

HIV & AIDS

In the North West of England 2009

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Executive Summary

In 2009, 6,238 HIV positive individuals accessed treatment and care from statutory treatment centres in the North West of England, representing an 8% increase on the number reported in 2008 (5,767 individuals). Diagnosed prevalence in the region was 80 per 100,000 population. The prevalence in Manchester local authority was 365.6 per 100,000, Salford was 229.6 per 100,000 and Blackpool 203.6 per 100,000. Areas with a prevalence of more than 200 per 100,000 are considered high prevalence in national guidelines and this has consequences for HIV testing activities. During 2009, there were 881 new cases of HIV, representing a 5% decrease from 2008 (925 cases) showing a fluctuating trend in recent years. New cases were classed as people who were new to the North West database in 2009, were not seen at a statutory treatment centre in the North West since 1994 and included transfers from outside the region.

This is the fourteenth annual report of the North West HIV/AIDS Monitoring Unit, presenting data on HIV positive individuals accessing treatment and care in the region. A total of 42 statutory centres in the region provided treatment and care for HIV positive individuals. Information is presented by local authority (LA), primary care trust (PCT) and treatment centre. Due to limited space, not all analyses by LA or PCT can be included. However, additional breakdowns can be found on the North West Public Health Observatory website: www.nwpho.org.uk/hiv2009.

New cases represented 14% of all cases, decreasing from 23%, in 2004. The predominant route of exposure to HIV for new cases was heterosexual sex (48%), followed by sex between men (MSM) (41%; tables 2.1 and 2.2), reflecting the national trend (figure 1.2). However, the proportion of new cases infected through MSM is higher in the North West (table 2.1) than nationally (figure 1.2). The number of new cases infected through other routes (injecting drug use, blood/tissue and mother to child) remained relatively low. The largest proportion of new cases presenting for treatment and care were categorised as asymptomatic (63%). However, 12 out of 14 deaths amongst individuals new to treatment services in the region in 2009 were due to an AIDS-related illness (table 2.3). This illustrates the continued need to ensure that people with HIV seek treatment at an earlier stage of their disease to maximise the effectiveness of treatment and improve prognosis.

The predominant mode of exposure to HIV for all individuals who accessed treatment in the North West continued to be sex between men, accounting for 51% of all cases in 2009 (table 3.1). However, there is considerable variation at county level. Of those whose infection route was known, 64% of Lancashire's and 57% of Cheshire's HIV positive residents were

infected through sex between men, compared with 38% of Merseyside's HIV positive population. There is greater variation across local authorities: 83% of HIV positive residents in Blackpool were infected via MSM compared with 27% in Hyndburn. Manchester local authority had the largest number of HIV positive residents infected through MSM (895 individuals) and through heterosexual sex (789 individuals). The Greater Manchester area had the largest number of HIV positive people infected through injecting drug use (78 individuals) which accounted for two thirds of all residents of the North West infected through this route. However, heterosexually infected individuals continued to be the second largest group in the North West region, accounting for 42% of all cases in 2009 (tables 3.1 and 3.2). This is a similar proportion to that seen in 2008 and reflects trends in the United Kingdom as a whole. Greater Manchester had the largest number of HIV positive individuals in the region accounting for three fifths of all cases (table 3.2) and 57% of new cases (table 2.2) presenting to statutory treatment centres in 2009.

The North West of England continued to be influenced by the global HIV situation, as reflected by the number and pattern of HIV infections acquired abroad. Over a third (37%) of all HIV positive individuals accessing treatment and care in the region were reported to have been infected outside the United Kingdom, the majority (71%) of whom were infected in sub-Saharan Africa (figure 3.2 and table 3.8). Heterosexual sex was the most common route of infection for those infected abroad (80%), a much higher proportion than amongst those known to be infected in the United Kingdom (15%). Nine percent of individuals infected abroad acquired HIV in South and South East Asia, with a similar proportion (8%) in Western Europe. Of those exposed in Western Europe, the greatest numbers were infected in Spain (figure 3.2). The role of exposure to HIV abroad was even more marked amongst new cases where 41% were reported to have acquired their infection abroad (figure 2.2 and table 2.7). People reported to have been infected in Zimbabwe accounted for a third of new cases known to have been infected abroad (figure 2.2).

Ethnicity was recorded for almost all individuals accessing treatment and care in 2009, the majority of whom (65%) were of white ethnicity (table 3.1). An increasing number of individuals treated in the region were from black and minority ethnic (BME) backgrounds (35%), a substantial over-representation when compared with the proportion of people from BME backgrounds in the general North West population (8%). An even greater proportion of new cases whose ethnicity was known (42%) were from BME communities (table 2.1). This demonstrates the increasing burden of HIV on BME communities in the region and the need for the continuation

and strengthening of HIV prevention activities. The characteristics of HIV positive individuals from BME communities, particularly amongst those of black African ethnicity, contrast with those of the white HIV positive population. Whereas white individuals with HIV were more likely to have been infected through MSM, heterosexual sex is the predominant route of infection amongst those of black African ethnicity (tables 2.1 and 3.1). There are proportionately more females from BME communities with HIV compared with white communities (table 3.7), which potentially impacts on the number of mother to child transmissions.

This report includes information on the residency status of those in treatment and care for HIV. This level of information is not available nationally, despite concern over the health of vulnerable groups such as asylum seekers. The number of individuals classed as non-UK nationals represented 20% of all HIV positive individuals in the region, a similar proportion seen in 2008 (19%). Over half (55%) of these individuals were asymptomatic, compared with 47% of UK nationals (table 3.13).

During 2009, the largest proportion (48%) of people accessing treatment and care services were using triple antiretroviral therapy (ART). Amongst those North West residents who had received an AIDS diagnosis, 96% were on ART. Amongst those who were asymptomatic, 62% were on therapy, a greater proportion than in 2008 (table 3.6). During the year, asymptomatic HIV positive people accumulated a total of 19,251 outpatient visits. People who had received an AIDS diagnosis had the highest mean number of outpatient visits (7.2 per person), whilst individuals who had died from an AIDS-related illness during the year required the most inpatient care (a mean number of 23.4 days per individual; table 3.12).

During 2009, 3,108 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by ten community

sector organisations (previously known in this report as voluntary agencies) in the region. The overall number of individuals seen by the community sector in 2009 was 10% higher than in 2008. A third of the individuals seen by community sector organisations in 2009 did not attend a statutory sector service during the year (table 4.3), illustrating the continuing contribution of the organisations to the care of HIV positive individuals for whom these organisations may be the sole provider of care. This also has particular significance for regional funding of HIV services, since individuals exclusively accessing community sector organisations are not included in the national statistics. This is important as regional statistics form the basis of the formula for the national distribution of funds for the care of HIV positive people.

For the eighth year running, information was requested from social services departments in the North West on the social care of HIV positive people. This year, five social services departments were able to contribute information on 250 individuals. The majority of people with HIV seen by social services departments also accessed statutory sector services in 2009 (table 5.1).

Information on trends for new and all cases of HIV in the North West from 2000 to 2009 are presented in chapter 6 and give an overall view of the changing pattern of HIV in the North West region.

We hope that the tables and figures presented in this report, and the extra analysis available on the website (www.nwpho.org.uk/hiv2009) provide the relevant North West HIV/AIDS information needed. In recognition of the evolving and dynamic nature of HIV, any comments and suggestions for improving the usefulness of this report in future years are welcomed (sexualhealth@ljamu.ac.uk).

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1. Introduction

Over the past fourteen years the North West HIV/AIDS Monitoring Unit have collected, collated, analysed and disseminated data on the treatment and care of HIV positive individuals in the region^[1-13]. The aim of this report is to provide a comprehensive and timely summary of the epidemiology of HIV. It begins with a global and national overview before focussing on 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 cases presenting for treatment and care in the region. Information on the community sector (previously known in these reports as voluntary agencies) and social care are presented in chapters 4 and 5, followed by trend data in chapter 6. Due to limited space, not all analyses by local authority (LA) or primary care trust (PCT) can be included here. However, additional tables can be found on the North West Public Health Observatory website: www.nwpho.org.uk/hiv2009.

We hope that the tables and figures presented within this report and the extra analysis available on the website provide the relevant North West HIV information required. In recognition of the evolving and dynamic nature of HIV, any comments and suggestions for improving the usefulness of this report in future years are welcomed.

Global Perspectives on HIV and AIDS^{*[14]}

Globally, the proportion of individuals infected with HIV has stabilised in the last eight years. However, due to increases in new diagnoses and the effects of improved and more widely available antiretroviral therapy, the number of people living with HIV continues to rise. There were an estimated 33.4 [31.1 – 35.8][†] million people infected with HIV globally in 2008, of whom 2.7 [2.4–3.0] million were new HIV infections. Young people accounted for around 40% of all new adult (aged 15 years and over) infections. An estimated 430,000 children aged under 15 years were infected in 2008, mostly from transmission in-utero, during delivery or post-partum through breastfeeding. There are thought to be 2.1 [1.2–2.9] million children aged under 15 years now living with HIV (almost 90% live in sub-Saharan Africa). The number of new infections in 2008 was around 18% lower than in 2001, due to expansion of services to prevent mother to child transmission.

Continued improvement in national HIV surveillance systems and estimates feed into the global epidemiological system. For

example, anonymous HIV testing in national household surveys was conducted in 11 countries in 2007 and 2008, most in sub-Saharan Africa; such data help local governments better tailor their response as well as feeding more reliable information into the global system.

UNAIDS note that since the recognition of AIDS nearly 30 years ago, there are signs of major progress in HIV response. This has been attributed in part to the substantial increase in access to HIV treatment in recent years. Coverage for services to prevent mother-to-child transmission rose from 10% in 2004 to 45% in 2008^[15]. An increase in antiretroviral therapy coverage from 7% in 2003 reaching 43% in 2008 (particularly in eastern and southern Africa), is strongly contributing to the global decline in the number of HIV-related deaths. The annual number of AIDS deaths declined from 2.2 [1.9–2.6] million in 2005 to 2 [1.7–2.4] million in 2008. Amongst deaths reported in 2008, 280,000 were in children aged under 15 years.

Despite advances, action is still needed to reach HIV prevention and treatment and care targets^[16-17]. UNAIDS reiterate that AIDS continues to be a major health priority and, despite improvements, AIDS-related illness is one of the leading causes of death globally and contributes towards premature mortality in decades to come. Further, the number of persons living with HIV continues to increase. Global solidarity in the response to AIDS is thus called for.

Epidemiological patterns are evolving by region and country, with changing characteristics of populations at greatest risk of infection. This underscores the need for targeting prevention to local needs, and the importance of decentralising AIDS responses. In most regions the epidemic is stabilising with sub-Saharan Africa remaining the most heavily affected with 71% of all new infections in 2008. However, the prevalence of new infections through sexual transmission is increasing in Eastern Europe, Central Asia, and other Asian countries. Further, resurgence of infections in men who have sex with men (MSM) in high income countries is well documented. Addressing the HIV epidemic amongst marginalised groups is particularly important. It was highlighted at the XVII International AIDS Conference, Mexico City in 2008, that in countries where there are no laws to protect sex workers, drug users and MSM, only a fraction of the population has access to prevention. This contrasts with access to services in countries where legal and human rights protection is available^[18]. UNAIDS noted that programmes to prevent new infections among such key populations are an important part of national AIDS responses.

* Unless otherwise stated, global data and information have been sourced from AIDS Epidemic Update 2009 and UNAIDS factsheets, using 2008 data.

† Figures in brackets indicate the reported range in estimated incidence from UNAIDS.

Important prevention programme gaps identified by UNAIDS includes failure to match national AIDS strategies to documented national needs or failures to prioritise focused HIV prevention programmes for key populations. Gaps in hyperendemic settings include lack of attention placed on HIV testing and counselling for serodiscordant couples, particularly amongst older heterosexual couples, and addressing intergenerational partnerships which increase vulnerability of young people. There is also a need to include people living with HIV in programme planning implementation and monitoring. To address these needs, UNAIDS has developed an outcome framework for 2009-2011 with nine priority areas (box 1)^[14].

Box 1: UNAIDS Outcome Framework, 2009 – 2011

- Reduce sexual transmission of HIV;
- Prevent mothers from dying and babies becoming infected with HIV;
- Ensure people living with HIV receive treatment;
- Prevent people living with HIV from dying from TB;
- Protect drug users from becoming infected with HIV;
- Remove punitive laws, policing, practices, stigma and discrimination that block effective responses to AIDS;
- Stop violence against girls and women;
- Empower young people to protect themselves from HIV;
- Enhance social protection for people affected by HIV.

Sub-Saharan Africa

Sub-Saharan Africa remains the global epicentre of the HIV pandemic. There were an estimated 22.4 [20.8–24.1] million people living with HIV in 2008, 1.9 [1.6–2.2] million of these were new infections. These figures account for approximately two thirds (67%) of the global total of infection (33.4 [31.1–35.8] million) and nearly three quarters (72%) of the global number of AIDS-related deaths. The epidemic has orphaned more than 14 million children in this region.

Although the epidemic in sub-Saharan Africa appears to be stabilising, this is often at high levels. Nine countries in Southern Africa each have an HIV prevalence of greater than 10%, including Swaziland with an adult prevalence of 26% and Lesotho with a stable 23% in 2008. HIV prevalence seems to have stabilised, and in some cases declined, in East Africa. In Burundi, prevalence amongst young people (aged 15-24 years) decreased in urban and semi-urban areas but increased in rural areas between 2002 and 2008. Prevalence in West and

Central Africa is lower than Southern Africa, but is still a concern in, for example, Cote d'Ivoire (3.9%) and Ghana (1.9%). Prevalence also varies within countries; in Kenya there is a 15-fold difference between North Eastern (0.8%) and Nyanza (14.9%) provinces. Genetic variability in the virus occurs; in 2005 over half of infections were subtype C, 14% subtype A, and 10% subtype G^[19]. Individuals with subtype D in Kenya and Uganda experience faster disease progression than subtypes A or C^[20].

Heterosexual intercourse remains the driving force behind the epidemic in sub-Saharan Africa. Women and girls continue to be disproportionately affected, accounting for 60% of infections. This results from social, legal and economic disadvantage, as well as their relatively greater physiological susceptibility to infection. In Southern Africa, young women aged 15-24 years have a three-fold higher rate of HIV than among men the same age. HIV prevalence appears to peak earlier in women (30-34 years) compared with men (35-44 years)^[21]. A further disparity occurs with marital status, with widowed, divorced, or separated women significantly more likely to be infected than single, married or cohabiting women. Marital status often relates to HIV infection, particularly among the widowed partners of infected men, and divorce following HIV diagnosis. Surveys also show a discordance in transmission, with over half of married or cohabiting women becoming infected by someone other than their current partner^[16,22].

Although the epidemic in sub-Saharan Africa is characterised by heterosexual transmission, it has become evident that the epidemic is becoming more varied. Nearly a third of all sex workers in seven African countries (Benin, Burundi, Cameroon, Ghana, Guinea-Bissau, Mali and Nigeria) are living with HIV^[23]. In Kenya, for example, HIV infections in MSM and injecting drug users (IDUs) are an increasing concern. Half of injecting drug users tested in Mombasa and Nairobi were HIV positive, while in Mombasa, 43% of men who only had sex with other men were HIV positive^[24-25]. Sex between men is illegal and stigmatised in many countries in sub-Saharan Africa, yet research shows that it is widespread and the needs of MSM in HIV prevention should be recognised^[26]. There are an estimated 221,000 people who inject drugs and who are HIV positive in sub-Saharan Africa (although these figures should be interpreted with caution as they are based on information from three countries) and these represent 12.4% of all injecting drug users in the region^[27].

Prevention strategies do not always correctly target drivers of the national epidemics. Prevention programmes inadequately cover older people, those in stable relationships, drug users, and men who have sex with men. Couple testing and services for serodiscordant couples are inadequate. Increasing use of HIV testing services is required as knowledge of HIV status

remains poor in many countries. A strengthening of services to accompany diagnosis is required as evidence shows HIV-infected individuals who know their status in Uganda were three times more likely to use a condom, with similar reports from other countries.

Nevertheless, in general the national epidemics appear to have stabilised or begun to decline, alongside the increase in resources provided to HIV/AIDS prevention and treatment. Since December 2008, nearly three million people (44% of adults and children with HIV) who needed antiretroviral therapy were estimated to be receiving it. As a result of increases in antiretroviral therapy provision in Kenya, for example, AIDS-related deaths have fallen by 29% since 2002. This has meant that, even though the rate of new infections is declining in sub-Saharan Africa, there was an increase in the number of people living with HIV in 2008 due to longevity enabled by improved access to treatment.

Asia

In Asia, there were an estimated 4.7 [3.8 – 5.5] million people living with HIV in 2008, of whom 350,000 [270,000 – 410,000] were newly infected, a fall from 400,000 in 2001. A similar number (330,000 [260,000 – 400,000]) were reported to have died from AIDS-related illnesses in 2008. While the epidemic in the region overall appears stable, HIV prevalence is increasing in some parts, such as Bangladesh and Pakistan. In heavily affected regions of India, HIV prevalence among pregnant women aged 15 to 24 years old declined by 54% between 2000 and 2007, and there has been a long term decline in prevalence in Cambodia.

The proportion of women living with HIV in the region rose from 19% in 2000 to 35% in 2008. While injecting drug users, sex workers and MSM have been the main population groups at risk, HIV transmission is expanding into lower-risk populations through transmission to sexual partners of those at most risk. Thus, in Thailand, the pattern of HIV transmission is changing to include people previously considered to be low risk, such as married women infected by their husbands who became infected through unprotected sex or use of contaminated equipment^[28]. In India, women accounted for 39% of the HIV prevalence in 2007. Heterosexual transmission has overtaken IDU as the main route of transmission in China, and it is reported 60% of sex workers do not consistently use condoms. In Myanmar, 18% of sex workers are infected. The overlap between IDU and buying or selling sex is a concern of many countries; in the Sichuan province in China, more than 40% of female and 34% of male IDUs were engaged in sex work.

While MSM transmission is under-researched in this region, evidence suggests a rise in HIV prevalence amongst this group.

About a third of MSM in Myanmar and Thailand are reported to have HIV. In Thailand, HIV prevalence is twice as high in male compared with female sex workers, and in Indonesia it is reported to be three times as high.

Success of the scale-up of treatment across the region is mixed, with 37% of those needing antiretroviral drugs receiving treatment. Thailand's efforts to arrest the epidemic stalled with the economic crisis in the 1990s. However, renewed national prevention efforts have more recently succeeded in reducing HIV incidence. Regionally, improvements are needed in promoting knowledge of HIV status and in the provision of testing services. In China, for example, it is estimated less than one in three people living with HIV have been diagnosed although financial support for the HIV programme increased threefold between 2003 and 2006.

Eastern Europe and Central Asia

The estimated number of people living with HIV in Eastern Europe and Central Asia reached 1.5 [1.4–1.7] million in 2008. Prevalence of HIV in this region is rising, with the situation particularly severe in Ukraine, Russian Federation and Estonia, where it exceeds 1%.

Injecting drug use is still the primary route of HIV infection in the region and the crossover with sex work increases the risk of transmission further. In the Russian Federation, research shows that 30% of sex workers had injected drugs^[16,29]. There is also increasing transmission among sexual partners of injecting drug users. In 2007 in Eastern Europe, injecting drug use accounted for over half (57%) of new HIV diagnoses^[30].

There has been progress made in treatment for HIV and prevention for injecting drug users, although this does still remain low. There have been a number of countries which have expanded access to antiretroviral therapy, although there were still only 22% of adults receiving treatment who needed it. In Estonia, harm reduction services for IDUs have improved, with more sterile needles than previously being distributed^[31].

With a growth of sexual transmission of HIV, there is the higher likelihood of mother-to-child transmission. However, one of the positive responses to HIV in this region has been the good coverage of services to prevent HIV transmission to the unborn baby, with more than 90% of pregnant women in 2008 being screened and treated if necessary.

Caribbean

In 2008, there were an estimated 240,000 [220,000 – 260,000] people living with HIV in the Caribbean. The region has an HIV

prevalence of 1%, with the second highest level of adult HIV infection outside sub-Saharan Africa. There were an estimated 20,000 new infections and approximately 12,000 deaths due to AIDS-related illnesses in 2008. AIDS-related illness was the fourth leading cause of death for women, and the fifth for men in 2004. HIV surveillance systems in several Caribbean countries are inadequate but the information suggests the epidemic in the region is stabilising with a decline in urban areas of Haiti and the Dominican Republic. Epidemiological and behavioural data suggest declines in new HIV infections in the latter are likely due to changes in sexual behaviour, including increased condom use and a reduction in partners. While prevalence is low in Cuba there is evidence this is increasing. Substantial variation in prevalence occurs within countries with, for example, a seven-fold difference between regions in the Dominican Republic. In Haiti, prevalence among pregnant women varied between 0.75% and 11.7%.

The main mode of transmission of HIV in the Caribbean is unprotected heterosexual sex. Women account for about half of all cases with adolescents and young women infected at a higher rate than males of the same age. Surveys report an extremely high rate of infection in sex workers, which is the main driver of infection, with a prevalence ranging from 27% in Guyana to 9% in Jamaica in 2005. Transmission also occurs in MSM, despite sex between men being illegal in a number of countries, and the risk of acquiring infection is high among male sex workers selling sex to tourists. In a study in 2006, 20% of MSM in Trinidad and Tobago were infected, and 31% in Jamaica. In the Dominican Republic studies show only half of MSM living with HIV use condoms, and transmission between males is responsible for a larger share of infections than previously recognised^[32]. Sex among men is driving the increase in HIV prevalence in Cuba. IDU is the most common transmission route in Puerto Rico, accounting for 40% of HIV incidence in males and 27% of new infections in females.

Treatment coverage increased from 10% in 2004 to 51% in 2008, and paediatric antiretroviral coverage reached 55% by 2008. Both are considerably higher than the global average of 42% and 38% respectively.

Latin America

An estimated 2 [1.8–2.2] million people live with HIV in Latin America. In 2008, 170,000 [150,000 – 200,000] new cases were reported along with an estimated 77,000 [66,000–89,000] AIDS-related deaths. Trends appear to have changed little in the past decade. The main mode of transmission continues to be MSM, sex workers and to a lesser extent IDUs. However, despite the well-defined risk populations, targeted preventive programmes are rare. The HIV prevalence among MSM ranges from 7.9% in El Salvador to 25.6% in Mexico. One in five MSM in Central America report also having sex with

females. HIV infection in females is predominantly among those in the sex trade. Surveys in Latin and Central American countries indicate infection rates in female sex workers of between 0.2% and 4%. In Argentina, rates are higher in male sex workers. Some 29% of two million Latin American IDUs are infected with HIV.

Funding for targeted interventions remains limited, although Mexico has increased funding for prevention services for MSM. However, HIV prevention programmes among sex workers appears to be having an impact on transmission, with increasing use of condoms leading to a drop in HIV infections. Antiretroviral coverage in Latin America is above the global average (54% in 2008).

North America, Western and Central Europe

In 2008 there were an estimated 2.3 [1.9 – 2.6] million people living with HIV in North America, Western and Central Europe. There were 55,000 [36,000 – 61,000] new HIV infections in North America and 30,000 [23,000 – 35,000] in Western and Central Europe. An estimated 38,000 [27,000–61,000] people died from an AIDS-related illness in 2008. Progress in reducing the number of new HIV infections has stalled in high income countries. Rates of newly reported cases of HIV in Europe nearly doubled between 2000 and 2007^[30]. Rates are highest in the USA but are relatively static, while an increase was noted in Canada between 2000 and 2005.

Epidemiological patterns of risk have evolved in high income countries. The number of new infections amongst MSM has increased while infections from IDUs have fallen. Unprotected sex between males has risen sharply in Western Europe. Thus, men outnumber women in both prevalence and new infections by more than 2:1. A third of new cases of HIV in the USA and Canada result from unprotected heterosexual sex.

The wide availability of antiretroviral drugs has had an impact on mortality statistics, with a substantial reduction in deaths in all countries. Mortality rates of people infected with HIV in the first five years are now similar to non-infected persons although mortality increases with duration of infection^[33]. Timely diagnosis has become the greatest challenge, with late diagnosis occurring in up to a third of persons in some countries. Undiagnosed infection facilitates transmission and increases the mortality risk. In the USA, routine voluntary testing in all health care settings is recommended, while other countries are developing strategies to widen testing opportunities for high risk populations.

Middle East and North Africa

Information for the Middle East and North Africa is limited and sporadic. An estimated 310,000 [250,000 – 380,000]

people were living with HIV in 2008 and, of these, 35,000 [24,000 – 46,000] were newly diagnosed. Epidemics in the region are relatively small scale, with the exception of southern Sudan and Djibouti, where HIV prevalence among pregnant women is 1%. More generally, transmission has occurred through unprotected paid sex, MSM and IDU. IDU-related HIV infection is a concern in this region, with nearly a million people injecting drugs and a tendency to share injecting equipment^[34]. Prevalence among drug users varies from 3% in Turkey to 12% in Oman. Surveys on MSM are rare due to criminalisation of same sex sexual activities; in Sudan 9% of MSM were infected with HIV. Heterosexual transmission may follow as in many countries, MSM may also have sex with women^[34]. Throughout the Middle East and North Africa there are an increasing number of new cases of HIV occurring in females as a result of their male partners' paid sex or drug use. In 2008, 4,600 children were newly infected, with antenatal prevention almost non-existent^[15].

Oceania

There were an estimated 59,000 [51,000 – 68,000] people living with HIV in Oceania in 2008, of which 3,900 [2,900 – 5,100] were newly reported. Epidemics in this area are mostly small, except in Papua New Guinea, where the number of new diagnoses continues to rise. Excluding the high income countries of Australia and New Zealand, Papua New Guinea accounted for 99% of reported HIV diagnoses in 2007 in the region with a higher prevalence in rural compared with urban communities. HIV in this country is primarily transmitted through heterosexual sex, apparently driven by unprotected paid sex. Young women are the highest risk group. Sex between men remains the primary mode of transmission in Australia and New Zealand, with 80% of new infections reported in males, predominantly in the 40-49 year old age group. After a sharp decline in the 1990s, reports of new HIV infections have increased in Australia in recent years. Between 1998 and 2007 newly acquired infections rose by 50% in some regions of Australia, although there has been a small fall nationwide between 2006 and 2008 (308 to 281). In New Zealand HIV diagnoses in MSM increased by 80% between 2000 and 2006. Evidence suggests the prevalence of unprotected sex in MSM has increased or remains high in many cities.

Global access to treatment and prevention

At the second United National General Assembly High Level Meeting on HIV/AIDS in 2006, countries agreed to work towards the goal of “universal access to comprehensive prevention programmes, treatment, care and support” to be achieved by 2010. These global commitments supplement the health-related United Nations Millennium Development Goals^[23], which established targets to combat HIV/AIDS as

well as to reduce child mortality, improve maternal health, malaria and other major diseases by 2015. By expanding the access to antiretroviral therapy there is evidence to suggest that morbidity and mortality rates are declining globally. Such programmes have resulted in behaviour change as well as a decreasing prevalence of HIV in highly burdened countries. However, many countries are far from achieving access goals. Some of the reasons for this include weak health systems, a critical shortage of human resources and a lack of long-term sustained financing.

Evidence that male circumcision is a valuable technology for reducing HIV risk in men is an important landmark in the history of HIV prevention^[35]. However, the World Health Organisation (WHO) states that male circumcision should never replace other known methods of HIV prevention and should be considered as part of a comprehensive HIV prevention package. WHO suggests this package includes: promoting delay in the onset of sexual relations, abstinence from penetrative sex and reduction in the number of sexual partners; providing and promoting correct and consistent use of male and female condoms; providing HIV testing and counselling services; and, providing services for the treatment of sexually transmitted infections.

HIV and AIDS in the United Kingdom

New diagnoses of HIV, AIDS and deaths of HIV positive individuals in the UK are reported to the Health Protection Agency (HPA) and the Scottish Centre for Infection and Environmental Health (SCIEH), who compile the data into six-monthly surveillance tables^[36].

HPA report the cumulative total of reported new HIV infections for the UK reached 108,726 by the end of 2009 (table 1.1). Of these, 6,900 were newly diagnosed in 2009 (figure adjusted for underreporting; observed total 5,963). We anticipate the current unadjusted estimate of 5,963 new diagnoses for 2009 will also be upgraded as HPA refine the final year dataset. Figures 1.1 and table 1.1 compare the trend of new cases of HIV infection in the UK with those specific to the North West of England^[36]. As with previous years, approximately half of all individuals newly diagnosed with HIV reside in London (2,736 of 5,442 in England and of 5,963 in the UK). Similarly, over half of all cases living with HIV reside in London (55,512 of 100,316 in England and 108,766 in the UK)^[36]. National policy will thus continue to be shaped by a strong bias towards the needs of London and the South East, with an under-representation of other regions^[36-40]. For the epidemiology of HIV in the North West, see chapters 2 and 3 of this report, which are based on surveillance data of treatment and care of HIV positive individuals in the region.

An additional tool for monitoring the HIV epidemic in the UK is provided by the unlinked anonymous HIV seroprevalence programme conducted by the HPA 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 and syphilis serology) after having irreversibly removed patient identifying details. This allows estimations of the extent of undiagnosed HIV infection in high risk groups as well as in the general population. The monitoring programme has been operating throughout England and Wales since 1990 and provides low cost estimates of current HIV prevalence^[41]. Results of the programme, combined with other HPA surveillance programmes, estimates that in 2008, there were 83,000 persons living with HIV in the UK, of whom, over a quarter (27%) were unaware of their infection^[42].

Men who have sex with men

Men who have sex with men (MSM) continue to be the group at greatest risk of acquiring HIV in the UK. The HPA recorded a cumulative total of 47,409 estimated cases of HIV acquired through sex between men. Amongst these, 2,530 were reported in 2008 and 2,126 in 2009. As noted previously, 2009 data are subject to reporting delays. To account for this, HPA have reported adjusted estimates, resulting in an estimate of 2,800 for 2008 and the same number for 2009. Using adjusted estimates, the HPA estimate almost a doubling in the number of new diagnoses in MSM from 2000 to 2009 (from 1,590 to 2,800). Where probable country of infection was reported, 73% of new diagnoses who were infected through sex between men reported by the end of December 2009, were most likely infected in the UK^[36]. Even though these figures as a whole remain high, the shape of the epidemic has changed in the UK over the past two decades. The overall proportion of new HIV diagnoses in the UK attributed to sex between men has decreased from 64% prior to 1994 to 36% (unadjusted figures) in 2009 (figure 1.2).

The 1980s saw substantial reductions in risky behaviours amongst MSM in response to HIV/AIDS. However, towards the end of the 1990s, the trends of sexual risk-taking behaviour appeared to increase again. Changes in risky sexual behaviour were reported in Dougan *et al.*'s longitudinal study that recruited males in gyms in London^[43]. Between 1998 and 2003, the percentage of males reporting high-risk sexual behaviour with a casual partner increased from 6.7% to 16.1%. This study recommended that sexual health promotion should target high-risk practices with casual partners since these, and not practices with steady partners, seem to account for the recent increase in high-risk behaviour^[43].

There is evidence that the recent increase in diagnoses of HIV in MSM in the UK is strongly influenced by an increase in uptake of HIV testing. Analysis of routine data from GUM clinics, the unlinked anonymous screening programme and CD4 surveillance in the UK revealed a substantial increase in the uptake of HIV testing that may explain the rise in HIV diagnoses^[44]. In 2008, the proportion of adults (aged over 15 years) diagnosed late (i.e. with a CD4 cell count less than 200 per mm³ within three months of diagnosis) was lowest amongst MSM (20%) compared with heterosexual women (36%) and heterosexual men (44%). Over half (55%) of individuals were diagnosed with a CD4 cell count of less than 350 per mm³ (the recommended threshold for commencing antiretroviral therapy)^[42].

The most recent Sigma Research's Gay Men's Sex Survey showed was carried out in 2008 and conducted in partnership with health promotion agencies, organisations and websites across the UK, amongst men who reported having had sex with a man in the previous year and/or had a non-heterosexual sexual identity. These data revealed that 27% of all males surveyed in England, and 27% of all North West males surveyed, had never been tested for HIV^[45]. The previous year's report showed in more detail that men with diagnosed HIV were the most likely and those who had never tested least likely, to engage in all the sexual risk indicators assessed in the survey^[46].

Table 1.1: Cumulative number of HIV diagnoses in the North West and the UK by infection route to December 2009

Source: Adapted from table 4, United Kingdom New HIV Diagnoses to end of December 2009, HPA

	Infection route						Total
	MSM*	Injecting Drug Use	Heterosexual	Blood/Tissue**	Mother to Child†	Other/Undetermined	
North West	4057 (52.5%)	286 (3.7%)	2911 (37.7%)	208 (2.7%)	118 (1.5%)	149 (1.9%)	7729
Total UK††	47409 (43.6%)	5244 (4.8%)	48295 (44.4%)	1948 (1.8%)	1856 (1.7%)	3974 (3.7%)	108726

*Includes 840 men who had also injected drugs.

