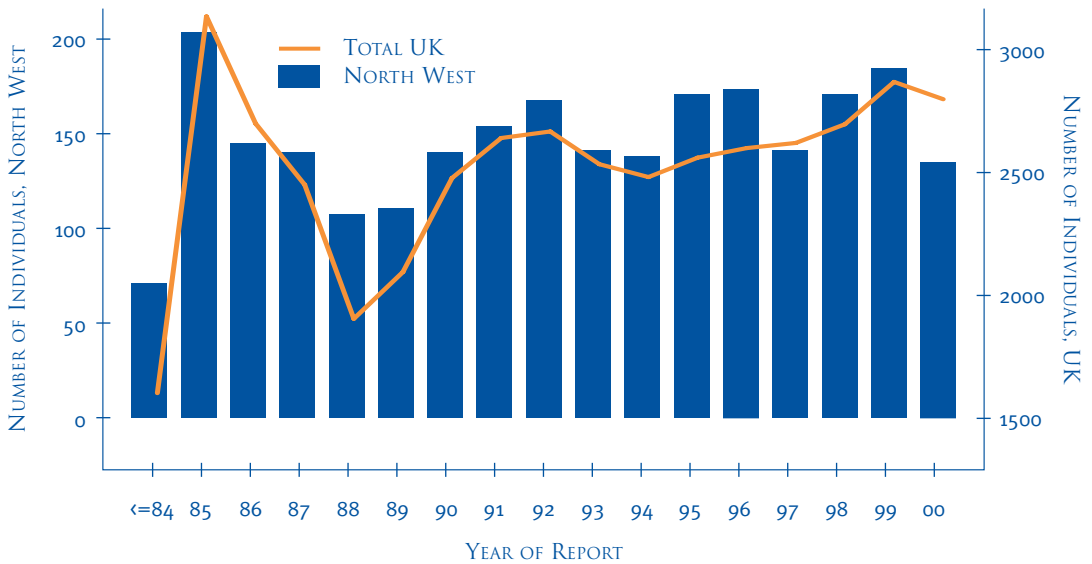
\* Includes 2 individuals with year of diagnosis unknown.

In the developed world, one of the challenges posed by HIV is maintaining an armory of drugs that are effective against HIV. The fact that treatment can be difficult to tolerate and complex to manage can lead to non-compliance with treatment regimes, ultimately hastening the evolution of treatment-resistant forms of the virus. Another challenge is maintaining levels of safer sex behaviour in the population. Worryingly, several richer countries report increases in risk behaviour, at least in part due to complacency generated by the effectiveness of treatment<sup>33</sup>.

There is a continuing need to fight discrimination against people with HIV. On one hand such individuals have an infection that is chronic but in many cases manageable, yet on the other hand continue to live with the stigma that surrounds HIV and AIDS. Of particular concern in the UK was the conviction of an HIV positive individual for transmitting HIV infection through consensual sex<sup>34</sup>, bringing up the possibility that individuals will be discouraged from having their infections diagnosed. Another example of potential discrimination against HIV positive people that has been highlighted recently is the denial of fertility treatment to couples where one or both are HIV positive. It can no longer be said that the babies would be any more at risk of losing their parents than for other risky conditions, which are currently supported with fertility treatment. Fertility treatment for couples where the male is HIV positive involves a sperm washing technique that appears to eliminate the virus. In a London unit there have been no instances of the partner or baby becoming HIV positive following 300 such sperm washes<sup>35</sup>.

**FIGURE 1.4 : NUMBER OF NEW HIV CASES IN THE NORTH WEST AND THE UK BY YEAR OF REPORT TO DECEMBER 2000**

(Source: AIDS/HIV Quarterly Surveillance Tables No.49, CDSC)



	<=84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	Total
North West Region	72	202	147	142	109	112	142	156	170	143	140	173	176	143	173	187	137	2524
Total UK	1611	3222	2764	2502	1929	2129	2531	2702	2730	2590	2535	2618	2659	2681	2761	2942	2868	43774

**Sub-Saharan Africa**

The latest figures suggest that the number of new HIV infections in sub-Saharan Africa may be levelling out. In the year 2000 an estimated 3.8 million adults and children were newly infected (see figure 1.2), compared to 4 million in 1999<sup>25</sup>. This stabilisation in the number of new cases may partly be because many sexually active people in the population are already infected, leaving a smaller pool of uninfected people. Also, successful prevention programmes in some countries (most notably in Uganda) have contributed to the reduction<sup>22</sup>. The prevalence of HIV varies hugely across the region, from under 2% (for example, Senegal and Gambia<sup>23</sup>) to over 20% (for example, Botswana<sup>23</sup> and South Africa<sup>36</sup>). The number of new HIV cases may again increase if the countries that currently have low prevalence do not continue to maintain their status.

Sub-Saharan Africa remains the only area where prevalence of HIV is higher in females than males. One reason for this may be because HIV is more easily transmitted from men to women. Also, women get infected at a younger age, and the young form the bulk of the population<sup>22</sup>. However, adult mortality from AIDS is higher in males, possibly because on average they are older when infected<sup>37</sup>.

**South and South East Asia**

During the course of 2000, an estimated 780,000 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 5.8 million (figure 1.1). Injecting drug use and commercial sex continue to drive the epidemics in Cambodia, Thailand and Myanmar (Burma)<sup>13,22</sup>. The trafficking of drugs is associated with HIV outbreaks: recent research has linked four different overland heroin export routes from Myanmar and Laos with dual epidemics of injecting drug use and HIV infection in India, China and Vietnam<sup>38</sup>.

In India, the prevalence of HIV is relatively low at 0.7% of the adult population. However, because the vast size of the population, India accounts for 10% of the global total of individuals with HIV (3.7 million cases)<sup>25</sup>. HIV prevalence also remains low in countries such as Pakistan and Bangladesh. Countries with a low prevalence of HIV face a different challenge, since the political costs of admitting to the existence of risk behaviours and identifying marginalised groups for prevention activities may be too great<sup>39</sup>. There is some argument that Bangladesh's predominantly Muslim culture would protect it from an HIV epidemic. Although monitoring systems detect a low prevalence<sup>25</sup>, surveys of poor areas bordering higher prevalence countries found that 25% of single men used prostitutes, suggesting potential for the spread of HIV<sup>40</sup>.

### Latin America and the Caribbean

These regions account for 1.8 million people living with HIV (figure 1.1). Initially, the epidemic in Latin America was similar to that in North America and Europe, with most cases in injecting drug users and men who have sex with men<sup>22</sup>. However, now the epidemic has a complex pattern, with male to male transmission predominant in Mexico, Chile and Cuba and injecting drug use being important in Brazil and Argentina. More recently there have been rapid increases in the proportion of HIV positive individuals who are infected by heterosexual sex.

The Caribbean has the highest levels of HIV outside Africa, because the predominant mode of transmission is sex between men and women and thus the epidemic is focussed on the general population. The overall prevalence of HIV is 2%, with the worst affected country being Haiti where 8% of the population is infected with HIV<sup>13</sup>.

### North America

An estimated 45,000 new infections occurred in North America during 2000 (figure 1.2), and these contribute to an estimated total of 920,000 people living with HIV (figure 1.1). HIV/AIDS surveillance in the USA is based on notifications of AIDS diagnoses. Since fewer individuals now go on to develop AIDS, it is more difficult to interpret epidemiological trends in HIV. The Centers for Disease Control are now trying to establish the reporting of new HIV diagnoses, but at present relatively few states are participating<sup>41</sup>. The group most affected remains men who have sex with men, accounting for 52% of AIDS cases (where route of infection is known) and 44% of new AIDS diagnoses. An increasing proportion (49%) of homosexually acquired AIDS cases are from ethnic minority groups. Homosexual men from ethnic minority groups are also infected at a younger age than their white counterparts<sup>42</sup>. Moreover, the incidence of AIDS and AIDS-related deaths has decreased more rapidly among whites than Hispanics or African Americans<sup>33</sup>. The situation in the USA has particular relevance for HIV epidemiology in the North West of England, since, of all the countries named by those infected abroad, the largest number has been attributed to the USA (see section 3, figure 3.3).

### Eastern Europe and Central Asia

Eastern Europe and Central Asia is the region with the fastest growing epidemic. There are now an estimated 700,000 people living with HIV, a staggering 67% increase on last year's figure of 420,000<sup>25</sup>. The majority of people with HIV are injecting drug users who live in the Russian Federation and Ukraine – areas characterised by political and economic instability and consequent high levels of drug use. The overlaps between the drug using and sex worker populations<sup>43</sup> and the huge increases in syphilis rates in Russia during the 1990s<sup>33</sup> are fuelling fears that the HIV epidemic will spread into the general heterosexual population. However, despite these ominous signs, there is as yet no proof that the epidemic has spread to the wider community<sup>44</sup>.

There has been a more recent explosion of HIV cases in Latvia, where injecting drug use and needle sharing is common<sup>45</sup>. A recent review of the research into drug risk behaviour in the newly independent states of the former Soviet Union confirm that needle sharing and 'front-loading' (where individuals divide prepared drugs with a used syringe) are common. However, the practice of using human blood in the preparation of drugs (previously suggested to be responsible for HIV transmission) now appears not to be a risk factor, since preparation involves boiling the mixture<sup>46</sup>.

The prevalence of HIV in other countries of the region remains low. However, travel within the region may lead to future spread of the epidemic. For example, diagnosed syphilis cases in Poland have been significantly linked with sex in the former Soviet Union<sup>46</sup>. Another HIV risk in Eastern Europe is through blood transfusions: for example in Azerbaijan and Georgia only 19% and 38% respectively of blood donations are screened for HIV<sup>47</sup>.

## Western Europe

At the end of 2000, the number of people living with HIV in Western Europe was estimated to be 540,000, of whom approximately 30,000 were newly infected in 2000. 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, from under 0.1% of the adult population in the Scandinavian countries to an estimated 0.58% and 0.74% in Spain and Portugal respectively – a greater than seven-fold difference<sup>43</sup>. Unlike in the UK, the epidemic in the rest of Western Europe is largely centred on injecting drug use. A recent study of HIV prevalence in female injecting drug users across cities in Europe found Madrid to have the highest prevalence among injectors (53%) and London to have the lowest (1.4%)<sup>48</sup>. However, reporting data are limited or not available 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)<sup>47</sup>.

Many Western European countries are popular holiday destinations for British tourists. Moreover, risk behaviour, particularly among young people, increases when on holiday<sup>49</sup>. In 1999, of the North West residents newly infected abroad, nine were infected in Spain – the largest number for any single country<sup>6</sup>.

## HIV AND AIDS IN THE UNITED KINGDOM – 2000

Concern has been growing in the United Kingdom over the continuing high number of new cases of HIV infection. The Government was originally due to address this issue in an HIV strategy. However, the HIV strategy is now to be incorporated within the sexual health strategy. The sexual health strategy, originally expected last year, is yet to be released, further delaying development of services and prevention strategies. Meanwhile, the sexual health of the UK continues to deteriorate, with increases in the levels of sexually transmitted infections such as chlamydia, gonorrhoea and syphilis<sup>50</sup>. These increases are particularly apparent in the North West of England<sup>50,51</sup>.

New diagnoses of HIV, development of AIDS and deaths of HIV positive people are reported to the Public Health Laboratory Service (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 section give an overview of trends in the UK using these data. However, the data under-represent some regions of the UK (notably the North West and Trent<sup>52-54</sup>). Sections 2 to 5 of this report are based on a survey 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.

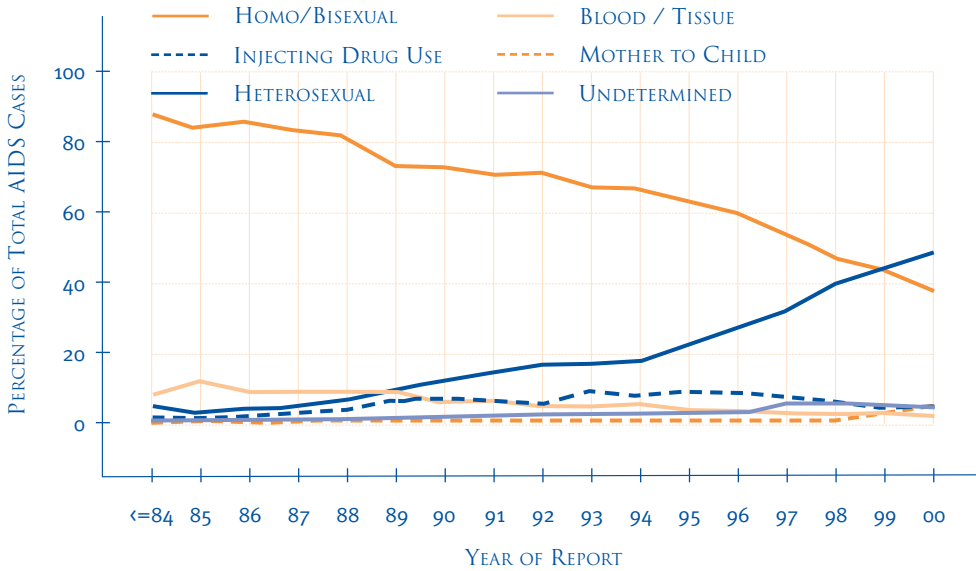
The number of people reported as being diagnosed with AIDS in the UK in 2000 was 478, bringing the cumulative total number of people with AIDS since notification began in 1982 to 17,538 (figure 1.3). The number of new AIDS cases represents a 74% decrease from 1994 when the number of AIDS diagnoses was 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.

Monitoring AIDS diagnoses is no longer an effective way to monitor the epidemic, since progressing to AIDS can result from one of a number of factors (for example failure to diagnose HIV, failure of treatment, compliance with treatment etc.). For this reason, data on newly reported HIV diagnoses give a more accurate picture of the prevalence and patterns of transmission. However, since the period between becoming infected and taking a test is variable, caution must be applied when interpreting test data. Individuals may seek an HIV test for a variety of reasons, which could directly relate to the length of time since the potential exposure occurred. For example, a test may confirm an HIV related illness following exposure several years previously, or concerns regarding a recent potential exposure may prompt more immediate testing. Advances in life-prolonging treatment, which are more effective if commenced early in the course of infection, may have increased the take up of tests.

The cumulative total of reported HIV infections in the UK rose to 43,774 at the end of 2000 (figure 1.4). Of these, 2,868 cases were newly identified in 2000. 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.

**FIGURE 1.5: NUMBER OF AIDS CASES IN THE UK BY YEAR OF REPORT AND INFECTION ROUTE OF HIV TO DECEMBER 2000**

(Source: AIDS/HIV Quarterly Surveillance Tables No.49, CDSC)



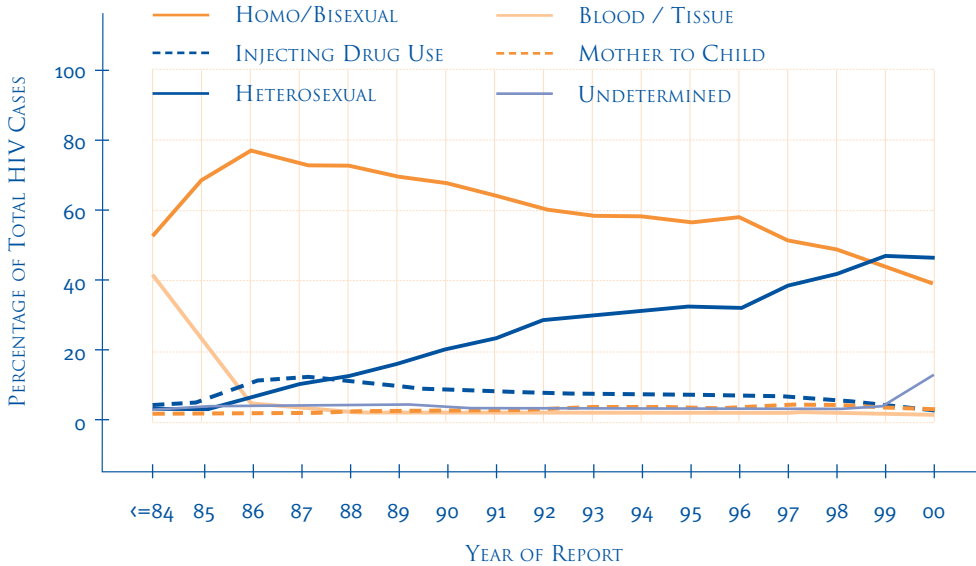
YEAR OF REPORT	INFECTION ROUTE						Total
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
<=1984	142	1	8	10	0	0	161
1985	207	2	6	27	3	2	247
1986	406	7	16	39	4	2	474
1987	567	16	26	58	6	8	681
1988	738	28	52	75	7	8	908
1989	810	63	98	91	8	12	1082
1990	924	82	140	69	17	10	1242
1991	989	88	193	82	17	19	1388
1992	1107	84	269	70	30	16	1576
1993	1192	153	307	79	42	11	1784
1994	1225	138	334	90	43	16	1846
1995	1105	150	395	49	39	19	1757
1996	840	116	384	30	32	13	1415
1997	567	77	334	23	52	6	1059
1998	355	43	298	15	41	10	762
1999	294	26	300	15	26	22	683
2000	186	21	231	7	20	13	478
<b>Total</b>	<b>11656*</b>	<b>1095</b>	<b>3391</b>	<b>829</b>	<b>387</b>	<b>187</b>	<b>17545**</b>

\* Includes 307 men who had also injected drugs

\*\* Includes 2 cases where year of diagnosis is unknown

FIGURE 1.6: NUMBER OF HIV CASES IN ENGLAND, WALES AND NORTHERN IRELAND\* BY YEAR OF REPORT AND INFECTION ROUTE OF HIV TO DECEMBER 2000

(Source: AIDS/HIV Quarterly Surveillance Tables No.49, CDSC)



YEAR OF REPORT	INFECTION ROUTE						Total
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undeter-mined	
<=1984	657	36	19	525	0	18	1263
1985	2037	113	50	661	3	93	2962
1986	1920	250	136	81	9	71	2469
1987	1682	257	211	44	5	73	2280
1988	1329	174	209	25	12	57	1808
1989	1405	176	333	22	11	68	2019
1990	1640	170	499	22	28	51	2415
1991	1640	190	602	21	28	54	2535
1992	1581	160	728	21	56	53	2600
1993	1426	151	720	15	65	47	2425
1994	1403	138	748	13	63	35	2400
1995	1399	159	791	18	56	52	2476
1996	1465	139	777	19	55	52	2507
1997	1302	132	948	24	72	44	2524
1998	1268	109	1092	8	88	53	2619
1999	1236	88	1309	15	61	92	2803
2000	1044	56	1270	7	49	321	2747
<b>Total</b>	<b>24434**</b>	<b>2498</b>	<b>10442</b>	<b>1541</b>	<b>661</b>	<b>1234</b>	<b>40852***</b>

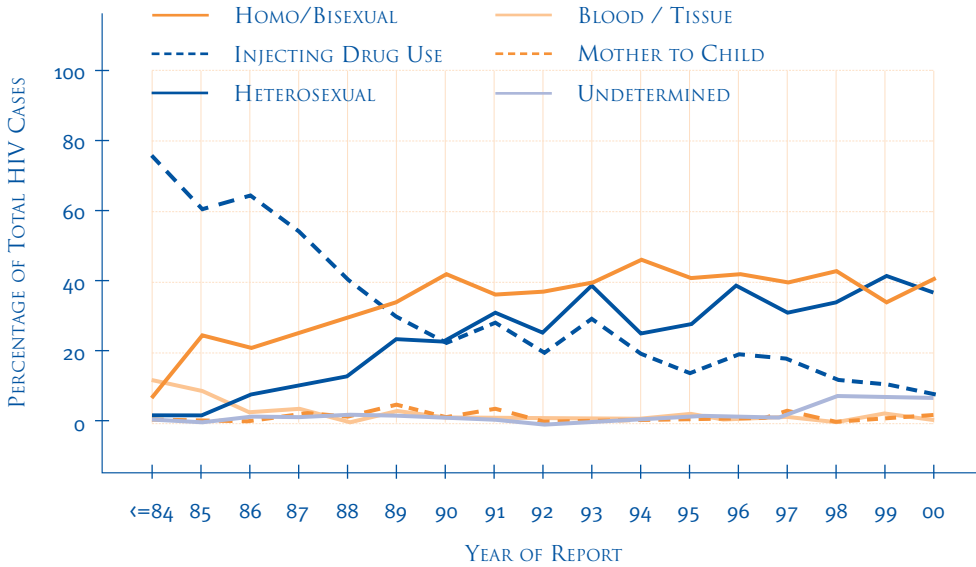
\* Includes 60 patients who were first reported from the Channel Islands

\*\* Includes 611 men who had also injected drugs

\*\*\* Includes 42 with sex not stated on report

FIGURE 1.7: NUMBER OF HIV CASES IN SCOTLAND BY YEAR OF REPORT AND INFECTION ROUTE OF HIV TO DECEMBER 2000

(Source: AIDS/HIV Quarterly Surveillance Tables No.49, CDSC)



YEAR OF REPORT	INFECTION ROUTE						Total
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
<=1984	26	272	5	44	0	2	349
1985	68	164	3	25	0	1	261
1986	67	198	20	7	1	4	297
1987	62	127	25	5	5	3	227
1988	42	56	31	0	1	3	133
1989	40	35	25	6	5	1	112
1990	52	28	35	2	1	1	119
1991	64	51	42	3	7	2	169
1992	51	27	50	2	1	0	131
1993	69	52	41	2	2	1	167
1994	68	29	38	4	1	3	143
1995	61	21	55	1	2	3	143
1996	69	32	50	2	2	3	158
1997	68	31	54	3	6	3	165
1998	65	19	51	1	0	11	147
1999	50	16	58	1	4	11	140
2000	52	11	45	3	1	9	121
<b>Total</b>	<b>974*</b>	<b>1169</b>	<b>628</b>	<b>111</b>	<b>39</b>	<b>61</b>	<b>2982</b>

\* Includes 36 men who had also injected drugs

An additional valuable tool for monitoring the HIV epidemic in the UK is provided by the unlinked anonymous HIV seroprevalence programme conducted by PHLS and the Institute of Child Health. Part of the programme involves 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 minimally biased estimates of current HIV prevalence<sup>55</sup>.

The epidemiology of HIV in the UK continues to be dominated by the situation in London, both in terms of the absolute numbers of people diagnosed<sup>56</sup>, but also in terms of the prevalence (i.e. the proportion of people infected) in the general population and in each of the risk groups<sup>57</sup>.

### Men who have sex with men

The category of homosexual exposure accounts for 66% of all AIDS cases so far reported in the UK (figure 1.5) and 60% of all HIV cases (figure 1.6), and therefore remains the largest group of people living with HIV in England, Wales and Northern Ireland. 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 78% in 1986 to 38% in 2000. 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 7.2%, significantly higher than that outside London (2.3%)<sup>57</sup>. It is estimated that around one third of HIV positive homosexual men are diagnosed late in the course of their infection, as evidenced by their low CD4 counts at diagnosis<sup>56</sup>.

The 1980s saw substantial reductions in risk behaviour among gay men in response to the AIDS crisis. However, levels of risk behaviour among gay men in USA have been increasing<sup>58</sup>. In the UK, following several years of stable levels of risk behaviour<sup>59</sup>, more recent annual surveys (1996-1998) show that gay men in London also appear to be following the trend for a reduction in safer sex behaviour<sup>60</sup>. This change in self-reported risk behaviour is mirrored by increasing levels of homosexually acquired gonorrhoea (by 36% between 1995 and 1999) in the UK<sup>57</sup>. As well as indicating increases in risk behaviour, sexually transmitted infections may also act as a co-factor in the transmission of HIV, as demonstrated for heterosexual transmission<sup>61</sup>. However, there have been fewer studies of the influence of sexually transmitted infections on HIV transmission during sex between men<sup>62</sup>.

It has been suggested that AIDS may not have had a great influence on younger gay men since, unlike many older gay men, they have not witnessed their partners and friends die from the disease. Another suggestion is that the increase in self-reported risk behaviour<sup>60</sup> could be a result of optimism over the effectiveness of antiretroviral therapy. A longitudinal study of HIV positive gay men in Amsterdam on therapy showed that those with undetectable levels of virus in their blood had increased levels of risk behaviour<sup>63</sup>. Yet more worrying is the suggestion that some HIV negative men may consider it erotic to have unprotected anal intercourse with an HIV positive man<sup>64</sup>. A recent survey of HIV positive individuals in the North West revealed a high proportion who claimed that some of their HIV negative partners were aware of their HIV status and yet refused to use condoms<sup>65</sup>.

Efforts to increase awareness of HIV have used community-based approaches, which are thought to be more effective models of health promotion. However, while peer education appears to be successful in the US, interventions in London failed to find a reduction in risk behaviour, possibly because of important cultural differences between UK and US gay men<sup>66</sup>.

One group of people about whom relatively little is known, and who are difficult to access, is men who have sex with both men and women. This group is important because it could bridge the gap between gay men and the heterosexual population. Research in the UK shows that these men are likely to be difficult to identify because fewer than half identify as bisexual and fewer than 1% identify as gay<sup>67</sup>. The men surveyed had similar numbers of male and female partners, and, in the year preceding the interview, 23% had unprotected anal sex with female partners and 18% had unprotected anal sex with male partners.

## Heterosexual sex

Sex between men and women now accounts for 26% of the total number of HIV diagnoses in England, Wales and Northern Ireland. However, for the second year running, heterosexual sex has accounted for the largest number of new cases, at 46% in 2000 (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). 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 ten times higher in London compared to any other region in the UK (248 per 100,000 compared to 18 per 100,000 in the North West: figure 1.9). For those HIV positive individuals infected through heterosexual sex, the majority (61%) are female<sup>66</sup>. Approximately 80% of all infected women in the UK are African and of these four-fifths contracted the virus through heterosexual sex<sup>68</sup>. This high level of HIV positive women increases the risk of vertical transmission.

In the UK, the vast majority of heterosexually acquired HIV cases are categorised as exposed abroad (figure 1.8), with sub-Saharan Africa being the predominant global region of transmission<sup>66</sup>. This is also reflected in the epidemiology of HIV in the North West, where, of those newly reported in 2000 who were exposed abroad, 46% were exposed in Africa (see section 2, figure 2.3). Black and ethnic minorities form the majority of heterosexually transmitted AIDS cases in the UK with black Africans constituting the largest group<sup>66</sup>. 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 2000 reside<sup>22</sup>.

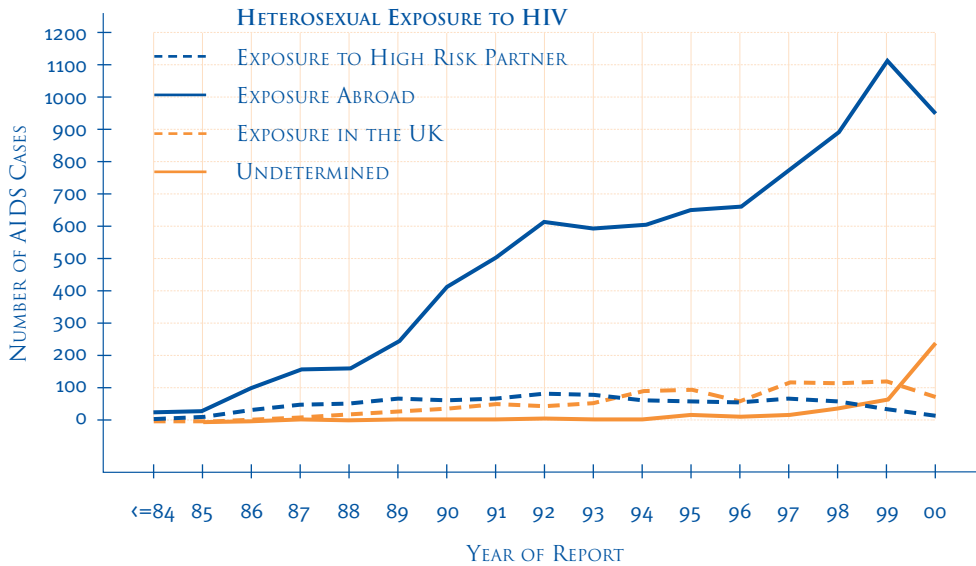
In the UK, 6% of the population are from the black and ethnic minority communities, and in the North West the figure is 3.8%<sup>69</sup>. The prevalence of HIV infection amongst these communities in the North West is 79 individuals per 100,000 compared to just 22 individuals per 100,000 for whites (section 3).

Heterosexuals present later than other groups for testing and treatment, as evidenced by low CD4 counts when newly diagnosed<sup>46</sup> and they are more likely to go on to develop AIDS within three months of having had their HIV diagnosis<sup>70</sup>. Because of the high proportion of ethnic minority individuals amongst the heterosexual HIV positive population, the outcome is that such individuals are not accessing treatment and care to the same extent as white people with HIV and have a poorer prognosis as a result<sup>71</sup>. It is not clear how much of this is failure to recruit heterosexuals into treatment, or how much is related to HIV positive individuals from ethnic minority groups having newly arrived in the country. Additionally, being from a minority ethnic group is a marker of low socio-economic status, which in itself is related to poorer health<sup>69</sup> and possibly HIV status (see later section on social deprivation and HIV in the North West).

Globally, migrants are often at greater risk of HIV infection than are resident populations<sup>72</sup>. During 2000 the UK received 97,900 asylum applications, 22% of the total number of applications lodged in Europe<sup>73</sup>. Refugees in the North West were located in the major cities of Liverpool and Manchester<sup>74</sup>. Although not all asylum seekers are from high HIV prevalent countries, 26% of all applications were from Africa<sup>73</sup>. Since April 2000, refugees have been dispersed away from traditional ports of entry and established screening systems for infectious diseases. The affected health authorities were not notified and therefore were unable to make appropriate provision for the new arrivals<sup>75,114</sup>. This has particular implications for HIV positive refugees. Some asylum applicants have experienced difficulty accessing primary healthcare, despite being entitled to full registration and free healthcare<sup>114</sup>. Currently the cost of healthcare is not a material issue in the consideration of asylum applications in the UK, and HIV positive refugees are not discriminated against on these grounds. This is not the case elsewhere, for example HIV positive individuals from Haiti have been detained in special camps in the US<sup>114,115</sup>. 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. Precise figures for the number of refugees dispersed into the North West region are not currently available. However, steps have been taken on Merseyside to address some of the healthcare needs of refugees with the establishment of an HIV Strategy Group for Asylum seekers<sup>116</sup>. Figures produced by this agency for the Liverpool area show many of the refugees belong to high-risk groups: of the 2309, 60% are aged 17 to 35, and 27% are from Africa.

