



Public Health
England

Annual epidemiological spotlight on HIV in the South West

2018 data

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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1 Summary

HIV remains an important public health problem in the South West.

New diagnoses

In 2018, an estimated 224 South West residents were newly diagnosed with HIV, accounting for 6% of new diagnoses in England. This represents a fall of 11% from 2017. Nationally, there has been a long-term trend for a decline in the overall number of new diagnoses due in the main to a fall in the number of new diagnoses in black Africans who have acquired HIV abroad.

The new diagnosis rate for South West residents aged 15 years or older (4.8 per 100,000) was below that of England in 2018 (8.7 per 100,000).

In 2018, 56% of all new diagnoses in South West residents were in gay, bisexual and other men who have sex with men (MSM) (compared to 55% in 2017 and 50% in 2009). The number of MSM resident in the South West newly diagnosed with HIV (125, adjusted for missing information) was 22% lower than in 2009. Of the MSM newly diagnosed with HIV 85% were white and 64% were UK-born.

Heterosexual contact was the second largest infection route for new diagnoses in South West residents in 2018 (39%). Infections in African born persons accounted for 42% of all heterosexually acquired cases in 2018 (n=32), compared to 55% (n=74) in 2009. Infections in UK born persons accounted for 38% of all heterosexually acquired cases in 2018.

Injecting drug use accounted for 4% of new diagnoses in South West residents.

Black Africans represented 15% of all newly diagnosed South West residents in 2018 (compared to 11% in 2017 and 23% in 2009). A small proportion of new diagnoses in 2018 were in black Caribbeans (1%).

The number of new diagnoses was highest in the 25-34-year age group in males and the 35-44-year age group in females in 2018.

Late diagnoses

Reducing late HIV diagnoses is one of the indicators in the Public Health Outcomes Framework. People who are diagnosed late have a tenfold risk of mortality within one year of diagnosis compared to those diagnosed promptly and they have increased healthcare costs.

It is of particular concern that a large proportion of South West residents with HIV are diagnosed late (45% from 2016 to 2018, compared to 43% in England), as defined by a CD4 count of less than 350 cells/mm³ at diagnosis.

In the South West, heterosexuals were more likely to be diagnosed late (55% of males, 48% of females) than MSM (37%). By ethnic group black Africans were more likely to be diagnosed late than the white population (52% and 44% respectively).

People living with diagnosed HIV

The 4,848 people living with diagnosed HIV in the South West in 2018 was 4% higher than 2017 and 73% higher than 2009. This increase is partly due to the effectiveness of HIV treatment, which has reduced the number of deaths from HIV.

The diagnosed prevalence rate of HIV in the South West in 2018 was 1.3 per 1,000 residents aged 15-59 years. This was lower than the 2.4 per 1,000 observed in England as a whole. Three local authorities in the South West had a diagnosed HIV prevalence in excess of 2 per 1,000 population aged 15-59 years in 2018, which is the threshold for expanded HIV testing. They were Bournemouth, Christchurch and Poole (2.7), Bristol (2.7) and Torbay (2.1).

The 2 most common probable routes of transmission for South West residents living with diagnosed HIV in 2018 were sex between men (52%) and sex between men and women (43%).

In 2018, 41% of those living with diagnosed HIV in the South West were aged between 35 and 49 years, and 44% were aged 50 years and over (up from 25% in 2009). Males represented 74% of South West residents living with diagnosed HIV in 2018 and females represented 26%.

In 2018, 74% of South West residents living with diagnosed HIV were white and 17% were black Africans. However, due to the relative sizes of the white and black African populations the rate per 1,000 population aged 15-59 years was much higher in black Africans (44.8 per 1,000) than in the white population (1.0 per 1,000).

Continuum of HIV care

HIV treatments (ART) continue to evolve and improve the clinical outcomes and life expectancy of people living with HIV. Early initiation of HIV treatment limits damage to the immune system and reduces the risk of developing complications. It has been demonstrated that the advantages of ART extend beyond personal clinical benefit. It is now widely understood that effective HIV treatment resulting in an 'undetectable' viral load prevents individuals living with HIV from passing on the virus sexually to sexual partners. The key message is that Undetectable = Untransmittable (U=U): Medicines to treat HIV can prevent the risk of sexual and vertical HIV transmission.¹

In the South West in 2018, 98% of residents were receiving anti-retroviral treatment. Of these, 97% were virally suppressed (viral load <200) and were very unlikely to pass on HIV, even if having sex without condoms (untransmissible virus). This compares to 97% in England receiving ART and 97% of these virally suppressed.

People living with undiagnosed HIV

Since the vast majority of people diagnosed with HIV are effectively treated, most new HIV infections are passed on from persons who are undiagnosed and unaware of their infection. In 2018, it is estimated that 13% (Credible Interval (CrI) 10%-17%) of people living with HIV in England, excluding London, were undiagnosed. This equates to an estimated 4,500 (CrI 3,000-7,500) undiagnosed people.

It is estimated that 2,400 MSM in England, outside London, are undiagnosed (CrI 1,100-5,100) and 2,000 heterosexuals (CrI 1,500-3,400), including 800 black Africans.

In England, outside London, the proportion undiagnosed varied by exposure group with the highest proportion undiagnosed among non-black African heterosexual men (10%, 5%-26%), non-black African heterosexual women (9%, 6%-12%) and people living with HIV who inject drugs (6%, CrI 1%-15%).

HIV testing

HIV testing is pivotal in reducing HIV transmission as it decreases the number of people living with HIV who are unaware of their infection. Increased HIV testing has led to earlier diagnosis and, once people know they have HIV, they can be linked into care and offered treatment.

HIV testing is the key to reducing late diagnosis. HIV test coverage (the proportion of eligible new attendees at specialist sexual health services who received an HIV test) fell slightly from 69% to 65% in the South West from 2017 to 2018. The HIV test coverage for the South West was similar to England overall (65%) in 2018.

The highest HIV test coverage in 2018 was reported in Bournemouth, Christchurch and Poole (84%) followed by Isle of Scilly (83%) and Devon (78%). The lowest HIV test coverage was reported in Gloucestershire (33%) followed by Somerset (55%).

By gender and sexual orientation, HIV test coverage was higher among MSM (86%) than among all men (75%) and lowest among women (58%) in the South West in 2018; In comparison, the proportions reported for HIV test coverage in the South West in MSM was lower than for England (88%) and all men (78%) but higher in women (55%) in 2018.

Condom use

Condoms are crucial in the prevention of HIV and STIs. However, there is evidence of an increase in condomless anal sex with casual partners since the early 2000s.¹ Additionally, almost half of sexually active young people said they have had sex without condoms with a new partner.