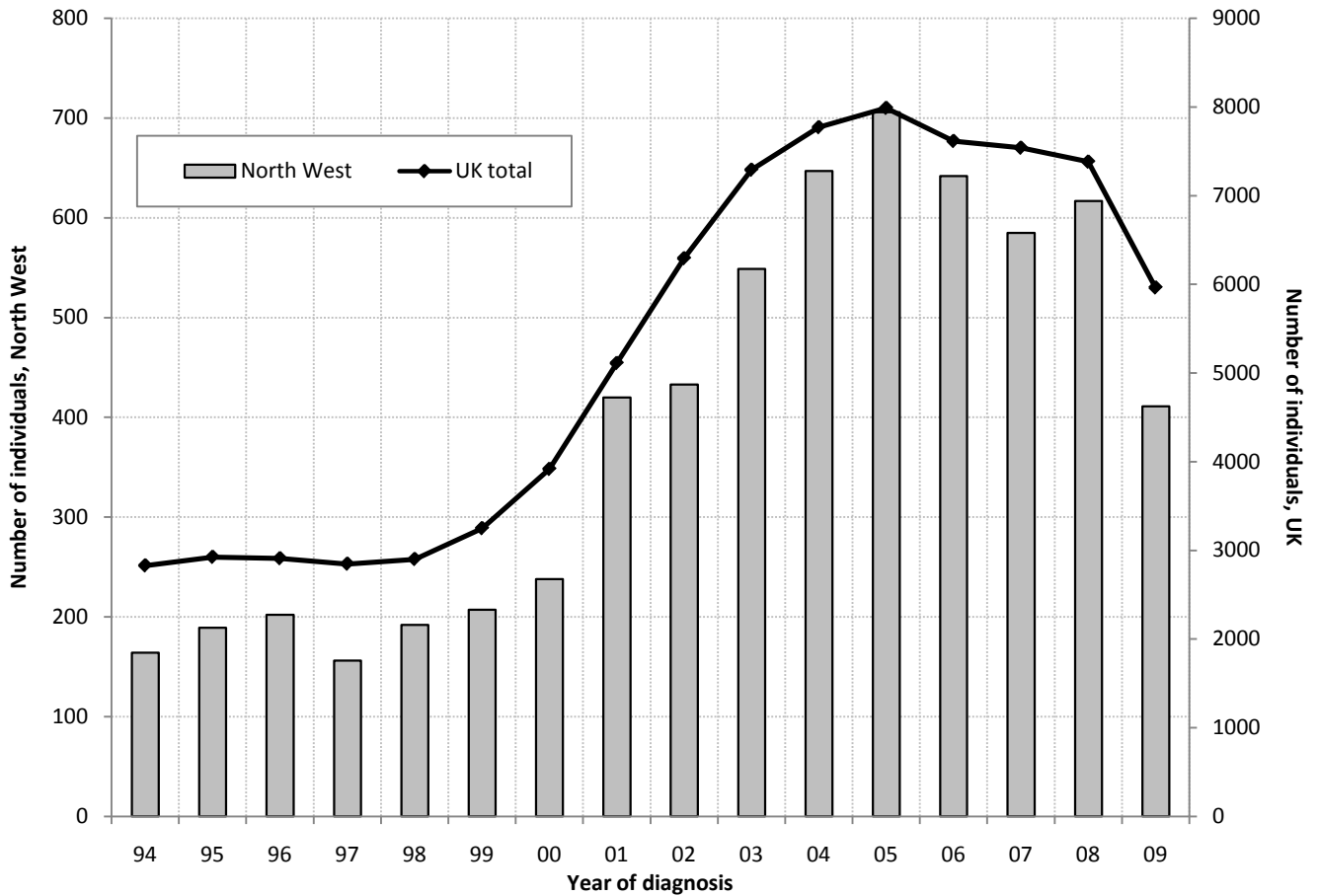
**All infections acquired through receipt of blood/tissue products diagnosed since 2002 were acquired outside the UK.

†Includes individuals born outside but diagnosed in the UK.

††Includes 40 cases where region is not known but excludes 40 cases where sex was not stated.

Figure 1.1: Number of new HIV diagnoses in the North West and the UK by year of diagnosis to December 2009

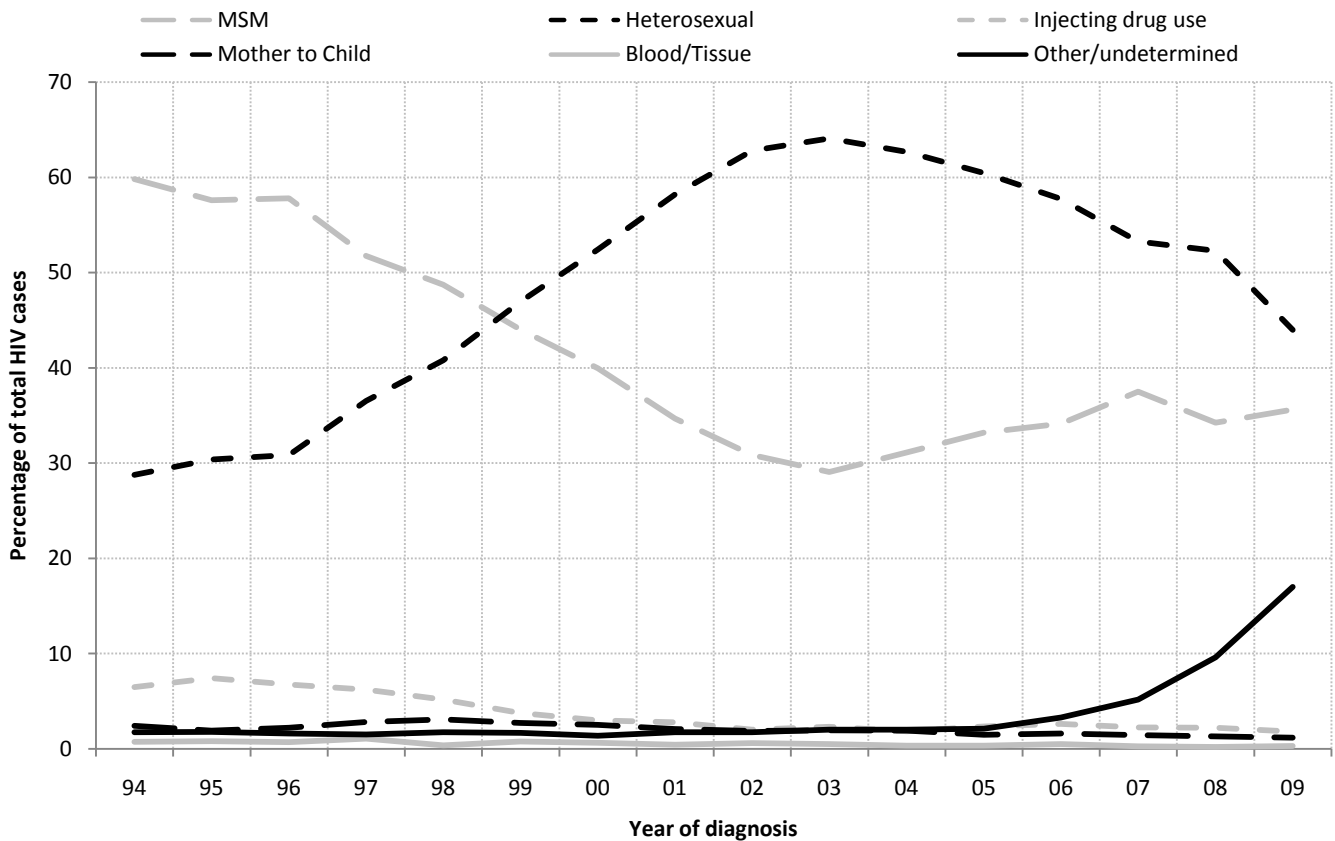
Source: Adapted from table 3, United Kingdom New HIV Diagnoses to end of December 2009 HPA



Numbers, particularly for recent years, will rise as further reports are received.

Figure 1.2: Infection route of HIV cases in the UK by year of diagnosis to December 2009

Source: Adapted from table 2, United Kingdom New HIV Diagnoses to end of December 2009, HPA



Heterosexual sex

Since 1999, heterosexual sex has accounted for the largest number of HIV diagnoses and outnumbered those acquired through sex between men, peaking in 2003 (64% of all UK diagnoses were acquired through heterosexual sex). Since 2003, the proportion infected through heterosexual sex has fallen and levelled off. However, even with reporting delay in 2009, 44% of individuals diagnosed acquired their infection through heterosexual sex, compared with 36% who had acquired HIV through sex between men (figure 1.2).

Of those HIV positive individuals infected through heterosexual sex, the majority (61%) were female^[36]. Figure 1.3 shows the number of cases acquired through heterosexual sex categorised by whether they were exposed in the UK through sex with high risk or lower risk partners or exposed abroad. This shows a decrease in the number of individuals exposed abroad since 2002 so that they are becoming closer in number to those infected through heterosexual sex in the UK.

Anonymous testing of all pregnant women can be used as an indicator of the prevalence of HIV in the general heterosexual population. Preliminary data reveal that the prevalence of HIV amongst pregnant women in England was 214 per 100,000 population in 2008 (figure 1.4)^[47].

Africa is the predominant global region of transmission for HIV infections acquired abroad with 79% of all those HIV infections acquired through heterosexual sex (unadjusted 2009 figures) probably being acquired in the region^[36]. This is also reflected in the epidemiology of HIV in the North West, where of those new cases in 2008 and infected abroad, over three quarters were exposed in sub-Saharan Africa (see chapter 2, figure 2.2). Individuals from black and minority ethnic (BME) communities make up a large proportion of heterosexually transmitted HIV cases in the UK, with black Africans constituting the largest proportion^[36]. These communities have close connections with sub-Saharan countries, the region in which two thirds of the global total of adults and children estimated to be living with HIV/AIDS at the end of 2008 reside^[14]. However, HIV is often stigmatised within African communities, which can prevent individuals from accessing services^[48] and disclosing their status to friends and family for extra support^[49].

Injecting drug use

Injecting drug use (IDU) accounts for 4.8% of the total diagnosed HIV infections in the UK to date^[36] (table 1.1). The proportion new infections acquired by this route in 2009 remained stable at 1.8% (figure 1.2). Other blood borne

infections, such as hepatitis B and C, are more infectious than HIV and can be transmitted during episodes of indirect sharing (for example sharing of filters, spoons or water when preparing drugs). While HIV prevalence remains fairly low, hepatitis B and C have risen significantly. The North West and London have equally high prevalence of hepatitis B (24% in 2007/08). The North West region also has the highest prevalence of hepatitis C in the country (58%)^[50]. Since HIV is less infectious than hepatitis C, those individuals who have had sufficient high risk exposure via IDU 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 hepatic disease and, for women, increases the probability of transmission of HIV to an infant during pregnancy or birth (see review in the North West report on hepatitis C^[51]). Analyses have revealed that in the North West people infected by IDU tend to suffer poorer health^[11,52].

Anonymous testing of injecting drug users attending specialist agencies reveals that, outside London, the prevalence of HIV amongst injectors is low (1% outside London compared with 4% in London in 2008)^[50]. Low prevalence amongst drug users in the UK compared with other countries in Europe has been attributed to harm reduction strategies such as needle exchange programmes^[53].

Blood or tissue

Since HIV screening and heat treatment were introduced for donated blood products in 1985, infection by this route has been rare. This is clearly indicated by the abrupt decline from 8% of all infections reported before and during 1991 to just 0.3% in 2009 (figure 1.2). All infections in the UK acquired through blood/tissue products diagnosed since 2002 were acquired outside the UK. A small number of cases continue to be diagnosed as a result of transfusions or blood products received overseas^[36]. 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 disease^[54]. 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^[55].

Between 1979 and 1985 about a fifth of patients with haemophilia in the UK were infected with HIV after treatment with contaminated clotting factor concentrates. Co-infection with the hepatitis C virus was also common and has contributed to high mortality amongst these individuals^[56]. A small proportion of individuals with haemophilia infected with HIV in the early 1980s are still alive and well, but there have

been an increasing number of deaths from liver disease in this patient group as a consequence of co-infection with hepatitis C^[56].

Mother to child

During 2008, 64% of women giving birth in England and Scotland lived in areas covered by unlinked anonymous surveillance system. In these survey areas, an estimated 1 per 486 women giving birth were HIV positive. The prevalence of HIV in women giving birth is highest in London (370 per 100,000) and whilst increasing, the prevalence in the rest of England is relatively low (150 per 100,000)^[42]. In 2009, 72 mother to child infections were reported. These figures will inevitably increase as the year progresses due to reporting delays of vertically transmitted HIV because the presence of maternal antibodies for up to 18 months after birth confounds the diagnosis. In 2008, 99 mother to child infections were reported, a decrease of 12 from 2007^[36].

Since 1994/95, the proportion of children presenting with HIV who were not born in the UK increased from 20% to 60% in 2000/02^[57]. HIV prevalence in mothers varies by global region and country of birth. Cumulative HIV data from HPA for 1995-2009 identified that, of 1,531 total mother to child diagnoses,

1,222 (80%) were in persons of black African ethnicity, and 89 (6%) were white^[36].

Interventions of use of ART for pregnant women with HIV, Caesarean sections and avoidance of breast feeding have all been successful at reducing the rates of vertical transmission from around 32% to 4%^[58]. The British HIV Association (BHIVA) updated their guidelines for the treatment of pregnant women in 2008^[59]. Currently, the main obstacle that prevents successful intervention is lack of knowledge by the mother of her HIV status. It is now policy to offer an HIV test to all pregnant women in order to increase the uptake of testing to 90%^[60-61]. The HPA North West's antenatal screening report presenting data from 2008 showed a regional HIV antenatal screening uptake rate of 91%, above the 90% government target and an increase in uptake since 2007 (86%), with the highest uptake (97%) in Cumbria and Lancashire^[62].

In the UK by 2009, there were 10,736 children born to HIV-infected women (cumulative total), of whom 76% (8,177 children) were uninfected, 8% (871 children) were infected and the remainder are currently of undetermined HIV status. In the North West, by the end of 2009 there were 624 births to HIV-infected women (cumulative total) of which 59% (371 children) were uninfected and 8% (51 children) were infected and a third are currently of undetermined status^[36].

Figure 1.3: Number of heterosexually acquired HIV cases in the UK by year of report to December 2009

Source: Adapted from table 5, United Kingdom New HIV Diagnoses to end of December 2009, HPA

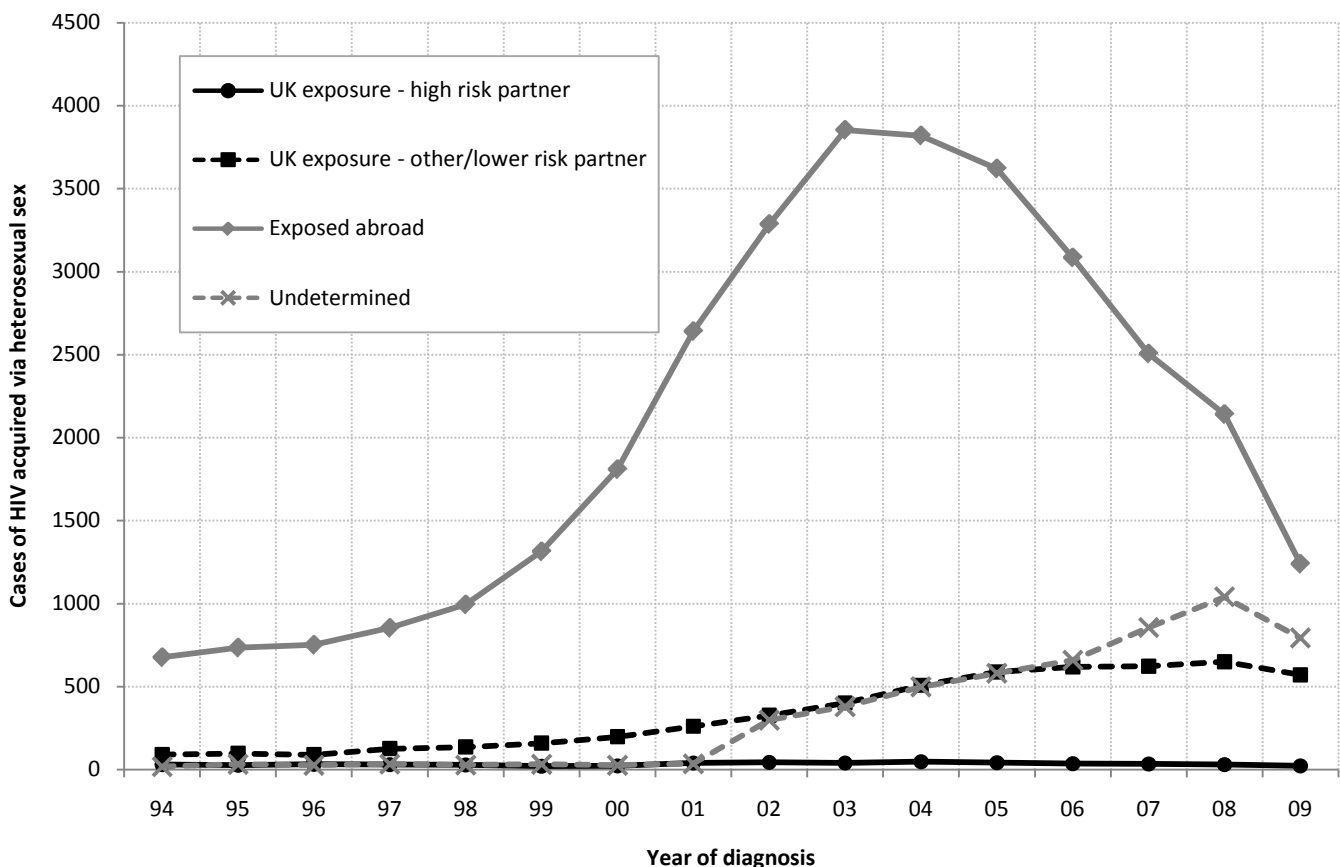
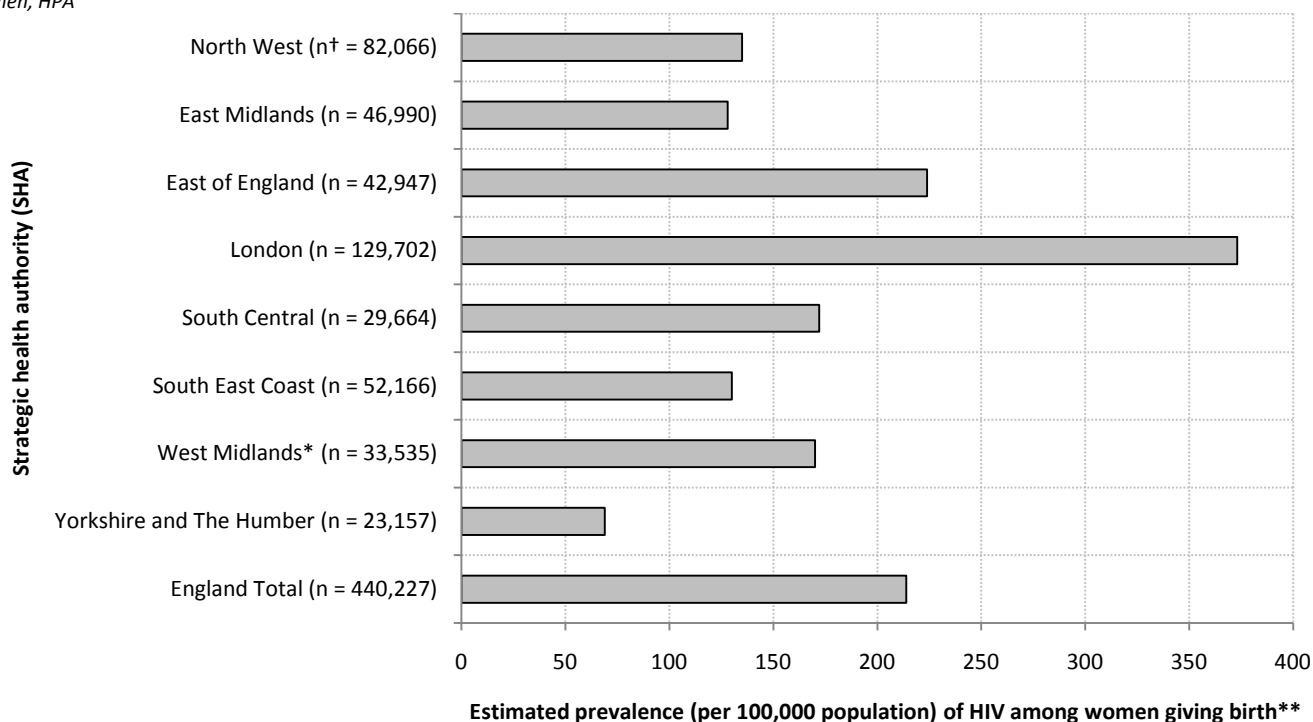


Figure 1.4: HIV prevalence amongst pregnant women in England, 2008 (newborn infant dried blood spots collected for metabolic screening)

Source: Adapted from data from the Unlinked Anonymous Dried Blood Spot Survey of newborn infants with NSHPC reports of live births to diagnosed HIV infected women, HPA



These data are preliminary and need to be considered with caution.

*Data for West Midlands SHA includes data from January to June 2008 only.

** Estimated prevalence of women giving birth who are HIV-infected in 2008 in that SHA. These data should be interpreted as an estimated prevalence and the number of positives should not be considered as the definitive number of HIV-infected women giving birth in that SHA.

† n = total tested; this is the total less insufficient samples and opt-outs.

For those children who are born with HIV in the UK, the prognosis has improved due to the advent of triple therapy: they are living longer, are less likely to require hospital admission and are less likely to progress to AIDS, as is the case in other developed countries^[63]. Consequently, services are being developed to address the needs of this group as they become young adults^[64].

HIV in non-UK nationals

Globally, migrants are at greater risk of HIV infection than are resident populations, irrespective of their country of origin^[65]. In the UK, asylum seekers suffer the highest levels of absolute material deprivation, marginalisation and stigmatisation. The prevalence of HIV amongst this group is likely to reflect that of their country of origin. Currently, asylum seekers have access to HIV care whilst seeking asylum. This is also the case for asylum seekers who have been refused asylum but are appealing. A High Court ruling in 2008 originally stated that unsuccessful asylum seekers could access free HIV care. However, the Department of Health appealed against this and the Court of Appeal ruled that failed asylum seekers are no longer considered exempt from charges^[66-67]. In previous years, due to the policy of dispersal without reference to

medical needs, many asylum seekers found themselves in areas where the medical services were unaware and unprepared for their health status and sometimes lacked sufficient expertise^[68]. An 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 HIV that is resistant to treatment if dispersed away from their source of treatment and support^[69]. This is due to the 95% adherence to antiretroviral therapy that is required to have the greatest effect in treating the virus. As a result of this, there were new guidelines from the National Asylum Support Service (NASS) about the dispersal of HIV positive asylum seekers. These require the consent of the person's consultant to dispersal and advance arrangements being made for continuity of care where the person is to be relocated^[70]. Further guidelines on the detention and removal of asylum seekers with HIV were published in June 2009 offering advice for healthcare and community sector professionals^[71].

During 2009, the UK received 29,845 asylum applications (including dependents), a 5% decrease compared with 2008 (31,315, including dependents). There are currently 6,485 asylum applicants residing in the North West receiving

supported accommodation from NASS, with a further 265 receiving subsistence only support. Within the North West, the largest numbers of asylum seekers in supported accommodation are located in Liverpool (1,375), Manchester (950) and Salford (670)^[72]. On a national level, no data are collected on how many asylum seekers seek treatment for HIV. Information for the North West about those known to be non-UK nationals is presented in tables 2.9 (chapter 2) and 3.13 (chapter 3).

HIV and AIDS in the North West of England 2009

Figure 1.1 and table 1.1 are taken from the HPA New HIV Diagnoses Surveillance Tables to illustrate the status of the HIV/AIDS epidemic in the North West in comparison with 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 in the North West, see the comprehensive overview in chapters 2 to 6 of this report.

By the end of 2009, a cumulative total of 7,729 HIV infections in the North West had been reported to the HPA (figure 1.1), including 411 new diagnoses during 2009 (although this figure will increase as more reports are received)^[36]. There were 45 newly diagnosed AIDS cases recorded in the North West in 2009, bringing the cumulative total to 1,777, 7% of the total number of AIDS cases reported in the UK^[36,73].

The pattern of HIV exposure amongst people living with HIV in the North West differs from that of the UK. The North West has a higher proportion of infections amongst MSM (52%, compared with the UK figure of 44%), and a lower proportion of people infected through heterosexual sex (38% compared with 44%) (table 1.1). As in previous years, the proportion of individuals exposed through the receipt of contaminated blood or blood products in the North West is approximately one third higher than the national figure. At least part of this is likely to be due to patients from other areas attending specialist haematology units in the region and in some cases moving residence for convenience of treatment.

The data in figure 1.4 are derived from the anonymous seroprevalence survey conducted by the HPA and show the level of HIV infection in pregnant women using newborn infant dried blood spots. Annual data for 2008 show an HIV prevalence of 214 per 100,000 population amongst women giving birth in England. The prevalence amongst pregnant women in the North West has increased from 103 per 100,000 in 2007 (data not shown) to 135 per 100,000 in 2008^[47].

Sexual health in the North West

The epidemiology of HIV in the North West needs to be set in the context of general sexual health in the region. In 2008, the latest year for which data are available, the North West saw 13% of all new episodes of the top five sexually transmitted infections (STIs; chlamydia, gonorrhoea, syphilis, genital warts and herpes) diagnosed in genito-urinary medicine (GUM) clinics in the UK, second only to London (19%). In addition, the North West saw a large percentage increase in the number of new STIs diagnosed from 2004 to 2008 (18%), the third highest increase in any region in England^[74].

These high rates of STIs also place a significant burden on the economy: research has estimated that the direct medical cost to the North West of newly acquired STIs in 2003 was almost £60 million^[75]. This estimate was based on the lifetime cost of treating STIs and included the expense of treating acute STIs and the sequelae of untreated or inadequately treated acute STIs. This is likely to have risen as diagnoses and attendances have increased substantially since then^[74]. The presence of STIs in the population not only serves as an indicator of sexual risk-taking behaviour, but also increase the probability of HIV transmission^[76].

Monitoring HIV and AIDS in the North West Region

Over the past 14 years, the North West HIV/AIDS Monitoring Unit has collected, collated, analysed and disseminated data on the treatment and care of HIV positive individuals in the North West. The NHS information strategy for 1998 to 2005 supports this level of clinical and public health monitoring. The strategy highlights the need for comprehensive, accurate information as an integral part of improving the public's health^[77]. In view of the sensitive nature of the information collected, data are anonymised and the Caldicott principles and recommendations (relating to data confidentiality and security) applied^[78].

Data were collected from over 40 statutory treatment centres including GUM clinics, infectious disease units, haematology clinics and a number of other specialist units and clinics^[1-13]. The data form part of the national dataset—the Survey of Prevalent Diagnosed HIV Infections (SOPHID). In 2009, our sixth regional mid-year report was produced to provide a timely update of HIV epidemiology and treatment to inform funding and planning of HIV treatment and prevention services^[79]. In addition, data are used at local authority (LA) level, as well as primary care trust (PCT) and regional level, to assist in service planning, development and evaluation, and provide analysis of the changing patterns of disease characteristics and prevalence. Figure 1.5 shows the number of people with HIV who contacted statutory treatment centres

in the North West of England between 1996 and 2009. 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/AIDS Monitoring Unit from across the region over the last 14 years, illustrate the increasing number of people accessing HIV services. There has been an increase (8%) in the number of HIV positive individuals attending treatment centres from 2008 to 2009. The continuing increase in the size of the HIV positive population is partly due to the decrease in the number of people dying from AIDS-related illnesses, but is also due to continued numbers of new cases. 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 HIV/AIDS Monitoring Unit also collects data from HIV/AIDS community sector organisations (previously known in this report as voluntary agencies) across the region (chapter 4) and for one of the centres based in Manchester, Body Positive North West (BPNW), this figure includes a number of individuals diagnosed through their point of care testing (POCT) scheme. BPNW's POCT scheme delivers free HIV testing clinics by staff and trained volunteers at five sites across the North West region^[80]. For the past seven years North West social services departments have also participated, providing data on HIV positive service users (chapter 5).

Methodology of monitoring HIV and AIDS in the North West

Statutory treatment clinics are prompted to complete and return forms or send electronic data twice a year. Forms contain basic data on each HIV positive individual already known to the HIV/AIDS Monitoring Unit, with up to date details from the most recent reporting period. Clinics are also prompted to report all new cases, either newly diagnosed or transferred from another clinic. Names of HIV positive individuals are not collected: instead, a one-way encryption of the surname, the soundex code, is used. This, in combination with date of birth and sex, defines a unique individual.

The demographic data collected for each person include: hospital number; soundex; date of birth; sex; postcode; ethnicity; residency status; transmission route of HIV; vital status; whether they were exposed abroad and country of exposure. For the purposes of this report, men who acquired HIV through sex with men (MSM) and who were also injecting drug users (IDUs) were included in the MSM category. Male to female transsexuals who acquired HIV through sex with men were recorded as male and age groups refer to the age of individuals at the end of December 2009, or at death. Ethnic group classifications are those used by the HPA HIV and STI Department, for SOPHID. Residency categories are adapted from the National Asylum Support Service (NASS) categories. The data requested on each individual for each six month

period include: number of outpatient visits; inpatient stays; home visits; day cases; latest CD4 counts and viral loads and dates taken; details of any antiretroviral therapy (ART) they are being prescribed; whether they are pregnant; clinical stage and the date they were last seen. Individuals are categorised as receiving the highest level of ART received from any treatment centre during the period and as the most advanced stage of disease recorded by any treatment centre. Additionally, for those who died, information on cause and date of death is requested.

Community sector organisations are prompted to send a basic dataset on the individuals attending their service on an annual basis. The information includes: soundex code, date of birth, sex, route of infection, ethnicity, residency status and pregnancy status. Body Positive North West, based in Manchester, provided information on the number of clients who were diagnosed through their point of care testing scheme which involves a rapid HIV test and completion of a short questionnaire^[80]. Data are collected from social services departments in a similar way to the community sector organisations. Individuals reported by community sector organisations and social services are matched to the statutory sector database by soundex, date of birth and sex, and any unknown information is updated from the statutory sector database.

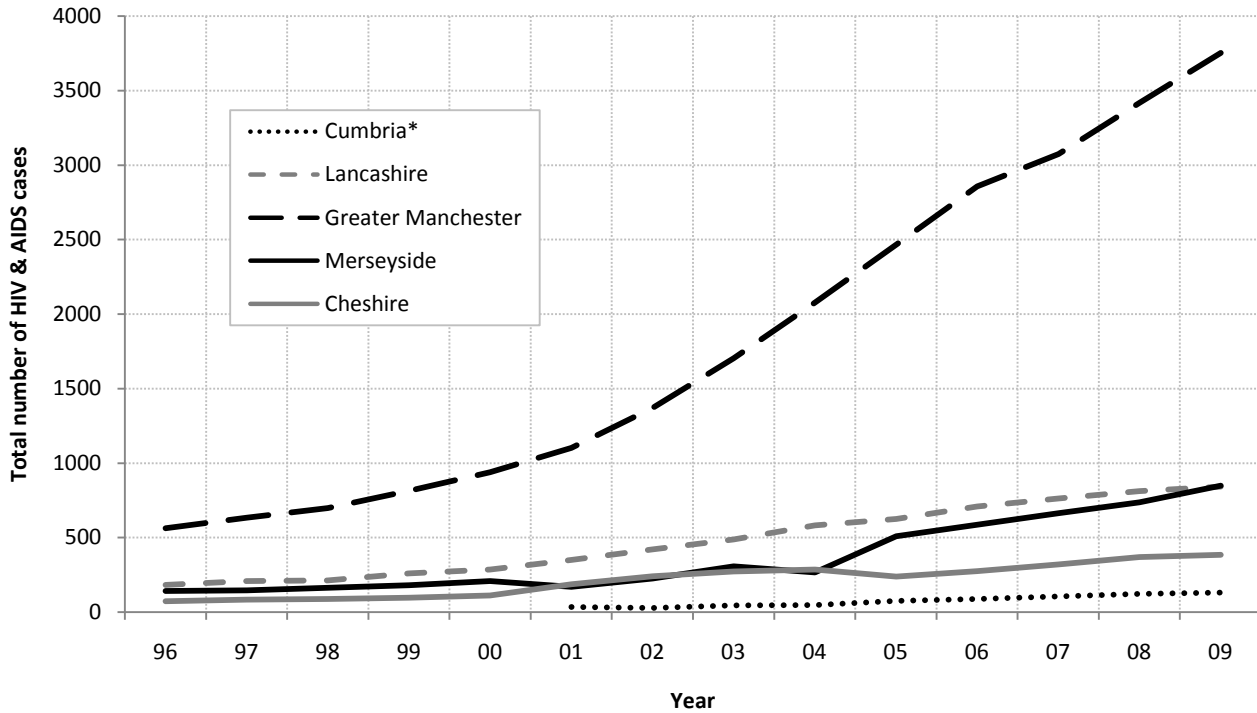
New cases are classed as people who are new to the North West database in 2009, have not been seen at a statutory treatment centre in the North West since 1994, and include transfers from outside of the region. New cases in the North West treatment and care database are not necessarily new diagnoses. However, the number of new cases used in the annual and mid-year reports are based on a comprehensive survey and, whilst slightly overestimating the number of new diagnoses, remain the most accurate indicator of new diagnoses in the North West.

