



HIV & AIDS

NORTH WEST OF ENGLAND 2003

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in the North West of England 2003

By Penny A. Cook, Jennifer Downing, Alyson Duckett, Pete Clark, Outub Syed and Mark A. Bellis

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Executive Summary

During 2003 the North West Region has seen the largest recorded number of new cases of HIV positive people accessing treatment and care since regional monitoring began. A total of 725 new HIV and AIDS cases (HIV positive individuals who had not previously been seen in North West statutory treatment centres prior to the year 2003) were reported during the year. This represents an 18% increase on last year's figure of 617. The total number of people treated for HIV in North West statutory treatment centres continues to rise at a rapid rate: during 2003 a total of 2,988 individuals accessed treatment and care, representing a 23% increase on the number reported in 2002 (2,429). Over the nine years since this level of monitoring began, there has been a three-fold increase in the HIV positive population in treatment in the North West (figure 1.12).

This is the eighth annual report of the North West HIV/AIDS Monitoring Unit, presenting data on HIV positive individuals accessing treatment and care in the North West Region. A total of 45 statutory centres within the North West provided treatment and care for HIV positive individuals resident throughout the region and beyond. We present analyses by treatment centre, as well as by primary care trust (PCT) and strategic health authority (SHA) of residence. It is not possible to present all possible breakdowns at PCT level, however, additional tables are available on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2003). This year, for the first time, we introduce a new chapter (see chapter 7), presenting trends in the epidemiology and treatment of HIV in the North West.

New cases represented 24% of all cases, a proportion similar to previous years. The predominant mode of exposure to HIV for new cases is heterosexual sex (53%); this route has overtaken homosexual sex (44%: table 2.3a) for the second year running, reflecting the trend that has been apparent nationally since 1999 (figure 1.6). The proportion of new cases exposed to HIV through homo/bisexual sex is higher in the North West (table 2.3a) than nationally (figure 1.6). The number of new cases who were exposed by other transmission routes (injecting drug use, blood or tissue and mother to child) remains relatively low. While the largest proportion of new cases presenting for treatment and care were categorised as asymptomatic (60%), the eleven new cases who died during 2003 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 predominant mode of exposure to HIV for those accessing treatment in the North West (new and existing cases) continues to be homosexual sex, accounting for 56% of all cases presenting to North West treatment centres in 2003 (table 3.2). There is, however, considerable variation across the three strategic health authorities, with 62% of the HIV positive residents of Cumbria and Lancashire having been infected by sex between men, compared to 47% of Cheshire and Merseyside residents (table 3.4a). The relatively high proportion of individuals infected by homosexual sex is reflected in the gender distribution of HIV and AIDS cases, with males representing 78% of all cases (table 3.5). Heterosexual sex continues to be the second largest exposure group, accounting for over a third of all cases in 2003 (table 3.2). This represents an increase on the proportion in 2002, reflecting trends for the United Kingdom as a whole. Greater Manchester SHA reports the highest number of HIV positive individuals in the North West, accounting for over half of all cases (table 3.3a) and new cases (table 2.2a) presenting to statutory treatment centres.

With regards to age distributions, the greatest proportion of cases are in the 30 to 44 age range (table 3.1). The proportion of HIV positive people in the older age groups (50 years and over) continues to increase, from 7% in 1996 to 12% in 2003 (table 3.1). This ageing cohort effect is likely to be due to the effectiveness of antiretroviral therapies and subsequent improvement in prognosis of many HIV positive individuals. However, those aged 55 years or over are more likely to have died during 2003 from an AIDS-related condition (2%) than are those younger than 55 years, of whom only 1% died. The proportion of the HIV positive population dying from AIDS related conditions has decreased over the years, from 10% in 1995 to 0.8% in 2003 (figure 1.12).

The North West of England continues to be influenced by the global AIDS pandemic, as reflected in the number and pattern of HIV infections acquired abroad. Almost one third of all HIV positive individuals accessing treatment and care in the North West were reported to have been infected outside the United Kingdom (table 3.12). Heterosexual sex continues to be the major method of exposure to HIV in those infected abroad (74%), a significantly higher proportion than in those known to have been infected in the United Kingdom (13%). Of all the infections contracted outside the United Kingdom, 63% were in sub-Saharan Africa (figure 3.1). Western Europe accounted for a further 11% of infections contracted abroad, with Spain being the most frequently reported western European country of exposure. The role of exposure abroad was even more pronounced for cases who were new in 2003, where 43% were reported to have been infected abroad (table 2.11). The number of new cases exposed to HIV in Zimbabwe has increased by 51% on 2002, and this year accounts for 42% of new cases known to have been exposed abroad (figure 2.1). This high number of cases reflects both the high prevalence of HIV and the political situation in Zimbabwe.

Ethnicity was recorded for 98% of individuals accessing treatment and care in 2003, most of whom (74%) were self-classified as white (table 3.8). However, an increasing proportion of individuals with HIV were from black and minority ethnic communities (26%); a substantial over-representation when considering the proportion of North West residents who are from minority ethnic communities (5.6%). An even higher proportion (46%) of new cases whose ethnicity was known were from minority ethnic communities (table 2.7), which has increased from 40% of new cases in 2002, demonstrating the increasing burden of HIV on these communities and the need for continuing and strengthening HIV prevention activities. The characteristics of HIV positive individuals from black and minority ethnic communities, 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 2.8 and 3.10). This results in there being proportionally more females from black and minority ethnic communities with HIV compared to white females (table 2.9 and 3.9) and more babies born with HIV infection (tables 2.8 and 3.10). Individuals from minority ethnic groups presenting for the first time during 2003 were no more likely to be at an advanced stage of disease than were white individuals.

We are now in our third year of collecting information on asylum seeker status of HIV positive individuals accessing HIV related care. This level of information is not available nationally, despite growing concern over the health of this vulnerable population. Since collection of this information began, the proportion of individuals who are asylum seekers has almost quadrupled, and this year represented 11% of all HIV positive individuals. During 2003, there were 316 individuals who were identified as being asylum seekers, an increase of 107% on last year's total of 153 (table 3.27). These individuals were more likely to be asymptomatic (58%) than were those who were known not to be asylum seekers (38%). The majority of those known to be asylum seekers resided in Greater Manchester SHA (69%) and most (96%) were black Africans (table 3.28).

During 2003, two thirds of individuals received triple or more combination therapy, including 12% who were taking quadruple or more therapy when they last attended treatment centres in the year (table 3.15). The level of triple or more therapy rose to 91% when considering those with an AIDS diagnosis, while only 39% of asymptomatic individuals were taking this level of therapy (table 3.16). 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.

We also collected information on the level of inpatient and outpatient care for the whole of the region. During 2003, 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 2003 required the most inpatient care. Home visits also formed a significant part of the care of HIV positive individuals (table 3.25), with those individuals who died during the year receiving the highest mean number of home visits.

During 2003, eight voluntary agencies in the North West reported care of 1,216 HIV positive individuals. Of these, 14% were not seen in North West statutory treatment centres during 2003, illustrating the continuing contribution of the voluntary sector to the care of those HIV positive individuals for whom the voluntary agencies may be the sole provider of care. This also has particular significance for regional funding of HIV services, since individuals accessing voluntary agencies but not the statutory sector are not included in the regional statistics provided to the Department of Health, the basis of the formula for the national distribution of funds for the care of HIV positive people.

This year, for the second time, we requested information from social services departments in the North West on the social care of HIV positive people. Twelve social services departments were able to take part, and contributed data on 272 individuals. Most (79%) social services' clients were also seen in the statutory sector in 2003. Services were provided for 34 individuals known to be asylum seekers.

Four hospices reported providing palliative care for HIV positive individuals during 2003. Four HIV positive individuals residing in three strategic health authorities received hospice care, accounting for 57 inpatient days (table 6.1). All four individuals also received care from the statutory sector during 2003. In addition, specialist drugs services contributed data on clients whom were known to be HIV positive (table 6.2). Eight individuals were reported by five drugs services, all of whom also received HIV treatment from elsewhere in the statutory sector in 2003.

We hope that the tables and figures provided in this report, together with additional analyses at PCT level available on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2003), address most of your HIV-related information requirements. However, additional analyses and further breakdown of the data can be provided on request. As ever, we value your suggestions as to any developments that would improve the usefulness of the report in future years.

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1. Introduction



Monitoring HIV and AIDS in the North West Region

This is the eighth annual report of The North West HIV/AIDS Monitoring Unit. Over the past nine years, we have collected, collated and disseminated data on the treatment and care of HIV positive individuals in the North West. The NHS information strategy for 1998 to 2005 supports this level of clinical and public health monitoring. The strategy highlights the need for comprehensive, accurate information as an integral part of improving the public's health¹. 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) applied².

Over the past nine 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 clinics³⁻⁹. The data collected form part of the national dataset - Survey of Prevalent Diagnosed HIV Infections (SOPHID). In addition, data are used at both regional, strategic health authority (SHA) and primary care trust (PCT) level to assist in service planning, development and evaluation as well as providing analysis of the changing patterns of disease prevalence and characteristics.

In addition to data collected from statutory treatment centres, we also access data from a number of additional sources of HIV care within the North West. For the second year twelve North West social service departments have participated, all of which have HIV positive service users. The Unit continues to collect data from HIV/AIDS voluntary organisations across the region. For the fifth year, we have gathered data relating to HIV positive individuals accessing specialist drug services in the North West. Hospices in the North West also continue to report care of HIV positive individuals to the Monitoring Unit.

The rest of this chapter gives an overview of the global and national epidemiology of HIV and AIDS, before discussing specific aspects in the North West Region. In chapter 2, we present analyses of new HIV cases in the North West, and in chapter 3 analyses of all HIV and AIDS cases presenting for treatment and care in the North West. Voluntary sector care and social service care is dealt with in chapters 4 and 5, followed by care from additional sources in chapter 6. This year, for the first time, we present trends in the epidemiology and treatment of HIV; these are given in chapter 7.

For reason of space not all analyses employing PCTs can be included here, but additional tables can be found on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2003). We hope that the tables and figures provided within the report, and the extra analyses on the website, answer most of your HIV-related information requirements. We would value your suggestions as to what additions would improve the usefulness of the report in future years.

Global perspectives on HIV and AIDS in 2003

The need for accurate surveillance for HIV/AIDS is critical: HIV infection remains incurable, is characterised by a high morbidity, is very expensive to treat and predominantly effects younger adults, often the most economically active individuals. Good surveillance is essential for measuring the success of prevention and treatment policies. In England and Wales, The National Strategy for Sexual Health and HIV emphasises the need for a sound evidence base for effective prevention campaigns¹⁰. The strategy for combating infectious diseases¹¹ places surveillance at the heart of tackling all infectious disease, including HIV/AIDS.

For many countries, accurate figures for the number of HIV positive individuals, AIDS cases and AIDS deaths are not available: the surveillance systems are not in place. The numbers employed in this report for countries outside the UK are drawn from the publications of UNAIDS/WHO. This year the UNAIDS has incorporated national population based survey data, including voluntary HIV testing, to improve their estimated HIV/AIDS figures. Consequently their estimates are lower than in 2002. However, this is a result of greater accuracy of figures, and does not represent a reduction in the number of individuals newly infected, living with, or dying from, HIV/AIDS¹².

In 2003, an estimated 40 million people were living with HIV (figure 1.1), 5 million of whom were newly infected (figure 1.2) and three million of whom died. The total number of lives claimed by the pandemic so far is estimated to be 30.9 million. Sub-Saharan Africa continues to bear the brunt of the AIDS epidemic: HIV/AIDS is now the leading cause of death in sub-Saharan Africa. It is estimated that 2.3 million Africans died of AIDS in 2003¹².

Figure 1.1: Number of adults and children estimated to be living with HIV/AIDS as of end 2003 Source: UNAIDS/WHO Report on the Global HIV/AIDS Epidemic – December 2003

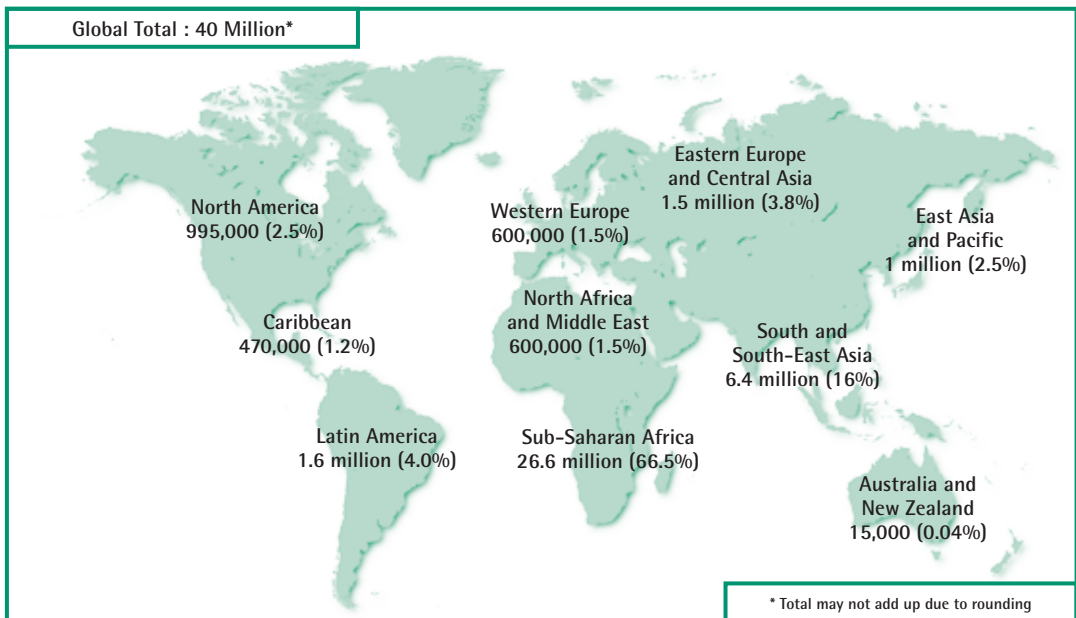
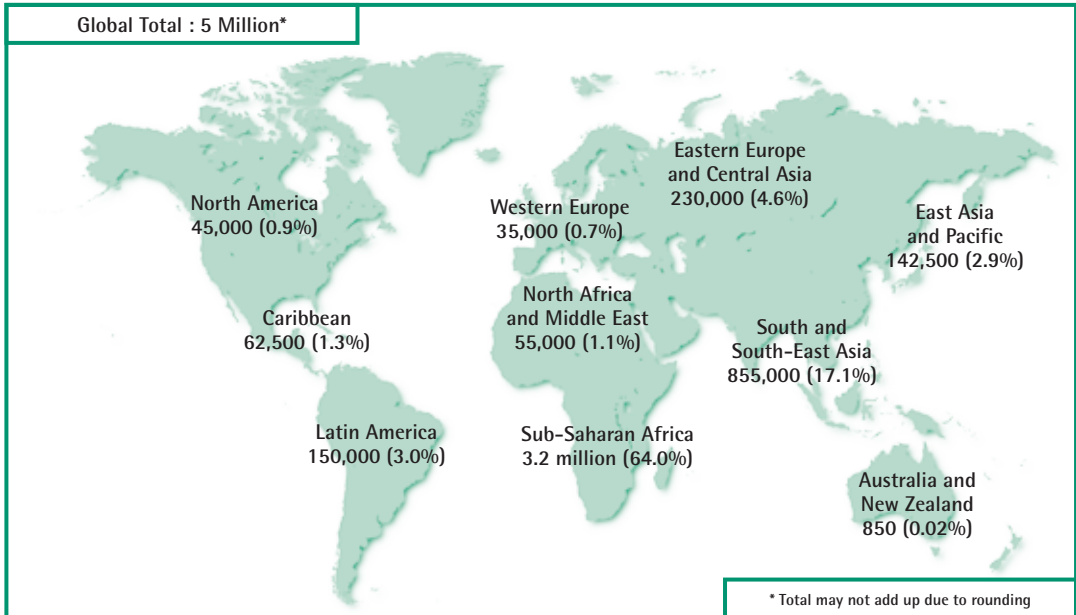


Figure 1.2: Number of adults and children estimated to be newly infected with HIV/AIDS during 2003 Source: UNAIDS/WHO Report on the Global HIV/AIDS Epidemic – December 2003



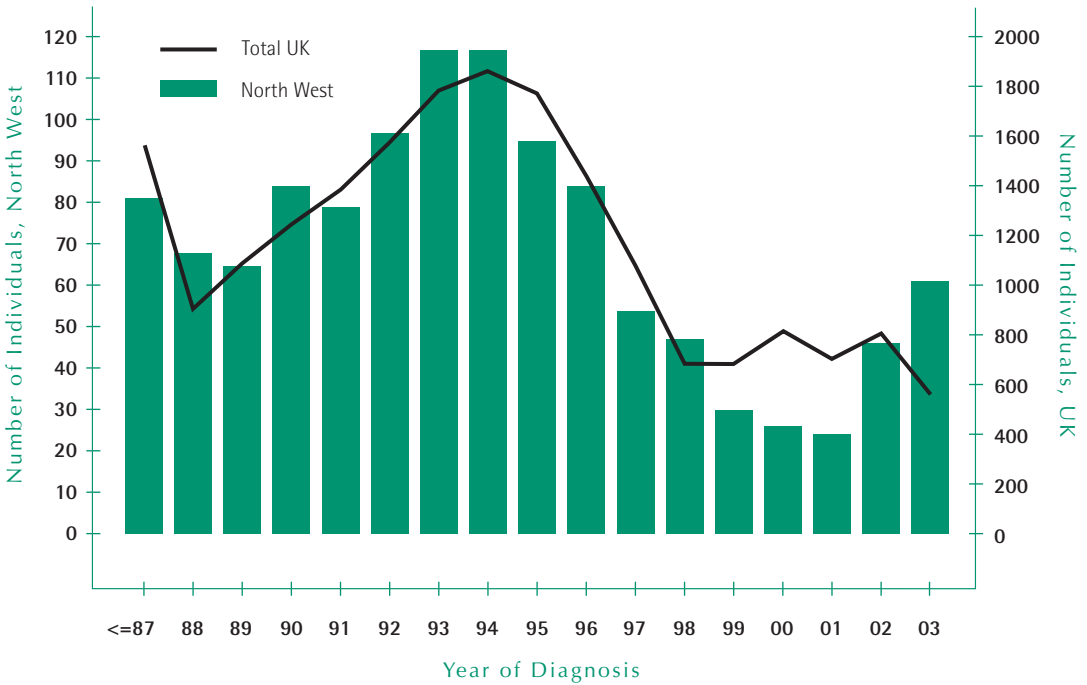
A global fund to fight AIDS, tuberculosis and malaria, became operational in January 2002. To date the fund has received pledges of US \$4.7 billion in financing through to 2008¹³, and has committed US \$2.1 billion of funding to support programmes in 125 countries¹⁴. However, this falls far short of the US \$10 billion the fund hopes to generate annually by 2005, consequently the World Health Organisation's target to provide antiretroviral treatment to three million people by 2005 will not be achieved¹⁴. In September 2003, The World Health Organisation (WHO) described the failure to deliver antiretroviral treatment to millions of AIDS sufferers as 'a global health emergency'. Approximately six million people living with HIV in developing countries require antiretroviral treatment, however less than 300,000 are receiving the appropriate medicines¹⁵. Manufacturers are helping with provision of antiretroviral drugs. However, having a supply of drugs does not solve the problem. It is also essential that developing countries have the infrastructure to deliver the drug regimen, and these countries must recognise and tackle the shortfalls in health services. They must also have the knowledge to make decisions about newer regimens, and be aware of the risk of resistance to antiretrovirals¹⁶.

Given the huge cost and practical difficulties of supplying antiretroviral drugs to those parts of the world most affected by HIV, a vaccine to prevent transmission of the virus remains the best hope for controlling the impact of the disease. Although the first candidate vaccine to reach phase III trials had disappointing results¹⁷, many other potential vaccines are undergoing clinical trials¹⁸. Strategies for delivering any forthcoming vaccines in developing countries should be put in place now, since national immunisation programmes will need to target adolescents and pre-adolescents; a group not currently targeted for other vaccines, yet not necessarily accessible in a school setting^{19,20}.

The epidemic in the developed world

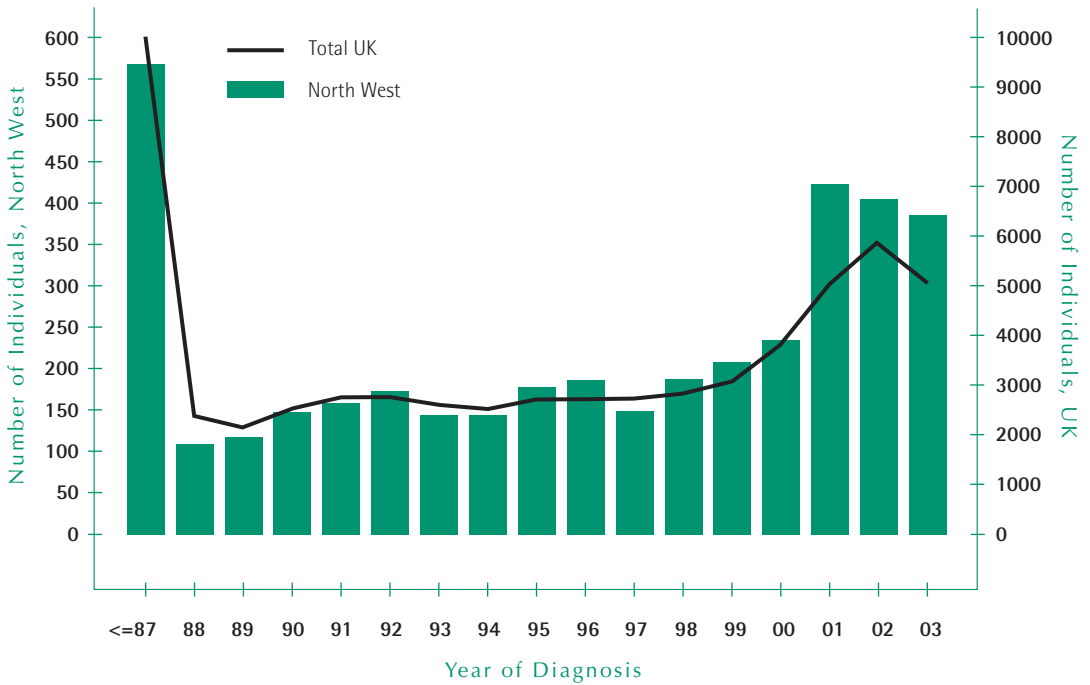
In richer countries, the epidemic continues to have a very different shape to that of the developing world, with the population living with HIV/AIDS growing as people have fewer opportunistic infections and live longer due to life-prolonging therapies²¹. Correspondingly, the number of people developing 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 with HIV continues at approximately the same rate (figure 1.4). Data from the US show that even those who go on to develop AIDS can expect to live nearly three years longer than those diagnosed in the mid 1980s²². In the developed world HIV remains focussed in marginalised communities, for example injecting drug users, homosexual men and minority ethnic groups.

Figure 1.3: Number of new AIDS cases in the North West and the UK by year of diagnosis to December 2003 Source: AIDS/HIV Quarterly Surveillance Tables No 61, HPA



	<=87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	Total
North West Region	81	68	65	84	79	97	117	117	95	84	54	47	30	26	24	46	61	1175
Total UK	1562	905	1082	1243	1390	1577	1785	1853	1769	1435	1073	784	747	813	704	807	560	20089

Figure 1.4: Number of new HIV cases in the North West and the UK by year of diagnosis to December 2003 Source: AIDS/HIV Quarterly Surveillance Tables No 61, HPA



	<=87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	Total
North West Region	567	109	116	146	157	172	147	147	179	187	149	187	207	235	423	405	385	3918
Total UK	10127	1941	2142	2545	2719	2740	2626	2569	2654	2690	2732	2815	3074	3830	5005	5847	5044	61100

Sub-Saharan Africa

Sub-Saharan Africa remains the region most severely affected by HIV/AIDS. In the year 2003 an estimated 3.2 million adults and children were newly infected (figure 1.2), bringing the total number of people living with HIV/AIDS to 26.6 million (figure 1.1). An estimated 2.3 million people (from a global figure of 3 million) died from HIV/AIDS in sub-Saharan Africa. The total number of people with HIV appears to have remained steady compared to last year's published figures, however, this is due to an improvement in the estimates and not a reduction in new cases of HIV¹².

The prevalence of HIV in sub-Saharan Africa varies greatly across its countries. Mauritius, Madagascar and Somalia had the lowest HIV prevalence amongst their adult populations at 0.1%, 0.3% and 1.0% respectively. In contrast, the adult population of Lesotho, Swaziland, Zimbabwe and Botswana had the highest HIV prevalence at 31%, 33%, 34% and 39% respectively²³.

The fact that the epidemic is centred on the heterosexual population in Africa, rather than a minority group, vastly increases the number of people at risk. This is reflected across all countries in sub-Saharan Africa where the female HIV positive population outweighs the male. HIV positive females represented 58% of the adult HIV positive population (aged 15-49) in 2001²³. Young women represent the group at highest risk of infection¹².

The high prevalence of HIV in sub-Saharan African countries, along with the political situation in some of these countries, accounts for large numbers of HIV positive individuals accessing care in the North West of England: of those newly reported in 2003 who were exposed abroad, 81% were exposed in Africa (see chapter 2, figure 2.1).

East Asia and the Pacific

An estimated one million people in East Asia and the Pacific are now living with HIV/AIDS in 2003 (see figures 1.1 and 1.2). The vast majority of these reside in China. Although China has a very low national prevalence of HIV, in some regions injecting drug users have been found to have very high prevalences of HIV (up to 80%) showing an emerging trend of unsafe injecting drug use¹². The number of HIV positive individuals in China is forecasted to rise to 10 million by the end of the decade²⁴.

Papua New Guinea is the country with the highest prevalence in the region, with an estimated 0.7% of the population infected²³, and could be on the brink of a serious outbreak. Because most transmission is heterosexual, and there is a culture of multiple sex partners, sexual violence and poverty, the epidemic could be on the scale of sub-Saharan Africa, and more serious than that in Thailand and Cambodia²⁵.

In common with other high-income countries, Japan has a very low prevalence of HIV²³. However, there is a steady increase in the number of reported HIV infections. There has also been a rise in sexually transmitted infections and an increase in sexual activity among young people¹².

South and South East Asia

During the course of 2003, an estimated 855,000 people became infected with HIV in South and South East Asia (figure 1.2), bringing the total number of people living with HIV and AIDS in this area to 6.4 million (figure 1.1). Behaviours in the region that are associated with the highest risk are unprotected sex between sex workers and clients, injecting drug use and sex between men.

In 2003, 300,000 people in India were estimated to be newly infected with HIV¹². Serious epidemics have begun in several regions. The highest risk of disease is among the sex worker population and the injecting drug user population where prevalences of over 50% and 70% respectively have been found. However, there is evidence that HIV is spreading into the wider population in rural areas.

Prevention campaigns focussed around condom promotion have been very successful in Thailand and Cambodia. In Cambodia, HIV prevalence amongst pregnant women fell from 3.2% in 1996 to 2.8% in 2002, and in sex workers from 42% in 1998 to 29% in 2002¹². If a response of similar scale is carried out in Vietnam, which currently has a low national prevalence, HIV could be prevented from leaving high risk groups (injecting drug users and sex workers) and entering the general population.

Latin America and the Caribbean

This region accounts for more than 2 million people living with HIV (figure 1.1). With over 100,000 deaths from AIDS in 2003, these countries have the highest regional death toll after sub-Saharan Africa. Men who have sex with men, bisexual men, unsafe sexual practices and injecting drug use are the main contributors to the HIV rates of Latin America and the Caribbean¹². In Central America national prevalence is around 1% in Guatemala, Honduras and Panama. However, higher prevalences are found among men who have sex with men, ranging from 9% in Nicaragua to 18% in El Salvador¹².

In the Caribbean heterosexual sex is the predominant route of HIV transmission. Several Caribbean countries have the highest rates of HIV outside sub-Saharan Africa, with the worst affected country being Haiti where 6% of the population is infected with HIV¹². However, despite the widespread civil unrest in the country, the Global Fund reports that their projects have continued uninterrupted²⁶.

North America

During 2003 an estimated 45,000 new infections occurred in the USA and Canada, 25% of which are attributed to injecting drug use (figure 1.2). An estimated one third of new infections in the USA occurred through heterosexual contact, and half of all new infections occurred amongst African-Americans, a large proportion of which are female²⁷. Among men, the most frequent route of infection was sex between men. However, women were most likely to be infected through unprotected sex with a male partner, who may be bisexual or injecting drugs. It is this kind of behaviour that has contributed to AIDS being a leading cause of death for African-American women aged 25-34¹². A major issue is the number of HIV positive African-American men who are unaware that they have the virus. Of the 850,000-950,000 people living with HIV/AIDS in the USA, approximately one quarter are unaware of their seropositive status¹². The USA has also seen a rise in other sexually transmitted infections, which suggests an increase in high-risk sexual behaviour, predominantly amongst young people and men who have sex with men²⁸.

Eastern Europe and Central Asia

The epidemic in Eastern Europe and Central Asia continues with an estimated 1.5 million people now living with HIV (figure 1.1). Of these cases, 230,000 were new in 2003 (figure 1.2). In 2003 AIDS claimed approximately 30,000 lives.

Injecting drug use and unsafe sex, in particular amongst young people, are the contributing factors to this epidemic. The majority of injecting drug users are young males. Across the region up to 25% of injecting drug users are estimated to be less than 20 years of age, whilst sharing injecting equipment is common practice¹².

The Russian Federation is one of the worst affected areas in the region with almost three quarters of all of the region's HIV infections. There are an estimated 1 million people aged 15-49 living with HIV in the Russian Federation¹². Studies show a relationship between behavioural and situational factors contributing to the continued spread of HIV. For example, fear of arrest discourages carrying of clean needles and in turn encourages sharing equipment at point of drug sale²⁹. A recent review on HIV prevention among IDUs in the Russian Federation concludes that the recently introduced harm reduction projects are associated with decreased risk behaviour among participating IDUs, but are limited in their coverage³⁰. Another striking pattern is the increasing numbers of newly diagnosed females in the region, at 33% in 2002 compared to 24% in 2001¹²; as a result, there has also been a sharp increase in the number of vertical transmissions of the virus³¹.

Western Europe

During 2003 there were an estimated 35,000 new infections in Western Europe resulting in an estimated total of 600,000 for the region. As in previous years, the number of AIDS related deaths has slowed, with approximately 3,000 in the past year, a reduction that can mostly be attributed to the use of antiretroviral therapies.

In most Western European countries, heterosexual sex is now the most commonly reported route of transmission for new HIV infections. The exceptions to this are Germany, Greece and the Netherlands (where homosexual sex is still the leading infection route) and Portugal (where injecting drug use accounts for most new infections)³¹. The prevalence of HIV varies widely in Western Europe, with a higher reporting rate of 25 per 100,000 in Portugal, 11 per 100,000 in Switzerland and 10 per 100,000 in UK to under 3 per 100,000 in Germany and Finland. A large proportion of the increase in new cases reported in 2002 were attributed to persons thought to have acquired HIV elsewhere, in a country with high HIV prevalence. This is seen particularly in Ireland and the UK³¹.

HIV and AIDS in the United Kingdom – 2003

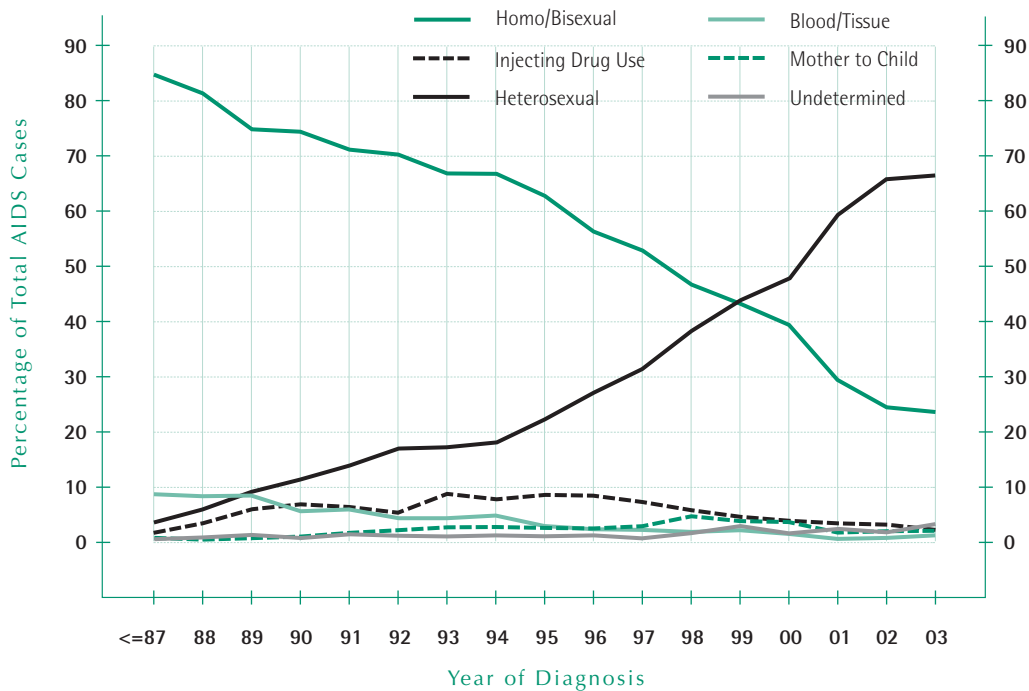
New diagnoses of HIV, development of AIDS and deaths of HIV positive people are reported to the Health Protection Agency (HIV and STD Division) and the Scottish Centre for Infection and Environmental Health, who compile the data into quarterly surveillance tables³². Figures 1.3 to 1.7 and tables 1.1 and 1.2 in this chapter give an overview of trends in the UK using these data. The majority of HIV positive people reside in London. This means that national policy is often shaped with a strong bias to the needs of London and the South East³³⁻³⁶. Additionally, the data under-represent some regions of the UK³³⁻³⁶. Chapters 2 to 5 of this report are based on monitoring of treatment and care of individuals with HIV or AIDS, and provide the most accurate and detailed information on HIV epidemiology available for the North West.

The number of people reported as being newly diagnosed with AIDS in the UK in 2003 alone was 560, bringing the cumulative total number of people with AIDS since notification began in 1982 to 20,089 (figure 1.3). The number of new AIDS cases represents a 70% 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 therapies²¹.

The cumulative total of reported HIV infections in the UK rose to 61,100 at the end of 2003 (figure 1.4). Of these, 5,044 cases were newly identified in 2003. The epidemiology of HIV in England, Wales and Northern Ireland is shifting as a result of changing patterns in the route of transmission of new infections (figures 1.5 and 1.6). The epidemiology of HIV differs in Scotland, as shown in figure 1.7.

An additional tool for monitoring the HIV epidemic in the UK is provided by the unlinked anonymous HIV seroprevalence programme conducted by the Health Protection Agency and the Institute of Child Health. Part of the programme involves the testing of blood samples that have been taken for other purposes, for example antenatal screening, after having irreversibly removed patient identifying details. This allows estimations of the extent of undiagnosed HIV infection in high risk groups as well as in the general population. The monitoring programme has been operating throughout England and Wales since 1990 and provides low cost estimates of current HIV prevalence³⁷. Results of the programme suggest that at the end of 2002 there were 49,500 adults infected with HIV in the UK, of whom 15,200 (31%) were unaware of their status³⁸.