HIV pre-exposure prophylaxis

HIV Pre Exposure Prophylaxis (HIV-PrEP) is the use of antiretroviral medicine by people who do not have HIV prior to a potential exposure to HIV to prevent acquisition of infection. Studies have shown that consistent use of HIV-PrEP can be an effective prevention intervention. HIV-PrEP has the potential, within a combination prevention approach, to have a significant role in the control of HIV transmission. The first phase of PrEP implementation is the 3-year clinical trial (The Impact Trial) which launched in October 2017 and aimed to recruit 26,000 participants in England.² As of October 2019, over 15,700 people across 153 clinics had received PrEP through the trial.

Key messages³

HIV prevalence, incidence and HIV care

There is evidence that combination prevention (including condom use, expanded HIV testing, prompt ART and the availability of pre-exposure prophylaxis (PrEP)) is working in the UK. For the third consecutive year, there have been steep declines in new diagnoses in gay and bisexual men (GBM) – the group with the highest transmission rate. Continued funding in prevention activities remains critical to curb the HIV epidemic. Further declines and the possibility of eliminating transmission of HIV in the UK will depend upon sustained prevention efforts and expansion to reach all.

Condom Use

Consistent condom use remains an extremely effective way to prevent HIV (and STI) transmission, however, in the UK, consistent condom use among key populations is insufficient. Work to improve condom use should address underlying factors that lead to risk taking behaviour, especially among GBM.

HIV testing

As it becomes progressively more challenging to discover and care for those living with undiagnosed HIV, it is essential that existing testing guidelines are fully implemented, and that these policies are applied equally in all areas.

Over half a million people (35% of those eligible for testing) were not tested for HIV when they attended a specialist SHS in 2018. Specialist SHS should consider how they can improve coverage to match the 99% achieved by antenatal screening services.

GBM who have had an anogenital bacterial STI within the last year have a high risk of acquiring HIV. When attending specialist SHS, they and other men who are having unprotected or casual sex with men, should be encouraged to have an HIV and STI screen every 3 months.

GBM who have not tested within the last 2 years (at the same specialist SHS) were more likely to test positive for HIV compared to GBM who tested more recently. Public messaging should prompt them, and all men who have ever had sex with another man, to test for HIV.

¹ PHE. Progress towards ending the HIV epidemic: 2018 report.
www.gov.uk/government/publications/hiv-in-the-united-kingdom

² www.prepimpacttrial.org.uk

³ PHE. HIV in the United Kingdom Towards Zero HIV transmissions by 2030 2019 report (data to end of 2018)

Full implementation of national HIV testing recommendations for areas of the country where prevalence of diagnosed HIV infection is 'high' or 'extremely high', and among high risk populations, is desirable. These recommendations include testing in a range of settings such as hospitals, general practices, and the community and through online e-services. These activities all continue to make HIV diagnoses and serve different populations who might not access SHS.

The programme of BBV testing in prisons identifies infections among those who may not access other testing services. The efforts to achieve the target testing threshold of 75% uptake are continuing.

Clinical care and treatment as prevention (TasP)

Providers of HIV care should encourage timely treatment initiation for people living with HIV. The number and proportion of people who begin ART and achieve viral suppression promptly following diagnosis is increasing. Further work is needed to achieve equity between population sub-groups.

While HIV treatment and viral suppression rates are very high in the diagnosed population, increased efforts are required to ensure those diagnosed are rapidly linked to, and retained, in HIV care. Services should have documented policies for managing those who do not fully engage with care, and where possible provide arrangements to address this.

As rates of other infections transmitted sexually such as gonorrhoea, syphilis, lymphogranuloma venereum, hepatitis C and Shigella have been shown to be higher in GBM who are living with HIV, it is important that GBM living with HIV are specifically made aware of the risks of these infections and how to prevent them.

The population of people living with diagnosed HIV is diversifying and growing older. It is critical that HIV and other services continue to evolve to meet the needs of older people living with HIV including the management of comorbidities and other complex health conditions.

As well as increasing awareness of HIV, efforts to reduce stigma and other socio-cultural barriers that prevent people from testing and seeking long-term care should be strengthened.

Partner notification (PN)

Partner notification following the diagnosis of HIV infection remains a highly effective way to detect undiagnosed HIV infections.

As undiagnosed HIV infections become rarer, strengthening the delivery of effective PN is essential to ending HIV transmission by 2030.

Needle and syringe provision (NSP) for people who inject drugs (PWID)

Easily accessible harm reduction interventions for PWID, including access to sterile injecting equipment via NSP and opioid substitution therapy (OST) needs to be provided for all PWID, in line with national guidance.⁴

Recommendations to the public

The most common way of getting HIV in the UK is through unprotected sexual contact⁵ with a person who is unaware of their HIV infection.

You can protect yourself from HIV through using a condom with new and casual partners and by using Pre-exposure Prophylaxis (PrEP). Condom use will also stop you getting or transmitting other STIs.

People with HIV are unable to pass on the infection sexually if they are on treatment and have undetectable levels of the virus. The message Undetectable = Untransmittable or “U=U” has been widely used and is endorsed by PHE. Links to further information resources are in Box A below.

Getting tested for HIV has never been easier, with free tests available through sexual health clinics, GP surgeries, as well as through a self-sampling service or by using a self-testing kit (see Box B below).

⁴ National Institute for Health and Care Excellence. Needle and syringe programmes Public health guideline [PH52]. 2014 [Available from: www.nice.org.uk/guidance/ph52]

⁵ Unprotected sex: HIV can be transmitted sexually if no protection is used and the sexual partner with HIV has a detectable viral load. Protective methods include consistent condom use, effective use of PrEP or use of antiretroviral treatment (ART) to achieve an undetectable viral load

⁶ You should discuss with your healthcare provider which STI tests are most appropriate for you, based on your risks and any symptoms you may have. It is important that you are tested according to national STI testing guidelines from the British Association for Sexual Health and HIV.

If you are a man and have ever had sex with another man, you should get tested for HIV.

Men who are having sex with other men should have an HIV test at least once a year and those who are having unprotected or casual sex with men should have an HIV test and STI screen⁶ (see Box C) every 3 months.

Black African men and women, and those born in countries where HIV is common (see Box D), should have an HIV test.

People who are having unprotected sex with new or casual partners from countries where HIV is common should test every year.

If you are diagnosed with HIV your partner(s) may need to have an HIV test as they may be unaware of their own HIV status. There are a number of ways that partners can be notified, and your healthcare provider will explain different options and support you with the process.

Anyone who is diagnosed with HIV will benefit from starting treatment immediately. By accepting early treatment, people living with HIV will be able to live a long and healthy life and will protect their sexual partners from the risk of acquiring the infection. HIV treatment is free to all in the UK regardless of immigration or residency status.