We encourage service providers to download a spreadsheet with pre-defined data collection fields from our secure document gateway and upload their completed data in the same way. All the large North West centres provide data this way and an increasing number of the smaller centres now submit data electronically. The remainder send details on paper forms. The vast majority of community sector organisations and social services departments send electronic data via the document gateway.

All service providers are asked to provide full postcodes to enable mapping to LA and PCT of residence (using postcode data supplied by the North West Public Health Observatory). Partial postcodes are mapped to a particular LA and PCT if more than 90% of individual postcodes within a partial postcode area map to one LA or PCT.

Figure 1.5: Total number of HIV and AIDS cases seen in statutory treatment centres in the North West 1996-2009 by county

Source: HIV & AIDS in the North West of England annual reports [1-13]



*Prior to 2001, area of residence was by health authority and did not include Cumbria

This method provides a good degree of accuracy when all but the last digit of the postcode is available with 97% matching to a PCT. However, if only the first part of the postcode (e.g. M12) is provided this allows only 86% to match to a PCT, and some first part postcodes do not even match to a single region. Partial postcodes that could not be mapped to LA or PCT were allocated to a county if possible, or coded as unknown. Analyses are given by county, LA and PCT.

For reasons of space, it is not possible to present all breakdowns at LA and PCT level. However, additional tables are available on the North West Public Health Observatory website:

www.nwpho.org.uk/hiv2009.

This is the sixth year for which data have been collected from the statutory treatment centres divided into two periods (from January to June 2009^[79] and July to December 2008).

2. New Cases 2009

During 2009, 881 new HIV cases presented to statutory treatment centres in the North West region. This number represents a 5% decrease from 2008 (925 cases)^[13], showing a fluctuating trend in recent years after the previous year's 13% increase. New cases are defined as individuals seen in the North West region in 2009 but not during the years 1995 to 2009 and include new cases who died during the year.

Data on newly reported cases of HIV assist in the identification of trends 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 prevention activities, but also for predicting future cases of HIV and its impact on treatment and care services in the North West of England. The aim of this chapter is to present information relating to new cases and, where appropriate, references are made to corresponding data from previous North West reports^[1-13]. For reasons of confidentiality and space, it is not possible to present all breakdowns at local authority (LA) or primary care trust (PCT) level. However, additional tables are available on the North West Public Health Observatory website:

www.nwpho.org.uk/hiv2009.

Figure 2.1 illustrates the number of new HIV cases per 100,000 population in the North West who attended statutory centres and resided within the region during 2009[‡]. The population sizes for each LA used in the calculations are provided by the North West Public Health Observatory and are mid-2008 estimates based on 2001 census data. The rate per 100,000 population of diagnosed HIV in 2009 across the region (amongst individuals with known area of residence within the North West) is 10.9 per 100,000 population. Manchester LA has the highest rate (43.7 per 100,000), followed by Salford with 31.8, then Blackpool (21 per 100,000) and Liverpool with 20.8 new cases per 100,000 population. These rates have remained relatively stable over the last few years.

Figure 2.2 shows the probable global region and country of HIV infection for new cases of HIV probably acquired outside the UK who presented in the North West for treatment and care in 2009. Forty one percent of new cases (361 individuals) were contracted abroad, nearly three quarters (73%) of which were acquired in sub-Saharan Africa. A further 7% were exposed in Western Europe, followed by South and South East Asia (6%), Eastern Europe and Central Asia (also 6%) and North Africa and Middle East (2%). Of the 361 new cases who probably acquired their infection abroad, country of exposure is available for 343 individuals (95%). Individuals reported to

have been infected in Zimbabwe continue to dominate the statistics, accounting for nearly a third (32%) of new cases where infection was thought to have been acquired abroad (117 cases). There were a high number of infections acquired in Nigeria (24 cases; 7%) and Malawi (22 cases; 6%), which represents an increase of 118% for Nigeria and a decrease of 24% for Malawi from 2008. Overall, 262 new people presented for treatment and care in the North West who were thought to have been infected in 25 different countries across sub-Saharan Africa. Infections from South and South East Asia were mostly acquired in Thailand, which (along with South Africa) accounts for the fourth largest number of new cases infected outside the UK (16 cases; 4%). Amongst those infected in Western Europe, most infections were acquired in Spain and Greece.

Table 2.1 illustrates the age distribution, stage of HIV disease and ethnicity of the new HIV cases by infection route and sex. Fourteen percent of all reported cases in 2009 were seen for the first time in the region in this year. The majority of newly reported cases (69%) occur in people between the ages of 25 and 44 years, with the greatest proportion amongst those aged between 30 and 34 years (22%), an older age group than in 2008 where the greatest proportion was seen in those aged 25-29 years. As seen in recent years, exposure through heterosexual sex accounts for the largest proportion of new cases (48%) followed by sex between men (41%), the same proportions seen in 2008. Ninety-two percent of young people aged 15-24 years, for whom route of exposure is known, were infected with HIV during sex (either sex between men or heterosexual sex).

The number of new infections attributed to IDU remains relatively low but has risen from 12 individuals in 2008 to 15 individuals in 2009. During the year, 16 new cases of vertical transmission (mother to child) were reported from North West treatment centres, the same figure seen in 2008. One new case was attributed to having received contaminated blood or tissue. The infection route for 61 new cases (7%) has not yet been determined.

HIV positive individuals categorised as asymptomatic continue to represent the largest proportion of new cases (63%), maintaining the observation that many HIV positive individuals are contacting services at a relatively early stage of their HIV disease. Of the 14 individuals classed as new cases who died during 2009, 12 had an AIDS-defining illness. Importantly, 10% of new cases first presented in the region with AIDS (including those who had died from an AIDS-related illness). Although this was a smaller proportion than seen in 2008, it shows that despite continued efforts to raise

[‡] Rate of new cases per 100,000 population calculations exclude those with unknown area of residence and those living outside the region.

awareness, a minority of individuals continue to present too late to benefit from life-prolonging treatment.

As in previous years, the majority of new HIV cases, for whom ethnicity is known, were of white ethnicity (58%), with 42% of cases occurring in a minority ethnic group. Black Africans account for 86% of cases in minority ethnic groups, with black African females exposed through heterosexual sex making up 21% of all new cases reported in 2009. Of all the females infected through heterosexual sex, 18% were white, compared with 76% who were of black African ethnicity. Of all the individuals infected through MSM, 91% were of white ethnicity.

Table 2.2 shows the LA of residence and the infection route of new HIV cases presenting in the North West for treatment and care in 2009. Although the infection route for 51% of all HIV positive individuals accessing treatment and care in 2009 was attributed to sex between men (chapter 3, table 3.1), this proportion was lower for new cases with 41% infected this way. Across the counties there were large differences in the route of infection. Whilst in 2008 the main route of infection in Cumbria was heterosexual, in 2009 there were more new cases infected via MSM (11 individuals; 69%) than through heterosexual sex (four individuals; 25%). In Greater Manchester, there were slightly more new cases infected via MSM (202 individuals) than through heterosexual sex (250 individuals). In Cheshire over half (52%) of new cases were infected through sex between men compared with 46% through heterosexual sex. Of those infected through sex between men and residing in Lancashire, over a third (36%) resided in Blackpool, an area with a large gay community. Manchester also has a large gay community and correspondingly, Greater Manchester accounted for 60% of new cases resident in the North West exposed through sex between men, with the second highest proportion (16%) in Lancashire.

Table 2.3 presents the breakdown of stage of HIV disease by LA. The widespread distribution of new HIV positive individuals demonstrates the importance of HIV prevention initiatives in every county. Residents of Greater Manchester accounted for over half (57%) of new HIV and AIDS cases presenting for treatment and care in the North West. Proportionately, Cumbria had the highest recorded percentage of AIDS cases (25%; four out of 16 cases), while over four fifths (86%) of those with HIV living in Merseyside were asymptomatic. Nearly all new cases who received care in the North West during 2009 (whose residential details were known) were resident within the region (98%). Of the 20 individuals known to live outside the region, 5% were reported to reside in the Isle of Man.

Table 2.4 illustrates new HIV and AIDS cases by stage of HIV disease, infection route and sex presenting in the North West region for treatment and care in 2009, by those resident in the North West, and total new cases treated in the North West. The figures show that 65% of new cases residing in the North West presented to services while asymptomatic, 8% were symptomatic, and 10% presented with AIDS (including those who had died from an AIDS-related illness). The predominant route of HIV exposure amongst women in treatment and care continues to be heterosexual sex (91%).

Table 2.5 shows new HIV cases presenting in the North West for treatment and care in 2009 by ethnicity and age group, by those resident in the North West and total new cases treated in the North West. Of North West residents, those aged between 30 and 34 years represented the largest group of new cases accessing treatment and care (22%). Over half (55%) were aged between 25 and 39 years. New cases tend to be younger (median age of 36 years) than all cases (median age 40 years), demonstrating the continuing need to encourage younger people at risk of HIV exposure to access services. The majority of new cases treated in the region in 2009 whose ethnicity was known were white (58%), a lower figure than the corresponding data for all cases (65%) (chapter 3, table 3.5). Of those HIV positive individuals whose ethnicity was known, 42% are from a black and minority ethnic (BME) group. This indicates a substantial over-representation of new HIV cases within BME communities, when compared with their overall proportion within the North West population (8%)^[81]. The incidence of diagnosed HIV is ten times higher in BME communities than in the white population in the North West (data not shown). This illustrates the need for specialist services such as the Black Health Agency (BHA) and specialist projects within the community sector to provide care and support for communities that have already been identified as having shorter life expectancies, together with poorer physical and mental health^[82].

Table 2.6 illustrates the sex, stage of HIV disease and infection abroad by ethnicity of new HIV cases presenting in the North West for treatment and care in 2009. The majority of women for whom ethnicity was known and who were treated in the region for the first time in 2009 were from a BME group (81%). Black Africans account for 76% of all new cases in women for whom ethnicity is known. Whilst in the white population the gender distribution is highly biased towards males (90%), 58% of the new cases in the BME group are female.

Considerable differences in presentation by stage of disease between ethnic groups were reported prior to 2002. For example, in 2001, 17% of white and 28% of BME individuals presented for the first time with AIDS, and in 2000 the margin was wider with 16% of white individuals already having AIDS compared with 34% of BME communities. However, in 2009,

as in more recent years, individuals from black and minority ethnic communities (for whom ethnicity and stage of disease were known) were as likely to present while still asymptomatic (78%) as were white individuals (76%). A similar proportion were symptomatic (8% compared with 11% of white individuals), or had AIDS (12% for BME groups compared with 11% for white individuals). This suggests that those from white and BME groups are becoming more likely to access care at an earlier stage of their disease, which will hopefully increase their life expectancy.

Forty-one percent all new cases of HIV and AIDS in 2009 were infections reported to have been contracted outside the UK. The exposure route for a further 144 cases was unknown, which could lead to an underestimation of the figures contracted abroad. For those whose exposure was known, 82% of those of white ethnicity were infected in the UK, while 96% of black Africans with HIV were infected outside the UK.

Table 2.7 shows the global region of HIV exposure by infection route of HIV for new HIV cases who presented in the North West for treatment and care in 2009. Of those infected abroad, the proportion who were infected through sex between men was 11%, a slight increase on 2008 (9%). For those new individuals reported to have been infected with HIV in the UK and for whom infection route was known, sex between men was the predominant mode of exposure (75%). The vast majority (83%) of individuals with heterosexually acquired HIV whose infections were contracted abroad, were acquired in sub-Saharan Africa, with a further 5% in South and South East Asia.

Western Europe accounted for the largest proportion of new cases acquired through sex between men abroad (37%). This could reflect the reported tendency of MSM to take risks while on holiday^[83]. Five out of the 15 new cases who were infected by IDU were thought to be infected in the UK. However, a further five were infected in Eastern Europe and Central Asia. IDU remains a major transmission route of HIV in many European countries^[84]. Although the risk of contracting HIV through IDU is relatively low in the UK, sharing injecting equipment remains a significant risk.

Table 2.8 illustrates the distribution of new HIV cases between North West treatment centres and by infection route (for a list of the abbreviated treatment centres, please see the glossary at the back of the report). The treatment centre with the largest number of new cases in 2009 was Manchester Centre for Sexual Health at Manchester Royal Infirmary (MRIG) with approximately 23% of new cases. As in previous years, large numbers of new cases were also seen at North Manchester Regional Infectious Disease Unit (NMG) and Royal Liverpool University Hospital department of GUM and Tropical and Infectious Disease Unit (RLG). Many treatment centres had fewer cases in 2009 than they did in 2008. However, some still had an increase in numbers. RLG had an increase in new cases of 13% and the GUM department at St Helens Hospital (SHH) had an increase of 200% on 2008 figures (although the baseline 2008 figure was low).

Table 2.9 presents the residency status of new HIV cases categorised by sex, age group, infection route, ethnicity, stage of HIV disease and area of residence. Of the 881 new cases, 504 cases (57%) were known to be UK nationals, and 162 (18%) were non-UK nationals. Nearly three quarters (74%) of non-UK nationals were asymptomatic, a greater proportion than UK nationals (62%).

Table 2.10 displays new HIV cases by infection route and PCT of residence. The figures show that Manchester PCT had the largest proportion of new HIV cases in treatment and care in the North West (24%; 214 individuals), followed by Liverpool PCT with 11% (97 individuals).

Table 2.11 shows new HIV cases by stage of disease and PCT of residence. Amongst those that were asymptomatic, 18% resided in Manchester PCT, followed by the next largest proportion (16%) in Liverpool PCT. Further analyses by PCT can be found on the North West Public Health Observatory website: www.nwpho.org.uk/hiv2009.

Figure 2.1: Number of new cases of HIV per 100,000 population by local authority of residence, 2009

Crude rate based on the number of new cases of HIV and AIDS residing in the North West and accessing the region's treatment centres per 100,000 of the population

Per 100,000 Population

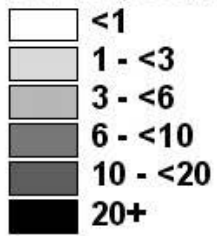
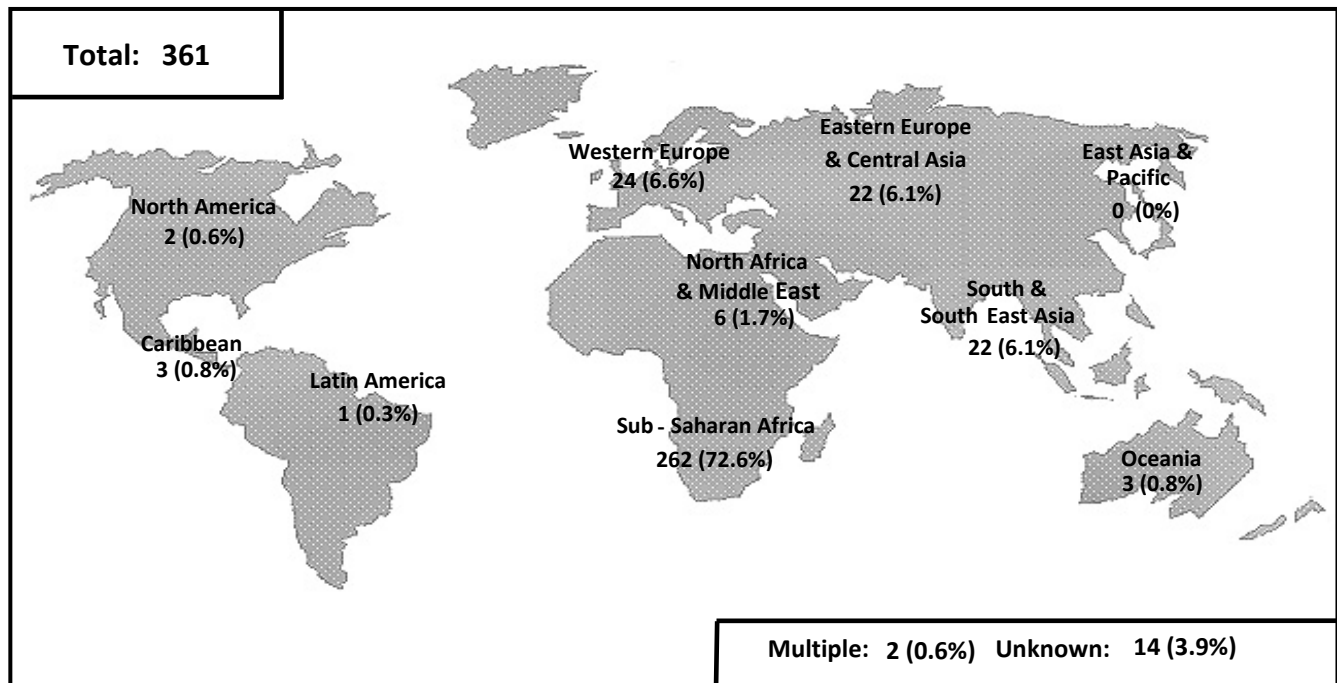


Figure 2.2: Global region and country of infection for new HIV and AIDS cases in the North West who probably acquired their infection outside the UK, 2009



Sub-Saharan Africa	262 (72.6%)
Angola	4 (1.1%)
Botswana	6 (1.7%)
Cameroon	3 (0.8%)
Cape Verde	1 (0.3%)
Congo	10 (2.8%)
Cote d'Ivoire	1 (0.3%)
Dem. Republic of Congo	1 (0.3%)
Eritrea	1 (0.3%)
Ethiopia	8 (2.2%)
Ghana	7 (1.9%)
Guinea	3 (0.8%)
Kenya	6 (1.7%)
Malawi	22 (6.1%)
Mozambique	1 (0.3%)
Namibia	2 (0.6%)
Nigeria	24 (6.6%)
Rwanda	3 (0.8%)
Sierra Leone	2 (0.6%)
Somalia	2 (0.6%)
South Africa	16 (4.4%)
Swaziland	1 (0.3%)
Tanzania	1 (0.3%)
Uganda	10 (2.8%)
Zambia	8 (2.2%)
Zimbabwe	117 (32.4%)
Unknown	1 (0.3%)
Multiple	1 (0.3%)

North America	2 (0.6%)
United States of America	2 (0.6%)

South & South East Asia	22 (6.1%)
Dem. Republic of Timor-Leste	1 (0.3%)
India	2 (0.6%)
Iran	1 (0.3%)
Pakistan	2 (0.6%)
Thailand	16 (4.4%)

Eastern Europe & Central Asia	22 (6.1%)
Croatia	1 (0.3%)
Hungary	1 (0.3%)
Latvia	7 (1.9%)
Poland	9 (2.5%)
Romania	2 (0.6%)
Russian Federation	2 (0.6%)

Western Europe	24 (6.6%)
Belgium	1 (0.3%)
France	2 (0.6%)
Germany	3 (0.8%)
Greece	4 (1.1%)
Italy	2 (0.6%)
Netherlands	1 (0.3%)
Portugal	3 (0.8%)
Republic of Ireland	1 (0.3%)
Spain	7 (1.9%)

Oceania	3 (0.8%)
Australia	3 (0.8%)

Caribbean	3 (0.8%)
Barbados	1 (0.3%)
Jamaica	2 (0.6%)

North Africa & Middle East	6 (1.7%)
Kuwait	1 (0.3%)
Qatar	1 (0.3%)
Sudan	2 (0.6%)
Turkey	1 (0.3%)
United Arab Emirates	1 (0.3%)

Latin America	1 (0.3%)
Brazil	1 (0.3%)

Multiple	2 (0.6%)
Unknown	14 (3.9%)

Total	361
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Table 2.1: Age distribution, stage of HIV disease and ethnic group of new HIV and AIDS cases by infection route and sex, 2009

		Infection Route										Total (100%)
		MSM	Injecting Drug Use		Hetero- sexual		Blood/ Tissue	Mother to Child		Undeter- mined		
		M	M	F	M	F	M	M	F	M	F	
Age Group	0-14							6	6			12
	15-19	2			2	4		2	2			12
	20-24	44	1	2	7	24				2	1	81
	25-29	55	1	1	22	37				7		123
	30-34	74	5		31	70				7	3	190
	35-39	67	3		30	56				9	5	170
	40-44	60	1		37	19				9		126
	45-49	29			27	19	1			7	2	85
	50-54	16	1		9	6				2	1	35
	55-59	9			8	5				2		24
	60+	8			10	1				4		23
Stage of HIV Disease	Asymptomatic	226	5	3	113	170		4	5	26	6	558
	Symptomatic	32	2		18	11	1	4		3		71
	AIDS	23	2		22	24			3	3	2	79
	AIDS Related Death	2	1		6	3						12
	Death Unrelated to AIDS									2		2
	Unknown	81	2		24	33				15	4	159
Ethnicity	White	330	10	3	69	44	1		1	28	2	488
	Black Caribbean	5			1	4				1		11
	Black African	5	1		95	183		8	7	2	6	307
	Black Other	1			2	1						4
	Indian/Pakistani/Bangladeshi	5			5					1	1	12
	Other Asian/Oriental	3			5	4						12
	Other/Mixed	7			4	1				1		13
	Unknown	8	1		2	4				16	3	34
Total	364	12	3	183	241	1	8	8	49	12	881	
%	41.3	1.4	0.3	20.8	27.4	0.1	0.9	0.9	5.6	1.4		

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

Age groups refer to the age of individuals at the end of December 2009, or at death.

Table 2.2: Local authority of residence of new HIV and AIDS cases by infection route, 2009

	Local Authority of Residence	Infection Route						Total (100%)
		MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	Carlisle	6 (85.7%)					1 (14.3%)	7
	Allerdale	1 (100%)						1
	Eden			1 (100%)				1
	Copeland	2 (100%)						2
	South Lakeland	1 (100%)						1
	Barrow-in-Furness	1 (25%)		3 (75%)				4
	Cumbria Total	11 (68.8%)		4 (25%)			1 (6.3%)	16
Lancashire	Lancaster	4 (44.4%)		4 (44.4%)		1 (11.1%)		9
	Wyre	1 (33.3%)		2 (66.7%)				3
	Fylde	3 (42.9%)		3 (42.9%)			1 (14.3%)	7
	Blackpool	19 (59.4%)		13 (40.6%)				32
	Blackburn with Darwen	5 (27.8%)		11 (61.1%)		1 (5.6%)	1 (5.6%)	18
	Ribble Valley			1 (100%)				1
	Pendle	3 (75%)	1 (25%)					4
	Burnley	2 (40%)		3 (60%)				5
	Rosendale	5 (100%)						5
	Preston	3 (37.5%)		3 (37.5%)			2 (25%)	8
	South Ribble	4 (100%)						4
	Chorley	2 (28.6%)		5 (71.4%)				7
	West Lancashire	2 (100%)						2
	Unknown Lancashire			1 (100%)				1
	Lancashire Total	53 (50%)	1 (0.9%)	46 (43.4%)		2 (1.9%)	4 (3.8%)	106
Greater Manchester	Wigan	7 (33.3%)		10 (47.6%)			4 (19%)	21
	Bolton	5 (13.9%)	2 (5.6%)	26 (72.2%)		2 (5.6%)	1 (2.8%)	36
	Bury	13 (54.2%)		8 (33.3%)			3 (12.5%)	24
	Rochdale	4 (16.7%)	1 (4.2%)	17 (70.8%)			2 (8.3%)	24
	Oldham	4 (17.4%)		17 (73.9%)			2 (8.7%)	23
	Salford	36 (48%)		35 (46.7%)			4 (5.3%)	75
	Manchester	90 (42.1%)	3 (1.4%)	103 (48.1%)	1 (0.5%)	6 (2.8%)	11 (5.1%)	214
	Tameside	8 (30.8%)		17 (65.4%)		1 (3.8%)		26
	Trafford	10 (55.6%)		7 (38.9%)			1 (5.6%)	18
	Stockport	5 (50%)		3 (30%)		1 (10%)	1 (10%)	10
	Unknown Greater Manchester	20 (74.1%)		7 (25.9%)				27
	Greater Manchester Total	202 (40.6%)	6 (1.2%)	250 (50.2%)	1 (0.2%)	10 (2%)	29 (5.8%)	498
Merseyside	Sefton	7 (22.6%)	4 (12.9%)	15 (48.4%)			5 (16.1%)	31
	Liverpool	27 (27.8%)	2 (2.1%)	58 (59.8%)		2 (2.1%)	8 (8.2%)	97
	Knowsley	8 (72.7%)		3 (27.3%)				11
	Wirral	2 (18.2%)		8 (72.7%)		1 (9.1%)		11
	St Helens	5 (38.5%)		7 (53.8%)			1 (7.7%)	13
	Merseyside Total	49 (30.1%)	6 (3.7%)	91 (55.8%)		3 (1.8%)	14 (8.6%)	163
Cheshire	Halton	4 (50%)		4 (50%)				8
	Warrington	4 (44.4%)		5 (55.6%)				9
	Cheshire West and Chester	8 (53.3%)		7 (46.7%)				15
	Cheshire East	8 (57.1%)	1 (7.1%)	5 (35.7%)				14
	Cheshire Total	24 (52.2%)	1 (2.2%)	21 (45.7%)				46
Total North West Residents		339 (40.9%)	14 (1.7%)	412 (49.7%)	1 (0.1%)	15 (1.8%)	48 (5.8%)	829
Isle of Man				1 (100%)				1
Out of Region		9 (47.4%)		3 (15.8%)		1 (5.3%)	6 (31.6%)	19
Unknown*		16 (50%)	1 (3.1%)	8 (25%)			7 (21.9%)	32
Total		364 (41.3%)	15 (1.7%)	424 (48.1%)	1 (0.1%)	16 (1.8%)	61 (6.9%)	881

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

* Includes one person of no fixed abode.

Table 2.3: Local authority of residence of new HIV and AIDS cases by stage of HIV disease, 2009

	Local Authority of Residence	Stage of Disease					Unknown	Total (100%)
		Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS		
Cumbria	Carlisle	5 (71.4%)		2 (28.6%)				7
	Allerdale	1 (100%)						1
	Eden	1 (100%)						1
	Copeland	1 (50%)	1 (50%)					2
	South Lakeland	1 (100%)						1
	Barrow-in-Furness	2 (50%)		2 (50%)				4
	Cumbria Total	11 (68.8%)	1 (6.3%)	4 (25%)				16
Lancashire	Lancaster	7 (77.8%)	1 (11.1%)	1 (11.1%)				9
	Wyre		1 (33.3%)	1 (33.3%)			1 (33.3%)	3
	Fylde	1 (14.3%)	3 (42.9%)	1 (14.3%)			2 (28.6%)	7
	Blackpool	15 (46.9%)	4 (12.5%)	1 (3.1%)	2 (6.3%)		10 (31.3%)	32
	Blackburn with Darwen	11 (61.1%)	4 (22.2%)	2 (11.1%)			1 (5.6%)	18
	Ribble Valley		1 (100%)					1
	Pendle	4 (100%)						4
	Burnley	4 (80%)	1 (20%)					5
	Rossendale	4 (80%)	1 (20%)					5
	Preston	3 (37.5%)	3 (37.5%)	1 (12.5%)			1 (12.5%)	8
	South Ribble	3 (75%)					1 (25%)	4
	Chorley	4 (57.1%)	1 (14.3%)				2 (28.6%)	7
	West Lancashire	2 (100%)						2
	Unknown Lancashire						1 (100%)	1
	Lancashire Total	58 (54.7%)	20 (18.9%)	7 (6.6%)	2 (1.9%)		19 (17.9%)	106
Greater Manchester	Wigan	14 (66.7%)		4 (19%)			3 (14.3%)	21
	Bolton	29 (80.6%)		5 (13.9%)	1 (2.8%)		1 (2.8%)	36
	Bury	18 (75%)	1 (4.2%)	3 (12.5%)			2 (8.3%)	24
	Rochdale	20 (83.3%)	2 (8.3%)	1 (4.2%)	1 (4.2%)			24
	Oldham	18 (78.3%)	2 (8.7%)	1 (4.3%)			2 (8.7%)	23
	Salford	46 (61.3%)	11 (14.7%)	5 (6.7%)	1 (1.3%)		12 (16%)	75
	Manchester	103 (48.1%)	18 (8.4%)	24 (11.2%)	3 (1.4%)	1 (0.5%)	65 (30.4%)	214
	Tameside	16 (61.5%)	3 (11.5%)	3 (11.5%)			4 (15.4%)	26
	Trafford	10 (55.6%)	1 (5.6%)	4 (22.2%)			3 (16.7%)	18
	Stockport	6 (60%)	2 (20%)	2 (20%)				10
	Unknown Greater Manchester	13 (48.1%)		1 (3.7%)			13 (48.1%)	27
	Greater Manchester Total	293 (58.8%)	40 (8%)	53 (10.6%)	6 (1.2%)	1 (0.2%)	105 (21.1%)	498
Merseyside	Sefton	29 (93.5%)					2 (6.5%)	31
	Liverpool	87 (89.7%)	1 (1%)	1 (1%)	1 (1%)	1 (1%)	6 (6.2%)	97
	Knowsley	9 (81.8%)	1 (9.1%)				1 (9.1%)	11
	Wirral	5 (45.5%)	2 (18.2%)	4 (36.4%)				11
	St Helens	10 (76.9%)	1 (7.7%)		2 (15.4%)			13
	Merseyside Total	140 (85.9%)	5 (3.1%)	5 (3.1%)	3 (1.8%)	1 (0.6%)	9 (5.5%)	163
Cheshire	Halton	7 (87.5%)			1 (12.5%)			8
	Warrington	8 (88.9%)					1 (11.1%)	9
	Cheshire West and Chester	9 (60%)	2 (13.3%)	4 (26.7%)				15
	Cheshire East	9 (64.3%)	1 (7.1%)	2 (14.3%)			2 (14.3%)	14
	Cheshire Total	33 (71.7%)	3 (6.5%)	6 (13%)	1 (2.2%)		3 (6.5%)	46
Total North West Residents		535 (64.5%)	69 (8.3%)	75 (9%)	12 (1.4%)	2 (0.2%)	136 (16.4%)	829
Isle of Man			1 (100%)					1
Out of Region		14 (73.7%)	1 (5.3%)	2 (10.5%)			2 (10.5%)	19
Unknown*		9 (28.1%)		2 (6.3%)			21 (65.6%)	32
Total		558 (63.3%)	71 (8.1%)	79 (9%)	12 (1.4%)	2 (0.2%)	159 (18%)	881

* Includes one person of no fixed abode.