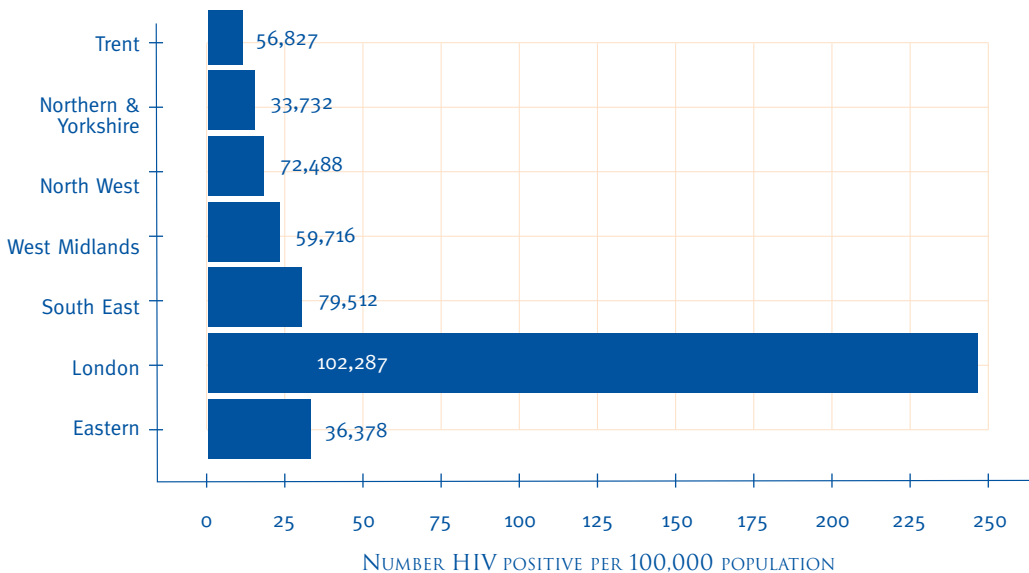
## FIGURE 1.8: NUMBER OF HETEROSEXUALLY ACQUIRED HIV CASES IN THE UK BY YEAR OF REPORT TO DECEMBER 2000

(Source: AIDS/HIV Quarterly Surveillance Tables No.49, CDSC)



## FIGURE 1.9: HIV PREVALENCE AMONG PREGNANT WOMEN IN ENGLAND, 1999 (NEWBORN INFANT DRIED BLOOD SPOTS COLLECTED FOR METABOLIC SCREENING)

(Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 1999)



Numbers by each bar represent sample sizes

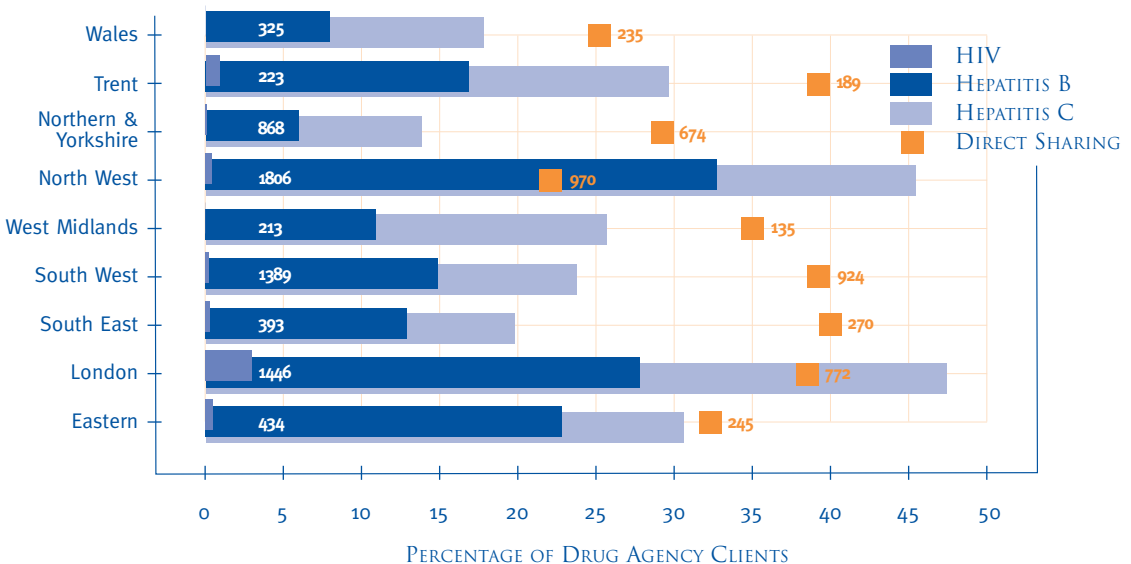
### Injecting drug users

Injecting drug use accounts for 6% 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 2000 has dropped to just 2%, the lowest reported since reporting started. In Scotland, the epidemic has historically been centred on injecting drug use, which accounted for 78% of infections up to and including 1984. This proportion has steadily decreased, and last year only 9% 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 0.4% in the North West. In London, an estimated 3% have HIV. Although these prevalence estimates are only available for drug users attending services, good surveillance information should also incorporate the size of the drug using population<sup>76</sup>. Recent research on the hidden population of drug users in the North West suggest that in the metropolitan areas of Liverpool and Manchester only a third of problematic drug users are known to health or criminal justice systems<sup>77</sup>.

The decreasing proportion of HIV associated with injecting drugs in Scotland and the consistently low proportion elsewhere in the UK have been attributed to the success of harm reduction strategies such as syringe exchange schemes<sup>78</sup>. However, other blood borne infections, such as hepatitis B and C, are more infectious 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 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%<sup>79,80</sup>. One implication of the high hepatitis C prevalence and its relative ease of transmission is that the vast majority of injecting drug users with HIV also have 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<sup>79</sup>). The extremely high prevalence of hepatitis C among HIV-infected injecting drug users may contribute to their excess mortality compared to other groups with HIV. This excess mortality has been detected by monitoring CD4 at death: HIV positive injecting drug users die with higher CD4 counts than average<sup>81</sup>.

**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, 1998-99 (VOLUNTARY SALIVA SAMPLES)**

(Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 1999)



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 42% of all infections reported before and during 1984 to just 0.3% in 2000 (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<sup>82</sup>. Recently, 5,579 transfusion recipients were followed up, and none had been infected with HIV as a result. This suggests that the current risk of a transfusion in the UK is very low, at less than one in 5,000<sup>83</sup>.

### Mother to child

During 2000, 49 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 61, there is an inevitable delay in reporting vertically transmitted HIV. This is because maternal antibodies are present for up to 18 months after birth and confounds the diagnosis. The equivalent figure published for 1999 was 31; however, by December 2000 this 1999 figure had been adjusted to 61. Thus it is likely that several more diagnoses for the year 2000 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%<sup>84</sup>. Further reductions in vertical transmission may arise from the recent discovery of a factor in the placenta that inhibits HIV infection<sup>85</sup>. Currently, the main obstacle that prevents successful intervention is lack of knowledge by the mother of her HIV status. Results from the anonymous unlinked seroprevalence programme suggest that an estimated 380 births to HIV infected women took place in 1999, that would have resulted in an estimated 55 infected infants. If all HIV infected mothers had been offered interventions, fewer than ten babies would have been born with HIV infection. Hence, 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 by 2002<sup>86</sup>. In London, the proportion of pregnant HIV positive women who were diagnosed before delivery increased from 50% in 1998 to 76% in 1999. However, there was less improvement outside the London area<sup>87</sup>.

## HIV AND AIDS IN THE NORTH WEST OF ENGLAND - 2000

Figures 1.3 and 1.4 and Tables 1.1 and 1.2 are taken from the PHLS 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 severely underestimate the number of cases in the North West <sup>52,53,87</sup>, 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 sections 2 to 5 of this report.

By the end of 2000, a cumulative total of 2,524 HIV infections in the North West had been reported to the Communicable Disease Surveillance Centre at PHLS, including 137 new cases during 2000 (Figure 1.4). There were ten newly diagnosed AIDS cases in the North West, bringing the cumulative total to 997, 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 living with AIDS 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 (18% compared to 25%) and a correspondingly higher proportion of men who were infected by having sex with men (64% compared to 58%) (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.

**TABLE 1.1: CUMULATIVE NUMBER OF AIDS CASES IN THE NORTH WEST AND THE UK BY INFECTION ROUTE OF HIV TO DECEMBER 2000**

(Source: AIDS/HIV Quarterly Surveillance Tables No.49, CDSC)

	INFECTION ROUTE					Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Other/Undetermined	
North West Region	670 (67.2%)	58 (5.8%)	142 (14.2%)	101 (10.1%)	26 (2.6%)	997
Total UK	11652 (66.4%)*	1095 (6.2%)	3391 (19.3%)	828 (4.7%)	572 (3.3%)**	17538

\* Includes 307 men who had also injected drugs

\*\* Includes 387 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 2000**

(Source: AIDS/HIV Quarterly Surveillance Tables No.49, CDSC)

	INFECTION ROUTE					Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Other/Undetermined	
North West Region	1621 (64.2%)	162 (6.4%)	445 (17.6%)	191 (7.6%)	104 (4.1%)	2524
Total UK	25379 (58.0%)*	3659 (8.4%)	11054 (25.3%)	1649 (3.8%)	1991 (4.5%)**	43774***

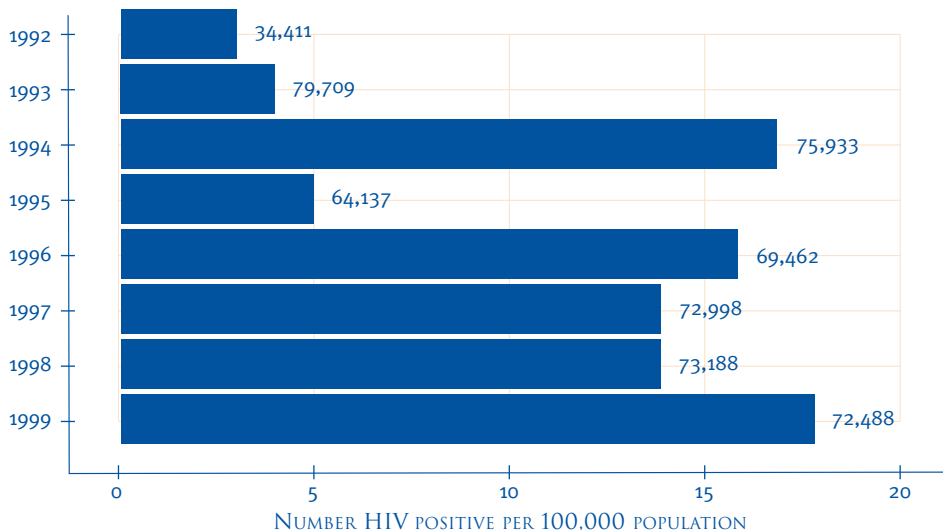
\* Includes 647 men who had also injected drugs

\*\* Includes 702 children of HIV infected mothers

\*\*\* Includes 42 with sex not stated on report

**FIGURE 1.11: HIV PREVALENCE AMONG PREGNANT WOMEN IN THE NORTH WEST, 1992-1999 (NEWBORN INFANT DRIED BLOOD SPOTS COLLECTED FOR METABOLIC SCREENING)**

(Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 1999)



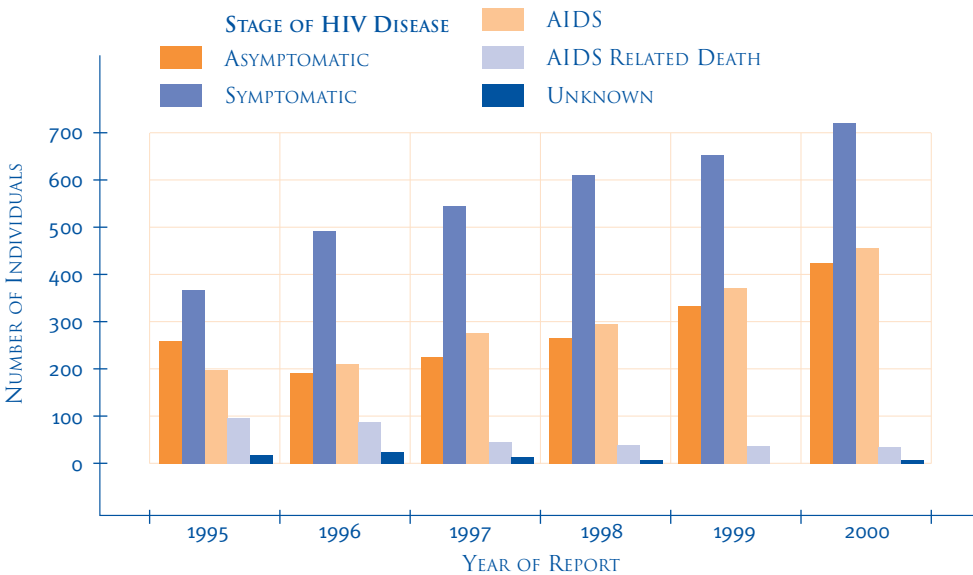
Numbers by each bar represent sample sizes

The data in figure 1.11 are derived from the anonymous seroprevalence survey conducted by the PHLS, 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 1999 show a slight increase in the prevalence of HIV from 14 per 100,000 to 18 per 100,000 pregnant women. This may correspond to the increasing importance of heterosexual transmission amongst the diagnosed HIV positive population, as reported last year<sup>6</sup> and in sections 2 and 3 of this report.

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 six years, illustrate the increasing number of people accessing HIV services. For the second year running, there has been a large increase (16%) in the number of HIV positive individuals attending treatment centres, and again, this increase is larger than that predicted nationally (11%)<sup>8</sup>. The 73% increase since 1995 is partly due to the decrease in the number of people dying from AIDS related illnesses (a 69% decrease since 1995), but also due to the continued level of new HIV cases (which this year has increased by 16%: see section 2). A full description of the epidemiology of HIV and AIDS in the North West is given in sections 2 to 5 of this report.

**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 who died during each year)



STAGE OF HIV DISEASE	YEAR OF REPORT					
	1995	1996	1997	1998	1999	2000
Asymptomatic	260 (27.6%)	192 (18.9%)	228 (20.5%)	266 (21.8%)	337 (23.9%)	423 (25.9%)
Symptomatic	370 (39.3%)	498 (49.1%)	552 (49.6%)	610 (50.1%)	660 (46.8%)	715 (43.8%)
AIDS	198 (21.0%)	213 (21.0%)	278 (25.0%)	297 (24.4%)	376 (26.7%)	458 (28.1%)
AIDS Related death	98 (10.4%)	87 (8.6%)	43 (3.9%)	38 (3.1%)	37 (2.6%)	30 (1.8%)
Unknown	15 (1.6%)	24 (2.4%)	12 (1.1%)	7 (0.6%)		6 (0.4%)
<b>Total (100%)</b>	<b>941</b>	<b>1014</b>	<b>1113</b>	<b>1218</b>	<b>1410</b>	<b>1632</b>

### **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 are the highest in England outside London<sup>50</sup>. 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<sup>59</sup>. Of the recent outbreaks of syphilis in the UK, the outbreak in Manchester continues to be the largest. Most of the people who contracted syphilis in the Manchester outbreak have been homosexual men<sup>51</sup>.

A recent survey of gay men infected with syphilis in the Manchester outbreak revealed high levels of anonymous sex, particularly unprotected oral sex, and low levels of awareness of the risk of syphilis transmission through unprotected oral sex<sup>51</sup>. The study also revealed a high level of use of the drug gamma hydroxybutyrate (GHB) during anonymous sex for its disinhibiting and aphrodisiac effects. There was a high level of co-infection between syphilis and HIV, with 30% of gay men interviewed also being HIV positive. Half of these HIV positive men stated that they had not changed their behaviour since their HIV diagnosis, leading to the recommendation that people with HIV should routinely be screened for sexually transmitted infections. In common with findings from London<sup>90</sup>, gay men did not perceive their general practitioner to be a good source of information about sexual health (with the exception of men attending the gay-friendly general practice in Manchester's gay village).

### **The economics of HIV and AIDS in the North West**

There have long been concerns over funding inequalities between regions<sup>52,53</sup>. In a move supposed to address these inequalities, the method by which funds for treatment and care of HIV positive individuals are allocated changed in the financial year 2000/2001. However, recent research has shown that these new funding arrangements have failed to address the inequity between regions<sup>54,87</sup>. Those with HIV in the north of England have an increased risk of death compared to those in the south, yet each HIV positive individual in the north is allocated less funding than an individual with HIV in the south.

The cost of treating an individual with HIV is higher for individuals who have developed AIDS, and therefore the ratio of AIDS cases to HIV cases without AIDS is an important indicator of resource requirements for the care of HIV positive individuals. Compared to the rest of the regions in England, the North West has a higher proportion of individuals with AIDS<sup>54</sup>. The economic analysis also forecasted that by 2005 there could be a population of 2,235 HIV positive individuals requiring treatment in the North West, and this will increase the costs of treatment by 37% in Greater Manchester, 34% in Lancashire and Cumbria and 31% in Merseyside and Cheshire<sup>54</sup>.

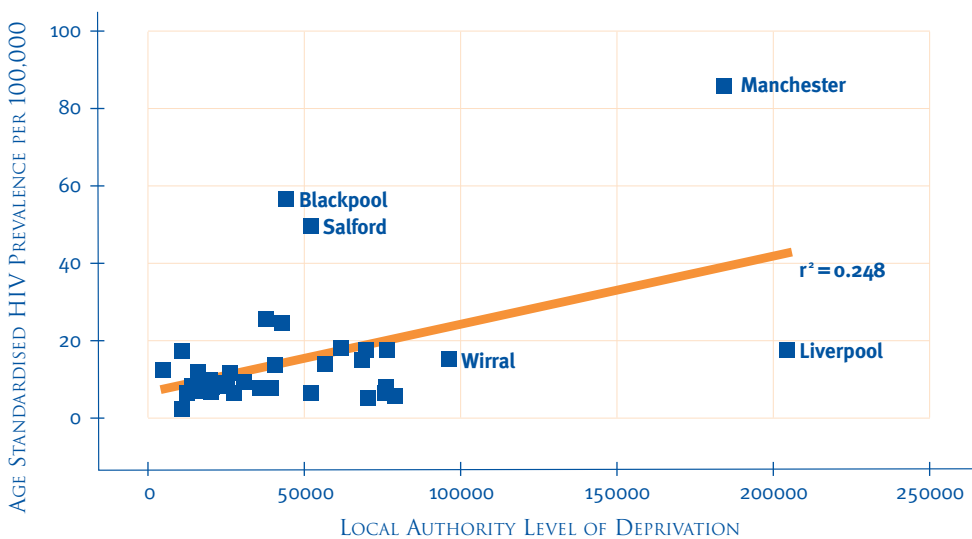
### **Social deprivation and HIV in the North West**

Since the publication of the 1999 report the unit has begun to explore the relationship between social deprivation and the prevalence of HIV in the region. The initial results suggest that social deprivation is a key variable within the dataset. Although the role of social inequality as a causal factor in poor health is widely recognised<sup>91,92</sup>, its relationship with the prevalence of HIV and AIDS has been under-explored in the UK. Globally HIV/AIDS has had a disproportionate impact on poor communities, with 96% of cases in the developing world<sup>25</sup>. In the developed world there have been a number of studies examining the relationship between measurements of inequality (such as income, employment status, education, and economic status) and sexual behaviour, with higher risk being a consistent feature for members of low socio-economic groups. Such studies have tended to be outside the UK (for example, the USA<sup>93,94</sup>, Australia<sup>95</sup>, France<sup>96</sup>, Netherlands<sup>97</sup>). Early studies within the UK<sup>98,99</sup> did not find an association between social class and safer sex, although these may not have involved sufficiently large or socially diverse populations<sup>100</sup>. More recent studies have identified a relationship between safe sex or HIV infection and social class<sup>99,100</sup>.

Figure 1.13 demonstrates the relationship between level of deprivation and age standardised HIV prevalence in the North West of England. In general, the more deprived local authorities (as indicated by the higher deprivation scores) have a higher prevalence of HIV, although there is some scatter in the data. Some of this scatter in the data points is explained by the ethnic and sexual demography of the region. Since the prevalence of HIV varies hugely between different ethnic groups, those areas with concentrations of high prevalence communities have accentuated infection levels. The uneven experience of deprivation as a function of ethnicity is well documented<sup>69</sup>, which tends to reinforce the high prevalence. Whilst no figures exist for the sexual demography of the North West Region, both Manchester and Blackpool have long established gay scenes which create a safer environment for men who have sex with men, leading to the concentration of this high risk group in small areas. Research in Germany has noted the tendency of gay men to move to cities with populations of 200,000 or more, irrespective of established gay scenes<sup>101</sup>.

The impact of poverty on HIV prevalence is compounded and distorted by the effects of ethnicity and sexuality, leading to a highly variable pattern of prevalence across the North West Region. It is hoped that the nature of these relationships between social deprivation, ethnicity, sexuality and HIV prevalence will be more clearly defined with additional research.

**FIGURE 1.13: THE RELATIONSHIP BETWEEN DEPRIVATION AND THE PREVALENCE OF HIV IN THE NORTH WEST OF ENGLAND**



Ward-based deprivation scores are taken from Department of the Environment, Transport and the Regions, Indices of Deprivation 2000 and averaged for each local authority. HIV data for each local authority are taken from the 1999 North West report<sup>68</sup>, age standardised using 1991 census data<sup>102</sup>.





## 2. NEW CASES 2000

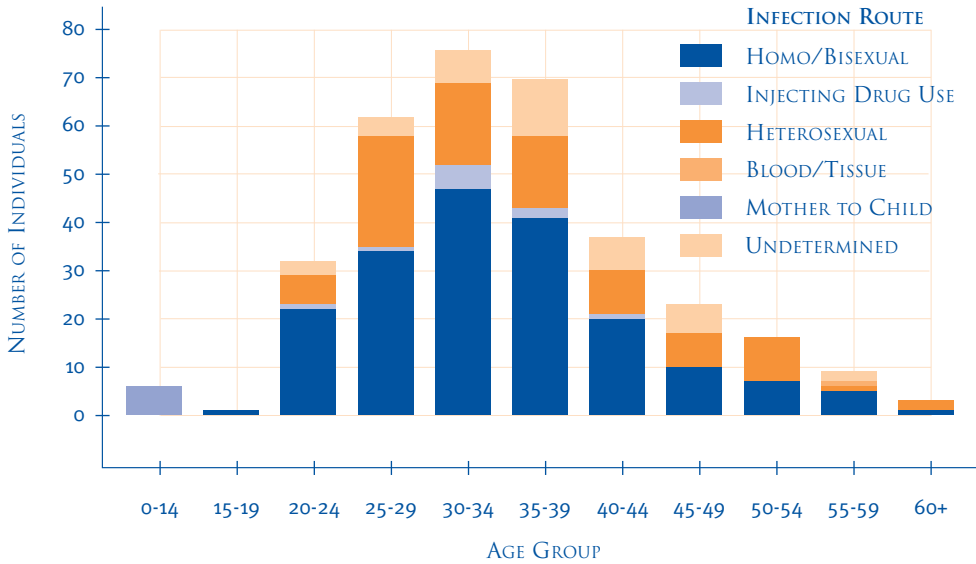
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During 2000, 335 new HIV and AIDS cases presented to statutory treatment centres in the North West Region. New cases are defined as individuals seen in the North West Region in 2000 but not during the years 1995 to 1999 and include new HIV positive individuals who died during the year. This represents a 16% increase on the number of new cases reported in 1999 (288)<sup>6</sup>, and is the largest increase since regional monitoring began in 1995.

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 section is to present information relating to new cases and, where appropriate, references are made to corresponding data from previous North West reports<sup>3-6</sup>.

**FIGURE 2.1: AGE DISTRIBUTION OF NEW HIV AND AIDS CASES BY INFECTION ROUTE OF HIV, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)



AGE GROUP	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
0-14					6 (100.0%)		6
15-19	1 (100.0%)						1
20-24	22 (68.8%)	1 (3.1%)	6 (18.8%)			3 (9.4%)	32
25-29	34 (54.8%)	1 (1.6%)	23 (37.1%)			4 (6.5%)	62
30-34	47 (61.8%)	5 (6.6%)	17 (22.4%)			7 (9.2%)	76
35-39	41 (58.6%)	2 (2.9%)	15 (21.4%)			12 (17.1%)	70
40-44	20 (54.1%)	1 (2.7%)	9 (24.3%)			7 (18.9%)	37
45-49	10 (43.5%)		7 (30.4%)			6 (26.1%)	23
50-54	7 (43.8%)		9 (56.3%)				16
55-59	5 (55.6%)		1 (11.1%)	1 (11.1%)		2 (22.2%)	9
60+	1 (33.3%)		2 (66.7%)				3
<b>Total</b>	<b>188 (56.1%)</b>	<b>10 (3.0%)</b>	<b>89 (26.6%)</b>	<b>1 (0.3%)</b>	<b>6 (1.8%)</b>	<b>41 (12.2%)</b>	<b>335</b>

Age ranges refer to the age of individuals at end of December 2000, or at death. Men who have had homosexual or bisexual exposure and 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 2000. Over a fifth (21%) of all reported cases in 2000 were seen for the first time during this year. The number of new cases during 2000 represents a 16% increase on the number seen in 1999. The majority of newly reported cases fall between the ages of 25 and 39 (62%), with incidence being highest in those aged 30-34 years (23%). Although homosexual sex remains the predominant method of HIV transmission (56%), heterosexual sex accounts for over a quarter of new cases seen. The proportion of new HIV and AIDS cases attributed to heterosexual exposure continues to rise, from 17% in 1997, to 21% in 1998, 23% in 1999 and 27% in 2000. Eighty eight percent of young people aged 15 to 24 years were infected with HIV during sex (either homosexual or heterosexual).

As seen in previous years the proportion of new HIV positive individuals infected through injecting drug use has declined, from 8% in 1997 to 3% in 2000. During the year six new cases of vertical transmission were reported from North West treatment centres. There has been an increase in the number of children born to HIV infected mothers, with over 300 births in the UK each year resulting in an estimated 55 infected infants in 1999<sup>57</sup>. Only one new case was reported as being attributed to having received contaminated blood or tissue, with this individual having been first found positive outside the region and having been infected prior to blood screening. The infection route for 41 new cases (12%) 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 4% (section 3, table 3.1).

**TABLE 2.1: RESIDENTIAL DISTRIBUTION OF NEW HIV AND AIDS CASES BY STAGE OF HIV DISEASE, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

HA OF RESIDENCE	STAGE OF HIV DISEASE					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
Bury & Rochdale	8 (36.4%)	7 (31.8%)	7 (31.8%)			22
East Lancashire	4 (50.0%)	2 (25.0%)	1 (12.5%)		1 (12.5%)	8
Liverpool	4 (20.0%)	11 (55.0%)	4 (20.0%)		1 (5.0%)	20
Manchester	41 (46.6%)	27 (30.7%)	16 (18.2%)	1 (1.1%)	3 (3.4%)	88
North Cheshire	1 (16.7%)	4 (66.7%)	1 (16.7%)			6
N. W. Lancashire	16 (40.0%)	15 (37.5%)	6 (15.0%)	3 (7.5%)		40
Salford & Trafford	23 (56.1%)	8 (19.5%)	8 (19.5%)	1 (2.4%)	1 (2.4%)	41
Sefton	3 (50.0%)	2 (33.3%)	1 (16.7%)			6
South Cheshire	15 (75.0%)	2 (10.0%)	2 (10.0%)	1 (5.0%)		20
South Lancashire	1 (100.0%)					1
St Helens & Knowsley	2 (50.0%)	2 (50.0%)				4
Stockport	5 (50.0%)	1 (10.0%)	4 (40.0%)			10
West Pennine	3 (20.0%)	8 (53.3%)	4 (26.7%)			15
Wigan & Bolton	6 (54.5%)	3 (27.3%)	2 (18.2%)			11
Wirral	3 (30.0%)	3 (30.0%)	4 (40.0%)			10
Isle of Man		1 (100%)				1
London	1 (50.0%)		1 (50.0%)			2
Northern & Yorkshire		1 (100.0%)				1
South West	1 (100.0%)					1
Trent	2 (100.0%)					2
Wales	3 (75.0%)		1 (25.0%)			4
West Midlands	4 (57.1%)	1 (14.3%)	2 (28.6%)			7
Abroad		3 (50.0%)	2 (33.3%)	1 (16.7%)		6
Not Known	6 (66.7%)	3 (33.3%)				9
<b>Total</b>	<b>152 (45.4%)</b>	<b>104 (31.0%)</b>	<b>66 (19.7%)</b>	<b>7 (2.1%)</b>	<b>6 (1.8%)</b>	<b>335</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'.

**Table 2.1** illustrates the clinical stage of HIV disease and residential distribution of new HIV and AIDS cases presenting in the North West for treatment in 2000. The figures refer to the clinical condition of individuals when last seen in the year 2000; individuals who died from AIDS related illnesses are presented in a separate category to other AIDS cases. The widespread distribution of new HIV positive individuals demonstrates the importance of HIV prevention initiatives in every district.

HIV positive individuals categorised as asymptomatic continue to represent the largest proportion of new cases (45%), with the proportion in each category being comparable to the 1999 data. This maintains the observation that HIV positive individuals are contacting services at a relatively early stage of their HIV disease. Of the seven new individuals who died during the year all had been diagnosed as having had AIDS defining illnesses. This shows that despite continuing media attention some individuals present too late to benefit from life-prolonging treatment.

Residents of Manchester Health Authority accounted for 26% of new HIV and AIDS cases presenting for treatment and care in the North West, a comparable proportion to the 1999 data (28%). The vast majority of new cases receiving care in the North West during 2000 were resident within the region (90%). Nearly a quarter (22%) of North West residents live in Merseyside and Cheshire, a 57% increase on the corresponding data from 1999 (14%). Residents of Greater Manchester and Lancashire represent 78% of all new cases living in the North West, a proportional 9% decrease on the 1999 data. Of the 24 individuals known to live outside the region, a quarter were reported as residing outside the UK.

**Table 2.2** shows the health authority of residence and the route of transmission of new HIV and AIDS cases presenting in the North West for treatment in 2000. Although the infection route for nearly two-thirds (65%) of all HIV positive individuals seen in 2000 was attributed to sex between men, this proportion was lower for new cases, where 56% were infected through homosexual/bisexual sex. The two main gay communities in the North West, Manchester and Blackpool<sup>103</sup>, account for nearly half (49%) of new cases exposed via homosexual sex who reside within the region.

The proportion of new cases exposed to HIV via heterosexual transmission (27%) represents a continuing increase when compared to previous years data (17% in 1997, 21% in 1998, 23% in 1999) and is also higher than the 20% of all cases exposed via this route of infection (section 3, table 3.3). For the first time heterosexual sex has become the major route of infection for new cases in several health authorities (East Lancashire 63%, Liverpool 60%, Sefton 67% and Wirral 70%).

**TABLE 2.2: RESIDENTIAL DISTRIBUTION OF NEW HIV AND AIDS CASES BY INFECTION ROUTE OF HIV, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

HA OF RESIDENCE	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
Bury & Rochdale	9 (40.9%)	1 (4.5%)	8 (36.4%)			4 (18.2%)	22
East Lancashire	2 (25.0%)	1 (12.5%)	5 (62.5%)				8
Liverpool	5 (25.0%)	3 (15.0%)	12 (60.0%)				20
Manchester	55 (62.5%)		19 (21.6%)			14 (15.9%)	88
North Cheshire	3 (50.0%)		2 (33.3%)		1 (16.7%)		6
N. W. Lancashire	30 (75.0%)		7 (17.5%)		2 (5.0%)	1 (2.5%)	40
Salford & Trafford	29 (70.7%)		2 (4.9%)			10 (24.4%)	41
Sefton	1 (16.7%)	1 (16.7%)	4 (66.7%)				6
South Cheshire	14 (70.0%)	1 (5.0%)	4 (20.0%)			1 (5.0%)	20
South Lancashire			1 (100.0%)				1
St Helens & Knowsley	2 (50.0%)		1 (25.0%)			1 (25.0%)	4
Stockport	4 (40.0%)	1 (10.0%)	4 (40.0%)			1 (10.0%)	10
West Pennine	10 (66.7%)	1 (6.7%)	1 (6.7%)			3 (20.0%)	15
Wigan & Bolton	8 (72.7%)		3 (27.3%)				11
Wirral	2 (20.0%)		7 (70.0%)	1 (10.0%)			10
Isle of Man			1 (100.0%)				1
London	2 (100.0%)						2
Northern & Yorkshire						1 (100.0%)	1
South West	1 (100.0%)						1
Trent	2 (100.0%)						2
Wales	1 (25.0%)		1 (25.0%)		1 (25.0%)	1 (25.0%)	4
West Midlands	1 (14.3%)		4 (57.1%)		2 (28.6%)		7
Abroad		1 (16.7%)	1 (16.7%)			4 (66.7%)	6
Not known	7 (77.8%)		2 (22.2%)				9
<b>Total</b>	<b>188 (56.1%)</b>	<b>10 (3.0%)</b>	<b>89 (26.6%)</b>	<b>1 (0.3%)</b>	<b>6 (1.8%)</b>	<b>41 (12.2%)</b>	<b>335</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category

**TABLE 2.3: RESIDENTIAL DISTRIBUTION OF NEW HIV AND AIDS CASES BY AGE CATEGORY, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

HA 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+	
Bury & Rochdale			3 (13.6%)	6 (27.3%)	5 (22.7%)	3 (13.6%)	2 (9.1%)		3 (13.6%)			22
East Lancashire			2 (25.0%)	1 (12.5%)	2 (25.0%)	2 (25.0%)		1 (12.5%)				8
Liverpool				5 (25.0%)	7 (35.0%)	3 (15.0%)	2 (10.0%)	2 (10.0%)	1 (5.0%)			20
Manchester			12 (13.6%)	18 (20.5%)	21 (23.9%)	18 (20.5%)	10 (11.4%)	4 (4.5%)	4 (4.5%)	1 (1.1%)		88
North Cheshire	1 (16.7%)				2 (33.3%)	2 (33.3%)			1 (16.7%)			6
N. W. Lancashire	2 (5.0%)	1 (2.5%)	3 (7.5%)	3 (7.5%)	10 (25.0%)	7 (17.5%)	5 (12.5%)	4 (10.0%)	2 (5.0%)	1 (2.5%)	2 (5.0%)	40
Salford & Trafford			5 (12.2%)	9 (22.0%)	7 (17.1%)	9 (22.0%)	7 (17.1%)	2 (4.9%)		2 (4.9%)		41
Sefton				2 (33.3%)		3 (50.0%)		1 (16.7%)				6
South Cheshire			2 (10.0%)	3 (15.0%)	5 (25.0%)	6 (30.0%)	1 (5.0%)	2 (10.0%)	1 (5.0%)			20
South Lancashire					1 (100.0%)							1
St Helens & Knowsley				1 (25.0%)			2 (50.0%)	1 (25.0%)				4
Stockport			1 (10.0%)	4 (40.0%)			2 (20.0%)	1 (10.0%)	1 (10.0%)	1 (10.0%)		10
West Pennine				1 (6.7%)	2 (13.3%)	5 (33.3%)	4 (26.7%)		1 (6.7%)	2 (13.3%)		15
Wigan & Bolton			1 (9.1%)	2 (18.2%)	4 (36.4%)	3 (27.3%)	1 (9.1%)					11
Wirral				1 (10.0%)	1 (10.0%)	3 (30.0%)	1 (10.0%)	1 (10.0%)		2 (20.0%)	1 (10.0%)	10
Isle of Man									1 (100.0%)			1
London					1 (50.0%)	1 (50.0%)						2
Northern & Yorkshire								1 (100.0%)				1
South West									1 (100.0%)			1
Trent					2 (100.0%)							2
Wales	1 (25.0%)		1 (25.0%)	1 (25.0%)				1 (25.0%)				4
West Midlands	2 (28.6%)			2 (28.6%)	2 (28.6%)	1 (14.3%)						7
Abroad				1 (16.7%)	2 (33.3%)	1 (16.7%)		2 (33.3%)				6
Not known			2 (22.2%)	2 (22.2%)	2 (22.2%)	3 (33.3%)						9
<b>Total</b>	<b>6 (1.8%)</b>	<b>1 (0.3%)</b>	<b>32 (9.6%)</b>	<b>62 (18.5%)</b>	<b>76 (22.7%)</b>	<b>70 (20.9%)</b>	<b>37 (11.0%)</b>	<b>23 (6.9%)</b>	<b>16 (4.8%)</b>	<b>9 (2.7%)</b>	<b>3 (0.9%)</b>	<b>335</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. Age ranges refer to the age of individuals at end of December 2000, or at death.