Figure 1.5: Number of AIDS cases in the UK by year of diagnosis and infection route of HIV to December 2003 Source: AIDS/HIV Quarterly Surveillance Tables No 61, HPA

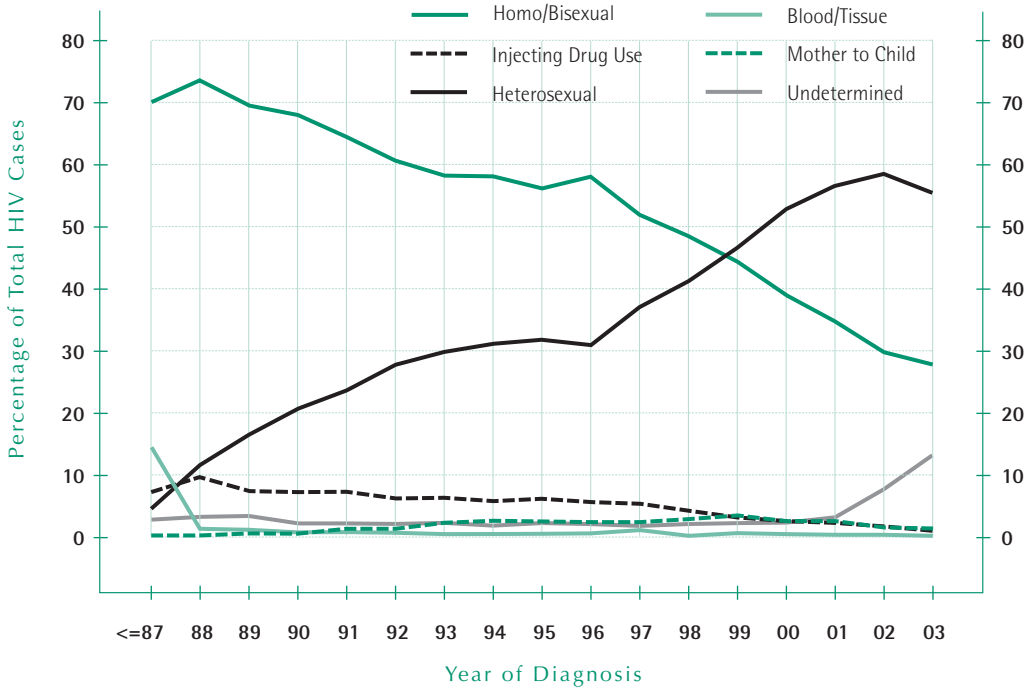


YEAR OF DIAGNOSIS	Infection Route						Total
	Homo/Bisexual*	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undeter-mined	
<=1987	1322	26	56	134	13	12	1563
1988	738	28	52	75	7	8	908
1989	810	64	98	91	8	12	1083
1990	925	82	140	69	17	10	1243
1991	989	88	194	82	18	19	1390
1992	1108	84	268	70	30	17	1577
1993	1193	154	308	79	41	11	1786
1994	1230	140	334	90	43	16	1853
1995	1111	152	395	52	40	19	1769
1996	851	118	389	32	34	12	1436
1997	575	78	339	24	52	5	1073
1998	366	44	305	15	42	12	784
1999	322	30	326	15	34	20	747
2000	320	38	388	12	43	12	813
2001	207	24	416	4	37	16	704
2002	205	25	530	7	26	14	807
2003	132	12	372	6	20	18	560
Total	12404	1187	4910	857	505	233	20096

* includes 325 men who had also injected drugs

Figure 1.6: Number of HIV cases in England, Wales and Northern Ireland by year of diagnosis and infection route of HIV to December 2003

Source: AIDS/HIV Quarterly Surveillance Tables No 61, HPA



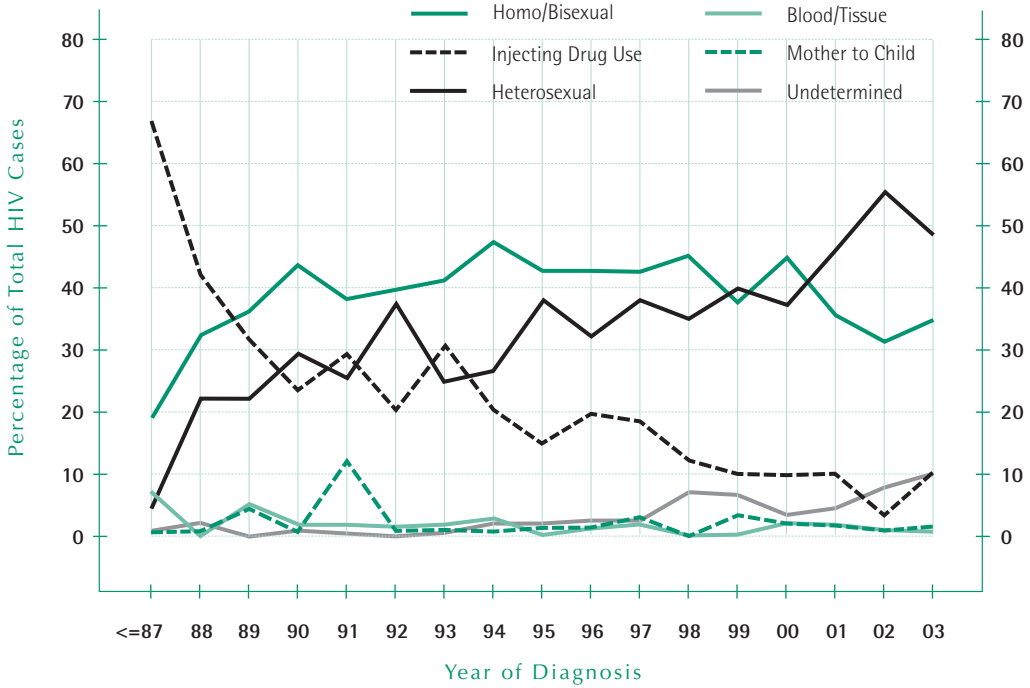
YEAR OF DIAGNOSIS	Infection Route						Total**
	Homo/Bisexual*	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
<=1987	6314	660	418	1311	17	254	8997
1988	1337	174	211	25	12	57	1818
1989	1413	176	334	22	11	68	2028
1990	1652	172	499	22	28	51	2429
1991	1649	191	603	21	30	55	2549
1992	1586	160	729	22	57	53	2608
1993	1437	152	731	15	64	59	2459
1994	1414	138	756	13	64	44	2430
1995	1411	160	798	19	59	59	2508
1996	1479	141	785	19	60	51	2535
1997	1336	137	952	26	75	46	2573
1998	1293	112	1103	9	94	52	2664
1999	1301	96	1368	20	77	63	2927
2000	1436	94	1945	21	99	89	3684
2001	1690	115	2792	22	79	154	4852
2002	1681	99	3299	26	98	435	5638
2003	1336	67	2676	16	85	643	4823
Total***	29765	2844	19999	1629	1009	2233	57522

* includes 683 men who had also injected drugs

** includes 43 with sex not stated on report

*** includes 79 patients who were first reported from the Channel Islands

Figure 1.7: Number of HIV cases in Scotland by year of diagnosis and infection diagnosis of HIV to December 2003 Source: AIDS/HIV Quarterly Surveillance Tables No 61, HPA



YEAR OF DIAGNOSIS	Infection Route						Total
	Homo/Bisexual*	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
<=1987	227	762	53	81	6	10	1139
1988	44	57	30	0	1	3	135
1989	42	37	26	6	5	0	116
1990	52	28	35	2	1	1	119
1991	66	51	44	3	7	1	172
1992	53	27	50	2	1	0	133
1993	70	52	42	2	2	1	169
1994	70	30	39	4	1	3	147
1995	63	22	56	1	2	3	147
1996	69	32	52	2	2	4	161
1997	69	31	55	3	5	4	167
1998	71	19	55	1	0	11	157
1999	56	16	60	1	5	10	148
2000	66	15	55	3	3	5	147
2001	57	16	74	3	3	7	160
2002	68	7	120	2	2	17	216
2003	78	8	109	2	4	23	224
Total	1221	1210	955	118	50	103	3657

* includes 40 men who had also injected drugs

Men who have sex with men

Amongst homo/bisexual men in the UK, HIV is currently the third most commonly diagnosed STI³⁸. The category of homosexual exposure accounts for 66% of all AIDS cases so far reported in the UK (figure 1.5) and 55% of all HIV cases (figure 1.6). However, the shape of the epidemic is changing, and the proportion of new HIV diagnoses attributed to sex between men has decreased from a high of 74% in 1987 to 28% in 2003. The pattern is different in Scotland, where men who have sex with men account for only 35% of the total number of people who have been diagnosed with HIV (figure 1.7).

The 1980s saw substantial reductions in risky behaviour among gay men in response to the AIDS crisis. Following several years of stable levels of risk behaviour³⁹, more recent annual surveys⁴⁰ show that gay men in London appear to be following a trend for a reduction in safer sex behaviour. A recent survey indicates that half of homosexual men who had anal intercourse did so without a condom⁴¹. This change in self-reported risk behaviour is mirrored by increasing levels of homosexually acquired syphilis (by 616% between 1999 and 2002) in the UK³⁸. As well as indicating increases in risk behaviour, sexually transmitted infections may also act as a co-factor in the transmission of HIV⁴².

At the end of 2002 there were an estimated 22,600 homosexually infected HIV positive individuals living in the UK, of whom 5,500 (24%) were undiagnosed. The overall prevalence of HIV among homo/bisexual men was estimated to be 7%³⁸, although this was higher in London (26%) than elsewhere (4%)⁴³.

Heterosexual sex

Sex between men and women now accounts for 35% of the total number of HIV diagnoses in England, Wales and Northern Ireland. However, since 1999 heterosexual sex has accounted for the largest number of new cases, at 55% in 2003 (figure 1.6). Heterosexual cases are categorised as to whether they were exposed through sex with high-risk partners, were exposed abroad or exposed in the UK (figure 1.8). In 2003, 73% cases of heterosexually acquired HIV were contracted abroad. The prevalence of HIV in the general heterosexual population is also monitored by anonymous testing of pregnant women. These data reveal that the prevalence of HIV in the heterosexual population is ten times higher in London than the North West (399 per 100,000 compared to 33 per 100,000: figure 1.9). For those HIV positive individuals infected through heterosexual sex, the majority (59%) are female³².

Sub-Saharan Africa is the predominant global region of transmission for those HIV cases acquired abroad³². This is also reflected in the epidemiology of HIV in the North West, where, of those newly reported in 2003 and infected abroad, over three quarters were exposed in sub-Saharan Africa (see chapter 2, figure 2.1). Individuals from black and minority ethnic communities form the majority of heterosexually transmitted AIDS cases in the UK with black Africans constituting the largest group³². These communities have close connections with sub-Saharan societies, the region in which 67% of the global total of adults and children estimated to be living with HIV/AIDS at the end of 2003 reside (figure 1.1). However, HIV is often stigmatised within African communities, which can prevent individuals from accessing services⁴⁴.

At the end of 2002, there were an estimated 24,500 individuals living with heterosexually acquired HIV, of whom a high proportion (38%) were unaware of their HIV status. This was particularly the case among males, where 45% were undiagnosed³⁸.

Figure 1.8: Number of heterosexually acquired HIV cases in the UK by year of report to December 2003 Source: AIDS/HIV Quarterly Surveillance Tables No 61, HPA

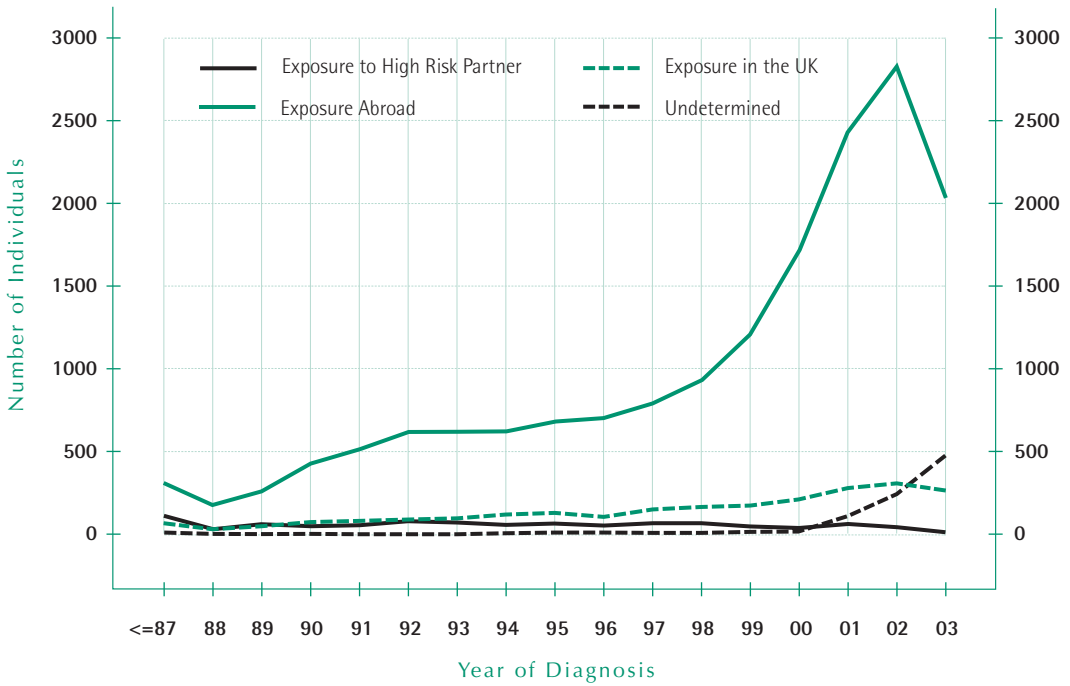
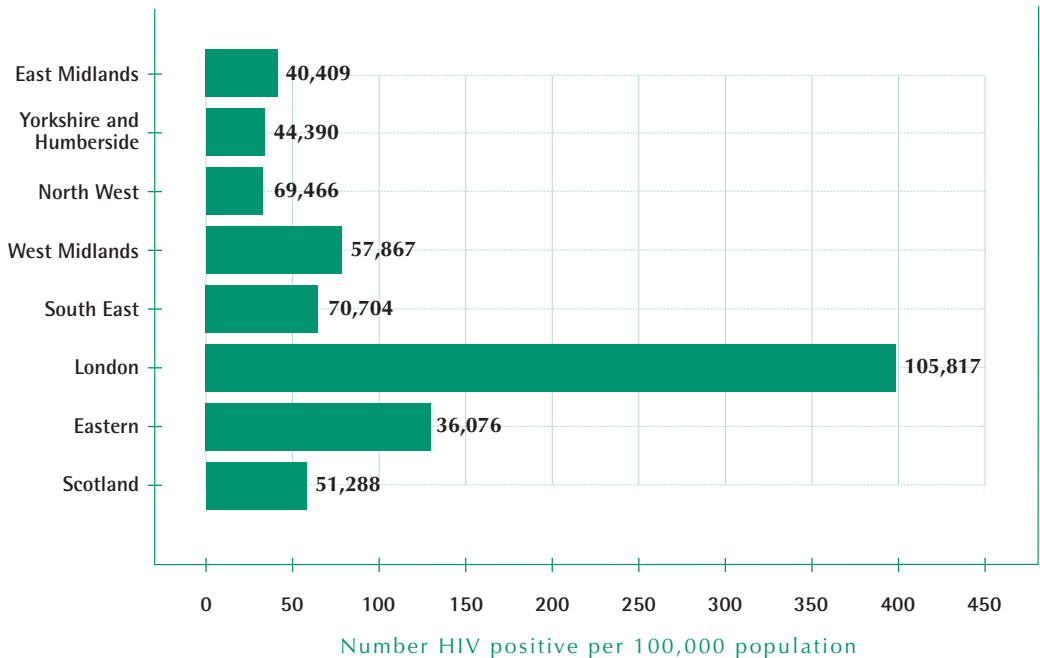


Figure 1.9: HIV prevalence among pregnant women in England, 2002 (newborn infant dried blood spots collected for metabolic screening)

Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 2002



Numbers by each bar represent sample sizes

Injecting drug users

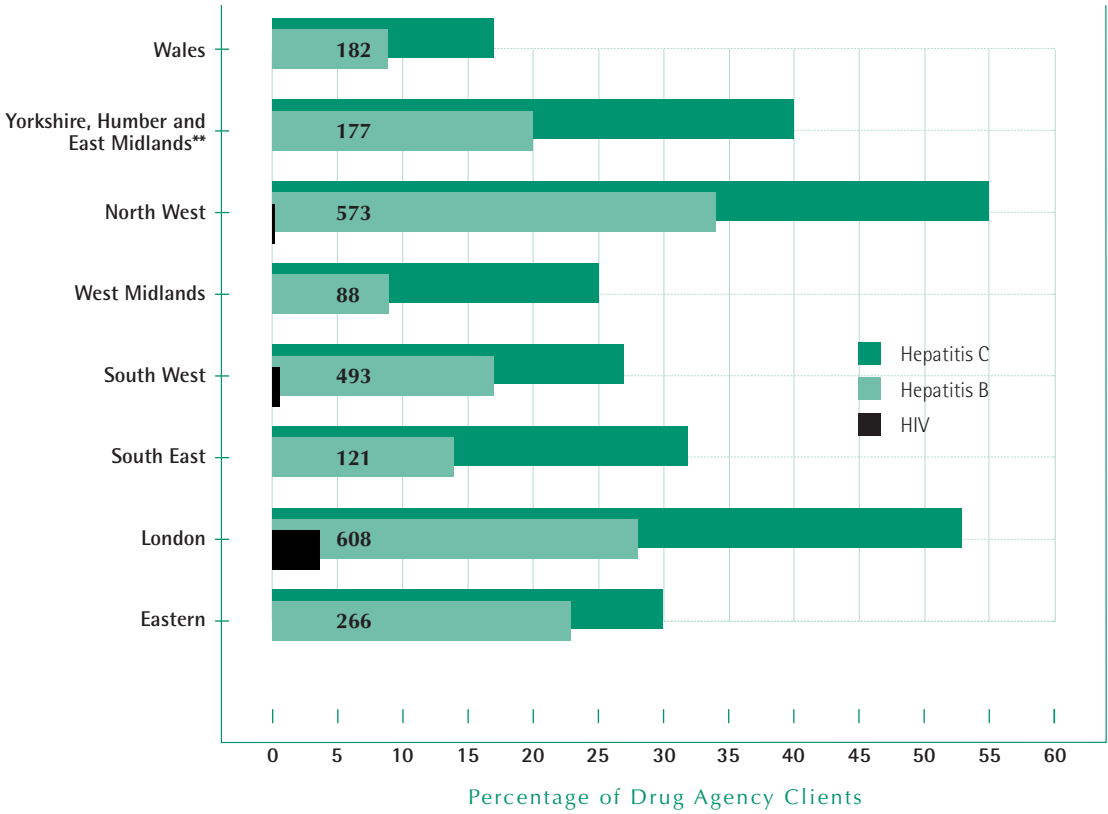
Injecting drug use accounts for 5% of the total diagnosed HIV infections in England, Wales and Northern Ireland to date (figure 1.6). The proportion newly diagnosed by this route in 2003 has dropped to just 1.4%, the same as 2002. In Scotland, the epidemic has historically been centred on injecting drug use, which accounted for 70% of infections up to and including 1986. This proportion has steadily decreased, and in 2003 only 3% of new infections were attributed to this route (figure 1.7).

Other blood borne infections, such as hepatitis B and C, are more infectious than HIV and are transmitted during episodes of indirect sharing (for example sharing of filters, spoons or water when preparing drugs). Figure 1.10 shows the prevalence of HIV, hepatitis B and hepatitis C amongst injecting drug users by region. While the prevalence of HIV remains fairly low, hepatitis B and C rise to alarming levels, with the North West showing the highest prevalence of both at 34% and 55% respectively. Because HIV is less infectious than hepatitis C, those individuals who have had sufficient high risk exposure via injecting drug use to acquire HIV are also likely to have been infected with hepatitis C. Having both infections makes the treatment of each more difficult to manage, increases the progression of hepatitis disease and, for women, increases the probability of transmission of HIV to an infant during pregnancy or birth (see review in the North West report⁴⁵).

Anonymous testing of injecting drug users attending services reveals that, outside London, the prevalence of HIV among injectors is low; at 0.17% in the North West compared to 4% in London (figure 1.10). At the end of 2002, there were an estimated 1,700 injecting drug users living with HIV, of whom 300 (18%) were unaware of their HIV status³⁸. The low prevalence among drug users in the UK compared to other countries in Europe has been attributed to harm reduction strategies such as needle exchanges⁴⁶.

Figure 1.10: Prevalence of HIV, hepatitis B and hepatitis C antibodies among injecting drug users attending drugs agencies, 2002 (voluntary saliva samples)

Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 2002



Numbers at the base of each bar represent the sample sizes.

Blood or tissue

Since the introduction of screening of donated blood for HIV and heat treatment of blood products in 1985, infection by these routes has been rare. This is clearly indicated by the abrupt decline from 19% of all infections reported before and during 1986 to just 0.3% in 2003 (figure 1.6).

A small number of cases continue to be diagnosed as a result of transfusions or blood products received overseas³⁸. After 1985, the rare instances of HIV infection via blood transfusions in the UK were the 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 disease⁴⁷. When 5,579 transfusion recipients were followed up, none had been infected with HIV as a result, suggesting that the current risk of transmission from a transfusion in the UK is very low: at less than one in 5,000⁴⁸.

Mother to child

During 2003, 85 infants were reported to have contracted HIV from their mothers (figure 1.6). This figure will inevitably increase as the year progresses as there is a delay in reporting vertically transmitted HIV, due to the presence of maternal antibodies for up to 18 months after birth that confound the diagnosis.

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%⁴⁹. Currently, the main obstacle that prevents successful intervention is lack of knowledge by the mother of her HIV status. It has recently become policy to offer an HIV test to all pregnant women with the aim of increasing the uptake of the test to 90% of all pregnant women^{50,51}. In 2003, 81% of pregnant HIV positive women in London were diagnosed before delivery⁵². There was a noticeable improvement in diagnosis prior to delivery in the North West in 2001/2002, at 76% of all HIV positive pregnant women as opposed to 37% in 1999/2000. This improvement would equate to 15 additional unborn babies having benefited from access to preventative measures.

For those children who are born with HIV in the UK, the prognosis has improved with the advent of triple therapy: they are living longer, are less likely to require hospital admission and are less likely to progress to AIDS⁵³. Consequently, services are being developed to address the needs of this group as they become young adults⁵⁴.

HIV and AIDS in the North West of England - 2003

Figures 1.3 and 1.4 and Tables 1.1 and 1.2 are taken from the Health Protection Agency Quarterly Surveillance Tables to illustrate the status of the HIV/AIDS epidemic in the North West by comparison to the rest of the UK. This information is useful for monitoring trends both nationally and regionally. For the most accurate and detailed information about people living with HIV and AIDS in the North West, see the comprehensive overview in chapters 2 to 5 of this report.

By the end of 2003, a cumulative total of 3,918 HIV infections in the North West had been reported to the Health Protection Agency, including 385* new diagnoses during 2003 (figure 1.4). There were 61 newly diagnosed AIDS cases in the North West in 2003, bringing the cumulative total to 1,175, 6% of the total number of AIDS cases reported in the UK (figure 1.3).

The pattern of exposure to HIV among people with AIDS in the North West is broadly similar to that of the UK, with the majority of people who have had an AIDS diagnosis reported as having been infected by homosexual sex (table 1.1). However, the North West has a lower proportion of people infected with HIV via heterosexual sex (19% compared to 24%) and a correspondingly higher proportion of men who were infected by having sex with men (59% compared to 51%) (table 1.2). As in previous years, the proportion of individuals exposed through the receipt of contaminated blood or blood products is approximately twice the national average for both HIV and AIDS cases. At least part of this is likely to be due to patients from other areas attending specialist haematology units in the North West Region and in some cases moving residence for convenience. The data in figure 1.11 are derived from the anonymous seroprevalence survey conducted by the Health Protection Agency, 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 2002 show an increase in the prevalence of HIV from 22 per 100,000 in 2001 to 33 per 100,000 pregnant women.

**This figure is lower than the number of new cases given in chapter 2 of this report due to under-reporting and reporting delays on the new diagnosis system.*

Table 1.1: Cumulative number of AIDS cases in the North West and the UK by infection route of HIV to December 2003 Source: AIDS/HIV Quarterly Surveillance Tables No 61, HPA

	Infection Route					Total (100%)
	Homo/Bisexual*	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Other/Undetermined**	
North West Region	743 (63.2%)	59 (5.0%)	227 (19.3%)	105 (8.9%)	41 (3.5%)	1175
Total UK	12400 (61.7%)	1187 (5.9%)	4910 (24.4%)	856 (4.3%)	736 (3.7%)	20089

* includes 325 men who had also injected drugs

** includes 505 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 2003 Source: AIDS/HIV Quarterly Surveillance Tables No 61, HPA

	Infection Route					Total*** (100%)
	Homo/Bisexual*	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Other/Undetermined**	
North West Region	2298 (58.7%)	189 (4.8%)	1016 (25.9%)	198 (5.1%)	217 (5.5%)	3918
Total UK	30955 (50.7%)	4043 (6.6%)	20925 (34.2%)	1744 (2.9%)	3390 (5.5%)	61100

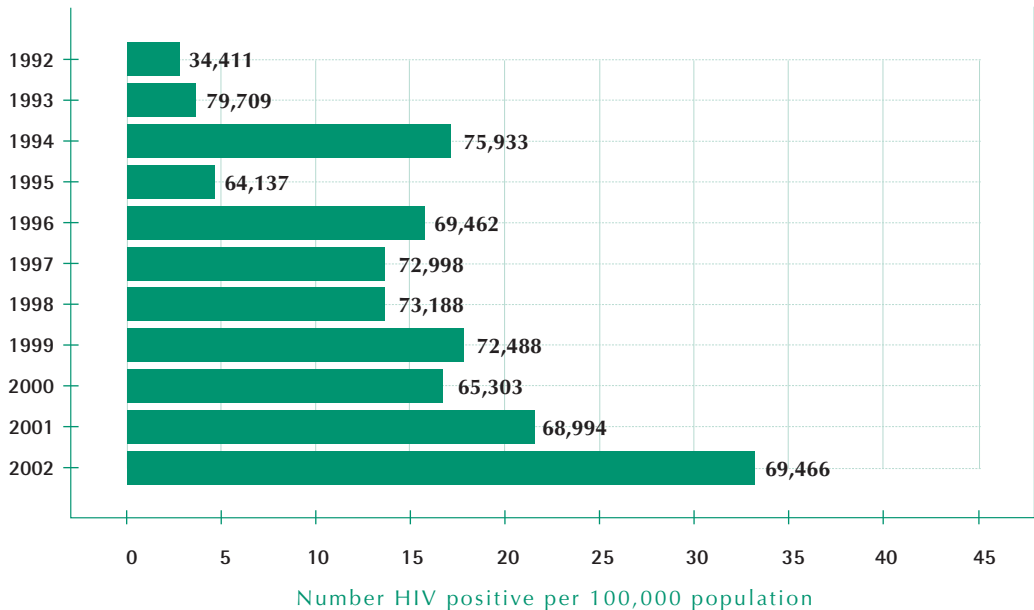
* includes 723 men who had also injected drugs

** includes 1059 children of HIV infected mothers

*** includes 43 with sex not stated on report

Figure 1.11: HIV prevalence among pregnant women in the North West, 1992-2002 (newborn infant dried blood spots collected for metabolic screening)

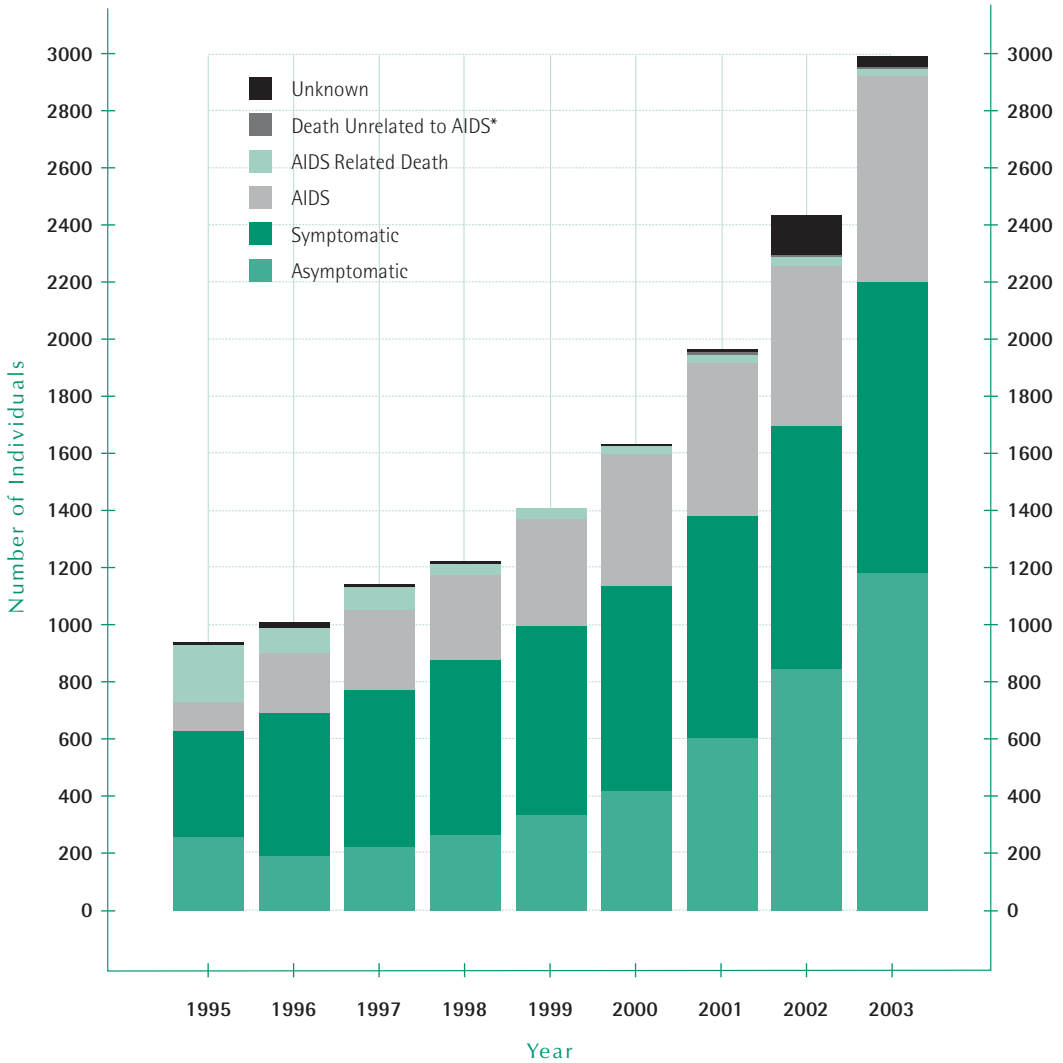
Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 2002



Numbers by each bar represent sample sizes

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

(All cases including those that died during each year)



STAGE OF HIV DISEASE	Year									
	1995	1996	1997	1998	1999	2000	2001	2002	2003	
Asymptomatic	260 (27.6%)	192 (18.9%)	228 (20.5%)	266 (21.8%)	337 (23.9%)	423 (25.9%)	606 (30.9%)	844 (34.7%)	1181 (39.5%)	
Symptomatic	370 (39.3%)	498 (49.1%)	552 (49.6%)	610 (50.1%)	660 (46.8%)	715 (43.8%)	774 (39.4%)	848 (34.9%)	1015 (34%)	
AIDS	198 (21.0%)	213 (21.0%)	278 (25.0%)	297 (24.4%)	376 (26.7%)	458 (28.1%)	534 (27.2%)	562 (23.1%)	725 (24.3%)	
AIDS related death	98 (10.4%)	87 (8.6%)	43 (3.9%)	38 (3.1%)	37 (2.6%)	30 (1.8%)	30 (1.5%)	28 (1.2%)	23 (0.8%)	
Death unrelated to AIDS*							6 (0.3%)	8 (0.3%)	7 (0.2%)	
Unknown	15 (1.6%)	24 (2.4%)	12 (1.1%)	7 (0.6%)		6 (0.4%)	14 (0.7%)	139 (5.7%)	37 (1.2%)	
TOTAL (100%)	941	1014	1113	1218	1410	1632	1964	2429	2988	

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

Figure 1.12 shows the number of people with HIV and AIDS who contacted statutory treatment centres in the North West of England. These data represent the most accurate and comprehensive source of information related to HIV and AIDS in the North West of England. The data collected by the North West HIV and AIDS Monitoring Unit, from across the region over the last nine years, illustrate the increasing number of people accessing HIV services. For the fourth year running, there has been a large increase (23%) in the number of HIV positive individuals attending treatment centres. This continuing increase in the size of the HIV positive population is partly due to the decrease in the number of people dying from AIDS related illnesses, but also due to an increasing number of new cases (which this year has increased by 18% on last year's total: see chapter 2). A full description of the epidemiology of HIV and AIDS in the North West is given in chapters 2 and 3 of this report.

The sexual health of the North West

There is particular concern about the sexual health of the North West population, where rates of sexually transmitted infections such as gonorrhoea, genital warts and syphilis amongst males and Chlamydia amongst females were the highest in England outside London in 2002³⁸. 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, through weakening the defences of the genital tract⁵⁵. Of the recent outbreaks of syphilis in the UK, the outbreak in Manchester continues to be one of the largest. Between January 1999 and March 2004, there have been a total of 615 cases, with 167 of these being diagnosed during the year 2003⁵⁶. Prior to the outbreak, only about seven cases would have been expected per year in Greater Manchester⁵⁷. Of the total number of syphilis cases, gay or bisexual men make up 83% and 23.6% were HIV positive⁵⁶. Investigations of those infected during the outbreak revealed high levels of anonymous unprotected oral sex⁵⁸⁻⁶¹. As part of these investigations, individuals without syphilis were recruited into the study. Of particular concern was the fact that 62% of HIV positive individuals without syphilis exhibited the same patterns of high risk behaviour as the syphilis infected group, as did 16% of the HIV negative individuals⁶².

Asylum seekers and HIV

Globally, migrants are often at greater risk of HIV infection than are resident populations, irrespective of their country of origin⁶³. A recent inquiry by the All-Party Parliamentary Group on AIDS concluded that while resident in the UK, asylum seekers were at an increased risk of developing resistance to treatment if dispersed away from their source of treatment and support. This is due to the 95% adherence to antiretroviral therapy that is required to have the greatest effect in treating the virus⁶⁴.

During 2003 the UK received 49,370 asylum applications, 41% less than in 2002⁶⁵. Although not all asylum seekers are from high HIV prevalent countries, 17% of all applications were from Africa in 2003. Somalia was the most common nationality of asylum seekers in 2003, whilst Zimbabwe was the fourth most common nationality, a 57% decrease on the 2002 figures⁶⁵.

According to Home Office statistics, there are currently 9,100 new asylum applicants residing in the North West receiving support from the National Asylum Support Service⁶⁶. Within this region, the largest numbers of asylum seekers are located in Manchester, (1,860) and Liverpool, (1,470). For the third year, the North West HIV/AIDS Monitoring Unit has requested information about HIV positive individuals' asylum seeker status. Since last year, the number of such individuals has increased by 107%, from 153 to 316. Information about those known to be asylum seekers is presented in tables 3.27 and 3.28.

2. New Cases 2003

During 2003, 725 new HIV and AIDS cases presented to statutory treatment centres in the North West Region. This is the largest number in any year since reporting began. New cases are defined as individuals seen in the North West Region in 2003 but not during the years 1995 to 2002 and include new HIV positive individuals who died during the year. The number of new cases has increased by 18% on the number of new cases reported in 2002 (617)⁹. This increase is lower than last year's increase of 37% and similar to the 16% increase seen in 2000.

Data regarding newly reported cases of HIV infections assist in the identification of trends in incidence and represent the most up to date information on the characteristics of HIV infection and transmission. Such information is valuable not only for planning and evaluating the success of preventive activities, but also for predicting the future incidence of HIV and AIDS and its impact on treatment and care services in the North West of England. The aim of this chapter is to present information relating to new cases and, where appropriate, references are made to corresponding data from previous North West reports³⁻⁹.

Analyses are given by strategic health authorities (SHAs) and primary care trusts (PCTs). PCTs have been allocated on the basis of postcode data, provided by the North West Public Health Observatory. It is not possible to present all analyses by PCT; further PCT data are available from the North West Public Health Observatory website (www.nwpho.org.uk/hiv2003).

2. New Cases 2003

Table 2.1: Age distribution of new HIV and AIDS cases by infection route of HIV, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 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					7 (100%)		7
15-19	4 (36.4%)		6 (54.5%)			1 (9.1%)	11
20-24	26 (34.7%)	1 (1.3%)	45 (60%)			3 (4%)	75
25-29	35 (30.4%)	3 (2.6%)	70 (60.9%)			7 (6.1%)	115
30-34	69 (39.9%)	2 (1.2%)	88 (50.9%)			14 (8.1%)	173
35-39	63 (46.7%)	1 (0.7%)	65 (48.1%)	1 (0.7%)		5 (3.7%)	135
40-44	51 (50%)		44 (43.1%)			7 (6.9%)	102
45-49	27 (56.3%)		18 (37.5%)			3 (6.3%)	48
50-54	12 (44.4%)		13 (48.1%)			2 (7.4%)	27
55-59	7 (38.9%)		6 (33.3%)			5 (27.8%)	18
60+	6 (42.9%)		6 (42.9%)	2 (14.3%)			14
Total	300 (41.4%)	7 (1%)	361 (49.8%)	3 (0.4%)	7 (1%)	47 (6.5%)	725

Age ranges refer to the age of individuals at end of December 2003, 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 2.1 illustrates the age distribution and infection route of new HIV and AIDS cases presenting in the North West for treatment in 2003. Almost a quarter of all reported cases in 2003 were seen for the first time during this year. The majority of newly reported cases fall between the ages of 25 and 44 (72%), with incidence being highest in those aged 30-34 years (24%). As seen last year, exposure by heterosexual sex accounts for more new cases (50%) than does homosexual sex (41%). Thus the North West now follows the trend that has been apparent in England, Wales and Northern Ireland since 1999 (see chapter 1, figure 1.6). The majority of the young people aged 15 to 24 years for whom route of exposure is known were infected with HIV during sex (either homosexual or heterosexual); injecting drug use was the route in only one case in this age group.

The proportion of new HIV positive individuals infected through injecting drugs has remained low this year (1%), a trend that has followed the decline over recent years.

During the year seven new cases of vertical transmission were reported from North West treatment centres. Three new cases were reported as being attributed to having received contaminated blood or tissue. The infection route for 47 new cases (7%) 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 this year is only 5% (chapter 3, table 3.2).