Box A: Information on HIV prevention

Information about preventing HIV

- www.nhs.uk/conditions/hiv-and-aids
- www.aidsmap.com/about-hiv
- www.tht.org.uk/hiv-and-sexual-health

Information about HIV treatment & U=U

- www.i-base.info

Information about Pre-exposure Prophylaxis (PrEP) and how to access PrEP in the UK

- England: www.prepimpacttrial.org.uk
- www.iwantprepnw.co.uk
- <https://prepster.info/>

Box B: Ways to get an HIV test

All HIV testing by the NHS is free and confidential for everyone, regardless of immigration or residency status.

There are many ways to get tested for HIV:

- go to a sexual health clinic or a community testing site
- ask your GP for an HIV test
- request a self-sampling kit online or obtain a self-testing kit

You can find your nearest sexual health service using the following link:

- England: www.nhs.uk/Service-Search/Sexual-health-services/LocationSearch/1847

Your local community testing site can be found using the following link:

- www.aidsmap.com/european-test-finder

You can request a self-sampling kit online via www.freetesting.hiv. Other local online services can be found by searching your local authority's webpage.

Box C: What is an STI screen?

An STI screen consists of tests for different STIs. Most commonly this would be for chlamydia, gonorrhoea and syphilis. Tests for other STIs are not normally needed if you do not have any symptoms; the nurses and doctors at your local sexual health service can provide advice on which STIs you should be tested for. All STI testing by the NHS is free and confidential for everyone, regardless of immigration or residency status.

You can find your nearest sexual health service using the following link:

- England:
www.nhs.uk/Service-Search/Sexual-health-services/LocationSearch/1847

Further information on STIs is available here:

- www.nhs.uk/conditions/sexually-transmitted-infections-stis
- www.sexwise.fpa.org.uk/stis

Box D: Countries where HIV is common*

Africa

Angola, Benin, Botswana, Burundi, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Equatorial Guinea, Eswatini, Ethiopia, Gabon, the Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritius, Mozambique, Namibia, Nigeria, Republic of the Congo, Rwanda, Sierra Leone, South Africa, South Sudan, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

Latin America and the Caribbean

Antigua and Barbuda, Bahamas, Barbados, Belize, Guyana, Haiti, Jamaica, Panama, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago

Europe

Ukraine

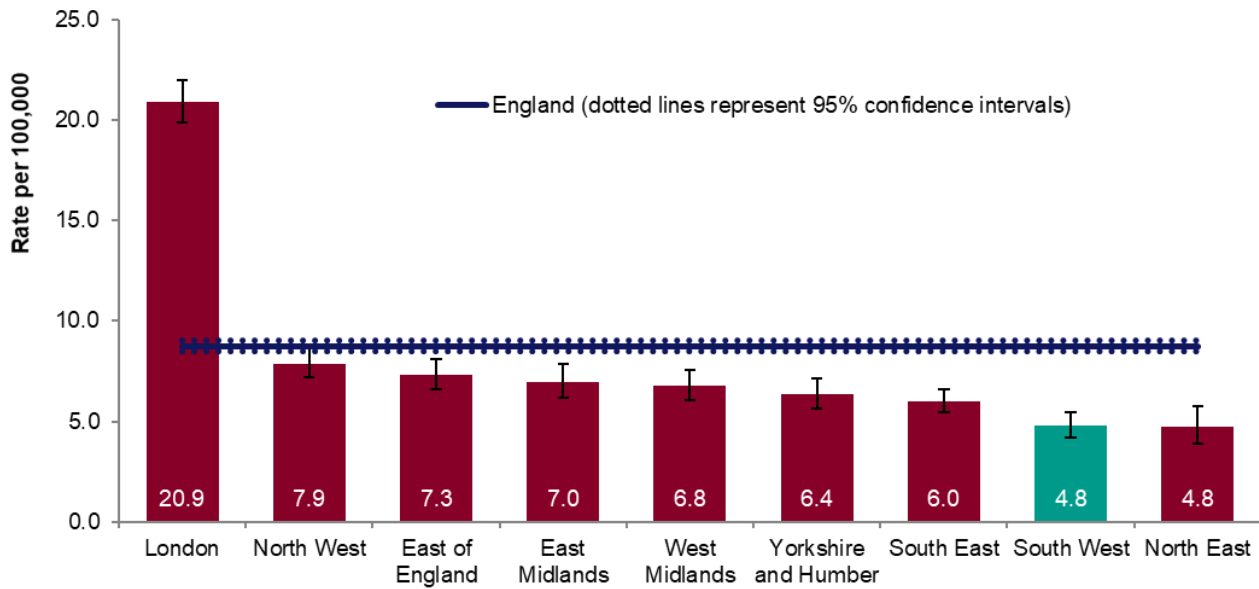
Asia

Thailand

* Countries where HIV prevalence in the population overall is reported by UNAIDS to be 1% or greater

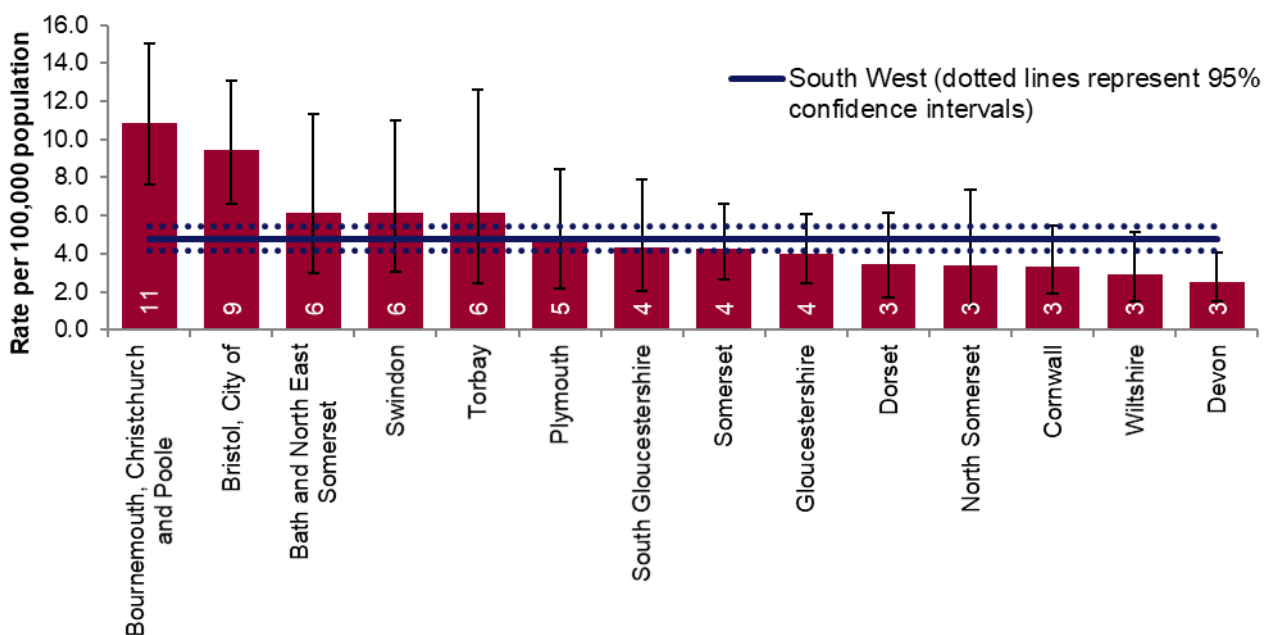
2 Charts, tables and maps

Figure 1: New HIV diagnoses per 100,000 population aged 15 years or older by PHE centre of residence, 2018



