

## 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.

# ACKNOWLEDGEMENTS

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A large number of people have been involved in the collection of data for this report.

We would like to thank them all, especially Mike Abbot, Pam Beswick, Lorraine Birtwhistle, Alastair Campbell, Sue Capstick, Lesley Capstick, Dave Chapman, Andrea Dodd, Sue Doherty, Barbara Downes, Steve Earle, Margaret Ellam, John Ellershaw, Carol Evans, Chris Flewitt, Janet Ford, Cath Garstang, Beryl Gilbert, Stephanie Gomm, Hilary Grant, Karen Haig, Renata Hewart, Maureen Holloway, Mary Hopper, Pam Jackson, Michelle Jenkins, Linda Johnstone, Howard Jones, Jayne Keane, Karen Kelly, Alan Kinney, Janet Lace, Anne Mather, Sam Maybe-Puttock, Gabriel McDermott, Denise McDowell, Pauline Molyneax, Jo Moody, Cynthia Murphy, Ged Murphy, Chris Newman, Mark Newman, Kirit Patel, Tim Pickstone, Tony Proom, Anthony Quinnell, Ranjana Rani, Sue Russell, Cath Sharratt, Janice Sheath, Lindsey Shone, Chris Simpson, Ian Smith, Lesley Smith-Payne, Pat Sutcliffe, Lesley Thompson, Helen Tinker, Sue Toomer, Lesley Trollip, Sally Webb-Jones and Alyson Wiggins.

Thanks are due to everyone in the Public Health Sector at Liverpool John Moores University for their support, particularly Juliet Hounsome, Diana Leighton and Jim McVeigh. We would also like to acknowledge the continued support of John Ashton (Regional Director of Public Health), John Astbury (Consultant in Public Health, Morecambe Bay Health Authority), Ken Mutton (Consultant Virologist, PHLS North West), and Rod Thomson (Public Health Project Co-ordinator, Sefton Health Authority).