Table 2.2a: Residential distribution of new HIV and AIDS cases by stage of HIV disease, January-December 2003: strategic health authority (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

SHA OF RESIDENCE	Stage of HIV Disease					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
Cumbria and Lancashire	47 (47.5%)	25 (25.3%)	20 (20.2%)	4 (4%)	3 (3%)	99
Cheshire and Merseyside	93 (62.8%)	27 (18.2%)	21 (14.2%)	5 (3.4%)	2 (1.4%)	148
Greater Manchester	257 (61.3%)	82 (19.6%)	64 (15.3%)	2 (0.5%)	14 (3.3%)	419
Isle of Man	3 (60%)		2 (40%)			5
East Midlands	1 (100%)					1
London	1 (33.3%)	1 (33.3%)	1 (33.3%)			3
Scotland		1 (100%)				1
Wales	2 (100%)					2
West Midlands	1 (50%)	1 (50%)				2
Yorkshire and The Humber	1 (33.3%)	1 (33.3%)	1 (33.3%)			3
Unknown	28 (66.7%)	3 (7.1%)	5 (11.9%)		6 (14.3%)	42
Total	434 (59.9%)	141 (19.4%)	114 (15.7%)	11 (1.5%)	25 (3.4%)	725

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

Table 2.2b: Residential distribution of new HIV and AIDS cases by stage of HIV disease, January-December 2003: Cumbria and Lancashire primary care trusts

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

PCT OF RESIDENCE	Stage of HIV Disease					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
Carlisle and District	2 (66.7%)	1 (33.3%)				3
Eden Valley	3 (75%)	1 (25%)				4
West Cumbria	1 (33.3%)		2 (66.7%)			3
Morecambe Bay		1 (50%)	1 (50%)			2
Blackpool	17 (47.2%)	9 (25%)	6 (16.7%)	1 (2.8%)	3 (8.3%)	36
Fylde	3 (60%)		1 (20%)	1 (20%)		5
Wyre	1 (25%)	2 (50%)	1 (25%)			4
Preston	7 (50%)	2 (14.3%)	5 (35.7%)			14
Hyndburn and Ribble Valley	2 (40%)	2 (40%)		1 (20%)		5
Burnley, Pendle and Rossendale	1 (25%)	2 (50%)		1 (25%)		4
Blackburn with Darwen	4 (40%)	4 (40%)	2 (20%)			10
Chorley and South Ribble	4 (57.1%)	1 (14.3%)	2 (28.6%)			7
West Lancashire	2 (100%)					2
Total	47 (47.5%)	25 (25.3%)	20 (20.2%)	4 (4%)	3 (3%)	99

Table 2.2c: Residential distribution of new HIV and AIDS cases by stage of HIV disease, January-December 2003: Cheshire and Merseyside primary care trusts

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

PCT OF RESIDENCE	Stage of HIV Disease					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
Southport and Formby	6 (60%)	2 (20%)	2 (20%)			10
South Sefton	8 (72.7%)	1 (9.1%)	1 (9.1%)	1 (9.1%)		11
North Liverpool	8 (72.7%)	3 (27.3%)				11
Central Liverpool	27 (56.3%)	11 (22.9%)	6 (12.5%)	2 (4.2%)	2 (4.2%)	48
South Liverpool	13 (81.3%)	1 (6.3%)	1 (6.3%)	1 (6.3%)		16
Knowsley	5 (100%)					5
St Helens	1 (100%)					1
Halton	1 (50%)	1 (50%)				2
Warrington	2 (33.3%)	1 (16.7%)	3 (50%)			6
Birkenhead and Wallasey	2 (33.3%)	2 (33.3%)	2 (33.3%)			6
Bebington and West Wirral		1 (100%)				1
Ellesmere Port and Neston	2 (100%)					2
Cheshire West	9 (90%)		1 (10%)			10
Central Cheshire	3 (42.9%)	2 (28.6%)	2 (28.6%)			7
Eastern Cheshire	6 (50%)	2 (16.7%)	3 (25%)	1 (8.3%)		12
Total	93 (62.8%)	27 (18.2%)	21 (14.2%)	5 (3.4%)	2 (1.4%)	148

Table 2.2d: Residential distribution of new HIV and AIDS cases by stage of HIV disease, January-December 2003: Greater Manchester primary care trusts

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

PCT OF RESIDENCE	Stage of HIV Disease					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
Ashton, Leigh and Wigan	8 (80%)	1 (10%)	1 (10%)			10
Bolton	18 (64.3%)	7 (25%)	3 (10.7%)			28
Bury	16 (66.7%)	5 (20.8%)	3 (12.5%)			24
Heywood and Middleton	1 (100%)					1
Rochdale	3 (50%)	1 (16.7%)	2 (33.3%)			6
Salford	40 (60.6%)	12 (18.2%)	10 (15.2%)		4 (6.1%)	66
Trafford North	8 (38.1%)	7 (33.3%)	5 (23.8%)	1 (4.8%)		21
Trafford South	1 (50%)	1 (50%)				2
North Manchester	58 (65.9%)	17 (19.3%)	9 (10.2%)		4 (4.5%)	88
Central Manchester	60 (57.1%)	18 (17.1%)	22 (21%)	1 (1%)	4 (3.8%)	105
South Manchester	13 (68.4%)	3 (15.8%)	3 (15.8%)			19
Oldham	12 (70.6%)	1 (5.9%)	3 (17.6%)		1 (5.9%)	17
Tameside and Glossop	8 (53.3%)	4 (26.7%)	2 (13.3%)		1 (6.7%)	15
Stockport	11 (64.7%)	5 (29.4%)	1 (5.9%)			17
Total	257 (61.3%)	82 (19.6%)	64 (15.3%)	2 (0.5%)	14 (3.3%)	419

Table 2.2a illustrates the clinical stage of HIV disease of new HIV and AIDS cases presenting in the North West for treatment in 2003, broken down by strategic health authority of residence. The figures refer to the clinical condition of individuals when last seen in the year 2003; individuals who died from AIDS related illnesses are presented in a separate category to other AIDS cases.

HIV positive individuals categorised as asymptomatic continue to represent the largest proportion of new cases (60%), with the proportion in each category being comparable to the 2002 data. This maintains the observation that HIV positive individuals are contacting services at a relatively early stage of their HIV disease. Of the eleven new individuals who died during the year all had been first diagnosed as having had AIDS defining illnesses. This shows that despite continued efforts to raise awareness, individuals are continuing to present too late to benefit from life-prolonging treatment.

Tables 2.2b, c and d present the breakdown of stage of disease by primary care trust within each of the three strategic health authorities (Cumbria and Lancashire, table 2.2b; Cheshire and Merseyside, table 2.2c; and Greater Manchester, table 2.2d). The widespread distribution of new HIV positive individuals demonstrates the importance of HIV prevention initiatives in every primary care trust.

Residents of Greater Manchester SHA accounted for over half (58%) of new HIV and AIDS cases presenting for treatment and care in the North West. However, at 19%, it was Cheshire and Merseyside SHA that saw the biggest increase on last years' figures, compared to a 17% increase in Greater Manchester SHA and a 3% increase in Cumbria and Lancashire. The vast majority of new cases receiving care in the North West during 2003 were resident within the region (92%). Of the 17 individuals known to live outside the region, 29% were reported as residing on the Isle of Man, 18% in London and 18% in Yorkshire and the Humber.

Table 2.3a shows the strategic health authority of residence and the route of transmission of new HIV and AIDS cases presenting in the North West for treatment in 2003. Although the infection route for 56% of all HIV positive individuals seen in 2003 was attributed to sex between men (chapter 3, table 3.2), this proportion was lower for new cases, where 41% were infected through homosexual/bisexual sex. Across the strategic health authorities there are large differences in the route of infection. Whilst Cheshire and Merseyside is mainly heterosexual (55%) and relatively few homo/bisexual (28%), Cumbria and Lancashire is the reverse, with 35% heterosexual and 63% homo/bisexual.

Tables 2.3b, c and d show route of infection of new HIV and AIDS cases and the PCT of residence for each of the strategic health authorities. Of those infected through homo/bisexual sex in Cumbria and Lancashire, 53% reside in Blackpool, an area with a large gay community. Manchester also has a large gay community⁶⁶, and correspondingly, North Manchester and Central Manchester PCTs account for 46% of new cases exposed via homosexual sex who reside within the region.

The proportion of new cases exposed to HIV via heterosexual transmission (50%) represents a large increase when compared to previous years data (21% in 1998 and 41% in 2002) and is also higher than the 33% of all cases exposed via this route of infection (chapter 3, table 3.2).

Table 2.3a: Residential distribution of new HIV and AIDS cases by infection route of HIV, January-December 2003: strategic health authority

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

SHA OF RESIDENCE	Infection Route						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
Cumbria and Lancashire	62 (62.6%)		35 (35.4%)			2 (2%)	99
Cheshire and Merseyside	41 (27.7%)	3 (2%)	81 (54.7%)		1 (0.7%)	22 (14.9%)	148
Greater Manchester	169 (40.3%)	3 (0.7%)	220 (52.5%)	3 (0.7%)	6 (1.4%)	18 (4.3%)	419
Isle of Man	2 (40%)		3 (60%)				5
East Midlands	1 (100%)						1
London			1 (33.3%)			2 (66.7%)	3
Scotland			1 (100%)				1
Wales	1 (50%)					1 (50%)	2
West Midlands	2 (100%)						2
Yorkshire and The Humber	1 (33.3%)		2 (66.7%)				3
Unknown	21 (50%)	1 (2.4%)	18 (42.9%)			2 (4.8%)	42
Total	300 (41.4%)	7 (1%)	361 (49.8%)	3 (0.4%)	7 (1%)	47 (6.5%)	725

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

Table 2.3b: Residential distribution of new HIV and AIDS cases by infection route of HIV, January-December 2003: Cumbria and Lancashire primary care trusts

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

PCT OF RESIDENCE	Infection Route			Total (100%)
	Homo/Bisexual	Heterosexual	Undetermined	
Carlisle and District		2 (66.7%)	1 (33.3%)	3
Eden Valley	2 (50%)	1 (25%)	1 (25%)	4
West Cumbria	2 (66.7%)	1 (33.3%)		3
Morecambe Bay	1 (50%)	1 (50%)		2
Blackpool	33 (91.7%)	3 (8.3%)		36
Fylde	4 (80%)	1 (20%)		5
Wyre	4 (100%)			4
Preston	4 (28.6%)	10 (71.4%)		14
Hyndburn and Ribble Valley	1 (20%)	4 (80%)		5
Burnley, Pendle and Rossendale	3 (75%)	1 (25%)		4
Blackburn with Darwen	2 (20%)	8 (80%)		10
Chorley and South Ribble	6 (85.7%)	1 (14.3%)		7
West Lancashire		2 (100%)		2
Total	62 (62.6%)	35 (35.4%)	2 (2%)	99

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

Table 2.3c: Residential distribution of new HIV and AIDS cases by infection route of HIV, January-December 2003: Cheshire and Merseyside primary care trusts

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

PCT OF RESIDENCE	Infection Route					Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Mother to Child	Undetermined	
Southport and Formby			9 (90%)		1 (10%)	10
South Sefton	3 (27.3%)		2 (18.2%)		6 (54.5%)	11
North Liverpool	1 (9.1%)		6 (54.5%)	1 (9.1%)	3 (27.3%)	11
Central Liverpool	8 (16.7%)	1 (2.1%)	36 (75%)		3 (6.3%)	48
South Liverpool	2 (12.5%)		11 (68.8%)		3 (18.8%)	16
Knowsley	2 (40%)		2 (40%)		1 (20%)	5
St Helens			1 (100%)			1
Halton	1 (50%)				1 (50%)	2
Warrington	3 (50%)	1 (16.7%)	1 (16.7%)		1 (16.7%)	6
Birkenhead and Wallasey	4 (66.7%)		1 (16.7%)		1 (16.7%)	6
Bebington and West Wirral	1 (100%)					1
Ellesmere Port and Neston	1 (50%)		1 (50%)			2
Cheshire West	6 (60%)	1 (10%)	3 (30%)			10
Central Cheshire	2 (28.6%)		5 (71.4%)			7
Eastern Cheshire	7 (58.3%)		3 (25%)		2 (16.7%)	12
Total	41 (27.7%)	3 (2%)	81 (54.7%)	1 (0.7%)	22 (14.9%)	148

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

Table 2.3d: Residential distribution of new HIV and AIDS cases by infection route of HIV, January-December 2003: Greater Manchester primary care trusts

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

PCT OF RESIDENCE	Infection Route						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Ashton, Leigh and Wigan	3 (30%)		6 (60%)			1 (10%)	10
Bolton	7 (25%)		19 (67.9%)	1 (3.6%)	1 (3.6%)		28
Bury	6 (25%)	1 (4.2%)	16 (66.7%)			1 (4.2%)	24
Heywood and Middleton			1 (100%)				1
Rochdale	2 (33.3%)		3 (50%)			1 (16.7%)	6
Salford	37 (56.1%)	1 (1.5%)	27 (40.9%)			1 (1.5%)	66
Trafford North	7 (33.3%)		10 (47.6%)	1 (4.8%)	1 (4.8%)	2 (9.5%)	21
Trafford South	2 (100%)						2
North Manchester	40 (45.5%)	1 (1.1%)	42 (47.7%)		1 (1.1%)	4 (4.5%)	88
Central Manchester	37 (35.2%)		58 (55.2%)	1 (1%)	2 (1.9%)	7 (6.7%)	105
South Manchester	7 (36.8%)		12 (63.2%)				19
Oldham	7 (41.2%)		10 (58.8%)				17
Tameside and Glossop	2 (13.3%)		11 (73.3%)		1 (6.7%)	1 (6.7%)	15
Stockport	12 (70.6%)		5 (29.4%)				17
Total	169 (40.3%)	3 (0.7%)	220 (52.5%)	3 (0.7%)	6 (1.4%)	18 (4.3%)	419

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

Table 2.4 illustrates the residential distribution of new HIV and AIDS cases presenting in the North West for treatment in 2003, categorised by age group. Individuals aged 30-34 represent the largest group of new cases accessing treatment and care (24%). As would be expected, new cases tend to be younger (median age of 35 years) than the age distribution of all cases (median age 38 years). Thus, individuals under the age of 25 represent a larger proportion of new cases (13%) than all cases (7%: chapter 3, table 3.7), demonstrating the continuing need to encourage young people at risk of HIV exposure to access services. Across the strategic health authorities there are slight variations in age distributions. In Cumbria and Lancashire individuals aged 35-39 represent the largest group of new cases (median age 38 years), whilst in Cheshire and Merseyside and Greater Manchester the largest number of new cases are in the 30-34 age range (median ages 35 and 34 years respectively) Individuals aged 50 years or older represent 8% of all new cases seen during 2003, the same proportion as in 2002.

Table 2.4: Residential distribution of new HIV and AIDS cases by age category, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

SHA OF RESIDENCE	Age Group											Total (100%)
	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	
Cumbria and Lancashire		1 (1%)	6 (6.1%)	15 (15.2%)	17 (17.2%)	24 (24.2%)	18 (18.2%)	7 (7.1%)	5 (5.1%)	2 (2%)	4 (4%)	99
Cheshire and Merseyside	1 (0.7%)	4 (2.7%)	15 (10.1%)	26 (17.6%)	31 (20.9%)	21 (14.2%)	28 (18.9%)	11 (7.4%)	4 (2.7%)	5 (3.4%)	2 (1.4%)	148
Greater Manchester	6 (1.4%)	4 (1%)	49 (11.7%)	64 (15.3%)	112 (26.7%)	76 (18.1%)	49 (11.7%)	25 (6%)	17 (4.1%)	9 (2.1%)	8 (1.9%)	419
Isle of Man				1 (20%)	1 (20%)	1 (20%)	1 (20%)	1 (20%)				5
East Midlands					1 (100%)							1
London					1 (33.3%)	2 (66.7%)						3
Scotland				1 (100%)								1
Wales					1 (50%)	1 (50%)						2
West Midlands						1 (50%)	1 (50%)					2
Yorkshire and The Humber			1 (33.3%)			1 (33.3%)	1 (33.3%)					3
Unknown		2 (4.8%)	4 (9.5%)	8 (19%)	9 (21.4%)	8 (19%)	4 (9.5%)	4 (9.5%)	1 (2.4%)	2 (4.8%)		42
Total	7 (1%)	11 (1.5%)	75 (10.3%)	115 (15.9%)	173 (23.9%)	135 (18.6%)	102 (14.1%)	48 (6.6%)	27 (3.7%)	18 (2.5%)	14 (1.9%)	725

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. Age ranges refer to the age of individuals at end of December 2003, or at death. For a breakdown of age category by primary care trust, please see the North West Public Health Observatory website: www.nwpho.org.uk/hiv2003/table2-4.htm

Table 2.5: Residential distribution of new HIV and AIDS cases by sex, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

SHA OF RESIDENCE	Sex		Total (100%)
	Male	Female	
Cumbria and Lancashire	82 (82.8%)	17 (17.2%)	99
Cheshire and Merseyside	91 (61.5%)	57 (38.5%)	148
Greater Manchester	259 (61.8%)	160 (38.2%)	419
Isle of Man	4 (80%)	1 (20%)	5
East Midlands	1 (100%)		1
London	2 (66.7%)	1 (33.3%)	3
Scotland	1 (100%)		1
Wales	2 (100%)		2
West Midlands	2 (100%)		2
Yorkshire and The Humber	2 (66.7%)	1 (33.3%)	3
Unknown	27 (64.3%)	15 (35.7%)	42
Total	473 (65.2%)	252 (34.8%)	725

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of sex by primary care trust, please see the North West Public Health Observatory website: www.nwpho.org.uk/hiv2003/table2-5.htm

Table 2.5 illustrates the residential distribution of new HIV and AIDS cases presenting in the North West for treatment in 2003, categorised by sex. As in previous years, the majority of new cases in 2003 were men (65%). This is largely due to the relatively high proportion of homo/bisexual sex as a method of exposure to HIV. Although more men were newly infected in 2003 (473 individuals) compared to 2002 (445 individuals), the proportion of individuals who are male has decreased from 72% reflecting the increasing numbers of new cases who are heterosexually infected. Of the three SHAs, Cumbria and Lancashire has the highest proportion of men (83%), consistent with the high proportion of homosexual exposure (63%: table 2.3a).

The number of female new cases has increased by over a third, from 172 in 2002 to 252 in 2003, and the proportion of new HIV cases that are female has increased from 28% to 35% in the same time period. This may have a knock-on effect on the number of mother to child infections, especially in minority ethnic communities, since 85% of females are self-defined as being from an ethnic minority (table 2.9).

Table 2.6 illustrates the route of transmission of new HIV and AIDS cases presenting in the North West Region for treatment in 2003, categorised by sex. For the second year running, heterosexual sex has overtaken homosexual sex as the predominant mode of HIV exposure. The proportion of individuals infected by sex between men has decreased slightly from 46% in 2002, for those of whom route of infection was known, to 44% this year. This is a continuation on the decline seen in previous years such as 2001 when the proportion was 54%.

The predominant method of exposure to HIV amongst women continues to be heterosexual sex (96%). Of those HIV positive individuals whose route of infection has been identified, 53% of new cases presenting in the North West had their infection attributed to heterosexual sex. This compares to 34% of all cases seen during 2003 (chapter 3, table 3.6) and 51% of new cases seen during 2002, reflecting the growing issue of heterosexual transmission of HIV in the North West and in the United Kingdom as a whole (chapter 1, figure 1.6). Seven new cases were identified as having been infected via injecting drug use (four men and three women); this represents an increase on last years' figure.

Table 2.6: Infection route of new HIV and AIDS cases by sex, January-December

2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

SEX	Infection Route						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
Male	300 (63.4%)	4 (0.8%)	120 (25.4%)	1 (0.2%)	4 (0.8%)	44 (9.3%)	473
Female		3 (1.2%)	241 (95.6%)	2 (0.8%)	3 (1.2%)	3 (1.2%)	252
Total	300 (41.4%)	7 (1%)	361 (49.8%)	3 (0.4%)	7 (1%)	47 (6.5%)	725

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

Table 2.7: Residential distribution of new HIV and AIDS cases by ethnic group, January-December 2003

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

SHA OF RESIDENCE	Ethnicity								Total (100%)
	White	Black Caribbean	Black African	Black Other	Indian/Pakistani/Bangladeshi	Other Asian/Oriental	Other/Mixed	Unknown	
Cumbria and Lancashire	79 (79.8%)		17 (17.2%)		1 (1%)	1 (1%)	1 (1%)		99
Cheshire and Merseyside	85 (57.4%)	1 (0.7%)	55 (37.2%)	2 (1.4%)		4 (2.7%)		1 (0.7%)	148
Greater Manchester	182 (43.4%)	6 (1.4%)	203 (48.4%)	2 (0.5%)		2 (0.5%)	10 (2.4%)	14 (3.3%)	419
Isle of Man	3 (60%)		2 (40%)						5
East Midlands	1 (100%)								1
London	3 (100%)								3
Scotland			1 (100%)						1
Wales	2 (100%)								2
West Midlands	1 (50%)	1 (50%)							2
Yorkshire and The Humber	2 (66.7%)		1 (33.3%)						3
Unknown	28 (66.7%)	2 (4.8%)	9 (21.4%)			2 (4.8%)		1 (2.4%)	42
Total	386 (53.2%)	10 (1.4%)	288 (39.7%)	4 (0.6%)	1 (0.1%)	9 (1.2%)	11 (1.5%)	16 (2.2%)	725

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of ethnicity by primary care trust, please see the North West Public Health Observatory website:

www.nwpho.org.uk/hiv2003/table2-7.htm

Table 2.7 illustrates the residential distribution of new HIV and AIDS cases presenting in the North West for treatment in 2003, categorised by ethnic group. Ethnic group classifications are those used by the Health Protection Agency AIDS and STD Centre, for the Survey Of Prevalent Diagnosed HIV Infections (SOPHID).

The majority of new cases in 2003 whose ethnicity was known were self-defined as white (54%), a lower figure than the corresponding data for all cases (74%) (chapter 3, table 3.8). Of those HIV positive individuals whose ethnicity was known, 46% are self-defined as being from a minority ethnic group, compared to 40% in 2002. This indicates a substantial over representation of new HIV cases within black and minority ethnic communities, when compared to their overall proportion within the North West population (5.6%)⁹⁷. Thus, the incidence of diagnosed HIV is 14 times higher in black and minority ethnic communities than in the white population in the North West. However, there are substantial differences across the North West in terms of the proportion of new HIV cases that are from black and

minority ethnic populations, ranging from 20% in Cumbria and Lancashire (same percentage as last year) to 55% in Greater Manchester (up from 51% last year). The proportion of new cases who are from black and minority ethnic communities (46%) is higher than the 26% identified within all cases, in particular those self-defined as black African (41% for new cases, 21% for all cases) (chapter 3, table 3.8). This illustrates the change in the ethnic distribution of HIV and AIDS cases and the need for specialist services such as The Black Health Agency (BHA) and specialist projects within the voluntary sector to provide care and support for communities which have already been identified as having shorter life expectancies, together with poorer physical and mental health⁶⁸.

Table 2.8: Ethnic distribution of new HIV and AIDS cases by infection route of HIV, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

ETHNICITY	Infection Route						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
White	280 (72.5%)	6 (1.6%)	64 (16.6%)	2 (0.5%)		34 (8.8%)	386
Black Caribbean	1 (10%)		8 (80%)			1 (10%)	10
Black African	4 (1.4%)		273 (94.8%)	1 (0.3%)	7 (2.4%)	3 (1%)	288
Black Other		1 (25%)	3 (75%)				4
Indian/Pakistani/Bangladeshi			1 (100%)				1
Other Asian/Oriental			7 (77.8%)			2 (22.2%)	9
Other/Mixed	8 (72.7%)		3 (27.3%)				11
Unknown	7 (43.8%)		2 (12.5%)			7 (43.8%)	16
Total	300 (41.4%)	7 (1%)	361 (49.8%)	3 (0.4%)	7 (1%)	47 (6.5%)	725

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

Table 2.8 illustrates the ethnic group and HIV exposure category of new HIV and AIDS cases presenting in the North West for treatment in 2003. Whilst heterosexual sex accounts for the largest number of new cases over all, there are differences between ethnic groups. Of the 323 individuals self-classified as being from a black or minority ethnic community, most (91%) were infected heterosexually while only 4% were infected by sex between men. In contrast, amongst white individuals, most (73%) were infected by sex between men, with only 17% infected heterosexually. All seven of the children infected by mother to child transmission were from the black African community. A decisive factor influencing the dissimilar distribution of infection route across ethnicity of new cases of HIV and AIDS may be the role of exposure abroad (table 2.13).

Table 2.9: Ethnic distribution of new HIV and AIDS cases by sex, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

SEX	Ethnicity								Total
	White	Black Caribbean	Black African	Black Other	Indian/Pakistani/Bangladeshi	Other Asian/Oriental	Other/Mixed	Unknown	
Male	350 (90.7%)	7 (70%)	88 (30.6%)	1 (25%)	1 (100%)	4 (44.4%)	9 (81.8%)	13 (81.3%)	473 (65.2%)
Female	36 (9.3%)	3 (30%)	200 (69.4%)	3 (75%)		5 (55.6%)	2 (18.2%)	3 (18.8%)	252 (34.8%)
Total (100%)	386	10	288	4	1	9	11	16	725

Table 2.9 illustrates the ethnic group and sex of new HIV and AIDS cases presenting in the North West for treatment in 2003. As in previous years the majority of new HIV and AIDS cases are male (65%) with 74% of these being self-defined as white, up from 58% last year. The majority of women seen in the region for the first time in 2003 are self-defined as being from a minority ethnic group (86%). Black Africans account for 80% of all female new cases for whom ethnicity is known. Whilst in the white population the gender distribution is highly biased towards males (91%), 66% of the new black and minority ethnic cases are female. This is predominately due to the lower proportion of homosexual exposure in black and minority ethnic communities and higher levels of heterosexual exposure to HIV (table 2.8).

Table 2.10: Ethnic distribution of new HIV and AIDS cases by clinical stage of HIV disease January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

ETHNICITY	Stage of HIV Disease					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
White	235 (60.9%)	81 (21%)	51 (13.2%)	6 (1.6%)	13 (3.4%)	386
Black Caribbean	5 (50%)	2 (20%)	1 (10%)	1 (10%)	1 (10%)	10
Black African	168 (58.3%)	54 (18.8%)	60 (20.8%)	4 (1.4%)	2 (0.7%)	288
Black Other	3 (75%)		1 (25%)			4
Indian/Pakistani/Bangladeshi	1 (100%)					1
Other Asian/Oriental	7 (77.8%)	1 (11.1%)			1 (11.1%)	9
Other/Mixed	9 (81.8%)	1 (9.1%)			1 (9.1%)	11
Unknown	6 (37.5%)	2 (12.5%)	1 (6.3%)		7 (43.8%)	16
Total	434 (59.9%)	141 (19.4%)	114 (15.7%)	11 (1.5%)	25 (3.4%)	725

Table 2.10 illustrates the ethnic group and clinical stage of new HIV and AIDS cases presenting in the North West for treatment in 2003. The figures refer to the clinical condition of individuals when last seen in the year 2003; individuals who died from AIDS related illnesses are presented in a separate category to other AIDS cases.

Overall, 60% of new HIV and AIDS cases presented while still asymptomatic, 16% were categorised as AIDS and 2% died during the year. Prior to 2002 we reported considerable differences among ethnic groups. For example, in 2001, 18% of white and 27% of non-white individuals presented for the first time already with AIDS, and in 2000 the margin was wider with 16% of white individuals already having AIDS compared to 34% of non-white ethnic communities. This year, as seen last year, individuals from black and minority ethnic communities were just as likely to present while still asymptomatic (61%) as were white individuals (63%) and no more likely to be symptomatic (18% compared to 22% of white individuals), to have AIDS (20% compared to 14%) or die (2% for both white and non-white). This suggests that those from black and minority ethnic communities are becoming more likely to access care at an early stage of their disease, and hopefully prolonging their life expectancy.

Table 2.11 illustrates route of infection of new cases and whether or not exposure to HIV occurred abroad. Forty three percent of all new cases of HIV and AIDS were reported to have been contracted outside the UK. As in previous years heterosexual sex continues to be the major method of exposure to HIV in those infected abroad with 90% of those individuals infected via this route. Of those infected abroad, the proportion who were infected via homosexual sex has decreased in 2003 to 6%, from 10% in 2002. For those new individuals reported to have been infected with HIV in the UK, sex between men is the predominant mode of exposure (79%).

Table 2.11: The role of contact abroad in exposure to HIV of new HIV and AIDS cases by infection route, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases 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	20 (6.4%)	2 (0.6%)	281 (90.1%)	1 (0.3%)	4 (1.3%)	4 (1.3%)	312
No	216 (79.1%)	3 (1.1%)	32 (11.7%)	2 (0.7%)	1 (0.4%)	19 (7%)	273
Unknown	64 (45.7%)	2 (1.4%)	48 (34.3%)		2 (1.4%)	24 (17.1%)	140
Total	300 (41.4%)	7 (1%)	361 (49.8%)	3 (0.4%)	7 (1%)	47 (6.5%)	725

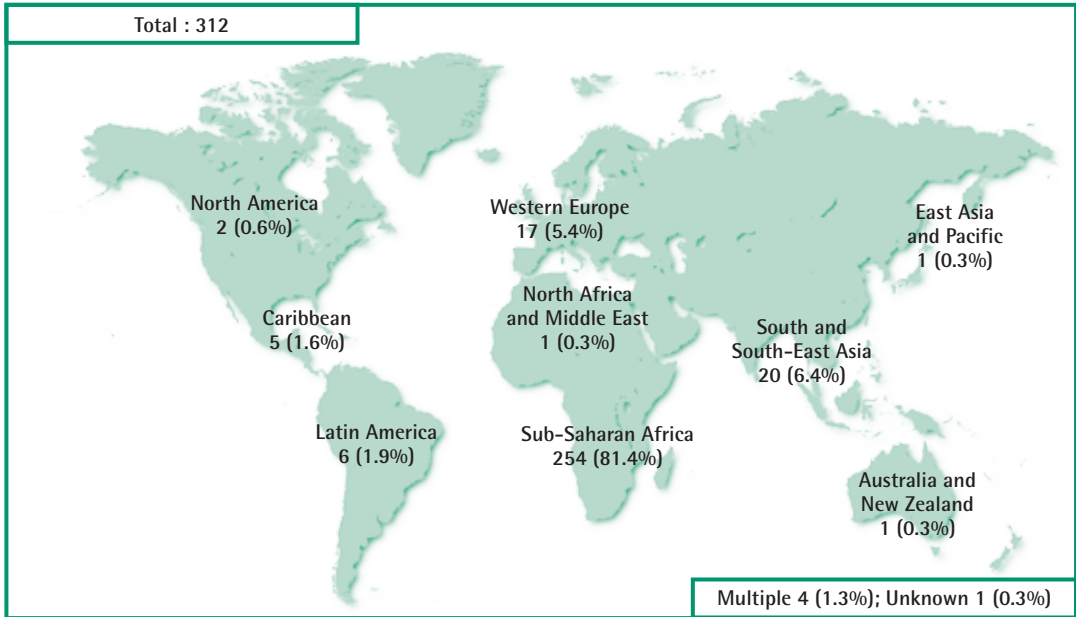
Men who have had homosexual or bisexual exposure and who are also injecting drug users are included in the homo/bisexual category.

Figure 2.1 shows the global region and country of HIV transmission for new cases acquired outside the UK presenting in the North West for treatment in 2003. Over three quarters of all HIV infections contracted abroad were acquired in sub-Saharan Africa (81%), with a further 6% in South and South East Asia and 5% in Western Europe.

Of the 312 new cases who probably acquired their infection abroad, the country of probable exposure is available for 294 individuals (94%). Individuals reported to have been infected in Zimbabwe dominate the statistics (a trend also seen last year), accounting for 42% of all infections thought to have been acquired abroad (130 individuals). Countries in Sub Saharan Africa also account for the next two largest numbers of new cases, South Africa 7% (21 individuals) and Malawi 5% (15 individuals). Thailand accounts for the fourth highest number of infections attributed to a single country (14 individuals), a change from 2002 when it was the second highest country of infection. Infections acquired in Western Europe were most likely to be from Italy, Spain, Southern Ireland or the Netherlands.

Figure 2.1: Global region and country of new HIV and AIDS cases who probably acquired their infection outside the UK, January-December 2003

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)



Sub-Saharan Africa	254 (81.4%)	Zambia	7 (2.2%)	Italy	4 (1.3%)
Angola	3 (1%)	Zimbabwe	130 (41.7%)	Netherlands	2 (0.6%)
Botswana	5 (1.6%)	Unknown	7 (2.2%)	Portugal	1 (0.3%)
Burundi	4 (1.3%)	Multiple	4 (1.3%)	Spain	4 (1.3%)
Cameroon	5 (1.6%)	East Asia and the Pacific	1 (0.3%)	Multiple	1 (0.3%)
Congo	8 (2.6%)	China	1 (0.3%)	North Africa and Middle East	1 (0.3%)
Cote d'Ivoire	2 (0.6%)	Australia and New Zealand	1 (0.3%)	Sudan	1 (0.3%)
Dem. Republic of Congo	1 (0.3%)	Australia	1 (0.3%)	North America	2 (0.6%)
Ethiopia	3 (1%)	South and South East Asia	20 (6.4%)	United States of America	2 (0.6%)
Gambia	2 (0.6%)	Cambodia	1 (0.3%)	Caribbean	5 (1.6%)
Ghana	2 (0.6%)	Indonesia	1 (0.3%)	Dominican Republic	1 (0.3%)
Kenya	6 (1.9%)	Malaysia	1 (0.3%)	Jamaica	4 (1.3%)
Malawi	15 (4.8%)	Singapore	1 (0.3%)	Latin America	6 (1.9%)
Namibia	2 (0.6%)	Sri Lanka	1 (0.3%)	Brazil	3 (1%)
Nigeria	10 (3.2%)	Thailand	14 (4.5%)	Colombia	1 (0.3%)
Rwanda	3 (1%)	Multiple	1 (0.3%)	Costa Rica	1 (0.3%)
Somalia	2 (0.6%)	Western Europe	17 (5.4%)	El Salvador	1 (0.3%)
South Africa	21 (6.7%)	Belgium	1 (0.3%)	Multiple	4 (1.3%)
Swaziland	1 (0.3%)	Eire	2 (0.6%)	Unknown	1 (0.3%)
Tanzania	1 (0.3%)	France	1 (0.3%)	Total	312 (100%)
Uganda	10 (3.2%)	Germany	1 (0.3%)		

Table 2.12: Global region and infection route of HIV of new cases who probably acquired their infection outside the UK, January-December 2003

(New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 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	
Australia and New Zealand	1 (100%)						1
Caribbean			5 (100%)				5
East Asia and Pacific			1 (100%)				1
Latin America	2 (33.3%)		3 (50%)			1 (16.7%)	6
North Africa and Middle East			1 (100%)				1
North America	2 (100%)						2
South and South-East Asia	2 (10%)		17 (85%)			1 (5%)	20
Sub-Saharan Africa	1 (0.4%)		246 (96.9%)	1 (0.4%)	4 (1.6%)	2 (0.8%)	254
Western Europe	9 (52.9%)	2 (11.8%)	6 (35.3%)				17
Multiple	2 (50%)		2 (50%)				4
Unknown	1 (100%)						1
Total	20 (6.4%)	2 (0.6%)	281 (90.1%)	1 (0.3%)	4 (1.3%)	4 (1.3%)	312

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

Table 2.12 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 2003. The vast majority (88%) of individuals with heterosexually acquired HIV whose infections were probably contracted abroad were acquired in sub-Saharan Africa, with a further 6% contracted in South and South East Asia. Heterosexually acquired HIV in sub-Saharan Africa accounts for 68% of all new cases attributed to this mode of infection (table 2.11). Heterosexual exposure in sub-Saharan Africa is spread across 22 different countries, reflecting the extent of the epidemic in that continent¹².

Western Europe accounted for the largest number of new cases acquired via homosexual sex while abroad (45%). This could reflect the reported tendency of gay men to take risks while on holiday⁶⁹. Two out of the seven new cases that were infected by injecting drug use were thought to be infected abroad, both of which were in western Europe. Injecting drug use remains a major transmission route of HIV in many western European countries³¹. Although the risk of contracting HIV via injecting drug use is relatively low in the UK due to the low prevalence of HIV among this group (chapter 1, figure 1.10) sharing injecting equipment abroad remains a significant risk.

Table 2.13: The role of contact abroad in exposure to HIV of new HIV and AIDS cases by ethnicity, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

HIV EXPOSURE ABROAD	Ethnicity								Total
	White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Yes	48 (12.4%)	6 (60%)	248 (86.1%)	1 (25%)		6 (66.7%)	3 (27.3%)		312 (43%)
No	251 (65%)		9 (3.1%)	1 (25%)	1 (100%)	2 (22.2%)	5 (45.5%)	4 (25%)	273 (37.7%)
Unknown	87 (22.5%)	4 (40%)	31 (10.8%)	2 (50%)		1 (11.1%)	3 (27.3%)	12 (75%)	140 (19.3%)
Total (100%)	386	10	288	4	1	9	11	16	725

Table 2.13 shows exposure to HIV abroad by ethnic group of new HIV and AIDS cases who presented in the North West for treatment in 2003. Of those self-defined as white, 12% were reported as having probably been infected with HIV whilst abroad. This is not the case for those from black and ethnic communities where 82% are reported as being exposed to HIV whilst abroad, with this figure rising slightly to 86% amongst individuals self-defined as black African. The role of contact abroad to HIV has not been identified in 23% of white HIV positive individuals accessing treatment in 2003 and 13% of black and ethnic minorities.

Table 2.14: Stage of HIV disease of new HIV and AIDS cases by level of antiretroviral therapy, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

STAGE OF HIV DISEASE	Level of Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or more	
Asymptomatic	316 (72.8%)		1 (0.2%)	111 (25.6%)	6 (1.4%)	434
Symptomatic	43 (30.5%)	1 (0.7%)		82 (58.2%)	15 (10.6%)	141
AIDS	31 (27.2%)		1 (0.9%)	65 (57%)	17 (14.9%)	114
AIDS related death	5 (45.5%)			6 (54.5%)		11
Unknown	20 (80%)			4 (16%)	1 (4%)	25
Total	415 (57.2%)	1 (0.1%)	2 (0.3%)	268 (37%)	39 (5.4%)	725

Table 2.14 refers to the clinical condition of individuals when last seen in the year 2003; individuals who died from AIDS related illnesses are presented in a separate category to other AIDS cases. Individuals are categorised by the highest level of combination therapy they received from any treatment centre in the North West during 2003.