**Table 2.3** illustrates the residential distribution of all HIV and AIDS cases presenting in the North West for treatment in 2000, categorised by age group. Individuals aged 30-34 represent the largest group of new cases accessing treatment and care (23%). As for all cases, the age distribution for new HIV and AIDS cases remains concentrated in the 30-39 age range, accounting for 44% of all new individuals seen (compared to 46% for all cases). As would be expected, new cases tend to be younger (median age of 34 years, with 90% aged between 22 and 53 years) than the age distribution of all cases (median age 37 years, 90% aged between 24 and 56 years). Thus, individuals under the age of 25 represent a larger proportion of new cases (12%) than all cases (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 2000, a comparable proportion to 1999.

Several health authorities with relatively low numbers of HIV positive residents have had substantial increases in the number of new cases reported in 2000 when compared to data from 1999, such as Bury & Rochdale (633% increase), North Cheshire (500% increase) and South Cheshire (122% increase). No new cases resident in Morecambe Bay Health Authority were reported in 2000.

**TABLE 2.4: RESIDENTIAL DISTRIBUTION OF NEW HIV AND AIDS CASES BY SEX, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

HA OF RESIDENCE	SEX		Total (100%)
	Male	Female	
Bury & Rochdale	16 (72.7%)	6 (27.3%)	22
East Lancashire	6 (75.0%)	2 (25.0%)	8
Liverpool	16 (80.0%)	4 (20.0%)	20
Manchester	75 (85.2%)	13 (14.8%)	88
North Cheshire	4 (66.7%)	2 (33.3%)	6
N. W. Lancashire	34 (85.0%)	6 (15.0%)	40
Salford & Trafford	40 (97.6%)	1 (2.4%)	41
Sefton	3 (50.0%)	3 (50.0%)	6
South Cheshire	17 (85.0%)	3 (15.0%)	20
South Lancashire	1 (100.0%)		1
St Helens & Knowsley	3 (75.0%)	1 (25.0%)	4
Stockport	8 (80.0%)	2 (20.0%)	10
West Pennine	14 (93.3%)	1 (6.7%)	15
Wigan & Bolton	10 (90.9%)	1 (9.1%)	11
Wirral	5 (50.0%)	5 (50.0%)	10
Isle of Man		1 (100.0%)	1
London	2 (100.0%)		2
Northern & Yorkshire	1 (100.0%)		1
South West	1 (100.0%)		1
Trent	2 (100.0%)		2
Wales	3 (75.0%)	1 (25.0%)	4
West Midlands	4 (57.1%)	3 (42.9%)	7
Abroad	4 (66.7%)	2 (33.3%)	6
Not known	9 (100.0%)		9
<b>Total</b>	<b>278 (83.0%)</b>	<b>57 (17.0%)</b>	<b>335</b>

Table 2.4 illustrates the residential distribution of new HIV and AIDS cases presenting in the North West for treatment in 2000, categorised by sex. As in previous years, the vast majority of new cases in 2000 were male (83%). This is largely due to the high proportion of homosexual/bisexual sex between men as a method of exposure to HIV. Although more men were newly infected in 2000 compared to 1999, the proportion of individuals who are male has decreased from 90% in 1999 to 83% in 2000. Residents of eight of the North West health authorities had above the 17% average of female new cases living in the region. The number of female new cases has nearly doubled from 29 in 1999 to 57 in 2000, and the proportion of new HIV cases that are female has increased from 10% to 17%. This may have a knock-on effect on the number of mother to child infections, especially in ethnic minority communities since over half (54%) of females are self-defined as being from an ethnic minority (table 2.8).

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'.

**TABLE 2.5: INFECTION ROUTE OF NEW HIV AND AIDS CASES BY SEX, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

INFECTION ROUTE	SEX		Total
	Male	Female	
Homo/Bisexual	188 (67.6%)		188 (56.1%)
Injecting Drug Use	8 (2.9%)	2 (3.5%)	10 (3.0%)
Heterosexual	42 (15.1%)	47 (82.5%)	89 (26.6%)
Blood/Tissue		1 (1.8%)	1 (0.3%)
Mother to Child	3 (1.1%)	3 (5.3%)	6 (1.8%)
Undetermined	37 (13.3%)	4 (7.0%)	41 (12.2%)
<b>Total (100%)</b>	<b>278</b>	<b>57</b>	<b>335</b>

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 2000, categorised by sex. Although sex between men remains the most common route of infection for new HIV cases, the proportion of individuals infected by this route has declined by 10% from 62% in 1999 to 56% in 2000, while the proportion of heterosexually acquired HIV has increased by 17% (from 23% in 1999 to 27% in 2000). The predominant method of exposure to HIV amongst women continues to be heterosexual sex. Of those HIV positive individuals whose route of infection has been identified, 30% of new cases presenting in the North West had their infection attributed to heterosexual sex. This compares to 21% of all cases seen during 2000 (section 3, table 3.5) and 25% of new cases seen during 1999, reflecting the growing issue of heterosexual transmission of HIV in the North West and in the United Kingdom as a whole (figure 1.6). In the UK over two-thirds of HIV positive children were born to heterosexually infected women, with over 95% of these reported as being exposed to HIV whilst abroad<sup>57</sup>. As in previous years, the majority of new individuals infected with HIV via injecting drug use were male (80%).

**Table 2.6** illustrates the residential distribution of new HIV and AIDS cases presenting in the North West for treatment in 2000, categorised by ethnic group. Ethnic group classifications are adapted from the 1991 Census Questionnaire and are those utilised by the Public Health Laboratory Service AIDS and STD Centre, for the Survey of Prevalent Diagnosed HIV Infections (SOPHID).

The majority of new cases in 2000 whose ethnicity was known were self-defined as white (80%), a lower figure than the corresponding data for all cases (88%) (section 3, table 3.7). Of those HIV positive individuals whose ethnicity was classified, one fifth are self-defined as being from an ethnic minority, compared to 15% in 1999. This indicates a substantial over representation of new HIV cases within black and ethnic minority communities, when compared to their overall proportion within the North West population (3.8%)<sup>69</sup>. Thus, the incidence of HIV is eight times higher in black and ethnic minority groups than in the white population in the North West. However, there are significant variations in the proportion of people from black and ethnic minority populations across the region, ranging from below 1% (Morecambe Bay and St Helens & Knowsley) to over 12% (Manchester)<sup>102</sup>. The proportion of new cases within black and ethnic minority communities (19%) is higher than the 12% identified within all cases, in particular those self-defined as black African (11% for new cases, 6% for all cases) (section 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 Sexual Health Project (Bhaf) 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<sup>69</sup>.

**TABLE 2.6: RESIDENTIAL DISTRIBUTION OF NEW HIV AND AIDS CASES BY ETHNIC GROUP, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

HA OF RESIDENCE	ETHNICITY							Total (100%)
	White	Black African	Black Caribbean	Black Other	Indian/Pakistani/Bangladeshi	Other/Mixed	Not Known	
Bury & Rochdale	14 (63.6%)	3 (13.6%)			2 (9.1%)	1 (4.5%)	2 (9.1%)	22
East Lancashire	8 (100.0%)							8
Liverpool	12 (60.0%)	7 (35.0%)			1 (5.0%)			20
Manchester	57 (64.8%)	13 (14.8%)	1 (1.1%)	2 (2.3%)	4 (4.5%)	4 (4.5%)	7 (8.0%)	88
North Cheshire	5 (83.3%)					1 (16.7%)		6
N. W. Lancashire	35 (87.5%)	3 (7.5%)				1 (2.5%)	1 (2.5%)	40
Salford & Trafford	34 (82.9%)	1 (2.4%)				1 (2.4%)	5 (12.2%)	41
Sefton	6 (100.0%)							6
South Cheshire	15 (75.0%)	3 (15.0%)				1 (5.0%)	1 (5.0%)	20
South Lancashire	1 (100.0%)							1
St Helens & Knowsley	4 (100.0%)							4
Stockport	9 (90.0%)					1 (10.0%)		10
West Pennine	14 (93.3%)				1 (6.7%)			15
Wigan & Bolton	9 (81.8%)			1 (9.1%)			1 (9.1%)	11
Wirral	7 (70.0%)	3 (30.0%)						10
Isle of Man	1 (100.0%)							1
London	2 (100.0%)							2
Northern & Yorkshire	1 (100.0%)							1
South West	1 (100.0%)							1
Trent	1 (50.0%)		1 (50.0%)					2
Wales	4 (100.0%)							4
West Midlands	5 (71.4%)	1 (14.3%)				1 (14.3%)		7
Abroad	2 (33.3%)	2 (33.3%)		1 (16.7%)		1 (16.7%)		6
Unknown	6 (66.7%)	1 (11.1%)		2 (22.2%)				9
<b>Total</b>	<b>253 (75.5%)</b>	<b>37 (11.0%)</b>	<b>2 (0.6%)</b>	<b>6 (1.8%)</b>	<b>8 (2.4%)</b>	<b>12 (3.6%)</b>	<b>17 (5.1%)</b>	<b>335</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'.

**TABLE 2.7: ETHNIC DISTRIBUTION OF NEW HIV AND AIDS CASES BY INFECTION ROUTE OF HIV, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

ETHNICITY	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
White	171 (67.6%)	9 (3.6%)	44 (17.4%)	1 (0.4%)	4 (1.6%)	24 (9.5%)	253
Black African	2 (5.4%)		30 (81.1%)		1 (2.7%)	4 (10.8%)	37
Black Caribbean	1 (50.0%)		1 (50.0%)				2
Black Other			5 (83.3%)			1 (16.7%)	6
Indian / Pakistani / Bangladeshi	1 (12.5%)		6 (75.0%)			1 (12.5%)	8
Other / Mixed	6 (50.0%)	1 (8.3%)	3 (25.0%)		1 (8.3%)	1 (8.3%)	12
Not Known	7 (41.2%)					10 (58.8%)	17
<b>Total</b>	<b>188 (56.1%)</b>	<b>10 (3.0%)</b>	<b>89 (26.6%)</b>	<b>1 (0.3%)</b>	<b>6 (1.8%)</b>	<b>41 (12.2%)</b>	<b>335</b>

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 2000. Whilst sex between men remains the predominant mode of HIV transmission amongst new cases, this is not the case for those self-defined as being from an ethnic minority group. Of the 65 individuals from these communities, homosexual sex accounted for only 15% of new cases, while heterosexual sex accounted for 69%. The proportion infected by heterosexual sex is even higher in black African HIV positive individuals (81%), with only two new cases of homosexually acquired HIV in 2000. The number of new cases whose ethnicity is self-defined as other or mixed has increased four-fold from those seen in 1999 (three individuals). 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 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

ETHNICITY	SEX		Total (100%)
	Male	Female	
White	227 (89.7%)	26 (10.3%)	253
Black African	13 (35.1%)	24 (64.9%)	37
Black Caribbean	2 (100.0%)		2
Black Other	4 (66.7%)	2 (33.3%)	6
Indian / Pakistani / Bangladeshi	5 (62.5%)	3 (37.5%)	8
Other / Mixed	10 (83.3%)	2 (16.7%)	12
Not Known	17 (100.0%)		17
<b>Total</b>	<b>278 (83.0%)</b>	<b>57 (17.0%)</b>	<b>335</b>

**Table 2.8** illustrates the ethnic group and sex of new HIV and AIDS cases presenting in the North West for treatment in 2000. As in previous years the vast majority of new HIV and AIDS individuals are male (83%) with 82% of these being self-defined as white. The majority of women seen in the region for the first time in 2000 are self-defined as being from an ethnic minority (54%), with black Africans accounting for over three-quarters of these (77%).

The gender distribution of members of black and ethnic minorities is more evenly spread than is the case for the white population, with 48% being female, rising to 65% amongst black Africans. This is predominately due to the lower proportion of homosexual exposure and higher levels of heterosexual exposure to HIV within black and ethnic minorities (table 2.7).

## TABLE 2.9: ETHNIC DISTRIBUTION OF NEW HIV AND AIDS CASES BY CLINICAL STAGE OF HIV DISEASE, JANUARY-DECEMBER 2000

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

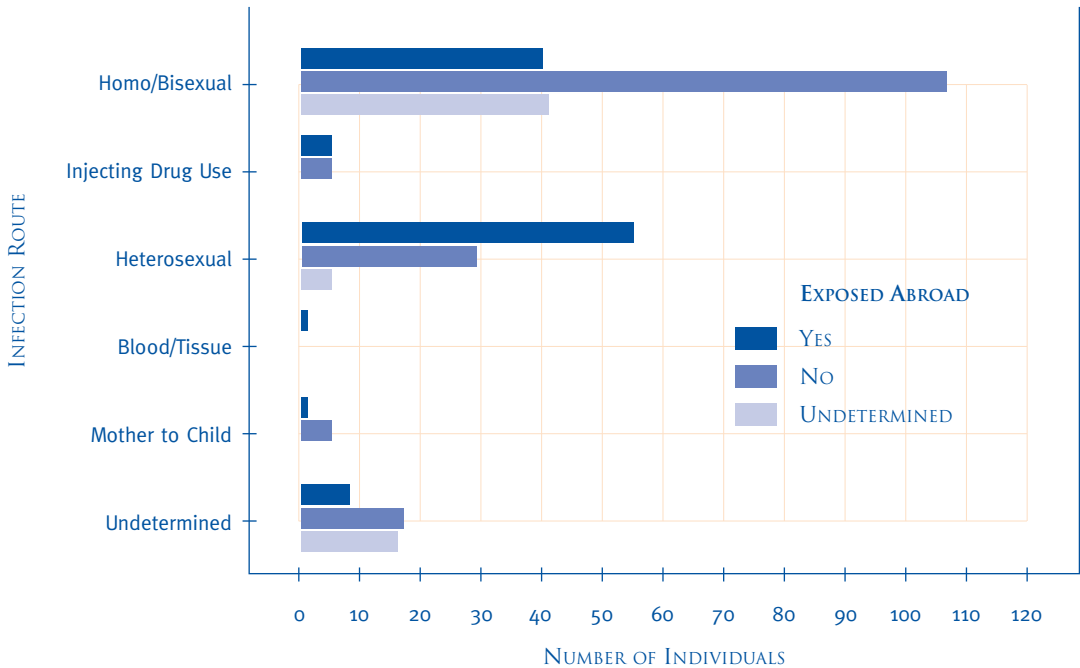
ETHNICITY	STAGE OF HIV DISEASE					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
White	123 (48.6%)	81 (32.0%)	41 (16.2%)	6 (2.4%)	2 (0.8%)	253
Black African	11 (29.7%)	12 (32.4%)	12 (32.4%)	1 (2.7%)	1 (2.7%)	37
Black Caribbean	2 (100.0%)					2
Black Other	3 (50.0%)	1 (16.7%)	2 (33.3%)			6
Indian / Pakistani / Bangladeshi	4 (50.0%)	1 (12.5%)	3 (37.5%)			8
Other / Mixed	3 (25.0%)	4 (33.3%)	5 (41.7%)			12
Not Known	6 (35.3%)	5 (29.4%)	3 (17.6%)		3 (17.6%)	17
<b>Total</b>	<b>152 (45.4%)</b>	<b>104 (31.0%)</b>	<b>66 (19.7%)</b>	<b>7 (2.1%)</b>	<b>6 (1.8%)</b>	<b>335</b>

**Table 2.9** illustrates the ethnic group and clinical stage of new HIV and AIDS cases presenting in the North West for treatment in 2000. The figures refer to the clinical condition of individuals when last seen in the year 2000; individuals who died from AIDS related illnesses are presented in a separate category to other AIDS cases.

Overall, 45% of new HIV and AIDS cases presented while still asymptomatic, 20% were categorised as AIDS and 2% died during the year. However, there are still considerable variations between ethnic groups. Whereas 34% of new cases from black and ethnic minority communities presented with an AIDS defining illness, only 16% of white new cases presented at this stage. This late presentation at treatment centres shows the need to encourage ethnic minorities to access care at an early stage of their disease, receive therapy and therefore prolong their life expectancy. The reason for the late diagnosis of individuals from black and ethnic minority communities may be that in the developed world marginalized groups are less likely to take HIV tests<sup>64</sup>. It may also be the case that new individuals have moved in to the region from elsewhere in the UK or from abroad whilst already at a later stage of their disease<sup>71</sup>.

## FIGURE 2.2: THE ROLE OF CONTACT ABROAD IN EXPOSURE TO HIV OF NEW HIV AND AIDS CASES BY INFECTION ROUTE, JANUARY-DECEMBER 2000

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)



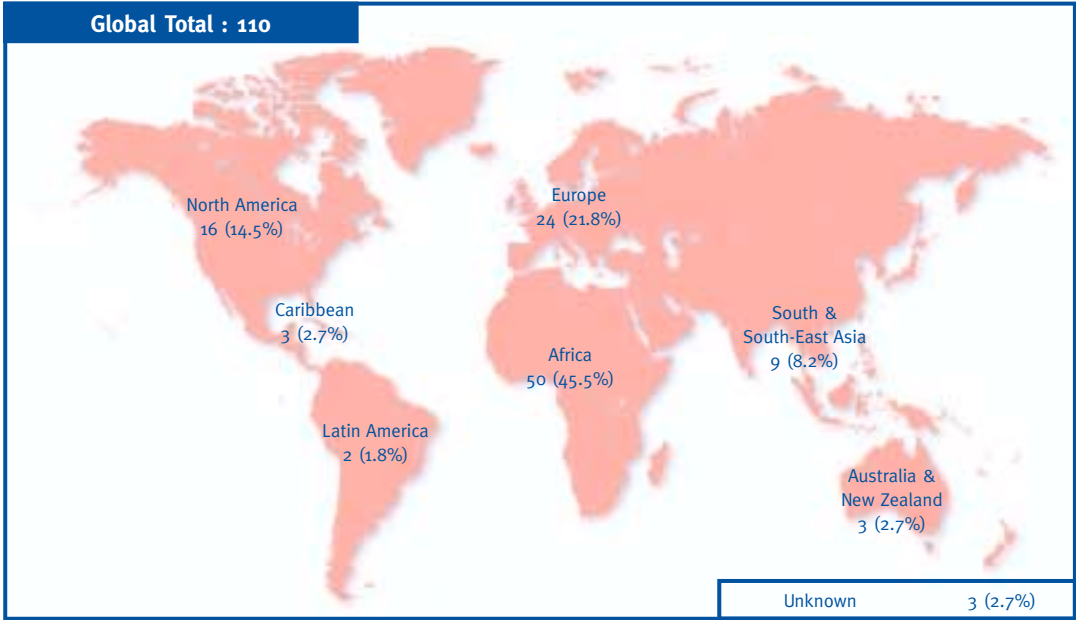
EXPOSED ABROAD	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
Yes	40 (36.4%)	5 (4.5%)	55 (50.0%)	1 (0.9%)	1 (0.9%)	8 (7.3%)	110
No	107 (65.6%)	5 (3.1%)	29 (17.8%)		5 (3.1%)	17 (10.4%)	163
Not Known	41 (66.1%)		5 (8.1%)			16 (25.8%)	62
<b>Total</b>	<b>188 (56.1%)</b>	<b>10 (3.0%)</b>	<b>89 (26.6%)</b>	<b>1 (0.3%)</b>	<b>6 (1.8%)</b>	<b>41 (12.2%)</b>	<b>335</b>

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 exposure abroad and the route of infection of new HIV and AIDS cases presenting in the North West for treatment in 2000. A third of all new cases of HIV and AIDS were reported to have been contracted outside the UK, compared to 27% in 1999. However, it is difficult to interpret trends in infection abroad, because the proportion of cases where infection abroad is unknown has decreased considerably, from 41% in 1999 to 19% in 2000. As in previous years heterosexual sex continues to be the major method of exposure to HIV in those infected abroad with half of those individuals infected via this route. Of those infected abroad, the proportion who were infected via homosexual sex has increased (from 28% in 1998 to 30% in 1999 and 36% in 2000). For those new individuals reported to have been infected with HIV in the UK, sex between men is the predominant mode of exposure (66%).

## FIGURE 2.3: GLOBAL REGION AND COUNTRY OF EXPOSURE OF NEW HIV AND AIDS CASES WHO PROBABLY ACQUIRED THEIR INFECTION OUTSIDE THE UK, JANUARY-DECEMBER 2000

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)



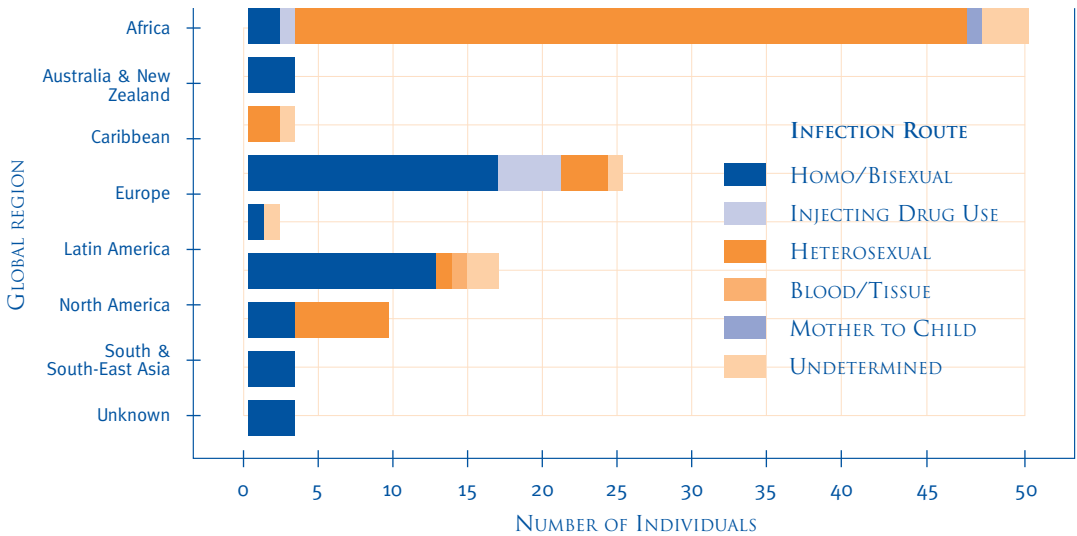
Africa	50 (45.5%)	Australia & New Zealand	3 (2.7%)	Latin America	2 (1.8%)
Angola	1 (0.9%)	Australia	2 (1.8%)	Brazil	1 (0.9%)
Botswana	2 (1.8%)	New Zealand	1 (0.9%)	Mexico	1 (0.9%)
Dem. Rep. of Congo	3 (2.7%)	<b>Caribbean</b>	<b>3 (2.7%)</b>	<b>North America</b>	<b>16 (14.5%)</b>
Eritrea	1 (0.9%)	Jamaica	3 (2.7%)	USA	16 (14.5%)
Kenya	3 (2.7%)	<b>Europe</b>	<b>24 (21.8%)</b>	<b>S. &amp; S. E. Asia</b>	<b>9 (8.2%)</b>
Lesotho	1 (0.9%)	Austria	1 (0.9%)	Pakistan	2 (1.8%)
Malawi	2 (1.8%)	Belgium	1 (0.9%)	Thailand	6 (5.5%)
Nigeria	1 (0.9%)	France	1 (0.9%)	Unknown	1 (0.9%)
Rwanda	2 (1.8%)	Germany	4 (3.6%)	<b>Unknown</b>	<b>3 (2.7%)</b>
Senegal	1 (0.9%)	Gran Canaria	2 (1.8%)	<b>Total</b>	<b>110 (100%)</b>
Somalia	3 (2.7%)	Italy	2 (1.8%)		
South Africa	5 (4.5%)	Netherlands	1 (0.9%)		
Swaziland	1 (0.9%)	Portugal	4 (3.6%)		
Uganda	4 (3.6%)	Spain	4 (3.6%)		
Zambia	8 (7.3%)	Sweden	1 (0.9%)		
Zimbabwe	8 (7.3%)	Unknown	3 (2.7%)		
Unknown	4 (3.6%)				

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 2000. Nearly half (46%) of all HIV infections contracted abroad were acquired in Africa, with 22% infected in Europe and 15% in North America.

Of the 110 new cases who probably acquired their infection abroad, the country of probable exposure is available for 99 individuals (90%). The USA accounted for the largest number of HIV infections (15%), followed by Zambia (7%) and Zimbabwe (7%). Exposure in Africa is spread across 16 different countries, all within sub-Saharan Africa, illustrating the impact of the current epidemic in Africa and its influence on the situation in the UK<sup>104</sup>.

### FIGURE 2.4: GLOBAL REGION AND INFECTION ROUTE OF NEW HIV AND AIDS CASES WHO PROBABLY ACQUIRED THEIR INFECTION OUTSIDE THE UK, JANUARY-DECEMBER 2000

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)



GLOBAL REGION	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
Africa	2 (4.0%)	1 (2.0%)	43 (86.0%)		1 (2.0%)	3 (6.0%)	50
Australia & New Zealand	3 (100.0%)						3
Caribbean			2 (66.7%)			1 (33.3%)	3
Europe	16 (66.7%)	4 (16.7%)	3 (12.5%)			1 (4.2%)	24
Latin America	1 (50.0%)					1 (50.0%)	2
North America	12 (75.0%)		1 (6.3%)	1 (6.3%)		2 (12.5%)	16
South & South-East Asia	3 (33.3%)		6 (66.7%)				9
Unknown	3 (100.0%)						3
<b>Total</b>	<b>40 (36.4%)</b>	<b>5 (4.5%)</b>	<b>55 (50.0%)</b>	<b>1 (0.9%)</b>	<b>1 (0.9%)</b>	<b>8 (7.3%)</b>	<b>110</b>

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

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 2000. Over three quarters (78%) of heterosexually acquired new cases whose infections were probably contracted abroad were acquired in Africa; a 26% increase on the proportion of new cases infected in Africa in 1999. Heterosexually acquired HIV in Africa now accounts for 48% of new cases attributed to this mode of infection (table 2.2). Heterosexual exposure in Africa is spread across 14 different countries, all within sub-Saharan Africa, reflecting the extent of the epidemic in that continent<sup>22</sup>.

Europe accounted for the largest number of new cases acquired via homosexual sex (40%), followed by North America (30%). This could reflect the tendency of gay men to take risks while on holiday<sup>65</sup>. The predominant mode of HIV transmission in many European countries is drug use<sup>22,47</sup>. Although the numbers of new HIV infections contracted abroad due to injecting drug use remain relatively low (five individuals), the majority of them have been attributed to countries within Europe (one in Austria and three in Portugal).

**TABLE 2.10: THE ROLE OF CONTACT ABROAD IN EXPOSURE TO HIV OF NEW HIV AND AIDS CASES BY ETHNICITY, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

HIV EXPOSURE ABROAD	ETHNICITY							Total
	White	Black African	Black Caribbean	Black Other	Indian/Pakistani/Bangladeshi	Other/Mixed	Not Known	
Yes	58 (22.9%)	33 (89.2%)	1 (50.0%)	5 (83.3%)	5 (62.5%)	8 (66.7%)		110 (32.8%)
No	152 (60.1%)	2 (5.4%)	1 (50.0%)	1 (16.7%)	1 (12.5%)	3 (25.0%)	3 (17.6%)	163 (48.7%)
Not Known	43 (17.0%)	2 (5.4%)			2 (25.0%)	1 (8.3%)	14 (82.4%)	62 (18.5%)
<b>Total (100%)</b>	<b>253</b>	<b>37</b>	<b>2</b>	<b>6</b>	<b>8</b>	<b>12</b>	<b>17</b>	<b>335</b>

Table 2.10 shows the global region of HIV transmission by ethnic group of new HIV and AIDS cases acquired outside the UK who presented in the North West for treatment in 2000. Nearly a quarter (23%) of new cases self-defined as white were reported as having probably been infected with HIV whilst abroad. This is not the case for those from black and ethnic communities where 80% are reported as being exposed to HIV whilst abroad, with this figure rising to 89% amongst individuals self-defined as black African. The role of contact abroad to HIV has not been identified in 17% of white HIV positive individuals accessing treatment in 2000, compared to 8% 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<sup>106</sup>. The proportion of white individuals for whom exposure abroad is known has improved from 57% in 1999 to 83% in 2000, allowing more confidence to be placed on this aspect of HIV epidemiology of the North West.

**TABLE 2.11: STAGE OF HIV DISEASE OF NEW HIV AND AIDS CASES BY LEVEL OF ANTIRETROVIRAL THERAPY, JANUARY-DECEMBER 2000**

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

STAGE OF HIV DISEASE	LEVEL OF ANTIRETROVIRAL THERAPY				Total (100%)
	None	Dual	Triple	Quadruple or More	
Asymptomatic	126 (82.9%)		24 (15.8%)	2 (1.3%)	152
Symptomatic	46 (44.2%)	1 (1.0%)	44 (42.3%)	13 (12.5%)	104
AIDS	12 (18.2%)		48 (72.7%)	6 (9.1%)	66
AIDS Related Death	2 (28.6%)	1 (14.3%)	4 (57.1%)		7
Unknown	6 (100.0%)				6
<b>Total</b>	<b>192 (57.3%)</b>	<b>2 (0.6%)</b>	<b>120 (35.8%)</b>	<b>21 (6.3%)</b>	<b>335</b>

**Table 2.11** refers to the clinical condition of individuals when last seen in the year 2000; 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, on their most recent presentation during 2000.

As illustrated, 42% of new HIV and AIDS cases presenting in the North West during 2000 received triple or more combination therapy when last seen during 2000. There are now more antiretroviral drugs available to HIV positive individuals than ever before, and this has led to more people being on more complex drug regimes. There was an increase in the number of individuals receiving quadruple or more therapy, from 12 (4%) in 1999 to 21 (6%) in 2000. While antiretroviral therapy was not prescribed for 57% of new cases, less than 1% of new cases were prescribed dual therapy and no new cases of HIV and AIDS were prescribed mono 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<sup>107</sup>.