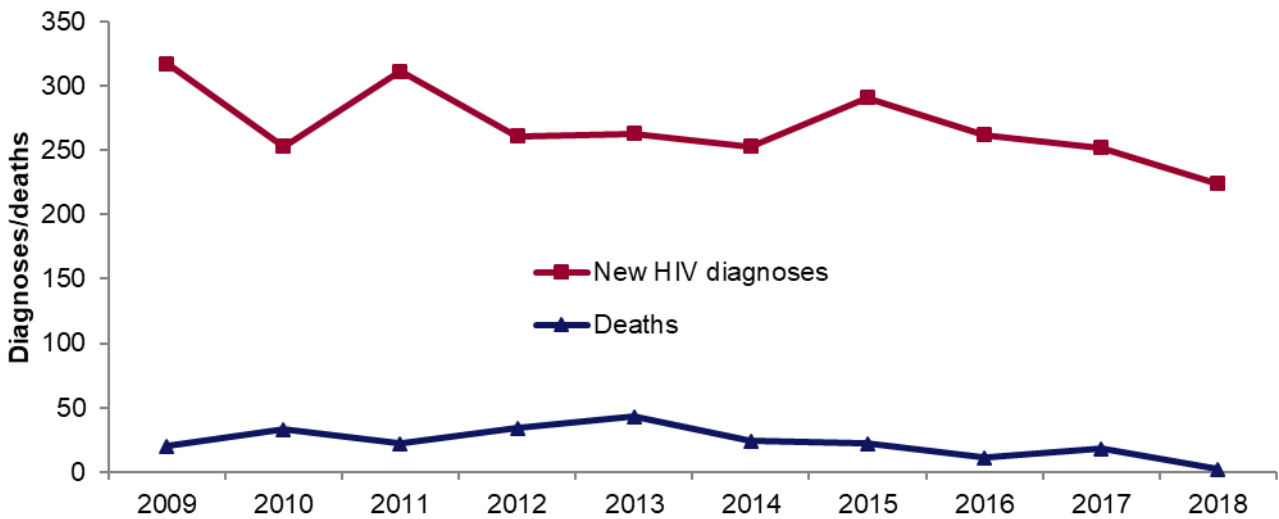
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
 The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.

Figure 2: New HIV diagnoses per 100,000 population aged 15 years or older by upper tier local authority of residence, South West residents, 2018



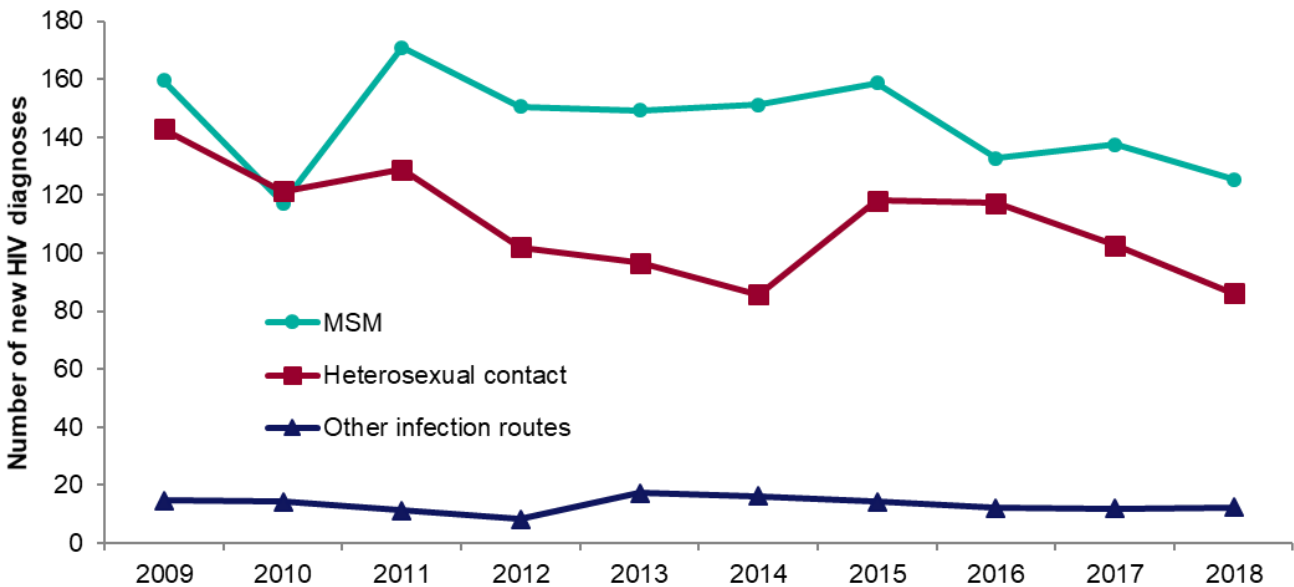
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
 The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.

Figure 3: New HIV diagnoses and deaths, South West residents, 2009-2018



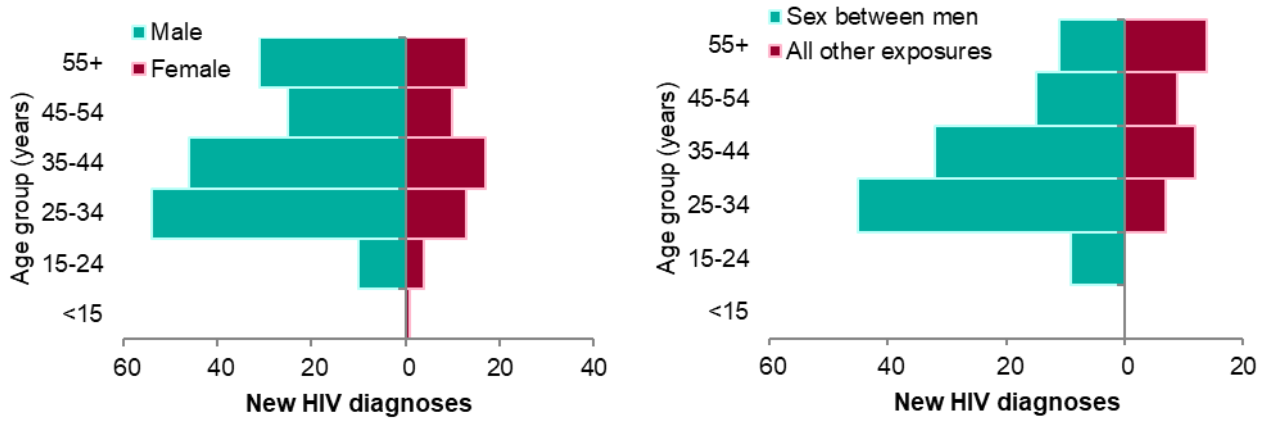
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
 The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.
 *Numbers may rise as further reports are received. This will impact on interpretation of trends in more recent years.