As illustrated, 42% of new HIV and AIDS cases presenting in the North West received triple or more combination therapy when last seen during 2003. The number of new individuals receiving quadruple or more therapy has increased from 25 (4%) in 2002 to 39 (5%) in 2003. While antiretroviral therapy was not prescribed for 57% of new cases, fewer than 1% of new cases were prescribed mono or dual therapy. This low level of mono and dual therapy is consistent with the current British HIV Association (BHIVA) guidelines on the treatment of HIV disease, which recommends the use of a triple or more regime⁷⁰.

The majority (72%) of new cases categorised as AIDS received triple or more combination therapy, while 69% of those classed as symptomatic received this level of therapy. The data also illustrate that 73% of new cases

categorised as asymptomatic were not receiving any antiretroviral therapy at the end of 2003. The latest BHIVA guidelines advocate the initiation of therapy when the CD4 count is in the range of 200-350, taking into account symptoms, rate of CD4 decline, viral load and age⁷⁰. There are, therefore, implications for a continued increase in demand and supply of combination antiretroviral therapy.

Table 2.15: Distribution of new HIV and AIDS cases by treatment centre, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

TREATMENT CENTRE	NEW CASES	TREATMENT CENTRE	NEW CASES	TREATMENT CENTRE	NEW CASES
AHC	1	LEII	1	SALG	19
APH	7	MAC	9	SHH	3
BLAG	44	MGP	23	SPG	14
BLK	4	MRI	60	STP	19
BLKG	11	MRIG	72	TAMG	4
BOLG	29	NMG	192	TRAG	5
BURG	4	NMGG	46	WAR	8
BURY	13	NOB	6	WGH	1
CHR	14	OLDG	6	WHIT	1
CUM	7	PG	24	WIGG	7
DDU	1	QSC	43	WITG	26
FGH	3	RLG	102	WORK	2
HAL	2	RLI	1		
LEI	6	ROCG	6		

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report. Numbers cannot be totalled as some individuals may attend two or more treatment locations thus exaggerating the totals.

Table 2.15 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 2003 was the Infectious Disease Unit at North Manchester General Hospital (NMG), with 23% of new cases. As in previous years, large numbers of new cases were also seen at Manchester Royal Infirmary Department of Genito-Urinary Medicine (MRIG) and Royal Liverpool University Hospital Department of Genito-Urinary Medicine (RLG). Several treatment centres have seen increases in the number of new cases in 2003 compared to 2002, for example Bury GUM (BURY) saw a 333% increase (from three to 13), Blackpool Victoria Hospital GUM (BLAG) saw a 109% increase (from 21 to 44) and Manchester Royal Infirmary Outpatients Department (MRI) has seen over twice as many new patients (from 26 to 60).

Although the larger hospitals reported the most new cases it is the smaller ones that have the higher proportion of new cases relative to their total case load (For example, Royal Albert Edward Infirmary GUM 100%, Trafford General Hospital GUM 63% and Warrington Hospital GUM 62%; see chapter 3, table 3.17). This illustrates the importance these smaller treatment centres have in attracting individuals who think they have contracted HIV or other sexually transmitted diseases.

Figure 2.2: Population prevalence of new HIV and AIDS cases by primary care trust, January-December 2003 (New cases are defined as individuals seen in the North West Region in 2003 but not between 1995 and 2002 and include new cases who died during the year)

Per 100,000 Population

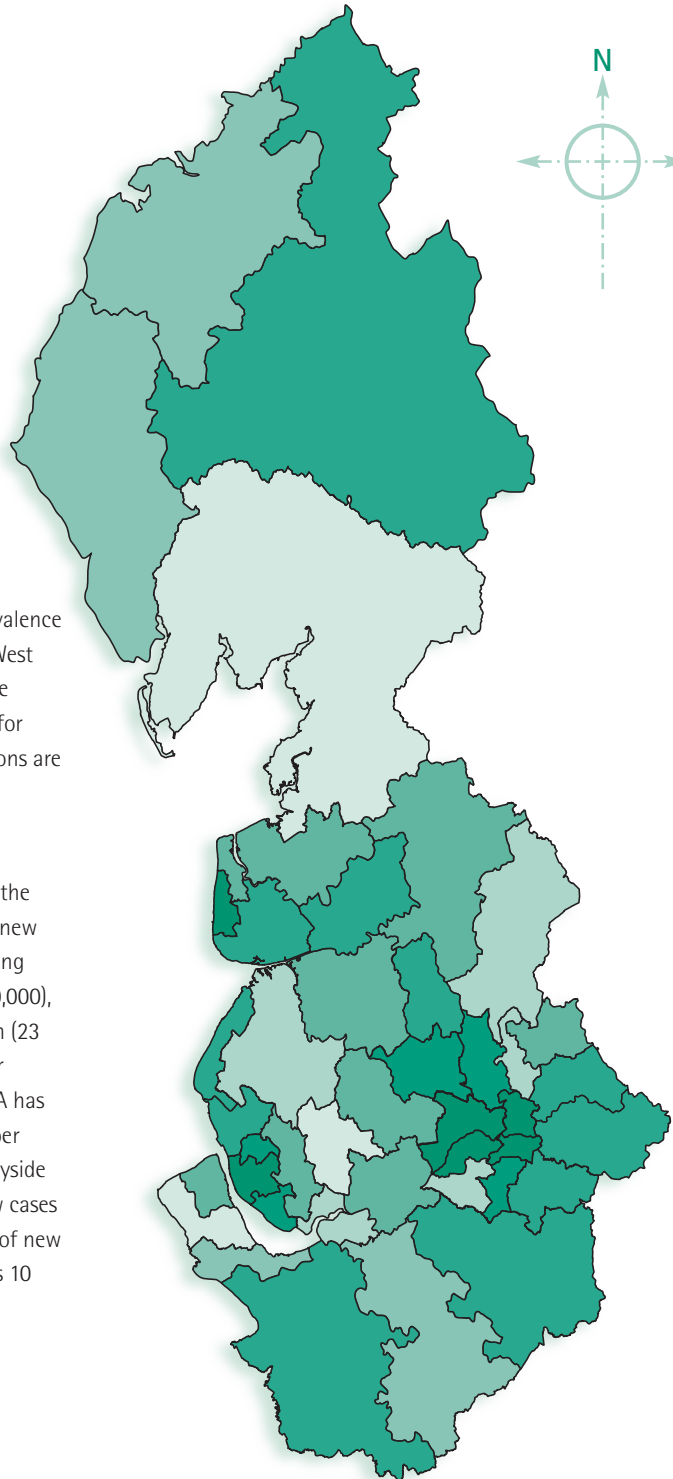
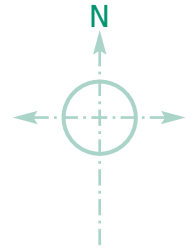


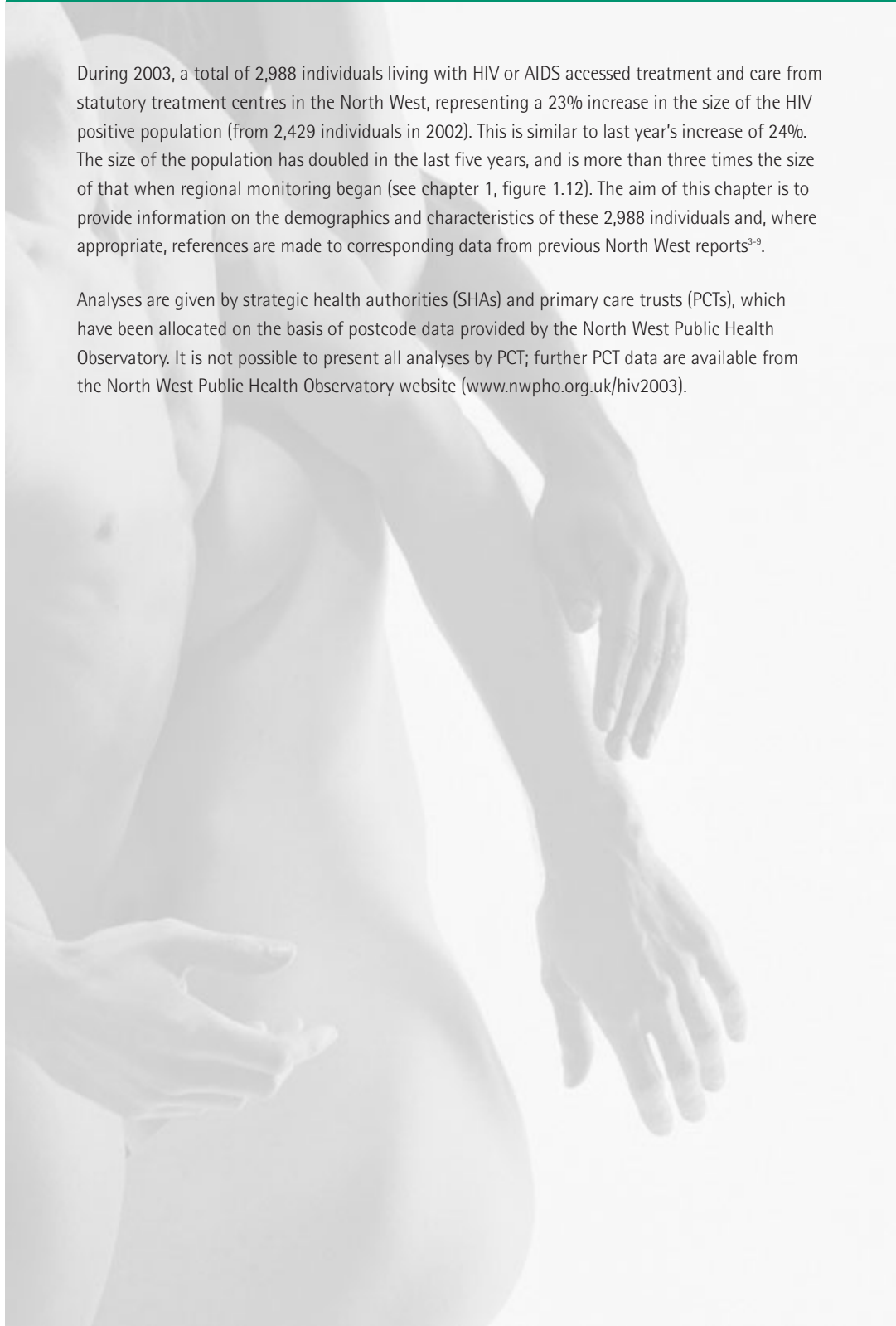
Figure 2.2 illustrates the population prevalence of new HIV and AIDS cases in the North West who attended statutory centres within the region during 2003. The population sizes for each PCT used in the prevalence calculations are provided by the North West Public Health Observatory based on 2001 census data.

Central and North Manchester PCTs have the highest prevalence of new cases, with 75 new cases per 100,000 population in each during 2003, followed by Salford PCT (31 per 100,000), Blackpool (25 per 100,000), Trafford North (23 per 100,000) and Central Liverpool (21 per 100,000). Overall, Greater Manchester SHA has the highest prevalence of new cases (17 per 100,000), followed by Cheshire and Merseyside and Cumbria and Lancashire (6 and 5 new cases per 100,000 respectively). The prevalence of new cases throughout the entire North West is 10 per 100,000.

3. All Cases 2003

During 2003, a total of 2,988 individuals living with HIV or AIDS accessed treatment and care from statutory treatment centres in the North West, representing a 23% increase in the size of the HIV positive population (from 2,429 individuals in 2002). This is similar to last year's increase of 24%. The size of the population has doubled in the last five years, and is more than three times the size of that when regional monitoring began (see chapter 1, figure 1.12). The aim of this chapter is to provide information on the demographics and characteristics of these 2,988 individuals and, where appropriate, references are made to corresponding data from previous North West reports³⁻⁹.

Analyses are given by strategic health authorities (SHAs) and primary care trusts (PCTs), which have been allocated on the basis of postcode data provided by the North West Public Health Observatory. It is not possible to present all analyses by PCT; further PCT data are available from the North West Public Health Observatory website (www.nwpho.org.uk/hiv2003).



3. All Cases 2003

Table 3.1: Age distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2003 (All cases seen during 2003 including those who died during the year)

AGE GROUP	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
0-14	12 (26.7%)	19 (42.2%)	14 (31.1%)				45
15-19	14 (70%)	4 (20%)	1 (5%)			1 (5%)	20
20-24	99 (69.7%)	26 (18.3%)	13 (9.2%)			4 (2.8%)	142
25-29	217 (61.3%)	83 (23.4%)	42 (11.9%)	2 (0.6%)		10 (2.8%)	354
30-34	277 (48.1%)	169 (29.3%)	115 (20%)	6 (1%)	1 (0.2%)	8 (1.4%)	576
35-39	257 (39.1%)	240 (36.5%)	148 (22.5%)	1 (0.2%)	2 (0.3%)	10 (1.5%)	658
40-44	157 (29.7%)	218 (41.2%)	149 (28.2%)	4 (0.8%)		1 (0.2%)	529
45-49	74 (24%)	121 (39.3%)	107 (34.7%)	3 (1%)	3 (1%)		308
50-54	36 (20.3%)	74 (41.8%)	61 (34.5%)	4 (2.3%)		2 (1.1%)	177
55-59	26 (28%)	28 (30.1%)	35 (37.6%)	2 (2.2%)	1 (1.1%)	1 (1.1%)	93
60+	12 (14%)	33 (38.4%)	40 (46.5%)	1 (1.2%)			86
Total	1181 (39.5%)	1015 (34%)	725 (24.3%)	23 (0.8%)	7 (0.2%)	37 (1.2%)	2988

Age ranges refer to the age of individuals at end of December 2003, or at death.

Table 3.1 shows a breakdown of the age and clinical stage of disease of HIV positive individuals attending for treatment and care in 2003. The figures refer to the clinical condition of individuals when last seen in 2003; individuals who died are presented in separate categories. The age distribution remained concentrated in the 30-44 year age range, accounting for more than half of all cases (59%) and, as would be expected, shows little deviation from previous years. The entire population of HIV positive individuals in treatment was older (median age of 38 years) than the cases that were new to treatment in 2003 (median age of 35 years). New cases were more likely to be under 25 years (13%, see chapter 2, table 2.1) when compared to all cases (7%).

The proportion of HIV positive individuals in the older age groups (50 years and over) continues to increase, from 7% in 1996 to 12% in 2003. 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 2003 (2%) than are those younger than 55 years (1%). Those in the age range 15 to 39 years were the most likely to be classed as asymptomatic.

The proportion of individuals with HIV who died during the year decreased from 9% in 1996 to 2% in 2000. In 2001, we modified data collection to distinguish between death related to AIDS and death unrelated to AIDS. In 2003, 0.8% of individuals died of AIDS related death. Of the 30 individuals who died in 2003, 77% died of an AIDS related condition and seven (23%) died of other causes. Two of the seven had been classed as asymptomatic, and the remaining five as symptomatic.

Table 3.2: Age distribution of total HIV and AIDS cases by infection route of HIV, January-December 2003 (All cases seen during 2003 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				1 (2.2%)	43 (95.6%)	1 (2.2%)	45
15-19	8 (40%)		8 (40%)	1 (5%)	2 (10%)	1 (5%)	20
20-24	70 (49.3%)	2 (1.4%)	61 (43%)	3 (2.1%)		6 (4.2%)	142
25-29	168 (47.5%)	7 (2%)	160 (45.2%)	3 (0.8%)		16 (4.5%)	354
30-34	305 (53%)	12 (2.1%)	218 (37.8%)	10 (1.7%)		31 (5.4%)	576
35-39	393 (59.7%)	19 (2.9%)	204 (31%)	16 (2.4%)		26 (4%)	658
40-44	332 (62.8%)	22 (4.2%)	140 (26.5%)	13 (2.5%)		22 (4.2%)	529
45-49	207 (67.2%)	7 (2.3%)	70 (22.7%)	10 (3.2%)		14 (4.5%)	308
50-54	114 (64.4%)	3 (1.7%)	51 (28.8%)	2 (1.1%)		7 (4%)	177
55-59	42 (45.2%)	4 (4.3%)	35 (37.6%)	2 (2.2%)		10 (10.8%)	93
60+	43 (50%)		34 (39.5%)	4 (4.7%)		5 (5.8%)	86
Total	1682 (56.3%)	76 (2.5%)	981 (32.8%)	65 (2.2%)	45 (1.5%)	139 (4.7%)	2988

Age ranges refer to the age of individuals at end of December 2003, 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 3.2 shows the age distribution of all HIV and AIDS cases presenting in the North West for treatment in 2003, categorised by infection route of HIV. Sex between men remains the most common route of infection among people with HIV in the North West (56% of all cases). The proportion of people infected through heterosexual sex continues to increase, from 15% in 1996 to 33% in 2003. It is anticipated that the proportion of individuals infected by heterosexual sex will continue to increase in view of the increasing proportion of new cases who have been heterosexually infected (50% in 2003: chapter 2, table 2.1). HIV positive heterosexuals tend to be younger than HIV positive homosexuals with a median age of 36 and 39 respectively.

The number of individuals exposed to HIV via injecting drug use remains low at 3%, with the most common age groups being 35 to 44 years (54% of cases). The proportion of people infected by contaminated blood or tissue and vertical transmission remains low at 2% each.

Table 3.3a illustrates the strategic health authority of residence and clinical stage of HIV disease for all HIV positive and AIDS cases presenting to a North West treatment centre in 2003. The figures refer to the clinical condition of individuals when last seen in 2003; individuals who died are presented in separate categories. The highest numbers of people with HIV live in Greater Manchester SHA (57% of the total number of people). As in previous years, the vast majority of people treated in the North West were also resident in the North West (94%).

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)³⁵. Overall, 40% were asymptomatic, 34% were symptomatic and 24% were classified as having AIDS.

Tables 3.3b, c and d present the breakdown of stage of disease by PCT within each of the three SHAs (Cumbria and Lancashire, table 3.3b; Cheshire and Merseyside, table 3.3c; and Greater Manchester, table 3.3d). There is variation among primary care trusts as to the proportion of individuals with AIDS, from only 6% in Ellesmere Port and Neston PCT to 35% in Preston PCT.

Table 3.3a: Residential distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2003: strategic health authority

(All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria and Lancashire	166 (31.1%)	206 (38.6%)	149 (28%)	6 (1.1%)		6 (1.1%)	533
Cheshire and Merseyside	254 (43.8%)	176 (30.3%)	138 (23.8%)	9 (1.6%)	1 (0.2%)	2 (0.3%)	580
Greater Manchester	675 (39.6%)	593 (34.8%)	402 (23.6%)	7 (0.4%)	4 (0.2%)	22 (1.3%)	1703
Isle of Man	8 (50%)	4 (25%)	3 (18.8%)	1 (6.3%)			16
East Midlands	4 (80%)	1 (20%)					5
East of England		1 (50%)	1 (50%)				2
London	4 (57.1%)	1 (14.3%)	1 (14.3%)		1 (14.3%)		7
Scotland	1 (50%)	1 (50%)					2
South East			3 (100%)				3
South West		2 (100%)					2
Wales	12 (44.4%)	3 (11.1%)	12 (44.4%)				27
West Midlands	8 (57.1%)	5 (35.7%)	1 (7.1%)				14
Yorkshire and The Humber	12 (36.4%)	13 (39.4%)	8 (24.2%)				33
Abroad		1 (100%)					1
Unknown	37 (61.7%)	8 (13.3%)	7 (11.7%)		1 (1.7%)	7 (11.7%)	60
Total	1181 (39.5%)	1015 (34%)	725 (24.3%)	23 (0.8%)	7 (0.2%)	37 (1.2%)	2988

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

Table 3.3b: Residential distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2003: Cumbria and Lancashire primary care trusts.

(All cases seen during 2003 including those who died during the year)

PCT OF RESIDENCE	Stage of HIV Disease					Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	
Carlisle and District	11 (55%)	4 (20%)	5 (25%)			20
Eden Valley	8 (88.9%)	1 (11.1%)				9
West Cumbria	9 (56.3%)	2 (12.5%)	5 (31.3%)			16
Morecambe Bay	12 (40%)	11 (36.7%)	7 (23.3%)			30
Blackpool	42 (23.9%)	73 (41.5%)	53 (30.1%)	3 (1.7%)	5 (2.8%)	176
Fylde	7 (28%)	7 (28%)	10 (40%)	1 (4%)		25
Wyre	11 (35.5%)	10 (32.3%)	9 (29%)		1 (3.2%)	31
Preston	24 (31.2%)	26 (33.8%)	27 (35.1%)			77
Hyndburn and Ribble Valley	6 (23.1%)	14 (53.8%)	5 (19.2%)	1 (3.8%)		26
Burnley, Pendle and Rossendale	7 (19.4%)	21 (58.3%)	7 (19.4%)	1 (2.8%)		36
Blackburn with Darwen	13 (34.2%)	20 (52.6%)	5 (13.2%)			38
Chorley and South Ribble	8 (26.7%)	10 (33.3%)	12 (40%)			30
West Lancashire	8 (42.1%)	7 (36.8%)	4 (21.1%)			19
Total	166 (31.1%)	206 (38.6%)	149 (28%)	6 (1.1%)	6 (1.1%)	533

Table 3.3c: Residential distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2003: Cheshire and Merseyside primary care trusts

(All cases seen during 2003 including those who died during the year)

PCT OF RESIDENCE	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Southport and Formby	10 (34.5%)	12 (41.4%)	7 (24.1%)				29
South Sefton	11 (37.9%)	10 (34.5%)	7 (24.1%)	1 (3.4%)			29
North Liverpool	12 (63.2%)	5 (26.3%)	2 (10.5%)				19
Central Liverpool	67 (46.5%)	41 (28.5%)	31 (21.5%)	3 (2.1%)		2 (1.4%)	144
South Liverpool	25 (56.8%)	9 (20.5%)	8 (18.2%)	1 (2.3%)	1 (2.3%)		44
Knowsley	8 (44.4%)	7 (38.9%)	3 (16.7%)				18
St Helens	8 (33.3%)	8 (33.3%)	7 (29.2%)	1 (4.2%)			24
Halton	2 (12.5%)	5 (31.3%)	9 (56.3%)				16
Warrington	14 (41.2%)	12 (35.3%)	8 (23.5%)				34
Birkenhead and Wallasey	20 (32.3%)	24 (38.7%)	17 (27.4%)	1 (1.6%)			62
Bebington and West Wirral	4 (33.3%)	5 (41.7%)	3 (25%)				12
Ellesmere Port and Neston	13 (76.5%)	3 (17.6%)	1 (5.9%)				17
Cheshire West	28 (65.1%)	6 (14%)	9 (20.9%)				43
Central Cheshire	16 (36.4%)	15 (34.1%)	13 (29.5%)				44
Eastern Cheshire	16 (35.6%)	14 (31.1%)	13 (28.9%)	2 (4.4%)			45
Total	254 (43.8%)	176 (30.3%)	138 (23.8%)	9 (1.6%)	1 (0.2%)	2 (0.3%)	580

Table 3.3d: Residential distribution of total HIV and AIDS cases by stage of HIV disease, January-December 2003: Greater Manchester primary care trusts

(All cases seen during 2003 including those who died during the year)

PCT OF RESIDENCE	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Ashton, Leigh and Wigan	21 (50%)	13 (31%)	8 (19%)				42
Bolton	53 (45.3%)	36 (30.8%)	28 (23.9%)				117
Bury	31 (35.6%)	33 (37.9%)	23 (26.4%)				87
Heywood and Middleton	8 (33.3%)	8 (33.3%)	8 (33.3%)				24
Rochdale	8 (20%)	16 (40%)	15 (37.5%)			1 (2.5%)	40
Salford	105 (44.1%)	85 (35.7%)	42 (17.6%)	1 (0.4%)		5 (2.1%)	238
Trafford North	22 (37.3%)	23 (39%)	12 (20.3%)	1 (1.7%)	1 (1.7%)		59
Trafford South	12 (29.3%)	21 (51.2%)	8 (19.5%)				41
North Manchester	138 (40.2%)	124 (36.2%)	73 (21.3%)	1 (0.3%)	1 (0.3%)	6 (1.7%)	343
Central Manchester	175 (41.6%)	130 (30.9%)	107 (25.4%)	3 (0.7%)	1 (0.2%)	5 (1.2%)	421
South Manchester	25 (32.5%)	26 (33.8%)	24 (31.2%)			2 (2.6%)	77
Oldham	21 (37.5%)	14 (25%)	19 (33.9%)			2 (3.6%)	56
Tameside and Glossop	22 (31.4%)	31 (44.3%)	15 (21.4%)		1 (1.4%)	1 (1.4%)	70
Stockport	34 (38.6%)	33 (37.5%)	20 (22.7%)	1 (1.1%)			88
Total	675 (39.6%)	593 (34.8%)	402 (23.6%)	7 (0.4%)	4 (0.2%)	22 (1.3%)	1703

Table 3.4a: Residential distribution of total HIV and AIDS cases by infection route of HIV, January-December 2003: strategic health authority

(All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	Infection Route						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Cumbria and Lancashire	328 (61.5%)	11 (2.1%)	158 (29.6%)	14 (2.6%)	10 (1.9%)	12 (2.3%)	533
Cheshire and Merseyside	275 (47.4%)	16 (2.8%)	220 (37.9%)	21 (3.6%)	5 (0.9%)	43 (7.4%)	580
Greater Manchester	994 (58.4%)	48 (2.8%)	542 (31.8%)	26 (1.5%)	26 (1.5%)	67 (3.9%)	1703
Isle of Man	5 (31.3%)		11 (68.8%)				16
East Midlands	3 (60%)		2 (40%)				5
East of England	1 (50%)					1 (50%)	2
London	2 (28.6%)		1 (14.3%)			4 (57.1%)	7
Scotland	1 (50%)		1 (50%)				2
South East	1 (33.3%)		2 (66.7%)				3
South West	1 (50%)		1 (50%)				2
Wales	11 (40.7%)		8 (29.6%)	2 (7.4%)	4 (14.8%)	2 (7.4%)	27
West Midlands	4 (28.6%)		6 (42.9%)	1 (7.1%)		3 (21.4%)	14
Yorkshire and The Humber	25 (75.8%)		7 (21.2%)			1 (3%)	33
Abroad	1 (100%)						1
Unknown	30 (50%)	1 (1.7%)	22 (36.7%)	1 (1.7%)		6 (10%)	60
Total	1682 (56.3%)	76 (2.5%)	981 (32.8%)	65 (2.2%)	45 (1.5%)	139 (4.7%)	2988

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

Table 3.4b: Residential distribution of total HIV and AIDS cases by infection route of HIV, January-December 2003: Cumbria and Lancashire primary care trusts

(All cases seen during 2003 including those who died during the year)

PCT OF RESIDENCE	Infection Route						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Carlisle and District	9 (45%)	1 (5%)	9 (45%)			1 (5%)	20
Eden Valley	5 (55.6%)		3 (33.3%)			1 (11.1%)	9
West Cumbria	8 (50%)		5 (31.3%)	1 (6.3%)	1 (6.3%)	1 (6.3%)	16
Morecambe Bay	17 (56.7%)	2 (6.7%)	10 (33.3%)			1 (3.3%)	30
Blackpool	155 (88.1%)	1 (0.6%)	14 (8%)	4 (2.3%)	1 (0.6%)	1 (0.6%)	176
Fylde	17 (68%)		5 (20%)	1 (4%)	1 (4%)	1 (4%)	25
Wyre	23 (74.2%)	1 (3.2%)	6 (19.4%)			1 (3.2%)	31
Preston	28 (36.4%)		40 (51.9%)	2 (2.6%)	6 (7.8%)	1 (1.3%)	77
Hyndburn and Ribble Valley	8 (30.8%)	1 (3.8%)	16 (61.5%)	1 (3.8%)			26
Burnley, Pendle and Rossendale	22 (61.1%)	3 (8.3%)	7 (19.4%)	3 (8.3%)		1 (2.8%)	36
Blackburn with Darwen	14 (36.8%)	1 (2.6%)	23 (60.5%)				38
Chorley and South Ribble	15 (50%)	1 (3.3%)	10 (33.3%)	1 (3.3%)	1 (3.3%)	2 (6.7%)	30
West Lancashire	7 (36.8%)		10 (52.6%)	1 (5.3%)		1 (5.3%)	19
Total	328 (61.5%)	11 (2.1%)	158 (29.6%)	14 (2.6%)	10 (1.9%)	12 (2.3%)	533

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

Table 3.4c: Residential distribution of total HIV and AIDS cases by infection route of HIV, January-December 2003: Cheshire and Merseyside primary care trusts

(All cases seen during 2003 including those who died during the year)

PCT OF RESIDENCE	Infection Route						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Southport and Formby	9 (31%)	1 (3.4%)	16 (55.2%)	1 (3.4%)		2 (6.9%)	29
South Sefton	10 (34.5%)		7 (24.1%)	3 (10.3%)		9 (31%)	29
North Liverpool	6 (31.6%)		9 (47.4%)		1 (5.3%)	3 (15.8%)	19
Central Liverpool	49 (34%)	3 (2.1%)	79 (54.9%)	6 (4.2%)		7 (4.9%)	144
South Liverpool	15 (34.1%)	1 (2.3%)	23 (52.3%)	1 (2.3%)		4 (9.1%)	44
Knowsley	10 (55.6%)	1 (5.6%)	5 (27.8%)			2 (11.1%)	18
St Helens	15 (62.5%)		7 (29.2%)	1 (4.2%)		1 (4.2%)	24
Halton	8 (50%)	1 (6.3%)	3 (18.8%)	1 (6.3%)	1 (6.3%)	2 (12.5%)	16
Warrington	20 (58.8%)	1 (2.9%)	10 (29.4%)	1 (2.9%)		2 (5.9%)	34
Birkenhead and Wallasey	35 (56.5%)	4 (6.5%)	17 (27.4%)	1 (1.6%)	1 (1.6%)	4 (6.5%)	62
Bebington and West Wirral	8 (66.7%)		4 (33.3%)				12
Ellesmere Port and Neston	5 (29.4%)		10 (58.8%)		2 (11.8%)		17
Cheshire West	29 (67.4%)	2 (4.7%)	9 (20.9%)	2 (4.7%)		1 (2.3%)	43
Central Cheshire	31 (70.5%)		11 (25%)	1 (2.3%)		1 (2.3%)	44
Eastern Cheshire	25 (55.6%)	2 (4.4%)	10 (22.2%)	3 (6.7%)		5 (11.1%)	45
Total	275 (47.4%)	16 (2.8%)	220 (37.9%)	21 (3.6%)	5 (0.9%)	43 (7.4%)	580

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

Table 3.4d: Residential distribution of total HIV and AIDS cases by infection route of HIV, January-December 2003: Greater Manchester primary care trusts

(All cases seen during 2003 including those who died during the year)

PCT OF RESIDENCE	Infection Route						Total (100%)
	Homo/Bisexual	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Ashton, Leigh and Wigan	16 (38.1%)		20 (47.6%)	2 (4.8%)	1 (2.4%)	3 (7.1%)	42
Bolton	44 (37.6%)	4 (3.4%)	62 (53%)	3 (2.6%)	4 (3.4%)		117
Bury	43 (49.4%)	2 (2.3%)	34 (39.1%)	4 (4.6%)	1 (1.1%)	3 (3.4%)	87
Heywood and Middleton	14 (58.3%)	2 (8.3%)	5 (20.8%)	2 (8.3%)		1 (4.2%)	24
Rochdale	17 (42.5%)	3 (7.5%)	14 (35%)	1 (2.5%)	3 (7.5%)	2 (5%)	40
Salford	171 (71.8%)	6 (2.5%)	52 (21.8%)	1 (0.4%)		8 (3.4%)	238
Trafford North	35 (59.3%)	1 (1.7%)	17 (28.8%)	1 (1.7%)	2 (3.4%)	3 (5.1%)	59
Trafford South	31 (75.6%)	4 (9.8%)	4 (9.8%)	2 (4.9%)			41
North Manchester	215 (62.7%)	9 (2.6%)	96 (28%)	1 (0.3%)	4 (1.2%)	18 (5.2%)	343
Central Manchester	247 (58.7%)	6 (1.4%)	141 (33.5%)	3 (0.7%)	7 (1.7%)	17 (4%)	421
South Manchester	42 (54.5%)	4 (5.2%)	28 (36.4%)			3 (3.9%)	77
Oldham	23 (41.1%)	5 (8.9%)	21 (37.5%)	2 (3.6%)		5 (8.9%)	56
Tameside and Glossop	38 (54.3%)	1 (1.4%)	25 (35.7%)	1 (1.4%)	2 (2.9%)	3 (4.3%)	70
Stockport	58 (65.9%)	1 (1.1%)	23 (26.1%)	3 (3.4%)	2 (2.3%)	1 (1.1%)	88
Total	994 (58.4%)	48 (2.8%)	542 (31.8%)	26 (1.5%)	26 (1.5%)	67 (3.9%)	1703

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

Table 3.4a displays the route of transmission of HIV for all HIV positive and AIDS cases presenting in the North West for treatment in 2003, by strategic health authority of residence. Homosexual sex continues to be the dominant mode of HIV transmission (56%). However, there are considerable variations within the North West, with 62% of the HIV positive residents of Cumbria and Lancashire SHA compared to only 47% of Cheshire and Merseyside SHA residents having been infected by sex between men. Greater Manchester continues to report by far the highest number of HIV positive injecting drug users, accounting for 63% of all residents of the North West infected by this route.

Tables 3.4b, c and d present the breakdown of route of infection by PCT within each of the three SHAs (Cumbria and Lancashire, table 3.4b; Cheshire and Merseyside, table 3.4c; and Greater Manchester, table 3.4d). Considerable variation in the proportions of residents infected by homosexual sex can be seen across primary care trusts, for example from only 34% in Central Liverpool PCT to 88% in Blackpool PCT.

Table 3.5 shows the sex and strategic health authority of residence of all HIV and AIDS cases presenting in the North West for treatment in 2003. As in previous years, the vast majority of all cases are male (78%), primarily due to the relatively high number of individuals exposed to HIV via homosexual or bisexual sex (table 3.4a). The proportion of women has increased steadily from 11% in 1996 to 22% this year. As would be expected, the highest proportion of females is found in Cheshire and Merseyside SHA (24%), the SHA with the highest number of heterosexual HIV infections.

Table 3.6 illustrates the sex and route of transmission of all HIV and AIDS cases presenting for treatment in the North West in 2003. Amongst men, the largest category of individuals living with HIV was those infected by sex between men (72%), while most women had been infected by heterosexual sex (90%). An even greater proportion of female new cases (96%) were infected by this route (chapter 2, table 2.6), highlighting the growing issue of heterosexual transmission of HIV. Less than half (40%) of those infected by heterosexual sex are male. As in previous years, the majority of injecting drug users are male (72%).

Table 3.5: Residential distribution of total HIV and AIDS cases by sex, January-December 2003 (All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	Sex		Total (100%)
	Male	Female	
Cumbria and Lancashire	438 (82.2%)	95 (17.8%)	533
Cheshire and Merseyside	442 (76.2%)	138 (23.8%)	580
Greater Manchester	1317 (77.3%)	386 (22.7%)	1703
Isle of Man	11 (68.8%)	5 (31.3%)	16
East Midlands	4 (80%)	1 (20%)	5
East of England	2 (100%)		2
London	6 (85.7%)	1 (14.3%)	7
Scotland	2 (100%)		2
South East	2 (66.7%)	1 (33.3%)	3
South West	2 (100%)		2
Wales	24 (88.9%)	3 (11.1%)	27
West Midlands	11 (78.6%)	3 (21.4%)	14
Yorkshire and The Humber	27 (81.8%)	6 (18.2%)	33
Abroad	1 (100%)		1
Unknown	43 (71.7%)	17 (28.3%)	60
Total	2332 (78%)	656 (22%)	2988

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of sex by primary care trust, please see the North West Public Health Observatory website: www.nwpho.org.uk/hiv2003/table3-5.htm

Table 3.6: Infection route of HIV of total HIV and AIDS cases by sex, January-December 2003 (All cases and new cases seen during 2003 including those who died during the year)

INFECTION ROUTE	Sex		Total
	Male	Female	
Homo/Bisexual	1682 (72.1%)		1682 (56.3%)
Injecting Drug Use	55 (2.4%)	21 (3.2%)	76 (2.5%)
Heterosexual	394 (16.9%)	587 (89.5%)	981 (32.8%)
Blood/Tissue	54 (2.3%)	11 (1.7%)	65 (2.2%)
Mother to Child	22 (0.9%)	23 (3.5%)	45 (1.5%)
Undetermined	125 (5.4%)	14 (2.1%)	139 (4.7%)
Total (100%)	2332	656	2988

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

Table 3.7: Residential distribution of total HIV and AIDS cases by age category, January-December 2003 (All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	Age Group											Total (100%)
	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	
Cumbria and Lancashire	9 (1.7%)	3 (0.6%)	20 (3.8%)	45 (8.4%)	82 (15.4%)	122 (22.9%)	105 (19.7%)	58 (10.9%)	44 (8.3%)	17 (3.2%)	28 (5.3%)	533
Cheshire and Merseyside	6 (1%)	8 (1.4%)	33 (5.7%)	68 (11.7%)	113 (19.5%)	117 (20.2%)	107 (18.4%)	56 (9.7%)	31 (5.3%)	24 (4.1%)	17 (2.9%)	580
Greater Manchester	26 (1.5%)	7 (0.4%)	83 (4.9%)	224 (13.2%)	347 (20.4%)	378 (22.2%)	290 (17%)	175 (10.3%)	94 (5.5%)	43 (2.5%)	36 (2.1%)	1703
Isle of Man				2 (12.5%)	1 (6.3%)	3 (18.8%)	6 (37.5%)	3 (18.8%)	1 (6.3%)			16
East Midlands					1 (20%)	1 (20%)			2 (40%)	1 (20%)		5
East of England						1 (50%)	1 (50%)					2
London					3 (42.9%)	2 (28.6%)	1 (14.3%)	1 (14.3%)				7
Scotland				1 (50%)	1 (50%)							2
South East					2 (66.7%)			1 (33.3%)				3
South West						2 (100%)						2
Wales	4 (14.8%)		1 (3.7%)	1 (3.7%)	3 (11.1%)	4 (14.8%)	6 (22.2%)	1 (3.7%)	2 (7.4%)	4 (14.8%)	1 (3.7%)	27
West Midlands				2 (14.3%)	4 (28.6%)	4 (28.6%)	2 (14.3%)	1 (7.1%)			1 (7.1%)	14
Yorkshire and The Humber			1 (3%)	1 (3%)	6 (18.2%)	9 (27.3%)	5 (15.2%)	6 (18.2%)	1 (3%)	2 (6.1%)	2 (6.1%)	33
Abroad								1 (100%)				1
Unknown		2 (3.3%)	4 (6.7%)	10 (16.7%)	13 (21.7%)	15 (25%)	6 (10%)	5 (8.3%)	2 (3.3%)	2 (3.3%)	1 (1.7%)	60
Total	45 (1.5%)	20 (0.7%)	142 (4.8%)	354 (11.8%)	576 (19.3%)	658 (22%)	529 (17.7%)	308 (10.3%)	177 (5.9%)	93 (3.1%)	86 (2.9%)	2988

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. Age ranges refer to the age of individuals at end of December 2003, or at death. For a breakdown of age by primary care trust, please see the North West Health Observatory website: www.nwpho.org.uk/hiv2003/table3-7.htm

Table 3.7 shows the strategic health authority of residence of all HIV and AIDS cases presenting for treatment in the North West in 2003, 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 7% in 2003. During 2003 the age group with the largest number of individuals is 35 to 39 years (658). The proportion of HIV positive people in the older age groups (50 years and over), which had increased between 1996 and 2001 (from 7% to 12%), now appears to have stabilised at 12% in 2003. Cumbria and Lancashire SHA has the highest proportion of individuals aged over 50 years (17%) compared to Cheshire and Merseyside SHA (12%) and Greater Manchester SHA (10%).