Table 2.4: New HIV and AIDS cases by stage of HIV disease, infection route and sex, 2009

	Stage of disease	Infection Route										Total (100%)	
		MSM		Injecting Drug Use		Heterosexual		Blood/Tissue	Mother to Child		Undetermined		
		M	M	F	M	F	M	M	F	M	F		
Total North West Residents	Asymptomatic	215	5	3	110	168		3	5	20	6	535	
	Symptomatic	31	2		18	10	1	4		3		69	
	AIDS	22	1		22	22			3	3	2	75	
	AIDS Related Death	2	1		6	3						12	
	Death Unrelated to AIDS									2		2	
	Unknown	69	2		23	30				10	2	136	
	Total	339	11	3	179	233	1	7	8	38	10	829	
%	40.9	1.3	0.4	21.6	28.1	0.1	0.8	1.0	4.6	1.2			
All individuals treated in North West	Asymptomatic	226	5	3	113	170		4	5	26	6	558	
	Symptomatic	32	2		18	11	1	4		3		71	
	AIDS	23	2		22	24			3	3	2	79	
	AIDS Related Death	2	1		6	3						12	
	Death Unrelated to AIDS									2		2	
	Unknown	81	2		24	33				15	4	159	
	Total	364	12	3	183	241	1	8	8	49	12	881	
%	41.3	1.4	0.3	20.8	27.4	0.1	0.9	0.9	5.6	1.4			

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

Table 2.5: New HIV and AIDS cases by age category and ethnic group, 2009

	Age Group	Ethnicity								Total (100%)
		White	Black Caribbean	Black African	Black Other	Indian/Pakistani/Bangladeshi	Other Asian/Oriental	Other/Mixed	Unknown	
Total North West Residents	0-14	1		10						11
	15-19	6		5						11
	20-24	60		12	1	1		2	1	77
	25-29	61	3	37		5	1	2	7	116
	30-34	85	2	82		2	3	3	4	181
	35-39	81	2	69	1	1	3	1	4	162
	40-44	65	2	44	1		3	1	3	119
	45-49	45		26	1		1	1	4	78
	50-54	20		9				1	1	31
	55-59	16		6					1	23
	60+	16		1		2			1	20
	Total	456	9	301	4	11	11	11	26	829
%	55.0	1.1	36.3	0.5	1.3	1.3	1.3	3.1		
All individuals treated in North West	0-14	1		11						12
	15-19	6		6						12
	20-24	63	1	12	1	1		2	1	81
	25-29	66	3	39		5	1	2	7	123
	30-34	92	3	82		2	3	4	4	190
	35-39	85	2	70	1	1	4	1	6	170
	40-44	71	2	44	1		3	1	4	126
	45-49	49		27	1		1	1	6	85
	50-54	21		9		1		1	3	35
	55-59	16		6				1	1	24
	60+	18		1		2			2	23
	Total	488	11	307	4	12	12	13	34	881
%	55.4	1.2	34.8	0.5	1.4	1.4	1.5	3.9		

Age groups refer to the ages of individuals at the end of December 2009, or at death.

Table 2.6: Sex, stage of HIV disease and HIV exposure abroad of new HIV and AIDS cases by ethnic group, 2009

		Ethnicity							Total (100%)	
		White	Black Caribbean	Black African	Black Other	Indian/Pakistani/Bangladeshi	Other Asian/Oriental	Other/Mixed		Unknown
Sex	Male	438 (71%)	7 (1.1%)	111 (18%)	3 (0.5%)	11 (1.8%)	8 (1.3%)	12 (1.9%)	27 (4.4%)	617
	Female	50 (18.9%)	4 (1.5%)	196 (74.2%)	1 (0.4%)	1 (0.4%)	4 (1.5%)	1 (0.4%)	7 (2.7%)	264
Stage of Disease	Asymptomatic	298 (53.4%)	7 (1.3%)	209 (37.5%)	2 (0.4%)	6 (1.1%)	10 (1.8%)	7 (1.3%)	19 (3.4%)	558
	Symptomatic	44 (62%)		25 (35.2%)					2 (2.8%)	71
	AIDS	41 (51.9%)		31 (39.2%)	2 (2.5%)		1 (1.3%)	2 (2.5%)	2 (2.5%)	79
	AIDS Related Death	6 (50%)		5 (41.7%)		1 (8.3%)				12
	Death Unrelated to AIDS	1 (50%)							1 (50%)	2
	Unknown	98 (61.6%)	4 (2.5%)	37 (23.3%)		5 (3.1%)	1 (0.6%)	4 (2.5%)	10 (6.3%)	159
HIV Exposure Abroad	UK	345 (91.8%)	5 (1.3%)	10 (2.7%)	2 (0.5%)	6 (1.6%)		3 (0.8%)	5 (1.3%)	376
	Abroad	74 (20.5%)	4 (1.1%)	261 (72.3%)	1 (0.3%)	2 (0.6%)	9 (2.5%)	7 (1.9%)	3 (0.8%)	361
	Unknown	69 (47.9%)	2 (1.4%)	36 (25%)	1 (0.7%)	4 (2.8%)	3 (2.1%)	3 (2.1%)	26 (18.1%)	144
Total		488 (55.4%)	11 (1.2%)	307 (34.8%)	4 (0.5%)	12 (1.4%)	12 (1.4%)	13 (1.5%)	34 (3.9%)	881

Table 2.7: Global region of exposure by infection route for new HIV and AIDS cases, 2009

Region of HIV Exposure	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Abroad	41 (11.4%)	7 (1.9%)	287 (79.5%)	1 (0.3%)	12 (3.3%)	13 (3.6%)	361
<i>Caribbean</i>	2		1				3
<i>Eastern Europe & Central Asia</i>	6	5	11				22
<i>Latin America</i>	1						1
<i>North Africa & Middle East</i>	2		3		1		6
<i>North America</i>	1		1				2
<i>Oceania</i>	3						3
<i>South & South East Asia</i>	5		14	1		2	22
<i>Sub-Saharan Africa</i>	3	1	238		11	9	262
<i>Western Europe</i>	15	1	7			1	24
<i>Multiple</i>	1					1	2
<i>Unknown</i>	2		12				14
UK	277 (73.7%)	5 (1.3%)	81 (21.5%)		4 (1.1%)	9 (2.4%)	376
Unknown	46 (31.9%)	3 (2.1%)	56 (38.9%)			39 (27.1%)	144
Total	364 (41.3%)	15 (1.7%)	424 (48.1%)	1 (0.1%)	16 (1.8%)	61 (6.9%)	881

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

Table 2.8: Distribution of treatment for new HIV and AIDS cases by infection route, 2009

Treatment Centre	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
AHC					3 (100%)		3
APH	3 (30%)		7 (70%)				10
ARM	2 (100%)						2
BLAG	21 (55.3%)		16 (42.1%)			1 (2.6%)	38
BLKG	6 (33.3%)	1 (5.6%)	10 (55.6%)			1 (5.6%)	18
BOLG	10 (18.9%)	2 (3.8%)	40 (75.5%)			1 (1.9%)	53
BURG	6 (54.5%)	1 (9.1%)	4 (36.4%)				11
BURY	2 (33.3%)		4 (66.7%)				6
CHR	6 (46.2%)		7 (53.8%)				13
CUMB	9 (81.8%)		1 (9.1%)			1 (9.1%)	11
FGH			3 (100%)				3
HAL	2 (66.7%)		1 (33.3%)				3
JAR	7 (46.7%)	1 (6.7%)	5 (33.3%)			2 (13.3%)	15
LCN	3 (30%)	2 (20%)	4 (40%)			1 (10%)	10
LEI	8 (66.7%)		4 (33.3%)				12
MAC	4 (100%)						4
MGP	11 (100%)						11
MRIG	115 (57.5%)		77 (38.5%)			8 (4%)	200
NMG	40 (28.4%)	5 (3.5%)	75 (53.2%)	1 (0.7%)	11 (7.8%)	9 (6.4%)	141
NMGG	17 (51.5%)	1 (3%)	8 (24.2%)			7 (21.2%)	33
NOBL			1 (100%)				1
OLDG	4 (20%)		15 (75%)			1 (5%)	20
PG	11 (42.3%)		12 (46.2%)			3 (11.5%)	26
RLG	37 (27%)	1 (0.7%)	86 (62.8%)		1 (0.7%)	12 (8.8%)	137
RLI	4 (50%)		3 (37.5%)		1 (12.5%)		8
ROCG	2 (20%)		8 (80%)				10
SALG	13 (31.7%)		27 (65.9%)			1 (2.4%)	41
SHH	13 (61.9%)		4 (19%)			4 (19%)	21
SPG	5 (26.3%)	4 (21.1%)	8 (42.1%)			2 (10.5%)	19
STP	3 (42.9%)		3 (42.9%)			1 (14.3%)	7
TAMG	5 (27.8%)	1 (5.6%)	12 (66.7%)				18
TRAG	5 (62.5%)		3 (37.5%)				8
WAR	4 (44.4%)		5 (55.6%)				9
WGH	1 (100%)						1
WIGG	1 (12.5%)		2 (25%)			5 (62.5%)	8
WITG	24 (66.7%)		10 (27.8%)			2 (5.6%)	36
WORK	1 (100%)						1

*For a definition of the abbreviated statutory treatment centres please refer to the glossary at the back of the report.
Columns cannot be totalled as some individuals may attend two or more treatment locations, thus exaggerating the totals.
Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.*

Table 2.9: Residency status of new HIV and AIDS cases by sex, age group, infection route, ethnicity, stage of HIV disease and area of residence, 2009

		Residency Status							Total
		UK National	Asylum Seeker	Overseas Student	Temporary Visitor	Refugee	Other*	Unknown	
Sex	Male	422 (83.7%)	35 (36.1%)	8 (47.1%)	5 (83.3%)	5 (31.3%)	11 (42.3%)	131 (60.9%)	617 (70%)
	Female	82 (16.3%)	62 (63.9%)	9 (52.9%)	1 (16.7%)	11 (68.8%)	15 (57.7%)	84 (39.1%)	264 (30%)
Age Group	0-14	1 (0.2%)					2 (7.7%)	9 (4.2%)	12 (1.4%)
	15-19	4 (0.8%)	3 (3.1%)			2 (12.5%)	1 (3.8%)	2 (0.9%)	12 (1.4%)
	20-24	63 (12.5%)	4 (4.1%)	3 (17.6%)			2 (7.7%)	9 (4.2%)	81 (9.2%)
	25-29	73 (14.5%)	5 (5.2%)	3 (17.6%)	4 (66.7%)	1 (6.3%)	5 (19.2%)	32 (14.9%)	123 (14%)
	30-34	94 (18.7%)	34 (35.1%)	5 (29.4%)	1 (16.7%)	8 (50%)	4 (15.4%)	44 (20.5%)	190 (21.6%)
	35-39	92 (18.3%)	20 (20.6%)	3 (17.6%)		1 (6.3%)	6 (23.1%)	48 (22.3%)	170 (19.3%)
	40-44	68 (13.5%)	19 (19.6%)		1 (16.7%)		5 (19.2%)	33 (15.3%)	126 (14.3%)
	45-49	55 (10.9%)	5 (5.2%)	2 (11.8%)		4 (25%)		19 (8.8%)	85 (9.6%)
	50-54	20 (4%)	5 (5.2%)	1 (5.9%)				9 (4.2%)	35 (4%)
	55-59	17 (3.4%)	2 (2.1%)				1 (3.8%)	4 (1.9%)	24 (2.7%)
60+	17 (3.4%)						6 (2.8%)	23 (2.6%)	
Infection Route	MSM	307 (60.9%)	3 (3.1%)	1 (5.9%)	3 (50%)		6 (23.1%)	44 (20.5%)	364 (41.3%)
	Injecting Drug Use	6 (1.2%)	1 (1%)				1 (3.8%)	7 (3.3%)	15 (1.7%)
	Heterosexual	167 (33.1%)	89 (91.8%)	14 (82.4%)	3 (50%)	15 (93.8%)	16 (61.5%)	120 (55.8%)	424 (48.1%)
	Blood/Tissue							1 (0.5%)	1 (0.1%)
	Mother to Child	1 (0.2%)	3 (3.1%)			1 (6.3%)	2 (7.7%)	9 (4.2%)	16 (1.8%)
	Undetermined	23 (4.6%)	1 (1%)	2 (11.8%)			1 (3.8%)	34 (15.8%)	61 (6.9%)
Ethnicity	White	417 (82.7%)			2 (33.3%)	1 (6.3%)	8 (30.8%)	60 (27.9%)	488 (55.4%)
	Black Caribbean	8 (1.6%)						3 (1.4%)	11 (1.2%)
	Black African	54 (10.7%)	91 (93.8%)	16 (94.1%)	3 (50%)	15 (93.8%)	15 (57.7%)	113 (52.6%)	307 (34.8%)
	Black Other	2 (0.4%)	1 (1%)					1 (0.5%)	4 (0.5%)
	Indian/Pakistani/Bangladeshi	8 (1.6%)						4 (1.9%)	12 (1.4%)
	Other Asian/Oriental	5 (1%)	4 (4.1%)					3 (1.4%)	12 (1.4%)
	Other/Mixed	5 (1%)	1 (1%)	1 (5.9%)	1 (16.7%)		3 (11.5%)	2 (0.9%)	13 (1.5%)
Unknown	5 (1%)						29 (13.5%)	34 (3.9%)	
Stage of HIV Disease	Asymptomatic	311 (61.7%)	75 (77.3%)	10 (58.8%)	5 (83.3%)	13 (81.3%)	17 (65.4%)	127 (59.1%)	558 (63.3%)
	Symptomatic	45 (8.9%)	8 (8.2%)					18 (8.4%)	71 (8.1%)
	AIDS	38 (7.5%)	10 (10.3%)	3 (17.6%)	1 (16.7%)	1 (6.3%)	2 (7.7%)	24 (11.2%)	79 (9%)
	AIDS Related Death	6 (1.2%)	1 (1%)			1 (6.3%)	1 (3.8%)	3 (1.4%)	12 (1.4%)
	Death Unrelated to AIDS	1 (0.2%)						1 (0.5%)	2 (0.2%)
	Unknown	103 (20.4%)	3 (3.1%)	4 (23.5%)		1 (6.3%)	6 (23.1%)	42 (19.5%)	159 (18%)
Area of Residence	Cumbria	15 (3%)						1 (0.5%)	16 (1.8%)
	Lancashire	88 (17.5%)	5 (5.2%)	1 (5.9%)		3 (18.8%)	4 (15.4%)	5 (2.3%)	106 (12%)
	Greater Manchester	243 (48.2%)	44 (45.4%)	15 (88.2%)	6 (100%)	13 (81.3%)	14 (53.8%)	163 (75.8%)	498 (56.5%)
	Merseyside	84 (16.7%)	47 (48.5%)	1 (5.9%)			4 (15.4%)	27 (12.6%)	163 (18.5%)
	Cheshire	41 (8.1%)	1 (1%)				1 (3.8%)	3 (1.4%)	46 (5.2%)
	Out of Region**	14 (2.8%)						6 (2.8%)	20 (2.3%)
	Unknown***	19 (3.8%)					3 (11.5%)	10 (4.7%)	32 (3.6%)
Total (100%)		504	97	17	6	16	26	215	881

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

Age groups refer to the age of individuals at the end of December 2009, or at death.

* Includes residency status defined as 'Migrant Worker', 'Dependent', and 'Other'.

** Includes Isle of Man.

*** Includes one person of no fixed abode.

Table 2.10: Primary care trust (PCT) of residence of new HIV and AIDS cases by infection route, 2009

PCT of Residence	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Cumbria	11 (68.8%)		4 (25%)			1 (6.3%)	16
North Lancashire	8 (42.1%)		9 (47.4%)		1 (5.3%)	1 (5.3%)	19
Blackpool	19 (59.4%)		13 (40.6%)				32
Blackburn with Darwen	5 (27.8%)		11 (61.1%)		1 (5.6%)	1 (5.6%)	18
East Lancashire	10 (66.7%)	1 (6.7%)	4 (26.7%)				15
Central Lancashire	11 (52.4%)		8 (38.1%)			2 (9.5%)	21
Unknown Lancashire			1 (100%)				1
Ashton, Leigh & Wigan	7 (33.3%)		10 (47.6%)			4 (19%)	21
Bolton	5 (13.9%)	2 (5.6%)	26 (72.2%)		2 (5.6%)	1 (2.8%)	36
Bury	13 (54.2%)		8 (33.3%)			3 (12.5%)	24
Heywood, Middleton & Rochdale	4 (16.7%)	1 (4.2%)	17 (70.8%)			2 (8.3%)	24
Oldham	4 (17.4%)		17 (73.9%)			2 (8.7%)	23
Salford	36 (48%)		35 (46.7%)			4 (5.3%)	75
Manchester	90 (42.1%)	3 (1.4%)	103 (48.1%)	1 (0.5%)	6 (2.8%)	11 (5.1%)	214
Tameside & Glossop	8 (30.8%)		17 (65.4%)		1 (3.8%)		26
Trafford	10 (55.6%)		7 (38.9%)			1 (5.6%)	18
Stockport	5 (50%)		3 (30%)		1 (10%)	1 (10%)	10
Unknown Greater Manchester	20 (74.1%)		7 (25.9%)				27
Sefton	7 (22.6%)	4 (12.9%)	15 (48.4%)			5 (16.1%)	31
Liverpool	27 (27.8%)	2 (2.1%)	58 (59.8%)		2 (2.1%)	8 (8.2%)	97
Knowsley	8 (72.7%)		3 (27.3%)				11
Wirral	2 (18.2%)		8 (72.7%)		1 (9.1%)		11
Halton & St Helens	9 (42.9%)		11 (52.4%)			1 (4.8%)	21
Warrington	4 (44.4%)		5 (55.6%)				9
Western Cheshire	6 (54.5%)		5 (45.5%)				11
Central and Eastern Cheshire	10 (55.6%)	1 (5.6%)	7 (38.9%)				18
Isle of Man			1 (100%)				1
Out of Region	9 (47.4%)		3 (15.8%)		1 (5.3%)	6 (31.6%)	19
Unknown*	16 (50%)	1 (3.1%)	8 (25%)			7 (21.9%)	32
Total	364 (41.3%)	15 (1.7%)	424 (48.1%)	1 (0.1%)	16 (1.8%)	61 (6.9%)	881

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

* Includes one person of no fixed abode.

Table 2.11: Primary care trust (PCT) of residence of new HIV and AIDS cases by stage of disease, 2009

PCT of Residence	Stage of Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	11 (68.8%)	1 (6.3%)	4 (25%)				16
North Lancashire	8 (42.1%)	5 (26.3%)	3 (15.8%)			3 (15.8%)	19
Blackpool	15 (46.9%)	4 (12.5%)	1 (3.1%)	2 (6.3%)		10 (31.3%)	32
Blackburn with Darwen	11 (61.1%)	4 (22.2%)	2 (11.1%)			1 (5.6%)	18
East Lancashire	12 (80%)	3 (20%)					15
Central Lancashire	12 (57.1%)	4 (19%)	1 (4.8%)			4 (19%)	21
Unknown Lancashire						1 (100%)	1
Ashton, Leigh & Wigan	14 (66.7%)		4 (19%)			3 (14.3%)	21
Bolton	29 (80.6%)		5 (13.9%)	1 (2.8%)		1 (2.8%)	36
Bury	18 (75%)	1 (4.2%)	3 (12.5%)			2 (8.3%)	24
Heywood, Middleton & Rochdale	20 (83.3%)	2 (8.3%)	1 (4.2%)	1 (4.2%)			24
Oldham	18 (78.3%)	2 (8.7%)	1 (4.3%)			2 (8.7%)	23
Salford	46 (61.3%)	11 (14.7%)	5 (6.7%)	1 (1.3%)		12 (16%)	75
Manchester	103 (48.1%)	18 (8.4%)	24 (11.2%)	3 (1.4%)	1 (0.5%)	65 (30.4%)	214
Tameside & Glossop	16 (61.5%)	3 (11.5%)	3 (11.5%)			4 (15.4%)	26
Trafford	10 (55.6%)	1 (5.6%)	4 (22.2%)			3 (16.7%)	18
Stockport	6 (60%)	2 (20%)	2 (20%)				10
Unknown Greater Manchester	13 (48.1%)		1 (3.7%)			13 (48.1%)	27
Sefton	29 (93.5%)					2 (6.5%)	31
Liverpool	87 (89.7%)	1 (1%)	1 (1%)	1 (1%)	1 (1%)	6 (6.2%)	97
Knowsley	9 (81.8%)	1 (9.1%)				1 (9.1%)	11
Wirral	5 (45.5%)	2 (18.2%)	4 (36.4%)				11
Halton & St Helens	17 (81%)	1 (4.8%)		3 (14.3%)			21
Warrington	8 (88.9%)					1 (11.1%)	9
Western Cheshire	7 (63.6%)	2 (18.2%)	2 (18.2%)				11
Central and Eastern Cheshire	11 (61.1%)	1 (5.6%)	4 (22.2%)			2 (11.1%)	18
Isle of Man		1 (100%)					1
Out of Region	14 (73.7%)	1 (5.3%)	2 (10.5%)			2 (10.5%)	19
Unknown*	9 (28.1%)		2 (6.3%)			21 (65.6%)	32
Total	558 (63.3%)	71 (8.1%)	79 (9%)	12 (1.4%)	2 (0.2%)	159 (18%)	881

* Includes one person of no fixed abode.

3. All Cases 2009

During 2009, a total of 6,238 individuals living with HIV accessed treatment and care from statutory treatment centres in the North West, representing an 8% increase in the size of the HIV positive population (from 5,767 individuals in 2008). This is a slightly smaller increase than that seen between 2007 and 2008 (11%). This figure is very close to the figure predicted (6,211 individuals) using the historical pattern seen at the mid year points from 2004 to 2008^[79]. The aim of this chapter is to provide information on the demographics and characteristics of these 6,238 individuals and, where appropriate, references are made to corresponding data from previous North West reports^[1-13]. For reasons of confidentiality and space, it is not possible to present all breakdowns at local authority (LA) and primary care trust (PCT) level. However, additional tables are available on the North West Public Health Observatory website: www.nwpho.org.uk/hiv2009.

Epidemiology of HIV in the North West

Figure 3.1 illustrates the crude population prevalence of HIV in the North West based on all cases who resided in the North West and attended statutory treatment centres within the region during 2009[§]. The population sizes for each LA used in the prevalence calculations are provided by the North West Public Health Observatory and are mid-2008 estimates based on 2001 census data. Across the region, the prevalence of HIV was 80.3 per 100,000 population. There was a more than ten-fold difference between LAs: the prevalence in Manchester LA was 365.6 per 100,000, Salford was 229.6 per 100,000 and Blackpool 203.6 per 100,000. The areas with the lowest prevalence were Allerdale (18.7 per 100,000), Copeland (19.8 per 100,000) and Halton (21.8 per 100,000 population).

Figure 3.2 illustrates the global region and country of infection for those 2,313 HIV positive individuals presenting for treatment in the North West in 2009 who were probably infected abroad. Of all the infections contracted outside the United Kingdom, 71% were acquired in sub-Saharan Africa. This high proportion reflects the impact of the pandemic in sub-Saharan Africa where the prevalence of HIV is extremely high^[14]. Nine percent of people who were infected abroad were infected in South and South East Asia, with a similar proportion (8%) in Western Europe. The exact country of infection is known for 2,136 individuals (92%). The infections acquired outside the UK were spread across 104 different countries, with the largest number of infections contracted in Zimbabwe (32%). The second largest number of infections acquired outside the UK were acquired in Thailand (145 cases; 6%). Exposure in sub-Saharan Africa was spread across 36

countries. Of those infected in Western Europe, the largest number were infected in Spain (57 individuals), reflecting the extent of the epidemic in that country^[14], the large number of people who travel between the United Kingdom and Spain and the increased propensity to take risks when on holiday^[85-88].

Table 3.1 shows the infection route and sex of all HIV and AIDS cases presenting in the North West for treatment in 2009, categorised by age group, stage of HIV disease and ethnicity. Sex between men (MSM) remains the most common route of infection amongst people with HIV in the North West (51% of all cases). However the proportion of people infected through heterosexual sex continues to increase, from 15% in 1996 to 42% in 2009. The percentage of individuals exposed to HIV via injecting drug use (IDU), those infected by contaminated blood or tissue and mother to child transmission all remain low at 2% or less per route.

On average, those who were infected through heterosexual sex were younger (median age 39 years) than those infected through MSM (42 years) and IDU (also 42 years). The overall age distribution remained concentrated in the 30-44 year age range, accounting for more than half of all cases (54%) and shows little deviation from previous years. New cases were more likely to be under 25 years (12%, see chapter 2, table 2.1) compared with all cases (6%). The proportion of HIV positive individuals in the older age groups (50 years and over) has increased steadily each year (from 14% in 2006 to 17% in 2009), which is a large increase from 7% when local monitoring began in 1996. This ageing cohort effect is likely to be due to the effectiveness of antiretroviral therapy and subsequent improved prognosis and longevity of many HIV positive individuals.

The proportion of individuals with HIV who died during the year decreased from 9% in 1996 to 1% in 2009. Of the 47 individuals who died in 2009, 51% died of an AIDS-related condition (a decrease from 56% in 2008) and 23 (49%) died of other causes.

Amongst those for whom ethnicity was known (6,179 individuals), 65% were of white ethnicity. Those from black and minority ethnic (BME) communities make up 35% of the total HIV positive population accessing care in the North West, with black Africans representing the greatest proportion within BME groups (83%).

Table 3.2 shows LA and county of residence by infection route. Although sex between men continues to be the dominant mode of HIV transmission (51%) amongst those with HIV who are resident in the North West region, there is considerable

[§] Prevalence per 100,000 population calculations include all ages and exclude those with unknown area of residence and those living outside the region.

variation at county level. Of those whose infection route was known, 64% of Lancashire's and 57% of Cheshire's HIV positive residents were infected via MSM compared with 38% of Merseyside's HIV positive residents. There is greater variation across LAs: 83% of HIV positive residents in Blackpool were infected through sex between men compared with 27% in Hyndburn. Barrow-in-Furness in Cumbria was the LA with the greatest proportion of infections acquired via heterosexual sex (68%), although absolute numbers were low. Nearly two thirds (63%; 307 individuals) of the HIV positive population living in Liverpool LA were infected through heterosexual sex. Manchester LA had the largest number of HIV positive residents infected through MSM (895 cases) and through heterosexual sex (789 cases). The county of Greater Manchester had the greatest number of HIV positive individuals infected through IDU (78 individuals) which accounts for 66% of all residents of the North West infected by this route.

Table 3.3 illustrates the LA, county of residence and stage of HIV disease for all HIV and AIDS cases presenting to a North West treatment centres in 2009. The data refer to the clinical condition of individuals when last seen in 2009; individuals who died are presented in separate categories. The greatest number of people with HIV live in Greater Manchester (60% of the total number of people seen in the North West). As in previous years, the vast majority of people treated in the North West were also resident in the North West (96%). The proportion of people at different stages of HIV disease will have an impact on the funding of HIV treatment and care, since those at a more advanced stage require more hospital care^[39]. There is variation between stages of disease across the counties; Merseyside had 63% presenting as asymptomatic, whilst Lancashire had 40%.

Table 3.4 gives a breakdown of ethnicity and county by infection route and sex. Of those infected through heterosexual sex who were treated in the North West region 72% were from BME/mixed background, compared with 28% who were of white ethnicity. In contrast, of those infected via MSM, 95% were of white ethnicity and only 4% were from BME/mixed ethnic backgrounds. Individuals from black and minority ethnic or mixed communities are substantially over-represented amongst the HIV positive population when compared with their proportion in the North West population as a whole (35% of all cases, compared with 8% of the North West population)^[81]. Prevalence in BME communities is seven times higher in the white population in the North West (data not shown). The proportion of the HIV positive population from BME/mixed backgrounds varies between counties, with Greater Manchester and Merseyside having the largest proportion (41% and 40%, respectively) whilst Cumbria has the smallest proportion (12%).

Table 3.5 shows a breakdown of age by ethnicity for all North West residents and for all those individuals treated for HIV in the region. Of all those who accessed treatment and care in the North West, black African individuals tended to be younger (55% aged between 25 and 39 years) than white individuals (38% aged 25 to 39 years).

Table 3.6 shows the distribution of total HIV and AIDS cases by stage of HIV disease, county and level of antiretroviral therapy (ART). The largest proportion of individuals (48%) were using triple therapy, followed by 26% using quadruple or more. Amongst those North West residents who had received an AIDS diagnosis, 96% were on ART. Amongst those who were asymptomatic, 62% were on ART. There was little variation between the proportion of individuals on ART between counties, ranging from 73% in Greater Manchester to 81% in Lancashire.

Table 3.7 gives a breakdown of ethnicity by sex, stage of HIV disease and whether or not individuals acquired HIV abroad. Although overall there were more males (72%) than females with HIV, amongst black Africans, 65% were female and amongst those defined as other Asian/Oriental, 59% were female. The largest proportion of HIV positive individuals were asymptomatic (49%), followed by symptomatic individuals (25%). Amongst white HIV positive individuals, 46% were asymptomatic. In contrast to the 14% of white individuals infected abroad, 80% of those classed as from black and minority ethnic groups were exposed to HIV abroad.

Table 3.8 illustrates the global region of exposure and route of infection of all HIV cases. Over a third (37%) of all cases reported were exposed to HIV abroad, up from 19% in 1998. The majority (80%) of those infected abroad were infected through heterosexual sex, the vast majority of these were infected in sub-Saharan Africa (82%). Heterosexual sex was the most common route of infection in those infected in sub-Saharan Africa (93%), the Caribbean (80%), South and South East Asia (78%), North Africa and Middle East (58%), Latin America (58%), East Asia and Pacific (57%) and Eastern Europe and Central Asia (53%). In contrast, those infected in Oceania, North America and Western Europe were more likely to have been infected through sex between men (83%, 77% and 60%, respectively).

Care of HIV positive people by North West statutory treatment centres

Table 3.9 presents the number of HIV positive people seeking care in North West treatment centres by infection route (for a list of the abbreviated treatment centres, please see the glossary at the back of this report). The Infectious Disease Unit at North Manchester General Hospital (NMG) provides care for the greatest number of HIV positive individuals in the

North West (1,614). Manchester Centre for Sexual Health at Manchester Royal Infirmary (MRIG) provided treatment for 1,199 individuals, the Royal Liverpool University Hospital department of GUM and Tropical and Infectious Disease Unit (RLG) provided care for 779 individuals and Blackpool Victoria Hospital (BLAG) provided care for 396 individuals with HIV in 2009. There is considerable variation in the profile of HIV positive individuals between different treatment centres. Ninety-six percent of individuals attending a specialist general practice in Manchester (MGP) had been exposed to HIV through sex between men compared with the overall rate of 51% of all HIV cases within the region (table 3.1). 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).

Table 3.10 refers to the highest level of ART prescribed by each treatment centres during 2009. 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 ART to 88% of their patients. The proportion taking triple or more therapy is higher in persons attending the specialist haematology centres at RLH and MRIH (91% each). There are few individuals on mono or dual therapy in accordance with the latest BHIVA guidelines^[89].

Table 3.11 illustrates the distribution of all HIV cases presenting in the North West for treatment in 2009 by LA of residence and the number of statutory treatment centres attended. The majority (91%) attended only one treatment centre. However, this varied across counties: residents of Cumbria and Cheshire were more likely to attend only one treatment centre (98% and 92% respectively), compared with people residing in Lancashire (91%), Greater Manchester (91%) and Merseyside (88%). It should be noted that these numbers refer only to treatment centres within the North West. Attendance at multiple treatment centres could be due to a change in residence or simultaneously accessing treatment and care from more than one treatment centre.

Table 3.12 shows the total and mean number of outpatient visits, day cases, inpatient episodes, inpatient days and home visits per HIV positive individual treated at each centre. NMG provided the greatest number of outpatient visits, accounting for nearly a quarter (21%) of all attendances across the region, with Manchester Centre for Sexual Health at Manchester Royal Infirmary (MRIG) reporting the second greatest number of visits. However, MRIG provided a higher mean number of outpatient visits per HIV positive person than NMG. NMG also provided the greatest number of day cases (94% of the total), inpatient episodes (43% of the total) and inpatient days (54%), with RLG providing the next highest number of inpatient episodes (20%).

Some of the treatment centres provided a significant number of home visits, with Liverpool Community Nursing (LCN) providing 45% of the total home visits, followed by Alder Hey Children's Hospital in Liverpool (AHC; 34%), NMG (8%) and BLAG (3%). AHC provided the greatest number of home visits per HIV positive person (16.6 per patient).

Asymptomatic HIV positive individuals accumulated a total of 19,251 outpatient visits. People who had received an AIDS diagnosis had the highest mean number of outpatient visits (7.2). Individuals who died of an AIDS-related illness during 2009 spent the greatest mean number of days as inpatients (23.4 days).

HIV in non-UK nationals

Table 3.13 shows the residency status of all individuals who accessed treatment and care in the North West in 2009 by sex, age group, infection route, ethnicity, stage of HIV disease and area of residence. A total of 1,242 (an increase of 124 from 2008) individuals were known to be non-UK nationals (20% of the total HIV positive population). The residency status of 7% was unknown. Over half the non-UK nationals were classified as asylum seekers (52%). Refugees (16%) and overseas students (11%) were the other main categories. Nearly two thirds (65%) of HIV positive non-UK nationals were female, compared with 16% of UK-national HIV positive individuals. There is also a large difference in the proportion of heterosexual cases between UK national and non-UK nationals (27% compared with 91%). Non-UK nationals were younger (median age 37) than UK-national HIV positive population (median age 42 years). The majority (96%) of asylum seekers were black African. Most of the known HIV positive non-UK nationals were resident in Greater Manchester (72%), with the next largest number living in Merseyside (19% of the total).

Fifty five percent of non-UK nationals were reported to be asymptomatic, suggesting that individuals usually access treatment while still healthy and thus may benefit from life-prolonging treatment. In UK nationals, 47% were classified as asymptomatic. A similar proportion of non-UK and UK nationals had received an AIDS diagnosis (23% and 21%, respectively). A similar proportion of non-UK nationals (0.4%) and UK nationals (0.8%) died in 2009.