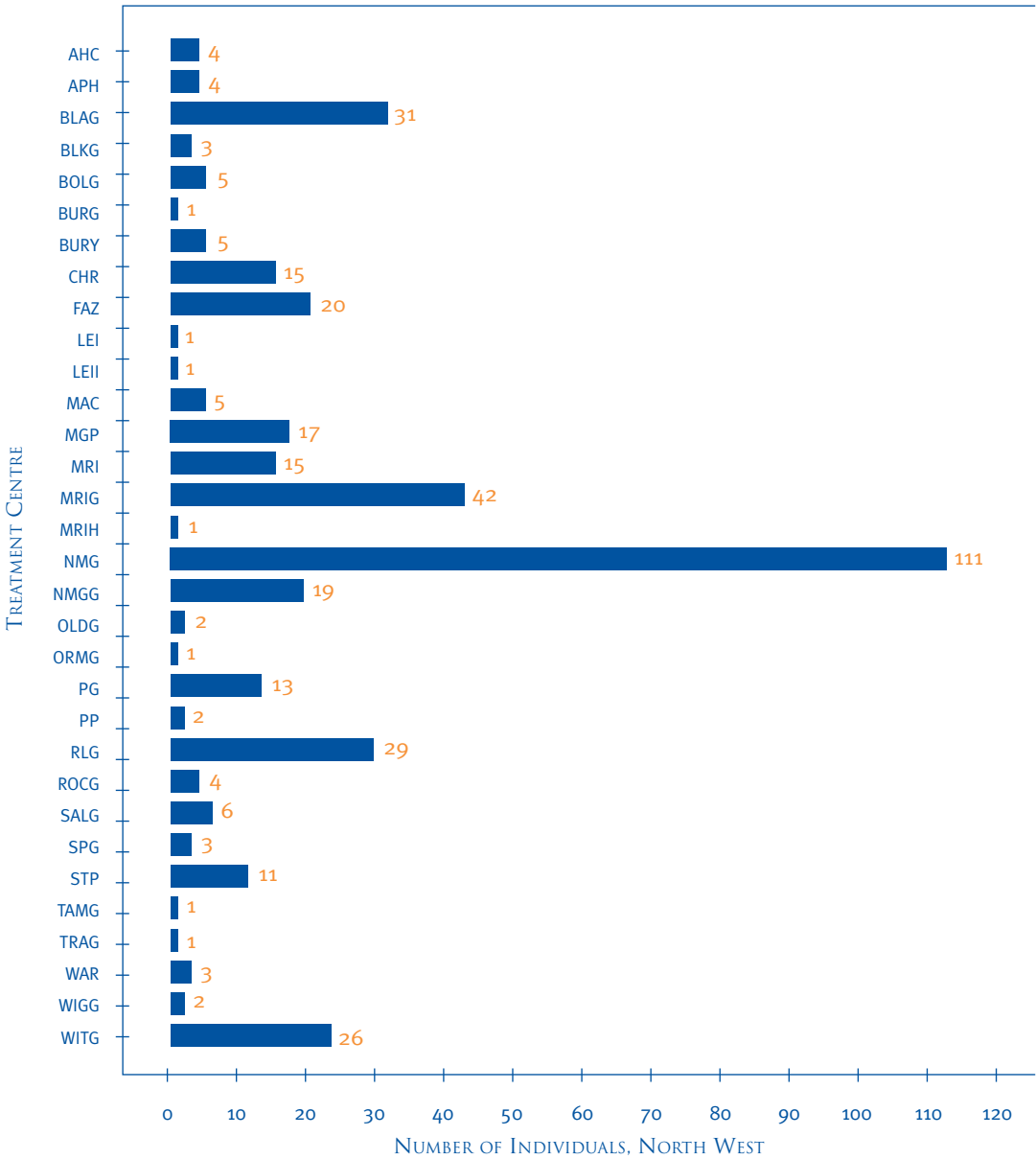
The majority (82%) of new cases categorised as AIDS received triple or more combination therapy, while over half (55%) of those classed as symptomatic received this level of therapy. The data also illustrate that 83% of new cases categorised as asymptomatic were not receiving any antiretroviral therapy at the end of 2000, an increase on the 75% in 1999. 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<sup>107</sup>. There are, therefore, implications for a continued increase in demand and supply of combination antiretroviral therapy.

**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 2000 was the Infectious Disease Unit at North Manchester General Hospital (NMG), with 33% of new cases. As in previous years, large numbers of new cases were also seen at Blackpool Victoria Hospital Department of Genito-Urinary Medicine (BLAG), Manchester Royal Infirmary Department of Genito-Urinary Medicine (MRIG) and Royal Liverpool University Hospital Department of Genito-Urinary Medicine (RLG). Several treatment centres have seen large increases in the number of new cases seen in 2000 compared to 1999, for example RLG (53% increase from 19 to 29), the Countess of Chester Hospital (CHR) (275% increase from four to 15), the University Hospital Aintree (FAZ) (233% increase from six to 20), Withington Hospital (WITG) (100% increase from 13 to 26) and Alder Hey Children's Hospital (AHC) who did not see any new cases in 1999, but saw four in 2000.

Although the larger hospitals see the most new cases it is the smaller ones that have the higher proportion of all cases that are new (Bury General Hospital 83%, Royal Oldham Hospital 100%, Warrington Hospital 60%). This illustrates the importance these smaller treatment centres have in attracting individuals who think they have contracted HIV or other sexually transmitted diseases.

## FIGURE 2.5: DISTRIBUTION OF NEW HIV AND AIDS CASES BY TREATMENT CENTRE, JANUARY-DECEMBER 2000

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)



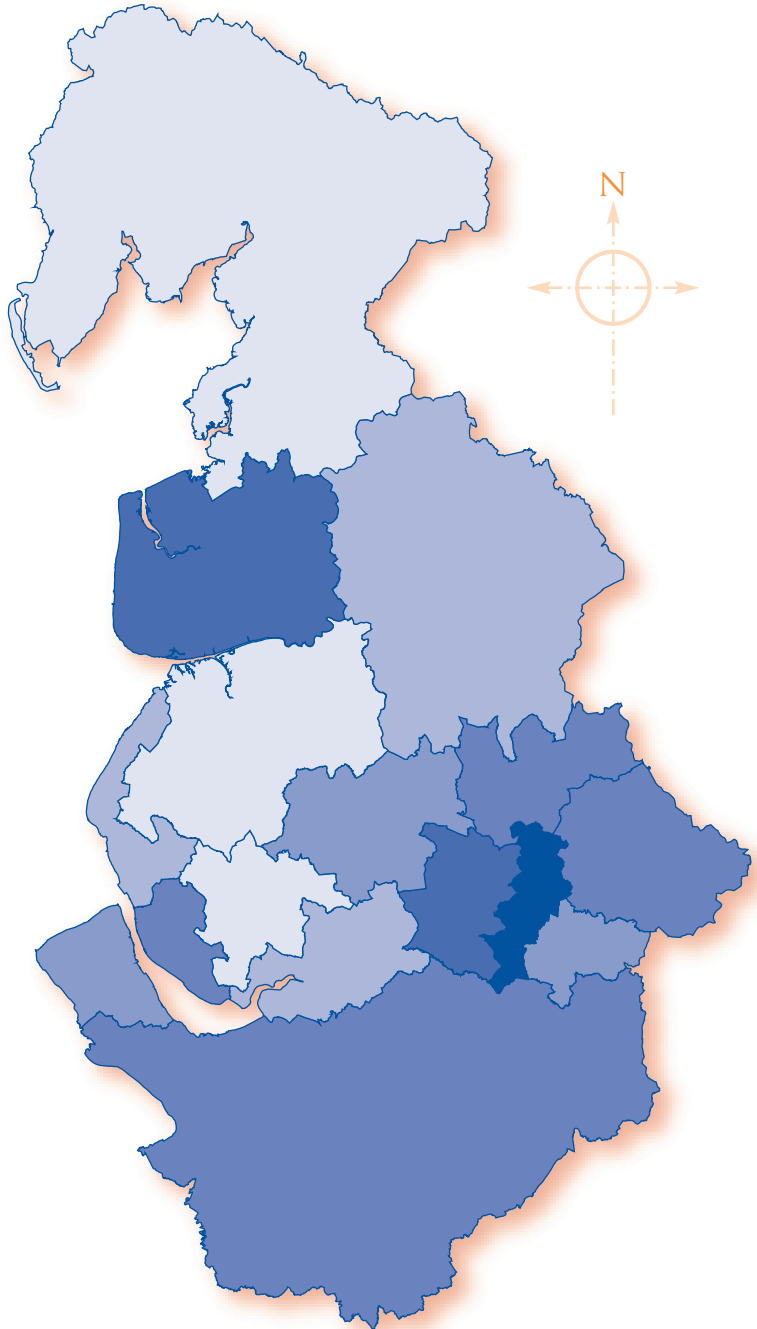
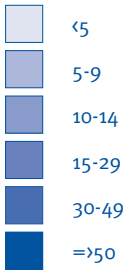
For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report.

## FIGURE 2.6: RESIDENTIAL DISTRIBUTION OF NEW HIV AND AIDS CASES BY HEALTH AUTHORITY, JANUARY-DECEMBER 2000

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)

Figure 2.6 illustrates the residential distribution of new HIV and AIDS cases in the North West who attended statutory centres within the region during 2000. For a description of the residential distribution of new HIV and AIDS cases in the North West of England see tables 2.1 to 2.4.

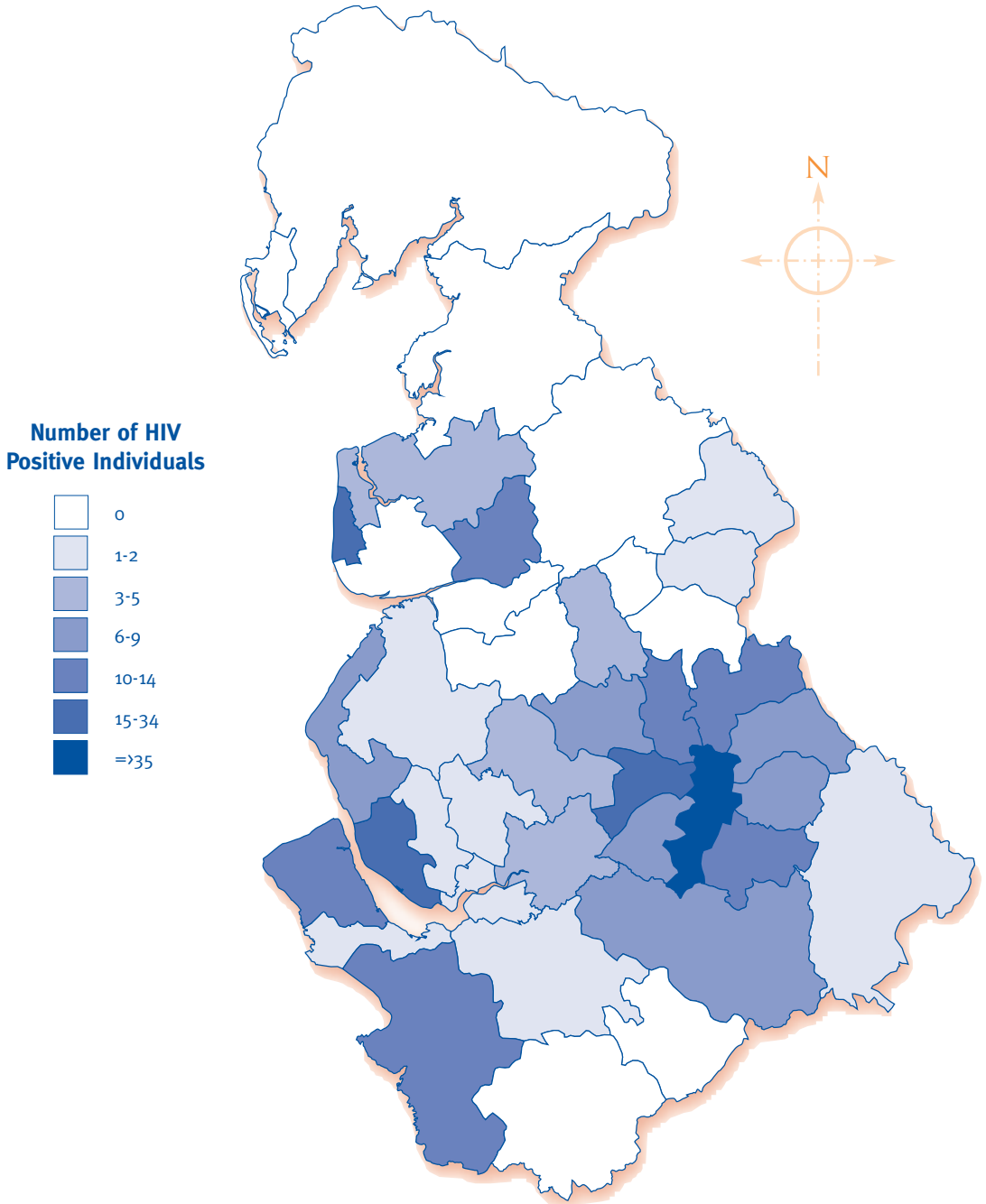
### Number of HIV Positive Individuals





## FIGURE 2.8 : RESIDENTIAL DISTRIBUTION OF NEW HIV AND AIDS CASES BY LOCAL AUTHORITY, JANUARY-DECEMBER 2000

(New cases are defined as individuals seen in the North West Region in 2000 but not between 1995 and 1999 and include new cases who died during the year)



LOCAL AUTHORITY OF RESIDENCE	NUMBER OF HIV POSITIVE INDIVIDUALS	
	Reported	Adjusted
Barrow-in-Furness	0	0
Blackburn	4	5
Blackpool	24	24
Bolton	6	6
Burnley	1	1
Bury	10	10
Chester	12	12
Chorley	0	0
Congleton	0	0
Crewe & Nantwich	0	0
Ellesmere Port & Neston	1	1
Fylde	0	0
Halton	1	1
High Peak	1	1
Hyndburn	0	0
Knowsley	2	2
Lancaster	0	0
Liverpool	20	20
Macclesfield	6	6
Manchester	88	88
Oldham	7	7
Pendle	2	2
Preston	12	12
Ribble Valley	0	0
Rochdale	12	12
Rossendale	0	0
Salford	33	33
Sefton	6	6
South Lakeland	0	0
South Ribble	0	0
St Helens	2	2
Stockport	10	10
Tameside	7	7
Trafford	8	8
Vale Royal	1	1
Warrington	4	5
West Lancashire	1	1
Wigan	5	5
Wirral	10	10
Wyre	4	4
LA Not Reported	2	
<b>Total</b>	<b>302</b>	<b>302</b>

Figure 2.8 illustrates the distribution of new HIV and AIDS cases in the North West who attended statutory centres within the region during 2000, by local authority of residence. Local authority of residence is available for 99% of the 302 new cases residing within the North West ('reported figures'). The remaining two new cases have been distributed on a population basis within the health authority of residence ('adjusted figures'). Manchester Local Authority accounted for the highest number of new HIV and AIDS cases (88), representing 29% of all new HIV and AIDS cases residing within the North West. Other local authorities that reported relatively high numbers of new cases of HIV and AIDS are Blackpool (24), Chester (12), Liverpool (20), Preston (12), Rochdale (12) and Salford (33).





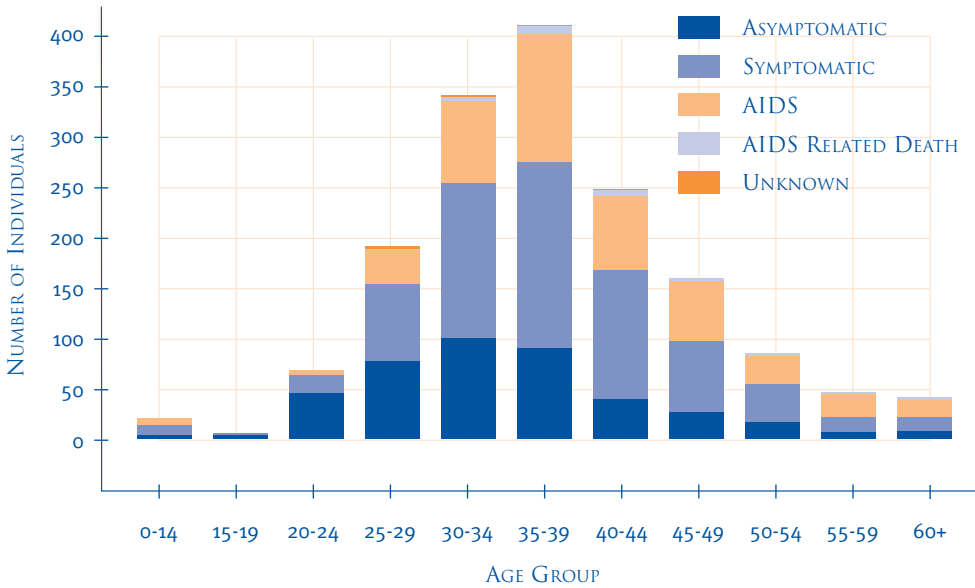
### 3. ALL CASES 2000

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During 2000, a total of 1,632 individuals living with HIV or AIDS accessed treatment and care from statutory treatment centres in the North West. This is a 16% increase on last year's total of 1,410 individuals, and is the second year running that an increase in the size of the HIV positive population of this magnitude has been recorded. Overall, since this level of monitoring began in the North West in 1995, there has been a 73% increase in the number of people with HIV (figure 1.12). The aim of this section is to provide information on the demographics and characteristics of these 1,632 individuals and, where appropriate, references are made to corresponding data from previous North West reports<sup>3,6</sup>.

**FIGURE 3.1: AGE DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY STAGE OF HIV DISEASE, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)



AGE GROUP	STAGE OF HIV DISEASE					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
0-14	4 (19.0%)	10 (47.6%)	7 (33.3%)			21
15-19	4 (66.7%)	2 (33.3%)				6
20-24	46 (66.7%)	18 (26.1%)	5 (7.2%)			69
25-29	78 (40.6%)	77 (40.1%)	34 (17.7%)	1 (0.5%)	2 (1.0%)	192
30-34	101 (29.4%)	155 (45.1%)	82 (23.8%)	4 (1.2%)	2 (0.6%)	344
35-39	91 (22.0%)	186 (44.9%)	128 (30.9%)	8 (1.9%)	1 (0.2%)	414
40-44	40 (16.0%)	129 (51.6%)	74 (29.6%)	6 (2.4%)	1 (0.4%)	250
45-49	27 (16.8%)	71 (44.1%)	60 (37.3%)	3 (1.9%)		161
50-54	17 (19.8%)	38 (44.2%)	28 (32.6%)	3 (3.5%)		86
55-59	7 (14.9%)	15 (31.9%)	23 (48.9%)	2 (4.3%)		47
60+	8 (19.0%)	14 (33.3%)	17 (40.5%)	3 (7.1%)		42
<b>Total</b>	<b>423 (25.9%)</b>	<b>715 (43.8%)</b>	<b>458 (28.1%)</b>	<b>30 (1.8%)</b>	<b>6 (0.4%)</b>	<b>1632</b>

Age ranges refer to the age of individuals at end of December 2000, 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 2000. The figures refer to the clinical condition of individuals when last seen in 2000; individuals who died from AIDS related illnesses are presented in a separate category to the other AIDS cases. The age distribution remained concentrated in the 30-39 year age range, accounting for nearly half of all cases (46%) and, as would be expected, shows little deviation from previous years. The entire population of HIV positive individuals in treatment was older than the cases that were new to treatment in 2000. Whereas the most common age of all cases is 35-39 years (25%), new cases were most commonly aged between 30 and 34 years (23%, see section 2). New cases were more likely to be under 25 years (12%) when compared 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 2000. 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 2000 from an AIDS-related condition (6%) than are those younger than 55 years, of whom only 2% died. Those in the age range 15 to 29 years were the most likely to be asymptomatic for HIV infection.

The proportion of AIDS related deaths has decreased from 9% in 1996 to 4% in 1997 to under 2% in 2000. Of the 30 individuals who died in 2000, 26 (87%) had AIDS and four (13%) were classed as asymptomatic.

**TABLE 3.1: AGE DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY INFECTION ROUTE OF HIV, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

AGE GROUP	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
0-14					21 (100.0%)		21
15-19	2 (33.3%)			3 (50.0%)	1 (16.7%)		6
20-24	48 (69.6%)	2 (2.9%)	12 (17.4%)	3 (4.3%)		4 (5.8%)	69
25-29	126 (65.6%)	7 (3.6%)	44 (22.9%)	11 (5.7%)		4 (2.1%)	192
30-34	236 (68.6%)	19 (5.5%)	70 (20.3%)	12 (3.5%)		7 (2.0%)	344
35-39	284 (68.6%)	25 (6.0%)	73 (17.6%)	14 (3.4%)		18 (4.3%)	414
40-44	165 (66.0%)	20 (8.0%)	41 (16.4%)	11 (4.4%)		13 (5.2%)	250
45-49	107 (66.5%)	4 (2.5%)	31 (19.3%)	9 (5.6%)		10 (6.2%)	161
50-54	48 (55.8%)	5 (5.8%)	24 (27.9%)	6 (7.0%)		3 (3.5%)	86
55-59	28 (59.6%)	1 (2.1%)	14 (29.8%)	1 (2.1%)		3 (6.4%)	47
60+	24 (57.1%)		15 (35.7%)	1 (2.4%)		2 (4.8%)	42
<b>Total</b>	<b>1068 (65.4%)</b>	<b>83 (5.1%)</b>	<b>324 (19.9%)</b>	<b>71 (4.4%)</b>	<b>22 (1.3%)</b>	<b>64 (3.9%)</b>	<b>1632</b>

Age ranges refer to the age of individuals at end of December 2000, 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 2000, categorised by infection route of HIV. Sex between men remains the most common route of infection among people with HIV in the North West (65% of all cases). The proportion of people infected through heterosexual sex continues to increase, from 15% in 1996 to 20% in 2000. It is anticipated that the proportion of individuals infected by heterosexual sex will continue to increase in view of the increasing proportion of heterosexual cases that are new cases (27% in 2000: section 2, figure 2.1). Correspondingly, there is likely to be an increase in the number of babies born with HIV: infants newly reported in 2000 represent 27% of all children infected by mother to child transmission. Conversely, the proportion of all homosexually infected people who are newly reported in 2000 is lower at 18%.

The proportion of those infected by heterosexual sex is greater amongst older individuals (50 years and over), at 30%. The number of individuals exposed to HIV via injecting drug use remains low at 5%, with the most common age group being 35 to 39 years (30% of cases). The proportion of people infected by contaminated blood or tissue and vertical transmission remains also relatively low (4%).

**TABLE 3.2: RESIDENTIAL DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY STAGE OF HIV DISEASE, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	STAGE OF HIV DISEASE					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
Bury & Rochdale	14 (16.9%)	39 (47.0%)	30 (36.1%)			83
East Lancashire	12 (24.0%)	25 (50.0%)	10 (20.0%)	2 (4.0%)	1 (2.0%)	50
Liverpool	17 (18.5%)	42 (45.7%)	29 (31.5%)	3 (3.3%)	1 (1.1%)	92
Manchester	118 (26.5%)	207 (46.4%)	114 (25.6%)	4 (0.9%)	3 (0.7%)	446
Morecambe Bay	6 (27.3%)	7 (31.8%)	8 (36.4%)	1 (4.5%)		22
North Cheshire	11 (34.4%)	14 (43.8%)	6 (18.8%)	1 (3.1%)		32
N. W. Lancashire	42 (22.5%)	85 (45.5%)	56 (29.9%)	4 (2.1%)		187
Salford & Trafford	48 (24.7%)	92 (47.4%)	49 (25.3%)	4 (2.1%)	1 (0.5%)	194
Sefton	7 (23.3%)	12 (40.0%)	11 (36.7%)			30
South Cheshire	35 (43.8%)	25 (31.3%)	18 (22.5%)	2 (2.5%)		80
South Lancashire	6 (20.7%)	11 (37.9%)	12 (41.4%)			29
St Helens & Knowsley	9 (33.3%)	12 (44.4%)	5 (18.5%)	1 (3.7%)		27
Stockport	14 (28.0%)	20 (40.0%)	16 (32.0%)			50
West Pennine	14 (15.6%)	45 (50.0%)	30 (33.3%)	1 (1.1%)		90
Wigan & Bolton	18 (23.7%)	35 (46.1%)	18 (23.7%)	5 (6.6%)		76
Wirral	19 (32.2%)	19 (32.2%)	20 (33.9%)	1 (1.7%)		59
Eastern			2 (100.0%)			2
Isle of Man		2 (50.0%)	2 (50.0%)			4
London	1 (25.0%)	1 (25.0%)	2 (50.0%)			4
Northern & Yorkshire	2 (25.0%)	5 (62.5%)	1 (12.5%)			8
South West	1 (50.0%)	1 (50.0%)				2
Trent	6 (50.0%)	4 (33.3%)	2 (16.7%)			12
Wales	7 (41.2%)	1 (5.9%)	9 (52.9%)			17
West Midlands	7 (58.3%)	2 (16.7%)	3 (25.0%)			12
Abroad	3 (21.4%)	5 (35.7%)	5 (35.7%)	1 (7.1%)		14
Not Known	6 (60.0%)	4 (40.0%)				10
<b>Total</b>	<b>423 (25.9%)</b>	<b>715 (43.8%)</b>	<b>458 (28.1%)</b>	<b>30 (1.8%)</b>	<b>6 (0.4%)</b>	<b>1632</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also organised as a distinct category.

**Table 3.2** illustrates the 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 2000. These figures refer to the clinical condition of individuals when last seen in the year 2000; individuals who died from AIDS related illnesses are presented in a separate category to other AIDS cases. The highest number of people with HIV live in Manchester Health Authority (27%). 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 3.26)<sup>54</sup>. Overall, 26% were asymptomatic, 44% were symptomatic and 28% were classified as having AIDS. However, there is variation among health authorities, with South Cheshire having the highest proportion of asymptomatic cases (44%) and South Lancashire having the highest proportion of AIDS cases (41%).

**TABLE 3.3: RESIDENTIAL DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY INFECTION ROUTE OF HIV, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Bury & Rochdale	43 (51.8%)	6 (7.2%)	18 (21.7%)	9 (10.8%)	3 (3.6%)	4 (4.8%)	83
East Lancashire	28 (56.0%)	2 (4.0%)	12 (24.0%)	7 (14.0%)		1 (2.0%)	50
Liverpool	42 (45.7%)	7 (7.6%)	36 (39.1%)	6 (6.5%)		1 (1.1%)	92
Manchester	337 (75.6%)	29 (6.5%)	57 (12.8%)	1 (0.2%)	2 (0.4%)	20 (4.5%)	446
Morecambe Bay	13 (59.1%)	4 (18.2%)	5 (22.7%)				22
North Cheshire	13 (40.6%)	1 (3.1%)	13 (40.6%)	3 (9.4%)	1 (3.1%)	1 (3.1%)	32
N. W. Lancashire	135 (72.2%)	4 (2.1%)	31 (16.6%)	8 (4.3%)	6 (3.2%)	3 (1.6%)	187
Salford & Trafford	154 (79.4%)	6 (3.1%)	17 (8.8%)	5 (2.6%)	1 (0.5%)	11 (5.7%)	194
Sefton	12 (40.0%)	1 (3.3%)	11 (36.7%)	5 (16.7%)		1 (3.3%)	30
South Cheshire	54 (67.5%)	1 (1.3%)	14 (17.5%)	8 (10.0%)	1 (1.3%)	2 (2.5%)	80
South Lancashire	13 (44.8%)		11 (37.9%)	2 (6.9%)	1 (3.4%)	2 (6.9%)	29
St Helens & Knowsley	18 (66.7%)	1 (3.7%)	5 (18.5%)	1 (3.7%)		2 (7.4%)	27
Stockport	30 (60.0%)	3 (6.0%)	12 (24.0%)	3 (6.0%)	1 (2.0%)	1 (2.0%)	50
West Pennine	60 (66.7%)	5 (5.6%)	18 (20.0%)	2 (2.2%)		5 (5.6%)	90
Wigan & Bolton	46 (60.5%)	3 (3.9%)	20 (26.3%)	5 (6.6%)	1 (1.3%)	1 (1.3%)	76
Wirral	30 (50.8%)	6 (10.2%)	20 (33.9%)	2 (3.4%)	1 (1.7%)		59
Eastern	2 (100.0%)						2
Isle of Man	1 (25.0%)		3 (75.0%)				4
London	3 (75.0%)		1 (25.0%)				4
Northern & Yorkshire	6 (75.0%)		1 (12.5%)			1 (12.5%)	8
South West	1 (50.0%)		1 (50.0%)				2
Trent	10 (83.3%)	1 (8.3%)	1 (8.3%)				12
Wales	6 (35.3%)	1 (5.9%)	4 (23.5%)	3 (17.6%)	1 (5.9%)	2 (11.8%)	17
West Midlands	4 (33.3%)		5 (41.7%)	1 (8.3%)	2 (16.7%)		12
Abroad		2 (14.3%)	5 (35.7%)		1 (7.1%)	6 (42.9%)	14
Not Known	7 (70.0%)		3 (30.0%)				10
<b>Total</b>	<b>1068 (65.4%)</b>	<b>83 (5.1%)</b>	<b>324 (19.9%)</b>	<b>71 (4.4%)</b>	<b>22 (1.3%)</b>	<b>64 (3.9%)</b>	<b>1632</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also 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 3.4: RESIDENTIAL DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY SEX, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	SEX		Total (100%)
	Male	Female	
Bury & Rochdale	68 (81.9%)	15 (18.1%)	83
East Lancashire	45 (90.0%)	5 (10.0%)	50
Liverpool	73 (79.3%)	19 (20.7%)	92
Manchester	408 (91.5%)	38 (8.5%)	446
Morecambe Bay	19 (86.4%)	3 (13.6%)	22
North Cheshire	25 (78.1%)	7 (21.9%)	32
N. W. Lancashire	165 (88.2%)	22 (11.8%)	187
Salford & Trafford	185 (95.4%)	9 (4.6%)	194
Sefton	20 (66.7%)	10 (33.3%)	30
South Cheshire	73 (91.3%)	7 (8.8%)	80
South Lancashire	22 (75.9%)	7 (24.1%)	29
St Helens & Knowsley	23 (85.2%)	4 (14.8%)	27
Stockport	41 (82.0%)	9 (18.0%)	50
West Pennine	78 (86.7%)	12 (13.3%)	90
Wigan & Bolton	61 (80.3%)	15 (19.7%)	76
Wirral	47 (79.7%)	12 (20.3%)	59
Eastern	2 (100.0%)		2
Isle of Man	1 (25.0%)	3 (75.0%)	4
London	4 (100.0%)		4
Northern & Yorkshire	8 (100.0%)		8
South West	2 (100.0%)		2
Trent	12 (100.0%)		12
Wales	16 (94.1%)	1 (5.9%)	17
West Midlands	9 (75.0%)	3 (25.0%)	12
Abroad	10 (71.4%)	4 (28.6%)	14
Not Known	9 (90.0%)	1 (10.0%)	10
<b>Total</b>	<b>1426 (87.4%)</b>	<b>206 (12.6%)</b>	<b>1632</b>

Table 3.3 displays the route of transmission of HIV for all HIV positive and AIDS cases presenting in the North West for treatment in 2000, by health authority of residence. Homosexual sex continues to be the dominant mode of HIV transmission (65%). However, there are considerable variations within the North West, with 76% of the HIV positive residents of the health authorities of Manchester, North West Lancashire and Salford & Trafford having been infected by sex between men. Between them, these three health authorities account for 59% of all cases seen in the North West who were infected by this route. As was the case in 1999, 50% or fewer of the HIV positive residents of North Cheshire, Sefton and South Lancashire were infected by homosexual or bisexual sex, and in 2000 this was also the case for Liverpool Health Authority. Correspondingly, these four health authorities all had 35% or more of their HIV positive residents infected by heterosexual sex, a considerably higher proportion than that for the whole region (20%). Manchester continues to report by far the highest number of HIV positive injecting drug users, accounting for 37% of all residents of the North West infected by this route.

Table 3.4 shows the sex and health authority of residence of all HIV and AIDS cases presenting in the North West for treatment in 2000. As in previous years, the vast majority of all cases are male (87%), primarily due to the relatively high number of individuals exposed to HIV via homosexual or bisexual sex (table 3.3). The number of HIV positive women accessing treatment and care in the North West has steadily increased, from 115 in 1996 to 206 in 2000. The number of women with HIV is increasing at a faster rate (an increase of 25% on 1999's total of 165) than is the number of men (an increase of 15% from 1245 in 1999). As would be expected, higher proportions of females are found in the health authorities with higher levels of infection by heterosexual sex: Liverpool (21% female), North Cheshire (22%), South Lancashire (24%) and in Sefton one third were female.

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also organised as a distinct category.

**TABLE 3.5: INFECTION ROUTE OF HIV OF TOTAL HIV AND AIDS CASES BY SEX, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

INFECTION ROUTE	SEX		Total
	Male	Female	
Homo/Bisexual	1068 (74.9%)		1068 (65.4%)
Injecting Drug Use	63 (4.4%)	20 (9.7%)	83 (5.1%)
Heterosexual	163 (11.4%)	161 (78.2%)	324 (19.9%)
Blood/Tissue	63 (4.4%)	8 (3.9%)	71 (4.4%)
Mother to Child	10 (0.7%)	12 (5.8%)	22 (1.3%)
Undetermined	59 (4.1%)	5 (2.4%)	64 (3.9%)
<b>Total (100%)</b>	<b>1426</b>	<b>206</b>	<b>1632</b>

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 2000. Amongst men, the largest category of individuals living with HIV was those infected by sex between men (75%), while most women had been infected by heterosexual sex (78%). An even greater proportion of female new cases (83%) were infected by this route (section 2, table 2.5), highlighting the growing issue of heterosexual transmission of HIV. Around half of those infected by heterosexual sex are male. As in previous years, the majority of injecting drug users are male (76%).

**Table 3.6** shows the residential distribution of all HIV and AIDS cases presenting for treatment in the North West in 2000, 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 2000. However, the age group with the largest number of individuals has changed from 30 to 34 years in 1999 to 35 to 39 years in 2000, suggesting an ageing population of HIV positive people in the North West. 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 2000. Wirral, Stockport and East Lancashire have the eldest cohorts of HIV positive individuals, with 24%, 20% and 20% respectively being 50 years or over, compared to the 11% average.