Table 3.8: Residential distribution of total HIV and AIDS cases by ethnic group, January-December 2003 (All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	Ethnicity								Total (100%)
	White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Cumbria and Lancashire	450 (84.4%)	5 (0.9%)	51 (9.6%)		8 (1.5%)	5 (0.9%)	11 (2.1%)	3 (0.6%)	533
Cheshire and Merseyside	445 (76.7%)	3 (0.5%)	107 (18.4%)	2 (0.3%)	1 (0.2%)	7 (1.2%)	11 (1.9%)	4 (0.7%)	580
Greater Manchester	1129 (66.3%)	11 (0.6%)	441 (25.9%)	8 (0.5%)	17 (1%)	21 (1.2%)	28 (1.6%)	48 (2.8%)	1703
Isle of Man	14 (87.5%)		2 (12.5%)						16
East Midlands	5 (100%)								5
East of England	1 (50%)							1 (50%)	2
London	6 (85.7%)							1 (14.3%)	7
Scotland			1 (50%)					1 (50%)	2
South East			2 (66.7%)			1 (33.3%)			3
South West	1 (50%)		1 (50%)						2
Wales	25 (92.6%)					1 (3.7%)	1 (3.7%)		27
West Midlands	8 (57.1%)	1 (7.1%)	2 (14.3%)					3 (21.4%)	14
Yorkshire and The Humber	24 (72.7%)	1 (3%)	3 (9.1%)			1 (3%)	1 (3%)	3 (9.1%)	33
Abroad						1 (100%)			1
Unknown	44 (73.3%)	3 (5%)	9 (15%)		1 (1.7%)	2 (3.3%)		1 (1.7%)	60
Total	2152 (72%)	24 (0.8%)	619 (20.7%)	10 (0.3%)	27 (0.9%)	39 (1.3%)	52 (1.7%)	65 (2.2%)	2988

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of ethnicity by primary care trust, please see the North West Public Health Observatory website: www.nwpho.org.uk/hiv2003/table3-8.htm

Table 3.8 shows a breakdown of ethnicity by strategic health authority for all those individuals with HIV or AIDS who attended statutory treatment centres in the North West in 2003. Ethnic group classifications are those utilised by the Health Protection Agency AIDS and STD Centre, for the Survey of Prevalent Diagnosed HIV Infections (SOPHID).

The self-classification of ethnicity was recorded for 98% of cases, most of whom (74%) were white. The remaining 26% were from black and minority ethnic communities, and this proportion has increased from 20% last year. This is a reflection of the increasing proportion of new cases from black and minority ethnic communities (from 29% in 2000 to 46% in 2003: chapter 2, table 2.7). These data show an increase in the number of individuals from black and minority ethnic communities presenting for treatment and care in the North West of England. Moreover, individuals from black and minority ethnic communities are substantially over represented among the HIV positive population when compared to their proportion in the North West population as a whole (5.6%)⁶⁷. Thus, the prevalence in black and minority ethnic communities is 5.6 times higher than in the white population in the North West.

HIV positive individuals classified as black African comprise the largest minority ethnic group, at 21% of all cases and 80% of known non-white individuals. This proportion from black African communities has been increasing over the years, from 3% in 1998, to 6% in 2000. These data highlight the need for specific HIV prevention initiatives within black and minority ethnic communities. However, the black African community is not homogenous and requires a culturally sensitive and diverse approach⁷¹. Of the three North West SHAs, Greater Manchester has the highest proportion of black and minority ethnic individuals (31%) compared to Cumbria and Lancashire (15%) and Cheshire and Merseyside (23%).

Table 3.9: Ethnic distribution of total HIV and AIDS cases by sex, January-December 2003 (All cases seen during 2003 including those who died during the year)

ETHNICITY	Sex		Total (100%)
	Male	Female	
White	1948 (90.5%)	204 (9.5%)	2152
Black Caribbean	18 (75%)	6 (25%)	24
Black African	223 (36%)	396 (64%)	619
Black Other	6 (60%)	4 (40%)	10
Indian/Pakistani/Bangladeshi	18 (66.7%)	9 (33.3%)	27
Other Asian/Oriental	22 (56.4%)	17 (43.6%)	39
Other/Mixed	40 (76.9%)	12 (23.1%)	52
Unknown	57 (87.7%)	8 (12.3%)	65
Total	2332 (78%)	656 (22%)	2988

Table 3.9 shows the ethnic group and sex of all individuals with HIV presenting in the North West for treatment in 2003. The vast majority of HIV and AIDS cases were male (78%). However, this is not the case for members of black and minority ethnic communities, where cases are much more evenly distributed between the sexes. Over half of all HIV positive individuals from minority ethnic groups were female (58%). This higher proportion of females with HIV is largely due to the predominance of heterosexual sex, rather than sex between men, as the route of transmission in black and minority ethnic communities (table 3.10). Sixty four percent of diagnosed HIV positive black Africans are female. This female bias may be explained if females are more at risk of acquiring HIV through heterosexual sex, or more likely to present to treatment centres for diagnosis and treatment, or both.

Table 3.10: Ethnic distribution of total HIV and AIDS cases by infection route of HIV, January-December 2003 (All cases seen during 2003 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	1589 (73.8%)	71 (3.3%)	340 (15.8%)	58 (2.7%)	13 (0.6%)	81 (3.8%)	2152
Black Caribbean	7 (29.2%)		15 (62.5%)	1 (4.2%)		1 (4.2%)	24
Black African	18 (2.9%)		563 (91%)	3 (0.5%)	22 (3.6%)	13 (2.1%)	619
Black Other	2 (20%)	1 (10%)	7 (70%)				10
Indian/Pakistani/Bangladeshi	8 (29.6%)	1 (3.7%)	13 (48.1%)	3 (11.1%)	1 (3.7%)	1 (3.7%)	27
Other Asian/Oriental	7 (17.9%)		25 (64.1%)		1 (2.6%)	6 (15.4%)	39
Other/Mixed	28 (53.8%)	1 (1.9%)	13 (25%)		8 (15.4%)	2 (3.8%)	52
Unknown	23 (35.4%)	2 (3.1%)	5 (7.7%)			35 (53.8%)	65
Total	1682 (56.3%)	76 (2.5%)	981 (32.8%)	65 (2.2%)	45 (1.5%)	139 (4.7%)	2988

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 illustrates the ethnic group and route of transmission of HIV and AIDS cases presenting in the North West in 2003. Although most individuals with HIV were infected by sex between men (56%), this is not the case among black and minority ethnic communities where homosexual sex accounted for only 9% of cases and heterosexual sex was the main route of transmission (82% of cases). Within black African communities, this situation is even more apparent, with heterosexual sex accounting for 91% of cases. Because of the high proportion of HIV positive black Africans who are female (table 3.9) there are a correspondingly high proportion of HIV cases that were acquired by mother to child transmission (4%).

Table 3.11: Ethnic distribution of total HIV and AIDS cases by age group, January-December 2003 (All cases seen during 2003 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	12 (0.6%)	14 (0.7%)	84 (3.9%)	193 (9%)	371 (17.2%)	496 (23%)	422 (19.6%)	247 (11.5%)	156 (7.2%)	80 (3.7%)	77 (3.6%)	2152
Black Caribbean			5 (20.8%)	2 (8.3%)	6 (25%)	3 (12.5%)	4 (16.7%)	3 (12.5%)	1 (4.2%)			24
Black African	22 (3.6%)	5 (0.8%)	42 (6.8%)	125 (20.2%)	157 (25.4%)	125 (20.2%)	76 (12.3%)	35 (5.7%)	17 (2.7%)	8 (1.3%)	7 (1.1%)	619
Black Other			1 (10%)	3 (30%)	2 (20%)		3 (30%)			1 (10%)		10
Indian/Pakistani/ Bangladeshi	1 (3.7%)	1 (3.7%)	1 (3.7%)	4 (14.8%)	5 (18.5%)	8 (29.6%)	4 (14.8%)	1 (3.7%)	1 (3.7%)		1 (3.7%)	27
Other Asian/Oriental	1 (2.6%)		2 (5.1%)	8 (20.5%)	10 (25.6%)	5 (12.8%)	5 (12.8%)	8 (20.5%)				39
Other/Mixed	8 (15.4%)		4 (7.7%)	9 (17.3%)	8 (15.4%)	10 (19.2%)	7 (13.5%)	4 (7.7%)		1 (1.9%)	1 (1.9%)	52
Unknown	1 (1.5%)		3 (4.6%)	10 (15.4%)	17 (26.2%)	11 (16.9%)	8 (12.3%)	10 (15.4%)	2 (3.1%)	3 (4.6%)		65
Total	45 (1.5%)	20 (0.7%)	142 (4.8%)	354 (11.8%)	576 (19.3%)	658 (22%)	529 (17.7%)	308 (10.3%)	177 (5.9%)	93 (3.1%)	86 (2.9%)	2988

Table 3.11 displays the ethnicity and age group of HIV and AIDS cases presenting for treatment in the North West in 2003. White individuals tended to be older, with a median age of 39 years while black Africans had a median age of 34. The fact that those from black and minority ethnic communities tend to be younger and infected by heterosexual sex suggests that in the future the rates of mother to child transmission may increase. The higher proportion of black Africans and those self-classified as 'Other/mixed' in the 0-14 year age group (4% and 15% respectively) compared to white individuals (1%) are a reflection of the higher rates of mother to child transmission in these groups (table 3.10).

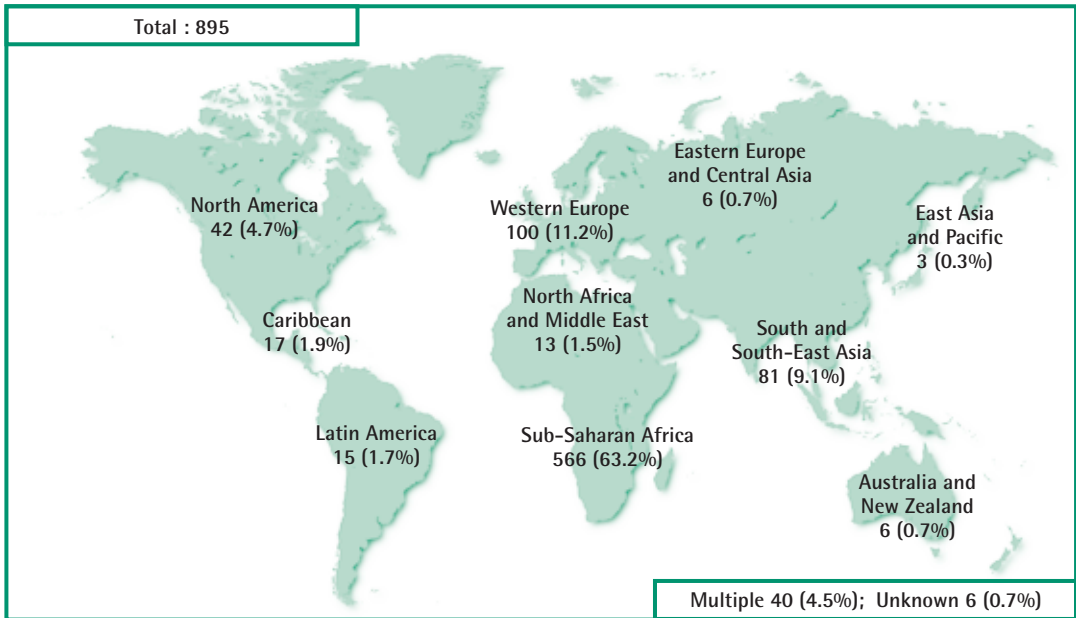
Table 3.12: The role of contact abroad in exposure to HIV of total HIV and AIDS cases, January-December 2003 (All cases seen during 2003 including those who died during the year)

HIV EXPOSURE ABROAD	Infection Route						Total (100%)
	Homo/ Bisexual	Injecting Drug Use	Hetero- sexual	Blood/ Tissue	Mother to Child	Undeter- mined	
Yes	177 (19.8%)	15 (1.7%)	663 (74.1%)	7 (0.8%)	15 (1.7%)	18 (2%)	895
No	1220 (76.8%)	46 (2.9%)	207 (13%)	58 (3.7%)	20 (1.3%)	37 (2.3%)	1588
Undetermined	285 (56.4%)	15 (3%)	111 (22%)		10 (2%)	84 (16.6%)	505
Total	1682 (56.3%)	76 (2.5%)	981 (32.8%)	65 (2.2%)	45 (1.5%)	139 (4.7%)	2988

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

Figure 3.1: Global region and country of total HIV and AIDS cases who probably acquired their infection outside the UK, January-December 2003

(All cases seen during 2003 including those who died during the year)



Sub-Saharan Africa	566 (63.2%)	Australia and New Zealand	6 (0.7%)	Portugal	10 (1.1%)
Angola	6 (0.7%)	Australia	6 (0.7%)	Spain	26 (2.9%)
Botswana	15 (1.7%)	South and South-East Asia	81 (9.1%)	Multiple	2 (0.2%)
Burundi	7 (0.8%)	Cambodia	1 (0.1%)	Unknown	6 (0.7%)
Cameroon	7 (0.8%)	India	3 (0.3%)	North Africa and Middle East	13 (1.5%)
Congo	25 (2.8%)	Indonesia	1 (0.1%)	Egypt	3 (0.3%)
Cote d'Ivoire	3 (0.3%)	Malaysia	2 (0.2%)	Israel	1 (0.1%)
Dem. Republic of Congo	4 (0.4%)	Pakistan	11 (1.2%)	Saudi Arabia	1 (0.1%)
Eritrea	1 (0.1%)	Philippines	3 (0.3%)	Sudan	6 (0.7%)
Ethiopia	7 (0.8%)	Singapore	1 (0.1%)	United Arab Emirates	2 (0.2%)
Gambia	4 (0.4%)	Sri Lanka	1 (0.1%)	North America	42 (4.7%)
Ghana	8 (0.9%)	Thailand	53 (5.9%)	Canada	4 (0.4%)
Guinea	1 (0.1%)	Multiple	1 (0.1%)	United States of America	38 (4.2%)
Kenya	23 (2.6%)	Unknown	4 (0.4%)	Caribbean	17 (1.9%)
Liberia	1 (0.1%)	Eastern Europe and Central Asia	6 (0.7%)	Dominican Republic	2 (0.2%)
Malawi	28 (3.1%)	Croatia	1 (0.1%)	Jamaica	13 (1.5%)
Namibia	3 (0.3%)	Russian Federation	2 (0.2%)	Unknown	2 (0.2%)
Nigeria	20 (2.2%)	Unknown	3 (0.3%)	Latin America	15 (1.7%)
Rwanda	5 (0.6%)	Western Europe	100 (11.2%)	Brazil	6 (0.7%)
Sierra Leone	1 (0.1%)	Balearics	1 (0.1%)	Colombia	2 (0.2%)
Somalia	12 (1.3%)	Belgium	3 (0.3%)	Costa Rica	1 (0.1%)
South Africa	44 (4.9%)	Canary Islands	6 (0.7%)	El Salvador	1 (0.1%)
Swaziland	4 (0.4%)	Denmark	1 (0.1%)	Guatemala	1 (0.1%)
Tanzania	9 (1%)	Eire	6 (0.7%)	Guyana	1 (0.1%)
Uganda	27 (3%)	France	5 (0.6%)	Mexico	1 (0.1%)
Zambia	27 (3%)	Germany	11 (1.2%)	Peru	1 (0.1%)
Zimbabwe	228 (25.5%)	Gibraltar	1 (0.1%)	Venezuela	1 (0.1%)
Multiple	25 (2.8%)	Greece	3 (0.3%)	Multiple	40 (4.5%)
Unknown	21 (2.3%)	Italy	12 (1.3%)	Unknown	6 (0.7%)
East Asia and Pacific	3 (0.3%)	Malta	1 (0.1%)	Total (100%)	895
China	2 (0.2%)	Netherlands	5 (0.6%)		
Taiwan	1 (0.1%)	Norway	1 (0.1%)		

Table 3.12 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 2003. These data show the significant influence of global trends of the pandemic on the epidemiology of HIV in the North West Region. Almost a third (30%) of all cases were reported to have been exposed to HIV abroad. The role that exposure abroad plays in the epidemiology of HIV in the North West appears to be increasing in importance, with the proportion of people infected abroad having increased from 19% in 1998. However, part of this increase may be due to the fact that there has also been an improved level of reporting, with the proportion of cases for whom data on exposure abroad are available increasing from 48% in 1997, to 83% in 2003. Heterosexual sex continued to be the predominant mode of transmission of those HIV positive individuals who were infected abroad (74%) compared to only 13% of those known to be infected in the UK.

Figure 3.1 illustrates the global region and country of infection for those 895 HIV positive individuals presenting for treatment in the North West in 2003 who were probably infected abroad. Of all the infections contracted outside the United Kingdom, 63% were exposed in sub-Saharan Africa. This high proportion reflects the impact of the pandemic in sub-Saharan Africa, where the prevalence of HIV is extremely high¹². A further 11% of people who were infected abroad were infected in Western Europe and 9% in South and South East Asia.

Of the 895 individuals who were probably infected abroad, the country of infection is known for 785 individuals (88%). A total of 73 different countries have been named for those HIV positive people infected abroad, with Zimbabwe representing the country where the largest number of infections were contracted, at 29% of those where the country is known, up from 9% last year. Exposure in sub-Saharan Africa was spread across 26 countries. Of those exposed in Western Europe, 26% were infected in Spain, reflecting the extent of the epidemic in that country³¹, the large number of people that travel between the United Kingdom and Spain, and the increased propensity to take risks when on holiday^{69,72,73}.

Table 3.13: Global region and infection route of HIV cases who probably acquired their infection outside the UK, January-December 2003

(All cases seen during 2003 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	
Australia and New Zealand	6 (100%)						6
Caribbean	2 (11.8%)		15 (88.2%)				17
East Asia and Pacific	1 (33.3%)		1 (33.3%)			1 (33.3%)	3
Eastern Europe and Central Asia	3 (50%)		3 (50%)				6
Latin America	7 (46.7%)	1 (6.7%)	6 (40%)			1 (6.7%)	15
North Africa and Middle East	2 (15.4%)		10 (76.9%)			1 (7.7%)	13
North America	35 (83.3%)	2 (4.8%)	3 (7.1%)	1 (2.4%)		1 (2.4%)	42
South and South-East Asia	17 (21.3%)		59 (72.8%)	1 (1.3%)		4 (5%)	81
Sub-Saharan Africa	12 (2.1%)	1 (0.2%)	529 (93.5%)	4 (0.7%)	13 (2.3%)	7 (1.2%)	566
Western Europe	58 (58%)	11 (11%)	27 (27%)	1 (1%)	1 (1%)	2 (2%)	100
Multiple	30 (75%)		9 (22.5%)		1 (2.5%)		40
Unknown	4 (66.7%)		1 (16.7%)			1 (16.7%)	6
Total	177 (19.8%)	15 (1.7%)	663 (74.1%)	7 (0.8%)	15 (1.7%)	18 (2%)	895

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

Table 3.13 shows the route of infection of those infected abroad categorised by the global region of their exposure. Of all HIV infections acquired abroad, most were exposed via heterosexual sex (74%). For those exposed in sub-Saharan Africa (63% of all those infected abroad), the proportion infected by this route is much higher, at 94%. Eleven percent of those infected abroad were infected in Western Europe, over a fifth of whom were infected by sharing injecting equipment. Seventy three percent of all injecting drug users who were exposed abroad were infected in Western Europe, with the largest numbers of these having been exposed in Spain (three individuals) and Portugal (three). This is a reflection of the fact that drug use remains a major transmission route of HIV in many western European countries (in particular Mediterranean Europe)³¹.

Table 3.14: The role of contact abroad in exposure to HIV of total HIV and AIDS cases by ethnicity, January-December 2003

(All cases seen during 2003 including those who died during the year)

HIV EXPOSURE ABROAD	Ethnicity								Total (100%)
	White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Yes	312 (34.9%)	15 (1.7%)	501 (56%)	5 (0.6%)	11 (1.2%)	26 (2.9%)	21 (2.3%)	4 (0.4%)	895
No	1499 (94.4%)	4 (0.3%)	31 (2%)	2 (0.1%)	15 (0.9%)	6 (0.4%)	22 (1.4%)	9 (0.6%)	1588
Unknown	341 (67.5%)	5 (1%)	87 (17.2%)	3 (0.6%)	1 (0.2%)	7 (1.4%)	9 (1.8%)	52 (10.3%)	505
Total	2152 (72%)	24 (0.8%)	619 (20.7%)	10 (0.3%)	27 (0.9%)	39 (1.3%)	52 (1.7%)	65 (2.2%)	2988

Table 3.15: Residential distribution of total HIV and AIDS cases by level of antiretroviral therapy, January-December 2003

(All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	Level of Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or More	
Cumbria and Lancashire	151 (28.3%)	3 (0.6%)	3 (0.6%)	316 (59.3%)	60 (11.3%)	533
Cheshire and Merseyside	214 (36.9%)	3 (0.5%)	1 (0.2%)	271 (46.7%)	91 (15.7%)	580
Greater Manchester	571 (33.5%)	1 (0.1%)	2 (0.1%)	936 (55%)	193 (11.3%)	1703
Isle of Man	8 (50%)			7 (43.8%)	1 (6.3%)	16
East Midlands	2 (40%)		1 (20%)	2 (40%)		5
East of England	1 (50%)			1 (50%)		2
London	3 (42.9%)			4 (57.1%)		7
Scotland	1 (50%)			1 (50%)		2
South East				2 (66.7%)	1 (33.3%)	3
South West	1 (50%)			1 (50%)		2
Wales	7 (25.9%)	1 (3.7%)		11 (40.7%)	8 (29.6%)	27
West Midlands	6 (42.9%)			7 (50%)	1 (7.1%)	14
Yorkshire and The Humber	2 (6.1%)		1 (3%)	24 (72.7%)	6 (18.2%)	33
Abroad	1 (100%)					1
Unknown	39 (65%)	1 (1.7%)		17 (28.3%)	3 (5%)	60
Total	1007 (33.7%)	9 (0.3%)	8 (0.3%)	1600 (53.5%)	364 (12.2%)	2988

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of level of antiretroviral therapy by primary care trust, please see the North West Public Health Observatory website: www.nwpho.org.uk/hiv2003/table3-15.htm

Table 3.14 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 2003. Thirty percent of all cases were reported to have been exposed abroad. However, there were considerable differences between ethnic groups. While the majority of white HIV positive individuals (70%) were thought to have been exposed in the United Kingdom, this was only true for 5% of black Africans.

Table 3.15 shows the level of antiretroviral therapy received by HIV positive individuals attending for treatment and care in the North West during 2003, broken down by strategic health authority of residence. Individuals are categorised by the highest level of combination therapy they received from any treatment centre in the North West during 2003. Two thirds (66%) of HIV positive individuals were receiving triple or more combination therapy in the year 2003. The proportion of people receiving four or more drugs remains about the same (12%) as 2002. Around a third (34%) of HIV positive individuals were not receiving any antiretroviral therapy, a comparable proportion to 2002. Of those known to be resident outside the region, but who accessed treatment in the North West, 71% received antiretroviral therapy. In line with British HIV Association Guidelines⁷⁰, use of mono or dual therapy was rare, at less than 1%.

Table 3.16: Stage of HIV disease of total HIV and AIDS cases by level of antiretroviral therapy, January-December 2003

(All cases seen during 2003 including those who died during the year)

STAGE OF DISEASE	Level of Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or More	
Asymptomatic	714 (60.5%)	3 (0.3%)	3 (0.3%)	418 (35.4%)	43 (3.6%)	1181
Symptomatic	187 (18.4%)	4 (0.4%)	4 (0.4%)	659 (64.9%)	161 (15.9%)	1015
AIDS	61 (8.4%)	2 (0.3%)	1 (0.1%)	504 (69.5%)	157 (21.7%)	725
AIDS related death	12 (52.2%)			10 (43.5%)	1 (4.3%)	23
Death unrelated to AIDS	2 (28.6%)			4 (57.1%)	1 (14.3%)	7
Unknown	31 (83.8%)			5 (13.5%)	1 (2.7%)	37
Total	1007 (33.7%)	9 (0.3%)	8 (0.3%)	1600 (53.5%)	364 (12.2%)	2988

Table 3.16 refers to the clinical condition of individuals when last seen in 2003; individuals who died are presented in separate categories. Individuals are categorised by the highest level of antiretroviral therapy they received from any treatment centre in the North West during 2003. The vast majority (91%) of those categorised as having had an AIDS defining illness received triple or more combination therapy, whilst over three quarters (80%) of those who were symptomatic received this level of therapy. In contrast, most asymptomatic individuals (60%) were not receiving any antiretroviral therapy. This has implications for the future demand for drug therapy, since many of these individuals will require drug treatment when their HIV disease progresses.

Table 3.17 refers to the level of antiretroviral therapy received when HIV positive individuals last presented for treatment and care in the North West during 2003, by treatment centre. The Infectious Disease Unit at North Manchester General Hospital (NMG), the treatment centre that sees the most individuals in the North West, prescribed triple or more antiretroviral therapy to 78% of their patients. The data illustrate a variation in the level of antiretroviral therapy prescribed across treatment centres in the region. For those receiving antiretroviral therapy, the most common level was triple therapy. Patients newly commencing treatment are more likely to be prescribed triple or more therapy (see chapter 2, table 2.14).

Table 3.17: Distribution of treatment for total HIV and AIDS cases by level of antiretroviral therapy, January-December 2003

(All cases seen during 2003 including those who died during the year)

TREATMENT CENTRE	Level of Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or More	
AHC				4 (40%)	6 (60%)	10
APH	18 (50%)			15 (41.7%)	3 (8.3%)	36
BLAG	80 (37.2%)			107 (49.8%)	28 (13%)	215
BLK	3 (37.5%)		1 (12.5%)	3 (37.5%)	1 (12.5%)	8
BLKG	9 (22.5%)	1 (2.5%)		28 (70%)	2 (5%)	40
BOLG	40 (33.3%)			64 (53.3%)	16 (13.3%)	120
BOOT	1 (9.1%)			10 (90.9%)		11
BURG	6 (40%)			7 (46.7%)	2 (13.3%)	15
BURY	16 (59.3%)			9 (33.3%)	2 (7.4%)	27
CHR	32 (47.1%)			29 (42.6%)	7 (10.3%)	68
CPED	1 (100%)					1
CUMB	18 (56.3%)			11 (34.4%)	3 (9.4%)	32
DDU	4 (100%)					4
FGH	3 (60%)			2 (40%)		5
HAL	3 (100%)					3
LEI	6 (33.3%)			12 (66.7%)		18
LEII	4 (44.4%)			5 (55.6%)		9
MAC	7 (25.9%)			16 (59.3%)	4 (14.8%)	27
MGP	97 (60.6%)	1 (0.6%)	7 (4.4%)	37 (23.1%)	18 (11.3%)	160
MRI	69 (35%)			91 (46.2%)	37 (18.8%)	197
MRIIG	115 (50.9%)		2 (0.9%)	89 (39.4%)	20 (8.8%)	226
MRIH	6 (15.4%)	1 (2.6%)		29 (74.4%)	3 (7.7%)	39
NMG	236 (22%)			729 (67.9%)	109 (10.1%)	1074
NMGG	70 (63.1%)	2 (1.8%)		34 (30.6%)	5 (4.5%)	111
NOBL	8 (66.7%)			4 (33.3%)		12
OLDG	18 (100%)					18
PG	31 (29.5%)		3 (2.9%)	63 (60%)	8 (7.6%)	105
PP	3 (60%)			2 (40%)		5
QSC	188 (100%)					188
RLG	144 (38.1%)	5 (1.3%)	1 (0.3%)	168 (44.4%)	60 (15.9%)	378
RLH	2 (14.3%)			11 (78.6%)	1 (7.1%)	14
RLI	2 (11.8%)			15 (88.2%)		17
ROCG	14 (38.9%)			16 (44.4%)	6 (16.7%)	36
SALG	19 (42.2%)			26 (57.8%)		45
SHH	6 (46.2%)			7 (53.8%)		13
SPG	17 (45.9%)			15 (40.5%)	5 (13.5%)	37
STP	30 (38%)		1 (1.3%)	35 (44.3%)	13 (16.5%)	79
TAMG	5 (100%)					5
TRAG	2 (25%)			6 (75%)		8
WAR	10 (76.9%)			2 (15.4%)	1 (7.7%)	13
WGH				8 (100%)		8
WHIT				4 (80%)	1 (20%)	5
WIGG	7 (100%)					7
WITG	86 (62.8%)		1 (0.7%)	37 (27%)	13 (9.5%)	137
WORK	1 (12.5%)	1 (12.5%)		4 (50%)	2 (25%)	8

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 3.18 illustrates the residential distribution of all HIV and AIDS cases presenting to treatment centres in the North West in 2003. Most individuals with HIV or AIDS present to treatment centres close to where they live. The Infectious Disease Unit at North Manchester General Hospital (NMG) saw the largest number of people (1,074), and the largest number of residents outside the North West Region (37, 3% of its patients). However, some of the other treatment centres had higher proportions of residents from outside the region, for example the haematology department at Alder Hey Children's Hospital (AHC), because it is a specialist unit, at 40% and the Countess of Chester Hospital GUM (CHR) at 16%.

Table 3.19 illustrates the clinical stage of all HIV and AIDS cases presenting for treatment in the North West during 2003, by treatment centre. The figures refer to the clinical condition of individuals when last seen in the year 2003; HIV positive individuals who died are presented in separate categories to other cases. In the North West, the treatment of HIV and AIDS cases is divided primarily between the large infectious disease unit, genitourinary medicine clinics and haematology clinics. Care is also provided by a number of other hospital units and a specialist general practice.

Forty percent of all HIV and AIDS individuals presenting for treatment in the North West during 2003 were categorised as symptomatic, with 24% classed as AIDS (table 3.3a). The largest HIV and AIDS treatment centre in the North West, the Infectious Disease Unit at North Manchester General Hospital (NMG), provides care for 36% of all HIV positive individuals presenting in the North West, including 47% 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 2003, by treatment centre. There are considerable variations in the proportions of method of exposure to HIV between different treatment centres. Ninety five percent of individuals attending a specialist general practice in Manchester (MGP) had been exposed to HIV via homosexual sex compared to an overall rate of 56% of all HIV and AIDS cases within the region (table 3.4a). 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 (1,074), representing a 16% increase on the previous year. A number of other treatment centres have seen sharper increases: Manchester Royal Infirmary (MRI) with 40% and North Manchester General GUM (NMGG) with 48%.

Table 3.21 illustrates the age distribution of all HIV and AIDS cases presenting for treatment in the North West during 2003, by treatment centre. The age distribution of HIV cases remains (as in previous years) concentrated in the 30-44 age range, accounting for 59% of all cases (table 3.2). Age ranges are proportionally represented throughout most treatment sites, with the exception of centres specialising in paediatric care, which are: Alder Hey Children's Hospital (AHC), the paediatric department at West Cumberland Hospital (CPED), Booth Hall Children's Hospital (BOOT) and the paediatric department at the Royal Preston Hospital (PP), where all individuals are under 15 years of age.