HIV data by primary care trust (PCT) of residence

Table 3.14 shows PCT of residence by infection route. Several PCTs have a larger proportion of individuals infected through heterosexual sex than through MSM. The highest proportions of individuals infected through heterosexual sex lived in Blackburn with Darwen PCT (64%) and Liverpool PCT (63%), the same proportions seen in 2008. Eighty-three percent of those residing in Blackpool PCT were infected through sex

between men and eight percent (eight individuals) of those individuals with HIV living in Sefton PCT were infected through IDU. Amongst those residing in regions outside the North West who were treated in the region 3% were infected through blood/tissue and 5% through mother to child, suggesting that these individuals are travelling to specialist treatment centres in the region.

Table 3.15 displays PCT of residence by stage of HIV disease. There are 12 PCTs (Blackburn with Darwen; Ashton, Leigh &

Wigan; Bolton; Oldham; Salford; Manchester; Sefton; Liverpool; Knowsley; Halton & St Helens; Warrington; and Western Cheshire) where asymptomatic individuals represent a larger proportion than those who are symptomatic or have an AIDS-related illness. In all other PCTs, proportionately fewer individuals were recorded as asymptomatic. Further analyses by PCT can be found on the North West Public Health Observatory website: www.nwpho.org.uk/hiv2009.

Figure 3.1: Number of cases of HIV per 100,000 population by local authority of residence, 2009

Crude rate based on the number of cases of HIV and AIDS residing in the North West and accessing the region's treatment centres per 100,000 of the population

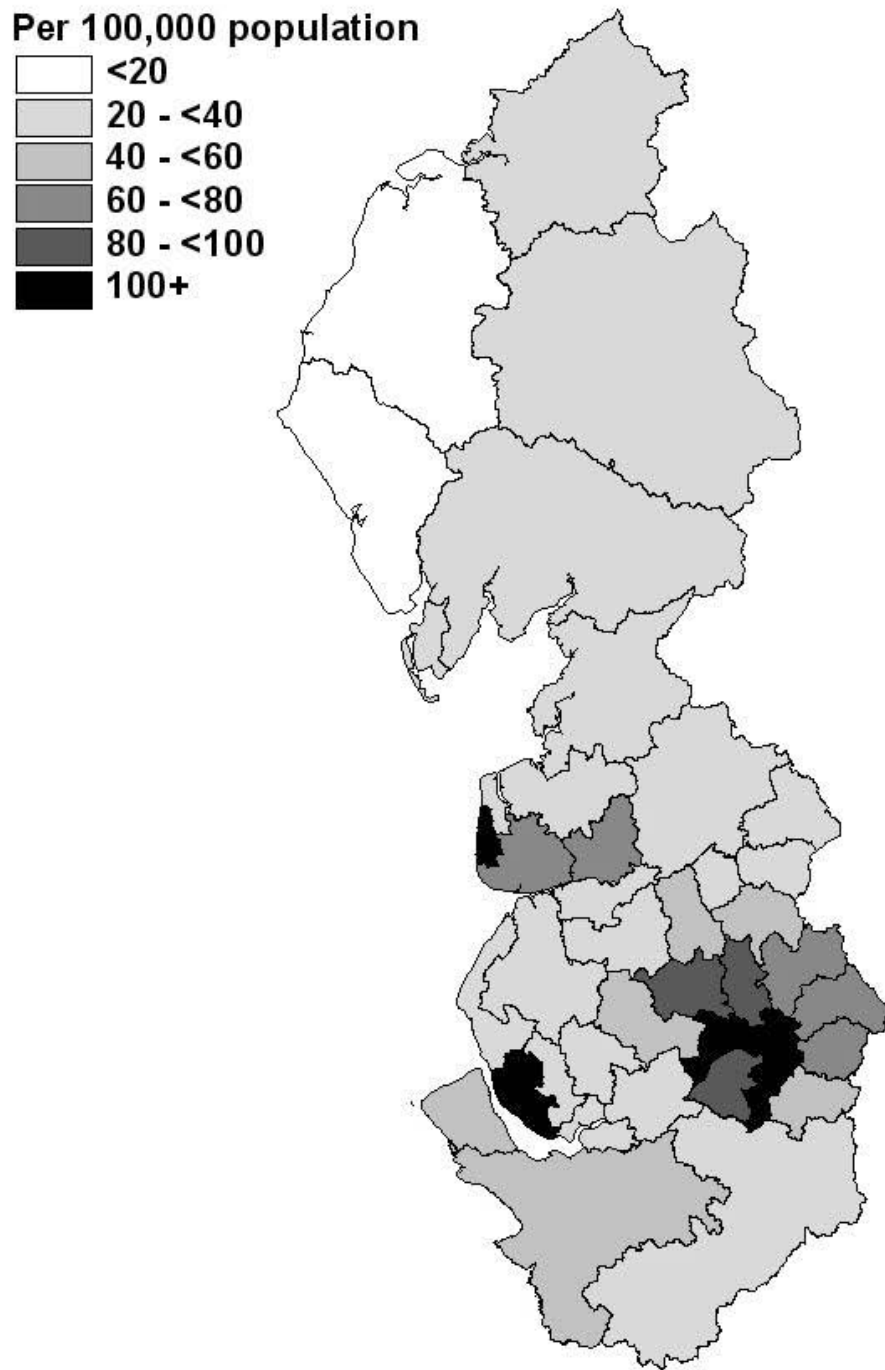
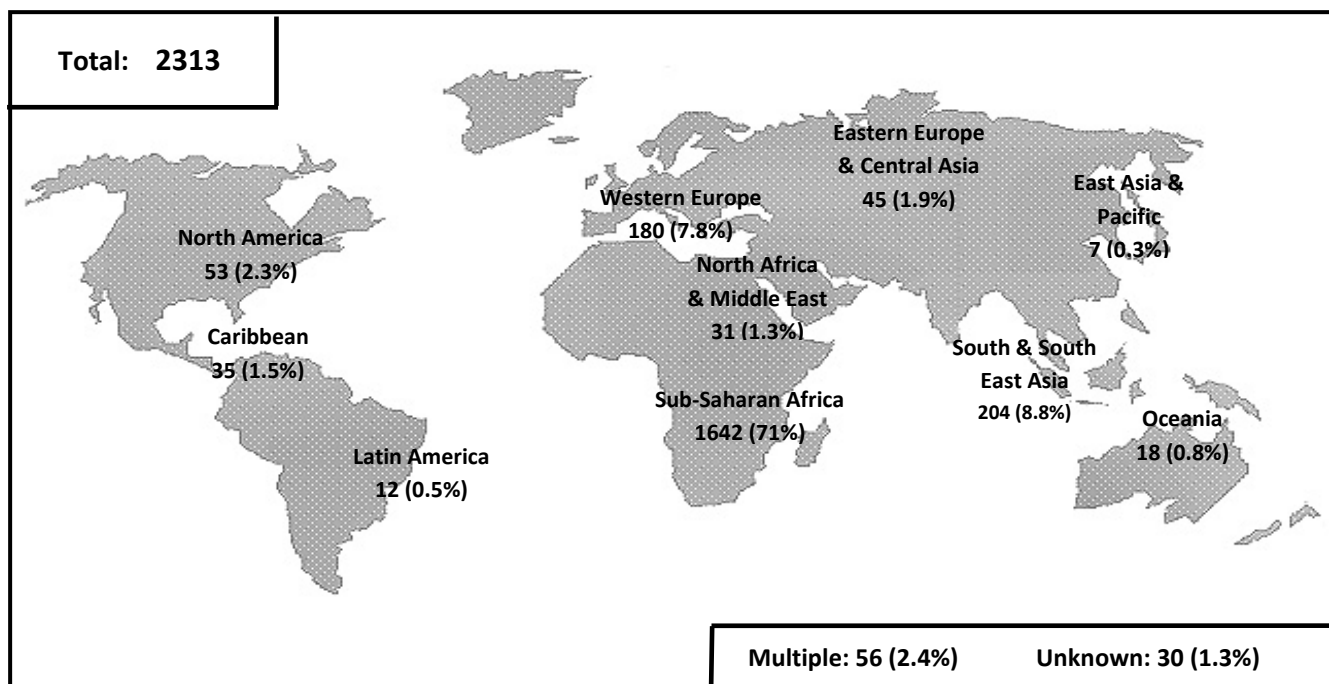


Figure 3.2: Global region and country of infection for all HIV and AIDS cases in the North West who probably acquired their infection outside the UK, 2009



Sub-Saharan Africa	1642 (71%)
Angola	15 (0.6%)
Botswana	26 (1.1%)
Burundi	11 (0.5%)
Cameroon	35 (1.5%)
Cape Verde	1 (0.04%)
Central African Republic	1 (0.04%)
Chad	1 (0.04%)
Congo	52 (2.2%)
Cote d'Ivoire	12 (0.5%)
Dem. Republic of Congo	9 (0.4%)
Equatorial Guinea	1 (0.04%)
Eritrea	21 (0.9%)
Ethiopia	21 (0.9%)
Gabon	1 (0.04%)
Gambia	7 (0.3%)
Ghana	22 (1%)
Guinea	6 (0.3%)
Kenya	48 (2.1%)
Lesotho	1 (0.04%)
Liberia	5 (0.2%)
Malawi	133 (5.8%)
Mozambique	3 (0.1%)
Namibia	4 (0.2%)
Niger	1 (0.04%)
Nigeria	95 (4.1%)
Rwanda	12 (0.5%)
Senegal	1 (0.04%)
Sierra Leone	9 (0.4%)
Somalia	19 (0.8%)
South Africa	122 (5.3%)
Swaziland	5 (0.2%)
Tanzania	17 (0.7%)
Togo	2 (0.1%)
Uganda	39 (1.7%)
Zambia	84 (3.6%)
Zimbabwe	734 (31.7%)
Unknown	62 (2.7%)
Multiple	4 (0.2%)

South & South East Asia	204 (8.8%)
Bangladesh	1 (0.04%)
Brunei Darussalam	1 (0.04%)
Cambodia	1 (0.04%)
Dem. Republic of Timor-Leste	1 (0.04%)
India	17 (0.7%)
Indonesia	2 (0.1%)
Iran	3 (0.1%)
Malaysia	2 (0.1%)
Pakistan	14 (0.6%)
Philippines	2 (0.1%)
Singapore	3 (0.1%)
Sri Lanka	1 (0.04%)
Thailand	145 (6.3%)
Vietnam	2 (0.1%)
Unknown	5 (0.2%)
Multiple	4 (0.2%)

Eastern Europe & Central Asia	45 (1.9%)
Belarus	1 (0.04%)
Croatia	2 (0.1%)
Estonia	2 (0.1%)
Georgia	1 (0.04%)
Hungary	2 (0.1%)
Latvia	9 (0.4%)
Poland	21 (0.9%)
Romania	3 (0.1%)
Russian Federation	3 (0.1%)
Unknown	1 (0.04%)

Oceania	18 (0.8%)
Australia	17 (0.7%)
New Zealand	1 (0.04%)

North America	53 (2.3%)
Canada	4 (0.2%)
United States of America	48 (2.1%)
Unknown	1 (0.04%)

Caribbean	35 (1.5%)
Barbados	1 (0.04%)
Jamaica	30 (1.3%)
St Lucia	1 (0.04%)
Trinidad and Tobago	1 (0.04%)
Unknown	2 (0.1%)

Western Europe	180 (7.8%)
Austria	1 (0.04%)
Balearics	2 (0.1%)
Belgium	3 (0.1%)
Canary Islands	9 (0.4%)
Finland	2 (0.1%)
France	13 (0.6%)
Germany	17 (0.7%)
Gibraltar	1 (0.04%)
Greece	7 (0.3%)
Italy	13 (0.6%)
Malta	2 (0.1%)
Netherlands	13 (0.6%)
Portugal	23 (1%)
Republic of Ireland	4 (0.2%)
Slovenia	1 (0.04%)
Spain	57 (2.5%)
Sweden	1 (0.04%)
Unknown	7 (0.3%)
Multiple	4 (0.2%)

North Africa & Middle East	31 (1.3%)
Cyprus	2 (0.1%)
Egypt	2 (0.1%)
Israel	1 (0.04%)
Jordan	1 (0.04%)
Kuwait	1 (0.04%)
Libyan Arab Jamahiriya	2 (0.1%)
Morocco	2 (0.1%)
Qatar	1 (0.04%)
Saudi Arabia	2 (0.1%)
Sudan	10 (0.4%)
Turkey	3 (0.1%)
United Arab Emirates	3 (0.1%)
Unknown	1 (0.04%)

Latin America	12 (0.5%)
Brazil	7 (0.3%)
Colombia	1 (0.04%)
Guatemala	1 (0.04%)
Guyana	2 (0.1%)
Mexico	1 (0.04%)

Multiple	56 (2.4%)
Unknown	30 (1.3%)

Total 2313

Table 3.1: Age distribution, stage of HIV disease and ethnicity of all HIV and AIDS cases by infection route and sex 2009

		Infection Route										Total (100%)	
		MSM	Injecting Drug Use		Hetero- sexual		Blood/ Tissue		Mother to Child		Undeter- mined		
		M	M	F	M	F	M	F	M	F	M		F
Age Group	0-14								37	57			94
	15-19	3			2	11			13	13			42
	20-24	112	2	2	21	68			2	3	2	1	213
	25-29	276	5	3	67	212	6		1		11		581
	30-34	435	14	3	128	369	5				16	3	973
	35-39	563	19	5	192	374	10	1			19	8	1191
	40-44	641	21	4	222	274	12	2			14	3	1193
	45-49	518	20	4	163	151	7	3			19	4	889
	50-54	302	8	4	94	74	7	2			7	1	499
	55-59	193	3		64	33	3	1			6		303
60+	130	7		75	29	5	4			10		260	
Stage of HIV Disease	Asymptomatic	1503	34	13	497	905	8	2	13	31	47	11	3064
	Symptomatic	882	33	10	225	311	27	5	26	23	13	1	1556
	AIDS	645	27	2	262	320	16	6	14	19	26	3	1340
	AIDS Related Death	8	2		8	5					1		24
	Death Unrelated to AIDS	12			2	4	3				2		23
	Unknown	123	3		34	50	1				15	5	231
Ethnicity	White	3021	88	25	390	336	51	8	7	12	68	6	4012
	Black Caribbean	20	1		20	35				1	1		78
	Black African	19	3		558	1118	1		39	51	7	8	1804
	Black Other	9	1		3	9							22
	Indian/Pakistani/Bangladeshi	30	1		24	15	2	2		1	2	2	79
	Other Asian/Oriental	15			16	44	1	2	1	2	1	1	83
	Other/Mixed	43	3		14	27		1	6	6	1		101
	Unknown	16	2		3	11					24	3	59
Total	3173	99	25	1028	1595	55	13	53	73	104	20	6238	
%	50.9	1.6	0.4	16.5	25.6	0.9	0.2	0.8	1.2	1.7	0.3		

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category. Age groups refer to the age of individuals at the end of December 2009, or at death.

Table 3.2: Local authority of residence of all HIV and AIDS cases by infection route, 2009

	Local Authority of Residence	Infection Route						Total (100%)
		MSM	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Cumbria	Carlisle	20 (55.6%)	1 (2.8%)	12 (33.3%)	1 (2.8%)		2 (5.6%)	36
	Allerdale	12 (63.2%)		6 (31.6%)		1 (5.3%)		19
	Eden	9 (64.3%)		5 (35.7%)				14
	Copeland	7 (46.7%)		5 (33.3%)	1 (6.7%)	1 (6.7%)	1 (6.7%)	15
	South Lakeland	12 (44.4%)	1 (3.7%)	11 (40.7%)	1 (3.7%)	1 (3.7%)	1 (3.7%)	27
	Barrow-in-Furness	6 (31.6%)		13 (68.4%)				19
	Unknown Cumbria	1 (100%)						1
	Cumbria Total	67 (51.1%)	2 (1.5%)	52 (39.7%)	3 (2.3%)	3 (2.3%)	4 (3.1%)	131
Lancashire	Lancaster	24 (58.5%)		15 (36.6%)	1 (2.4%)	1 (2.4%)		41
	Wyre	32 (71.1%)		13 (28.9%)				45
	Fylde	37 (71.2%)	1 (1.9%)	11 (21.2%)	1 (1.9%)	1 (1.9%)	1 (1.9%)	52
	Blackpool	257 (82.9%)	3 (1%)	44 (14.2%)	5 (1.6%)	1 (0.3%)		310
	Blackburn with Darwen	25 (28.1%)	1 (1.1%)	57 (64%)	2 (2.2%)	1 (1.1%)	3 (3.4%)	89
	Ribble Valley	6 (37.5%)		9 (56.3%)			1 (6.3%)	16
	Pendle	15 (65.2%)	2 (8.7%)	3 (13%)	1 (4.3%)		2 (8.7%)	23
	Hyndburn	7 (26.9%)		17 (65.4%)		1 (3.8%)	1 (3.8%)	26
	Burnley	9 (32.1%)		16 (57.1%)	1 (3.6%)	1 (3.6%)	1 (3.6%)	28
	Rosendale	24 (77.4%)	2 (6.5%)	4 (12.9%)		1 (3.2%)		31
	Preston	44 (44.4%)	1 (1%)	48 (48.5%)		3 (3%)	3 (3%)	99
	South Ribble	16 (59.3%)	1 (3.7%)	9 (33.3%)		1 (3.7%)		27
	Chorley	16 (57.1%)	1 (3.6%)	9 (32.1%)			2 (7.1%)	28
	West Lancashire	16 (61.5%)		8 (30.8%)	2 (7.7%)			26
	Unknown Lancashire			2 (100%)				2
	Lancashire Total	528 (62.6%)	12 (1.4%)	265 (31.4%)	13 (1.5%)	11 (1.3%)	14 (1.7%)	843
Greater Manchester	Wigan	51 (34.5%)	1 (0.7%)	85 (57.4%)	3 (2%)	3 (2%)	5 (3.4%)	148
	Bolton	78 (30%)	9 (3.5%)	155 (59.6%)	5 (1.9%)	10 (3.8%)	3 (1.2%)	260
	Bury	100 (56.2%)	2 (1.1%)	65 (36.5%)	1 (0.6%)	3 (1.7%)	7 (3.9%)	178
	Rochdale	60 (37.3%)	8 (5%)	83 (51.6%)	4 (2.5%)	4 (2.5%)	2 (1.2%)	161
	Oldham	50 (34.2%)	3 (2.1%)	86 (58.9%)	2 (1.4%)	2 (1.4%)	3 (2.1%)	146
	Salford	366 (67.5%)	10 (1.8%)	152 (28%)	1 (0.2%)	3 (0.6%)	10 (1.8%)	542
	Manchester	895 (50%)	37 (2.1%)	789 (44.1%)	4 (0.2%)	42 (2.3%)	23 (1.3%)	1790
	Tameside	73 (49.3%)	4 (2.7%)	67 (45.3%)		3 (2%)	1 (0.7%)	148
	Trafford	113 (57.1%)	4 (2%)	70 (35.4%)	4 (2%)	3 (1.5%)	4 (2%)	198
	Stockport	91 (62.8%)		43 (29.7%)	2 (1.4%)	6 (4.1%)	3 (2.1%)	145
	Unknown Greater Manchester	27 (71.1%)		11 (28.9%)				38
	Greater Manchester Total	1904 (50.7%)	78 (2.1%)	1606 (42.8%)	26 (0.7%)	79 (2.1%)	61 (1.6%)	3754
Merseyside	Sefton	34 (32.1%)	8 (7.5%)	55 (51.9%)	2 (1.9%)		7 (6.6%)	106
	Liverpool	144 (29.3%)	8 (1.6%)	307 (62.5%)	5 (1%)	12 (2.4%)	15 (3.1%)	491
	Knowsley	29 (61.7%)	1 (2.1%)	16 (34%)			1 (2.1%)	47
	Wirral	61 (44.2%)	4 (2.9%)	67 (48.6%)	2 (1.4%)	3 (2.2%)	1 (0.7%)	138
	St Helens	41 (68.3%)		16 (26.7%)	1 (1.7%)		2 (3.3%)	60
	Unknown Merseyside	3 (50%)		3 (50%)				6
Merseyside Total	312 (36.8%)	21 (2.5%)	464 (54.7%)	10 (1.2%)	15 (1.8%)	26 (3.1%)	848	
Cheshire	Halton	15 (53.6%)		12 (42.9%)		1 (3.6%)		28
	Warrington	43 (53.8%)	1 (1.3%)	33 (41.3%)	1 (1.3%)	2 (2.5%)		80
	Cheshire West and Chester	85 (55.6%)	3 (2%)	55 (35.9%)	3 (2%)	6 (3.9%)	1 (0.7%)	153
	Cheshire East	74 (60.2%)	2 (1.6%)	43 (35%)	3 (2.4%)		1 (0.8%)	123
	Cheshire Total	217 (56.5%)	6 (1.6%)	143 (37.2%)	7 (1.8%)	9 (2.3%)	2 (0.5%)	384
Total North West Residents		3028 (50.8%)	119 (2%)	2530 (42.4%)	59 (1%)	117 (2%)	107 (1.8%)	5960
Isle of Man		9 (40.9%)		12 (54.5%)	1 (4.5%)			22
Out of Region		106 (55.5%)	2 (1%)	59 (30.9%)	5 (2.6%)	9 (4.7%)	10 (5.2%)	191
Abroad				1 (100%)				1
Unknown*		30 (46.9%)	3 (4.7%)	21 (32.8%)	3 (4.7%)		7 (10.9%)	64
Total		3173 (50.9%)	124 (2%)	2623 (42%)	68 (1.1%)	126 (2%)	124 (2%)	6238

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

* Includes four people of no fixed abode and five people who declined to give any residential information.

Table 3.3: Local authority of residence of all HIV and AIDS cases by stage of HIV disease, 2009

	Local Authority of Residence	Stage of HIV Disease						Total (100%)
		Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	Carlisle	19 (52.8%)	4 (11.1%)	12 (33.3%)			1 (2.8%)	36
	Allerdale	7 (36.8%)	7 (36.8%)	3 (15.8%)	1 (5.3%)		1 (5.3%)	19
	Eden	10 (71.4%)	3 (21.4%)	1 (7.1%)				14
	Copeland	2 (13.3%)	7 (46.7%)	5 (33.3%)	1 (6.7%)			15
	South Lakeland	11 (40.7%)	8 (29.6%)	8 (29.6%)				27
	Barrow-in-Furness	11 (57.9%)	1 (5.3%)	6 (31.6%)		1 (5.3%)		19
	Unknown Cumbria	1 (100%)						1
	Cumbria Total	61 (46.6%)	30 (22.9%)	35 (26.7%)	2 (1.5%)	1 (0.8%)	2 (1.5%)	131
Lancashire	Lancaster	25 (61%)	8 (19.5%)	8 (19.5%)				41
	Wyre	15 (33.3%)	14 (31.1%)	14 (31.1%)		1 (2.2%)	1 (2.2%)	45
	Fylde	17 (32.7%)	18 (34.6%)	12 (23.1%)		2 (3.8%)	3 (5.8%)	52
	Blackpool	111 (35.8%)	111 (35.8%)	73 (23.5%)	2 (0.6%)	2 (0.6%)	11 (3.5%)	310
	Blackburn with Darwen	49 (55.1%)	22 (24.7%)	17 (19.1%)			1 (1.1%)	89
	Ribble Valley	5 (31.3%)	4 (25%)	7 (43.8%)				16
	Pendle	11 (47.8%)	7 (30.4%)	5 (21.7%)				23
	Hyndburn	9 (34.6%)	9 (34.6%)	8 (30.8%)				26
	Burnley	18 (64.3%)	7 (25%)	2 (7.1%)			1 (3.6%)	28
	Rossendale	10 (32.3%)	17 (54.8%)	3 (9.7%)			1 (3.2%)	31
	Preston	35 (35.4%)	35 (35.4%)	26 (26.3%)		2 (2%)	1 (1%)	99
	South Ribble	12 (44.4%)	6 (22.2%)	8 (29.6%)			1 (3.7%)	27
	Chorley	13 (46.4%)	9 (32.1%)	4 (14.3%)			2 (7.1%)	28
	West Lancashire	8 (30.8%)	11 (42.3%)	6 (23.1%)		1 (3.8%)		26
	Unknown Lancashire		1 (50%)				1 (50%)	2
Lancashire Total	338 (40.1%)	279 (33.1%)	193 (22.9%)	2 (0.2%)	8 (0.9%)	23 (2.7%)	843	
Greater Manchester	Wigan	85 (57.4%)	32 (21.6%)	27 (18.2%)			4 (2.7%)	148
	Bolton	154 (59.2%)	47 (18.1%)	57 (21.9%)	1 (0.4%)		1 (0.4%)	260
	Bury	77 (43.3%)	63 (35.4%)	36 (20.2%)			2 (1.1%)	178
	Rochdale	77 (47.8%)	39 (24.2%)	41 (25.5%)	1 (0.6%)	3 (1.9%)		161
	Oldham	78 (53.4%)	34 (23.3%)	32 (21.9%)			2 (1.4%)	146
	Salford	264 (48.7%)	150 (27.7%)	105 (19.4%)	3 (0.6%)	2 (0.4%)	18 (3.3%)	542
	Manchester	839 (46.9%)	444 (24.8%)	394 (22%)	6 (0.3%)	4 (0.2%)	103 (5.8%)	1790
	Tameside	71 (48%)	41 (27.7%)	29 (19.6%)			7 (4.7%)	148
	Trafford	83 (41.9%)	57 (28.8%)	53 (26.8%)		1 (0.5%)	4 (2%)	198
	Stockport	60 (41.4%)	54 (37.2%)	29 (20%)			2 (1.4%)	145
	Unknown Greater Manchester	19 (50%)	1 (2.6%)	3 (7.9%)			15 (39.5%)	38
	Greater Manchester Total	1807 (48.1%)	962 (25.6%)	806 (21.5%)	11 (0.3%)	10 (0.3%)	158 (4.2%)	3754
	Merseyside	Sefton	68 (64.2%)	20 (18.9%)	16 (15.1%)			2 (1.9%)
Liverpool		348 (70.9%)	56 (11.4%)	71 (14.5%)	2 (0.4%)	2 (0.4%)	12 (2.4%)	491
Knowsley		28 (59.6%)	7 (14.9%)	11 (23.4%)			1 (2.1%)	47
Wirral		52 (37.7%)	44 (31.9%)	41 (29.7%)	1 (0.7%)			138
St Helens		36 (60%)	13 (21.7%)	9 (15%)	2 (3.3%)			60
Unknown Merseyside		4 (66.7%)		1 (16.7%)	1 (16.7%)			6
Merseyside Total		536 (63.2%)	140 (16.5%)	149 (17.6%)	6 (0.7%)	2 (0.2%)	15 (1.8%)	848
Cheshire	Halton	20 (71.4%)	3 (10.7%)	4 (14.3%)	1 (3.6%)			28
	Warrington	57 (71.3%)	10 (12.5%)	12 (15%)			1 (1.3%)	80
	Cheshire West and Chester	84 (54.9%)	30 (19.6%)	37 (24.2%)		1 (0.7%)	1 (0.7%)	153
	Cheshire East	47 (38.2%)	33 (26.8%)	39 (31.7%)	1 (0.8%)		3 (2.4%)	123
	Cheshire Total	208 (54.2%)	76 (19.8%)	92 (24%)	2 (0.5%)	1 (0.3%)	5 (1.3%)	384
Total North West Residents		2950 (49.5%)	1487 (24.9%)	1275 (21.4%)	23 (0.4%)	22 (0.4%)	203 (3.4%)	5960
Isle of Man		7 (31.8%)	9 (40.9%)	6 (27.3%)				22
Out of Region		82 (42.9%)	52 (27.2%)	50 (26.2%)	1 (0.5%)	1 (0.5%)	5 (2.6%)	191
Abroad				1 (100%)				1
Unknown*		25 (39.1%)	8 (12.5%)	8 (12.5%)			23 (35.9%)	64
Total		3064 (49.1%)	1556 (24.9%)	1340 (21.5%)	24 (0.4%)	23 (0.4%)	231 (3.7%)	6238

* Includes four people of no fixed abode and five people who declined to give any residential information.

Table 3.4: All HIV and AIDS cases by infection route, sex, county of residence and ethnicity, 2009

	Ethnicity	Infection Route										Total (100%)	
		MSM	Injecting Drug Use		Hetero-sexual		Blood/Tissue		Mother to Child		Undetermined		
		M	M	F	M	F	M	F	M	F	M		F
Cumbria	White	67	2		20	18	2		2		2	1	114
	BME*/mixed				2	12	1		1				16
	Unknown										1		1
	Total	67	2		22	30	2	1	1	2	3	1	131
	%	51.1	1.5		16.8	22.9	1.5	0.8	0.8	1.5	2.3	0.8	
Lancashire	White	514	10		77	69	8	2	4		12		696
	BME/mixed	12	2		37	81	1	2	3	4	1	1	144
	Unknown	2				1							3
	Total	528	12		114	151	9	4	3	8	13	1	843
	%	62.6	1.4		13.5	17.9	1.1	0.5	0.4	0.9	1.5	0.1	
Greater Manchester	White	1798	53	16	141	113	19	2	5	3	31	3	2184
	BME/mixed	98	7		455	890	3	2	28	43	6	7	1539
	Unknown	8	2		1	6					12	2	31
	Total	1904	62	16	597	1009	22	4	33	46	49	12	3754
	%	50.7	1.7	0.4	15.9	26.9	0.6	0.1	0.9	1.2	1.3	0.3	
Merseyside	White	296	15	6	73	76	7	3	1		16	1	494
	BME/mixed	13			105	205			6	8	2	2	341
	Unknown	3			2	3					5		13
	Total	312	15	6	180	284	7	3	6	9	23	3	848
	%	36.8	1.8	0.7	21.2	33.5	0.8	0.4	0.7	1.1	2.7	0.4	
Cheshire	White	214	3	3	50	35	7		1		1		314
	BME/mixed	3			23	34			4	4		1	69
	Unknown					1							1
	Total	217	3	3	73	70	7		4	5	1	1	384
	%	56.5	0.8	0.8	19	18.2	1.8		1	1.3	0.3	0.3	
Out of region**	White	107	2		21	24	6		2	1	6		169
	BME/mixed	6			7	19			4	2	1		39
	Unknown	2									3		5
	Total	115	2		28	43	6		6	3	10		213
	%	54	0.9		13.1	20.2	2.8		2.8	1.4	4.7		
Abroad	White				1								1
	Total				1								1
	%				100								
Unknown***	White	25	3		7	1	2	1				1	40
	BME/mixed	4			6	7					2		19
	Unknown	1									3	1	5
	Total	30	3		13	8	2	1			5	2	64
	%	46.9	4.7		20.3	12.5	3.1	1.6			7.8	3.1	
Total	White	3021	88	25	390	336	51	8	7	12	68	6	4012
	BME/mixed	136	9		635	1248	4	5	46	61	12	11	2167
	Unknown	16	2		3	11					24	3	59
	Total	3173	99	25	1028	1595	55	13	53	73	104	20	6238
	%	50.9	1.6	0.4	16.5	25.6	0.9	0.2	0.8	1.2	1.7	0.3	

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

* BME = Black and minority ethnic

** Includes Isle of Man.

*** Includes four people of no fixed abode and five people who declined to give any residential information.

Table 3.5: Age group of all HIV and AIDS cases by ethnicity, 2009

	Age Group	Ethnicity							Total	
		White	Black Caribbean	Black African	Black Other	Indian/Pakistani/Bangladeshi	Other Asian/Oriental	Other/Mixed		Unknown
Total North West Residents	0-14	10	1	64			2	8		85
	15-19	11	1	26		1	1	1		41
	20-24	157	6	36	2	1		4	1	207
	25-29	316	16	181	1	12	8	11	10	555
	30-34	484	16	368	4	14	19	24	10	939
	35-39	659	13	412	4	13	21	20	8	1150
	40-44	741	9	345	4	17	12	11	5	1144
	45-49	615	9	186	6	4	7	5	7	839
	50-54	365	1	87	1	7	4	7	3	475
	55-59	235	3	34		3	1	4	3	283
	60+	209	1	23		5	2		2	242
	Total	3802	76	1762	22	77	77	95	49	5960
%	63.8	1.3	29.6	0.4	1.3	1.3	1.6	0.8		
All individuals treated in North West	0-14	13	1	68			2	10		94
	15-19	11	1	27		1	1	1		42
	20-24	161	7	36	2	1	1	4	1	213
	25-29	335	16	187	1	12	8	12	10	581
	30-34	510	17	373	4	14	20	25	10	973
	35-39	682	13	424	4	13	24	20	11	1191
	40-44	782	9	349	4	18	12	12	7	1193
	45-49	657	9	192	6	4	7	5	9	889
	50-54	383	1	89	1	8	5	7	5	499
	55-59	252	3	36		3	1	5	3	303
	60+	226	1	23		5	2		3	260
	Total	4012	78	1804	22	79	83	101	59	6238
%	64.3	1.3	28.9	0.4	1.3	1.3	1.6	0.9		

Age groups refer to the ages of individuals at the end of December 2009, or at death.