Figure 4: New HIV diagnoses by probable route of infection (adjusted for missing route of infection information), South West residents, 2009-2018 (please see footnote on interpreting trends)*



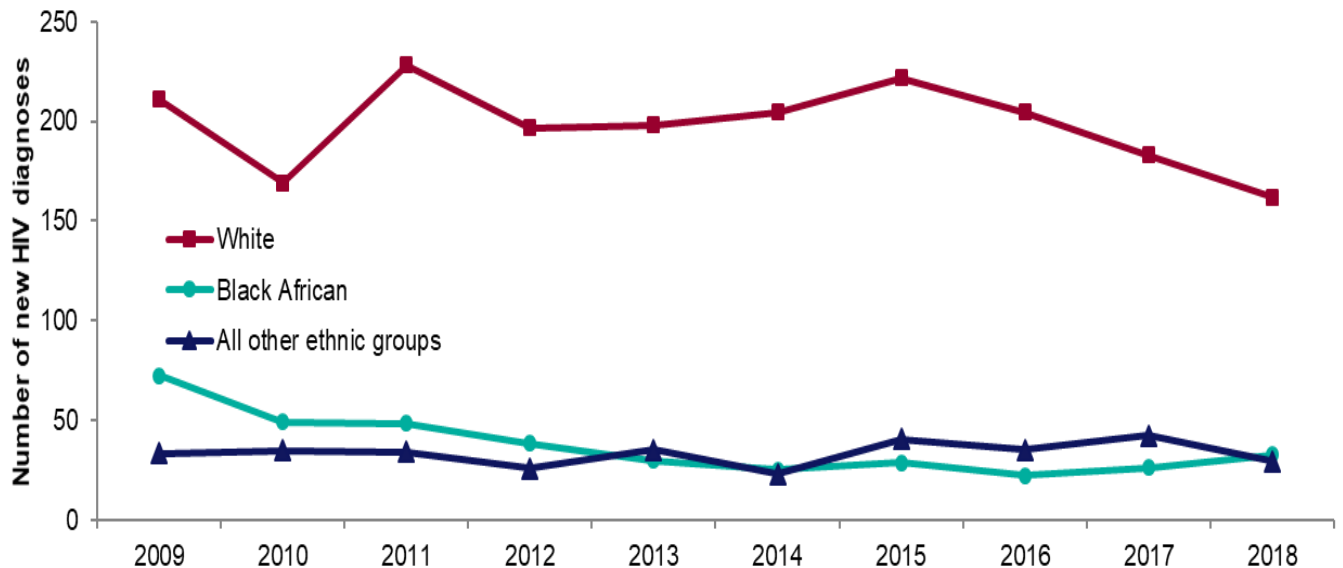
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
 The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.
 *Numbers may rise as further reports are received and more information is obtained on area of residence of those diagnosed. This is more likely to affect more recent year, particularly 2018. Please see important note on data earlier in this report. This will impact on interpretation of trends in more recent years.

Figure 5: Number of new HIV diagnoses by age group and gender (A) and probable route of infection in males (B), South West residents, 2018



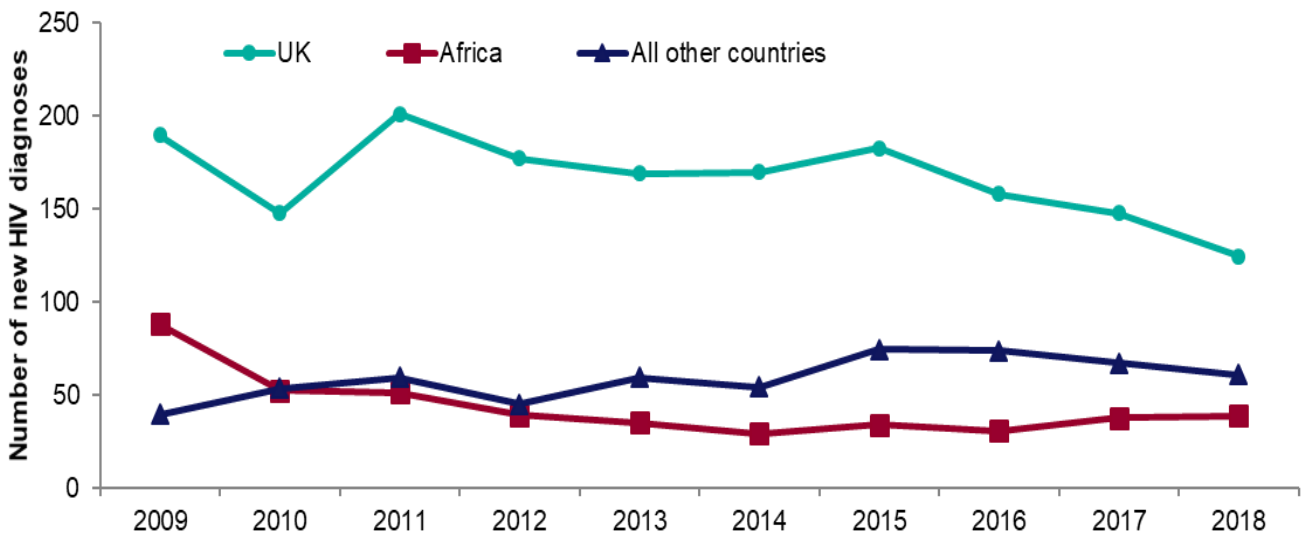
Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
 The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.

Figure 6: Number of new HIV diagnoses by ethnic group (adjusted for missing ethnic group information), South West residents, 2009-2018 (please see footnote on interpreting trends)*



Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).
 The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.
 *Numbers may rise as further reports are received and more information is obtained on area of residence of those diagnosed. This is more likely to affect more recent years, particularly 2018. Please see important note on data earlier in this report. This will impact on interpretation of trends in more recent years.