Table 3.18: Residential distribution of total HIV and AIDS cases by treatment centre, January to December 2003 (All cases seen during 2003 including those who died during the year)

SHA	PCT of Residence	AHC	APH	BLAG	BLK	BLKG	BOLG	BOOT	BURG	BURY	CHR	CPED	CUMB	DDU	FGH	HAL	LEI	LEII	MAC	MGP	
Cumbria and Lancashire	Carlisle and District												20								
	Eden Valley			1									8								
	West Cumbria											1	2								
	Morecambe Bay			2											2						
	Blackpool			159																	
	Fylde			21			2														
	Wyre			23																	
	Preston			1			2														
	Hyndburn and Ribble Valley			1	5	9	3		1												
	Burnley, Pendle and Rossendale						1		12	1											
	Blackburn with Darwen					30	1														
	Chorley and South Ribble						2		1												
	West Lancashire																				
Cheshire and Merseyside	Southport and Formby																				
	South Sefton																				
	North Liverpool	1																			
	Central Liverpool	1		2			1							2							
	South Liverpool													1							
	Knowsley		1																		
	St Helens																				
	Halton	1									1					2					
	Warrington										2										
	Birkenhead and Wallasey	1	26								5			1							
	Bebington and West Wirral		5								2										
	Ellesmere Port and Neston	2	3								9										
	Cheshire West											36						2			1
Central Cheshire																	15	9	3		
Eastern Cheshire																				18	
Greater Manchester	Ashton, Leigh and Wigan						6													1	
	Bolton						79	2									1				
	Bury						3			22										1	
	Heywood and Middleton									1	1										
	Rochdale							1												1	
	Salford						2				1									51	
	Trafford North																			3	
	Trafford South																				
	North Manchester			1			3	3												42	
	Central Manchester		1			1	1	3		1										52	
	South Manchester																			1	
	Oldham						2														
	Tameside and Glossop							1												1	
Stockport							1		1						1				1	1	
Out of Region	4		1	1		12					11		1							3	2
Abroad																					
Unknown			3	2				1	1			1		3					1	4	
Total	10	36	215	8	40	120	11	15	27	68	1	32	4	5	3	18	9	27		160	

MRI	MRIG	MRIH	NMG	NMGG	NOBL	OLDG	PG	PP	OSC	RLG	RLH	RLI	ROCG	SALG	SHH	SPG	STP	TAMG	TRAG	WAR	WGH	WHIT	WIGG	WITG	WORK
									1																
									2	1		11										7	5		8
1			7				2		2	1															
1	1	3	8				5		142																
			2				2		16																
			5				2		20																
	1	2	9				59	4	1	1						1									
		2	9						1																
1	1	2	18										1											1	
	2		4				2							1											
		1	4				20	1		1															
							3			6	1			1	1	8									
1		2								8						21									
										28	2														
										18															
			3	1	1		1		2	133	5				1	1					2				
							1			42	1					1									
										17					2										
1	1		3	1						15	1				6										
	1	1								10						1					1				
	2		11							10	1				1						9				4
1	1		1							32	1														
										5															
										4															
		2	4							6															
1			13	1						4			1		1										2
1	3	2	12														9								4
5	2	2	14	8						4						1							6	1	
2	2	2	32				1			1													1		
3	3	4	50	9										1			1		2						2
1		2	16	1										4											
	1	2	17	1		2								21											
17	22	1	130	27										1	39		1								12
7	9		32	3										1	1		1		5						10
5	2	1	23	1							1						1								11
29	37	1	235	38		1			1	2		2	3	1			2								10
95	106	1	207	11						1				1			6		1						37
10	3		42	1													5								30
4	4	2	42	1		15								2			1								
2	8		53	2										1			6	5							1
6	4	3	29	1											1	1	43				1				5
1	4	1	36	2	11		1			23	1					1	3					1			
			1																						
6	8		2	2			6		2	5		4	1			2									7
197	226	39	1074	111	12	18	105	5	188	378	14	17	36	45	13	37	79	5	8	13	8	5	7	137	8

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

Table 3.19: Distribution of treatment for total HIV and AIDS cases by stage of HIV disease, January-December 2003 (All cases seen during 2003 including those who died during the year)

TREATMENT CENTRE	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
AHC	2 (20%)	4 (40%)	4 (40%)				10
APH	13 (36.1%)	11 (30.6%)	11 (30.6%)	1 (2.8%)			36
BLAG	58 (27%)	81 (37.7%)	72 (33.5%)	4 (1.9%)			215
BLK		4 (50%)	3 (37.5%)	1 (12.5%)			8
BLKG	16 (40%)	23 (57.5%)	1 (2.5%)				40
BOLG	63 (52.5%)	28 (23.3%)	29 (24.2%)				120
BOOT	2 (18.2%)	5 (45.5%)	4 (36.4%)				11
BURG	3 (20%)	11 (73.3%)	1 (6.7%)				15
BURY	11 (40.7%)	9 (33.3%)	6 (22.2%)			1 (3.7%)	27
CHR	49 (72.1%)	7 (10.3%)	12 (17.6%)				68
CPED	1 (100%)						1
CUMB	21 (65.6%)	5 (15.6%)	6 (18.8%)				32
DDU	2 (50%)	1 (25%)				1 (25%)	4
FGH	4 (80%)	1 (20%)					5
HAL	2 (66.7%)	1 (33.3%)					3
LEI	8 (44.4%)	4 (22.2%)	6 (33.3%)				18
LEII	3 (33.3%)		6 (66.7%)				9
MAC	15 (55.6%)	6 (22.2%)	5 (18.5%)	1 (3.7%)			27
MGP	52 (32.5%)	68 (42.5%)	25 (15.6%)	1 (0.6%)	1 (0.6%)	13 (8.1%)	160
MRI	77 (39.1%)	61 (31%)	56 (28.4%)			3 (1.5%)	197
MRIG	152 (67.3%)	54 (23.9%)	20 (8.8%)				226
MRIH	4 (10.3%)	25 (64.1%)	10 (25.6%)				39
NMG	265 (24.7%)	455 (42.4%)	340 (31.7%)	8 (0.7%)	6 (0.6%)		1074
NMGG	69 (62.2%)	30 (27%)	11 (9.9%)			1 (0.9%)	111
NOBL	7 (58.3%)	2 (16.7%)	3 (25%)				12
OLDG	4 (22.2%)	3 (16.7%)	8 (44.4%)			3 (16.7%)	18
PG	29 (27.6%)	43 (41%)	33 (31.4%)				105
PP	3 (60%)		2 (40%)				5
QSC	45 (23.9%)	71 (37.8%)	60 (31.9%)	4 (2.1%)		8 (4.3%)	188
RLG	163 (43.1%)	117 (31%)	88 (23.3%)	8 (2.1%)	1 (0.3%)	1 (0.3%)	378
RLH	4 (28.6%)	6 (42.9%)	4 (28.6%)				14
RLI	10 (58.8%)	3 (17.6%)	4 (23.5%)				17
ROCG	10 (27.8%)	17 (47.2%)	9 (25%)				36
SALG	25 (55.6%)	16 (35.6%)	4 (8.9%)				45
SHH	8 (61.5%)	2 (15.4%)	3 (23.1%)				13
SPG	20 (54.1%)	8 (21.6%)	9 (24.3%)				37
STP	31 (39.2%)	27 (34.2%)	21 (26.6%)				79
TAMG	3 (60%)	1 (20%)				1 (20%)	5
TRAG	6 (75%)	1 (12.5%)		1 (12.5%)			8
WAR	6 (46.2%)	3 (23.1%)	4 (30.8%)				13
WGH	2 (25%)	3 (37.5%)	3 (37.5%)				8
WHIT	2 (40%)		3 (60%)				5
WIGG	5 (71.4%)	1 (14.3%)	1 (14.3%)				7
WITG	66 (48.2%)	44 (32.1%)	22 (16.1%)			5 (3.6%)	137
WORK	5 (62.5%)	1 (12.5%)	2 (25%)				8

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Table 3.20: Distribution of treatment for total HIV and AIDS cases by infection route of HIV, January-December 2003 (All cases seen during 2003 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					9 (90%)	1 (10%)	10
APH	23 (63.9%)		12 (33.3%)			1 (2.8%)	36
BLAG	184 (85.6%)	2 (0.9%)	23 (10.7%)	2 (0.9%)	2 (0.9%)	2 (0.9%)	215
BLK	3 (37.5%)		5 (62.5%)				8
BLKG	10 (25%)	1 (2.5%)	29 (72.5%)				40
BOLG	49 (40.8%)	2 (1.7%)	69 (57.5%)				120
BOOT					11 (100%)		11
BURG	9 (60%)	3 (20%)	3 (20%)				15
BURY	10 (37%)	1 (3.7%)	15 (55.6%)	1 (3.7%)			27
CHR	44 (64.7%)	2 (2.9%)	22 (32.4%)				68
CPED					1 (100%)		1
CUMB	16 (50%)	1 (3.1%)	13 (40.6%)			2 (6.3%)	32
DDU		3 (75%)	1 (25%)				4
FGH	3 (60%)		1 (20%)			1 (20%)	5
HAL	3 (100%)						3
LEI	11 (61.1%)		6 (33.3%)	1 (5.6%)			18
LEII	5 (55.6%)		4 (44.4%)				9
MAC	15 (55.6%)		9 (33.3%)	1 (3.7%)		2 (7.4%)	27
MGP	152 (95%)	2 (1.3%)	2 (1.3%)			4 (2.5%)	160
MRI	118 (59.9%)	4 (2%)	68 (34.5%)	3 (1.5%)		4 (2%)	197
MRIG	161 (71.2%)	2 (0.9%)	56 (24.8%)		1 (0.4%)	6 (2.7%)	226
MRIH			3 (7.7%)	36 (92.3%)			39
NMG	612 (57%)	44 (4.1%)	321 (29.9%)	8 (0.7%)	28 (2.6%)	61 (5.7%)	1074
NMGG	75 (67.6%)		32 (28.8%)			4 (3.6%)	111
NOBL	4 (33.3%)		8 (66.7%)				12
OLDG	7 (38.9%)	3 (16.7%)	8 (44.4%)				18
PG	43 (41%)	1 (1%)	52 (49.5%)		3 (2.9%)	6 (5.7%)	105
PP					5 (100%)		5
QSC	168 (89.4%)	3 (1.6%)	15 (8%)		1 (0.5%)	1 (0.5%)	188
RLG	144 (38.1%)	11 (2.9%)	174 (46%)	9 (2.4%)		40 (10.6%)	378
RLH	1 (7.1%)			13 (92.9%)			14
RLI	9 (52.9%)	1 (5.9%)	7 (41.2%)				17
ROCG	20 (55.6%)	1 (2.8%)	15 (41.7%)				36
SALG	28 (62.2%)	1 (2.2%)	16 (35.6%)				45
SHH	9 (69.2%)		4 (30.8%)				13
SPG	11 (29.7%)		24 (64.9%)			2 (5.4%)	37
STP	57 (72.2%)	1 (1.3%)	19 (24.1%)			2 (2.5%)	79
TAMG	2 (40%)		2 (40%)			1 (20%)	5
TRAG	4 (50%)		3 (37.5%)	1 (12.5%)			8
WAR	6 (46.2%)	1 (7.7%)	4 (30.8%)			2 (15.4%)	13
WGH	3 (37.5%)	1 (12.5%)	3 (37.5%)			1 (12.5%)	8
WHIT			3 (60%)	1 (20%)		1 (20%)	5
WIGG	2 (28.6%)		4 (57.1%)			1 (14.3%)	7
WITG	110 (80.3%)	4 (2.9%)	22 (16.1%)			1 (0.7%)	137
WORK	6 (75%)		2 (25%)				8

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 2003 (All cases seen during 2003 including those who died during the year)

TREATMENT CENTRE	Age Group											Total (100%)
	0-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	
AHC	10 (100%)											10
APH			1 (2.8%)	4 (11.1%)	10 (27.8%)	6 (16.7%)	5 (13.9%)	3 (8.3%)	1 (2.8%)	4 (11.1%)	2 (5.6%)	36
BLAG	2 (0.9%)	1 (0.5%)	7 (3.3%)	15 (7%)	32 (14.9%)	52 (24.2%)	45 (20.9%)	27 (12.6%)	17 (7.9%)	4 (1.9%)	13 (6%)	215
BLK				1 (12.5%)		2 (25%)	2 (25%)	1 (12.5%)	1 (12.5%)		1 (12.5%)	8
BLKG		1 (2.5%)		10 (25%)	7 (17.5%)	7 (17.5%)	8 (20%)	2 (5%)	3 (7.5%)	1 (2.5%)	1 (2.5%)	40
BOLG			8 (6.7%)	15 (12.5%)	19 (15.8%)	27 (22.5%)	21 (17.5%)	12 (10%)	10 (8.3%)	5 (4.2%)	3 (2.5%)	120
BOOT	11 (100%)											11
BURG				1 (6.7%)	1 (6.7%)	5 (33.3%)	2 (13.3%)	1 (6.7%)	3 (20%)		2 (13.3%)	15
BURY				8 (29.6%)	4 (14.8%)	6 (22.2%)	4 (14.8%)	1 (3.7%)	2 (7.4%)	1 (3.7%)	1 (3.7%)	27
CHR			3 (4.4%)	12 (17.6%)	12 (17.6%)	18 (26.5%)	14 (20.6%)	4 (5.9%)	1 (1.5%)	4 (5.9%)		68
CPED	1 (100%)											1
CUMB			1 (3.1%)	4 (12.5%)	9 (28.1%)	5 (15.6%)	2 (6.3%)	5 (15.6%)	3 (9.4%)	1 (3.1%)	2 (6.3%)	32
DDU			1 (25%)		1 (25%)	1 (25%)				1 (25%)		4
FGH						1 (20%)	2 (40%)	1 (20%)		1 (20%)		5
HAL			2 (66.7%)				1 (33.3%)					3
LEI		1 (5.6%)	1 (5.6%)	1 (5.6%)	4 (22.2%)	4 (22.2%)	3 (16.7%)		3 (16.7%)		1 (5.6%)	18
LEII				2 (22.2%)	1 (11.1%)	1 (11.1%)		1 (11.1%)	2 (22.2%)	1 (11.1%)	1 (11.1%)	9
MAC				1 (3.7%)	4 (14.8%)	8 (29.6%)	4 (14.8%)	1 (3.7%)	5 (18.5%)	3 (11.1%)	1 (3.7%)	27
MGP		1 (0.6%)	3 (1.9%)	21 (13.1%)	34 (21.3%)	44 (27.5%)	28 (17.5%)	18 (11.3%)	8 (5%)	2 (1.3%)	1 (0.6%)	160
MRI			14 (7.1%)	29 (14.7%)	46 (23.4%)	32 (16.2%)	42 (21.3%)	16 (8.1%)	9 (4.6%)	8 (4.1%)	1 (0.5%)	197
MRIG	1 (0.4%)	2 (0.9%)	21 (9.3%)	50 (22.1%)	55 (24.3%)	40 (17.7%)	33 (14.6%)	16 (7.1%)	6 (2.7%)		2 (0.9%)	226
MRIH				3 (7.7%)	7 (17.9%)	11 (28.2%)	8 (20.5%)	8 (20.5%)		2 (5.1%)		39
NMG	27 (2.5%)	3 (0.3%)	30 (2.8%)	100 (9.3%)	203 (18.9%)	253 (23.6%)	203 (18.9%)	141 (13.1%)	62 (5.8%)	23 (2.1%)	29 (2.7%)	1074
NMGG		1 (0.9%)	11 (9.9%)	19 (17.1%)	27 (24.3%)	26 (23.4%)	16 (14.4%)	4 (3.6%)	6 (5.4%)	1 (0.9%)		111
NOBL				2 (16.7%)	1 (8.3%)	3 (25%)	3 (25%)	3 (25%)				12
OLDG			3 (16.7%)	1 (5.6%)	5 (27.8%)	2 (11.1%)	4 (22.2%)	1 (5.6%)	1 (5.6%)		1 (5.6%)	18
PG	3 (2.9%)		7 (6.7%)	9 (8.6%)	21 (20%)	22 (21%)	19 (18.1%)	9 (8.6%)	5 (4.8%)	4 (3.8%)	6 (5.7%)	105
PP	5 (100%)											5
OSC	1 (0.5%)	1 (0.5%)	8 (4.3%)	13 (6.9%)	29 (15.4%)	46 (24.5%)	41 (21.8%)	22 (11.7%)	15 (8%)	3 (1.6%)	9 (4.8%)	188
RLG		6 (1.6%)	22 (5.8%)	48 (12.7%)	74 (19.6%)	68 (18%)	78 (20.6%)	39 (10.3%)	18 (4.8%)	15 (4%)	10 (2.6%)	378
RLH		1 (7.1%)	2 (14.3%)	1 (7.1%)	3 (21.4%)	3 (21.4%)	2 (14.3%)	1 (7.1%)	1 (7.1%)			14
RLI				2 (11.8%)	1 (5.9%)	4 (23.5%)	2 (11.8%)	1 (5.9%)	4 (23.5%)	3 (17.6%)		17
ROCG			1 (2.8%)	5 (13.9%)	9 (25%)	8 (22.2%)	4 (11.1%)	3 (8.3%)	5 (13.9%)	1 (2.8%)		36
SALG		1 (2.2%)	2 (4.4%)	8 (17.8%)	12 (26.7%)	10 (22.2%)	8 (17.8%)	2 (4.4%)	1 (2.2%)		1 (2.2%)	45
SHH		1 (7.7%)	1 (7.7%)	2 (15.4%)	4 (30.8%)	4 (30.8%)	1 (7.7%)					13
SPG			4 (10.8%)	9 (24.3%)	7 (18.9%)	7 (18.9%)	6 (16.2%)	2 (5.4%)		1 (2.7%)	1 (2.7%)	37
STP		1 (1.3%)	4 (5.1%)	11 (13.9%)	10 (12.7%)	14 (17.7%)	10 (12.7%)	9 (11.4%)	6 (7.6%)	6 (7.6%)	8 (10.1%)	79
TAMG				1 (20%)	2 (40%)			1 (20%)			1 (20%)	5
TRAG				1 (12.5%)	1 (12.5%)	2 (25%)	1 (12.5%)	1 (12.5%)	2 (25%)			8
WAR			1 (7.7%)	1 (7.7%)	3 (23.1%)	2 (15.4%)	1 (7.7%)	1 (7.7%)	3 (23.1%)	1 (7.7%)		13
WGH				1 (12.5%)	3 (37.5%)	1 (12.5%)	1 (12.5%)	1 (12.5%)	1 (12.5%)	1 (12.5%)		8
WHIT					1 (20%)	2 (40%)	2 (40%)					5
WIGG			2 (28.6%)	1 (14.3%)		1 (14.3%)	2 (28.6%)			1 (14.3%)		7
WITG		1 (0.7%)	7 (5.1%)	14 (10.2%)	31 (22.6%)	38 (27.7%)	17 (12.4%)	13 (9.5%)	8 (5.8%)	4 (2.9%)	4 (2.9%)	137
WORK				1 (12.5%)	2 (25%)	2 (25%)	3 (37.5%)					8

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 2003 (All cases seen during 2003 including those who died during the year)

TREATMENT CENTRE	Sex		Total (100%)
	Male	Female	
AHC	6 (60%)	4 (40%)	10
APH	33 (91.7%)	3 (8.3%)	36
BLAG	201 (93.5%)	14 (6.5%)	215
BLK	5 (62.5%)	3 (37.5%)	8
BLKG	25 (62.5%)	15 (37.5%)	40
BOLG	76 (63.3%)	44 (36.7%)	120
BOOT	5 (45.5%)	6 (54.5%)	11
BURG	14 (93.3%)	1 (6.7%)	15
BURY	20 (74.1%)	7 (25.9%)	27
CHR	53 (77.9%)	15 (22.1%)	68
CPED		1 (100%)	1
CUMB	25 (78.1%)	7 (21.9%)	32
DDU	2 (50%)	2 (50%)	4
FGH	4 (80%)	1 (20%)	5
HAL	3 (100%)		3
LEI	17 (94.4%)	1 (5.6%)	18
LEII	7 (77.8%)	2 (22.2%)	9
MAC	25 (92.6%)	2 (7.4%)	27
MGP	157 (98.1%)	3 (1.9%)	160
MRI	141 (71.6%)	56 (28.4%)	197
MRIG	189 (83.6%)	37 (16.4%)	226
MRIH	34 (87.2%)	5 (12.8%)	39
NMG	831 (77.4%)	243 (22.6%)	1074
NMGG	91 (82%)	20 (18%)	111
NOBL	8 (66.7%)	4 (33.3%)	12
OLDG	10 (55.6%)	8 (44.4%)	18
PG	76 (72.4%)	29 (27.6%)	105
PP	1 (20%)	4 (80%)	5
QSC	180 (95.7%)	8 (4.3%)	188
RLG	266 (70.4%)	112 (29.6%)	378
RLH	14 (100%)		14
RLI	14 (82.4%)	3 (17.6%)	17
ROCG	29 (80.6%)	7 (19.4%)	36
SALG	34 (75.6%)	11 (24.4%)	45
SHH	10 (76.9%)	3 (23.1%)	13
SPG	24 (64.9%)	13 (35.1%)	37
STP	70 (88.6%)	9 (11.4%)	79
TAMG	4 (80%)	1 (20%)	5
TRAG	7 (87.5%)	1 (12.5%)	8
WAR	10 (76.9%)	3 (23.1%)	13
WGH	6 (75%)	2 (25%)	8
WHIT	3 (60%)	2 (40%)	5
WIGG	4 (57.1%)	3 (42.9%)	7
WITG	123 (89.8%)	14 (10.2%)	137
WORK	6 (75%)	2 (25%)	8

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 illustrates the number of male and female HIV and AIDS cases presenting for treatment in the North West in 2003, by treatment centre. The majority of all HIV and AIDS cases treated in the North West were male (78%; table 3.5), 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 95% of cases (table 3.20) and 98% of individuals were male. The Haematology Units in Manchester Royal Infirmary (MRIH) and Royal Liverpool University Hospital (RLH) also see more males because conditions such as haemophilia are more common among males, and many haemophiliacs were infected with HIV prior to screening of blood products. Exceptions to this male biased gender distribution occur at treatment centres specialising in paediatric care such as Alder Hey Children's Hospital (AHC) and the Paediatric Department at Royal Preston Hospital (PP) where males and females are equally likely to be affected.

Table 3.23: Residential distribution of total HIV and AIDS cases by number of treatment centres attended, January-December 2003

(All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	Treatment Centres Attended			Total (100%)
	One	Two	Three	
Cumbria and Lancashire	338 (63.4%)	190 (35.6%)	5 (0.9%)	533
Cheshire and Merseyside	525 (90.5%)	52 (9%)	3 (0.5%)	580
Greater Manchester	1384 (81.3%)	300 (17.6%)	19 (1.1%)	1703
Isle of Man	14 (87.5%)	2 (12.5%)		16
East Midlands	5 (100%)			5
East of England	2 (100%)			2
London	6 (85.7%)	1 (14.3%)		7
Scotland	2 (100%)			2
South East	3 (100%)			3
South West	2 (100%)			2
Wales	26 (96.3%)	1 (3.7%)		27
West Midlands	12 (85.7%)	2 (14.3%)		14
Yorkshire and The Humber	30 (90.9%)	3 (9.1%)		33
Abroad	1 (100%)			1
Unknown	59 (98.3%)	1 (1.7%)		60
Total	2409 (80.6%)	552 (18.5%)	27 (0.9%)	2988

Individuals living outside of the North West Region are grouped by region, and the Isle of Man is organised as a distinct category. For a breakdown of number of treatment centres by primary care trust, please see the North West Public Health Observatory website: www.nwpho.org.uk/hiv2003/table3-23.htm

Table 3.23 illustrates the residential distribution of all HIV and AIDS cases presenting in the North West for treatment in 2003 by the number of statutory treatment centres attended. The majority (81%) attended only one treatment centre, a comparable proportion to 2002. However, this varied across strategic health authorities, with residents of Cheshire and Merseyside being more likely to attend only one centre (91%) than those of Cumbria and Lancashire (63%) or Greater Manchester (81%). It should be noted that these numbers refer only to treatment centres within the North West.

Table 3.24 illustrates the overlap of treatment of HIV and AIDS cases between treatment centres in the North West during 2003. The diagonal (in bold) represents the number of individuals who used each treatment centre as their sole provider of care during 2003, and the right hand column shows the total numbers accessing each treatment centre. For example, although 1,074 individuals accessed care from North Manchester General Infectious Disease Unit (NMG), only 73% (787) used NMG as their sole provider of care. North Manchester General patients also attended Manchester Royal Infirmary Outpatient Department (MRI, 49 individuals) and a specialist general practice in Manchester (MGP, 87 individuals). Involvement and specialism by GPs in the area of sexual health and HIV is promoted in the National Strategy for Sexual Health and HIV⁴. 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 2003.

Table 3.25 displays the amount of outpatient days, day cases, inpatient days, inpatient episodes and home visits attributed to HIV and AIDS cases accessing care from the statutory sector during 2003. The data are displayed as the total number of days, episodes or visits and the mean number of days, episodes or visits per HIV positive individual treated by that centre. This is the fifth year that information on inpatient and outpatient care for the whole of the North West Region has been collected, allowing comparisons to be made with the data from 1999 to 2002.

As was the case in the years 1999 to 2002, in the year 2003 North Manchester General Infectious Disease Unit (NMG) provided the highest number of outpatient visits. Outpatient visits at NMG accounted for 28% of all attendances across the region, with the Department of Genito-Urinary Medicine at the Royal Liverpool University Hospital (RLG) reporting the second highest number of visits, and a higher mean number of outpatient visits per HIV positive person. Noble's Isle of Man Hospital (NOBL) provided the highest mean number of outpatient visits with 13.1 visits per patient.

North Manchester General Infectious Disease Unit (NMG) also provided the highest number of day cases (75% of the total), inpatient episodes (50% of the total) and inpatient days (47%), with the Department of Genito-Urinary Medicine at the Royal Liverpool University Hospital (RLG) providing the next highest numbers of inpatient episodes at 19% of the total.

Some of the treatment centres provided a significant number of home visits, with North Manchester General Infectious Disease Unit (NMG) providing the most at 1,465 (63% of the total). This is the third year that we have collected data on home visits. The mean number per patient has increased from none in 2001 to 0.6 this year, reflecting improvements in data reporting and collection. Royal Oldham Hospital GUM (OLDG) provided the highest number of home visits per HIV positive person (9.7 per patient). Oldham is the only hospital to see more people at home than in the outpatient department.

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 during 2003. The data show the increasing level and different type of care required as HIV disease progresses. While asymptomatic individuals required on average 7 outpatient visits per patient, 8 visits were required per symptomatic patient rising to 9 visits for each patient with an AIDS diagnosis. Those who died of an AIDS related illness during the year had on average of only 3.1 outpatient visits during 2003 but required by far the largest amount of inpatient care, at an average of 33.4 days each. In contrast, asymptomatic, symptomatic and AIDS patients required only 0.5, 2.3 and 5.6 days of inpatient care respectively. Levels of care were similar in 2003 compared to 2001 and 2002, with the overall mean number of outpatient visits dropping slightly (from 9.3 to 8.5 to 7.7 visits per HIV positive individual) and the number of inpatient days decreasing slightly from 3.8 in 2001, 2.9 in 2002 to 2.6 in 2003.

Table 3.27 presents a breakdown of asylum seeker status by stage of HIV disease for all those individuals who presented for treatment in the North West in 2003. A total of 316 individuals were known to be asylum seekers (11% of the total HIV positive population). The proportion of individuals who are asylum seekers has almost quadrupled since 2001 (from 3%). Asylum seeker status for 5% was unknown.

The majority (58%) of asylum seekers were reported to be still asymptomatic, suggesting that individuals usually access treatment while still healthy and thus may benefit by life-prolonging treatment. This compares to the non-asylum seeking population, where only 38% are classified as asymptomatic. Of the known asylum seekers 20% had an AIDS diagnosis, compared to 25% of non-asylum seekers. A similar proportion of asylum seekers and non-asylum seekers died in 2003, at 1% of each.

Table 3.24: Overlap of total HIV and AIDS cases between different centres of treatment, January-December 2003 (All cases seen during 2003 including those who died during the year)

	AHC	APH	BLAG	BLK	BLKG	BOLG	BOOT	BURG	BURY	CHR	CPED	CUMB	DDU	FGH	HAL	LEI	LEII	MAC	MGP	MRI	MRIG	MRIH	NMG
AHC	10																						
APH		30								1													
BLAG			38			1													1				5
BLK				5	2																		1
BLKG				2	36			1															1
BOLG			1			114															1		2
BOOT							0																11
BURG					1			13															1
BURY									18													1	7
CHR		1								57									1				5
CPED											1												
CUMB												31											
DDU													2										
FGH														5									
HAL															0							1	
LEI																13	2						2
LEII																2	7						
MAC																		26					1
MGP			1							1										22	18	21	87
MRI																				18	129	2	3
MRIG						1									1					21	2	170	28
MRIH									1												3	33	3
NMG			5	1	1	2	11	1	7	5						2		1	87	49	28	3	787
NMGG									1							1			9		1		21
NOBL																					1		
OLDG																							14
PG			1			1																	1
PP																							
QSC			175			1													1				7
RLG		5	2			1				4		1	2		1				1		1		2
RLH																							
RLI																							1
ROCG									1														2
SALG																					1		4
SHH																							1
SPG																							
STP																			3	2			13
TAMG																							4
TRAG																							1
WAR															1								3
WGH																							
WHIT																							
WIGG																							2
WITG																			11	1	2		28
WORK																							

NMGG	NOBL	OLDG	PG	PP	OSC	RLG	RLH	RLI	ROCG	SALG	SHH	SPG	STP	TAMG	TRAG	WAR	WGH	WHIT	WIGG	WITG	WORK	TOTAL	
																						10	
						5																36	
			1		175	2																215	
																						8	
																						40	
			1		1	1																120	
																						11	
																						15	
1									1													27	
						4																68	
						1																1	
						2																32	
							2															4	
																						5	
						1										1						3	
1																						18	
																						9	
																						27	
9					1	1							3								11	160	
													2									1	197
1	1					1				1											2	226	
																						39	
21		14	1		7	2		1	2	4	1		13	4	1	3				2	28	1074	
73									1	1										3	1	111	
			9			2																12	
			4																			18	
				96	2	1	1										2					105	
				2	3																	5	
				1		9	2															188	
		2		1		2	338	5			5	5				3						378	
						5	9															14	
								16														17	
1									32													36	
1										39			1									45	
						5					6		1									13	
						5						32										37	
										1	1		59	1							1	79	
												1	1									5	
															7							8	
						3										7						13	
			2														6					8	
																		5				5	
3																				2		7	
1												1									101	137	
																						8	8

**The diagonal (in bold) represents the number of individuals who solely used each treatment centre in 2003. **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 3.25: Distribution of total and mean number of outpatient visits, day cases, inpatient episodes, inpatient days and home visits by treatment centre, January-December 2003 (All cases seen during 2003 including those who died during the year)

TREATMENT CENTRE	Outpatient Visits		Day Cases		Inpatient Episodes		Inpatient Days		Home Visits	
	Total	Mean	Total	Mean	Total	Mean	Total	Mean	Total	Mean
AHC	103	10.3	1	0.1	8	0.8	51	5.1	22	2.2
APH	387	10.8	105	2.9	11	0.3	94	2.6	0	0
BLAG	857	4.0	2	0	41	0.2	693	3.2	1	0
BLK	18	2.3	0	0	4	0.5	95	11.9	0	0
BLKG	273	6.8	1	0	26	0.7	155	3.9	0	0
BOLG	910	7.6	0	0	8	0.1	114	1.0	0	0
BOOT	29	2.6	4	0.4	9	0.8	25	2.3	0	0
BURG	111	7.4	1	0.1	1	0.1	5	0.3	2	0.1
BURY	142	5.3	0	0	30	1.1	38	1.4	6	0.2
CHR	526	7.7	3	0	12	0.2	97	1.4	7	0.1
CPED	4	4.0	0	0	0	0	0	0	5	5.0
CUMB	123	3.8	0	0	1	0	5	0.2	0	0
DDU	27	6.8	0	0	0	0	0	0	12	3.0
FGH	9	1.8	0	0	1	0.2	20	4.0	0	0
HAL	11	3.7	0	0	0	0	0	0	0	0
LEI	168	9.3	1	0.1	0	0	0	0	1	0.1
LEII	38	4.2	4	0.4	5	0.6	57	6.3	0	0
MAC	208	7.7	0	0	5	0.2	96	3.6	29	1.1
MGP	867	5.4	0	0	0	0	0	0	1	0
MRI	1537	7.8	3	0	6	0	262	1.3	0	0
MRIG	1945	8.6	2	0	4	0	52	0.2	1	0
MRIH	211	5.4	6	0.2	7	0.2	179	4.6	0	0
NMG	6312	5.9	492	0.5	363	0.3	3591	3.3	1465	1.4
NMGG	940	8.5	0	0	1	0	41	0.4	0	0
NOBL	157	13.1	3	0.3	8	0.7	96	8.0	102	8.5
OLDG	56	3.1	0	0	0	0	0	0	175	9.7
PG	612	5.8	0	0	8	0.1	145	1.4	1	0
PP	14	2.8	0	0	2	0.4	14	2.8	0	0
QSC	1020	5.4	0	0	0	0	0	0	154	0.8
RLG	2528	6.7	14	0	136	0.4	1581	4.2	0	0
RLH	63	4.5	0	0	2	0.1	35	2.5	0	0
RLI	48	2.8	4	0.2	4	0.2	58	3.4	11	0.6
ROCG	269	7.5	0	0	0	0	0	0	0	0
SALG	170	3.8	0	0	0	0	0	0	19	0.4
SHH	103	7.9	1	0.1	0	0	0	0	2	0.2
SPG	356	9.6	0	0	2	0.1	2	0.1	1	0
STP	482	6.1	2	0	0	0	0	0	9	0.1
TAMG	11	2.2	0	0	0	0	0	0	2	0.4
TRAG	79	9.9	2	0.3	2	0.3	33	4.1	15	1.9
WAR	66	5.1	1	0.1	1	0.1	2	0.2	0	0
WGH	29	3.6	0	0	1	0.1	32	4.0	8	1.0
WHIT	31	6.2	1	0.2	2	0.4	17	3.4	8	1.6
WIGG	31	4.4	0	0	12	1.7	12	1.7	0	0
WITG	1004	7.3	0	0	0	0	0	0	249	1.8
WORK	62	7.8	2	0.3	0	0	0	0	7	0.9
Total	22947	6.4	655	0.2	723	0.2	7697	2.1	2315	0.6

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

Table 3.26: Distribution of total and mean number of outpatient episodes, day cases, inpatient episodes, inpatient days and home visits by stage of HIV disease, January-December 2003 (All cases seen during 2003 including those who died during the year)

STAGE OF HIV DISEASE	Outpatient Visits		Day Cases		Inpatient Episodes		Inpatient Days		Home Visits	
	Sum	Mean	Sum	Mean	Sum	Mean	Sum	Mean	Sum	Mean
Asymptomatic	8215	7.0	95	0.1	112	0.1	561	0.5	497	0.4
Symptomatic	8171	8.1	264	0.3	252	0.2	2290	2.3	769	0.8
AIDS	6235	8.6	259	0.4	309	0.4	4024	5.6	948	1.3
AIDS related death	71	3.1	17	0.7	41	1.8	769	33.4	79	3.4
Death unrelated to AIDS	54	7.7	20	2.9	9	1.3	53	7.6	14	2.0
Unknown	201	5.4	0	0.0	0	0.0	0	0.0	8	0.2
Total	22947	7.7	655	0.2	723	0.2	7697	2.6	2315	0.8

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

Table 3.27: Asylum seeker status by stage of HIV disease, January-December 2003

ASYLUM SEEKER STATUS	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Yes	183 (57.9%)	64 (20.3%)	64 (20.3%)	3 (0.9%)	1 (0.3%)	1 (0.3%)	316
No	946 (37.6%)	899 (35.7%)	630 (25%)	18 (0.7%)	6 (0.2%)	20 (0.8%)	2519
Unknown	52 (34%)	52 (34%)	31 (20.3%)	2 (1.3%)		16 (10.5%)	153
Total	1181 (39.5%)	1015 (34%)	725 (24.3%)	23 (0.8%)	7 (0.2%)	37 (1.2%)	2988

Table 3.28 shows the strategic health authority of residence by sex, age group, infection route and ethnicity of those individuals known to be refugees who accessed treatment and care in the North West in 2003. Most of the known HIV positive refugees (69%) were resident in Greater Manchester SHA, with a further 23% residing in Cheshire and Merseyside SHA and 7% in Cumbria and Lancashire. There were more females (66%) than males (34%), and the vast majority (96%) were infected via heterosexual sex. Asylum seekers were younger than the general HIV positive population (see chapter 3, table 3.1), with half (52%) being aged between 25 and 34 years. The majority (96%) of asylum seekers were self-defined as black African.

Table 3.28: Residential distribution of individuals known to be asylum seekers by sex, age group, infection route, ethnicity, January-December 2003

SEX	SHA of Residence					Total (100%)
	Cumbria and Lancashire	Cheshire and Merseyside	Greater Manchester	Out of Region	Unknown	
Male	9 (8.5%)	28 (26.4%)	68 (64.2%)	1 (0.9%)		106
Female	13 (6.2%)	44 (21%)	149 (71%)	1 (0.5%)	3 (1.4%)	210
AGE GROUP						
0-14		1 (14.3%)	6 (85.7%)			7
15-19		1 (100%)				1
20-24	3 (10%)	7 (23.3%)	19 (63.3%)		1 (3.3%)	30
25-29	7 (9.9%)	21 (29.6%)	42 (59.2%)		1 (1.4%)	71
30-34	4 (4.3%)	19 (20.7%)	68 (73.9%)	1 (1.1%)		92
35-39	3 (4.8%)	14 (22.2%)	45 (71.4%)	1 (1.6%)		63
40-44	3 (9.4%)	6 (18.8%)	22 (68.8%)		1 (3.1%)	32
45-49	1 (10%)	1 (10%)	8 (80%)			10
50-54	1 (14.3%)	2 (28.6%)	4 (57.1%)			7
55-59			3 (100%)			3
INFECTION ROUTE						
Homo/Bisexual		1 (25%)	3 (75%)			4
Heterosexual	22 (7.3%)	70 (23.1%)	206 (68%)	2 (0.7%)	3 (1%)	303
Mother to Child			6 (100%)			6
Other/Unknown		1 (33.3%)	2 (66.7%)			3
ETHNICITY						
White		1 (50%)	1 (50%)			2
Black Caribbean			1 (50%)		1 (50%)	2
Black African	21 (6.9%)	67 (22%)	212 (69.7%)	2 (0.7%)	2 (0.7%)	304
Indian/Pakistani/Bangladeshi		1 (100%)				1
Other Asian/Oriental	1 (50%)		1 (50%)			2
Other/Mixed		2 (66.7%)	1 (33.3%)			3
Unknown		1 (50%)	1 (50%)			2
Total	22 (7%)	72 (22.8%)	217 (68.7%)	2 (0.6%)	3 (0.9%)	316

Figure 3.2: Population prevalence of total HIV and AIDS cases by primary care trust, January-December 2003 (All cases seen during 2003 including those who died during the year)

Per 100,000 Population

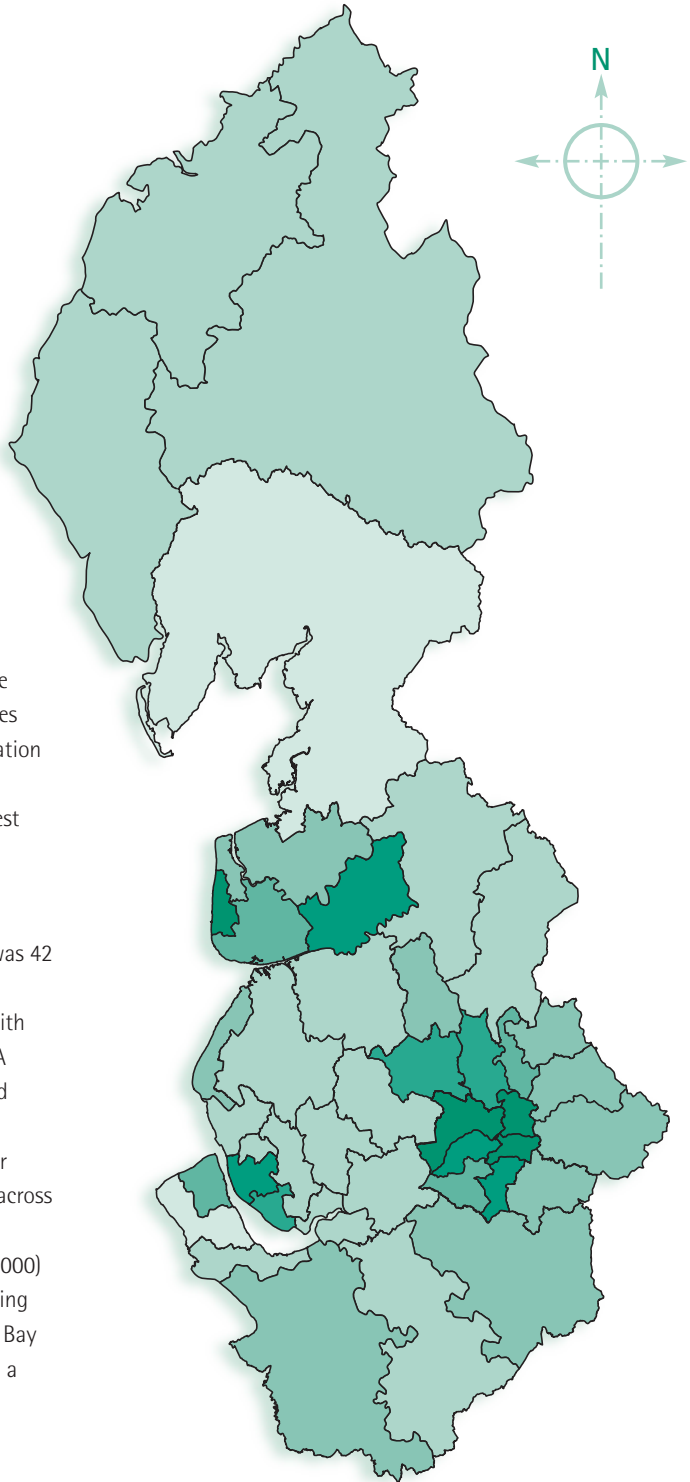


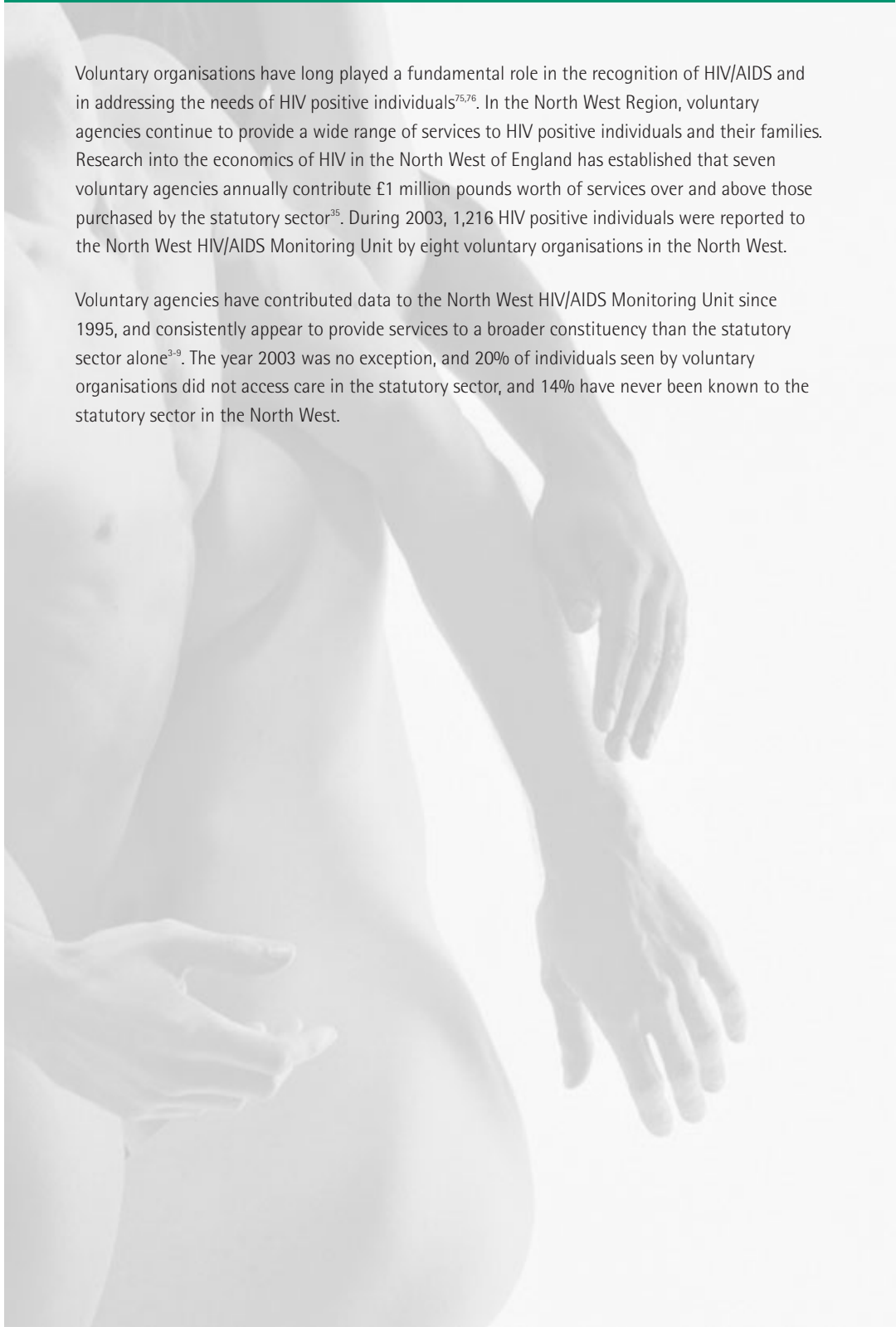
Figure 3.2 illustrates the population prevalence of all HIV and AIDS cases in the North West who attended statutory centres within the region during 2003. The population sizes for each PCT used in the prevalence calculations are provided by the North West Public Health Observatory based on 2001 census data.