Table 3.6: All HIV and AIDS cases by stage of HIV disease, level of antiretroviral therapy and county of residence, 2009

	Stage of HIV Disease	Level of Antiretroviral Therapy					Total (100%)
		None	Mono	Dual	Triple	Quadruple or More	
Cumbria	Asymptomatic	27			28	6	61
	Symptomatic	1			20	9	30
	AIDS				19	16	35
	AIDS Related Death	1			1		2
	Death Unrelated to AIDS				1		1
	Unknown				1	1	2
	Cumbria Total	29 (22.1%)			70 (53.4%)	32 (24.4%)	131
Lancashire	Asymptomatic	122			152	64	338
	Symptomatic	22			168	89	279
	AIDS	5			117	71	193
	AIDS Related Death	2					2
	Death Unrelated to AIDS				4	4	8
	Unknown	12			6	5	23
	Lancashire Total	163 (19.3%)			447 (53%)	233 (27.6%)	843
Greater Manchester	Asymptomatic	736		3	714	354	1807
	Symptomatic	87		3	532	340	962
	AIDS	40			408	358	806
	AIDS Related Death	2			3	6	11
	Death Unrelated to AIDS	4		1	2	3	10
	Unknown	138			11	9	158
	Greater Manchester Total	1007 (26.8%)		7 (0.2%)	1670 (44.5%)	1070 (28.5%)	3754
Merseyside	Asymptomatic	180	1	1	266	88	536
	Symptomatic	16	1		93	30	140
	AIDS	3		1	108	37	149
	AIDS Related Death	2		1	3		6
	Death Unrelated to AIDS	2					2
	Unknown	14			1		15
	Merseyside Total	217 (25.6%)	2 (0.2%)	3 (0.4%)	471 (55.5%)	155 (18.3%)	848
Cheshire	Asymptomatic	69			113	26	208
	Symptomatic	6			49	21	76
	AIDS	5			54	33	92
	AIDS Related Death				2		2
	Death Unrelated to AIDS	1					1
	Unknown	5					5
	Cheshire Total	86 (22.4%)			218 (56.8%)	80 (20.8%)	384
Total North West Residents	Asymptomatic	1134	1	4	1273	538	2950
	Symptomatic	132	1	3	862	489	1487
	AIDS	53		1	706	515	1275
	AIDS Related Death	7		1	9	6	23
	Death Unrelated to AIDS	7		1	7	7	22
	Unknown	169			19	15	203
	Total North West Residents	1502 (25.2%)	2 (0.03%)	10 (0.2%)	2876 (48.3%)	1570 (26.3%)	5960
Isle of Man	Isle of Man	4	1		12	5	22
	Out of Region	31	3		100	57	191
	Abroad				1		1
	Unknown*	38			15	11	64
	Total	1575 (25.2%)	6 (0.1%)	10 (0.2%)	3004 (48.2%)	1643 (26.3%)	6238

* Includes four people of no fixed abode and five people who declined to give any residential information.
 NB. Some individuals who are on unusually high or low ART combinations may be taking part in clinical trials.

Table 3.7: Ethnic distribution of all HIV and AIDS cases by sex, stage of HIV disease and exposure abroad, 2009

		Ethnicity							Total	
		White	Black Caribbean	Black African	Black Other	Indian/Pakistani/Bangladeshi	Other Asian/Oriental	Other/Mixed		Unknown
Sex	Male	3625 (80.3%)	42 (0.9%)	627 (13.9%)	13 (0.3%)	59 (1.3%)	34 (0.8%)	67 (1.5%)	45 (1%)	4512
	Female	387 (22.4%)	36 (2.1%)	1177 (68.2%)	9 (0.5%)	20 (1.2%)	49 (2.8%)	34 (2%)	14 (0.8%)	1726
Stage of HIV Disease	Asymptomatic	1865 (60.9%)	52 (1.7%)	965 (31.5%)	11 (0.4%)	38 (1.2%)	41 (1.3%)	59 (1.9%)	33 (1.1%)	3064
	Symptomatic	1099 (70.6%)	10 (0.6%)	376 (24.2%)	4 (0.3%)	17 (1.1%)	19 (1.2%)	23 (1.5%)	8 (0.5%)	1556
	AIDS	872 (65.1%)	10 (0.7%)	393 (29.3%)	6 (0.4%)	18 (1.3%)	21 (1.6%)	14 (1%)	6 (0.4%)	1340
	AIDS Related Death	16 (66.7%)		7 (29.2%)		1 (4.2%)				24
	Death Unrelated to AIDS	19 (82.6%)		3 (13%)					1 (4.3%)	23
	Unknown	141 (61%)	6 (2.6%)	60 (26%)	1 (0.4%)	5 (2.2%)	2 (0.9%)	5 (2.2%)	11 (4.8%)	231
Exposure Abroad	UK	3080 (94.3%)	35 (1.1%)	58 (1.8%)	6 (0.2%)	28 (0.9%)	12 (0.4%)	39 (1.2%)	8 (0.2%)	3266
	Abroad	560 (24.2%)	30 (1.3%)	1558 (67.4%)	11 (0.5%)	42 (1.8%)	60 (2.6%)	43 (1.9%)	9 (0.4%)	2313
	Unknown	372 (56.4%)	13 (2%)	188 (28.5%)	5 (0.8%)	9 (1.4%)	11 (1.7%)	19 (2.9%)	42 (6.4%)	659
Total		4012 (64.3%)	78 (1.3%)	1804 (28.9%)	22 (0.4%)	79 (1.3%)	83 (1.3%)	101 (1.6%)	59 (0.9%)	6238

Table 3.8: Global region of HIV exposure by infection route of all HIV and AIDS cases, 2009

Region of HIV Exposure	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
Abroad	294 (12.7%)	31 (1.3%)	1861 (80.5%)	19 (0.8%)	73 (3.2%)	35 (1.5%)	2313
<i>Caribbean</i>	7		28				35
<i>East Asia & Pacific</i>	3		4				7
<i>Eastern Europe & Central Asia</i>	12	7	24	1	1		45
<i>Latin America</i>	5		7				12
<i>North Africa & Middle East</i>	8	2	18		2	1	31
<i>North America</i>	41	2	7	1	1	1	53
<i>Oceania</i>	15		3				18
<i>South & South East Asia</i>	32	1	159	5	1	6	204
<i>Sub-Saharan Africa</i>	17	4	1526	9	66	20	1642
<i>Western Europe</i>	108	15	49	3	1	4	180
<i>Multiple</i>	37		15		1	3	56
<i>Unknown</i>	9		21				30
UK	2563 (78.5%)	80 (2.4%)	496 (15.2%)	49 (1.5%)	42 (1.3%)	36 (1.1%)	3266
Unknown	316 (48%)	13 (2%)	266 (40.4%)		11 (1.7%)	53 (8%)	659
Total	3173 (50.9%)	124 (2%)	2623 (42%)	68 (1.1%)	126 (2%)	124 (2%)	6238

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

Table 3.9: Distribution of treatment for all HIV and AIDS cases by infection route, 2009

Treatment Centre	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/Tissue	Mother to Child	Undetermined	
AHC					28 (100%)		28
APH	35 (44.3%)		43 (54.4%)			1 (1.3%)	79
ARM	19 (82.6%)	1 (4.3%)	1 (4.3%)			2 (8.7%)	23
BLAG	319 (80.6%)	5 (1.3%)	65 (16.4%)	4 (1%)	2 (0.5%)	1 (0.3%)	396
BLK	2 (100%)						2
BLKG	31 (27.9%)	2 (1.8%)	73 (65.8%)	1 (0.9%)		4 (3.6%)	111
BOLG	97 (29.9%)	9 (2.8%)	214 (66%)	2 (0.6%)		2 (0.6%)	324
BURG	20 (48.8%)	2 (4.9%)	17 (41.5%)			2 (4.9%)	41
BURY	23 (42.6%)		31 (57.4%)				54
CHR	81 (55.9%)	3 (2.1%)	60 (41.4%)		1 (0.7%)		145
CUMB	32 (55.2%)	1 (1.7%)	21 (36.2%)	1 (1.7%)	1 (1.7%)	2 (3.4%)	58
FGH	7 (33.3%)	1 (4.8%)	12 (57.1%)	1 (4.8%)			21
HAL	6 (75%)		2 (25%)				8
JAR	25 (47.2%)	1 (1.9%)	24 (45.3%)			3 (5.7%)	53
LCN	29 (41.4%)	6 (8.6%)	31 (44.3%)	2 (2.9%)		2 (2.9%)	70
LEI	38 (62.3%)		22 (36.1%)	1 (1.6%)			61
MAC	33 (71.7%)	1 (2.2%)	10 (21.7%)	1 (2.2%)		1 (2.2%)	46
MGP	178 (96.2%)	2 (1.1%)	5 (2.7%)				185
MRIG	696 (58%)	6 (0.5%)	474 (39.5%)	15 (1.3%)		8 (0.7%)	1199
MRIH			3 (9.4%)	29 (90.6%)			32
NMG	769 (47.6%)	66 (4.1%)	644 (39.9%)	8 (0.5%)	87 (5.4%)	40 (2.5%)	1614
NMGG	114 (56.7%)	1 (0.5%)	78 (38.8%)		1 (0.5%)	7 (3.5%)	201
NOBL	9 (56.3%)		7 (43.8%)				16
OLDG	32 (40.5%)		45 (57%)			2 (2.5%)	79
PG	91 (48.7%)	2 (1.1%)	84 (44.9%)	1 (0.5%)	2 (1.1%)	7 (3.7%)	187
PP					2 (100%)		2
RLG	280 (35.9%)	16 (2.1%)	451 (57.9%)	6 (0.8%)	3 (0.4%)	23 (3%)	779
RLH				11 (100%)			11
RLI	21 (51.2%)		18 (43.9%)	1 (2.4%)	1 (2.4%)		41
ROCG	31 (41.9%)		43 (58.1%)				74
SALG	86 (51.5%)	1 (0.6%)	79 (47.3%)			1 (0.6%)	167
SHH	60 (70.6%)	1 (1.2%)	19 (22.4%)			5 (5.9%)	85
SPG	27 (34.6%)	5 (6.4%)	42 (53.8%)			4 (5.1%)	78
STP	78 (60.5%)		49 (38%)			2 (1.6%)	129
TAMG	30 (61.2%)	1 (2%)	18 (36.7%)				49
TRAG	5 (62.5%)		3 (37.5%)				8
WAR	28 (56%)		22 (44%)				50
WGH	12 (57.1%)		8 (38.1%)			1 (4.8%)	21
WHIT			1 (50%)			1 (50%)	2
WIGG	1 (12.5%)		2 (25%)			5 (62.5%)	8
WITG	213 (76.1%)	4 (1.4%)	58 (20.7%)	1 (0.4%)		4 (1.4%)	280
WORK	11 (55%)		7 (35%)	1 (5%)	1 (5%)		20

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.

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

Table 3.10: Distribution of treatment for all HIV and AIDS cases by level of antiretroviral therapy, 2009

Treatment Centre	Level of Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or More	
AHC	8 (28.6%)			12 (42.9%)	8 (28.6%)	28
APH	19 (24.1%)	1 (1.3%)	1 (1.3%)	35 (44.3%)	23 (29.1%)	79
ARM	23 (100%)					23
BLAG	80 (20.2%)			207 (52.3%)	109 (27.5%)	396
BLK				2 (100%)		2
BLKG	31 (27.9%)			53 (47.7%)	27 (24.3%)	111
BOLG	88 (27.2%)			192 (59.3%)	44 (13.6%)	324
BURG	9 (22%)			22 (53.7%)	10 (24.4%)	41
BURY	9 (16.7%)			32 (59.3%)	13 (24.1%)	54
CHR	13 (9%)			102 (70.3%)	30 (20.7%)	145
CUMB	16 (27.6%)			33 (56.9%)	9 (15.5%)	58
FGH	6 (28.6%)			10 (47.6%)	5 (23.8%)	21
HAL	6 (75%)			1 (12.5%)	1 (12.5%)	8
JAR	53 (100%)					53
LCN	70 (100%)					70
LEI	25 (41%)			23 (37.7%)	13 (21.3%)	61
MAC	14 (30.4%)			27 (58.7%)	5 (10.9%)	46
MGP	185 (100%)					185
MRIG	567 (47.3%)			372 (31%)	260 (21.7%)	1199
MRIH	3 (9.4%)			14 (43.8%)	15 (46.9%)	32
NMG	188 (11.6%)		6 (0.4%)	760 (47.1%)	660 (40.9%)	1614
NMGG	62 (30.8%)		2 (1%)	100 (49.8%)	37 (18.4%)	201
NOBL	3 (18.8%)			7 (43.8%)	6 (37.5%)	16
OLDG	25 (31.6%)			36 (45.6%)	18 (22.8%)	79
PG	33 (17.6%)			99 (52.9%)	55 (29.4%)	187
PP	1 (50%)			1 (50%)		2
RLG	180 (23.1%)	9 (1.2%)	4 (0.5%)	457 (58.7%)	129 (16.6%)	779
RLH	1 (9.1%)			6 (54.5%)	4 (36.4%)	11
RLI	8 (19.5%)			25 (61%)	8 (19.5%)	41
ROCG	15 (20.3%)			39 (52.7%)	20 (27%)	74
SALG	52 (31.1%)		1 (0.6%)	81 (48.5%)	33 (19.8%)	167
SHH	26 (30.6%)			38 (44.7%)	21 (24.7%)	85
SPG	23 (29.5%)			40 (51.3%)	15 (19.2%)	78
STP	25 (19.4%)			74 (57.4%)	30 (23.3%)	129
TAMG	26 (53.1%)			17 (34.7%)	6 (12.2%)	49
TRAG	8 (100%)					8
WAR	16 (32%)			29 (58%)	5 (10%)	50
WGH	2 (9.5%)			13 (61.9%)	6 (28.6%)	21
WHIT				1 (50%)	1 (50%)	2
WIGG	8 (100%)					8
WITG	79 (28.2%)			146 (52.1%)	55 (19.6%)	280
WORK	5 (25%)			9 (45%)	6 (30%)	20

* ARM, LCN, & MGP are support services and do not prescribe ART.

NB. Some individuals who are on unusually high or low ART combinations may be taking part in clinical trials.

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 3.11: Local authority of residence of all HIV and AIDS cases by number of treatment centres attended, 2009

	Local Authority of Residence	Treatment Centres Attended			Total (100%)
		One	Two	Three	
Cumbria	Carlisle	36 (100%)			36
	Allerdale	19 (100%)			19
	Eden	14 (100%)			14
	Copeland	14 (93.3%)	1 (6.7%)		15
	South Lakeland	27 (100%)			27
	Barrow-in-Furness	17 (89.5%)	2 (10.5%)		19
	Unknown Cumbria	1 (100%)			1
	Cumbria Total	128 (97.7%)	3 (2.3%)		131
Lancashire	Lancaster	37 (90.2%)	4 (9.8%)		41
	Wyre	44 (97.8%)	1 (2.2%)		45
	Fylde	52 (100%)			52
	Blackpool	300 (96.8%)	10 (3.2%)		310
	Blackburn with Darwen	63 (70.8%)	24 (27%)	2 (2.2%)	89
	Ribble Valley	14 (87.5%)	2 (12.5%)		16
	Pendle	15 (65.2%)	6 (26.1%)	2 (8.7%)	23
	Hyndburn	20 (76.9%)	5 (19.2%)	1 (3.8%)	26
	Burnley	21 (75%)	7 (25%)		28
	Rosendale	28 (90.3%)	3 (9.7%)		31
	Preston	95 (96%)	4 (4%)		99
	South Ribble	24 (88.9%)	3 (11.1%)		27
	Chorley	28 (100%)			28
	West Lancashire	22 (84.6%)	3 (11.5%)	1 (3.8%)	26
	Unknown Lancashire	2 (100%)			2
Lancashire Total	765 (90.7%)	72 (8.5%)	6 (0.7%)	843	
Greater Manchester	Wigan	145 (98%)	3 (2%)		148
	Bolton	252 (96.9%)	8 (3.1%)		260
	Bury	169 (94.9%)	7 (3.9%)	2 (1.1%)	178
	Rochdale	148 (91.9%)	13 (8.1%)		161
	Oldham	140 (95.9%)	6 (4.1%)		146
	Salford	470 (86.7%)	68 (12.5%)	4 (0.7%)	542
	Manchester	1609 (89.9%)	172 (9.6%)	9 (0.5%)	1790
	Tameside	140 (94.6%)	8 (5.4%)		148
	Trafford	180 (90.9%)	17 (8.6%)	1 (0.5%)	198
	Stockport	130 (89.7%)	14 (9.7%)	1 (0.7%)	145
	Unknown Greater Manchester	38 (100%)			38
	Greater Manchester Total	3421 (91.1%)	316 (8.4%)	17 (0.5%)	3754
Merseyside	Sefton	96 (90.6%)	10 (9.4%)		106
	Liverpool	421 (85.7%)	62 (12.6%)	8 (1.6%)	491
	Knowsley	40 (85.1%)	7 (14.9%)		47
	Wirral	130 (94.2%)	7 (5.1%)	1 (0.7%)	138
	St Helens	50 (83.3%)	10 (16.7%)		60
	Unknown Merseyside	6 (100%)			6
Merseyside Total	743 (87.6%)	96 (11.3%)	9 (1.1%)	848	
Cheshire	Halton	28 (100%)			28
	Warrington	69 (86.3%)	11 (13.8%)		80
	Cheshire West and Chester	141 (92.2%)	12 (7.8%)		153
	Cheshire East	114 (92.7%)	9 (7.3%)		123
	Cheshire Total	352 (91.7%)	32 (8.3%)		384
Total North West Residents		5409 (90.8%)	519 (8.7%)	32 (0.5%)	5960
Isle of Man		20 (90.9%)	2 (9.1%)		22
Out of Region		182 (95.3%)	9 (4.7%)		191
Abroad		1 (100%)			1
Unknown*		59 (92.2%)	5 (7.8%)		64
Total		5671 (90.9%)	535 (8.6%)	32 (0.5%)	6238

* Includes four people of no fixed abode and five people who declined to give any residential information.

Table 3.12: Distribution of total and mean number of outpatient visits, day cases, inpatient episodes, inpatient days and home visits by treatment centre and stage of HIV disease, 2009

		Outpatient Visits		Day Cases		Inpatient Episodes		Inpatient Days		Home Visits	
		Total	Mean	Total	Mean	Total	Mean	Total	Mean	Total	Mean
Treatment Centre	AHC	122	4.36	4	0.14	5	0.18	12	0.43	464	16.57
	APH	429	5.43	2	0.03	5	0.06	35	0.44	13	0.16
	ARM	436	18.96								
	BLAG	2869	7.24	10	0.03	34	0.09	311	0.79	37	0.09
	BLK	7	3.50								
	BLKG	631	5.68	1	0.01	7	0.06	59	0.53	2	0.02
	BOLG	1970	6.08	7	0.02	16	0.05	279	0.86		
	BURG	314	7.66	1	0.02	5	0.12	69	1.68	7	0.17
	BURY	222	4.11							3	0.06
	CHR	707	4.88	4	0.03	14	0.10	116	0.80	1	0.01
	CUMB	295	5.09	6	0.10	17	0.29	68	1.17	1	0.02
	FGH	41	1.95			2	0.10	160	7.62		
	HAL	43	5.38	2	0.25	6	0.75	7	0.88	3	0.38
	JAR	285	5.38							74	1.40
	LCN	431	6.16							612	8.74
	LEI	491	8.05	4	0.07	8	0.13	110	1.80		
	MAC	353	7.67	2	0.04	1	0.02	43	0.93		
	MGP	994	5.37								
	MRIG	8060	6.72			43	0.04	907	0.76		
	MRIH	157	4.91	10	0.31	4	0.13	25	0.78		
	NMG	8324	5.16	985	0.61	264	0.16	4637	2.87	105	0.07
	NMGG	571	2.84								
	NOBL	128	8.00			1	0.06	3	0.19		
	OLDG	537	6.80								
	PG	986	5.27			11	0.06	190	1.02	5	0.03
	PP	3	1.50								
	RLG	4822	6.19			126	0.16	998	1.28		
	RLH	41	3.73								
	RLI	109	2.66			3	0.07	31	0.76		
	ROCG	309	4.18							3	0.04
	SALG	1180	7.07	1	0.01	1	0.01	1	0.01		
	SHH	486	5.72	2	0.02	11	0.13	45	0.53		
	SPG	563	7.22			3	0.04	9	0.12	9	0.12
	STP	617	4.78	2	0.02	13	0.10	20	0.16		
TAMG	373	7.61							4	0.08	
TRAG	26	3.25			2	0.25	24	3.00			
WAR	303	6.06			3	0.06	50	1.00	1	0.02	
WGH	55	2.62			1	0.05	3	0.14			
WHIT	5	2.50			1	0.50	2	1.00			
WIGG	9	1.13									
WITG	1822	6.51	2	0.01	6	0.02	245	0.88	1	0.00	
WORK	65	3.25	7	0.35	7	0.35	65	3.25	9	0.45	
Stage of HIV Disease	Asymptomatic	19251	6.28	28	0.01	154	0.05	1584	0.52	355	0.12
	Symptomatic	9932	6.38	657	0.42	147	0.09	1271	0.82	407	0.26
	AIDS	9585	7.15	350	0.26	270	0.20	4915	3.67	495	0.37
	AIDS Related Death	129	5.38	12	0.50	31	1.29	562	23.42	14	0.58
	Death Unrelated to AIDS	69	3.00			10	0.43	55	2.39	3	0.13
	Unknown	1225	5.30	5	0.02	8	0.03	137	0.59	80	0.35
Total	40191	6.44	1052	0.17	620	0.10	8524	1.37	1354	0.22	

Table 3.13: Residency status of all cases of HIV and AIDS by sex, age group, infection route, ethnicity, stage of HIV disease and area of residence, 2009

		Residency Status							Total
		UK National	Asylum Seeker	Overseas Student	Temporary Visitor	Refugee	Other***	Unknown	
Sex	Male	3836 (84.1%)	214 (33.1%)	52 (39.7%)	24 (45.3%)	61 (30.5%)	82 (38.9%)	243 (56.1%)	4512 (72.3%)
	Female	727 (15.9%)	433 (66.9%)	79 (60.3%)	29 (54.7%)	139 (69.5%)	129 (61.1%)	190 (43.9%)	1726 (27.7%)
Age Group	0-14	38 (0.8%)	12 (1.9%)			1 (0.5%)	16 (7.6%)	27 (6.2%)	94 (1.5%)
	15-19	21 (0.5%)	9 (1.4%)			3 (1.5%)	7 (3.3%)	2 (0.5%)	42 (0.7%)
	20-24	170 (3.7%)	14 (2.2%)	8 (6.1%)		5 (2.5%)	5 (2.4%)	11 (2.5%)	213 (3.4%)
	25-29	389 (8.5%)	64 (9.9%)	24 (18.3%)	10 (18.9%)	19 (9.5%)	26 (12.3%)	49 (11.3%)	581 (9.3%)
	30-34	607 (13.3%)	165 (25.5%)	25 (19.1%)	8 (15.1%)	41 (20.5%)	46 (21.8%)	81 (18.7%)	973 (15.6%)
	35-39	815 (17.9%)	157 (24.3%)	33 (25.2%)	9 (17%)	43 (21.5%)	35 (16.6%)	99 (22.9%)	1191 (19.1%)
	40-44	866 (19%)	127 (19.6%)	20 (15.3%)	13 (24.5%)	40 (20%)	45 (21.3%)	82 (18.9%)	1193 (19.1%)
	45-49	728 (16%)	59 (9.1%)	16 (12.2%)	5 (9.4%)	23 (11.5%)	20 (9.5%)	38 (8.8%)	889 (14.3%)
	50-54	426 (9.3%)	23 (3.6%)	5 (3.8%)	2 (3.8%)	17 (8.5%)	5 (2.4%)	21 (4.8%)	499 (8%)
	55-59	268 (5.9%)	12 (1.9%)		5 (9.4%)	3 (1.5%)	4 (1.9%)	11 (2.5%)	303 (4.9%)
60+	235 (5.2%)	5 (0.8%)		1 (1.9%)	5 (2.5%)	2 (0.9%)	12 (2.8%)	260 (4.2%)	
Infection Route	MSM	3052 (66.9%)	9 (1.4%)	5 (3.8%)	9 (17%)	1 (0.5%)	27 (12.8%)	70 (16.2%)	3173 (50.9%)
	Injecting Drug Use	109 (2.4%)	1 (0.2%)				3 (1.4%)	11 (2.5%)	124 (2%)
	Heterosexual	1217 (26.7%)	612 (94.6%)	123 (93.9%)	43 (81.1%)	196 (98%)	155 (73.5%)	277 (64%)	2623 (42%)
	Blood/Tissue	61 (1.3%)	2 (0.3%)	1 (0.8%)			3 (1.4%)	1 (0.2%)	68 (1.1%)
	Mother to Child	54 (1.2%)	20 (3.1%)			3 (1.5%)	22 (10.4%)	27 (6.2%)	126 (2%)
	Undetermined	70 (1.5%)	3 (0.5%)	2 (1.5%)	1 (1.9%)		1 (0.5%)	47 (10.9%)	124 (2%)
Ethnicity	White	3855 (84.5%)	5 (0.8%)	3 (2.3%)	8 (15.1%)	3 (1.5%)	37 (17.5%)	101 (23.3%)	4012 (64.3%)
	Black Caribbean	58 (1.3%)	2 (0.3%)	5 (3.8%)	1 (1.9%)	1 (0.5%)	3 (1.4%)	8 (1.8%)	78 (1.3%)
	Black African	413 (9.1%)	619 (95.7%)	120 (91.6%)	38 (71.7%)	193 (96.5%)	157 (74.4%)	264 (61%)	1804 (28.9%)
	Black Other	17 (0.4%)	1 (0.2%)			1 (0.5%)	2 (0.9%)	1 (0.2%)	22 (0.4%)
	Indian/Pakistani/Bangladeshi	63 (1.4%)	3 (0.5%)	1 (0.8%)	1 (1.9%)		5 (2.4%)	6 (1.4%)	79 (1.3%)
	Other Asian/Oriental	60 (1.3%)	8 (1.2%)	1 (0.8%)	3 (5.7%)	1 (0.5%)	2 (0.9%)	8 (1.8%)	83 (1.3%)
	Other/Mixed	77 (1.7%)	9 (1.4%)	1 (0.8%)	2 (3.8%)	1 (0.5%)	5 (2.4%)	6 (1.4%)	101 (1.6%)
	Unknown	20 (0.4%)						39 (9%)	59 (0.9%)
Stage of HIV Disease	Asymptomatic	2155 (47.2%)	379 (58.6%)	73 (55.7%)	24 (45.3%)	97 (48.5%)	110 (52.1%)	226 (52.2%)	3064 (49.1%)
	Symptomatic	1248 (27.4%)	119 (18.4%)	22 (16.8%)	16 (30.2%)	44 (22%)	43 (20.4%)	64 (14.8%)	1556 (24.9%)
	AIDS	965 (21.1%)	138 (21.3%)	30 (22.9%)	13 (24.5%)	56 (28%)	45 (21.3%)	93 (21.5%)	1340 (21.5%)
	AIDS Related Death	16 (0.4%)	2 (0.3%)			1 (0.5%)	1 (0.5%)	4 (0.9%)	24 (0.4%)
	Death Unrelated to AIDS	21 (0.5%)					1 (0.5%)	1 (0.2%)	23 (0.4%)
	Unknown	158 (3.5%)	9 (1.4%)	6 (4.6%)		2 (1%)	11 (5.2%)	45 (10.4%)	231 (3.7%)
Area of Residence	Cumbria	122 (2.7%)			5 (9.4%)		2 (0.9%)	2 (0.5%)	131 (2.1%)
	Lancashire	769 (16.9%)	26 (4%)	3 (2.3%)	1 (1.9%)	10 (5%)	18 (8.5%)	16 (3.7%)	843 (13.5%)
	Greater Manchester	2527 (55.4%)	382 (59%)	120 (91.6%)	42 (79.2%)	182 (91%)	169 (80.1%)	332 (76.7%)	3754 (60.2%)
	Merseyside	571 (12.5%)	220 (34%)	4 (3.1%)	1 (1.9%)	2 (1%)	8 (3.8%)	42 (9.7%)	848 (13.6%)
	Cheshire	350 (7.7%)	11 (1.7%)	2 (1.5%)		3 (1.5%)	6 (2.8%)	12 (2.8%)	384 (6.2%)
	Out of Region*	181 (4%)	6 (0.9%)		4 (7.5%)	2 (1%)	4 (1.9%)	16 (3.7%)	213 (3.4%)
	Abroad						1 (0.5%)		1 (0.02%)
	Unknown**	43 (0.9%)	2 (0.3%)	2 (1.5%)		1 (0.5%)	3 (1.4%)	13 (3%)	64 (1%)
Total		4563	647	131	53	200	211	433	6238

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

Age groups refer to the ages of individuals at the end of December 2009, or at death.

* Includes Isle of Man.

** Includes four people of no fixed abode and five people who declined to give any residential information.

***Includes residency status defined as 'Migrant worker', 'Dependant' and 'Other'.

Table 3.14: Primary care trust of residence of all HIV and AIDS cases by infection route, 2009

PCT of Residence	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Undetermined	
Cumbria	67 (51.1%)	2 (1.5%)	52 (39.7%)	3 (2.3%)	3 (2.3%)	4 (3.1%)	131
North Lancashire	93 (67.4%)	1 (0.7%)	39 (28.3%)	2 (1.4%)	2 (1.4%)	1 (0.7%)	138
Blackpool	257 (82.9%)	3 (1%)	44 (14.2%)	5 (1.6%)	1 (0.3%)		310
Blackburn with Darwen	25 (28.1%)	1 (1.1%)	57 (64%)	2 (2.2%)	1 (1.1%)	3 (3.4%)	89
East Lancashire	61 (49.2%)	4 (3.2%)	49 (39.5%)	2 (1.6%)	3 (2.4%)	5 (4%)	124
Central Lancashire	92 (51.1%)	3 (1.7%)	74 (41.1%)	2 (1.1%)	4 (2.2%)	5 (2.8%)	180
Unknown Lancashire			2 (100%)				2
Ashton, Leigh & Wigan	51 (34.5%)	1 (0.7%)	85 (57.4%)	3 (2%)	3 (2%)	5 (3.4%)	148
Bolton	78 (30%)	9 (3.5%)	155 (59.6%)	5 (1.9%)	10 (3.8%)	3 (1.2%)	260
Bury	100 (56.2%)	2 (1.1%)	65 (36.5%)	1 (0.6%)	3 (1.7%)	7 (3.9%)	178
Heywood, Middleton & Rochdale	60 (37.3%)	8 (5%)	83 (51.6%)	4 (2.5%)	4 (2.5%)	2 (1.2%)	161
Oldham	50 (34.2%)	3 (2.1%)	86 (58.9%)	2 (1.4%)	2 (1.4%)	3 (2.1%)	146
Salford	366 (67.5%)	10 (1.8%)	152 (28%)	1 (0.2%)	3 (0.6%)	10 (1.8%)	542
Manchester	895 (50%)	37 (2.1%)	789 (44.1%)	4 (0.2%)	42 (2.3%)	23 (1.3%)	1790
Tameside & Glossop	80 (51%)	4 (2.5%)	69 (43.9%)		3 (1.9%)	1 (0.6%)	157
Trafford	113 (57.1%)	4 (2%)	70 (35.4%)	4 (2%)	3 (1.5%)	4 (2%)	198
Stockport	91 (62.8%)		43 (29.7%)	2 (1.4%)	6 (4.1%)	3 (2.1%)	145
Unknown Greater Manchester	27 (71.1%)		11 (28.9%)				38
Sefton	34 (32.1%)	8 (7.5%)	55 (51.9%)	2 (1.9%)		7 (6.6%)	106
Liverpool	144 (29.3%)	8 (1.6%)	307 (62.5%)	5 (1%)	12 (2.4%)	15 (3.1%)	491
Knowsley	29 (61.7%)	1 (2.1%)	16 (34%)			1 (2.1%)	47
Wirral	61 (44.2%)	4 (2.9%)	67 (48.6%)	2 (1.4%)	3 (2.2%)	1 (0.7%)	138
Halton & St Helens	56 (63.6%)		28 (31.8%)	1 (1.1%)	1 (1.1%)	2 (2.3%)	88
Unknown Merseyside	3 (50%)		3 (50%)				6
Warrington	43 (53.8%)	1 (1.3%)	33 (41.3%)	1 (1.3%)	2 (2.5%)		80
Western Cheshire	66 (52%)	3 (2.4%)	50 (39.4%)	2 (1.6%)	6 (4.7%)		127
Central and Eastern Cheshire	93 (62.4%)	2 (1.3%)	48 (32.2%)	4 (2.7%)		2 (1.3%)	149
Isle of Man	9 (40.9%)		12 (54.5%)	1 (4.5%)			22
Out of Region	99 (54.4%)	2 (1.1%)	57 (31.3%)	5 (2.7%)	9 (4.9%)	10 (5.5%)	182
Abroad			1 (100%)				1
Unknown*	30 (46.9%)	3 (4.7%)	21 (32.8%)	3 (4.7%)		7 (10.9%)	64
Total	3173 (50.9%)	124 (2%)	2623 (42%)	68 (1.1%)	126 (2%)	124 (2%)	6238

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

* Includes four people of no fixed abode and five people who declined to give any residential information.