**TABLE 3.6: RESIDENTIAL DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY AGE CATEGORY, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA 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+
Bury & Rochdale	3 (3.6%)		3 (3.6%)	11 (13.3%)	19 (22.9%)	23 (27.7%)	9 (10.8%)	9 (10.8%)	5 (6.0%)	1 (1.2%)		83
East Lancashire			3 (6.0%)	4 (8.0%)	11 (22.0%)	9 (18.0%)	8 (16.0%)	5 (10.0%)	6 (12.0%)	4 (8.0%)		50
Liverpool		2 (2.2%)	1 (1.1%)	11 (12.0%)	25 (27.2%)	23 (25.0%)	14 (15.2%)	6 (6.5%)	5 (5.4%)	1 (1.1%)	4 (4.3%)	92
Manchester	2 (0.4%)		30 (6.7%)	69 (15.5%)	93 (20.9%)	116 (26.0%)	76 (17.0%)	37 (8.3%)	16 (3.6%)	4 (0.9%)	3 (0.7%)	446
Morecambe Bay				2 (9.1%)	4 (18.2%)	9 (40.9%)		3 (13.6%)	2 (9.1%)	2 (9.1%)		22
North Cheshire	1 (3.1%)		1 (3.1%)	1 (3.1%)	7 (21.9%)	7 (21.9%)	5 (15.6%)	7 (21.9%)	2 (6.3%)		1 (3.1%)	32
N. W. Lancashire	6 (3.2%)	1 (0.5%)	5 (2.7%)	13 (7.0%)	35 (18.7%)	52 (27.8%)	33 (17.6%)	17 (9.1%)	7 (3.7%)	10 (5.3%)	8 (4.3%)	187
Salford & Trafford		1 (0.5%)	10 (5.2%)	27 (13.9%)	43 (22.2%)	43 (22.2%)	32 (16.5%)	22 (11.3%)	5 (2.6%)	5 (2.6%)	6 (3.1%)	194
Sefton		1 (3.3%)	1 (3.3%)	2 (6.7%)	5 (16.7%)	10 (33.3%)	5 (16.7%)	4 (13.3%)	1 (3.3%)		1 (3.3%)	30
South Cheshire	1 (1.3%)		3 (3.8%)	13 (16.3%)	24 (30.0%)	21 (26.3%)	4 (5.0%)	7 (8.8%)	3 (3.8%)	1 (1.3%)	3 (3.8%)	80
South Lancashire	1 (3.4%)		2 (6.9%)	2 (6.9%)	5 (17.2%)	4 (13.8%)	7 (24.1%)	4 (13.8%)	1 (3.4%)	1 (3.4%)	2 (6.9%)	29
St Helens & Knowsley			1 (3.7%)	3 (11.1%)	7 (25.9%)	5 (18.5%)	4 (14.8%)	2 (7.2%)	3 (11.1%)	2 (7.4%)		27
Stockport	1 (2.0%)		1 (2.0%)	5 (10.0%)	5 (10.0%)	12 (24.0%)	11 (22.0%)	5 (10.0%)	5 (10.0%)	4 (8.0%)	1 (2.0%)	50
West Pennine			2 (2.2%)	9 (10.0%)	16 (17.8%)	23 (25.6%)	19 (21.1%)	10 (11.1%)	4 (4.4%)	5 (5.6%)	2 (2.2%)	90
Wigan & Bolton	1 (1.3%)		1 (1.3%)	9 (11.8%)	14 (18.4%)	20 (26.3%)	13 (17.1%)	7 (9.2%)	5 (6.6%)	2 (2.6%)	4 (5.3%)	76
Wirral	1 (1.7%)	1 (1.7%)	1 (1.7%)	2 (3.4%)	13 (22.0%)	17 (28.8%)	5 (8.5%)	5 (8.5%)	8 (13.6%)	3 (5.1%)	3 (5.1%)	59
Eastern											2 (100.0%)	2
Isle of Man					1 (25.0%)	1 (25.0%)		1 (25.0%)	1 (25.0%)			4
London					1 (25.0%)	2 (50.0%)			1 (25.0%)			4
Northern & Yorkshire						2 (25.0%)	1 (12.5%)	3 (37.5%)		1 (12.5%)	1 (12.5%)	8
South West						1 (50.0%)			1 (50.0%)			2
Trent					5 (41.7%)	2 (16.7%)	1 (8.3%)	2 (16.7%)	2 (16.7%)			12
Wales	1 (5.9%)		1 (5.9%)	2 (11.8%)	1 (5.9%)	2 (11.8%)	3 (17.6%)	2 (11.8%)	3 (17.6%)	1 (5.9%)	1 (5.9%)	17
West Midlands	2 (16.7%)		1 (8.3%)	2 (16.7%)	4 (33.3%)	3 (25.0%)						12
Abroad	1 (7.1%)			3 (21.4%)	3 (21.4%)	4 (28.6%)		3 (21.4%)				14
Not Known			2 (20.0%)	2 (20.0%)	3 (30.0%)	3 (30.0%)						10
<b>Total</b>	<b>21 (1.3%)</b>	<b>6 (0.4%)</b>	<b>69 (4.2%)</b>	<b>192 (11.8%)</b>	<b>344 (21.1%)</b>	<b>414 (25.4%)</b>	<b>250 (15.3%)</b>	<b>161 (9.9%)</b>	<b>86 (5.3%)</b>	<b>47 (2.9%)</b>	<b>42 (2.6%)</b>	<b>1632</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also organised as a distinct category. Age ranges refer to the age of individuals at end of December 2000, or at death.

**TABLE 3.7: RESIDENTIAL DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY ETHNIC GROUP, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	ETHNICITY							Total (100%)
	White	Black African	Black Caribbean	Black Other	Indian/Pakistani/Bangladeshi	Other/Mixed	Not Known	
Bury & Rochdale	71 (85.5%)	6 (7.2%)			3 (3.6%)	1 (1.2%)	2 (2.4%)	83
East Lancashire	47 (94.0%)	1 (2.0%)			2 (4.0%)			50
Liverpool	71 (77.2%)	17 (18.5%)			1 (1.1%)	2 (2.2%)	1 (1.1%)	92
Manchester	366 (82.1%)	35 (7.8%)	4 (0.9%)	5 (1.1%)	12 (2.7%)	11 (2.5%)	13 (2.9%)	446
Morecambe Bay	20 (90.9%)					1 (4.5%)	1 (4.5%)	22
North Cheshire	30 (93.8%)	1 (3.1%)				1 (3.1%)		32
N. W. Lancashire	163 (87.2%)	13 (7.0%)	2 (1.1%)		6 (3.2%)	2 (1.1%)	1 (0.5%)	187
Salford & Trafford	173 (89.2%)	5 (2.6%)	2 (1.0%)	1 (0.5%)	2 (1.0%)	4 (2.1%)	7 (3.6%)	194
Sefton	29 (96.7%)						1 (3.3%)	30
South Cheshire	73 (91.3%)	4 (5.0%)				2 (2.5%)	1 (1.3%)	80
South Lancashire	23 (79.3%)		1 (3.4%)			4 (13.8%)	1 (3.4%)	29
St Helens & Knowsley	26 (96.3%)	1 (3.7%)						27
Stockport	46 (92.0%)	3 (6.0%)				1 (2.0%)		50
West Pennine	86 (95.6%)	1 (1.1%)			2 (2.2%)	1 (1.1%)		90
Wigan & Bolton	62 (81.6%)	6 (7.9%)		1 (1.3%)	3 (3.9%)	1 (1.3%)	3 (3.9%)	76
Wirral	53 (89.8%)	5 (8.5%)				1 (1.7%)		59
Eastern	2 (100.0%)							2
Isle of Man	4 (100.0%)							4
London	4 (100.0%)							4
Northern & Yorkshire	7 (87.5%)						1 (12.5%)	8
South West	1 (50.0%)	1 (50.0%)						2
Trent	11 (91.7%)		1 (8.3%)					12
Wales	17 (100.0%)							17
West Midlands	9 (75.0%)	2 (16.7%)				1 (8.3%)		12
Abroad	4 (28.6%)	3 (21.4%)	1 (7.1%)	1 (7.1%)	3 (21.4%)	2 (14.3%)		14
Not Known	7 (70.0%)	1 (10.0%)		2 (20.0%)				10
<b>Total</b>	<b>1405 (86.1%)</b>	<b>105 (6.4%)</b>	<b>11 (0.7%)</b>	<b>10 (0.6%)</b>	<b>34 (2.1%)</b>	<b>35 (2.1%)</b>	<b>32 (2.0%)</b>	<b>1632</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also organised as a distinct category.

**Table 3.7** shows a breakdown of ethnicity by health authority for all those individuals with HIV or AIDS who attended statutory treatment centres in the North West in 2000. Ethnic group classifications are adapted from the 1991 census questionnaire and are those utilised by the Public Health Laboratory Service AIDS and STD Centre, for the Survey of Prevalent Diagnosed HIV Infections (SOPHID).

The self-classification of ethnicity was recorded for 98% of cases, most of whom (88%) were white. The remaining 12% were from black and ethnic minority communities, and this proportion has increased from 10% last year. This is a reflection of the increasing proportion of new cases from black and ethnic minority communities (from 15% in 1999 to 19% in 2000: section 2, table 2.6). These data show an increase in the number of individuals from black and ethnic minority groups presenting for treatment and care in the North West of England. Moreover, individuals from black and ethnic minority communities are substantially over represented among the HIV positive population when compared to their proportion in the North West population as a whole (3.8%)<sup>102</sup>. Thus, individuals from black and ethnic minority groups in the North West are 3.5 times more likely to be HIV positive than are their white counterparts.

Within the North West there were wide variations in the distribution of HIV positive individuals from black and ethnic minority communities. In some North West health authorities (for example, St Helens & Knowsley, East Lancashire and Sefton), virtually all individuals were self defined as white, whereas in Liverpool, only 77% were white.

HIV positive individuals classified as black African comprise the largest ethnic minority group, at 6% of all cases and 54% of non-white individuals. This proportion from black African communities has been increasing over the years, from 3% in 1998, to 5% in 1999. These data highlight the need for specific HIV prevention initiatives within black and ethnic minority communities. However, the black African community is not homogenous and requires a culturally sensitive and diverse approach<sup>68</sup>.

### TABLE 3.8: ETHNIC DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY SEX, JANUARY-DECEMBER 2000

(All cases seen during 2000 including those who died during the year)

ETHNICITY	SEX		Total (100%)
	Male	Female	
White	1289 (91.7%)	116 (8.3%)	1405
Black African	43 (41.0%)	62 (59.0%)	105
Black Caribbean	9 (81.8%)	2 (18.2%)	11
Black Other	7 (70.0%)	3 (30.0%)	10
Indian / Pakistani / Bangladeshi	23 (67.6%)	11 (32.4%)	34
Other / Mixed	25 (71.4%)	10 (28.6%)	35
Not Known	30 (93.8%)	2 (6.3%)	32
<b>Total</b>	<b>1426 (87.4%)</b>	<b>206 (12.6%)</b>	<b>1632</b>

**Table 3.8** shows the ethnic group and sex of all individuals with HIV presenting in the North West for treatment in 2000. The vast majority of HIV and AIDS cases were male (87%). However, this is not the case for members of black and ethnic minority communities, where cases are much more evenly distributed between the sexes. Nearly half of all HIV positive individuals from ethnic minorities were female (45%), and this proportion rises to 59% when considering black Africans alone. 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 ethnic minority groups (table 3.9).

**TABLE 3.9: ETHNIC DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY INFECTION ROUTE OF HIV, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

ETHNICITY	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
White	1016 (72.3%)	79 (5.6%)	190 (13.5%)	67 (4.8%)	10 (0.7%)	43 (3.1%)	1405
Black African	5 (4.8%)		90 (85.7%)		5 (4.8%)	5 (4.8%)	105
Black Caribbean	4 (36.4%)		6 (54.5%)	1 (9.1%)			11
Black Other	1 (10.0%)		8 (80.0%)			1 (10.0%)	10
Indian / Pakistani / Bangladeshi	6 (17.6%)	1 (2.9%)	20 (58.8%)	3 (8.8%)	1 (2.9%)	3 (8.8%)	34
Other / Mixed	17 (48.6%)	2 (5.7%)	9 (25.7%)		6 (17.1%)	1 (2.9%)	35
Not Known	19 (59.4%)	1 (3.1%)	1 (3.1%)			11 (34.4%)	32
<b>Total</b>	<b>1068 (65.4%)</b>	<b>83 (5.1%)</b>	<b>324 (19.9%)</b>	<b>71 (4.4%)</b>	<b>22 (1.3%)</b>	<b>64 (3.9%)</b>	<b>1632</b>

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

**TABLE 3.10: ETHNIC DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY AGE GROUP, JANUARY-DECEMBER 2000**

(All cases seen during 2000 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	9 (0.6%)	6 (0.4%)	62 (4.4%)	153 (10.9%)	283 (20.1%)	364 (25.9%)	218 (15.5%)	147 (10.5%)	80 (5.7%)	44 (3.1%)	39 (2.8%)	1405
Black African	5 (4.8%)		2 (1.9%)	19 (18.1%)	30 (28.6%)	20 (19.0%)	14 (13.3%)	7 (6.7%)	4 (3.8%)	2 (1.9%)	2 (1.9%)	105
Black Caribbean				2 (18.2%)	5 (45.5%)	2 (18.2%)	1 (9.1%)	1 (9.1%)				11
Black Other			1 (10.0%)		1 (10.0%)	6 (60.0%)	1 (10.0%)			1 (10.0%)		10
Indian / Pakistani / Bangladeshi	1 (2.9%)			5 (14.7%)	10 (29.4%)	7 (20.6%)	7 (20.6%)	2 (5.9%)	1 (2.9%)		1 (2.9%)	34
Other / Mixed	6 (17.1%)		2 (5.7%)	8 (22.9%)	8 (22.9%)	4 (11.4%)	5 (14.3%)	1 (2.9%)	1 (2.9%)			35
Not Known			2 (6.3%)	5 (15.6%)	7 (21.9%)	11 (34.4%)	4 (12.5%)	3 (9.4%)				32
<b>Total</b>	<b>21 (1.3%)</b>	<b>6 (0.4%)</b>	<b>69 (4.2%)</b>	<b>192 (11.8%)</b>	<b>344 (21.1%)</b>	<b>414 (25.4%)</b>	<b>250 (15.3%)</b>	<b>161 (9.9%)</b>	<b>86 (5.3%)</b>	<b>47 (2.9%)</b>	<b>42 (2.6%)</b>	<b>1632</b>

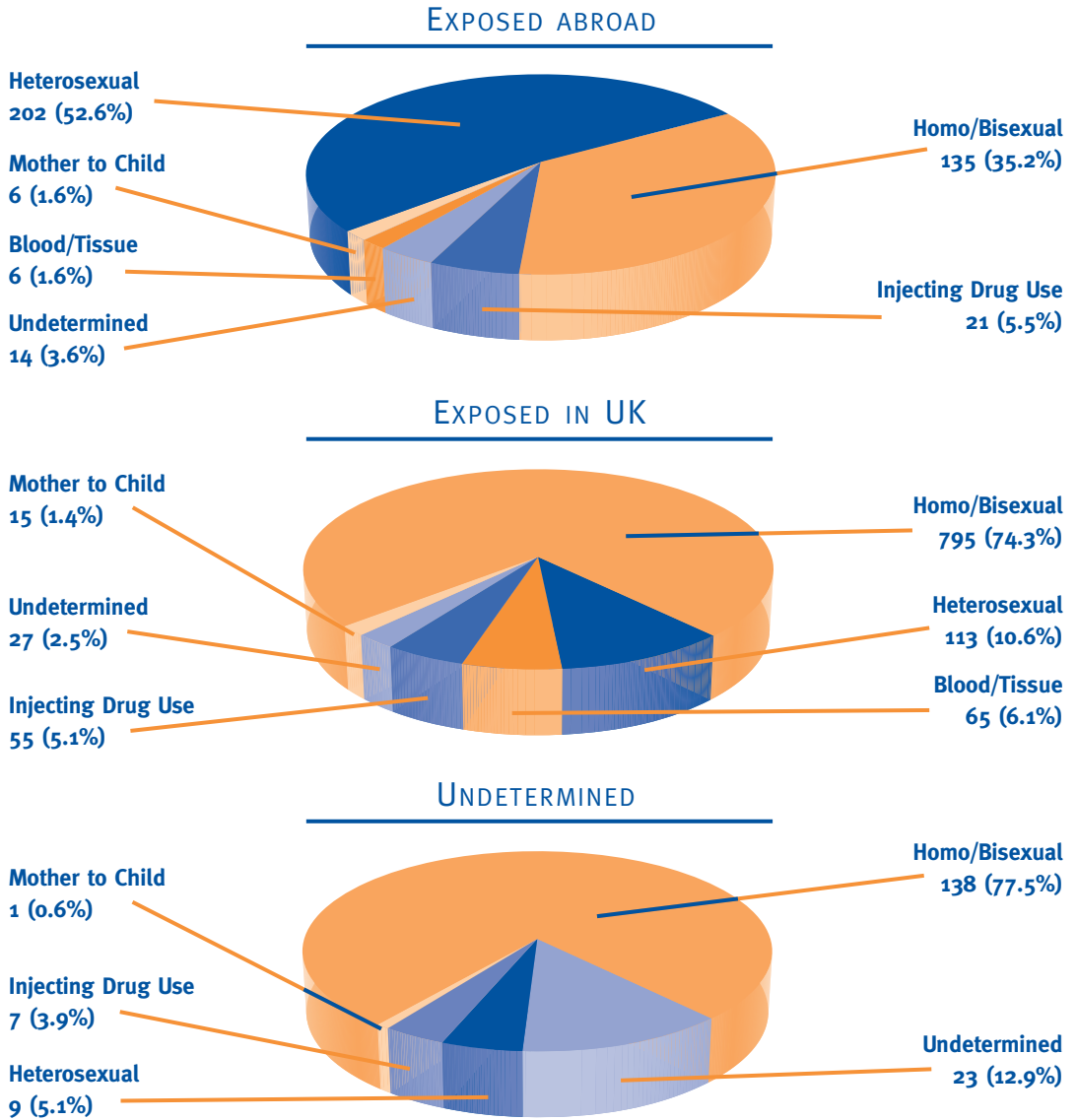
**Table 3.9** illustrates the ethnic group and route of transmission of HIV and AIDS cases presenting in the North West in 2000. Although most individuals with HIV were infected by sex between men (65%), this is not the case among black and ethnic minority communities where homosexual sex accounted for only 17% of cases and heterosexual sex was the main route of transmission (68% of cases). Within black African communities, this situation is even more apparent, with heterosexual sex accounting for 86% 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 mother to child transmission of HIV.

**Table 3.10** displays the ethnicity and age group of HIV and AIDS cases presenting for treatment in the North West in 2000. White individuals tended to be older, with a median age of 37 years (with 90% of the population lying between the range 25 to 55 years) while black Africans were on average 35 years (90% in the range 28 to 46 years) and black Caribbeans were 34 years (90% of whom were between 20 to 53 years). The fact that those from black and ethnic minority 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 classified as 'other' or 'mixed' in the 0-14 year age group (5% and 17% 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** 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 2000. These data show the significant influence of global trends of the pandemic on the epidemiology of HIV in the North West Region. Almost a quarter (24%) of all cases were reported to have been exposed to HIV infection 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% (1998) to 21% in 1999 and 24% in 2000. 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% (1997), 69% (1998), 79% (1999) to 89% in the year 2000. Heterosexual sex continued to be the predominant mode of transmission of those HIV positive individuals who were infected abroad (53%) compared to only 11% of those infected in the UK.

**FIGURE 3.2: THE ROLE OF CONTACT ABROAD IN EXPOSURE TO HIV OF TOTAL HIV AND AIDS CASES BY INFECTION ROUTE, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

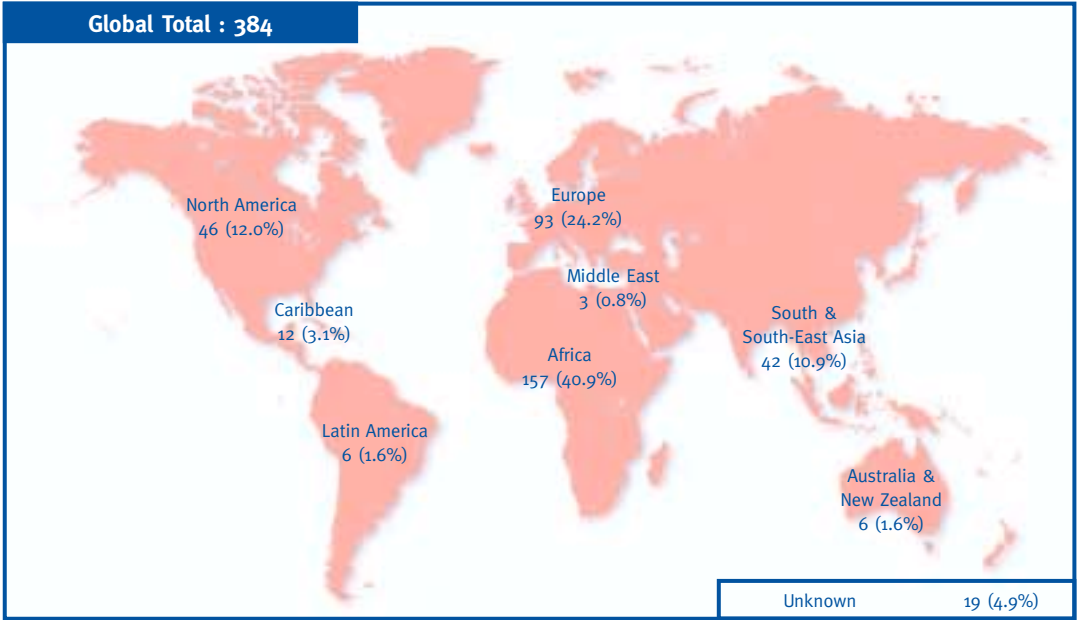


HIV EXPOSURE ABROAD	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
Yes	135 (35.2%)	21 (5.5%)	202 (52.6%)	6 (1.6%)	6 (1.6%)	14 (3.6%)	384
No	795 (74.3%)	55 (5.1%)	113 (10.6%)	65 (6.1%)	15 (1.4%)	27 (2.5%)	1070
Undetermined	138 (77.5%)	7 (3.9%)	9 (5.1%)		1 (0.6%)	23 (12.9%)	178
<b>Total</b>	<b>1068 (65.4%)</b>	<b>83 (5.1%)</b>	<b>324 (19.9%)</b>	<b>71 (4.4%)</b>	<b>22 (1.3%)</b>	<b>64 (3.9%)</b>	<b>1632</b>

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 AND COUNTRY OF EXPOSURE OF TOTAL HIV AND AIDS CASES WHO PROBABLY ACQUIRED THEIR INFECTION OUTSIDE THE UK, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)



<b>Africa</b>	<b>157 (40.9%)</b>	<b>Australia &amp; New Zealand</b>	<b>6 (1.6%)</b>	Switzerland	1 (0.3%)
Angola	1 (0.3%)	Australia	5 (1.3%)	Tenerife	1 (0.3%)
Botswana	6 (1.6%)	New Zealand	1 (0.3%)	Unknown	12 (3.1%)
Dem. Rep. of Congo	4 (1.0%)	<b>Caribbean</b>	<b>12 (3.1%)</b>	<b>Latin America</b>	<b>6 (1.6%)</b>
Egypt	1 (0.3%)	Jamaica	9 (2.3%)	Brazil	1 (0.3%)
Eritrea	1 (0.3%)	St Lucia	1 (0.3%)	Columbia	1 (0.3%)
Gambia	1 (0.3%)	Trinidad	1 (0.3%)	Guatemala	1 (0.3%)
Ghana	1 (0.3%)	Unknown	1 (0.3%)	Guyana	1 (0.3%)
Kenya	12 (3.1%)	<b>Europe</b>	<b>93 (24.2%)</b>	Mexico	2 (0.5%)
Lesotho	1 (0.3%)	Austria	1 (0.3%)	<b>Middle East</b>	<b>3 (0.8%)</b>
Malawi	6 (1.6%)	Belgium	2 (0.5%)	Israel	1 (0.3%)
Morocco	1 (0.3%)	Croatia	1 (0.3%)	Saudia Arabia	1 (0.3%)
Nigeria	5 (1.3%)	Cyprus	1 (0.3%)	United Arab Emirates	1 (0.3%)
Rwanda	3 (0.8%)	France	4 (1.0%)	<b>North America</b>	<b>46 (12.0%)</b>
Senegal	1 (0.3%)	Germany	9 (2.3%)	Canada	2 (0.5%)
Somalia	6 (1.6%)	Gibraltar	1 (0.3%)	USA	43 (11.2%)
South Africa	15 (3.9%)	Gran Canaria	2 (0.5%)	<b>South &amp; S E Asia</b>	<b>42 (10.9%)</b>
Sudan	3 (0.8%)	Ireland	6 (1.6%)	India	3 (0.8%)
Swaziland	1 (0.3%)	Italy	7 (1.8%)	Malaysia	1 (0.3%)
Tanzania	5 (1.3%)	Malta	1 (0.3%)	Pakistan	9 (2.3%)
Uganda	14 (3.6%)	Netherlands	8 (2.1%)	Thailand	25 (6.5%)
Zambia	27 (7.0%)	Portugal	8 (2.1%)	Unknown	4 (4.9%)
Zimbabwe	16 (4.2%)	Spain	26 (6.8%)	<b>Unknown</b>	<b>19 (4.9%)</b>
Unknown	26 (6.8%)	Sweden	2 (0.5%)	<b>Total</b>	<b>384 (100.0%)</b>

**Figure 3.3** illustrates the global region and country of infection for those 384 HIV positive individuals presenting for treatment in the North West in 2000 who were probably infected abroad. Of all the infections contracted outside the United Kingdom, 41% were infected in Africa. This high proportion reflects the impact of the pandemic, particularly in sub-Saharan Africa, where the prevalence of HIV is extremely high<sup>13,22</sup>. A further 24% of people who were infected abroad were infected in Europe, 12% in North America and 11% in South and South East Asia.

Of the 384 individuals who were probably infected abroad, the country of infection is known for 322 individuals (84%). A total of 58 different countries have been named for those HIV positive people infected abroad, with the USA representing the country where the largest number of infections were contracted (13% of those where the country is known). Of those exposed in Europe, 28% were infected in Spain, reflecting the extent of the epidemic in that country<sup>47</sup>, the large number of people that travel between the United Kingdom and Spain, and the increased propensity to take risks when on holiday<sup>49,105</sup>. Exposure in Africa was spread across 22 countries. The vast majority of those exposed in Africa were exposed in sub-Saharan Africa (96% of cases where the African country of infection was known). However, the African country of infection was unknown in a high proportion (17%) of cases.

**TABLE 3.11: GLOBAL REGION AND INFECTION ROUTE OF TOTAL HIV AND AIDS CASES WHO PROBABLY ACQUIRED THEIR INFECTION OUTSIDE THE UK, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

GLOBAL REGION	INFECTION ROUTE						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
Africa	16 (10.2%)	1 (0.6%)	130 (82.8%)	2 (1.3%)	4 (2.5%)	4 (2.5%)	157
Australia & New Zealand	6 (100.0%)						6
Caribbean			11 (91.7%)			1 (8.3%)	12
Europe	53 (57.0%)	18 (19.4%)	17 (18.3%)	1 (1.1%)	1 (1.1%)	3 (3.2%)	93
Latin America	2 (33.3%)		3 (50.0%)			1 (16.7%)	6
Middle East			3 (100.0%)				3
North America	36 (78.3%)	2 (4.3%)	4 (8.7%)	2 (4.3%)		2 (4.3%)	46
South & South-East Asia	13 (31.0%)		26 (61.9%)	1 (2.4%)		2 (4.8%)	42
Unknown	9 (47.4%)		8 (42.1%)		1 (5.3%)	1 (5.3%)	19
<b>Total</b>	<b>135 (35.2%)</b>	<b>21 (5.5%)</b>	<b>202 (52.6%)</b>	<b>6 (1.6%)</b>	<b>6 (1.6%)</b>	<b>14 (3.6%)</b>	<b>384</b>

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, over half were exposed via heterosexual sex (53%). For those exposed in Africa (41% of all those infected abroad), the proportion infected by this route is much higher, at 83%. Almost a quarter of those infected abroad were infected in Europe, nearly a fifth of whom were infected by sharing injecting equipment. Eighty six percent of all injecting drug users who were exposed abroad were infected in Europe, with the largest number of these having been exposed in Spain (seven individuals). This is a reflection of the fact that the drug using community remains the focus of the HIV epidemic in Spain, as in much of the rest of Western Europe (in particular Mediterranean Europe).

**TABLE 3.12: THE ROLE OF CONTACT ABROAD IN EXPOSURE TO HIV OF TOTAL HIV AND AIDS CASES BY ETHNICITY, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HIV EXPOSURE ABROAD	ETHNICITY							Total
	White	Black African	Black Caribbean	Black Other	Indian/Pakistani/Bangladeshi	Other/Mixed	Not Known	
Yes	238 (16.9%)	91 (86.7%)	6 (54.5%)	9 (90.0%)	21 (61.8%)	19 (54.3%)		384 (23.5%)
No	1017 (72.4%)	10 (9.5%)	4 (36.4%)	1 (10.0%)	9 (26.5%)	14 (40.0%)	15 (46.9%)	1070 (65.6%)
Not known	150 (10.7%)	4 (3.8%)	1 (9.1%)		4 (11.8%)	2 (5.7%)	17 (53.1%)	178 (10.9%)
<b>Total (100%)</b>	<b>1405</b>	<b>105</b>	<b>11</b>	<b>10</b>	<b>34</b>	<b>35</b>	<b>32</b>	<b>1632</b>

**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 2000. Nearly a quarter 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 (72%) are thought to have been exposed in the United Kingdom, this was only true for 10% of black Africans. The high proportion of white individuals for whom exposure abroad is unknown may reflect reluctance to pursue this topic with white individuals.

**Table 3.13** shows the level of antiretroviral therapy received by individuals attending for treatment for HIV or AIDS in the North West in 2000, broken down by 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 2000. Nearly two thirds (65%) of HIV positive individuals were receiving triple or more combination therapy in the year 2000. The number of individuals on this level of combination therapy has increased by 16% on 1999 figures, the same as the increase in the overall number of HIV positive people accessing services in the North West during 2000. This is different to the situation in the previous year, where the increase in the number of people taking triple or more therapy was far greater (22%) than the increase in the size of the HIV positive population (16%). The data suggest a slight increase in the number of people taking four or more drugs, from 12% in 1999 to 13% in 2000. A third of HIV positive individuals were not on any antiretroviral therapy, a comparable proportion to 1999. Sixty three percent of those not resident in the region, but who access treatment in the North West received antiretroviral therapy. In line with British HIV Association Guidelines<sup>107</sup>, use of mono or dual therapy was rare. In 2000, no individuals received mono therapy and only 1% received dual therapy.

**TABLE 3.13: RESIDENTIAL DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY LEVEL OF ANTIRETROVIRAL THERAPY, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	ANTIRETROVIRAL THERAPY				Total (100%)
	None	Dual	Triple	Quadruple or More	
Bury & Rochdale	26 (31.3%)		46 (55.4%)	11 (13.3%)	83
East Lancashire	14 (28.0%)	3 (6.0%)	23 (46.0%)	10 (20.0%)	50
Liverpool	33 (35.9%)		57 (62.0%)	2 (2.2%)	92
Manchester	189 (42.4%)	2 (0.4%)	201 (45.1%)	54 (12.1%)	446
Morecambe Bay	3 (13.6%)		18 (81.8%)	1 (4.5%)	22
North Cheshire	8 (25.0%)	1 (3.1%)	16 (50.0%)	7 (21.9%)	32
N. W. Lancashire	57 (30.5%)	9 (4.8%)	95 (50.8%)	26 (13.9%)	187
Salford & Trafford	65 (33.5%)		109 (56.2%)	20 (10.3%)	194
Sefton	8 (26.7%)		19 (63.3%)	3 (10.0%)	30
South Cheshire	30 (37.5%)	1 (1.3%)	43 (53.8%)	6 (7.5%)	80
South Lancashire	5 (17.2%)	2 (6.9%)	18 (62.1%)	4 (13.8%)	29
St Helens & Knowsley	10 (37.0%)		15 (55.6%)	2 (7.4%)	27
Stockport	13 (26.0%)		31 (62.0%)	6 (12.0%)	50
West Pennine	18 (20.0%)		50 (55.6%)	22 (24.4%)	90
Wigan & Bolton	21 (27.6%)	1 (1.3%)	38 (50.0%)	16 (21.1%)	76
Wirral	19 (32.2%)	1 (1.7%)	30 (50.8%)	9 (15.3%)	59
Eastern	1 (50.0%)		1 (50.0%)		2
Isle of Man	1 (25.0%)		2 (50.0%)	1 (25.0%)	4
London	3 (75.0%)		1 (25.0%)		4
Northern & Yorkshire	1 (12.5%)	1 (12.5%)	5 (62.5%)	1 (12.5%)	8
South West	1 (50.0%)		1 (50.0%)		2
Trent	5 (41.7%)		7 (58.3%)		12
Wales	6 (35.3%)		10 (58.8%)	1 (5.9%)	17
West Midlands	1 (8.3%)	2 (16.7%)	6 (50.0%)	3 (25.0%)	12
Abroad	9 (64.3%)		5 (35.7%)		14
Not Known	5 (50.0%)		5 (50.0%)		10
<b>Total</b>	<b>552 (33.8%)</b>	<b>23 (1.4%)</b>	<b>852 (52.2%)</b>	<b>205 (12.6%)</b>	<b>1632</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also organised as a distinct category.