Across the region, the prevalence of HIV was 42 per 100,000 population. There were considerable differences between SHAs, with the prevalence in Greater Manchester SHA being 68 per 100,000, that of Cumbria and Lancashire SHA being 28 per 100,000 and Cheshire and Merseyside SHA being 25 per 100,000. The map illustrates the contrast across PCTs, with Central Manchester (303 per 100,000), North Manchester (293 per 100,000) and Blackpool PCTs (124 per 100,000) having the highest prevalence, while Morecambe Bay and Bebington and West Wirral PCTs have a prevalence of only 10 per 100,000.

4. Voluntary Agencies 2003

Voluntary organisations have long played a fundamental role in the recognition of HIV/AIDS and in addressing the needs of HIV positive individuals^{75,76}. In the North West Region, voluntary agencies continue to provide a wide range of services to HIV positive individuals and their families. Research into the economics of HIV in the North West of England has established that seven voluntary agencies annually contribute £1 million pounds worth of services over and above those purchased by the statutory sector³⁵. During 2003, 1,216 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by eight voluntary organisations in the North West.

Voluntary agencies have contributed data to the North West HIV/AIDS Monitoring Unit since 1995, and consistently appear to provide services to a broader constituency than the statutory sector alone³⁻⁹. The year 2003 was no exception, and 20% of individuals seen by voluntary organisations did not access care in the statutory sector, and 14% have never been known to the statutory sector in the North West.



4. Voluntary Agencies 2003

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 Body Positive North West 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. For all organisations, where information relating to infection route and ethnicity was not available from the voluntary sector, data have been updated from that provided from the statutory care providers (where available). Tables 4.1 to 4.6 illustrate key characteristics of individuals accessing care from individual voluntary agencies, whilst figure 4.1 and table 4.7 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 reports³⁻⁹.

Table 4.1: The proportion of HIV and AIDS cases presenting to voluntary organisations and the statutory sector in the North West, January-December 2003

(All cases seen during 2003 including those who died during the year).

STATUTORY SECTOR ATTENDANCE	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	GHT	HEAL	SAHIR
Never Seen		15 (39.5%)	4 (9.1%)	6 (14.3%)	24 (35.3%)	99 (10.6%)	3 (7.5%)	21 (17.4%)
Seen prior to 2003				5 (11.9%)	5 (7.4%)	56 (6%)		4 (3.3%)
Seen 2003	5 (100%)	23 (60.5%)	40 (90.9%)	31 (73.8%)	39 (57.4%)	779 (83.4%)	37 (92.5%)	96 (79.3%)
Total (100%)	5	38	44	42	68	934	40	121

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 4.1 illustrates the number of HIV positive individuals presenting to voluntary agencies in the North West during 2003 and the number who had also presented at statutory agencies in the North West, either during 2003 or prior to 2003. Four out of the seven agencies who reported last year recorded an increase in their client base during 2003 compared with 2002 figures: Barnardo's in Manchester (BARM) increased by 65%, Black Health Agency (BHA) increased by 91%, George House Trust (GHT) by 18% and Body Positive Cheshire and North Wales (BP Cheshire) by 3%. Three organisations have reduced numbers compared with 2002: Barnardo's Liverpool (BARL) decreased by 44%, Body Positive Blackpool by 41%, and Sahir House by 14%. The overall number of individuals seen by the voluntary sector in 2003 is 8% higher than in 2002 (1,216 compared with 1,121). The real increase in voluntary sector activity is likely to be greater, since this year one of the larger North West organisations (Body Positive North West) was unable to contribute data.

There is variation in the proportion of voluntary sector clients also seen within the statutory sector in 2003, ranging from 57% and 61% at BP Cheshire and Barnardo's in Manchester (BARM) respectively, to all of those seen by Barnardo's in Liverpool (BARL). The low level of North West statutory sector contact with BP Cheshire's clients may be explained by the geographical location of the organisation. Eighteen out of the 29 Body Positive Cheshire clients not in contact with the North West statutory sector during 2003 were reported to reside in Wales or the West Midlands. However, the situation is different at other voluntary agencies, where the vast majority of clients not in contact with statutory treatment centres in 2003, reside in the North West of England (93% for Barnardo's in Manchester, 92% for George House Trust, 92% for Sahir House and 100% for the remaining agencies except BARL where it is not applicable). A significant number of individuals have never been seen at statutory centres: up to 99 individuals at George House Trust. The data suggest that the voluntary sector may be the sole provider of care and support for a substantial number of these HIV positive individuals who do not access statutory care.

Table 4.2: Distribution of voluntary sector care for HIV and AIDS cases by infection route of HIV and sex, January-December 2003 (All cases seen during 2003 including those who died during the year).

INFECTION ROUTE	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	GHT	HEAL	SAHIR
Homo/Bisexual			1 (2.3%)	39 (92.9%)	42 (61.8%)	569 (60.9%)	35 (87.5%)	44 (36.4%)
Injecting Drug Use	1 (20%)	3 (7.9%)		1 (2.4%)	4 (5.9%)	5 (0.5%)		1 (0.8%)
Heterosexual	2 (40%)	23 (60.5%)	38 (86.4%)	2 (4.8%)	18 (26.5%)	337 (36.1%)	4 (10%)	39 (32.2%)
Blood/Tissue		1 (2.6%)	1 (2.3%)			2 (0.2%)		3 (2.5%)
Mother to Child	2 (40%)	11 (28.9%)			2 (2.9%)	12 (1.3%)	1 (2.5%)	
Undetermined			4 (9.1%)		2 (2.9%)	9 (1%)		34 (28.1%)
SEX								
Male	1 (20%)	12 (31.6%)	9 (20.5%)	41 (97.6%)	56 (82.4%)	705 (75.5%)	36 (90%)	83 (68.6%)
Female	4 (80%)	26 (68.4%)	35 (79.5%)	1 (2.4%)	12 (17.6%)	229 (24.5%)	4 (10%)	38 (31.4%)
Total (100%)	5	38	44	42	68	934	40	121

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 4.2 categorises individuals accessing voluntary care in 2003 according to infection route and sex. Apart from those attending the Black Health Agency (BHA) Barnardo's in Liverpool (BARL) and Barnardo's in Manchester (BARM), the majority of individuals presenting to voluntary agencies were exposed to infection by homosexual sex, ranging from 36% at SAHIR to 93% at Body Positive Blackpool. The main route of infection for BARL, BARM and BHA clients was heterosexual sex (40%, 61% and 86% respectively), with a high proportion of female service users (80%, 68% and 80% respectively). Barnardo's provides support for families with children affected by HIV. In some cases the HIV positive client is a parent, in other cases the child. Individuals accessing care from Sahir House in Liverpool also included a large group of individuals exposed through heterosexual sex (32%) and a correspondingly relatively high proportion of females (31%). A relatively high proportion of BP Cheshire and BARM clients were injecting drug users (at 6% and 8% respectively); a higher proportion than those infected by this route attending statutory services (3%: chapter 3, table 3.2).

Table 4.3 refers to HIV positive individuals accessing voluntary care during 2003, categorised according to age group. As was the case for individuals presenting to the statutory sector during 2003, the majority of clients at all voluntary organisations were aged between 30 and 44 years. The two organisations that saw the highest proportion of children were BARM and BARL (24% and 40% of clients were aged 14 years or under), as would be expected for organisations specialising in the needs of children. The numbers of service users aged 14 years or under has increased in three voluntary organisations since 2002. The organisation that sees the most children with HIV is George House Trust (18 HIV positive children aged 14 years or under). The differing profiles and characteristics of HIV positive clients accessing North West Voluntary agencies may in part reflect the different range of services provided and the varying strategies used to attract HIV positive clients.

Table 4.3: Distribution of voluntary sector care for HIV and AIDS cases by age group, January-December 2003 (All cases seen during 2003 including those who died during the year).

AGE GROUPS	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	GHT	HEAL	SAHIR
0-14	2 (40%)	9 (23.7%)		1 (2.4%)	3 (4.4%)	18 (1.9%)	1 (2.5%)	
15-19		2 (5.3%)				2 (0.2%)	1 (2.5%)	1 (0.8%)
20-24			2 (4.5%)	2 (4.8%)	4 (5.9%)	34 (3.6%)	3 (7.5%)	10 (8.3%)
25-29	1 (20%)	1 (2.6%)	8 (18.2%)	6 (14.3%)	12 (17.6%)	107 (11.5%)	3 (7.5%)	12 (9.9%)
30-34		10 (26.3%)	14 (31.8%)	4 (9.5%)	16 (23.5%)	202 (21.6%)	7 (17.5%)	28 (23.1%)
35-39	1 (20%)	7 (18.4%)	8 (18.2%)	8 (19%)	14 (20.6%)	216 (23.1%)	13 (32.5%)	25 (20.7%)
40-44	1 (20%)	5 (13.2%)	8 (18.2%)	11 (26.2%)	8 (11.8%)	169 (18.1%)	7 (17.5%)	27 (22.3%)
45-49		2 (5.3%)	2 (4.5%)	4 (9.5%)	4 (5.9%)	102 (10.9%)	4 (10%)	10 (8.3%)
50-54		2 (5.3%)	1 (2.3%)	3 (7.1%)	4 (5.9%)	47 (5%)	1 (2.5%)	7 (5.8%)
55-59				1 (2.4%)	3 (4.4%)	23 (2.5%)		1 (0.8%)
60+			1 (2.3%)	2 (4.8%)		14 (1.5%)		
Total (100%)	5	38	44	42	68	934	40	121

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 2003, or at death.

Table 4.4: Distribution of voluntary sector care for HIV and AIDS cases by ethnic group, January-December 2003 (All cases seen during 2003 including those who died during the year)

ETHNICITY	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	GHT	HEAL	SAHIR
White	2 (40%)	10 (26.3%)		42 (100%)	61 (89.7%)	659 (70.6%)	39 (97.5%)	91 (75.2%)
Black Caribbean			1 (2.3%)			11 (1.2%)	1 (2.5%)	
Black African	1 (20%)	23 (60.5%)	42 (95.5%)		5 (7.4%)	231 (24.7%)		12 (9.9%)
Black Other		3 (7.9%)	1 (2.3%)			10 (1.1%)		15 (12.4%)
Indian/Pakistani/Bangladeshi		1 (2.6%)						
Other Asian/Oriental						10 (1.1%)		
Other/Mixed	2 (40%)	1 (2.6%)			1 (1.5%)	12 (1.3%)		3 (2.5%)
Unknown					1 (1.5%)	1 (0.1%)		
Total (100%)	5	38	44	42	68	934	40	121

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 4.4 illustrates HIV positive individuals accessing North West based voluntary agencies during 2003, categorised by ethnic group. Ethnic group classifications are those used by the Health Protection Agency AIDS and STD Centre, for the Survey of Prevalent Diagnosed HIV Infections (SOPHID).

The vast majority of presentations to voluntary sector organisations were by individuals self-defined as white, for example 100% of BP Blackpool and 70% of GHT. However, both BARL and BARM provided care for high proportions of HIV positive individuals from black African communities (20% and 61% respectively), as did BHA, a specialist service for black and minority ethnic communities. GHT provided care for the largest number of HIV positive black Africans (231 individuals).

Table 4.5a: Residential distribution of voluntary sector care for HIV and AIDS cases, January-December 2003: strategic health authority

(All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	GHT	HEAL	SAHIR
Cumbria and Lancashire		6 (15.8%)	1 (2.3%)	40 (95.2%)		80 (8.6%)	40 (100%)	2 (1.7%)
Cheshire and Merseyside	4 (80%)				43 (63.2%)	36 (3.9%)		113 (93.4%)
Greater Manchester		30 (78.9%)	43 (97.7%)	2 (4.8%)		795 (85.1%)		4 (3.3%)
East Midlands						4 (0.4%)		
East of England						1 (0.1%)		
London						1 (0.1%)		
Scotland								1 (0.8%)
South West		2 (5.3%)				2 (0.2%)		
Wales	1 (20%)				21 (30.9%)	3 (0.3%)		1 (0.8%)
West Midlands					2 (2.9%)	4 (0.4%)		
Yorkshire and The Humber						6 (0.6%)		
Unknown					2 (2.9%)	2 (0.2%)		
Total (100%)	5	38	44	42	68	934	40	121

For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Rows cannot be totalled as some individuals may attend more than one voluntary organisation, thus exaggerating the totals. Individuals living outside of the North West Region are grouped by region.

Table 4.5b: Distribution of voluntary sector care for HIV and AIDS cases, January-December 2003: Cumbria and Lancashire primary care trusts

(All cases seen during 2003 including those who died during the year)

PCT OF RESIDENCE	Voluntary Agency					
	BARM	BHA	BP Blackpool	GHT	HEAL	SAHIR
Eden Valley				1 (1.3%)		
Morecambe Bay				2 (2.5%)		
Blackpool			39 (97.5%)	23 (28.8%)	30 (75%)	
Fylde			1 (2.5%)	4 (5%)	3 (7.5%)	
Wyre				3 (3.8%)	5 (12.5%)	
Preston	3 (50%)			21 (26.3%)		
Hyndburn and Ribble Valley				2 (2.5%)		
Burnley, Pendle and Rossendale	1 (16.7%)	1 (100%)		15 (18.8%)		
Blackburn with Darwen				4 (5%)		
Chorley and South Ribble	2 (33.3%)			5 (6.3%)	2 (5%)	
West Lancashire						2 (100%)
Total (100%)	6	1	40	80	40	2

For a definition of the abbreviated voluntary agencies please refer to the glossary at the back of the report. Rows cannot be totalled as some individuals may attend more than one voluntary organisation, thus exaggerating the totals.

Table 4.5c: Distribution of voluntary sector care for HIV and AIDS cases, January-December 2003: Cheshire and Merseyside primary care trusts

(All cases seen during 2003 including those who died during the year)

PCT OF RESIDENCE	Voluntary Agency			
	BARL	BP Cheshire	GHT	SAHIR
Southport and Formby				4 (3.5%)
South Sefton			3 (8.3%)	5 (4.4%)
North Liverpool			1 (2.8%)	7 (6.2%)
Central Liverpool		2 (4.7%)	4 (11.1%)	62 (54.9%)
South Liverpool			1 (2.8%)	4 (3.5%)
Knowsley				4 (3.5%)
St Helens			6 (16.7%)	5 (4.4%)
Halton			1 (2.8%)	1 (0.9%)
Warrington		6 (14%)	4 (11.1%)	2 (1.8%)
Birkenhead and Wallasey	2 (50%)	2 (4.7%)	2 (5.6%)	10 (8.8%)
Bebington and West Wirral		1 (2.3%)	1 (2.8%)	4 (3.5%)
Ellesmere Port and Neston	2 (50%)	4 (9.3%)		2 (1.8%)
Cheshire West		19 (44.2%)	5 (13.9%)	3 (2.7%)
Central Cheshire		7 (16.3%)	2 (5.6%)	
Eastern Cheshire		2 (4.7%)	6 (16.7%)	
Total (100%)	4	43	36	113

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 4.5d: Distribution of voluntary sector care for HIV and AIDS cases, January-December 2003: Greater Manchester primary care trusts

(All cases seen during 2003 including those who died during the year)

PCT OF RESIDENCE	Voluntary Agency				
	BARM	BHA	BP Blackpool	GHT	SAHIR
Ashton, Leigh and Wigan		1 (2.3%)		13 (1.6%)	
Bolton	3 (10%)	4 (9.3%)		37 (4.7%)	
Bury	2 (6.7%)	3 (7%)		25 (3.1%)	
Heywood and Middleton				9 (1.1%)	
Rochdale		1 (2.3%)		15 (1.9%)	
Salford	1 (3.3%)	3 (7%)		103 (13%)	2 (50%)
Trafford North	3 (10%)	1 (2.3%)		26 (3.3%)	
Trafford South				17 (2.1%)	1 (25%)
North Manchester	6 (20%)	10 (23.3%)	2 (100%)	203 (25.5%)	1 (25%)
Central Manchester	12 (40%)	16 (37.2%)		231 (29.1%)	
South Manchester	2 (6.7%)	2 (4.7%)		33 (4.2%)	
Oldham	1 (3.3%)	1 (2.3%)		21 (2.6%)	
Tameside and Glossop		1 (2.3%)		36 (4.5%)	
Stockport				26 (3.3%)	
Total (100%)	30	43	2	795	4

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 4.5a illustrates the residential distribution of HIV positive individuals accessing North West based voluntary agencies during 2003. 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 63% of BP Cheshire clients, to 100% at BHA and BP Blackpool and HEAL. BP Cheshire was the only voluntary organisation with a significant proportion of HIV positive clients from outside the region: 34% of their clients lived in Wales and the West Midlands, reflecting the geographical location of this agency and its catchment area.

Tables 4.5b, c and d present the primary care trust of residence of individuals attending voluntary agencies within each of the three strategic health authorities (Cumbria and Lancashire, table 4.5b; Cheshire and Merseyside, table 4.5c and Greater Manchester, table 4.5d). It is important to note that the data relate to voluntary sector clients for whom full attributable data have been provided (soundex code, date of birth and sex). Therefore, the number of individuals from each primary care trust attending voluntary agencies does not necessarily reflect the overall service activity of that organisation within a specific primary care trust.

Table 4.6 illustrates the crossover of care of HIV positive individuals between North West based voluntary agencies and the statutory organisations during 2003. The distribution of statutory treatment and care of voluntary agency clients reflects the geographical location of the voluntary agencies. However, the Infectious Disease Unit at North Manchester General Hospital (NMG), the largest HIV and AIDS treatment centre in the North West (chapter 3, table 3.17), accounts for a significant number of presentations by individuals accessing voluntary organisations across the whole region.

Table 4.6: Distribution of statutory treatment for HIV and AIDS cases presenting to voluntary organisations, January-December 2003

(All cases seen during 2003 including those who died during the year)

TREATMENT CENTRE	Voluntary Agency							
	BARL	BARM	BHA	BP Blackpool	BP Cheshire	GHT	HEAL	SAHIR
AHC	2				2			
APH						2		4
BLAG				25		17	31	
BLKG						3		
BOLG			3			26		
BOOT		2				8		
BURG						3		
BURY		1	1			9		
CHR	1				21	4		1
CUMB						1		
DDU								1
LEI					1	1		
LEII					2			
MAC					2	2		
MGP			1			66	1	
MRI			5			83		
MRIG			5	1		86		
MRIH						6		1
NMG		12	21	3	4	412		3
NMGG			3			26		
NOBL								2
OLDG		1	1			5		
PG		1				15	2	
PP		2						
QSC				26		19	30	
RLG	2		1	1	7	13		78
RLH					1	1		3
RLI						1		
ROCG						9		
SALG			2			14		
SHH						1		2
SPG								6
STP						21	1	
TAMG						3		
TRAG						2		
WAR					2	1		1
WIGG			1			1		
WITG			2			37		

For a definition of the abbreviated voluntary agencies and statutory treatment centres please refer to the glossary at the back of the report. Numbers cannot be totalled as some individuals may attend more than one treatment centre or voluntary agency thus exaggerating the totals.

Figure 4.1: The proportion of HIV and AIDS cases presenting to the voluntary sector and statutory sector in the North West, January-December 2003

(All cases seen during 2003 including those who died during the year)

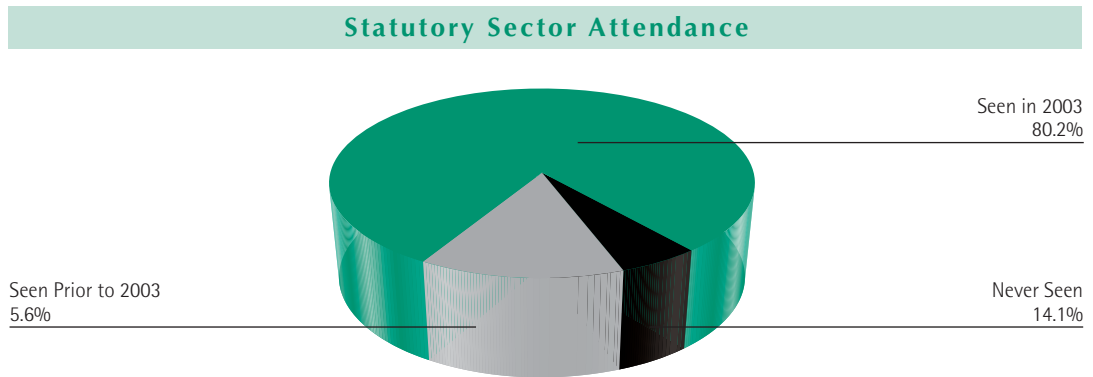


Figure 4.1 illustrates the proportion of HIV positive individuals presenting to voluntary agencies in the North West during 2003 who had and had not presented at statutory agencies in the North West, either during 2003 or prior to 2003. During 2003, 1,216 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by eight voluntary organisations in the North West. Of these individuals, 976 (80%) also attended statutory treatment centres during the year. Therefore, 240 (20%) of voluntary sector clients were unknown to statutory treatment centres within the North West during 2003 and are not, therefore, included in the regional statistics provided to the Department of Health. This may be partly explained by the fact that 13% of those individuals not accessing the statutory sector during 2003 reside outside the North West and may be receiving treatment and care from centres further afield.

Of the 240 HIV positive individuals not in contact with the statutory sector in 2003, 28% (68 individuals) had attended statutory treatment centres in the North West between 1995 and 2002. A total of 172 (14% 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 4.7 illustrates the infection route, sex, ethnicity and asylum seeker status of HIV positive individuals accessing the voluntary sector in the North West in 2003 by attendance at the statutory sector during the year. Because of the relatively high proportion of individuals for whom infection route 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 2003 was homosexual sex, accounting for 60% of cases where infection route has been determined. This represents a higher proportion than the 56% of individuals accessing the statutory sector for whom method of exposure has been determined (chapter 3, table 3.2). The year 2003 has seen a lower proportion of HIV positive clients from the voluntary sector who were exposed to HIV through injecting drug use (1%) than in the statutory sector (3%). A higher proportion of heterosexually exposed clients (36%) were seen at the voluntary sector compared to the statutory sector (33%: chapter 3, table 3.2). This has increased since 2001 when only 19% of voluntary sector clients were heterosexually exposed. The vast majority of voluntary sector clients were male (74%), primarily due to the relatively high rates of HIV infection via homosexual sex (60%). As in those HIV positive individuals accessing the statutory sector (chapter 3, table 3.8), the majority of voluntary sector clients are self-defined as white (71%) comparable to those who accessed statutory services (72%).

Table 4.7 also shows that 20% of individuals (240 out of 1,216) using voluntary services did not attend a statutory sector service during 2003. Of those where route of infection is known, a higher proportion of individuals exclusive to the voluntary sector in 2003 were exposed to HIV via homosexual sex (51%) than any other exposure category. Those HIV positive individuals accessing the voluntary sector but not the statutory sector in the North West during 2003 may represent a significant number of people for whom the voluntary sector is the sole provider of care. The overall ethnic distribution (67% white) and sex distribution (69% male) of those exclusively attending voluntary agencies was lower to those attending both types of service (72% white and 75% male).

In 2003, 13% (153 individuals) of all voluntary sector attendees were asylum seekers, a similar proportion to that of the statutory sector (11%, 316 individuals). Almost half (36%) of asylum seekers who access statutory services also access voluntary services (chapter 3, table 3.27). An additional 38 asylum seekers were seen by the voluntary sector and not by statutory services.

Table 4.7: HIV and AIDS cases presenting to the voluntary sector and statutory sector by infection route, sex, ethnicity and asylum seeker status, January-December 2003

(All cases seen during 2003 including those who died during the year)

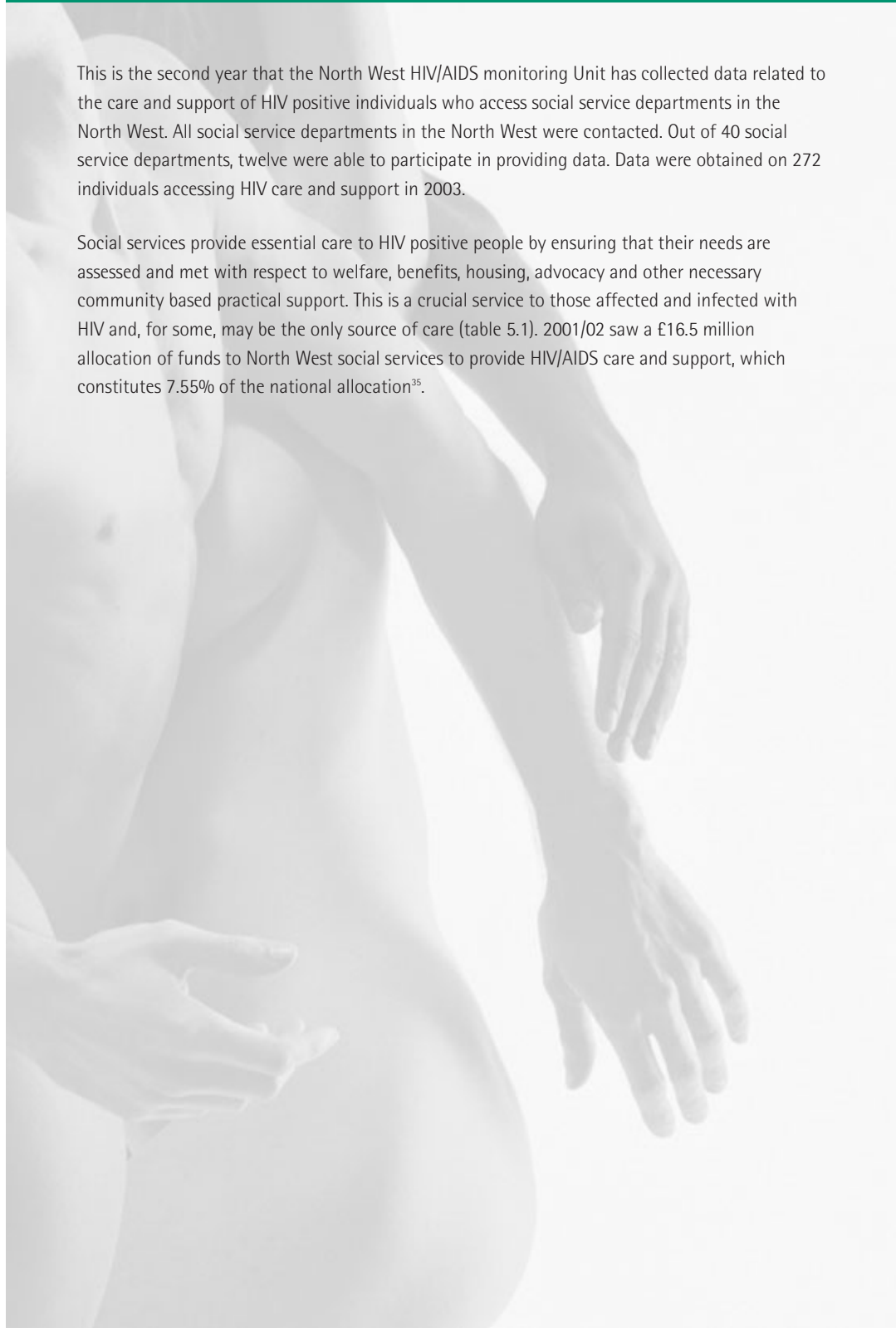
INFECTION ROUTE	Statutory Sector Attendance			Total
	Never Seen	Seen prior to 2003	Seen in 2003	
Homo/Bisexual	66 (46.8%)	56 (82.4%)	579 (60.4%)	701 (60%)
Injecting Drug Use	1 (0.7%)		13 (1.4%)	14 (1.2%)
Heterosexual	71 (50.4%)	12 (17.6%)	340 (35.5%)	423 (36.2%)
Blood/Tissue			6 (0.6%)	6 (0.5%)
Mother to child	3 (2.1%)		21 (2.2%)	24 (2.1%)
Sub Total (100%)	141	68	959	1168
Undetermined	31		17	48
ETHNICITY				
White	98 (57%)	62 (91.2%)	705 (72.2%)	865 (71.1%)
Black Caribbean	2 (1.2%)		10 (1%)	12 (1%)
Black African	60 (34.9%)	3 (4.4%)	217 (22.2%)	280 (23%)
Black Other/Black Unspecified	6 (3.5%)	2 (2.9%)	21 (2.2%)	29 (2.4%)
Indian/Pakistani/Bangladeshi			1 (0.1%)	1 (0.1%)
Other Asian/Oriental	3 (1.7%)	1 (1.5%)	6 (0.6%)	10 (0.8%)
Other/Mixed	3 (1.7%)		14 (1.4%)	17 (1.4%)
Unknown			2 (0.2%)	2 (0.2%)
Total (100%)	172	68	976	1216
SEX				
Male	104 (60.5%)	62 (91.2%)	736 (75.4%)	902 (74.2%)
Female	68 (39.5%)	6 (8.8%)	240 (24.6%)	314 (25.8%)
Total (100%)	172	68	976	1216
ASYLUM SEEKER STATUS				
Yes	38 (22.1%)		115 (11.8%)	153 (12.6%)
No	134 (77.9%)	68 (100%)	861 (88.2%)	1063 (87.4%)
Total (100%)	172	68	976	1216

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

5. Social Services 2003

This is the second year that the North West HIV/AIDS monitoring Unit has collected data related to the care and support of HIV positive individuals who access social service departments in the North West. All social service departments in the North West were contacted. Out of 40 social service departments, twelve were able to participate in providing data. Data were obtained on 272 individuals accessing HIV care and support in 2003.

Social services provide essential care to HIV positive people by ensuring that their needs are assessed and met with respect to welfare, benefits, housing, advocacy and other necessary community based practical support. This is a crucial service to those affected and infected with HIV and, for some, may be the only source of care (table 5.1). 2001/02 saw a £16.5 million allocation of funds to North West social services to provide HIV/AIDS care and support, which constitutes 7.55% of the national allocation³⁵.



5. Social Services 2003

Table 5.1: HIV and AIDS cases presenting to social service departments by sex, infection route, ethnicity, asylum seeker status and statutory sector attendance, January-December 2003 (All cases seen during 2003 including those who died during the year).

SEX	Social Service Department												Total*
	Barrow-in-Furness	Blackburn with Darwen	Blackpool Borough Council	Bury	Cheshire	Lancaster	Oldham	Salford	Tameside	Trafford	Warrington	Wigton	
Male	3 (75%)	27 (65.9%)	72 (92.3%)	6 (50%)	2 (66.7%)	5 (71.4%)	5 (83.3%)	45 (83.3%)	23 (67.6%)	21 (72.4%)	1 (50%)	2 (66.7%)	211 (77.6%)
Female	1 (25%)	14 (34.1%)	6 (7.7%)	6 (50%)	1 (33.3%)	2 (28.6%)	1 (16.7%)	9 (16.7%)	11 (32.4%)	8 (27.6%)	1 (50%)	1 (33.3%)	61 (22.4%)
INFECTION ROUTE													
Homo/Bisexual	1 (25%)	10 (24.4%)	67 (85.9%)	2 (16.7%)	2 (66.7%)	3 (42.9%)	4 (66.7%)	42 (77.8%)	18 (52.9%)	14 (48.3%)	1 (50%)	2 (66.7%)	165 (60.7%)
Injecting Drug Use	1 (25%)	1 (2.4%)	2 (2.6%)			1 (14.3%)		4 (7.4%)		3 (10.3%)			12 (4.4%)
Heterosexual	2 (50%)	30 (73.2%)	6 (7.7%)	7 (58.3%)	1 (33.3%)	3 (42.9%)	2 (33.3%)	8 (14.8%)	14 (41.2%)	10 (34.5%)	1 (50%)	1 (33.3%)	85 (31.3%)
Blood/Tissue			2 (2.6%)	2 (16.7%)					1 (2.9%)	2 (6.9%)			7 (2.6%)
Mother to Child			1 (1.3%)	1 (8.3%)					1 (2.9%)				3 (1.1%)
ETHNICITY													
White	4 (100%)	28 (68.3%)	75 (96.2%)	3 (25%)	2 (66.7%)	6 (85.7%)	5 (83.3%)	44 (81.5%)	24 (70.6%)	21 (72.4%)		3 (100%)	214 (78.7%)
Black Caribbean					1 (33.3%)			2 (3.7%)					3 (1.1%)
Black African		12 (29.3%)	1 (1.3%)	6 (50%)		1 (14.3%)	1 (16.7%)	6 (11.1%)	10 (29.4%)	4 (13.8%)	1 (50%)		42 (15.4%)
Black Other				1 (8.3%)									1 (0.4%)
Indian/Pakistani/Bangladeshi		1 (2.4%)	1 (1.3%)	1 (8.3%)						2 (6.9%)			5 (1.8%)
Other Asian/Oriental										1 (3.4%)	1 (50%)		2 (0.7%)
Other/Mixed			1 (1.3%)	1 (8.3%)				2 (3.7%)		1 (3.4%)			5 (1.8%)
ASYLUM SEEKER STATUS													
Yes		12 (29.3%)		2 (16.7%)	1 (33.3%)		1 (16.7%)	6 (11.1%)	10 (29.4%)	2 (6.9%)			34 (12.5%)
No	4 (100%)	24 (58.5%)	78 (100%)	10 (83.3%)	2 (66.7%)	7 (100%)	5 (83.3%)	48 (88.9%)	24 (70.6%)	27 (93.1%)	2 (100%)	3 (100%)	233 (85.7%)
Unknown		5 (12.2%)											5 (1.8%)
STATUTORY SECTOR ATTENDANCE													
Never seen	3 (75%)	1 (2.4%)	21 (26.9%)	1 (8.3%)				9 (16.7%)	15 (44.1%)				50 (18.4%)
Seen prior to 2003	1 (25%)		1 (1.3%)		1 (33.3%)		1 (16.7%)	2 (3.7%)		1 (3.4%)		1 (33.3%)	7 (2.6%)
Seen 2003		40 (97.6%)	56 (71.8%)	11 (91.7%)	2 (66.7%)	7 (100%)	5 (83.3%)	43 (79.6%)	19 (55.9%)	28 (96.6%)	2 (100%)	2 (66.7%)	215 (79%)
Total (100%)	4	41	78	12	3	7	6	54	34	29	2	3	272

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

Table 5.1 illustrates the number of HIV positive individuals presenting to each social service department by sex, infection route, ethnicity, refugee status and statutory sector attendance. More men were reported by social services than women (78%, ranging from 50% at Warrington and Bury to 92% at Blackpool Borough Council). The proportion of men reported was the same as that accessing the statutory sector for care (78%: chapter 3, table 3.5). This pattern was repeated in the data for exposure route: the proportion exposed via heterosexual sex was 31% in social services and 33% in the statutory sector. A lower proportion of social services attendees are from minority ethnic groups (21%) than attend statutory sector services (26%), (chapter 3, table 3.7).