Table 3.15: Primary care trust of residence of all HIV and AIDS cases by stage of disease, 2009

PCT of Residence	Infection Route						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	61 (46.6%)	30 (22.9%)	35 (26.7%)	2 (1.5%)	1 (0.8%)	2 (1.5%)	131
North Lancashire	57 (41.3%)	40 (29%)	34 (24.6%)		3 (2.2%)	4 (2.9%)	138
Blackpool	111 (35.8%)	111 (35.8%)	73 (23.5%)	2 (0.6%)	2 (0.6%)	11 (3.5%)	310
Blackburn with Darwen	49 (55.1%)	22 (24.7%)	17 (19.1%)			1 (1.1%)	89
East Lancashire	53 (42.7%)	44 (35.5%)	25 (20.2%)			2 (1.6%)	124
Central Lancashire	68 (37.8%)	61 (33.9%)	44 (24.4%)		3 (1.7%)	4 (2.2%)	180
Unknown Lancashire		1 (50%)				1 (50%)	2
Ashton, Leigh & Wigan	85 (57.4%)	32 (21.6%)	27 (18.2%)			4 (2.7%)	148
Bolton	154 (59.2%)	47 (18.1%)	57 (21.9%)	1 (0.4%)		1 (0.4%)	260
Bury	77 (43.3%)	63 (35.4%)	36 (20.2%)			2 (1.1%)	178
Heywood, Middleton & Rochdale	77 (47.8%)	39 (24.2%)	41 (25.5%)	1 (0.6%)	3 (1.9%)		161
Oldham	78 (53.4%)	34 (23.3%)	32 (21.9%)			2 (1.4%)	146
Salford	264 (48.7%)	150 (27.7%)	105 (19.4%)	3 (0.6%)	2 (0.4%)	18 (3.3%)	542
Manchester	839 (46.9%)	444 (24.8%)	394 (22%)	6 (0.3%)	4 (0.2%)	103 (5.8%)	1790
Tameside & Glossop	72 (45.9%)	47 (29.9%)	31 (19.7%)			7 (4.5%)	157
Trafford	83 (41.9%)	57 (28.8%)	53 (26.8%)		1 (0.5%)	4 (2%)	198
Stockport	60 (41.4%)	54 (37.2%)	29 (20%)			2 (1.4%)	145
Unknown Greater Manchester	19 (50%)	1 (2.6%)	3 (7.9%)			15 (39.5%)	38
Sefton	68 (64.2%)	20 (18.9%)	16 (15.1%)			2 (1.9%)	106
Liverpool	348 (70.9%)	56 (11.4%)	71 (14.5%)	2 (0.4%)	2 (0.4%)	12 (2.4%)	491
Knowsley	28 (59.6%)	7 (14.9%)	11 (23.4%)			1 (2.1%)	47
Wirral	52 (37.7%)	44 (31.9%)	41 (29.7%)	1 (0.7%)			138
Halton & St Helens	56 (63.6%)	16 (18.2%)	13 (14.8%)	3 (3.4%)			88
Unknown Merseyside	4 (66.7%)		1 (16.7%)	1 (16.7%)			6
Warrington	57 (71.3%)	10 (12.5%)	12 (15%)			1 (1.3%)	80
Western Cheshire	80 (63%)	22 (17.3%)	24 (18.9%)		1 (0.8%)		127
Central and Eastern Cheshire	51 (34.2%)	41 (27.5%)	52 (34.9%)	1 (0.7%)		4 (2.7%)	149
Isle of Man	7 (31.8%)	9 (40.9%)	6 (27.3%)				22
Out of Region	81 (44.5%)	46 (25.3%)	48 (26.4%)	1 (0.5%)	1 (0.5%)	5 (2.7%)	182
Abroad			1 (100%)				1
Unknown*	25 (39.1%)	8 (12.5%)	8 (12.5%)			23 (35.9%)	64
Total	3064 (49.1%)	1556 (24.9%)	1340 (21.5%)	24 (0.4%)	23 (0.4%)	231 (3.7%)	6238

* Includes four people of no fixed abode and five people who declined to give any residential information.

4. Community Sector 2009 (known in previous reports as Voluntary Agencies)

Community sector organisations have long played a fundamental role in the recognition of HIV/AIDS and in addressing the needs of HIV positive individuals^[90-91]. They are identified in the Department of Health's AIDS Service Grant circular as key providers of social care^[92] and the Department of Health anticipated an increasing role for the community and independent sector in HIV and sexual health care services as set out in the White Paper *Our health, our care, our say: a new direction for community service*^[93]. In the North West region, community sector organisations continue to provide a wide range of services including counselling, information, training, awareness-raising campaigns, complementary therapies, advocacy, free condoms, financial assistance, fundraising, support groups and help lines. Some also offer medical services such as nurse-led sessions run by local PCT staff and point of care testing. The majority of organisations provide services for a variety of people living with HIV and may run special sessions for women, gay men, African people and young people. Many organisations also provide care and support to the friends and family of those affected by HIV. Recent research has shown that those not known to the statutory sector were significantly more deprived than those accessing both community sector and statutory services and those accessing the statutory services alone^[94]. These data show that the community sector provide services to some of the most vulnerable HIV positive people in the North West. Research into the economics of HIV in the region established that seven community sector organisations annually contribute one million pounds worth of services over and above those purchased by the statutory sector^[39]. During 2009, 3,108 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by ten community sector organisations in the region, 10% more than the 2,834 seen in 2008. An additional organisation, Signposts, is included in the data for the first time this year. This organisation, covering Cumbria and Lancashire, aims to offer a co-ordinated care service with a specialist nurse and social worker, along with advice and information.

It is important to note that not all HIV/AIDS community sector organisations are able to provide attributable data (soundex, date of birth and sex) for the report. Organisations such as South Lancashire HEAL/Lancashire AIDS Line 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 community sector organisation do not necessarily reflect the overall service provision since organisations provide support for all those affected by HIV (including families, partners and carers of HIV positive people). For all community sector organisations, where information relating to infection route and ethnicity was not available, data have been updated from that provided from the

statutory care providers. Matching between databases relies on the same attributable data being provided by the community and statutory sector, underlining the need for accuracy in recording of soundex codes, dates of birth and sex. Tables 4.1 and 4.2 illustrate key characteristics of all individuals accessing care from each individual community sector organisation, and include duplicate information on some individuals as some attend more than one organisation. Table 4.3 is concerned with those HIV positive individuals accessing community sector care as a whole and contains only unique individuals. Where appropriate, references are made to corresponding data from previous North West reports^[1-13].

Community sector organisations 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 alone^[1-13]. In 2009, 33% of individuals seen by community sector organisations did not appear to access care in the statutory sector and 23% of individuals have never been treated by the statutory sector in the North West (table 4.3).

Table 4.1 illustrates demographic information on people with HIV presenting to ten community sector organisations in the North West during 2009, and the number who also presented at statutory agencies in the North West during 2009 or prior to but not in 2009. Most organisations reporting recorded an increase in their client numbers compared with the previous year: CLASS (140%); Black Health Agency (BHA, 41%); Sahir House (40%); Body Positive Cheshire and North Wales (BP Cheshire N. Wales, 39% increase); Body Positive North West (BP North West, 6%); and George House Trust (GHT, 6%). SHIVER and Barnardo's in Manchester (BARM) both saw a decrease on the previous year (67% and 8% respectively).

There is variation in the proportion of community sector clients also seen by the statutory sector in 2009, ranging from 80% at Sahir House to 29% at SHIVER in Blackpool. The majority of people not in contact with statutory treatment centres in 2009 reside in the North West of England (BARM, BHA, and BP Blackpool, 99%; Sahir, 98%; GHT, 97%; BP North West, 94%; BP Cheshire N. Wales, 78% and 100% for the remaining agencies; data not shown). A significant number of people have never been seen at statutory centres, for example, 319 individuals at GHT have apparently never been seen by the statutory sector. Although this needs to be interpreted with caution, since coding inaccuracies lead to inflation of this figure, these data suggest that the community sector may be the sole provider of care and support for a substantial number of HIV positive individuals.

For four of the community sector organisations that provided data for 2009, the largest proportion of individuals presenting for support acquired HIV through sex between men (BP Blackpool, 74%; BP Cheshire and North Wales, 67%; BP North West, 66%; GHT, 57%). The main route of infection for those seen at the other organisations was heterosexual sex (BHA 96%, BARM 66%, Sahir 45% and CLASS 38%) with a high proportion of female service users in two of these organisations (BHA, 75% and BARM, 80%). BARM provides support for families with children and young people affected by HIV. In some cases the HIV positive client is a parent, in other cases the young person. Three community sector organisations (BHA, SHIVER and Signposts) had no clients infected through injecting drug use.

The majority of clients at each of the community sector organisations were aged between 25 and 49 years. BARM treated the most clients aged 14 years or under (27 individuals, 15% of all those seen at BARM), as would be expected for an organisation specialising in the needs of young people.

The differing profiles and characteristics of HIV positive clients accessing North West community sector organisations in part reflects the different range of services provided and the varying strategies used to encourage HIV positive people to use the services.

For most community sector organisations, the majority of individuals seen in 2009 were of white ethnicity, ranging from 88% at BP Blackpool to 58% at Sahir. BHA, a specialist service for black and minority ethnic communities, provided care for a high proportion of HIV positive black Africans (98%), as did BARM (89%). GHT provided care for the largest number of HIV positive black Africans (678 individuals) an increase of 11% since 2008 (612 individuals), a greater increase than the overall increase in numbers at GHT (6%).

For all the community sector organisations, the majority of clients seen in 2009 were resident in the North West, ranging from 100% at CLASS and SHIVER to 78% at BP Cheshire and North Wales. BP Cheshire and North Wales was the only community sector organisation with a significant proportion of HIV positive clients from outside the region (22%), reflecting the proximity of the organisation to Wales and the West Midlands and the specific services it provides in North Wales.

Table 4.2 illustrates the crossover of care of HIV positive individuals between North West community sector organisations and the statutory organisations during 2009. The distribution of statutory treatment and care of community sector clients in part reflects the geographical

location of the community sector organisations. However, the Infectious Disease Unit at North Manchester General Hospital (NMG), the largest HIV treatment centre in the North West (chapter 3, table 3.9), accounts for a significant number of presentations by people accessing community sector organisations across the whole region (1,024). In addition, MRIG saw 666 people who also visited a community sector organisation.

Table 4.3 illustrates the infection route, sex, ethnicity and residency status of HIV positive individuals accessing the community sector in the North West in 2009 by attendance at the statutory sector during the year. Unlike table 4.1 and 4.2, this table shows information on unique individuals rather than everyone attending every organisation. Due to the relatively high proportion of individuals for whom infection route is unknown (particularly amongst those who have never attended the statutory sector), the percentages in the table are calculated on those for whom the information is known. The predominant route of exposure to HIV amongst community sector clients during 2009 was sex between men, accounting for 56% of cases. This is comparable to the 52% of individuals accessing the statutory sector for whom route of exposure has been determined (chapter 3, table 3.2). A similar proportion of those (whose infection route was known) seen in the community sector were infected through heterosexual sex (39%) compared with the statutory sector (43%; chapter 3, table 3.2). This has increased since 2001 when only 19% of community sector clients were exposed through heterosexual sex. In 2009, the vast majority of those using community sector services were male (70%), primarily due to the relatively high numbers of MSM with HIV. As with HIV positive individuals accessing the statutory sector (64%; chapter 3, table 3.5), the majority of community sector clients are of white ethnicity (63%) but this varies between services (table 4.1).

Table 4.3 also shows that 33% of individuals (1,029 out of 3,108) using community sector organisations did not attend a statutory sector service during 2009 and 23% have never been seen by the statutory sector. The profile of those who have never presented to the statutory sector is quite distinct: they are less likely to be MSM (44% compared with 59% accessing both the community and statutory sector in 2009 or prior to this) and more likely to be heterosexually infected (48% compared with 37%). They are also more likely to be black African (42% compared with 28%) and more likely to be an asylum seeker (13% compared with 8%). Those who have attended the statutory sector in the past but not in 2009 are more likely to be male (79%), MSM (69%), white (72%) and a UK national (75%).

Table 4.1: Attendance by HIV positive individuals at community sector organisations in the North West, by statutory sector attendance, sex, age group, infection route, ethnicity, residency status and North West residency, 2009

		Community Sector Organisation									
		BARM	BHA	BP Blackpool	BP Cheshire N. Wales	BP North West*	CLASS	GHT	Sahir	SHIVER	Signposts
Statutory Sector Attendance	Never seen	94 (51.1%)	39 (47%)	43 (55.8%)	52 (25%)	143 (13.9%)	5 (20.8%)	319 (15.8%)	32 (15.9%)	10 (71.4%)	
	Seen in 2009	88 (47.8%)	42 (50.6%)	28 (36.4%)	149 (71.6%)	747 (72.7%)	17 (70.8%)	1480 (73.2%)	160 (79.6%)	4 (28.6%)	6 (85.7%)
	Seen prior to 2009	2 (1.1%)	2 (2.4%)	6 (7.8%)	7 (3.4%)	137 (13.3%)	2 (8.3%)	222 (11%)	9 (4.5%)		1 (14.3%)
Sex	Male	37 (20.1%)	21 (25.3%)	64 (83.1%)	170 (81.7%)	795 (77.4%)	17 (70.8%)	1444 (71.4%)	122 (60.7%)	12 (85.7%)	5 (71.4%)
	Female	147 (79.9%)	62 (74.7%)	13 (16.9%)	38 (18.3%)	232 (22.6%)	7 (29.2%)	577 (28.6%)	79 (39.3%)	2 (14.3%)	2 (28.6%)
Age Group	0-14	27 (14.7%)		6 (7.8%)	1 (0.5%)	4 (0.4%)		19 (0.9%)	1 (0.5%)		
	15-19	18 (9.8%)		1 (1.3%)		3 (0.3%)		18 (0.9%)	1 (0.5%)		
	20-24	4 (2.2%)	1 (1.2%)	1 (1.3%)	11 (5.3%)	13 (1.3%)	1 (4.2%)	40 (2%)	8 (4%)	2 (14.3%)	
	25-29	20 (10.9%)	8 (9.6%)	9 (11.7%)	19 (9.1%)	62 (6%)	2 (8.3%)	160 (7.9%)	13 (6.5%)	2 (14.3%)	
	30-34	36 (19.6%)	13 (15.7%)	13 (16.9%)	26 (12.5%)	136 (13.2%)	3 (12.5%)	345 (17.1%)	41 (20.4%)	1 (7.1%)	
	35-39	39 (21.2%)	19 (22.9%)	14 (18.2%)	37 (17.8%)	196 (19.1%)	4 (16.7%)	407 (20.1%)	36 (17.9%)		2 (28.6%)
	40-44	22 (12%)	16 (19.3%)	17 (22.1%)	40 (19.2%)	226 (22%)	6 (25%)	412 (20.4%)	35 (17.4%)	1 (7.1%)	1 (14.3%)
	45-49	12 (6.5%)	13 (15.7%)	12 (15.6%)	31 (14.9%)	174 (16.9%)	5 (20.8%)	320 (15.8%)	35 (17.4%)	5 (35.7%)	1 (14.3%)
	50-54	3 (1.6%)	4 (4.8%)	2 (2.6%)	14 (6.7%)	106 (10.3%)		162 (8%)	20 (10%)	1 (7.1%)	1 (14.3%)
	55-59	2 (1.1%)	4 (4.8%)	1 (1.3%)	19 (9.1%)	68 (6.6%)	1 (4.2%)	89 (4.4%)	8 (4%)	1 (7.1%)	1 (14.3%)
60+	1 (0.5%)	5 (6%)	1 (1.3%)	10 (4.8%)	39 (3.8%)	2 (8.3%)	49 (2.4%)	3 (1.5%)	1 (7.1%)	1 (14.3%)	
Infection Route	MSM	2 (1.1%)		57 (74%)	139 (66.8%)	679 (66.1%)	7 (29.2%)	1145 (56.7%)	67 (33.3%)	3 (21.4%)	4 (57.1%)
	Injecting Drug Use	1 (0.5%)		1 (1.3%)	3 (1.4%)	15 (1.5%)	1 (4.2%)	24 (1.2%)	3 (1.5%)		
	Heterosexual	121 (65.8%)	80 (96.4%)	12 (15.6%)	59 (28.4%)	272 (26.5%)	9 (37.5%)	819 (40.5%)	90 (44.8%)	1 (7.1%)	3 (42.9%)
	Blood/Tissue	1 (0.5%)			1 (0.5%)	16 (1.6%)		1 (0.05%)	3 (1.5%)		
	Mother to Child	45 (24.5%)		6 (7.8%)	2 (1%)	4 (0.4%)		28 (1.4%)	2 (1%)		
	Undetermined	14 (7.6%)	3 (3.6%)	1 (1.3%)	4 (1.9%)	41 (4%)	7 (29.2%)	4 (0.2%)	36 (17.9%)	10 (71.4%)	
Ethnicity	White	11 (6%)	1 (1.2%)	68 (88.3%)	174 (83.7%)	761 (74.1%)	17 (70.8%)	1246 (61.7%)	116 (57.7%)	11 (78.6%)	6 (85.7%)
	Black Caribbean		1 (1.2%)		4 (1.9%)	12 (1.2%)		12 (0.6%)		1 (7.1%)	
	Black African	163 (88.6%)	81 (97.6%)	8 (10.4%)	4 (1.9%)	201 (19.6%)	4 (16.7%)	678 (33.5%)	76 (37.8%)		1 (14.3%)
	Black Other	3 (1.6%)			14 (6.7%)	8 (0.8%)	2 (8.3%)	24 (1.2%)	2 (1%)	1 (7.1%)	
	Indian/Pakistani/Bangladeshi	1 (0.5%)				10 (1%)		32 (1.6%)	2 (1%)		
	Other Asian/Oriental	2 (1.1%)			6 (2.9%)	3 (0.3%)			3 (1.5%)		
	Other/Mixed	4 (2.2%)		1 (1.3%)	3 (1.4%)	28 (2.7%)	1 (4.2%)	29 (1.4%)	1 (0.5%)	1 (7.1%)	
	Unknown				3 (1.4%)	4 (0.4%)			1 (0.5%)		
Residency	UK National	18 (9.8%)	3 (3.6%)	71 (92.2%)	184 (88.5%)	806 (78.5%)	20 (83.3%)	1264 (62.5%)	108 (53.7%)	4 (28.6%)	6 (85.7%)
	Asylum Seeker	52 (28.3%)	38 (45.8%)	1 (1.3%)	1 (0.5%)	69 (6.7%)	1 (4.2%)	144 (7.1%)	50 (24.9%)		
	Overseas Student	4 (2.2%)	3 (3.6%)		20 (9.6%)	11 (1.1%)		37 (1.8%)	1 (0.5%)		
	Migrant Worker		1 (1.2%)	1 (1.3%)	1 (0.5%)	12 (1.2%)		107 (5.3%)			1 (14.3%)
	Temporary Visitor	6 (3.3%)	1 (1.2%)			12 (1.2%)		12 (0.6%)			
	Other	8 (4.3%)	18 (21.7%)			37 (3.6%)	3 (12.5%)	153 (7.6%)	2 (1%)		
	Refugee	72 (39.1%)	18 (21.7%)	2 (2.6%)	2 (1%)	75 (7.3%)		273 (13.5%)	3 (1.5%)		
	Dependent	23 (12.5%)	1 (1.2%)			2 (0.2%)		29 (1.4%)			
Unknown	1 (0.5%)		2 (2.6%)		3 (0.3%)		2 (0.1%)	37 (18.4%)	10 (71.4%)		
North West Resident	Resident Outside North West	2 (1.1%)	1 (1.2%)	1 (1.3%)	46 (22.1%)	62 (6%)		56 (2.8%)	5 (2.5%)		
	North West Resident	182 (98.9%)	82 (98.8%)	76 (98.7%)	162 (77.9%)	965 (94%)	24 (100%)	1965 (97.2%)	196 (97.5%)	14 (100%)	7 (100%)
Total		184	83	77	208	1027	24	2021	201	14	7

For a definition of the abbreviated community sector organisation, please refer to the glossary at the back of the report.

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

Age groups refer to the ages of individuals at the end of December 2009, or at death.

Rows cannot be totalled horizontally as some individuals may appear in more than one row or column (i.e. those attending two or more organisations), thus exaggerating the totals.

*Includes ten individuals diagnosed through BP North West's point of care testing scheme.

Table 4.2: Distribution of statutory treatment for HIV and AIDS cases presenting to community sector organisations, 2009

Treatment Centre	Community Sector Organisation									
	BARM	BHA	BP Blackpool	BP Cheshire N.Wales	BP North West	CLASS	GHT	Sahir	SHIVER	Signposts
AHC	2			1	1			2		
APH							1	12		
ARM					1		7	12		
BLAG			23	1	7		29		4	1
BLKG	1				10		26			
BOLG	4	1			17		70			
BURG					3		5			
BURY	3	3			6		12			
CHR				66	3		6	2		
CUMB							2			1
FGH							1			
HAL				3			1	1		
JAR	1				9		19			
LCN	1						10	37		
LEI				33	1		3			
MAC				13	1		8			
MGP				1	62		74			
MRIG	23	18		6	203		414	2		
MRIH					4		3	1		
NMG	46	14		8	347		608	1		
NMGG	1	2			21		47			
NOBL							1	1		
OLDG	1	1			32		18			
PG			5		3	17	30			
PP	1				1					
RLG	1			11	14	1	49	129		1
RLH								1		
RLI					1		7			3
ROCG		2			4		24			
SALG	3	2		1	20		63			
SHH				1	6		15	8		
SPG					3		3	5		
STP	2				21		43	1		
TAMG					7		12			
TRAG					1					
WAR				18	4		5			
WGH							2			
WITG	2	1			57		63	1		
WORK							3			1

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

Table 4.3: HIV and AIDS cases presenting to the community and statutory sector by sex, infection route, ethnicity and residency status, 2009

		Statutory Sector Attendance			Total
		Never Seen	Seen in 2009	Seen Prior to 2009	
Sex	Male	410 (58.2%)	1516 (72.9%)	257 (79.3%)	2183 (70.2%)
	Female	295 (41.8%)	563 (27.1%)	67 (20.7%)	925 (29.8%)
Infection Route	MSM	262 (44.1%)	1187 (57.3%)	224 (69.3%)	1673 (56%)
	Injecting Drug Use	3 (0.5%)	33 (1.6%)	5 (1.5%)	41 (1.4%)
	Heterosexual	285 (48%)	802 (38.7%)	92 (28.5%)	1179 (39.5%)
	Blood/Tissue	5 (0.8%)	13 (0.6%)	2 (0.6%)	20 (0.7%)
	Mother to Child	39 (6.6%)	36 (1.7%)		75 (2.5%)
	Sub Total (100%)	594	2071	323	2988
	Undetermined	111	8	1	120
Ethnicity	White	343 (49.2%)	1379 (66.3%)	232 (71.6%)	1954 (63%)
	Black Caribbean	11 (1.6%)	10 (0.5%)	5 (1.5%)	26 (0.8%)
	Black African	292 (41.9%)	597 (28.7%)	65 (20.1%)	954 (30.8%)
	Black Other	12 (1.7%)	31 (1.5%)	5 (1.5%)	48 (1.5%)
	Indian/Pakistani/Bangladeshi	8 (1.1%)	27 (1.3%)	4 (1.2%)	39 (1.3%)
	Other Asian/Oriental	9 (1.3%)	5 (0.2%)		14 (0.5%)
	Other/Mixed	22 (3.2%)	30 (1.4%)	13 (4%)	65 (2.1%)
	Sub Total (100%)	697	2079	324	3100
Unknown	8			8	
Residency	UK	349 (53%)	1433 (69.1%)	240 (74.5%)	2022 (66.2%)
	Asylum Seeker	87 (13.2%)	180 (8.7%)	21 (6.5%)	288 (9.4%)
	Overseas Student	20 (3%)	28 (1.4%)	16 (5%)	64 (2.1%)
	Migrant Worker	30 (4.6%)	70 (3.4%)	12 (3.7%)	112 (3.7%)
	Temporary Visitor	17 (2.6%)	8 (0.4%)	5 (1.6%)	30 (1%)
	Other	41 (6.2%)	116 (5.6%)	8 (2.5%)	165 (5.4%)
	Refugee	92 (14%)	215 (10.4%)	20 (6.2%)	327 (10.7%)
	Dependent	22 (3.3%)	23 (1.1%)		45 (1.5%)
	Sub Total (100%)	658	2073	322	3053
	Unknown	47	6	2	55
Total	705	2079	324	3108	

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

5. Social Care Providers 2009

This is the eighth 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 services departments in the North West. Five social services departments were able to provide data for this report. Data were collected on 250 individuals accessing HIV care and support in 2009. One individual accessed two social services departments and their information is included in columns from both services.

Social services provide essential care to HIV positive people by ensuring that their needs are assessed and met with regard to welfare, benefits, housing, advocacy and other necessary community-based practical support. This is a crucial service to those affected by and infected with HIV and, for some, may be the only source of care (table 5.1). In 2009/2010, £21.8 million was made available for English local authorities through the AIDS Support Grant. Of this, £1.9 million was allocated to North West local authorities (9% of the national allocation)^[92]. It is important to note that not all clients will reveal their HIV status to social services; therefore these data represent only the number of people known to be HIV positive and accessing social services.

Table 5.1 illustrates the number of HIV positive individuals presenting to each social services department who provided us with data by sex, infection route, residency status and statutory sector attendance. Salford and Knowsley reported more men who use social services than women (82% and 71%, respectively). Amongst those seen by Manchester, Stockport

and Bolton social services departments the majority (72%, 76% and 75%, respectively) of individuals were infected through heterosexual sex whereas in Knowsley and Salford MSM was the predominant route of infection (57% and 73%, respectively).

At all social services departments the residency category with the largest proportion was UK national. However, a large proportion (35%) of individuals seen by Manchester and 27% seen by Stockport social services departments were asylum seekers.

The majority of individuals seen by each social services department had been seen at statutory services in the North West region since monitoring began in 1995. However, in Stockport and Manchester a large proportion of individuals had never been seen by statutory services (30%, and 19%, respectively). This indicates that social services departments may be the sole provider of care and support to some individuals who do not access statutory services.

Table 5.2 illustrates those receiving care from social services who also accessed North West community sector organisations in 2009. Every social services department had service users who also used community sector organisations, with at least one individual from each social services department attending the largest organisation (GHT).

Table 5.1: HIV and AIDS cases presenting to five social services departments by sex, infection route, residency status and statutory sector attendance, 2009

		Social Services Department				
		Bolton	Knowsley	Manchester	Salford	Stockport
Sex	Male	13 (46.4%)	5 (71.4%)	60 (47.2%)	46 (82.1%)	13 (39.4%)
	Female	15 (53.6%)	2 (28.6%)	67 (52.8%)	10 (17.9%)	20 (60.6%)
Infection Route	MSM	5 (17.9%)	4 (57.1%)	23 (18.1%)	41 (73.2%)	5 (15.2%)
	Injecting Drug Use	2 (7.1%)		5 (3.9%)	1 (1.8%)	
	Heterosexual	21 (75%)	3 (42.9%)	92 (72.4%)	14 (25%)	25 (75.8%)
	Mother to child					3 (9.1%)
	Undetermined			7 (5.5%)		
Residency	UK National	15 (53.6%)	6 (85.7%)	52 (40.9%)	45 (80.4%)	10 (30.3%)
	Asylum Seeker	6 (21.4%)	1 (14.3%)	45 (35.4%)	8 (14.3%)	9 (27.3%)
	Overseas Student			4 (3.1%)		1 (3%)
	Migrant Worker			2 (1.6%)	1 (1.8%)	1 (3%)
	Temporary Visitor	1 (3.6%)		6 (4.7%)		
	Other			9 (7.1%)		
	Refugee	6 (21.4%)		5 (3.9%)	2 (3.6%)	9 (27.3%)
	Dependent			1 (0.8%)		3 (9.1%)
	Unknown			3 (2.4%)		
Statutory Sector Attendance	Never seen	5 (17.9%)	1 (14.3%)	24 (18.9%)	14 (25%)	10 (30.3%)
	Seen in 2009	23 (82.1%)	6 (85.7%)	100 (78.7%)	37 (66.1%)	20 (60.6%)
	Seen prior to 2009			3 (2.4%)	5 (8.9%)	3 (9.1%)
Total (100%)		28	7	127	56	33

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

Table 5.2: Distribution of social services care for HIV and AIDS cases presenting to community sector organisations, 2009

	Community Sector Organisation					
	BARM	BHA	BP Cheshire N. Wales	BPNW	GHT	Sahir
Bolton	2			3	17	
Knowsley					1	1
Manchester	9	8		35	78	
Salford				17	26	
Stockport	4		1	5	15	1

6. HIV Trends

The North West HIV/AIDS Monitoring Unit has been collecting and collating data on the treatment and care of HIV positive individuals since 1996. This chapter presents trends broken down by county and local authority of residence. Data prior to 2000 cannot be presented here due to space restrictions and it should be noted that some variables were introduced to the surveillance system in later years.

The number of people accessing HIV services in the North West has increased year on year since recording began, and has risen by 515% since 1996 (from 1,014 individuals in 1996 to 6,238 individuals in 2009) (data not shown). There has been a continued increase (8%) in the size of the HIV positive population from 2008 to 2009. This is slightly smaller than the increase seen between 2007 and 2008 (11%), continuing the trend seen since 2002 (2002 to 2003: 23%; 2003 to 2004: 20%; 2004 to 2005: 17%; 2005 to 2006: 13%; 2006 to 2007: 9%; 2007 to 2008: 11%; table 6.2).

The number of new cases rose annually between 2000 and 2005, with the most dramatic increase in new cases seen between 2001 and 2002 (a rise of 37%). Since 2005, the numbers of new cases have fluctuated. Between 2008 and 2009, there was a decrease of 5%, following the increase of 13% between 2007 and 2008 (table 6.1).

Figure 6.1 shows proportional changes in the number of new cases from 2000 to 2009 by sexual route of HIV infection. Overall there has been an increase in new cases of 163% since 2000. However, the most striking change is the 376% increase in heterosexual infections. This is a trend that has been noted nationally^[42] and is accompanied by an increasing proportion of infections contracted overseas and amongst BME individuals.

It should be noted that although heterosexual cases now dominate the statistics, the annual number of new cases acquired through MSM also increased steadily, by 94% between 2000 and 2009. This stresses the need to maintain and develop prevention strategies amongst this group.

Table 6.1 shows the infection route of new HIV cases presenting in the North West from 2000 to 2009 subdivided by county of residence. The most common route of infection has altered over the years. In 2000, MSM still accounted for the majority of new HIV infections (56%) but by 2002 heterosexual sex overtook MSM for the first time as the main mode of HIV exposure and this has continued into 2009. In 2009 almost half of new cases were infected via heterosexual sex (48%), a similar proportion seen at its peak level in 2003 (50%). The number of infections acquired through IDU has remained low over the years; this may partly be due to the

early implementation of syringe exchange programmes across the North West. The data from 2009 show a 50% increase since 2000 of new cases of HIV transmitted through injecting drug use but also a 25% decrease since its peak in 2005 (20 new cases). The number of cases due to mother to child transmission has increased overall, with a 167% increase seen in 2009 compared with 2000, although no change since 2008. The absolute numbers are relatively low (16 in 2009), therefore, care needs to be taken when interpreting a large percentage change based on a low number. The increase in mother to child transmission is linked to the increase in the number of heterosexually infected HIV positive females, which in turn is linked to migration from high prevalence countries. Were it not for large improvements in diagnosis during pregnancy and effective prevention of HIV transmission to the infant (see chapter 1), the increase in the number of infected children would be much higher. The majority of cases of mother to child transmission seen in the North West have occurred overseas prior to arrival in the UK (see table 2.7).