**TABLE 3.14: STAGE OF HIV DISEASE OF TOTAL HIV AND AIDS CASES BY LEVEL OF ANTIRETROVIRAL THERAPY, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

STAGE OF HIV DISEASE	ANTIRETROVIRAL THERAPY				Total (100%)
	None	Dual	Triple	Quadruple or More	
Asymptomatic	288 (68.1%)	3 (0.7%)	120 (28.4%)	12 (2.8%)	423
Symptomatic	203 (28.4%)	18 (2.5%)	404 (56.5%)	90 (12.6%)	715
AIDS	46 (10.0%)	1 (0.2%)	313 (68.3%)	98 (21.4%)	458
AIDS Related Death	9 (30.0%)	1 (3.3%)	15 (50.0%)	5 (16.7%)	30
Unknown	6 (100.0%)				6
<b>Total</b>	<b>552 (33.8%)</b>	<b>23 (1.4%)</b>	<b>852 (52.2%)</b>	<b>205 (12.6%)</b>	<b>1632</b>

**Table 3.14** refers to the clinical condition of individuals when last seen in 2000; individuals who died from AIDS related illnesses are presented in a different category. Individuals are categorised by the highest level of antiretroviral therapy they received from any treatment centre in the North West during 2000. The vast majority (90%) of those categorised as having AIDS received triple or more combination therapy, whilst 69% of those who were symptomatic received this level of therapy. In contrast, most asymptomatic individuals (68%) were not receiving any antiretroviral therapy. This has implications for the future demand for drug therapy, since these individuals may 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 2000. The data illustrate a variation in the level of antiretroviral therapy across treatment centres in the region. Of the larger treatment centres, North Manchester General (NMG) reported providing the most quadruple (or more) therapy (23% of all those receiving therapy from NMG). For those receiving antiretroviral therapy, the most common level was triple therapy. No individuals received mono therapy and the level of dual therapy remains low across treatment centres in the North West. Individuals currently receiving dual therapy may be those whose HIV infection has been successfully managed for many years on dual therapy. Patients newly commencing treatment are more likely to be prescribed triple or more therapy (see section 2, table 2.11).

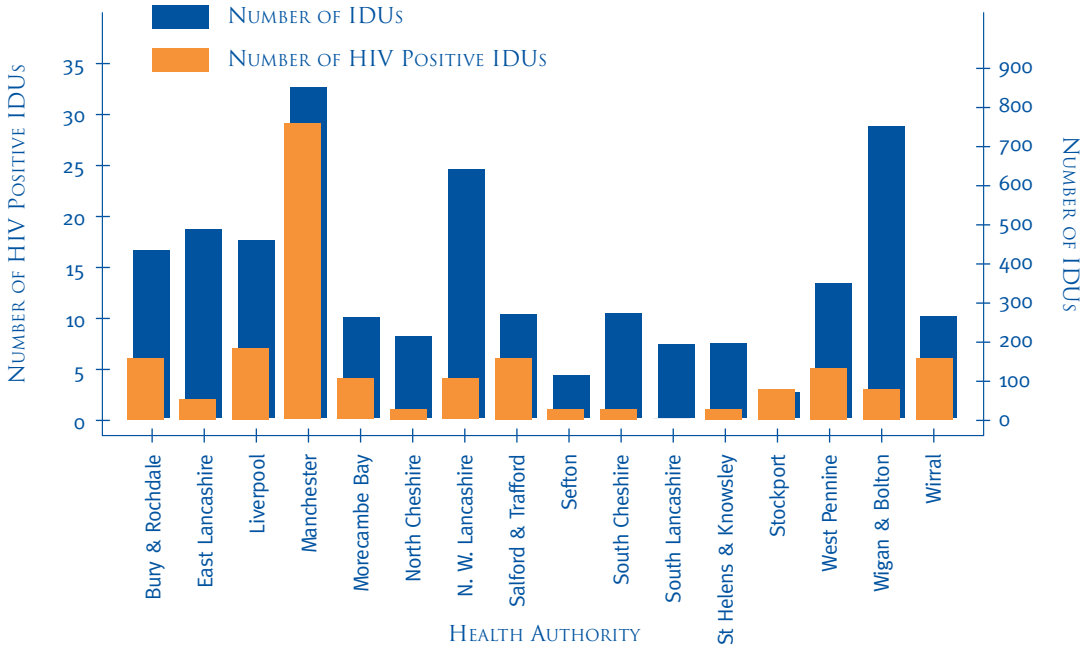
**TABLE 3.15: DISTRIBUTION OF TREATMENT FOR TOTAL HIV AND AIDS CASES BY LEVEL OF ANTIRETROVIRAL THERAPY, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

TREATMENT CENTRE	ANTIRETROVIRAL THERAPY				Total (100%)
	None	Dual	Triple	Quadruple or More	
AHC	2 (28.6%)	1 (14.3%)	2 (28.6%)	2 (28.6%)	7
APH	7 (29.2%)		17 (70.8%)		24
BLAG	53 (40.2%)	8 (6.1%)	60 (45.5%)	11 (8.3%)	132
BLK		1 (33.3%)	2 (66.7%)		3
BLKG	4 (36.4%)		4 (36.4%)	3 (27.3%)	11
BOLG	13 (28.9%)		24 (53.3%)	8 (17.8%)	45
BURG	4 (40.0%)	1 (10.0%)	4 (40.0%)	1 (10.0%)	10
BURY	6 (100.0%)				6
CHR	22 (61.1%)		13 (36.1%)	1 (2.8%)	36
DDU	5 (100.0%)				5
FAZ	25 (34.2%)		44 (60.3%)	4 (5.5%)	73
FGH			2 (100.0%)		2
HAL			1 (100.0%)		1
LEI			6 (100.0%)		6
LEII	1 (16.7%)		4 (66.7%)	1 (16.7%)	6
MAC	5 (27.8%)	2 (11.1%)	10 (55.6%)	1 (5.6%)	18
MGP	139 (100.0%)				139
MRI	41 (39.4%)		51 (49.0%)	12 (11.5%)	104
MRIG	68 (71.6%)	1 (1.1%)	25 (26.3%)	1 (1.1%)	95
MRIH	11 (22.9%)		33 (68.8%)	4 (8.3%)	48
NMG	172 (25.6%)	4 (0.6%)	379 (56.4%)	117 (17.4%)	672
NMGG	113 (90.4%)		11 (8.8%)	1 (0.8%)	125
OLDG	2 (100.0%)				2
ORMG	2 (40.0%)	2 (40.0%)	1 (20.0%)		5
PG	14 (25.9%)	4 (7.4%)	25 (46.3%)	11 (20.4%)	54
PP	3 (50.0%)		3 (50.0%)		6
RLG	50 (33.3%)	1 (0.7%)	83 (55.3%)	16 (10.7%)	150
RLH	7 (41.2%)		9 (52.9%)	1 (5.9%)	17
RLI	1 (10.0%)		9 (90.0%)		10
ROCG	7 (33.3%)		14 (66.7%)		21
SALG	7 (33.3%)		14 (66.7%)		21
SPG	5 (35.7%)		7 (50.0%)	2 (14.3%)	14
STP	37 (59.7%)	1 (1.6%)	19 (30.6%)	5 (8.1%)	62
TAMG	3 (100.0%)				3
TRAG	2 (100.0%)				2
WAR	5 (100.0%)				5
WGH			4 (100.0%)		4
WIGG	2 (66.7%)	1 (33.3%)			3
WITG	44 (55.0%)		29 (36.3%)	7 (8.8%)	80

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.

FIGURE 3.4: RESIDENTIAL DISTRIBUTION OF REPORTED HIV POSITIVE INJECTING DRUG USERS (IDUs) AND REPORTED INJECTING DRUG USERS BY HEALTH AUTHORITY OF AGENCY, JANUARY-DECEMBER 2000



Source: Drug Misuse in the North West of England, 2000 (provisional data)<sup>108</sup>

Figure 3.4 illustrates the residential distribution of HIV positive injecting drug users attending North West HIV statutory services in 2000, together with the number of drug users who have ever injected presenting to drug services during 2000. Injecting drug users are categorised by the health authority in which the agency (specialist drug services and NHS general practices) to which they present is located. The number of injecting drug users for each health authority is represented as the number of individuals who have presented to an agency with a new episode (an episode is defined as a presentation to an agency for the first time or after a break in contact of six months or more). The number attributed to each health authority cannot be totalled for the entire North West Region due to the possibility of individuals attending agencies in more than one health authority. There are considerable geographical variations in the data for both the level of HIV positive injecting drug users and the extent of injecting drug use across the region. Several health authorities have reported an increase in injecting drug users presenting to agencies, compared to data from 1999<sup>108</sup>. The most notable increases were reported in Bury & Rochdale (42%), Wirral (38%), Morecambe Bay (29%) (all of which had also significantly increased in 1999), Salford & Trafford (31%), North Cheshire (48%) and Manchester (47%). A significant decrease was reported in Stockport (45%).

During 2000 the number of HIV positive injecting drug users resident in the North West accessing HIV and AIDS statutory treatment centres has remained static at 79 individuals. Manchester represented the largest concentration of HIV positive injecting drug users (29), accounting for 37% of the regional total, a similar level to 1999. However, Manchester reported no new HIV positive injecting drug users in 2000 (section 2, table 2.2). Wigan & Bolton continue to report the second largest number of injecting drug users (751), but have a relatively low number of HIV positive injecting drug users resident within the district (three).

Overall, despite the continuing high number of injectors across the region, the numbers of HIV positive injecting drug users remain relatively low. This may be attributed to the early successful implementation of a comprehensive harm reduction strategy that included needle and syringe exchange schemes and accessible drug treatment programmes<sup>78</sup>. However, these strategies to combat HIV infection in injecting drug users have not been as effective at preventing hepatitis B and C, which remain serious threats to the health of injecting drug users<sup>79,80</sup>.

**TABLE 3.16: THE RELATIONSHIP BETWEEN HEALTH AUTHORITY OF TREATMENT AND HEALTH AUTHORITY OF RESIDENCE FOR TOTAL HIV AND AIDS CASES, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	HA OF TREATMENT CENTRE														
	Bury & Rochdale	East Lancashire	Liverpool	Manchester	Morecambe Bay	North Cheshire	N. W. Lancashire	Salford & Trafford	Sefton	South Cheshire	South Lancashire	Stockport	West Pennine	Wigan & Bolton	Wirral
Bury & Rochdale	22 (81.5%)			78 (6.2%)				2 (8.7%)				2 (3.2%)		3 (6.3%)	
East Lancashire	1 (3.7%)	20 (83.3%)		28 (2.2%)			4 (2.1%)								
Liverpool			79 (44.1%)	1 (0.1%)					24 (27.6%)						
Manchester	1 (3.7%)	2 (8.3%)	3 (1.7%)	604 (47.8%)			4 (2.1%)		3 (3.4%)	1 (1.5%)		19 (30.6%)	1 (20.0%)		
Morecambe Bay				7 (0.6%)	15 (93.8%)		2 (1.0%)					1 (1.6%)			
North Cheshire			11 (6.1%)	11 (0.9%)		6 (100.0%)			7 (8.0%)	3 (4.5%)					
N. W. Lancashire			2 (1.1%)	30 (2.4%)	1 (6.3%)		166 (86.5%)		1 (1.1%)						1 (2.1%)
Salford & Trafford	1 (3.7%)		5 (2.8%)	231 (18.3%)				21 (91.3%)				7 (11.3%)		4 (8.3%)	
Sefton			14 (7.8%)	3 (0.2%)					15 (17.2%)						1 (2.1%)
South Cheshire			6 (3.4%)	32 (2.5%)					1 (1.1%)	48 (72.7%)		3 (4.8%)			
South Lancashire		1 (4.2%)	5 (2.8%)	4 (0.3%)			11 (5.7%)		7 (8.0%)		5 (100.0%)				3 (6.3%)
St Helens & Knowsley			15 (8.4%)	6 (0.5%)			1 (0.5%)		5 (5.7%)						
Stockport				38 (3.0%)						1 (1.5%)		21 (33.9%)			
West Pennine	1 (3.7%)			102 (8.1%)								3 (4.8%)	4 (80.0%)		
Wigan & Bolton	1 (3.7%)		4 (2.2%)	41 (3.2%)								2 (3.2%)		36 (75.0%)	
Wirral			21 (11.7%)	1 (0.1%)					15 (17.2%)	2 (3.0%)					24 (100%)
Eastern				2 (0.2%)											
Isle of Man			3 (1.7%)	1 (0.1%)											
London			1 (0.6%)	1 (0.1%)			1 (0.5%)		1 (1.1%)						
Northern & Yorkshire		1 (4.2%)		7 (0.6%)											
South West				1 (0.1%)						1 (1.5%)					
Trent			1 (0.6%)	7 (0.6%)						2 (3.0%)		3 (4.8%)			
Wales			5 (2.8%)	5 (0.4%)					4 (4.6%)	5 (7.6%)					
West Midlands			3 (1.7%)	2 (0.2%)			1 (0.5%)		4 (4.6%)	2 (3.0%)		1 (1.6%)			
Abroad				14 (1.1%)											
Not Known			1 (0.6%)	6 (0.5%)			2 (1.0%)			1 (1.5%)					
<b>Total (100%)</b>	<b>27</b>	<b>24</b>	<b>179</b>	<b>1263</b>	<b>16</b>	<b>6</b>	<b>192</b>	<b>23</b>	<b>87</b>	<b>66</b>	<b>5</b>	<b>62</b>	<b>5</b>	<b>48</b>	<b>24</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also 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 3.16** illustrates the health authority of treatment for all HIV positive and AIDS cases presenting in the North West for treatment in 2000 in relation to their health authority of residence. Not all individuals resident in a particular district receive their treatment from within that health authority. Manchester Health Authority provides treatment for the highest number of HIV and AIDS cases in the North West. However, fewer than half (48%) of the individuals presenting for treatment are Manchester Health Authority residents. A similar situation is apparent in Stockport (34%), Liverpool (44%) and Sefton (17%).

**TABLE 3.17: DISTRIBUTION OF MERSEYSIDE AND CHESHIRE BASED TREATMENT FOR TOTAL HIV AND AIDS CASES BY HEALTH AUTHORITY OF RESIDENCE, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	MERSEYSIDE & CHESHIRE TREATMENT CENTRE												
	AHC	APH	CHR	DDU	FAZ	HAL	LEI	LEII	MAC	RLG	RLH	SPG	WAR
Liverpool	2 (28.6%)			2 (40.0%)	22 (30.1%)					70 (46.7%)	5 (29.4%)	2 (14.3%)	
Manchester			1 (2.8%)		3 (4.1%)					3 (2.0%)			
North Cheshire	1 (14.3%)		3 (8.3%)		7 (9.6%)	1 (100.0%)				8 (5.3%)	2 (11.8%)		5 (100.0%)
N. W. Lancashire					1 (1.4%)					2 (1.3%)			
Salford & Trafford										4 (2.7%)	1 (5.9%)		
Sefton				1 (20.0%)	8 (11.0%)					11 (7.3%)	2 (11.8%)	7 (50.0%)	
South Cheshire			25 (69.4%)		1 (1.4%)		5 (83.3%)	6 (100.0%)	12 (66.7%)	5 (3.3%)	1 (5.9%)		
South Lancashire					2 (2.7%)					4 (2.7%)	1 (5.9%)	5 (35.7%)	
St Helens & Knowsley					5 (6.8%)					14 (9.3%)	1 (5.9%)		
Stockport									1 (5.6%)				
Wigan & Bolton										3 (2.0%)	1 (5.9%)		
Wirral	1 (14.3%)	24 (100.0%)	2 (5.6%)	2 (40.0%)	15 (20.5%)					17 (11.3%)	1 (5.9%)		
Isle of Man										3 (2.0%)			
London					1 (1.4%)					1 (0.7%)			
South West									1 (5.6%)				
Trent									2 (11.1%)	1 (0.7%)			
Wales	1 (14.3%)		5 (13.9%)		4 (5.5%)					3 (2.0%)	1 (5.9%)		
West Midlands	2 (28.6%)				4 (5.5%)				2 (11.1%)		1 (5.9%)		
Not Known							1 (16.7%)			1 (0.7%)			
<b>Total (100%)</b>	<b>7</b>	<b>24</b>	<b>36</b>	<b>5</b>	<b>73</b>	<b>1</b>	<b>6</b>	<b>6</b>	<b>18</b>	<b>150</b>	<b>17</b>	<b>14</b>	<b>5</b>

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also 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 illustrates the residential distribution of all HIV and AIDS cases presenting to treatment centres located in Merseyside and Cheshire in 2000. The vast majority of HIV and AIDS cases presenting at treatment centres in Merseyside and Cheshire are resident within this area, however, care is also provided for individuals resident in a number of other districts across the North West, as well as further afield.

The Department of Genito-Urinary Medicine at the Royal Liverpool University Hospital (RLG) has the highest number of individuals attending for treatment, accounting for 41% of presentations in Merseyside and Cheshire. The Infectious Disease Unit at University Hospital Aintree (FAZ) provided care for the highest proportion of HIV positive individuals residing outside the health authority of its location (89%), with the Department of Haematology at The Royal Liverpool University Hospital (RLH) and Alder Hey Children's Hospital both providing the second highest proportion (71%).

**TABLE 3.18: DISTRIBUTION OF GREATER MANCHESTER AND LANCASHIRE BASED TREATMENT FOR TOTAL HIV AND AIDS CASES BY HEALTH AUTHORITY OF RESIDENCE, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	GREATER MANCHESTER & LANCASHIRE TREATMENT CENTRE																											
	BLAG	BLK	BLKG	BOLG	BURG	BURY	FGH	MGP	MRI	MRIG	MRIH	NMG	NMGG	OLDG	ORMG	PG	PP	RLI	ROCG	SALG	STP	TAMG	TRAG	WGH	WIGG	WITG		
Bury & Rochdale				3 (6.7%)		6 (100.0%)		1 (0.7%)	2 (1.9%)	1 (1.1%)	10 (20.8%)	52 (7.7%)	11 (8.8%)						16 (76.2%)	2 (9.5%)	2 (3.2%)						1 (1.3%)	
East Lancashire	1 (0.8%)	2 (66.7%)	10 (90.9%)		8 (80.0%)			1 (0.7%)		5 (5.3%)	6 (12.5%)	15 (2.2%)	1 (0.8%)			3 (5.6%)			1 (4.8%)									
Liverpool											1 (1.1%)																	
Manchester	1 (0.8%)		1 (9.1%)		1 (10.0%)			99 (71.2%)	64 (61.5%)	61 (64.2%)	1 (2.1%)	273 (40.6%)	57 (45.6%)			3 (5.6%)			1 (4.8%)		19 (30.6%)	1 (33.3%)					49 (61.3%)	
Morecombe Bay	1 (0.8%)						2 (100.0%)		1 (1.0%)			5 (10.4%)	1 (0.8%)			1 (1.9%)		9 (90.0%)			1 (1.6%)					4 (100.0%)		
North Cheshire											1 (2.1%)	8 (1.2%)															2 (2.5%)	
N. W. Lancashire	124 (93.9%)			1 (2.2%)							5 (10.4%)	24 (3.6%)	1 (0.8%)			37 (68.5%)	5 (83.3%)	1 (10.0%)										
Salford & Trafford				4 (8.9%)				36 (25.9%)	19 (18.3%)	18 (18.9%)	4 (8.3%)	112 (16.7%)	25 (20.0%)						1 (4.8%)	19 (90.5%)	7 (11.3%)		2 (100.0%)			17 (21.3%)		
Sefton				1 (2.2%)							3 (6.3%)																	
South Cheshire									2 (1.9%)	6 (12.5%)	19 (2.8%)	2 (1.6%)									3 (4.8%)					3 (3.8%)		
South Lancashire	1 (0.8%)			3 (6.7%)	1 (10.0%)						1 (2.1%)	2 (0.3%)	1 (0.8%)		5 (100.0%)	9 (16.7%)	1 (16.7%)											
St Helens & Knowsley	1 (0.8%)								1 (1.0%)			4 (0.6%)	1 (0.8%)															
Stockport								1 (0.7%)	7 (6.7%)	1 (1.1%)	3 (6.3%)	22 (3.3%)	2 (1.6%)								21 (33.9%)					2 (2.5%)		
West Pennine								1 (0.7%)	2 (1.9%)	4 (4.2%)	2 (4.2%)	73 (10.9%)	18 (14.4%)	2 (100.0%)					1 (4.8%)		3 (4.8%)	2 (66.7%)				2 (2.5%)		
Wigan & Bolton				33 (73.3%)					2 (1.9%)	1 (1.1%)	4 (8.3%)	28 (4.2%)	4 (3.2%)						1 (4.8%)		2 (3.2%)					3 (100.0%)	2 (2.5%)	
Wirral									1 (1.0%)																			
Eastern												2 (0.3%)																
Isle of Man										1 (1.1%)																		
London	1 (0.8%)												1 (0.1%)															
Northern & Yorkshire			1 (33.3%)									7 (1.0%)																
South West										1 (1.1%)																		
Trent										1 (1.1%)		4 (0.6%)									3 (4.8%)						2 (2.5%)	
Wales											2 (4.2%)	3 (0.4%)																
West Midlands	1 (0.8%)											2 (0.3%)									1 (1.6%)							
Abroad												14 (2.1%)																
Not Known	1 (0.8%)								3 (2.9%)			2 (0.3%)	1 (0.8%)				1 (1.9%)											
<b>Total (100%)</b>	<b>132</b>	<b>3</b>	<b>11</b>	<b>45</b>	<b>10</b>	<b>6</b>	<b>2</b>	<b>139</b>	<b>104</b>	<b>95</b>	<b>48</b>	<b>672</b>	<b>125</b>	<b>2</b>	<b>5</b>	<b>54</b>	<b>6</b>	<b>10</b>	<b>21</b>	<b>21</b>	<b>62</b>	<b>3</b>	<b>2</b>	<b>4</b>	<b>3</b>	<b>80</b>		

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also 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 3.18** illustrates the residential distribution of all HIV and AIDS cases presenting to treatment centres located in Greater Manchester and Lancashire in 2000. While the vast majority of HIV and AIDS cases attending treatment centres in Greater Manchester and Lancashire are resident within this area, care is also provided for individuals resident in other districts across the North West and further afield. Seventy percent of all presentations by HIV positive individuals who were resident outside the North West attended the Infectious Disease Unit at North Manchester General Hospital (NMG).

The Department of Haematology at Manchester Royal Infirmary (MRIH) provided care for the highest proportion of individuals residing outside the health authority of its location (98%), followed by Stepping Hill Hospital (STP) (65%) and NMG (59%). Several treatment centres had large increases in the number of HIV positive individuals accessing care, for example the specialist Manchester general practice (MGP) (28% increase on 1999), the Royal Preston Hospital (PG) (23%) and Withington Hospital (WITG) (38%). These increases are greater than that in the size of the HIV positive population in treatment in the North West (16%).

**Table 3.19** illustrates the clinical stage of all HIV and AIDS cases presenting for treatment in the North West during 2000, by treatment centre. The figures refer to the clinical condition of individuals when last seen in the year 2000; HIV positive individuals who died are presented in a separate category to other cases. In the North West, the treatment of HIV and AIDS cases is divided primarily between the two large infectious disease units, genitourinary medicine clinics and haematology clinics. Care is also provided by a number of other hospital units, specialist drug centres and general practices.

Forty four percent of all HIV and AIDS individuals presenting for treatment in the North West during 2000 were categorised as symptomatic, with 28% classed as AIDS (table 3.2). The largest HIV and AIDS treatment centre in the North West, the Infectious Disease Unit at North Manchester General Hospital (NMG), provides care for 41% 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 3.20** illustrates the infection route of all HIV and AIDS cases presenting for treatment in the North West in 2000, by treatment centre. There are considerable variations in the proportions of method of exposure to HIV between different treatment centres. Approximately 94% of individuals attending a specialist general practice in Manchester (MGP) had been exposed to HIV via homosexual sex compared to an overall rate of 65% of all HIV and AIDS cases within the region (table 3.3). 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 (672), representing an 8% increase on the previous year and a 55% increase on 1996. The Infectious Disease Unit at University Hospital Aintree (FAZ) reported a 43% increase on the number of individuals seen compared to 1999.

**Table 3.21** illustrates the age distribution of all HIV and AIDS cases presenting for treatment in the North West during 2000, by treatment centre. The age distribution of HIV cases remains (as in previous years) concentrated in the 30-39 age range, accounting for 46% 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 aged under 20 years.

**TABLE 3.19: DISTRIBUTION OF TREATMENT FOR TOTAL HIV AND AIDS CASES BY STAGE OF HIV DISEASE, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

TREATMENT CENTRE	STAGE OF HIV DISEASE					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
AHC	2 (28.6%)	2 (28.6%)	3 (42.9%)			7
APH	8 (33.3%)	4 (16.7%)	12 (50.0%)			24
BLAG	32 (24.2%)	62 (47.0%)	35 (26.5%)	3 (2.3%)		132
BLK		2 (66.7%)	1 (33.3%)			3
BLKG	5 (45.5%)	6 (54.5%)				11
BOLG	10 (22.2%)	15 (33.3%)	17 (37.8%)	3 (6.7%)		45
BURG	1 (10.0%)	4 (40.0%)	4 (40.0%)		1 (10.0%)	10
BURY		2 (33.3%)	4 (66.7%)			6
CHR	27 (75.0%)	6 (16.7%)	3 (8.3%)			36
DDU	1 (20.0%)	3 (60.0%)	1 (20.0%)			5
FAZ	20 (27.4%)	21 (28.8%)	29 (39.7%)	3 (4.1%)		73
FGH			2 (100.0%)			2
HAL		1 (100.0%)				1
LEI	3 (50.0%)		3 (50.0%)			6
LEII	1 (16.7%)		4 (66.7%)	1 (16.7%)		6
MAC	12 (66.7%)	3 (16.7%)	2 (11.1%)	1 (5.6%)		18
MGP	32 (23.0%)	72 (51.8%)	31 (22.3%)		4 (2.9%)	139
MRI	30 (28.8%)	41 (39.4%)	33 (31.7%)			104
MRIG	49 (51.6%)	34 (35.8%)	12 (12.6%)			95
MRIH	6 (12.5%)	29 (60.4%)	11 (22.9%)	2 (4.2%)		48
NMG	104 (15.5%)	328 (48.8%)	225 (33.5%)	15 (2.2%)		672
NMGG	17 (13.6%)	68 (54.4%)	40 (32.0%)			125
OLDG			2 (100.0%)			2
ORMG	2 (40.0%)		3 (60.0%)			5
PG	14 (25.9%)	25 (46.3%)	15 (27.8%)			54
PP	3 (50.0%)	2 (33.3%)	1 (16.7%)			6
RLG	32 (21.3%)	72 (48.0%)	44 (29.3%)	1 (0.7%)	1 (0.7%)	150
RLH	7 (41.2%)	6 (35.3%)	3 (17.6%)	1 (5.9%)		17
RLI	5 (50.0%)	2 (20.0%)	2 (20.0%)	1 (10.0%)		10
ROCG	1 (4.8%)	15 (71.4%)	5 (23.8%)			21
SALG	6 (28.6%)	11 (52.4%)	4 (19.0%)			21
SPG	4 (28.6%)	4 (28.6%)	6 (42.9%)			14
STP	17 (27.4%)	22 (35.5%)	23 (37.1%)			62
TAMG	2 (66.7%)	1 (33.3%)				3
TRAG	1 (50.0%)	1 (50.0%)				2
WAR	3 (60.0%)	2 (40.0%)				5
WGH	1 (25.0%)	1 (25.0%)	2 (50.0%)			4
WIGG	1 (33.3%)	1 (33.3%)	1 (33.3%)			3
WITG	28 (35.0%)	30 (37.5%)	20 (25.0%)	2 (2.5%)		80

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 INFECTION ROUTE OF HIV, JANUARY-DECEMBER 2000**

(All cases seen during 2000 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	Undetermined	
AHC				2 (28.6%)	5 (71.4%)		7
APH	14 (58.3%)	1 (4.2%)	8 (33.3%)	1 (4.2%)			24
BLAG	113 (85.6%)	3 (2.3%)	11 (8.3%)	4 (3.0%)		1 (0.8%)	132
BLK	3 (100.0%)						3
BLKG	6 (54.5%)		5 (45.5%)				11
BOLG	29 (64.4%)	1 (2.2%)	14 (31.1%)			1 (2.2%)	45
BURG	3 (30.0%)	1 (10.0%)	5 (50.0%)			1 (10.0%)	10
BURY	2 (33.3%)	1 (16.7%)	3 (50.0%)				6
CHR	25 (69.4%)		11 (30.6%)				36
DDU		4 (80.0%)	1 (20.0%)				5
FAZ	34 (46.6%)	7 (9.6%)	28 (38.4%)	2 (2.7%)		2 (2.7%)	73
FGH	1 (50.0%)	1 (50.0%)					2
HAL	1 (100.0%)						1
LEI	5 (83.3%)					1 (16.7%)	6
LEII	6 (100.0%)						6
MAC	11 (61.1%)	1 (5.6%)	5 (27.8%)	1 (5.6%)			18
MGP	131 (94.2%)	2 (1.4%)	5 (3.6%)			1 (0.7%)	139
MRI	90 (86.5%)	2 (1.9%)	11 (10.6%)	1 (1.0%)			104
MRIG	82 (86.3%)	2 (2.1%)	11 (11.6%)				95
MRIH			3 (6.3%)	45 (93.8%)			48
NMG	442 (65.8%)	48 (7.1%)	115 (17.1%)	6 (0.9%)	11 (1.6%)	50 (7.4%)	672
NMGG	98 (78.4%)	5 (4.0%)	18 (14.4%)			4 (3.2%)	125
OLDG	1 (50.0%)		1 (50.0%)				2
ORMG	1 (20.0%)		4 (80.0%)				5
PG	23 (42.6%)	1 (1.9%)	26 (48.1%)		3 (5.6%)	1 (1.9%)	54
PP					6 (100.0%)		6
RLG	72 (48.0%)	12 (8.0%)	54 (36.0%)	6 (4.0%)		6 (4.0%)	150
RLH			1 (5.9%)	16 (94.1%)			17
RLI	6 (60.0%)	2 (20.0%)	2 (20.0%)				10
ROCG	16 (76.2%)	2 (9.5%)	3 (14.3%)				21
SALG	19 (90.5%)		2 (9.5%)				21
SPG	7 (50.0%)		6 (42.9%)			1 (7.1%)	14
STP	44 (71.0%)	2 (3.2%)	15 (24.2%)	1 (1.6%)			62
TAMG	3 (100.0%)						3
TRAG	1 (50.0%)		1 (50.0%)				2
WAR	3 (60.0%)		2 (40.0%)				5
WGH	2 (50.0%)	1 (25.0%)	1 (25.0%)				4
WIGG	1 (33.3%)		2 (66.7%)				3
WITG	65 (81.3%)	6 (7.5%)	9 (11.3%)				80

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 3.21: DISTRIBUTION OF TREATMENT FOR TOTAL HIV AND AIDS CASES BY AGE CATEGORY, JANUARY-DECEMBER 2000