A total of 34 individuals known to be asylum seekers received care from social service departments, double the number reported in 2002. Blackburn with Darwen and Tameside both had the highest proportions (29%) of asylum seekers (12 individuals and 10 individuals respectively). Five social service departments claim that no refugees accessed their services in 2003. Table 5.1 also shows that 18% of individuals had not been seen in the statutory sector since monitoring began in 1995. This indicates that social service departments may be the sole provider of care and support to those individuals who do not access statutory services.

Table 5.2: Distribution of social service care for HIV and AIDS cases presenting to voluntary organisations, January-December 2003

(All cases seen during 2003 including those who died during the year).

SOCIAL SERVICE DEPARTMENT	Voluntary Agency						
	BARM	BHA	BP BlackPool	BP Cheshire	GHT	HEAL	SAHIR
Blackburn with Darwen					3		
Blackpool Borough Council			17		9	8	
Bury	1				8		
Cheshire					1		
Lancaster					1		
Oldham		1			4		
Salford					32		
Tameside					11		
Trafford		1			14		1
Warrington				1			

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

Table 5.2 illustrates those social service attendees who also accessed North West voluntary organisations in 2003. There is no crossover of care between Barrow-in-Furness or Wigton and the voluntary sector. Every voluntary organisation was accessed by at least one individual who also presented to social services. All social service departments with a crossover of care (with the exception of Warrington) had HIV positive individuals who have accessed George House Trust in 2003.

6. Additional providers of HIV treatment and care 2003

This is the fifth year that the North West HIV/AIDS Monitoring Unit has collected data relating to the care of HIV positive individuals attending hospices across the whole of the North West. All North West hospices that provide inpatient care were contacted. Palliative care, defined as the total (physical, emotional, social and spiritual) care of patients with life threatening disease and care of their families⁷⁷, was reported by four hospices in the North West during 2003. Information relating to HIV positive individuals receiving hospice care is presented in table 6.1. Due to the relatively small number of individuals (four 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 fifth 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 2003. Numbers of known HIV positive injecting drug users accessing specialist drug services in the North West are relatively low. This may reflect the successful implementation of harm reduction strategies in the 1980s⁷⁸. Information on HIV positive injecting drug users accessing specialist drug services is presented in table 6.2.



6. Additional providers of HIV treatment and care 2003

Table 6.1: HIV and AIDS care provided by North West hospices by strategic health authority (SHA) of residence, sex, age group, stage of HIV disease and level of inpatient care, January-December 2003

(All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	SHA of Hospice			Total
	Cumbria and Lancashire	Cheshire and Merseyside	Greater Manchester	
Cumbria and Lancashire	1			(25%)
Cheshire and Merseyside		2		(50%)
Greater Manchester			1	(25%)
SEX				
Male	1	2		3 (75%)
Female			1	1 (25%)
AGE GROUP				
30-34	1	1		2 (50%)
35-39			1	1 (25%)
40-44				
45-49				
50-54				
55-59				
60-64		1		1 (25%)
CLINICAL STAGE				
AIDS			1	1(25%)
AIDS related death		2		2 (50%)
Death unrelated to AIDS	1			1 (25%)
Total (100%)	1	2	1	4

INPATIENT CARE	SHA of Hospice			Total
	Cumbria and Lancashire	Cheshire and Merseyside	Greater Manchester	
Episodes	1	1	2	4
Days	7	22	28	57

Age ranges refer to the age of individuals at end of December 2003, or at death.

Table 6.1 illustrates the care provided by North West Hospices for HIV positive individuals, categorised by strategic health authority of residence, sex, age group, clinical stage of HIV disease and level of inpatient care provided. Four hospices (one in Merseyside, two in Greater Manchester and one in Lancashire) provided palliative care for HIV positive individuals resident in the North West during 2003. 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 services⁷⁹, in this instance the mean age was 47 years. Of the four individuals who received hospice care in 2003, one individual was classed as being symptomatic and three had an AIDS defining illness. Three of the four patients died, two deaths were AIDS related and one death was without AIDS. The four hospices provided 57 inpatient days during 2003, an average of 14 days per HIV positive individual who received inpatient care.

Table 6.2: HIV and AIDS care provided by North West drug services by strategic health authority (SHA) of residence, sex and age group, January-December 2003

(All cases seen during 2003 including those who died during the year)

SHA OF RESIDENCE	SHA of Drug Service			Total
	Cumbria and Lancashire	Cheshire and Merseyside	Greater Manchester	
Cumbria and Lancashire	1 (12.5%)			1 (12.5%)
Cheshire and Merseyside		5 (62.5%)		1 (62.5%)
Greater Manchester			2 (25%)	2 (25%)
SEX				
Male	1 (12.5%)	2 (25%)	1 (12.5%)	4 (50%)
Female		3 (37.5%)	1 (12.5%)	4 (50%)
AGE GROUP				
20-24		1 (12.5%)		1 (12.5%)
25-29				
30-34		2 (25%)	2 (25%)	4 (50%)
35-39		1 (12.5%)		1 (12.5%)
40-44				
45-49				
50-54	1 (12.5%)			1 (12.5%)
55-59		1 (12.5%)		1 (12.5%)
Total (100%)	1	5	2	8

Age ranges refer to the age of individuals at end of December 2003, or at death.

Table 6.2 illustrates the care provided by North West specialist drug agencies for HIV positive individuals, categorised by strategic health authority of residence, sex and age group. Data relating to drug service clients who are known to be HIV positive were provided by five agencies in the North West (contributing drugs services are listed at the end of this report). A total of eight HIV positive individuals were reported by drug services, all of whom attended statutory treatment centres during 2003.

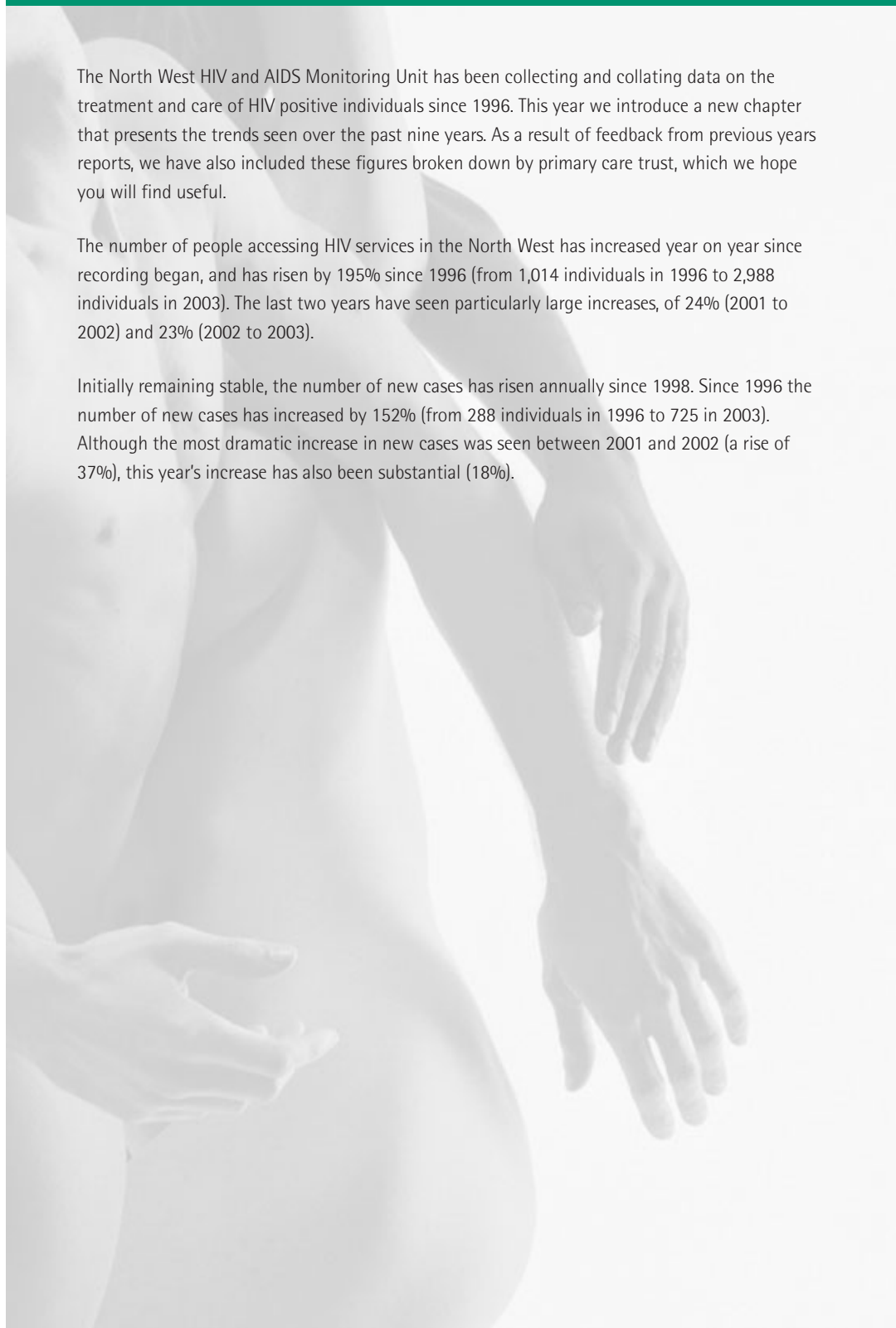
Individuals only attended drug services in the same strategic health authority that they were resident in. The majority of individuals that were reported lived within Cheshire and Merseyside (62.5%). The mean age of HIV positive people accessing North West drug services was 36 (range 20 to 55 years) compared to 41 years (range 28 to 56 years) for HIV positive injecting drug users accessing North West statutory treatment centres during 2003 (chapter 3, table 3.2).

7. Trends 1996 to 2003

The North West HIV and AIDS Monitoring Unit has been collecting and collating data on the treatment and care of HIV positive individuals since 1996. This year we introduce a new chapter that presents the trends seen over the past nine years. As a result of feedback from previous years reports, we have also included these figures broken down by primary care trust, which we hope you will find useful.

The number of people accessing HIV services in the North West has increased year on year since recording began, and has risen by 195% since 1996 (from 1,014 individuals in 1996 to 2,988 individuals in 2003). The last two years have seen particularly large increases, of 24% (2001 to 2002) and 23% (2002 to 2003).

Initially remaining stable, the number of new cases has risen annually since 1998. Since 1996 the number of new cases has increased by 152% (from 288 individuals in 1996 to 725 in 2003). Although the most dramatic increase in new cases was seen between 2001 and 2002 (a rise of 37%), this year's increase has also been substantial (18%).



7. Trends 1996 to 2003

Figure 7.1: Percentage change in new cases of HIV and AIDS by infection route of HIV, 1996-2003 (New cases are defined as individuals seen for the first time in a given year)



Figure 7.1 shows proportional increases in the number of new cases from 1996 to 2003 by route of HIV infection. Overall there has been an increase in new cases by 152% since 1996. However, the most striking change is the massive 569% increase in heterosexual infections. This is a trend that has been noted nationally³⁸ and is accompanied by an increasing proportion of infections contracted overseas and among minority ethnic groups.

It should be noted that although heterosexual cases now dominate the statistics, the number of new homosexual infections has also increased steadily, by 61% since 1996. This stresses the need to maintain prevention strategies amongst this group. The number of infections by injecting drug use has declined over the years; this may partly be due to the implementation of syringe exchange programmes across the North West. The number of mother to child transmissions has remained relatively stable, despite the large increase in heterosexual cases and corresponding increase in the number of HIV positive women. It is likely that expected increases in mother to child transmission have been offset by improvements in diagnosis during pregnancy and effective prevention of HIV transmission to the infant (see chapter 1).

Table 7.1: Number of new HIV and AIDS cases by infection route of HIV and strategic health authority of residence, 1996-2003

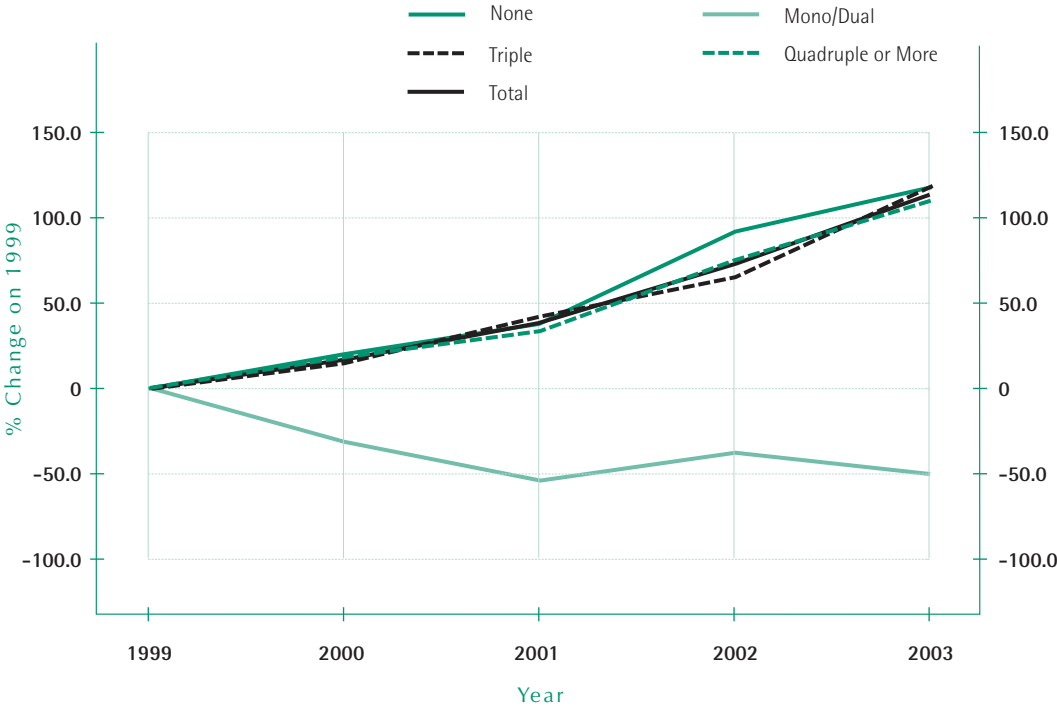
(New cases are defined as individuals seen for the first time in a given year)

SHA	INFECTION ROUTE	Year of Report								% Change 1996-2003	% Change 2002-2003
		1996	1997	1998	1999	2000	2001	2002	2003		
Cumbria and Lancashire	Homo/Bisexual	55	38	25	50	42	50	29	62	13	114
	Injecting Drug Use	3	12	0	1	2	5	3	0	-100	-100
	Heterosexual	18	16	8	19	14	24	39	35	94	-10
	Blood/Tissue	1	2	2	3	0	0	0	0	-100	
	Mother to Child	3	0	2	1	2	3	0	0	-100	
	Undetermined	4	4	4	6	4	5	25	2	-50	-92
	Total	84	72	41	80	64	87	96	99	18	3
Cheshire and Merseyside	Homo/Bisexual	31	32	31	22	27	34	41	41	32	0
	Injecting Drug Use	3	2	1	0	5	3	2	3	0	50
	Heterosexual	16	12	20	15	30	31	58	81	406	40
	Blood/Tissue	2	3	1	0	1	0	0	0	-100	
	Mother to Child	2	1	0	0	1	1	1	1	-50	0
	Undetermined	0	3	2	2	2	4	22	22		0
	Total	54	53	55	39	66	73	124	148	174	19
Greater Manchester	Homo/Bisexual	90	86	111	99	105	128	145	169	88	17
	Injecting Drug Use	6	7	9	8	2	4	0	3	-50	
	Heterosexual	16	15	25	28	36	92	146	220	1275	51
	Blood/Tissue	0	1	0	0	0	0	1	3		200
	Mother to Child	3	2	5	0	0	7	8	6	100	-25
	Undetermined	11	21	6	16	29	12	58	18	64	-69
	Total	126	132	156	151	172	243	358	419	233	17
North West Total	Homo/Bisexual	186	164	180	179	188	231	229	300	61	31
	Injecting Drug Use	15	21	12	10	10	13	5	7	-53	40
	Heterosexual	54	45	58	66	89	169	253	361	569	43
	Blood/Tissue	5	7	3	4	1	0	1	3	-40	200
	Mother to Child	8	3	7	1	6	11	9	7	-13	-22
	Undetermined	20	32	17	28	41	25	120	47	135	-61
	Total	288	272	277	288	335	449	617	725	152	18

Table 7.1 shows the infection route of new HIV and AIDS cases presenting in the North West from 1996 to 2003 broken down by strategic health authority of residence. The most common route of infection has altered over the years. From 1996 to 2001 homosexual/bisexual sex accounted for the majority of new HIV infections. However, 2002 saw a decrease in new homosexual cases, and for the first time heterosexual sex overtook homo/bisexual sex as the main mode of HIV exposure. In 2003, half of new cases were infected via heterosexual sex.

Across the strategic health authorities, Greater Manchester has seen the largest increase in new cases since 1996 (233%), followed by Cheshire and Merseyside which has seen a 174% increase in the same period and Cumbria and Lancashire with an 18% increase. At 19%, it was Cheshire and Merseyside that saw the biggest increase on last year's figures, compared to 17% in Greater Manchester and a 3% increase in Cumbria and Lancashire. All three SHAs have seen large increases in numbers of new heterosexual infections since 1996, the largest being 1275% in Greater Manchester (from 16 to 220 individuals). The number of new homosexual cases has also increased since 1996 across all SHAs, with the largest increase being seen in Greater Manchester (88%). This is consistent with the fact that the Manchester area has a large gay community⁶⁶ and evidence of high levels of sexual risk behaviour (as revealed in investigations of the ongoing syphilis outbreak⁵⁸⁻⁶¹).

Figure 7.2: Percentage change in total HIV and AIDS cases by level of antiretroviral therapy, 1999-2003 (All cases seen in a given year, including those who died that year)



Mono and dual therapies have been combined because of low numbers

Figure 7.2 illustrates proportional increases and decreases in the level of antiretroviral therapies prescribed to HIV positive individuals attending for treatment and care in the North West from 1999 to 2003. Individuals are categorised by the highest level of combination therapy they received in a given year. For the purpose of this figure, mono and dual therapies have been combined due to the small numbers involved. Since 1999 the numbers of individuals on triple, quadruple or more, and the number not taking any antiretroviral drugs, have all increased in line with the increasing numbers of HIV cases. Mono and dual therapy use has declined, a trend that is likely to relate to research⁸⁰ and guidelines⁷⁰ recommending triple or more antiretroviral drugs as the more effective form of therapy. It might have been expected that the number of people requiring more complex treatment regimes would be increasing as a result of people living longer with HIV and increases in drug resistant HIV in the population. However, trend data show no evidence for a disproportionately high rate of increase in the use of quadruple or more therapy.

Table 7.2 refers to the level of antiretroviral therapy received by all HIV positive individuals accessing treatment and care in the North West from 1999 to 2003 by SHA of residence. The proportion of people receiving triple or more therapy has remained stable, from 65% in 1999 to 66% in 2003. From 1999 to date, around a third of HIV positive individuals did not receive any antiretroviral therapy. Although relatively few people are prescribed mono therapy, the numbers prescribed this level of therapy has increased over the years, possibly due to its use in pregnant women. Giving HIV positive pregnant women a single antiretroviral drug (e.g. Zidovudine) during pregnancy can significantly reduce the chances of the infant becoming infected^{81,82}. With the increases in the numbers of females with HIV infection, the use of mono therapy may also rise in the future. Dual therapy use has slowly declined from 2% in 1999 to 0.2% in 2003.

The largest increase in the number of people in treatment for HIV between 1999 and 2003 was seen in Greater Manchester SHA, from 728 to 1703 (134%), followed by an 109% increase in Cheshire and Merseyside SHA and 54% in Cumbria and Lancashire SHA. Cheshire and Merseyside is the only SHA to see a large proportional increase in the number of individuals prescribed quadruple or more therapy (237%) compared to triple therapy (74%).

Table 7.3 shows the number of new cases of HIV and AIDS from 2001 to 2003 broken down by primary care trust of residence (PCT), together with the percentage changes from 2001 and last year. The PCT of residence has been collected since 2001, the year that PCTs were created. Caution should be taken when interpreting the percentage changes for those PCTs with small numbers of new cases.

In 2003, some PCTs that previously reported very low numbers of new cases of HIV have seen substantial increases since 2001 (for example North Liverpool, South Sefton and Trafford North). The two PCTs with the largest numbers of new cases, Central Manchester and North Manchester, had lower percentage increases (50% and 38% respectively) than the North West total (61%).

Table 7.4 shows data for all cases of HIV and AIDS presenting to North West treatment centres from 2001 to 2003, broken down by primary care trust of residence, along with the percentage changes from 2001 and last year. Some caution should be taken when interpreting the percentage changes for those PCTs with small numbers of HIV and AIDS cases.

North Manchester PCT has the largest number of HIV positive residents (343). There is now only one PCT with fewer than ten cases of HIV (Eden Valley). The largest percentage increases on 2001 were seen in North Liverpool (from one to 19), South Liverpool (nine to 44) and Blackburn with Darwen (17 to 38). Overall the numbers of HIV cases have increased annually. Of the three SHAs, Cheshire and Merseyside has seen the largest percentage increase in cases since 2001 at 57%, closely followed by a 54% increase in Greater Manchester. Since last year both Cheshire and Merseyside and Greater Manchester SHAs have seen a 24% increase in cases.

Table 7.2: Total number of HIV and AIDS cases by level of antiretroviral therapy and strategic health authority of residence, 1999-2003 (All cases seen in a given year, including those who died that year)

SHA	LEVEL OF ART	Year of Report					% Change 1999-2003	% Change 2002-2003
		1999	2000	2001	2002	2003		
Cumbria and Lancashire	None	98	97	116	137	151	54	10
	Mono	1				3	200	
	Dual	12	14	9	8	3	-75	-63
	Triple	182	204	219	258	316	74	22
	Quadruple or More	54	63	49	58	60	11	3
	Total	347	378	393	461	533	54	16
Cheshire and Merseyside	None	85	108	128	153	214	152	40
	Mono	0			2	3		50
	Dual	9	3	4	2	1	-89	-50
	Triple	156	180	198	237	271	74	14
	Quadruple or More	27	29	39	73	91	237	25
	Total	277	320	369	467	580	109	24
Greater Manchester	None	255	314	403	542	571	124	5
	Mono	0			1	1		0
	Dual	7	3	1	6	2	-71	-67
	Triple	376	425	566	663	936	149	41
	Quadruple or More	90	107	133	159	193	114	21
	Total	728	849	1103	1371	1703	134	24
North West Total	None	464	552	675	885	1007	117	14
	Mono	1			3	9	800	200
	Dual	33	23	16	18	8	-76	-56
	Triple	738	852	1039	1219	1600	117	31
	Quadruple or More	174	205	234	304	364	109	20
	Total	1410	1632	1964	2429	2988	112	23

Table 7.3: New cases by primary care trust of residence, 2001-2003

(New cases are defined as individuals seen for the first time in a given year)

SHA	PCT OF RESIDENCE	Year of Report			% Change 2001-2003	% Change 2002-2003
		2001	2002	2003		
Cumbria and Lancashire	Carlisle and District	1	6	3	200	-50
	Eden Valley		2	4		100
	West Cumbria	2	1	3	50	200
	Morecambe Bay	11	1	2	-82	100
	Blackpool	30	25	36	20	44
	Fylde	4		5	25	
	Wyre	8	7	4	-50	-43
	Preston	13	13	14	8	8
	Hyndburn and Ribble Valley	5	6	5	0	-17
	Burnley, Pendle and Rossendale	5	10	4	-20	-60
	Blackburn with Darwen	3	14	10	233	-29
	Chorley and South Ribble	3	5	7	133	40
	West Lancashire	2	6	2	0	-67
	Total	87	96	99	14	3
Cheshire and Merseyside	Southport and Formby	8	4	10	25	150
	South Sefton	2	3	11	450	267
	North Liverpool	1	3	11	1000	267
	Central Liverpool	21	39	48	129	23
	South Liverpool		13	16		23
	Knowsley	4	3	5	25	67
	St Helens	1	7	1	0	-86
	Halton	6	2	2	-67	0
	Warrington	6	6	6	0	0
	Birkenhead and Wallasey	3	10	6	100	-40
	Bebington and West Wirral	1	1	1	0	0
	Ellesmere Port and Neston	2	5	2	0	-60
	Cheshire West	3	11	10	233	-9
	Central Cheshire	4	11	7	75	-36
	Eastern Cheshire	8	6	12	50	100
	Unknown	3			-100	
Total	73	124	148	103	19	
Greater Manchester	Ashton, Leigh and Wigan	6	10	10	67	0
	Bolton	15	28	28	87	0
	Bury	8	14	24	200	71
	Heywood and Middleton		9	1		-89
	Rochdale	4	10	6	50	-40
	Salford	23	61	66	187	8
	Trafford North	6	7	21	250	200
	Trafford South	3	4	2	-33	-50
	North Manchester	64	69	88	38	28
	Central Manchester	70	96	105	50	9
	South Manchester	10	14	19	90	36
	Oldham	6	12	17	183	42
	Tameside and Glossop	7	13	15	114	15
	Stockport	18	11	17	-6	55
	Unknown	6			-100	
Total	246	358	419	70	17	
Out of Region	40	20	17	-58	-15	
Unknown	3	19	42	1300	121	
Total	449	617	725	61	18	

Table 7.4: All cases by primary care trust of residence, 2001-2003

(All cases seen in a given year, including those who died that year)

SHA	PCT OF RESIDENCE	Year of Report			% Change 2001-2003	% Change 2002-2003
		2001	2002	2003		
Cumbria and Lancashire	Carlisle and District	14	18	20	43	11
	Eden Valley	7	7	9	29	29
	West Cumbria	13	13	16	23	23
	Morecambe Bay	29	25	30	3	20
	Blackpool	139	155	176	27	14
	Fylde	19	19	25	32	32
	Wyre	21	30	31	48	3
	Preston	53	64	77	45	20
	Hyndburn and Ribble Valley	14	22	26	86	18
	Burnley, Pendle and Rossendale	24	35	36	50	3
	Blackburn with Darwen	17	28	38	124	36
	Chorley and South Ribble	21	25	30	43	20
	West Lancashire	14	20	19	36	-5
	Unknown	8			-100	
	Total	393	461	533	36	16
Cheshire and Merseyside	Southport and Formby	19	20	29	53	45
	South Sefton	17	19	29	71	53
	North Liverpool	1	8	19	1800	138
	Central Liverpool	97	113	144	48	27
	South Liverpool	9	29	44	389	52
	Knowsley	11	14	18	64	29
	St Helens	16	23	24	50	4
	Halton	18	17	16	-11	-6
	Warrington	26	31	34	31	10
	Birkenhead and Wallasey	42	57	62	48	9
	Bebington and West Wirral	8	10	12	50	20
	Ellesmere Port and Neston	11	18	17	55	-6
	Cheshire West	26	35	43	65	23
	Central Cheshire	29	38	44	52	16
	Eastern Cheshire	26	35	45	73	29
Unknown	13			-100		
Total	369	467	580	57	24	
Greater Manchester	Ashton, Leigh and Wigan	27	33	42	56	27
	Bolton	68	94	117	72	24
	Bury	51	64	87	71	36
	Heywood and Middleton	17	24	24	41	0
	Rochdale	31	37	40	29	8
	Salford	136	189	238	75	26
	Trafford North	29	34	59	103	74
	Trafford South	37	41	41	11	0
	North Manchester	220	283	343	56	21
	Central Manchester	268	342	421	57	23
	South Manchester	54	56	77	43	38
	Oldham	36	45	56	56	24
	Tameside and Glossop	56	57	70	25	23
	Stockport	64	72	88	38	22
	Unknown	9			-100	
Total	1103	1371	1703	54	24	
Out of Region	94	98	112	19	14	
Unknown	5	32	60	1100	88	
Total	1964	2429	2988	52	23	

Statutory treatment centres

- AHC** Alder Hey Children's Hospital, Haematology Treatment Centre, Eaton Road, Liverpool, L12 2AP, Tel: (0151) 228 4811
- APH** Arroe Park Hospital, Department of GUM, Arroe Park Road, Upton, Wirral, Merseyside, CH49 5PE, Tel: (0151) 678 5111
- BLAG** Victoria Hospital, Department of GUM, Whinney Heys Road, Blackpool, Lancashire, FY3 8NR, Tel: (01253) 300 000
- BLK** Blackburn Royal Infirmary, Bolton Road, Blackburn, BB2 3LR, Tel: (0154) 263 555
- BLKG** Blackburn Royal Infirmary, Department of GUM, Bolton Road, Blackburn, BB2 3LR, Tel: (0154) 263 555
- BOLG** Royal Bolton Hospital, Department of GUM, Minerva Road, Farnworth, Bolton, BL4 0JR, Tel: (01204) 390 390
- BOOT** Booth Hall Children's Hospital, Charlestown Road, Blackley, Manchester, M9 7AA, Tel: (0161) 795 7000
- BURG** Burnley General Hospital, Department of GUM, Casterton Avenue, Burnley, Lancashire, BB10 2PQ, Tel: (01282) 425 071
- BURY** Fairfield General Hospital, Rochdale Old Road, Bury, BL9 7TD, Tel: (0161) 764 6081
- CHR** The Countess of Chester Hospital, Department of GUM, Liverpool Road, Chester, Cheshire, CH2 1HJ, Tel: (01244) 365 000
- CPED** West Cumberland Hospital, Department of Paediatrics, Hensingham, Whitehaven, Cumbria, CA28 8JG, Tel: (01946) 693 181
- CUMB** Cumberland Infirmary, Department of GUM, Newtown Road, Carlisle, CA2 7HY, Tel: (01228) 523 444
- DDU** Liverpool Drug Dependency Unit, Hope House, 26 Rodney Street, Liverpool, L1 2TQ, Tel: (0151) 709 0516
- FGH** Furness General Hospital, Dalton Lane, Barrow in Furness, Cumbria, LA14 4LF, Tel: (01229) 870 870
- LEI** Leighton Hospital, Department of GUM, Middlewich Road, Crewe, Cheshire, CW1 4QJ, Tel: (01270) 255 141
- LEII** Leighton Hospital, Middlewich Road, Crewe, Cheshire, CW1 4QJ, Tel: (01270) 255 141
- MAC** Macclesfield District General Hospital, Department of GUM, Victoria Road, Macclesfield, Cheshire, SK10 3BL, Tel: (01625) 421 000
- MGP** 'The Docs' General Practice, Manchester, 55-59 Bloom Street, Manchester, M1 3LY, Tel: (0161) 237 9490

- MRI** Manchester Royal Infirmary, Outpatients Department, Oxford Road, Manchester, M13 9WL, Tel: (0161) 276 1234
- MRIG** Manchester Royal Infirmary, Department of GUM, Oxford Road, Manchester, M13 9WL, Tel: (0161) 276 1234
- MRIH** Manchester Royal Infirmary, Department of Haematology, Oxford Road, Manchester, M13 9WL, Tel: (0161) 276 1234
- NOBL** Noble's Isle of Man Hospital, Department of GUM, Westmorland Road, Douglas, Isle of Man, IM1 4QA, Tel: (01624) 642 642
- NMG** North Manchester General Hospital, Infectious Disease Unit, Delaunays Road, Crumpsall, Manchester, M8 5RB, Tel: (0161) 795 4567
- NMGG** North Manchester General Hospital, Department of GUM, Delaunays Road, Crumpsall, Manchester, M8 5RB, Tel: (0161) 795 4567
- OLDG** Royal Oldham Hospital, Department of GUM, Rochdale Road, Oldham, Lancashire, OL1 2JH, Tel: (0161) 624 0420
- PG** Royal Preston Hospital, Department of GUM, Sharoe Green Lane North, Fulwood, Preston, PR2 9HT, Tel: (01772) 716 565
- PP** Royal Preston Hospital, Paediatric Department, Sharoe Green Lane North, Fulwood, Preston, PR2 9HT, Tel: (01772) 716 565
- QSC** Queen Street Clinic, HIV Community Nursing Team, 18a Queen Street, Blackpool, FY1 1PD, Tel: (01253) 751 144
- RLG** Royal Liverpool University Hospital, Department of GUM, Prescot Street, Liverpool, L7 8XP, Tel: (0151) 706 2000
- RLH** Royal Liverpool University Hospital, Department of Haematology, Prescot Street, Liverpool, L7 8XP, Tel: (0151) 706 2000
- RLI** Royal Lancaster Infirmary, Ashton Road, Lancaster, LA1 4RP, Tel: (01524) 65944
- ROCG** Baillie Street Health Centre, Department of GUM, Baillie Street, Rochdale, OL16 1XS Tel: (01706) 517 655
- SALG** Hope Hospital, Department of GUM, Stott Lane, Salford, M6 8HD, Tel: (0161) 789 7373
- SHH** St Helens General Hospital, Department of GUM, Marshalls Cross Road, St Helens, WA9 3DA, Tel: (01744) 458 383
- SPG** Southport & Formby District General Hospital, Department of GUM, Town Lane, Kew, Southport, Merseyside, PR8 6PN, Tel: (01704) 547 471
- STP** Stepping Hill Hospital, Department of GUM, Poplar Grove, Stockport, Cheshire SK2 7JE, Tel: (0161) 483 1010
- TAMG** Tameside General Hospital, Department of GUM, Fountain Street, Ashton-under-Lyne, Lancashire, OL6 9RW, Tel: (0161) 331 5151

- TRAG** Trafford General Hospital, Department of GUM, Moorside Road, Urmston, Manchester, M41 5SL, Tel: (0161) 748 4022
- WAR** Warrington Hospital, Department of GUM, Lovely Lane, Warrington, Cheshire, WA5 1QG, Tel: (01925) 635 911
- WGH** Westmorland General Hospital, Outpatients Department, Burton Road, Kendal, Cumbria, LA9 7RG, Tel: (01539) 732 288
- WHIT** West Cumberland Hospital, Department of Haematology, Hensingham, Whitehaven, Cumbria, CA28 8JG, Tel: (01946) 693 181
- WIGG** Royal Albert Edward Infirmary, Department of GUM, Wigan Lane, Wigan, WN1 2NN, Tel: (01942) 244 000
- WITG** Withington Hospital, Department of GUM, Nell Lane, West Didsbury Manchester, M20 2LR, Tel: (0161) 445 8111
- WORK** Workington Infirmary, Department of GUM, Infirmary Road, Workington, Cumbria, CA14 2UN, Tel: (01946) 693 181

Voluntary agencies

- BARL** Barnardo's (Liverpool) Tel: (0151) 708 7323
- BARM** Barnardo's (Manchester) Tel: (0161) 273 2901
- BHA** Black Health Agency Tel: (0161) 226 9145
- BP Blackpool** Body Positive Blackpool Tel: (01253) 296 887
- BP Cheshire** Body Positive Cheshire and North Wales Tel: (01270) 653 150
- GHT** George House Trust Tel: (0161) 274 4499
- HEAL** Health Education A.I.D.s Liaison Tel: (01253) 290 052
- SAHIR** Sahir House Tel: (0151) 708 9080
(Mersey Body Positive and Merseyside AIDS Support Group)

Social Service Departments

Barrow-in-Furness	Tel: (01229) 894 345
Blackburn with Darwen	Tel: (01254) 587 887
Blackpool Borough Council	Tel: (01253) 477 933
Bury	Tel: (0161) 778 2586
Cheshire	Tel: (01244) 602 915
Lancaster	Tel: (01524) 583 630
Oldham	Tel: (0161) 911 4800
Salford	Tel: (0161) 607 6999
Tameside	Tel: (0161) 304 9725
Trafford	Tel: (0161) 912 1213
Warrington	Tel: (01942) 444 138
Wigton	Tel: (01697) 366 126

Drug services

Lancaster and District CDT	Tel: (01524) 389 851
Liverpool DDU	Tel: (0151) 709 0516
Oldham CDT	Tel: (0161) 624 9595
Tameside CDT	Tel: (0161) 342 2505
Warrington CDT	Tel: (01925) 415 176
Wirral Drug Service	Tel: (0151) 653 3871

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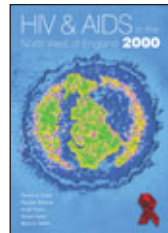
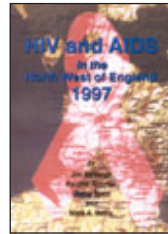
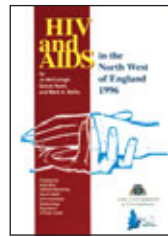
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