Across counties, Merseyside saw the largest increase in new cases since 2000 (308%), followed by Greater Manchester, which saw a 172% increase over the same period. All counties, with the exception of Merseyside, saw a decrease in numbers of new cases between 2008 and 2009. Merseyside saw an increase of 27%, whereas Cheshire had the greatest decrease (35%), followed by Cumbria (30%). The overall number of new heterosexual and MSM cases has risen since 2000 (376% and 94% respectively). However, all counties, with the exception of Lancashire and Merseyside, saw a decrease in the number of new cases infected through heterosexual sex since 2008. Only Cumbria and Merseyside reported a percentage increase in the number of new MSM cases (57% and 26%, respectively). This represents a switch from 2008 where these two counties were the only ones to see a decrease in new MSM cases. The greatest overall number of MSM cases remains in Greater Manchester (202 individuals). This is consistent with the large gay community in Manchester^[95] and evidence of high levels of sexual risk behaviour (as revealed in investigations of the syphilis outbreak^[96-100]). There was, however, a decrease of 2% in the overall number of new cases infected through MSM between 2008 and 2009.

Figure 6.2 illustrates proportional changes in the level of antiretroviral therapy (ART) prescribed to HIV positive individuals attending treatment and care centres in the North West from 2000 to 2009. Individuals are categorised by the highest level of combination therapy they received in a given year. Mono and dual therapies have been combined in this figure, due to the small numbers involved. Since 2000, the number of individuals on triple and quadruple or more therapy and the number not taking any antiretroviral drugs,

have all increased in line with the increasing number of HIV cases. Mono and dual therapy use have declined, in line with research^[101] and guidelines which define triple or more antiretroviral drugs as the most effective form of therapy^[89]. The small increase in 2007 in the use of mono and dual therapy seen in these regional figures may be due to data anomalies arising from the development of electronic reporting systems. Data from 2009 show that there has been a continued increase in the proportion of individuals prescribed triple and quadruple or more therapy.

Table 6.2 refers to the level of ART received by all HIV positive individuals accessing treatment and care in the North West from 2000 to 2009 by county of residence. Between 2000 and 2009, those receiving triple or more therapy have varied between 63% and 74% of all cases. From 2000 to 2007, around one third of HIV positive individuals did not receive ART in the reporting period. Since then, this proportion has decreased to 28% in 2008 and a quarter in 2009. Relatively few people are prescribed mono therapy and the number prescribed this level of therapy decreased between 2007 and 2008 (by 75%) and remained at the same level in 2009 (six individuals). This type of therapy is preferred during pregnancy and so its use continues to fluctuate over time. Giving HIV positive pregnant women a single antiretroviral drug (e.g. zidovudine) during pregnancy significantly reduces the chance of the infant becoming infected^[102], and remains a valid option for treatment during pregnancy (although the latest BHIVA guidelines are more complex)^[59]. With the increase in the number of women with HIV infection, the use of mono therapy may continue to fluctuate in the future. The proportion taking dual therapy has remained constant since 2001 (less than 1% of all cases). Between 2000 and 2009, the

largest percentage increase in the number of people in treatment for HIV was seen in Cumbria, rising from 12 to 131 (992%), followed by Merseyside (312%), Greater Manchester (305%), Cheshire (249%) and Lancashire (209%).

Table 6.3 shows the number of new cases of HIV from 2005 to 2009 subdivided by local authority (LA) of residence. Caution is needed when interpreting the percentage change for LAs with a small number of new cases. For example, the LAs with the largest proportional increases from 2005 to 2009 (e.g. Carlisle, Pendle and Knowsley) are those that had very few cases in 2005.

Table 6.4 shows data for all cases of HIV presenting to North West treatment centres from 2005 to 2009, subdivided by LA of residence. Again, caution is needed when interpreting the percentage changes for those LAs with relatively small numbers of HIV cases. The total numbers of HIV cases have increased annually. Of the five counties, Cumbria has seen the largest percentage increase since 2005 at 72%, followed by an increase of 67% in Merseyside, 61% in Cheshire, 52% in Greater Manchester and 35% in Lancashire. Manchester LA had the largest number of HIV positive residents in 2009 (1,790 individuals; a 46% increase since 2005). None of the LAs had fewer than 14 cases of HIV in 2009. The largest percentage increases since 2005 were seen in Barrow-in-Furness (from 4 to 19; 375%), Knowsley (from 19 to 47; 147%), Chorley (13 to 28 individuals; 115%) and Wigan (70 to 148 individuals; 111%). Since 2005 the number of HIV positive people seen at North West treatment centres who reside outside the region has increased by 38% (from 155 to 214 individuals).

Figure 6.1: Percentage change in number of new cases of HIV by selected infection route, 2000-2009

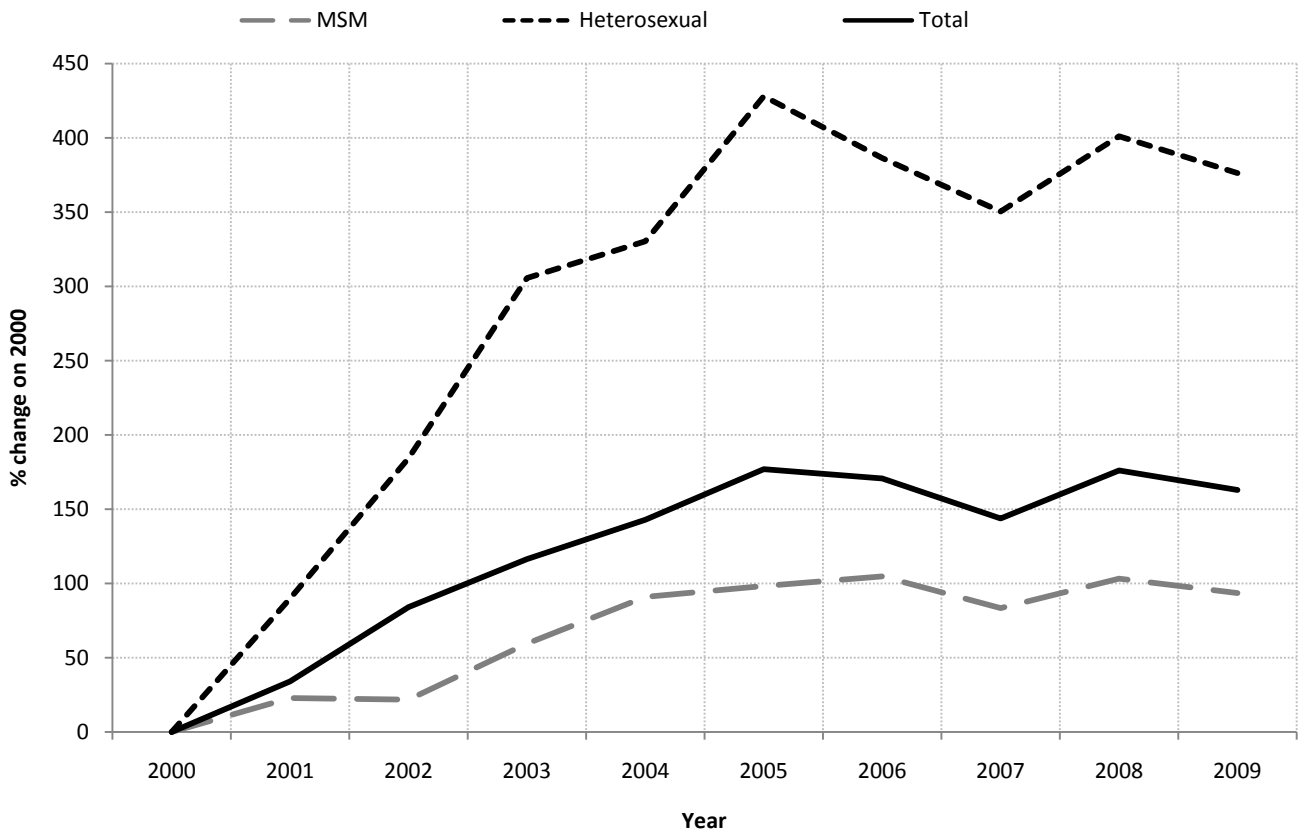


Figure 6.2: Percentage change in number of all cases of HIV by level of antiretroviral therapy, 2000-2009

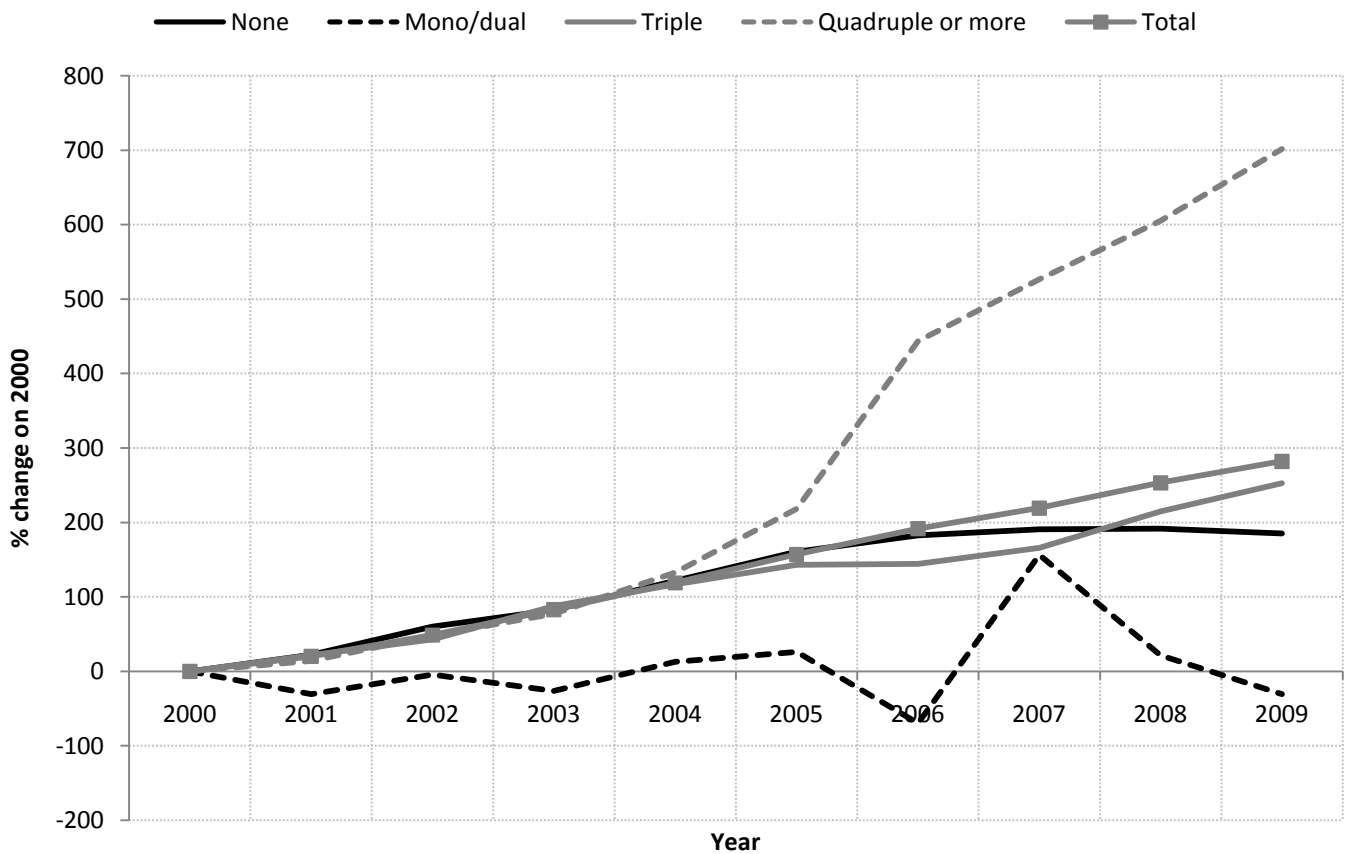


Table 6.1: Number of new HIV and AIDS cases by infection route of HIV and county of residence, 2000-2008

	Infection Route	Year										% Change 2000-2009	% Change 2008-2009
		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		
Cumbria	MSM		3	5	4	6	10	8	8	7	11		57
	Injecting Drug Use			1		1			1	1			-100
	Heterosexual		6	4	4	3	1	5	6	14	4		-71
	Blood/Tissue							1	1				
	Mother to Child								1				
	Undetermined				2	1	1	2		1	1		0
	Cumbria Total		9	10	10	11	12	16	17	23	16		-30
Lancashire	MSM	32	47	24	58	64	68	48	38	59	53	66	-10
	Injecting Drug Use		5	2		1	3	3	1		1		
	Heterosexual	13	18	35	31	39	33	42	44	42	46	254	10
	Blood/Tissue					1				1			-100
	Mother to Child	2	3					2	1	1	2	0	100
	Undetermined	1	5	26		1	5	11	5	7	4	300	-43
	Lancashire Total	48	78	87	89	106	109	106	89	110	106	121	-4
Greater Manchester	MSM	112	127	144	168	209	208	241	190	207	202	80	-2
	Injecting Drug Use	3	4		3	11	9	9	7	6	6	100	0
	Heterosexual	37	93	145	219	226	288	278	239	269	250	576	-7
	Blood/Tissue			1	3	1			2		1		
	Mother to Child		7	8	6	10	6	12	10	10	10		0
	Undetermined	31	11	57	18	23	26	24	13	30	29	-6	-3
	Greater Manchester Total	183	242	355	417	480	537	564	461	522	498	172	-5
Merseyside	MSM	10	18	17	21	31	18	33	43	39	49	390	26
	Injecting Drug Use	4	1		1	2	5	2	1	2	6	50	200
	Heterosexual	24	19	50	68	65	81	68	63	70	91	279	30
	Blood/Tissue	1										-100	
	Mother to Child			1	1	1	3	2	5	3	3		0
	Undetermined	1	2	15	18	1	12	10	8	14	14	1300	0
	Merseyside Total	40	40	83	109	100	119	115	120	128	163	308	27
Cheshire	MSM	16	14	23	20	10	25	26	29	38	24	50	-37
	Injecting Drug Use	1	2	2	2	1	1			1	1	0	0
	Heterosexual	6	11	8	13	17	18	18	25	28	21	250	-25
	Blood/Tissue					1			1				
	Mother to Child	1	1				2		3	1		-100	-100
	Undetermined	1	1	7	4	1	2	4	1	3		-100	-100
	Cheshire Total	25	29	40	39	30	48	48	59	71	46	84	-35
Total North West Residents*	MSM	172	209	213	271	321	329	356	308	350	339	97	-3
	Injecting Drug Use	8	12	5	6	16	18	14	10	10	14	75	40
	Heterosexual	80	147	243	335	351	421	411	377	423	412	415	-3
	Blood/Tissue	1		1	3	2		1	4	1	1	0	0
	Mother to Child	3	11	9	7	12	11	16	20	15	15	400	0
	Undetermined	34	19	105	42	27	46	51	27	55	48	41	-13
	Total	298	398	576	664	729	825	849	746	854	829	178	-3
Total	MSM	188	231	229	300	359	373	385	345	382	364	94	-5
	Injecting Drug Use	10	13	5	7	17	20	15	11	12	15	50	25
	Heterosexual	89	169	253	361	383	470	433	401	446	424	376	-5
	Blood/Tissue	1		1	3	4		3	4	2	1	0	-50
	Mother to Child	6	11	9	7	14	11	17	21	16	16	167	0
	Undetermined	41	25	120	47	37	54	54	35	67	61	49	-9
	Total	335	449	617	725	814	928	907	817	925	881	163	-5

Men who were exposed through sex with men (MSM) and were also injecting drug users are included in the MSM category.

*Individual county totals may not add up to Total North West Residents due to some individuals being categorised as living in the North West region but unknown area.

Table 6.2: Total number of HIV and AIDS cases by level of antiretroviral therapy and county of residence, 2000-2009

ART		Year										% Change 2000-2009	% Change 2008-2009
		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009		
Cumbria	None	2	11	16	21	28	27	26	29	34	29	1350	-15
	Mono				1								
	Triple	10	35	31	31	29	36	43	51	59	70	600	19
	Quadruple or more		5	4	6	8	13	20	26	30	32		7
	Cumbria Total	12	51	51	59	65	76	89	106	123	131	992	7
Lancashire	None	77	104	122	129	304	207	209	190	184	163	112	-11
	Mono				2		1						
	Dual	13	8	8	3	1	4	1	4			-100	
	Triple	142	181	223	283	211	319	342	385	418	447	215	7
	Quadruple or more	41	43	55	52	42	95	157	185	212	233	468	10
Lancashire Total	273	336	408	469	558	626	709	764	814	843	209	4	
Greater Manchester	None	328	397	537	566	753	840	955	988	993	1007	207	1
	Mono			1	1	8	6	2	4	2			-100
	Dual	3	1	7	2	5	4	1	21	2	7	133	250
	Triple	468	566	660	932	1091	1264	1207	1240	1494	1670	257	12
	Quadruple or more	127	132	158	192	223	353	693	822	927	1070	743	15
Greater Manchester Total	926	1096	1363	1693	2080	2467	2858	3075	3418	3754	305	10	
Merseyside	None	69	77	96	149	155	181	202	211	218	217	214	0
	Mono			1	3	2	4		17	3	2		-33
	Dual	1	3	2	1	3	2		5	13	3	200	-77
	Triple	120	118	146	169	180	203	243	301	376	471	293	25
	Quadruple or more	16	22	48	59	86	118	142	130	126	155	869	23
Merseyside Total	206	220	293	381	426	508	587	664	736	848	312	15	
Cheshire	None	38	43	53	63	64	73	85	95	90	86	126	-4
	Mono			1			1		1				
	Dual	2	1				2	2	1	1		-100	-100
	Triple	60	74	87	99	106	128	142	166	207	218	263	5
	Quadruple or more	10	14	23	30	28	35	45	57	70	80	700	14
Cheshire Total	110	132	164	192	198	239	274	320	368	384	249	4	
Total North West Residents*	None	516	632	825	929	1306	1328	1477	1513	1519	1502	191	-1
	Mono			3	7	10	12	2	22	5	2		-60
	Dual	19	13	17	6	9	12	4	31	16	10	-47	-38
	Triple	805	975	1147	1514	1625	1950	1977	2143	2554	2876	257	13
	Quadruple or more	198	216	288	339	389	614	1057	1220	1365	1570	693	15
Total	1538	1836	2280	2795	3339	3916	4517	4929	5459	5960	288	9	
Total	None	552	675	885	1007	1224	1441	1560	1606	1611	1575	185	-2
	Mono			3	9	12	15	2	24	6	6		0
	Dual	23	16	19	8	14	14	5	35	22	10	-57	-55
	Triple	852	1039	1218	1600	1847	2072	2080	2263	2682	3004	253	12
	Quadruple or more	205	234	304	364	477	653	1114	1284	1446	1643	701	14
Total	1632	1964	2429	2988	3574	4195	4761	5212	5767	6238	282	8	

*Individual county totals may not add up to Total North West Residents due to some individuals being categorised as living in the North West region but unknown area.

Table 6.3: New cases of HIV and AIDS by local authority of residence, 2005-2009

	Local Authority of Residence	Year					% change 2005-2009	% change 2008-2009
		2005	2006	2007	2008	2009		
Cumbria	Carlisle	1	3	3	6	7	600	17
	Allerdale	3	2	3	2	1	-67	-50
	Eden	3	5		3	1	-67	-67
	Copeland	3	2	2	2	2	-33	0
	South Lakeland	2	2	5	6	1	-50	-83
	Barrow-in-Furness		2	4	4	4		0
	Cumbria Total	12	16	17	23	16	33	-30
Lancashire	Lancaster	5	7	3	5	9	80	80
	Wyre	3	8	3	5	3	0	-40
	Fylde	7	6	7	5	7	0	40
	Blackpool	55	42	29	41	32	-42	-22
	Blackburn with Darwen	9	8	15	13	18	100	38
	Ribble Valley	5	3	1		1	-80	
	Pendle	1	2	4	6	4	300	-33
	Hyndburn	2	7	1	8		-100	-100
	Burnley	3	5	6	5	5	67	0
	Rosendale	2	2	1	2	5	150	150
	Preston	11	5	14	6	8	-27	33
	South Ribble	4	3		5	4	0	-20
	Chorley	2	6	1	7	7	250	0
	West Lancashire		2	4	2	2		0
	Unknown Lancashire					1		
Lancashire Total	109	106	89	110	106	-3	-4	
Greater Manchester	Wigan	18	18	18	18	21	17	17
	Bolton	53	21	41	48	36	-32	-25
	Bury	24	27	9	26	24	0	-8
	Rochdale	20	23	27	20	24	20	20
	Oldham	13	21	27	31	23	77	-26
	Salford	72	91	68	74	75	4	1
	Manchester	268	283	209	249	214	-20	-14
	Tameside	24	20	11	20	26	8	30
	Trafford	32	30	32	20	18	-44	-10
	Stockport	12	27	13	13	10	-17	-23
	Unknown Greater Manchester	1	3	6	3	27	2600	800
Greater Manchester Total	537	564	461	522	498	-7	-5	
Merseyside	Sefton	18	16	13	13	31	72	138
	Liverpool	74	67	74	81	97	31	20
	Knowsley	2	4	4	6	11	450	83
	Wirral	20	17	22	20	11	-45	-45
	St Helens	4	9	6	7	13	225	86
	Unknown Merseyside	1	2	1	1		-100	-100
Merseyside Total	119	115	120	128	163	37	27	
Cheshire	Halton	6	7	4	2	8	33	300
	Warrington	9	7	11	19	9	0	-53
	Cheshire West and Chester*	17	20	26	18	15	-12	-17
	Cheshire East**	16	14	18	32	14	-13	-56
	Unknown Cheshire							
Cheshire Total	48	48	59	71	46	-4	-35	
Total North West Residents		825	849	746	854	829	0	-3
Isle of Man		2	4	2	2	1	-50	-50
Out of Region		20	25	39	30	19	-5	-37
Abroad				2				
Unknown		81	29	28	39	32	-60	-18
Total		928	907	817	925	881	-5	-5

*Formerly Ellesmere Port & Neston, Chester and Vale Royal local authorities

**Formerly Macclesfield, Congleton and Crewe & Nantwich local authorities

Table 6.4: All cases of HIV and AIDS by local authority of residence, 2005-2009

	Local Authority of Residence	Year					% change 2005-2009	% change 2008-2009
		2005	2006	2007	2008	2009		
Cumbria	Carlisle	20	22	26	30	36	80	20
	Allerdale	12	12	16	18	19	58	6
	Eden	10	14	13	15	14	40	-7
	Copeland	13	11	13	15	15	15	0
	South Lakeland	17	20	24	29	27	59	-7
	Barrow-in-Furness	4	8	13	15	19	375	27
	Unknown Cumbria		2	1	1	1		0
	Cumbria Total	76	89	106	123	131	72	7
Lancashire	Lancaster	26	34	35	34	41	58	21
	Wyre	38	44	46	49	45	18	-8
	Fylde	35	42	46	49	52	49	6
	Blackpool	249	269	291	315	310	24	-2
	Blackburn with Darwen	53	60	70	78	89	68	14
	Ribble Valley	12	14	14	13	16	33	23
	Pendle	11	12	16	20	23	109	15
	Hyndburn	21	26	21	28	26	24	-7
	Burnley	16	24	27	27	28	75	4
	Rossendale	17	21	24	25	31	82	24
	Preston	83	86	96	96	99	19	3
	South Ribble	24	31	29	29	27	13	-7
	Chorley	13	18	17	22	28	115	27
	West Lancashire	26	27	26	27	26	0	-4
	Unknown Lancashire	2	1	6	2	2	0	0
Lancashire Total	626	709	764	814	843	35	4	
Greater Manchester	Wigan	70	86	105	123	148	111	20
	Bolton	177	181	208	233	260	47	12
	Bury	123	139	151	166	178	45	7
	Rochdale	98	123	133	134	161	64	20
	Oldham	74	89	110	137	146	97	7
	Salford	354	424	443	501	542	53	8
	Manchester	1227	1404	1505	1669	1790	46	7
	Tameside	96	111	108	129	148	54	15
	Trafford	144	160	179	184	198	38	8
	Stockport	98	135	123	134	145	48	8
	Unknown Greater Manchester	6	6	10	8	38	533	375
Greater Manchester Total	2467	2858	3075	3418	3754	52	10	
Merseyside	Sefton	72	75	83	81	106	47	31
	Liverpool	278	330	375	423	491	77	16
	Knowsley	19	26	29	38	47	147	24
	Wirral	103	110	126	136	138	34	1
	St Helens	33	40	44	50	60	82	20
	Unknown Merseyside	3	6	7	8	6	100	-25
	Merseyside Total	508	587	664	736	848	67	15
Cheshire	Halton	25	29	30	26	28	12	8
	Warrington	48	53	65	79	80	67	1
	Cheshire West and Chester*	93	110	135	150	153	65	2
	Cheshire East**	70	81	90	113	123	76	9
	Unknown Cheshire	3	1				-100	
	Cheshire Total	239	274	320	368	384	61	4
Total North West Residents		3916	4517	4929	5459	5960	52	9
Isle of Man		18	19	21	23	22	22	-4
Out of Region		135	165	191	207	191	41	-8
Abroad		2	3	3	1	1	-50	0
Unknown		124	57	68	77	64	-48	-17
Total		4195	4761	5212	5767	6238	49	8

*Formerly Ellesmere Port & Neston, Chester and Vale Royal local authorities

**Formerly Macclesfield, Congleton and Crewe & Nantwich local authorities

Glossary of Service Providers

Statutory Treatment Centres

AHC	Alder Hey Children's Hospital, Haematology Treatment Centre, Eaton Road, Liverpool, L12 2AP. Tel: (0151) 228 4811
APH	Arrowe Park Hospital, Department of GUM, Arrowe Park Road, Upton, Wirral, Merseyside, CH49 5PE. Tel: (0151) 678 5111
ARM	The Armistead Project, 1 st Floor, Musker Buildings, 1 Stanley St, Liverpool, L1 6AA. Tel: (0151) 227 1893
BLAG	Blackpool Sexual Health Services, Whitegate Health Centre, 150 Whitegate Drive, Blackpool, FY3 9ES. Tel: (01253) 303238
BLK	Blackburn Royal Infirmary, Haslingden Road, Blackburn, BB2 3HH. Tel: (01254) 263555
BLKG	Blackburn Royal Infirmary, Department of GUM, Haslingden Road, Blackburn, BB2 3HH. Tel: (01254) 734207
BOLG	Royal Bolton Hospital, Bolton Centre for Sexual Health, Minerva Road, Farnworth, Bolton, BL4 0JR. Tel: (01204) 390390
BURG	GUM Clinic, St Peter's Centre, Church St, Burnley, Lancashire, BB11 2DL. Tel: (01282) 644300
BURY	Fairfield General Hospital, Department of GUM, Rochdale Old Road, Bury, BL9 7TD. Tel: (0161) 764 6081
CHR	The Countess of Chester Hospital, Department of GUM, Liverpool Road, Chester, CH2 1HJ. Tel: (01244) 365000
CUMB	Cumberland Infirmary, Department of GUM, Newtown Road, Carlisle, CA2 7HY. Tel: (01228) 523444
FGH	Furness General Hospital, Dalton Lane, Barrow in Furness, Cumbria, LA14 4LF. Tel: (01229) 870870
HAL	Halton General Hospital, Department of GUM, Hospital Way, Runcorn, Cheshire. WA7 2DA. Tel: (01928) 714567
LCN	Liverpool Community HIV Specialist Nursing Team, Hartington Road Clinic, Hartington Road, Liverpool, L8 0SG. Tel: (0151) 285 2802
LEI	Leighton Hospital, Department of GUM, Middlewich Road, Crewe, Cheshire, CW1 4QJ. Tel: (01270) 255141
MAC	Macclesfield GUM, Assura Health & Wellbeing Centre, Sunderland Street, Macclesfield, Cheshire, SK11 6JL. Tel: (01625) 264116
MGP	'The Docs' General Practice, Manchester, 55-59 Bloom Street, Manchester, M1 3LY. Tel: (0161) 237 9490
MRIG	Manchester Royal Infirmary, Manchester Centre for Sexual Health, Hathersage Centre, 280 Upper Brook Street, Manchester, M13 0FH. Tel: (0161) 276 1234
MRIH	Manchester Royal Infirmary, Manchester Haemophilia Comprehensive Care Centre, Oxford Road, Manchester, M13 9WL. Tel: (0161) 276 1234
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
NOBL	Noble's Isle of Man Hospital, Department of GUM, Strang, Douglas, Isle of Man, IM4 4RJ. Tel: (01624) 650000
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
RLG	Royal Liverpool University Hospital, Department of GUM and Tropical and Infectious Disease Unit, Prescott Street, Liverpool, L7 8XP. Tel: (0151) 706 2000
RLH	Royal Liverpool University Hospital, Roald Dahl Haemostasis and Thrombosis Centre, Prescott Street, Liverpool, L7 8XP. Tel: (0151) 706 2000
RLI	Royal Lancaster Infirmary, Ashton Road, Lancaster, LA1 4RP. Tel: (01524) 65944

ROCG	Bridge Sexual Health Centre/GUM Clinic, 2 nd Floor, Stonehill Block, Rochdale Infirmary, Whitehall Street, Rochdale, OL12 0NB. Tel: (01706) 517655
SALG	The Goodman Centre for Sexual Health, Capio Oakland Hospital, 15 Lancaster Road, Salford, M6 8AQ. Tel: (0161) 212 5717
SHH	St Helens Hospital, Department of GUM, Marshalls Cross Road, St Helens, WA9 3DA. Tel: (01744) 646473
SPG	Southport & Formby District General Hospital, Department of GUM, Town Lane, Southport, Merseyside, PR8 6PN. Tel: (01704) 547471
STP	Stepping Hill Hospital, Department of GUM, Poplar Grove, Stockport, Cheshire SK2 7JE. Tel: (0161) 483 1010
TAMG	Tameside and Glossop Centre for Sexual Health, Orange Suite, Ashton Primary Care Centre, 193 Old Street, Ashton-under-Lyne, OL6 7SR. Tel: (0161) 331 6000
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) 635911
WGH	Westmorland General Hospital, Outpatients Department, Burton Road, Kendal, Cumbria, LA9 7RG. Tel: (01539) 732288
WHIT	West Cumberland Hospital, Department of Haematology, Hensingham, Whitehaven, Cumbria, CA28 8JG. Tel: (01946) 693181
WIGG	Wigan Health Centre, Department of GUM, Boston House, Frog Lane, Wigan, WN6 7BL. Tel: (01942) 244000
WITG	Withington Hospital, South Manchester Centre for Sexual Health, Nell Lane, West Didsbury, Manchester, M20 2LR. Tel: (0161) 434 5555
WORK	Workington Community Hospital, Department of GUM, Park Lane, Workington, Cumbria, CA14 2RW, Tel: (01900) 705000

Community Sector Organisations

BARM	Barnardo's (Manchester)	Tel: (0161) 273 2901
BHA	The Black Health Agency	Tel: (0161) 226 9145
BP Cheshire and N. Wales	Body Positive Cheshire and North Wales	Tel: (01270) 653150
BP North West	Body Positive North West	Tel: (0161) 882 2200
CLASS	Central Lancashire HIV Advice and Support Services	Tel: (01772) 253840
GHT	George House Trust	Tel: (0161) 274 4499
Sahir	Sahir House	Tel: (0151) 708 9080
SHIVER	Sexual Health, HIV, Education and Responses	Tel: (01253) 311431
Signposts	Signposts	Tel: (01524) 411541

Social Services Departments

Bolton		Tel: (01204) 333365
Knowsley		Tel: (0151) 443 5626
Manchester		Tel: (0161) 822 1300
Salford		Tel: (0161) 607 1499
Stockport		Tel: (0161) 474 3636

List of Abbreviations

AIDS - Acquired immunodeficiency syndrome

ART – Antiretroviral therapy

BME – Black and minority ethnic groups

CHR – Clinician HIV report

CPH – The Centre for Public Health based at Liverpool John Moores University

GUM - Genito-Urinary Medicine

HIV - Human immunodeficiency virus

HPA – Health Protection Agency

IDU – Injecting drug use/user

LA – Local authority

LSOA – Lower super output area

MSM – Men who have sex with men

NASS – National Asylum Support Service

NAT – National AIDS trust

ONS – Office of national statistics

PCT – Primary care trust

SCIEH – Scottish Centre for Infection and Environmental Health

SOPHID - Survey of Prevalent HIV Infections Diagnosed

STI – Sexually transmitted infection

UNAIDS – Joint United Nations Programme on HIV/AIDS

WHO – World Health Organisation

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