(All cases seen during 2000 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	5 (7.4%)	2 (28.6%)										7
APH		1 (4.2%)	1 (4.2%)		8 (33.3%)	3 (12.5%)	1 (4.2%)	2 (8.3%)	4 (16.7%)	2 (8.3%)	2 (8.3%)	24
BLAG		1 (0.8%)	6 (4.5%)	13 (9.8%)	31 (23.5%)	30 (22.7%)	22 (16.7%)	14 (10.6%)	4 (3.0%)	6 (4.5%)	5 (3.8%)	132
BLK					1 (33.3%)			1 (33.3%)			1 (33.3%)	3
BLKG			2 (18.2%)		1 (9.1%)	2 (18.2%)	2 (18.2%)	1 (9.1%)	2 (18.2%)	1 (9.1%)		11
BOLG		2 (4.4%)	4 (8.9%)	6 (13.3%)	6 (13.3%)	12 (26.7%)	5 (11.1%)	8 (17.8%)	2 (4.4%)	2 (4.4%)	4 (8.9%)	45
BURG				1 (10.0%)	2 (20.0%)	2 (20.0%)	2 (20.0%)	2 (20.0%)		1 (10.0%)		10
BURY					2 (33.3%)	1 (16.7%)	1 (16.7%)		2 (33.3%)			6
CHR			4 (11.1%)	6 (16.7%)	8 (22.2%)	13 (36.1%)		3 (8.3%)	2 (5.6%)			36
DDU					1 (20.0%)	2 (40.0%)	1 (20.0%)		1 (20.0%)			5
FAZ		1 (1.4%)	1 (1.4%)	6 (8.2%)	13 (17.8%)	23 (31.5%)	12 (16.4%)	8 (11.0%)	4 (5.5%)		5 (6.8%)	73
FGH					1 (50.0%)	1 (50.0%)						2
HAL							1 (100%)					1
LEI			1 (16.7%)	1 (16.7%)	1 (16.7%)			2 (33.3%)			1 (16.7%)	6
LEIH				1 (16.7%)	3 (50.0%)		1 (16.7%)	1 (16.7%)				6
MAC				3 (16.7%)	9 (50.0%)	3 (16.7%)		1 (5.6%)	2 (11.1%)			18
MGP			4 (2.9%)	22 (15.8%)	34 (24.5%)	40 (28.8%)	22 (15.8%)	10 (7.2%)	5 (3.6%)		2 (1.4%)	139
MRI			3 (2.9%)	13 (12.5%)	26 (25.0%)	32 (30.8%)	16 (15.4%)	6 (5.8%)	5 (4.8%)	1 (1.0%)	2 (1.9%)	104
MIRIG			12 (12.6%)	20 (21.1%)	27 (28.4%)	21 (22.1%)	6 (6.3%)	6 (6.3%)	2 (2.1%)	1 (1.1%)		95
MRIH			2 (4.2%)	9 (18.8%)	8 (16.7%)	10 (20.8%)	9 (18.8%)	6 (12.5%)	4 (8.3%)			48
NMG	10 (1.5%)	1 (0.1%)	24 (3.6%)	71 (10.6%)	129 (19.2%)	186 (27.7%)	132 (19.6%)	62 (9.2%)	24 (3.6%)	18 (2.7%)	15 (2.2%)	672
NMGG			6 (4.8%)	20 (16.0%)	32 (25.6%)	34 (27.2%)	14 (11.2%)	16 (12.8%)	2 (1.6%)	1 (0.8%)		125
OLDG							1 (50.0%)		1 (50.0%)			2
ORMG					3 (60.0%)	1 (20.0%)					1 (20.0%)	5
PG	3 (5.6%)		1 (1.9%)	6 (11.1%)	9 (16.7%)	13 (24.1%)	9 (16.7%)	5 (9.3%)	4 (7.4%)	2 (3.7%)	2 (3.7%)	54
PP	6 (100%)											6
RLG		1 (0.7%)	5 (3.3%)	15 (10.0%)	37 (24.7%)	39 (26.0%)	21 (14.0%)	11 (7.3%)	11 (7.3%)	7 (4.7%)	3 (2.0%)	150
RLH		3 (17.6%)		3 (17.6%)	3 (17.6%)	4 (23.5%)	1 (5.9%)	2 (11.8%)	1 (5.9%)			17
RLI				1 (10.0%)	1 (10.0%)	3 (30.0%)		2 (20.0%)	1 (10.0%)	2 (20.0%)		10
ROCG			1 (4.8%)	6 (28.6%)	6 (28.6%)	3 (14.3%)	1 (4.8%)	3 (14.3%)	1 (4.8%)			21
SALG			1 (4.8%)	2 (9.5%)	6 (28.6%)	9 (42.9%)		1 (4.8%)	1 (4.8%)		1 (4.8%)	21
SPG				1 (7.1%)	5 (35.7%)	3 (21.4%)	2 (14.3%)	2 (14.3%)	1 (7.1%)			14
STP		3 (4.8%)	10 (16.1%)	10 (16.1%)	8 (12.9%)	13 (21.0%)	11 (17.7%)	9 (14.5%)	5 (8.1%)	2 (3.2%)	1 (1.6%)	62
TAMG					2 (66.7%)	1 (33.3%)						3
TRAG			1 (50.0%)				1 (50.0%)					2
WAR					2 (40.0%)	2 (40.0%)		1 (20.0%)				5
WGH					1 (25.0%)	1 (25.0%)		1 (25.0%)	1 (25.0%)			4
WIGG					1 (33.3%)	1 (33.3%)			1 (33.3%)			3
WITG			2 (2.5%)	13 (16.3%)	17 (21.3%)	17 (21.3%)	11 (13.8%)	9 (11.3%)	6 (7.5%)	3 (3.8%)	2 (2.5%)	80

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 3.22: DISTRIBUTION OF TREATMENT FOR TOTAL HIV AND AIDS CASES BY SEX, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

TREATMENT CENTRE	SEX		Total (100%)
	Male	Female	
AHC	4 (57.1%)	3 (42.9%)	7
APH	22 (91.7%)	2 (8.3%)	24
BLAG	127 (96.2%)	5 (3.8%)	132
BLK	3 (100.0%)		3
BLKG	9 (81.8%)	2 (18.2%)	11
BOLG	35 (77.8%)	10 (22.2%)	45
BURG	8 (80.0%)	2 (20.0%)	10
BURY	4 (66.7%)	2 (33.3%)	6
CHR	31 (86.1%)	5 (13.9%)	36
DDU	2 (40.0%)	3 (60.0%)	5
FAZ	54 (74.0%)	19 (26.0%)	73
FGH	1 (50.0%)	1 (50.0%)	2
HAL	1 (100.0%)		1
LEI	6 (100.0%)		6
LEII	6 (100.0%)		6
MAC	17 (94.4%)	1 (5.6%)	18
MGP	136 (97.8%)	3 (2.2%)	139
MRI	96 (92.3%)	8 (7.7%)	104
MRIG	87 (91.6%)	8 (8.4%)	95
MRIH	42 (87.5%)	6 (12.5%)	48
NMG	593 (88.2%)	79 (11.8%)	672
NMGG	111 (88.8%)	14 (11.2%)	125
OLDG	2 (100.0%)		2
ORMG	4 (80.0%)	1 (20.0%)	5
PG	39 (72.2%)	15 (27.8%)	54
PP	2 (33.3%)	4 (66.7%)	6
RLG	117 (78.0%)	33 (22.0%)	150
RLH	16 (94.1%)	1 (5.9%)	17
RLI	10 (100.0%)		10
ROCG	18 (85.7%)	3 (14.3%)	21
SALG	20 (95.2%)	1 (4.8%)	21
SPG	12 (85.7%)	2 (14.3%)	14
STP	53 (85.5%)	9 (14.5%)	62
TAMG	3 (100.0%)		3
TRAG	2 (100.0%)		2
WAR	4 (80.0%)	1 (20.0%)	5
WGH	3 (75.0%)	1 (25.0%)	4
WIGG	2 (66.7%)	1 (33.3%)	3
WITG	76 (95.0%)	4 (5.0%)	80

**Table 3.22** illustrates the number of male and female HIV and AIDS cases presenting for treatment in the North West in 2000, by treatment centre. The vast majority of all HIV and AIDS cases treated in the North West were male (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 94% of cases (table 3.20) and 98% of individuals were male. Exceptions to this 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).

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 3.23: RESIDENTIAL DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY NUMBER OF TREATMENT CENTRES ATTENDED, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	TREATMENT CENTRES ATTENDED				Total (100%)
	One	Two	Three	Four	
Bury & Rochdale	59 (71.1%)	24 (28.9%)			83
East Lancashire	47 (94.0%)	3 (6.0%)			50
Liverpool	82 (89.1%)	8 (8.7%)	2 (2.2%)		92
Manchester	289 (64.8%)	125 (28.0%)	29 (6.5%)	3 (0.7%)	446
Morecambe Bay	20 (90.9%)	1 (4.5%)	1 (4.5%)		22
North Cheshire	26 (81.3%)	6 (18.8%)			32
N. W. Lancashire	174 (93.0%)	12 (6.4%)	1 (0.5%)		187
Salford & Trafford	136 (70.1%)	41 (21.1%)	17 (8.8%)		194
Sefton	27 (90.0%)	3 (10.0%)			30
South Cheshire	70 (87.5%)	10 (12.5%)			80
South Lancashire	23 (79.3%)	5 (17.2%)	1 (3.4%)		29
St Helens & Knowsley	27 (100.0%)				27
Stockport	40 (80.0%)	10 (20.0%)			50
West Pennine	72 (80.0%)	16 (17.8%)	2 (2.2%)		90
Wigan & Bolton	68 (89.5%)	8 (10.5%)			76
Wirral	56 (94.9%)	2 (3.4%)	1 (1.7%)		59
Eastern	2 (100.0%)				2
Isle of Man	4 (100.0%)				4
London	4 (100.0%)				4
Northern & Yorkshire	8 (100.0%)				8
South West	2 (100.0%)				2
Trent	11 (91.7%)	1 (8.3%)			12
Wales	15 (88.2%)	2 (11.8%)			17
West Midlands	11 (91.7%)	1 (8.3%)			12
Abroad	14 (100.0%)				14
Not Known	10 (100%)				10
<b>Total</b>	<b>1297 (79.5%)</b>	<b>278 (17.0%)</b>	<b>54 (3.3%)</b>	<b>3 (0.2%)</b>	<b>1632</b>

Individuals resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'. The Isle of Man is also organised as a distinct category.

**Table 3.23** illustrates the residential distribution of all HIV and AIDS cases presenting in the North West for treatment in 2000 by the number of statutory treatment centres attended. The majority (80%) attended only one treatment centre, a comparable proportion to 1999. However, there was considerable variation across health authorities, with residents of Manchester being more likely to have attended more than one treatment centre (35%). It should be noted that these numbers refer only to treatment centres within the North West.

**TABLE 3.24: OVERLAP OF TOTAL HIV AND AIDS BETWEEN DIFFERENT CENTRES OF TREATMENT, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

	AHC	APH	BLAG	BLK	BLKG	BOLG	BURG	BURY	CHR	DDU	FAZ	FGH	HAL	LEI	LEII	MAC	MGP	MRI	MRIG	MRIH	
AHC	<b>5</b>										1										
APH		<b>24</b>																			
BLAG			<b>124</b>								1						1				
BLK				<b>3</b>																	
BLKG					<b>11</b>																
BOLG						<b>41</b>															
BURG							<b>7</b>														
BURY								<b>0</b>													
CHR									<b>31</b>		1							1	1		
DDU										<b>0</b>	4										
FAZ											<b>58</b>		1				1				
FGH												<b>2</b>									
HAL													<b>1</b>								
LEI														<b>5</b>							
LEII															<b>3</b>						
MAC																<b>16</b>					
MGP																	<b>23</b>				
MRI																		<b>19</b>	12		
MRIG																			<b>8</b>	1	
MRIH																				<b>66</b>	
																					<b>42</b>

The diagonal (in bold) represents the number of individuals who solely used each treatment centre in 2000. For the number of individuals attending each combination of statutory treatment centres, consult both the rows and the columns. 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 3.24 illustrates the overlap of treatment of HIV and AIDS cases between treatment centres in the North West during 2000. The diagonal (in bold) represents the number of individuals who used each treatment centre as their sole provider of care during 2000, and the right hand column shows the total numbers accessing each treatment centre. For example, although 672 individuals accessed care from North Manchester General Infectious Disease Unit (NMG), only 64% (429) used NMG as their sole provider of care. North Manchester General patients also attended Manchester Royal Infirmary Outpatient Department (MRI, 27 individuals) and a specialist general practice in Manchester (MGP, 83 individuals). 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 2000.

	NMG	NMGG	OLDG	ORMG	PG	PP	RLG	RLH	RLI	ROCG	SALG	SPG	STP	TAMG	TRAG	WAR	WGH	WIGG	WITG	TOTAL
								2												7
																				24
	5				2		1						1							132
																				3
	1												2							11
	3																			45
	5									1										10
	1																			6
																1				36
																				5
	1			1			3	1				2								75
																				2
																				1
																				6
	2																			6
	2																			18
	83	23					1			1	1		5	1						8
	27	3											1							1
	9	1			1		3						2							1
	4												1							48
NMG	429	91	2		3		2		1	2	6		21	1	1	1				21
NMGG	25									2			5	2					2	2
OLDG		2																		2
ORMG			2									4								5
PG				1									1							54
PP					44	3			1											6
RLG						3														150
RLH							131	5												17
RLI								10												10
ROCG									8											21
SALG										14										21
SPG											14									14
STP												9								62
TAMG													34							3
TRAG														1						2
WAR															1					5
WGH																1				4
WIGG																	4			3
WITG																		1		80
																			50	

**TABLE 3.25: DISTRIBUTION OF TOTAL AND MEAN NUMBER OF OUTPATIENT VISITS, DAY CASES, INPATIENT EPISODES AND INPATIENT DAYS BY TREATMENT CENTRE, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

	OUTPATIENT VISITS		DAY CASES		INPATIENT EPISODES		INPATIENT DAYS	
	Total	Mean	Total	Mean	Total	Mean	Total	Mean
AHC	70	10.0	2	0.3	11	1.6	267	38.1
APH	501	20.9	99	4.1	14	0.6	88	3.7
BLAG	901	6.8	5	0.0	21	0.2	326	2.5
BLK	20	6.7	0	0.0	0	0.0	0	0.0
BLKG	78	7.1	0	0.0	3	0.3	45	4.1
BOLG	476	10.6	0	0.0	3	0.1	37	0.8
BURG	109	10.9	0	0.0	3	0.3	35	3.5
BURY	4	0.7	0	0.0	4	0.7	49	8.2
CHR	255	7.1	0	0.0	3	0.1	24	0.7
DDU	46	9.2	0	0.0	0	0.0	0	0.0
FAZ	451	6.2	5	0.1	63	0.9	676	9.3
FGH	6	3.0	0	0.0	2	1.0	4	2.0
HAL	12	12.0	0	0.0	0	0.0	0	0.0
LEI	99	16.5	2	0.3	0	0.0	0	0.0
LEII	28	4.7	18	3.0	0	0.0	0	0.0
MAC	195	10.8	0	0.0	1	0.1	7	0.4
MGP	806	5.8	0	0.0	0	0.0	0	0.0
MRI	990	9.5	1	0.0	4	0.0	24	0.2
MRIG	780	8.2	1	0.0	0	0.0	0	0.0
MRIH	367	7.6	2	0.0	20	0.4	290	6.0
NMG	5193	7.7	257	0.4	332	0.5	2702	4.0
NMGG	130	1.0	3	0.0	2	0.0	4	0.0
OLDG	1	0.5	0	0.0	1	0.5	21	10.5
ORMG	33	6.6	1	0.2	3	0.6	15	3.0
PG	413	7.6	5	0.1	11	0.2	492	9.1
PP	18	3.0	0	0.0	0	0.0	0	0.0
RLG	1780	11.9	3	0.0	61	0.4	623	4.2
RLH	107	6.3	21	1.2	13	0.8	231	13.6
RLI	37	3.7	0	0.0	6	0.6	110	11.0
ROCG	246	11.7	0	0.0	0	0.0	0	0.0
SALG	86	4.1	0	0.0	1	0.0	6	0.3
SPG	182	13.0	0	0.0	3	0.2	14	1.0
STP	304	4.9	10	0.2	7	0.1	20	0.3
TAMG	4	1.3	0	0.0	0	0.0	0	0.0
TRAG	26	13.0	0	0.0	0	0.0	0	0.0
WAR	12	2.4	0	0.0	0	0.0	0	0.0
WGH	18	4.5	0	0.0	0	0.0	0	0.0
WIGG	8	2.7	0	0.0	1	0.3	10	3.3
WITG	712	8.9	1	0.0	4	0.1	45	0.6
<b>Total</b>	<b>15504</b>	<b>7.6</b>	<b>436</b>	<b>0.2</b>	<b>597</b>	<b>0.3</b>	<b>6165</b>	<b>3.0</b>

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 divided by the total number of HIV positive individuals accessing the treatment centre.

**Table 3.25** displays the amount of outpatient days, day cases, inpatient days and inpatient episodes attributed to HIV and AIDS cases attending statutory treatment centres during 2000. The data are displayed as the total number of days or episodes and the mean number of days or episodes per HIV positive individual treated at that centre. This is the second year that this level of information on treatment and care for the whole of the North West Region has been collected, allowing comparisons to be made with the data from 1999.

As was the case in 1999, in the year 2000 North Manchester General Infectious Disease Unit (NMG) provided the highest number of outpatient visits, day cases, inpatient episodes and inpatient days. Outpatient visits at NMG accounted for 33% 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. The Department of Genito-Urinary Medicine at Arrowe Park Hospital (APH) provided the highest mean number of outpatient visits per HIV positive patient (20.9 visits), over twice the overall average (7.6 visits per patient).

North Manchester General Infectious Disease Unit (NMG) also provided the highest number of inpatient episodes (56% of the total) and inpatient days (44% of the total), with the Infectious Disease Unit at University Hospital Aintree (FAZ) and the Department of Genito-Urinary Medicine at the Royal Liverpool University Hospital (RLG) providing the next highest numbers of inpatient episodes (11% and 10% of the total respectively) and days (11% and 10%).

### TABLE 3.26: DISTRIBUTION OF TOTAL AND MEAN NUMBER OF OUTPATIENT EPISODES, DAY CASES, INPATIENT EPISODES AND INPATIENT DAYS BY STAGE OF HIV DISEASE, JANUARY-DECEMBER 2000

(All cases seen during 2000 including those who died during the year)

STAGE OF HIV DISEASE	OUTPATIENT VISITS		DAY CASES		INPATIENT EPISODES		INPATIENT DAYS	
	Total	Mean	Total	Mean	Total	Mean	Total	Mean
Asymptomatic	3104	7.0	52	0.1	36	0.1	212	0.5
Symptomatic	6849	9.6	147	0.2	196	0.3	1629	2.3
AIDS	5381	11.8	235	0.5	319	0.7	3587	7.8
AIDS Related Death	141	4.7	2	0.1	46	1.5	737	24.6
Unknown	29	4.8	0	0.0	0	0.0	0	0.0
<b>Total</b>	<b>15504</b>	<b>9.5</b>	<b>436</b>	<b>0.3</b>	<b>597</b>	<b>0.4</b>	<b>6165</b>	<b>3.8</b>

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

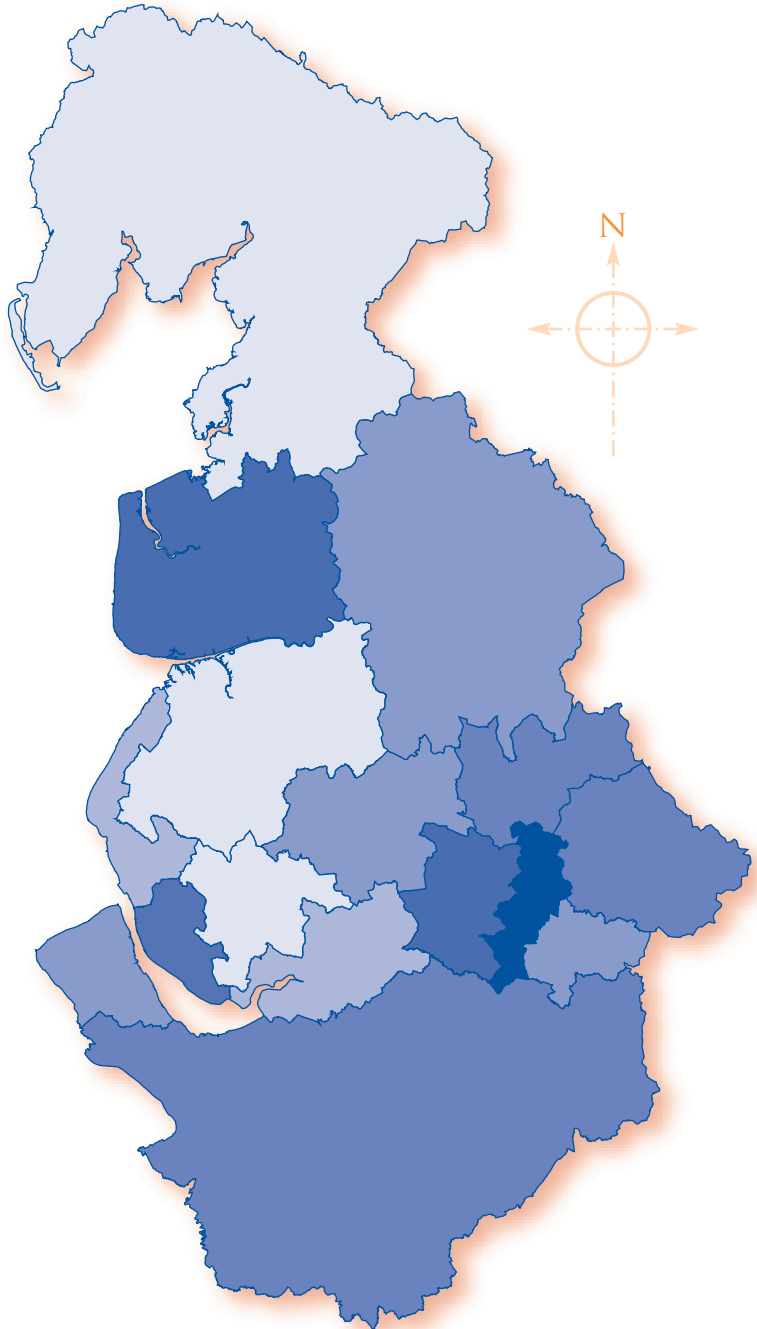
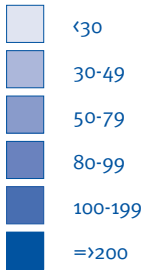
**Table 3.26** illustrates the distribution of patient care by clinical stage for all those HIV positive individuals accessing treatment and care in the North West in 2000. The data show the increasing level and different type of care required as HIV disease progresses. While asymptomatic individuals required on average 7.0 outpatient visits per patient, 9.6 visits were required per symptomatic patient rising to 11.8 visits for each patient with an AIDS diagnosis. Those who died during the year had an average of only 4.7 outpatient visits during 2000 but required by far the largest amount of inpatient care, at an average of 24.6 days each. In contrast, asymptomatic, symptomatic and AIDS patients required only 0.5, 2.3 and 7.8 days of inpatient care respectively. Levels of care were similar in 2000 compared to 1999, with the overall mean number of outpatient visits dropping slightly (from 10.4 to 9.5 visits per HIV positive individual) and the number of inpatient days increasing slightly from 3.5 to 3.8 days per patient.

### FIGURE 3.5: RESIDENTIAL DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY HEALTH AUTHORITY, JANUARY-DECEMBER 2000

(All cases seen during 2000 including those who died during the year)

Figure 3.5 illustrates the residential distribution of all HIV and AIDS cases in the North West who attended statutory centres within the region during 2000. For a description of the residential distribution of all HIV and AIDS cases in the North West of England see tables 3.2 to 3.4.

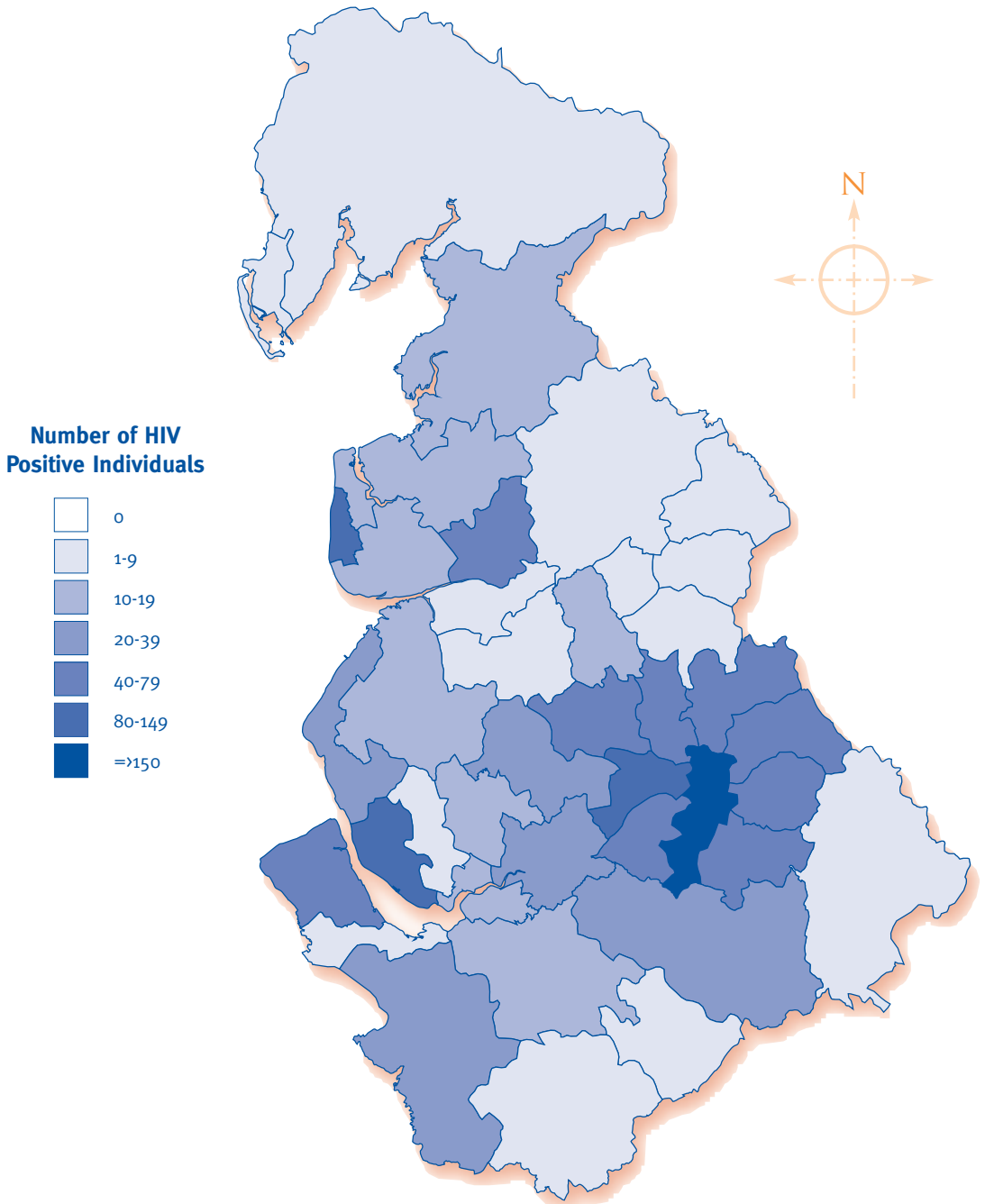
#### Number of HIV Positive Individuals





### FIGURE 3.7: RESIDENTIAL DISTRIBUTION OF TOTAL HIV AND AIDS CASES BY LOCAL AUTHORITY, JANUARY-DECEMBER 2000

(All cases seen during 2000 including those who died during the year)



LOCAL AUTHORITY OF RESIDENCE	NUMBER OF HIV POSITIVE INDIVIDUALS	
	Reported	Adjusted
Barrow-in-Furness	4	4
Blackburn	13	15
Blackpool	113	114
Bolton	51	51
Burnley	6	8
Bury	40	40
Chester	23	23
Chorley	9	9
Congleton	4	4
Crewe & Nantwich	9	9
Ellesmere Port & Neston	7	8
Fylde	13	14
Halton	10	10
High Peak	3	3
Hyndburn	4	5
Knowsley	8	8
Lancaster	10	10
Liverpool	92	92
Macclesfield	21	22
Manchester	446	446
Oldham	41	41
Pendle	7	9
Preston	44	46
Ribble Valley	5	6
Rochdale	43	43
Rossendale	5	7
Salford	128	128
Sefton	30	30
South Lakeland	8	8
South Ribble	8	8
St Helens	19	19
Stockport	50	50
Tameside	46	46
Trafford	66	66
Vale Royal	13	14
Warrington	12	22
West Lancashire	12	12
Wigan	25	25
Wirral	59	59
Wyre	12	13
LA Not Reported	19	
<b>Total</b>	<b>1547</b>	<b>1547</b>

Figure 3.7 illustrates the distribution of all HIV and AIDS cases in the North West who attended statutory centres within the region during 2000, by local authority of residence. Local authority of residence is available for 99% of the 1547 cases residing within North West ('reported figures'). The remaining 19 new cases have been distributed on a population basis within the health authority of residence ('adjusted figures'). Manchester Local Authority accounted for the highest number of HIV and AIDS cases, representing over a quarter (29%) of all HIV and AIDS cases residing within the North West. Other local authorities within Greater Manchester such as Salford (128), Trafford (66) and Bolton (51) were also reported to have relatively high numbers of HIV positive residents, as did Blackpool (113), Liverpool (92) and Wirral (59).





## 4. VOLUNTARY AGENCIES 2000

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Voluntary organisations have long played a fundamental role in the recognition of HIV/AIDS and in addressing the needs of HIV positive individuals<sup>20,109</sup>. In the North West Region, voluntary agencies continue to provide a wide range of services to HIV positive individuals and their families. Recent research into the economics of HIV in the North West of England has established that seven voluntary agencies annually contribute a million pounds worth of services over and above those purchased by the statutory sector<sup>54</sup>. During 2000, 1,004 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by seven voluntary organisations in the North West.

Voluntary agencies have contributed data to the North West HIV/AIDS Monitoring Unit since 1995, and have consistently been shown to have provided services to a broader constituency than the statutory sector alone<sup>3,6</sup>. The year 2000 was no exception, and 20% of individuals seen by voluntary organisations did not access care in the statutory sector, and 11% have never been known to the statutory sector.

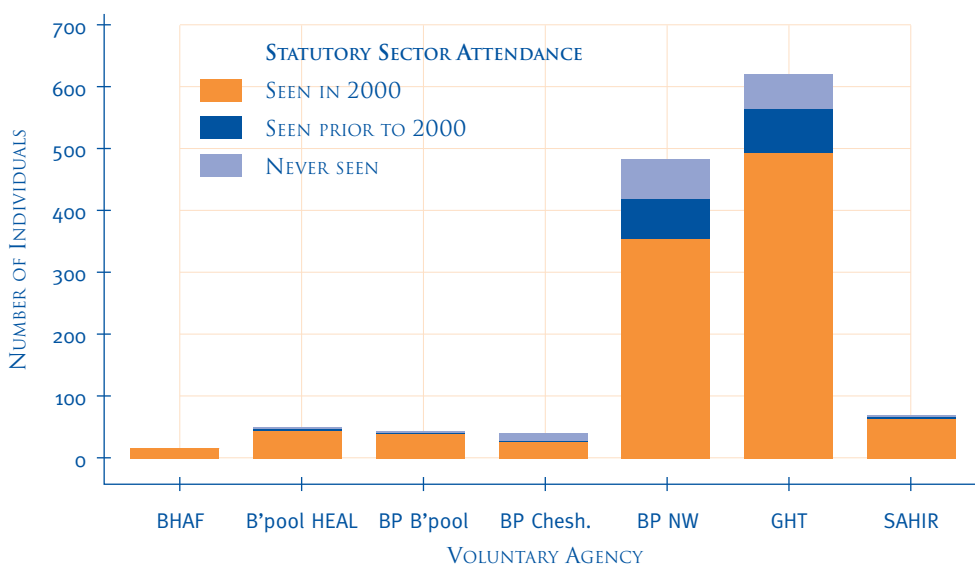
In recent years the context within which voluntary agencies in the UK operate has begun to change. Outside the region this has manifested itself in the closure of Body Positive in London, and the merger between Terrance Higgins Trust and London Lighthouse during 2000, reflecting a trend towards retrenchment in the voluntary sector in the face of cuts in Central Government spending<sup>20,54</sup>. Locally, Body Positive Cheshire was formed out of four organisations in January 1998 (Warrington Aidsline, Crewe and District AIDS relief, East Cheshire HIV Organisation and Cheshire and North Wales Body Positive). On Merseyside, Mersey Body Positive and Merseyside AIDS Support Group formally merged in 1999 to form Sahir House in Liverpool.

In Manchester during 2000, Healthy Gay Manchester combined with the Manchester Gay and Lesbian Switchboard to form the Lesbian and Gay Foundation. The changing framework within which voluntary organisations operate was the subject of a national conference held in Manchester in 2000<sup>10</sup>. Recently, a Greater Manchester HIV Investment Strategy Co-ordinator has been appointed to ensure a more coherent approach to HIV service provision. The provision of statutory services on a voluntary agency's premises, such as the co-operation between George House Trust and staff from Stockport GUM, marks a new departure in the provision of services and may be seen as a model for future work.

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 Signposts 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. 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<sup>3,6</sup>.

**FIGURE 4.1: THE PROPORTION OF HIV AND AIDS CASES PRESENTING TO VOLUNTARY ORGANISATIONS AND THE STATUTORY SECTOR IN THE NORTH WEST, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)



STATUTORY SECTOR ATTENDANCE	VOLUNTARY AGENCY						
	BHAF	B'pool HEAL	BP B'pool	BP Chesh.	BP NW	GHT	SAHIR
Seen in 2000	16 (94.1%)	70 (94.6%)	31 (91.2%)	33 (70.2%)	358 (76.8%)	550 (88.0%)	75 (90.4%)
Seen prior to 2000		3 (4.1%)	2 (5.9%)	3 (6.4%)	47 (10.1%)	42 (6.7%)	2 (2.4%)
Never seen	1 (5.9%)	1 (1.4%)	1 (2.9%)	11 (23.4%)	61 (13.1%)	33 (5.3%)	6 (7.2%)
<b>Total (100%)</b>	<b>17</b>	<b>74</b>	<b>34</b>	<b>47</b>	<b>466</b>	<b>625</b>	<b>83</b>

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.