Figure 7: Number of new HIV diagnoses by world region of birth (adjusted for missing world region of birth information), South West residents, 2009-2018 (please see footnote on interpreting trends)*

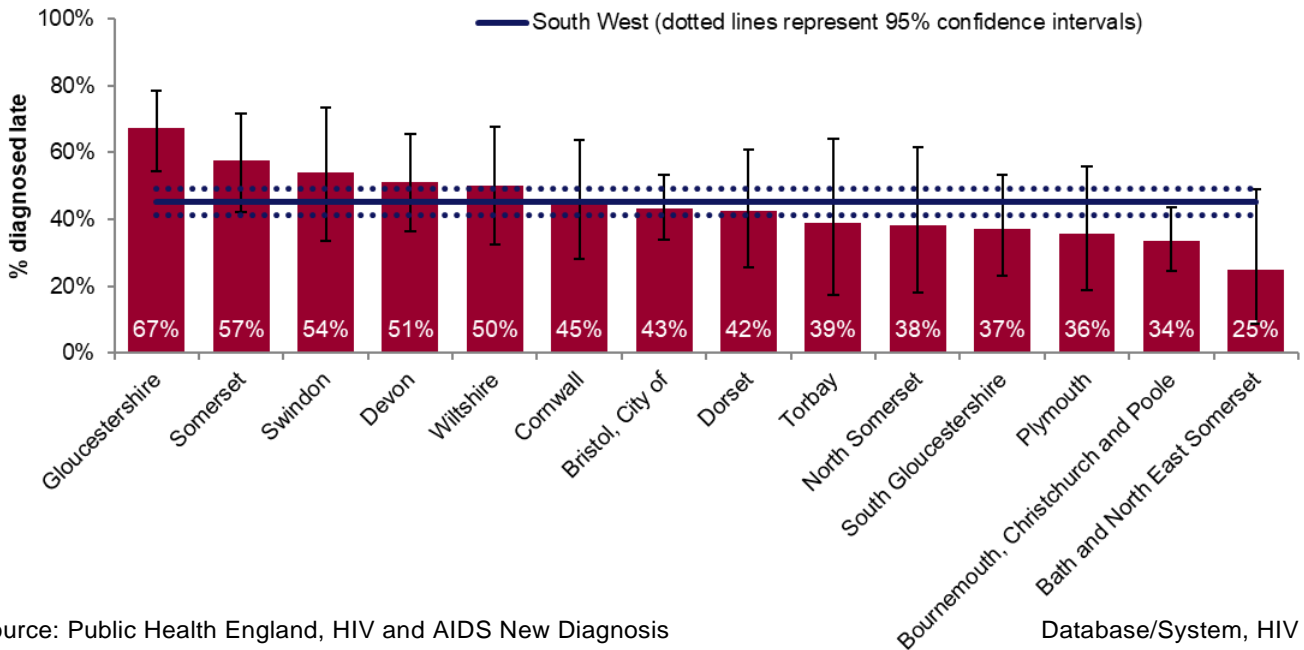


Source: Public Health England, HIV & AIDS New Diagnoses and Deaths (HANDD).

The number of new diagnoses will depend on accessibility of testing as well as infection and transmission.

*Numbers may rise as further reports are received and more information is obtained on area of residence of those diagnosed. This is more likely to affect more recent years, particularly 2018. Please see important note on data earlier in this report. This will impact on interpretation of trends in more recent years.

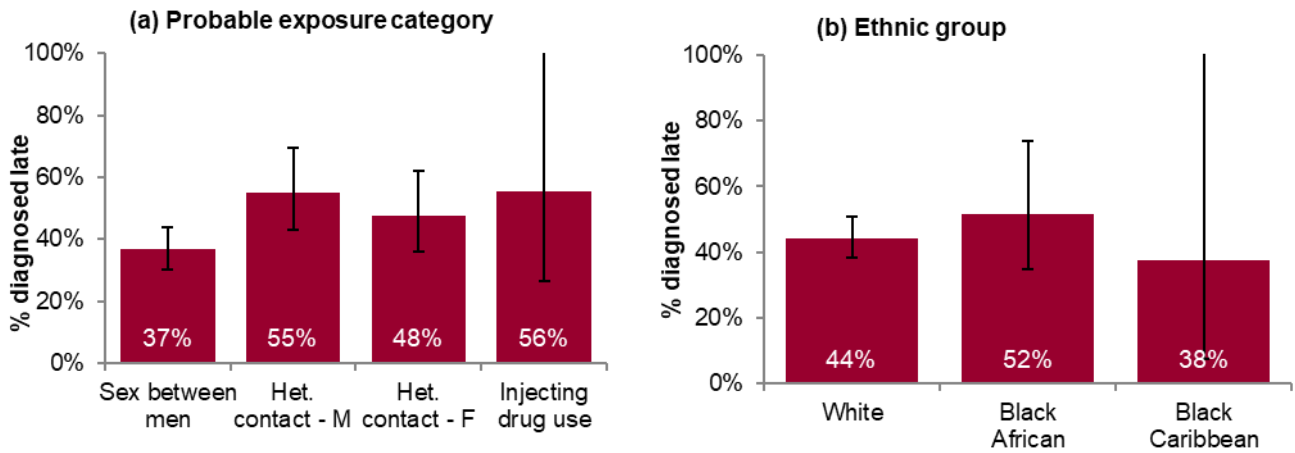
Figure 8: Percentage of new HIV diagnoses that were diagnosed late by upper tier local authority of residence, South West, aged 15 years and over, 2016-2018 *



Source: Public Health England, HIV and AIDS New Diagnosis Database/System, HIV & AIDS Reporting System (HARS).

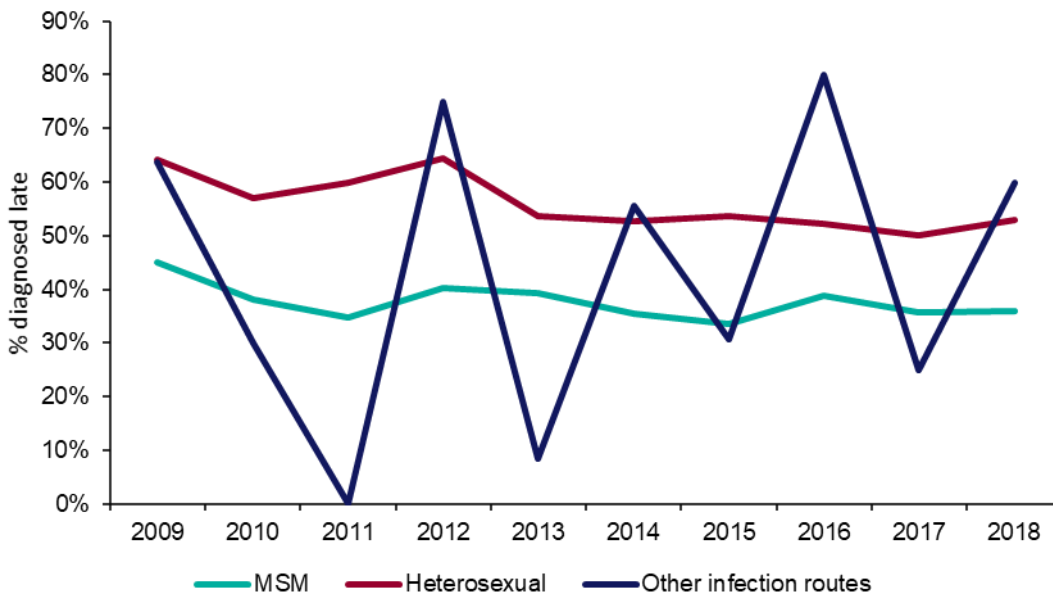
* Only includes new diagnoses for which CD4 count was reported within 91 days of diagnosis; late diagnosis defined as CD4 count <350 cells/mm³. Percentages for UTLAs with fewer than 5 late diagnoses are excluded as the denominator for this calculation is valid new HIV diagnoses which will always be lower than 10,000. The underlying population will impact on the proportion diagnosed late, for example MSM are less likely to be diagnosed late.

Figure 9: Percentage of new HIV diagnoses that were diagnosed late by probable route of infection (A) and ethnic group (B), South West residents, aged 15 years and over, 2016-2018*



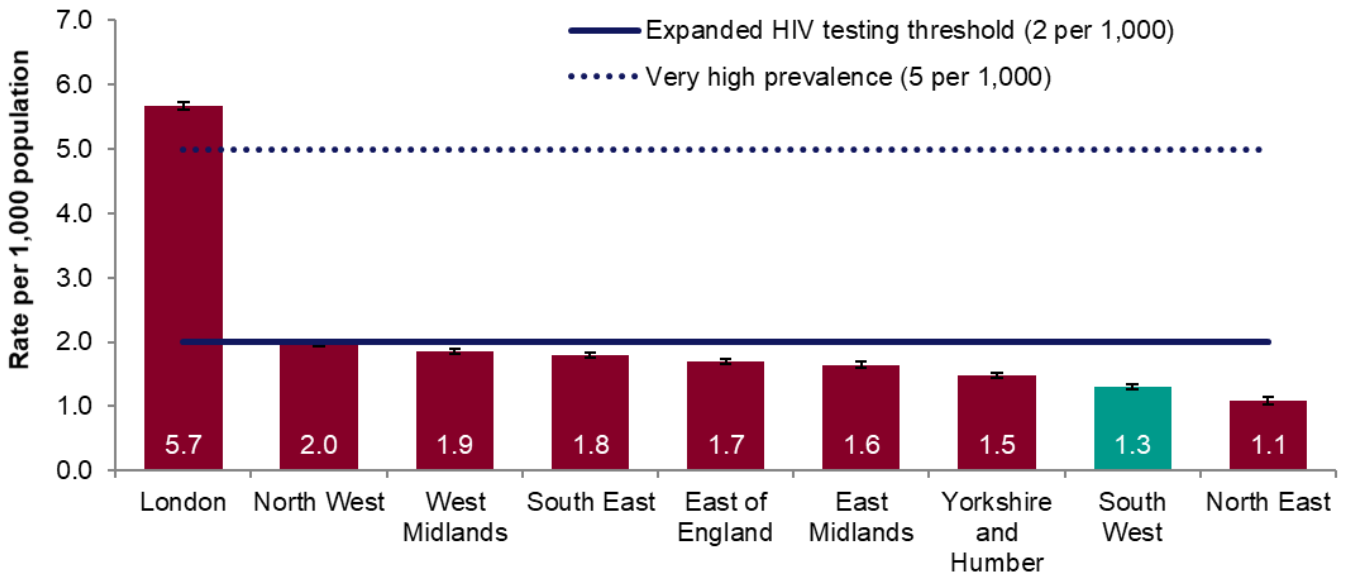
Source: Public Health England, HIV and AIDS New Diagnosis Database/System, HIV & AIDS Reporting System (HARS).
 * Only includes new diagnoses for which CD4 count was reported within 91 days of diagnosis; late diagnosis defined as CD4 count <350 cells/mm³.

Figure 10: Percentage of new HIV diagnoses that were diagnosed late by probable route of infection, South West residents, aged 15 years and over: 2009-2018



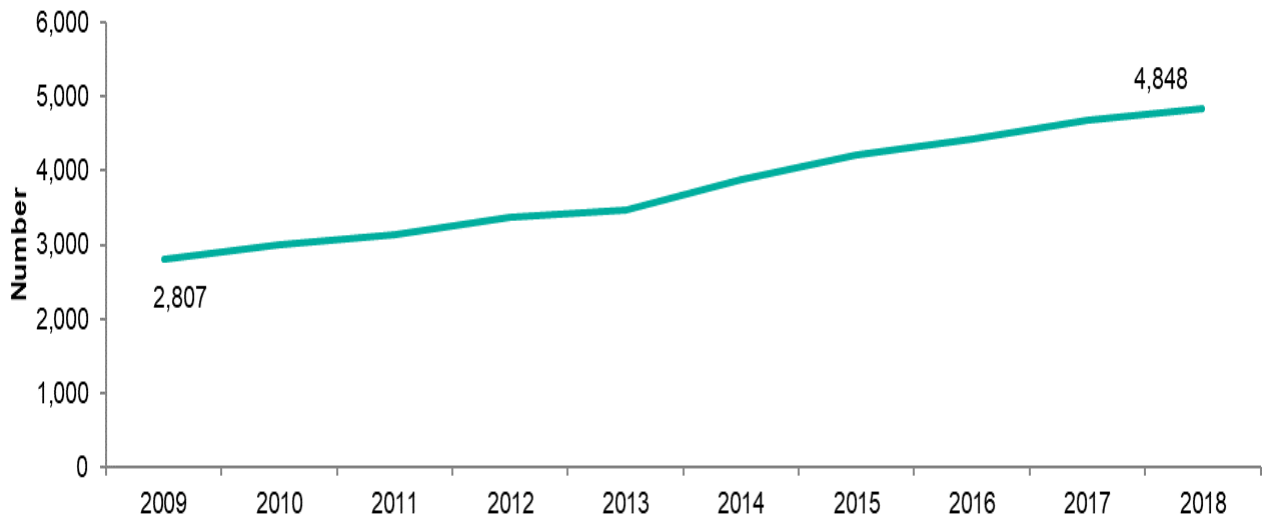
Source: Public Health England, HIV and AIDS New Diagnosis Database/System, HIV & AIDS Reporting System (HARS).
 * Only includes new diagnoses for which CD4 count was reported within 91 days of diagnosis; late diagnosis defined as CD4 count <350 cells/mm³.