**Figure 4.1** illustrates the proportion of HIV positive individuals presenting to voluntary agencies in the North West during 2000, who had and had not presented at statutory agencies in the North West, either during 2000 or prior to 2000. Three out of the seven agencies recorded an increase in their client base during 2000 compared with 1999 figures: Blackpool HEAL increased by 40%, Body Positive Cheshire by 9% and Sahir House by 9%. Four organisations have slightly reduced numbers compared with 2000: BHAF decreased by 6%, Body Positive Blackpool by 28%, Body Positive North West by 10% and George House Trust by 6%. The overall number of individuals seen by the voluntary sector in 2000 is slightly lower than in 1999 (1,004 compared with 1,012).

There is variation in the proportion of voluntary sector clients also seen within the statutory sector in 2000, ranging from 70% at Body Positive Cheshire to 95% at Blackpool HEAL. The low level of North West statutory sector contact with Body Positive Cheshire clients may be explained by the geographical location of the organisation. The majority of Body Positive Cheshire clients not in contact with the North West statutory sector during 2000 were reported to reside in Wales (73%). However, the situation is different at other voluntary agencies, where the vast majority of clients not in contact with statutory treatment centres in 2000 (or at any time since this level of monitoring began in 1995), reside in the North West of England (93% for Body Positive North West, 88% for George House Trust and 100% for the remaining agencies). A significant number of individuals have never been seen at statutory centres: up to 13% (61 individuals) at Body Positive North West. 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.

**TABLE 4.1: DISTRIBUTION OF VOLUNTARY SECTOR CARE FOR HIV AND AIDS CASES BY INFECTION ROUTE OF HIV AND SEX, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

INFECTION ROUTE	VOLUNTARY AGENCY						
	BHAF	B'pool HEAL	BP B'pool	BP Chesh.	BP NW	GHT	SAHIR
Homo/Bisexual		62 (83.8%)	32 (94.1%)	35 (74.5%)	338 (72.5%)	459 (73.4%)	38 (45.8%)
Injecting Drug User		2 (2.7%)	1 (2.9%)	2 (4.3%)	22 (4.7%)	48 (7.7%)	3 (3.6%)
Heterosexual	16 (94.1%)	7 (9.5%)	1 (2.9%)	9 (19.1%)	26 (5.6%)	97 (15.5%)	30 (36.1%)
Blood/Tissue					6 (1.3%)	11 (1.8%)	4 (4.8%)
Mother to Child	1 (5.9%)	3 (4.1%)		1 (2.1%)	1 (0.2%)	9 (1.4%)	1 (1.2%)
Undetermined					73 (15.7%)	1 (0.2%)	7 (8.4%)
<b>SEX</b>							
Male	7 (41.2%)	66 (89.2%)	33 (97.1%)	42 (89.4%)	428 (91.8%)	541 (86.6%)	61 (73.5%)
Female	10 (58.8%)	8 (10.8%)	1 (2.9%)	5 (10.6%)	38 (8.2%)	84 (13.4%)	22 (26.5%)
<b>Total (100%)</b>	<b>17</b>	<b>74</b>	<b>34</b>	<b>47</b>	<b>466</b>	<b>625</b>	<b>83</b>

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.

**Table 4.1** categorises individuals accessing voluntary care in 2000 according to infection route and sex. Apart from those attending BHAF and Sahir House, the majority of individuals presenting to voluntary agencies were exposed to infection by homosexual sex, ranging from 73% at Body Positive North West to 94% at Body Positive Blackpool. None of BHAF's clientele were infected by homosexual sex. This reflects the specialist nature of the BHAF service which addresses the needs of black and ethnic minority communities, among whom the majority are women (59%) and the principle transmission route is heterosexual sex (94%). Individuals accessing care from Sahir House in Liverpool were more likely to have been infected via homosexual sex (46%), but also included a large group also exposed through heterosexual sex (36%) and a correspondingly relatively high proportion of females (26%). A relatively high proportion (8%) of George House Trust clients were injecting drug users; a higher proportion than those infected by this route attending statutory services (5%: section 3, table 3.1).

**TABLE 4.2: DISTRIBUTION OF VOLUNTARY SECTOR CARE FOR HIV AND AIDS CASES BY AGE GROUP, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

AGE GROUP	VOLUNTARY AGENCY						
	BHAF	B'pool HEAL	BP B'pool	BP Chesh.	BP NW	GHT	SAHIR
0-14	1 (5.9%)	3 (4.1%)		1 (2.1%)	1 (0.2%)	8 (1.3%)	1 (1.2%)
15-19		1 (1.4%)				1 (0.2%)	
20-24		2 (2.7%)		5 (10.6%)	20 (4.3%)	19 (3.0%)	3 (3.6%)
25-29	2 (11.8%)	8 (10.8%)	6 (17.6%)	7 (14.9%)	54 (11.6%)	73 (11.7%)	9 (10.8%)
30-34	7 (41.2%)	20 (27.0%)	4 (11.8%)	8 (17.0%)	97 (20.8%)	134 (21.4%)	21 (25.3%)
35-39	2 (11.8%)	17 (23.0%)	9 (26.5%)	13 (27.7%)	129 (27.7%)	166 (26.6%)	25 (30.1%)
40-44	3 (17.6%)	14 (18.9%)	4 (11.8%)	5 (10.6%)	78 (16.7%)	113 (18.1%)	12 (14.5%)
45-49	1 (5.9%)	3 (4.1%)	6 (17.6%)	6 (12.8%)	47 (10.1%)	58 (9.3%)	7 (8.4%)
50-54		3 (4.1%)	1 (2.9%)	1 (2.1%)	25 (5.4%)	29 (4.6%)	4 (4.8%)
55-59		2 (2.7%)	2 (5.9%)		9 (1.9%)	14 (2.2%)	
60+	1 (5.9%)	1 (1.4%)	2 (5.9%)	1 (2.1%)	6 (1.3%)	10 (1.6%)	1 (1.2%)
<b>Total (100%)</b>	<b>17</b>	<b>74</b>	<b>34</b>	<b>47</b>	<b>466</b>	<b>625</b>	<b>83</b>

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 2000, or at death.

**Table 4.2** refers to HIV positive individuals accessing voluntary care during 2000, categorised according to age group. As was the case for individuals presenting to the statutory sector during 2000, the majority of clients at all voluntary organisations were aged between 25 and 39 years. However, there are age differences between organisations at the upper and lower age categories. The two voluntary organisations in Blackpool (Body Positive and HEAL) appear to attract HIV positive individuals from different age groups. Blackpool HEAL clients have an average (median) age of 36 years (with 90% of clients aged between 18 and 54 years) compared to a median age of 39 years (90% aged between 26 to 70 years) for Body Positive Blackpool. 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: DISTRIBUTION OF VOLUNTARY SECTOR CARE FOR HIV AND AIDS CASES BY ETHNIC GROUP, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

ETHNICITY	VOLUNTARY AGENCY						
	BHAF	B'pool HEAL	BP B'pool	BP Chesh.	BP NW	GHT	SAHIR
White		70 (94.6%)	33 (97.1%)	45 (95.7%)	374 (80.3%)	563 (90.1%)	76 (91.6%)
Black African	15 (88.2%)	4 (5.4%)	1 (2.9%)	1 (2.1%)	5 (1.1%)	42 (6.7%)	4 (4.8%)
Black Caribbean	1 (5.9%)				1 (0.2%)	2 (0.3%)	
Black Other					2 (0.4%)	3 (0.5%)	1 (1.2%)
Indian / Pakistani / Bangladeshi					1 (0.2%)	9 (1.4%)	
Other / Mixed	1 (5.9%)			1 (2.1%)	5 (1.1%)	6 (1.0%)	2 (2.4%)
Not Known					78 (16.7%)		
<b>Total (100%)</b>	<b>17</b>	<b>74</b>	<b>34</b>	<b>47</b>	<b>466</b>	<b>625</b>	<b>83</b>

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.

**Table 4.3** illustrates HIV positive individuals accessing North West based voluntary agencies during 2000, categorised by ethnic group. Ethnic group classifications are adapted from the 1991 Census Questionnaire and are those used by the Public Health Laboratory Service AIDS and STD Centre, for the Survey of Prevalent Diagnosed HIV Infections (SOPHID).

With the exception of BHAF, a specialist service for black and ethnic minority communities, the vast majority of presentations to voluntary sector organisations were by individuals self-defined as white, ranging from 90% at George House Trust to 97% at Body Positive Blackpool. Although proportionately small (7% of their clients), George House Trust provided care for the highest number of HIV positive individuals from black African communities (42 individuals).

**TABLE 4.4: DISTRIBUTION OF VOLUNTARY SECTOR CARE FOR HIV AND AIDS CASES BY HEALTH AUTHORITY OF RESIDENCE, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	VOLUNTARY AGENCY							
	BHAF	B'pool HEAL	BP B'pool	BP Chesh.	BP NW	GHT	SAHIR	
Bury & Rochdale	2 (11.8%)				18 (3.9%)	38 (6.1%)		
East Lancashire					7 (1.5%)	20 (3.2%)		
Liverpool					2 (0.4%)	6 (1.0%)	36 (43.4%)	
Manchester	11 (64.7%)	1 (1.4%)	1 (2.9%)		229 (49.1%)	254 (40.6%)	5 (6.0%)	
Morecambe Bay					2 (0.4%)	5 (0.8%)		
North Cheshire					8 (17.0%)	6 (1.3%)	3 (0.5%)	1 (1.2%)
N. W. Lancashire	1 (5.9%)	66 (89.2%)	26 (76.5%)	1 (2.1%)	12 (2.6%)	42 (6.7%)		
Salford & Trafford	1 (5.9%)	2 (5.9%)			90 (19.3%)	110 (17.6%)		
Sefton							3 (0.5%)	9 (10.8%)
South Cheshire					22 (46.8%)	8 (1.7%)	8 (1.3%)	1 (1.2%)
South Lancashire	4 (5.4%)					1 (0.2%)	5 (0.8%)	1 (1.2%)
St Helens & Knowsley	1 (1.4%)				2 (0.4%)	5 (0.8%)	5 (6.0%)	
Stockport					17 (3.6%)	17 (2.7%)		
West Pennine	1 (1.4%)		1 (2.9%)		40 (8.6%)	57 (9.1%)		
Wigan & Bolton	2 (11.8%)		1 (2.9%)		17 (3.6%)	37 (5.9%)		
Wirral					2 (4.3%)	2 (0.4%)	3 (0.5%)	19 (22.9%)
London					3 (0.6%)	2 (0.3%)		
Northern & Yorkshire					6 (1.3%)	3 (0.5%)		
Trent					1 (2.9%)	2 (0.4%)	5 (0.8%)	1 (1.2%)
Wales	1 (1.4%)		1 (2.9%)	14 (29.8%)	1 (0.2%)	3 (3.6%)		
West Midlands					1 (2.9%)		2 (0.3%)	
Northern Ireland					1 (0.2%)			
<b>Total (100%)</b>	<b>17</b>	<b>74</b>	<b>34</b>	<b>47</b>	<b>466</b>	<b>625</b>	<b>83</b>	

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 resident in health authorities within the North West Region are categorised on a district basis, whilst those living outside of the area are grouped by region. Individuals resident in Welsh health authorities have been amalgamated under the general heading 'Wales'.

**Table 4.4** illustrates the residential distribution of HIV positive individuals accessing North West based voluntary agencies during 2000. 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 70% of Body Positive Cheshire clients, to 91% at Body Positive Blackpool and 100% at BHAF. Body Positive Cheshire was the only voluntary organisation with a significant proportion of HIV positive clients from outside the region: 30% of their clients lived in Wales, reflecting the geographical location of this agency.

It is important to note that the data relate to voluntary sector clients for which full attributable data have been provided (soundex code, date of birth and sex). Therefore, the number of individuals from each health authority attending voluntary agencies does not necessarily reflect the overall service activity of that organisation within a specific health authority.

TABLE 4.5: DISTRIBUTION OF STATUTORY TREATMENT FOR HIV AND AIDS CASES PRESENTING TO VOLUNTARY ORGANISATIONS, JANUARY-DECEMBER 2000

(All cases seen during 2000 including those who died during the year)

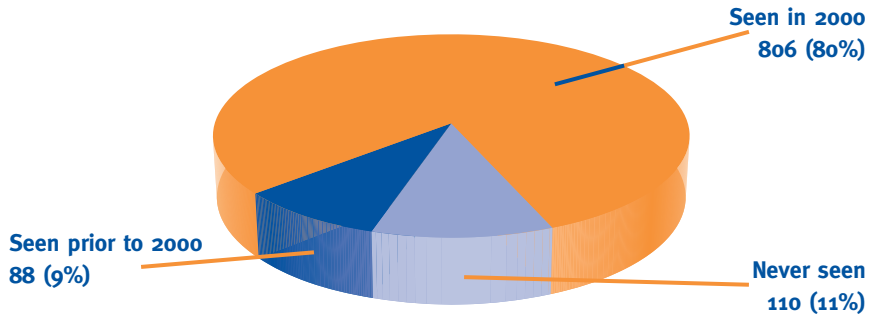
TREATMENT CENTRE	VOLUNTARY AGENCY						
	BHAF	B'pool HEAL	BP B'pool	BP Chesh.	BP NW	GHT	SAHIR
AHC							1
APH							4
BLAG		56	21		6	25	
BLKG					1	3	
BOLG			1		5	17	
BURG					1	5	
BURY					1	2	
CHR				14	3	2	2
DDU							3
FAZ		1		2	2	8	20
FGH						1	
HAL				1			
LEI				3			
LEII				3	1	1	
MAC				1	1	2	
MGP	1	1			71	76	1
MRI	1		1	1	41	46	
MRIG	3				25	39	1
MRIH					4	10	1
NMG	11	8	10	8	249	344	4
NMGG	3	2	1		60	59	
OLDG					1		
PG		9	1	1	3	11	
PP		2				1	
RLG		2	1	2	6	17	40
RLH							3
RLI					1	1	
ROCG					4	11	
SALG					9	11	
SPG							3
STP	2			1	22	37	1
TAMG					1		
TRAG						1	
WAR				2			
WITG	1				23	28	

For a definition of the abbreviated voluntary agencies 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 thus exaggerating the totals.

**Table 4.5** illustrates the crossover of care of HIV positive individuals between North West based voluntary agencies and the statutory organisations during 2000. 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 (section 3, table 3.15), accounts for a significant number of presentations by individuals accessing voluntary organisations across the whole region.

## FIGURE 4.2: THE PROPORTION OF HIV AND AIDS CASES PRESENTING TO THE VOLUNTARY SECTOR AND STATUTORY SECTOR IN THE NORTH WEST, JANUARY-DECEMBER 2000

(All cases seen during 2000 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 2000 who had and had not presented at statutory agencies in the North West, either during 2000 or prior to 2000. During 2000, 1004 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by seven voluntary organisations in the North West. Of these individuals, 806 (80%) also attended statutory treatment centres during the year. Therefore, 198 (20%) of voluntary sector clients were unknown to statutory treatment centres within the North West during 2000 and are not, therefore, included in the regional statistics provided to the Department of Health. This may be partly explained by the fact that 12% of those individuals not accessing the statutory sector during 2000 reside outside the North West (compared to only 2% of those who presented to both voluntary and statutory centres for care) and may be receiving treatment and care from centres further afield.

Of the 198 HIV positive individuals not in contact with the statutory sector in 2000, 44% (88 individuals) had attended statutory treatment centres in the North West between 1995 and 1999. A total of 110 (11% 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 and ethnicity of HIV positive individuals accessing the voluntary sector in the North West in 2000 by attendance at the statutory sector during the year. Because of the relatively high proportion of individuals for whom infection route and ethnicity 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 2000 was homosexual sex, accounting for three quarters of cases where infection route has been determined. This represents a higher proportion than the 65% of individuals accessing the statutory sector for whom method of exposure has been determined (section 3, table 3.1). While a similar proportion of HIV positive clients of both the voluntary and statutory sector were exposed to HIV via injecting drug use, a lower proportion of heterosexually exposed clients (16%) were seen at the voluntary sector compared to the statutory sector (21%: section 3, table 3.1). The vast majority of voluntary sector clients were male (87%), primarily due to the relatively high rates of HIV infection via homosexual sex (75%). As in those HIV positive individuals accessing the statutory sector (section 3, table 3.7), the majority of voluntary sector clients are self-defined as white (91%).

Table 4.6 also shows that one fifth of individuals (110 out of 1,004) using voluntary services did not attend a statutory sector service during 2000. Of those where route of infection is known, a higher proportion of individuals exclusive to the voluntary sector in 2000 were exposed to HIV via homosexual sex (78%) than any other exposure category. Those HIV positive individuals accessing the voluntary sector but not the statutory sector in the North West during 2000 may represent a significant number of people for whom the voluntary sector is the sole provider of care. The overall ethnic (88% white) and sex distribution (84% male) of those exclusively attending voluntary agencies was similar to those attending both types of service (92% white and 88% 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 is unavailable for 59% of those who had only ever been seen by the voluntary sector).

### TABLE 4.6: HIV AND AIDS CASES PRESENTING TO THE VOLUNTARY SECTOR AND STATUTORY SECTOR BY INFECTION ROUTE, SEX AND ETHNICITY, JANUARY-DECEMBER 2000

(All cases seen during 2000 including those who died during the year)

INFECTION ROUTE	STATUTORY SECTOR ATTENDANCE			TOTAL
	In 2000	Not in 2000	Not Seen	
Homo/Bisexual	592 (74.6%)	68 (81.0%)	32 (71.1%)	692 (75.0%)
Injecting Drug Use	53 (6.7%)	5 (6.0%)	1 (2.2%)	59 (6.4%)
Heterosexual	123 (15.5%)	9 (10.7%)	11 (24.4%)	143 (15.5%)
Blood/Tissue	15 (1.9%)	2 (2.4%)		17 (1.8%)
Mother to Child	11 (1.4%)		1 (2.2%)	12 (1.3%)
<b>Sub Total (100%)</b>	<b>794</b>	<b>84</b>	<b>45</b>	<b>923</b>
Undetermined	12	4	65	81
ETHNICITY				
White	735 (91.9%)	66 (89.2%)	45 (86.5%)	846 (91.4%)
Black African	43 (5.4%)	3 (4.1%)	4 (7.7%)	50 (5.4%)
Black Caribbean	3 (0.4%)			3 (0.3%)
Black Other	2 (0.3%)	2 (2.7%)	1 (1.9%)	5 (0.5%)
Indian / Pakistani / Bangladeshi	8 (1.0%)		1 (1.9%)	9 (1.0%)
Other / Mixed	9 (1.1%)	3 (4.1%)	1 (1.9%)	13 (1.4%)
<b>Sub Total (100%)</b>	<b>800</b>	<b>74</b>	<b>52</b>	<b>926</b>
Not Known	6	14	58	78
SEX				
Male	708 (87.8%)	82 (93.2%)	84 (76.4%)	874 (87.1%)
Female	98 (12.2%)	6 (6.8%)	26 (23.6%)	130 (12.9%)
<b>Total (100%)</b>	<b>806</b>	<b>88</b>	<b>110</b>	<b>1004</b>

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



## 5. ADDITIONAL PROVIDERS OF HIV TREATMENT AND CARE 2000

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This is the second 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 listed in the directory of hospices<sup>111</sup> as providing inpatient care were contacted. Out of 32 hospices contacted, 29 (91%) replied and 24 (83%) of these had not provided care for any HIV positive individuals during 2000. Palliative care, defined as the total (physical, emotional, social and spiritual) care of patients with life threatening disease and care of their families<sup>112</sup> was reported by five hospices in the North West during 2000. Information relating to HIV positive individuals attending hospices for inpatient care is presented in table 5.1. Due to relatively few individuals receiving hospice care (six 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 second 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 2000. 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 (section 3, table 3.1), reflecting the successful implementation of harm reduction strategies in the 1980s<sup>78</sup>. Information on HIV positive injecting drug users accessing specialist drug services is presented in table 5.2.

**TABLE 5.1: HIV AND AIDS CARE PROVIDED BY NORTH WEST HOSPICES BY HEALTH AUTHORITY OF RESIDENCE, SEX, AGE GROUP, STAGE OF HIV DISEASE AND LEVEL OF INPATIENT CARE, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	HA OF HOSPICE					TOTAL
	Liverpool	Morecambe Bay	Salford & Trafford	South Cheshire	Wigan & Bolton	
Liverpool	1					1 (16.7%)
Morecambe Bay		1				1 (16.7%)
Salford & Trafford			1			1 (16.7%)
South Cheshire				1		1 (16.7%)
Wigan & Bolton					2	2 (33.3%)
<b>SEX</b>						
Male		1		1	2	4 (66.7%)
Female	1		1			2 (33.3%)
<b>AGE GROUP</b>						
25-29		1				1 (16.7%)
35-39			1			1 (16.7%)
40-44	1					1 (16.7%)
50-54				1		1 (16.7%)
60+					2	2 (33.3%)
<b>CLINICAL STAGE</b>						
AIDS related death	1	1	1	1	2	6 (100.0%)
<b>Total (100%)</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>6</b>

INPATIENT CARE	HA OF HOSPICE					TOTAL
	Liverpool	Morecambe Bay	Salford & Trafford	South Cheshire	Wigan & Bolton	
Episodes	1	1	1	2	3	8
Days	22	8	5	27	32	94

Age ranges refer to the age of individuals at end of December 2000, or at death.

**Table 5.1** illustrates the care provided by North West hospices for HIV positive individuals, categorised by health authority of residence, sex, age group, clinical stage of HIV disease and level of inpatient care provided. Five generic hospices (one in Merseyside, one in Cheshire, two in Greater Manchester and one in Lancashire) provided palliative care for HIV positive individuals resident in the North West during 2000. All the individuals receiving hospice care also attended North West statutory treatment centres during the year.

As identified in previous studies, the age group of HIV positive people accessing care from hospices is often younger than other groups presenting at these services<sup>13</sup>, and in this instance the mean age was 47 years (range 29 to 62 years). All six individuals who received inpatient care in 2000 died during the year; all were classed as having had an AIDS defining illness. The five reporting hospices provided 94 inpatient days during 2000, an average of 16 days per HIV positive individual seen.

**TABLE 5.2: HIV AND AIDS CARE PROVIDED BY NORTH WEST DRUG SERVICES BY HEALTH AUTHORITY OF RESIDENCE, SEX AND AGE GROUP, JANUARY-DECEMBER 2000**

(All cases seen during 2000 including those who died during the year)

HA OF RESIDENCE	HA OF DRUG SERVICE						TOTAL
	Liverpool	Manchester	Morecambe Bay	North Cheshire	West Pennine	Wirral	
Liverpool	2 (40.0%)						2 (10.0%)
Manchester		5 (71.4%)					5 (25.0%)
Morecambe Bay			1 (100.0%)				1 (5.0%)
North Cheshire				1 (100.0%)			1 (5.0%)
Sefton	1 (20.0%)						1 (5.0%)
Stockport		2 (28.6%)					2 (10.0%)
West Pennine					3 (100.0%)		3 (15.0%)
Wirral	2 (40.0%)					3 (100.0%)	5 (25.0%)
<b>SEX</b>							
Male	2 (40.0%)	6 (85.7%)	1 (100.0%)	1 (100.0%)	2 (66.7%)	2 (66.7%)	14 (70.0%)
Female	3 (60.0%)	1 (14.3%)			1 (33.3%)	1 (33.3%)	6 (30.0%)
<b>AGE GROUP</b>							
20-24				1 (100.0%)			1 (5.0%)
25-29					1 (33.3%)		1 (5.0%)
30-34	1 (20.0%)	2 (28.6%)				1 (33.3%)	4 (20.0%)
35-39	2 (40.0%)	3 (42.9%)				2 (66.7%)	7 (35.0%)
40-44	1 (20.0%)	2 (28.6%)			2 (66.7%)		5 (25.0%)
45-49			1 (100.0%)				1 (5.0%)
50-54	1 (20.0%)						1 (5.0%)
<b>Total (100%)</b>	<b>5</b>	<b>7</b>	<b>1</b>	<b>1</b>	<b>3</b>	<b>3</b>	<b>20</b>

Age ranges refer to the age of individuals at end of December 2000, or at death

**Table 5.2** illustrates the care provided by North West specialist drug agencies for HIV positive individuals, categorised by health authority of residence, sex and age group. Data relating to drug service clients who are known to be HIV positive were provided by seven agencies, based in six health authorities (contributing drugs services are listed at the end of this report). A total of 20 HIV positive individuals were reported by seven drug services in 2000, with the vast majority also attending statutory treatment centres (90%).

The health authorities of Manchester (25%) and Wirral (25%) account for the highest number of reported HIV positive individuals accessing specialist drug services in the North West. The remaining cases reside in Liverpool (two individuals), Morecambe Bay (one), North Cheshire (one), Sefton (one), Stockport (two) and West Pennine (three). Nearly a third (30%) of HIV positive injecting drug users accessing drug services were female, a higher proportion than that seen amongst those infected via injecting drug use attending the statutory sector (24%, section 3, table 3.5). This demonstrates the importance of collecting data from appropriate services that provide additional care to HIV positive individuals in the North West.

# GLOSSARY

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## Statutory treatment centres

<b>AHC</b>	Alder Hey Children's Hospital, Haematology Treatment Centre, Eaton Road, Liverpool, L12 2AP, Tel: (0151) 228 4811
<b>APH</b>	Arrowe Park Hospital, Department of GUM, Arrowe Park Road, Upton, Wirral, Merseyside, CH49 5PE, Tel: (0151) 678 5111
<b>BLAG</b>	Victoria Hospital, Department of GUM, Whinney Heys Road, Blackpool, Lancashire, FY3 8NR, Tel: (01253) 300 000
<b>BLK</b>	Blackburn Royal Infirmary, Bolton Road, Blackburn, BB2 3LR, Tel: (0154) 263 555
<b>BLKG</b>	Blackburn Royal Infirmary, Department of GUM, Bolton Road, Blackburn, BB2 3LR, Tel: (0154) 263 555
<b>BOLG</b>	Royal Bolton Hospital, Department of GUM, Minerva Road, Farnworth, Bolton, BL4 0JR, Tel: (01204) 390 390
<b>BURG</b>	Burnley General Hospital, Department of GUM, Casterton Avenue, Burnley, Lancashire, BB10 2PQ, Tel: (01282) 425 071
<b>BURY</b>	Bury General Hospital, Walmersley Road, Bury, BL9 6PG, Tel: (0161) 764 6081
<b>CHR</b>	The Countess of Chester Hospital, Department of GUM, Liverpool Road, Chester, Cheshire, CH2 1UL, Tel: (01244) 365 000
<b>DDU</b>	Liverpool Drug Dependency Unit, 26 Rodney Street, Liverpool, Merseyside, L1 2TQ, Tel: (0151) 709 0516
<b>FAZ</b>	University Hospital Aintree, Infectious Disease Unit, Lower Lane, Liverpool, L9 7AL, Tel: (0151) 525 5980
<b>FGH</b>	Furness General Hospital, Dalton Lane, Barrow in Furness, Cumbria, LA14 4LF, Tel: (01229) 870 870
<b>HAL</b>	Halton General Hospital, Department of GUM, Hospital Way, Runcorn, Cheshire, WA7 2DA, Tel: (01928) 714 567
<b>LEI</b>	Leighton Hospital, Department of GUM, Middlewich Road, Crewe, Cheshire, CW1 4QJ, Tel: (01270) 255 141
<b>LEII</b>	Leighton Hospital, Middlewich Road, Crewe, Cheshire, CW1 4QJ, Tel: (01270) 255 141
<b>MAC</b>	Macclesfield District General Hospital, Department of GUM, Victoria Road, Macclesfield, Cheshire, SK10 3BL, Tel: (01625) 421 000
<b>MGP</b>	'The Docs' General Practice, Manchester, 55-59 Bloom Street, Manchester, M1 3LY, Tel: (0161) 237 9490
<b>MRI</b>	Manchester Royal Infirmary, Outpatients Department, Oxford Road, Manchester, M13 9WL, Tel: (0161) 276 1234
<b>MRIIG</b>	Manchester Royal Infirmary, Department of GUM, Oxford Road, Manchester, M13 9WL, Tel: (0161) 276 1234

<b>MRIH</b>	Manchester Royal Infirmary, Department of Haematology, Oxford Road, Manchester, M13 9WL, Tel: (0161) 276 1234
<b>NMG</b>	North Manchester General Hospital, Infectious Disease Unit, Delaunays Road, Crumpsall, Manchester, M8 5RB, Tel: (0161) 795 4567
<b>NMGG</b>	North Manchester General Hospital, Department of GUM, Delaunays Road, Crumpsall, Manchester, M8 5RB, Tel: (0161) 795 4567
<b>OLDG</b>	Royal Oldham Hospital, Department of GUM, Rochdale Road, Oldham, Lancashire, OL1 2JH, Tel: (0161) 624 0420
<b>ORMG</b>	Ormskirk and District General Hospital, Department of GUM, Wigan Road, Ormskirk, Lancashire, L39 2AZ, Tel: (01695) 577 111
<b>PG</b>	Royal Preston Hospital, Department of GUM, Sharoe Green Lane North, Fulwood, Preston, PR2 9HT, Tel: (01772) 716 565
<b>PP</b>	Royal Preston Hospital, Paediatric Department, Sharoe Green Lane North, Fulwood, Preston, PR2 9HT, Tel: (01772) 716 565
<b>RLG</b>	Royal Liverpool University Hospital, Department of GUM, Prescot Street, Liverpool, L7 8XP, Tel: (0151) 706 2000
<b>RLH</b>	Royal Liverpool University Hospital, Department of Haematology, Prescot Street, Liverpool, L7 8XP, Tel: (0151) 706 2000
<b>RLI</b>	Royal Lancaster Infirmary, Ashton Road, Lancaster, LA1 4RP, Tel: (01524) 65944
<b>ROCG</b>	Baillie Street Health Centre, Department of GUM, Baillie Street, Rochdale, OL16 1XS Tel: (01706) 517 655
<b>SALG</b>	Hope Hospital, Department of GUM, Stott Lane, Salford, M6 8HD, Tel: (0161) 789 7373
<b>SPG</b>	Southport & Formby District General Hospital, Department of GUM, Town Lane, Kew, Southport, Merseyside, PR8 6PN, Tel: (01704) 547 471
<b>STP</b>	Stepping Hill Hospital, Department of GUM, Poplar Grove, Stockport, Cheshire SK2 7JE, Tel: (0161) 483 1010
<b>TAMG</b>	Tameside General Hospital, Department of GUM, Fountain Street, Ashton-under-Lyne, Lancashire, OL6 9RW, Tel: (0161) 331 5151
<b>TRAG</b>	Trafford General Hospital, Department of GUM, Moorside Road, Urmston, Manchester, M41 5SL, Tel: (0161) 748 4022
<b>WAR</b>	Warrington Hospital, Department of GUM, Lovely Lane, Warrington, Cheshire, WA5 1QG, Tel: (01925) 635 911
<b>WGH</b>	Westmorland General Hospital, Outpatients Department, Burton Road, Kendal, Cumbria, LA9 7RG, Tel: (01539) 732 288
<b>WIGG</b>	Royal Albert Edward Infirmary, Department of GUM, Wigan Lane, Wigan, WN1 2NN, Tel: (01942) 244 000
<b>WITG</b>	Withington Hospital, Department of GUM, Nell Lane, Manchester, M20 2LR, Tel: (0161) 445 8111

## Voluntary agencies

<b>BHAF</b>	The Black Sexual Health Project, Tel: (0161) 226 9145
<b>B'pool HEAL</b>	Blackpool HEAL (Health Education AIDS Liaison), Tel: (01253) 290 052
<b>BP B'pool</b>	Body Positive Blackpool, Tel: (01253) 296 887
<b>BP Chesh.</b>	Body Positive Cheshire, Tel: (01244) 400 415
<b>BP NW</b>	Body Positive North West, Tel: (0161) 873 8100
<b>GHT</b>	George House Trust, Tel: (0161) 274 4499
<b>SAHIR</b>	Sahir House (Mersey Body Positive & Merseyside AIDS Support Group), Tel: (0151) 708 9080

## Drug services

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

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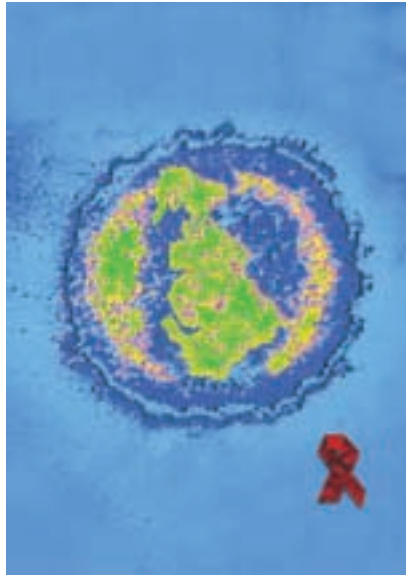
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# HIV and AIDS in the North West of England 2000

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