Figure 11: Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by PHE Centre, 2018



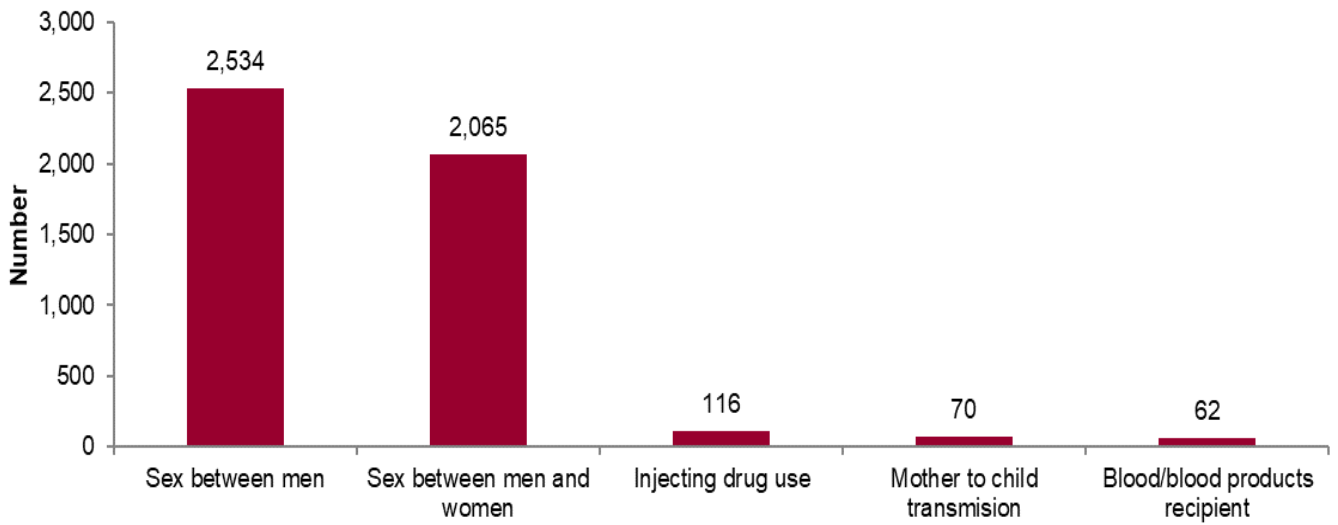
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 12: Number of residents living with diagnosed HIV, the South West, 2009-2018



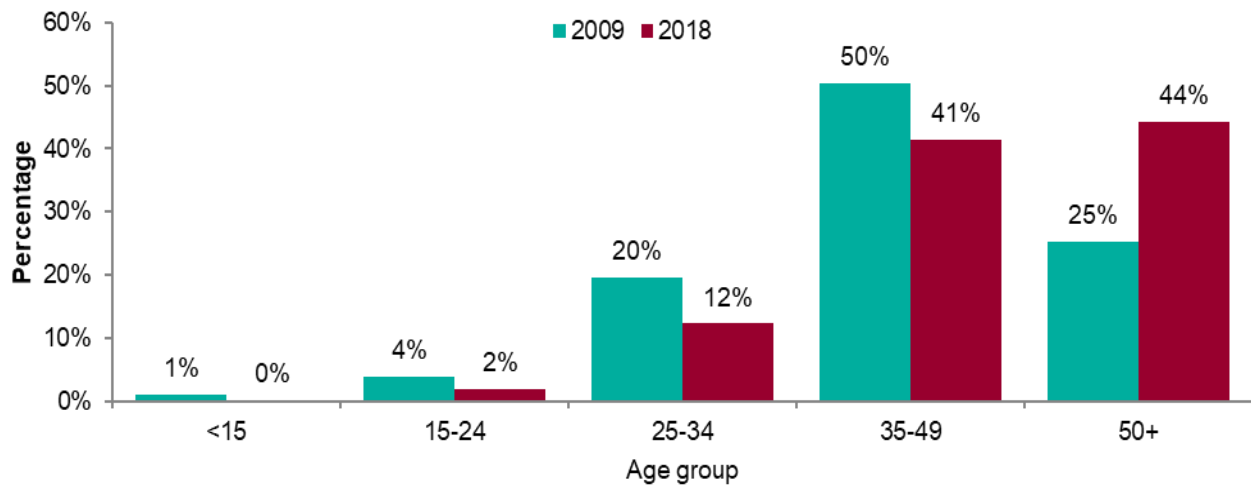
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 13: Number of residents living with diagnosed HIV and accessing care by probable route of transmission (adjusted for missing information), the South West, 2018



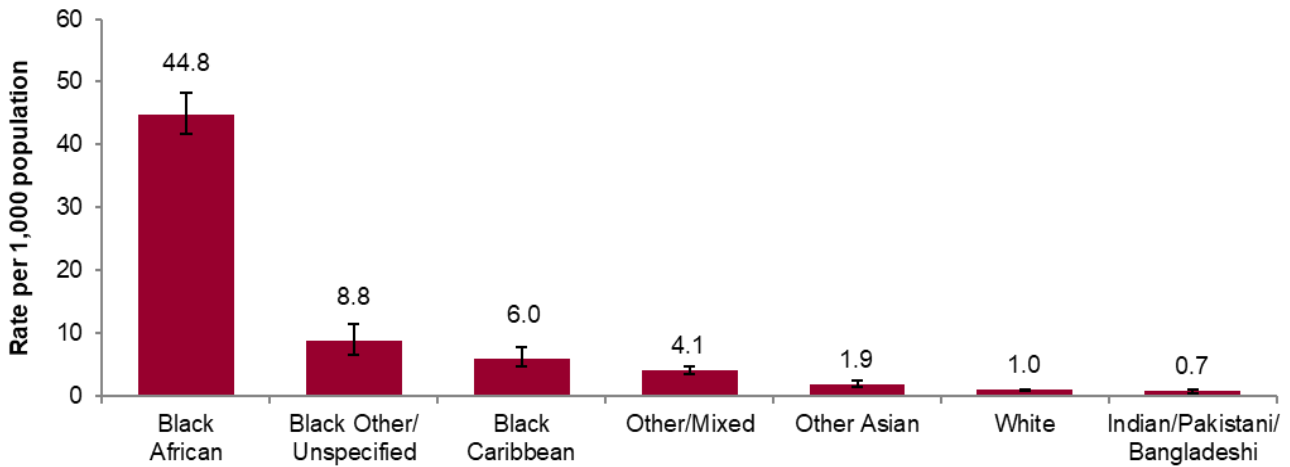
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 14: Percentage of residents with diagnosed HIV and accessing care by age group, the South West, 2009 and 2018



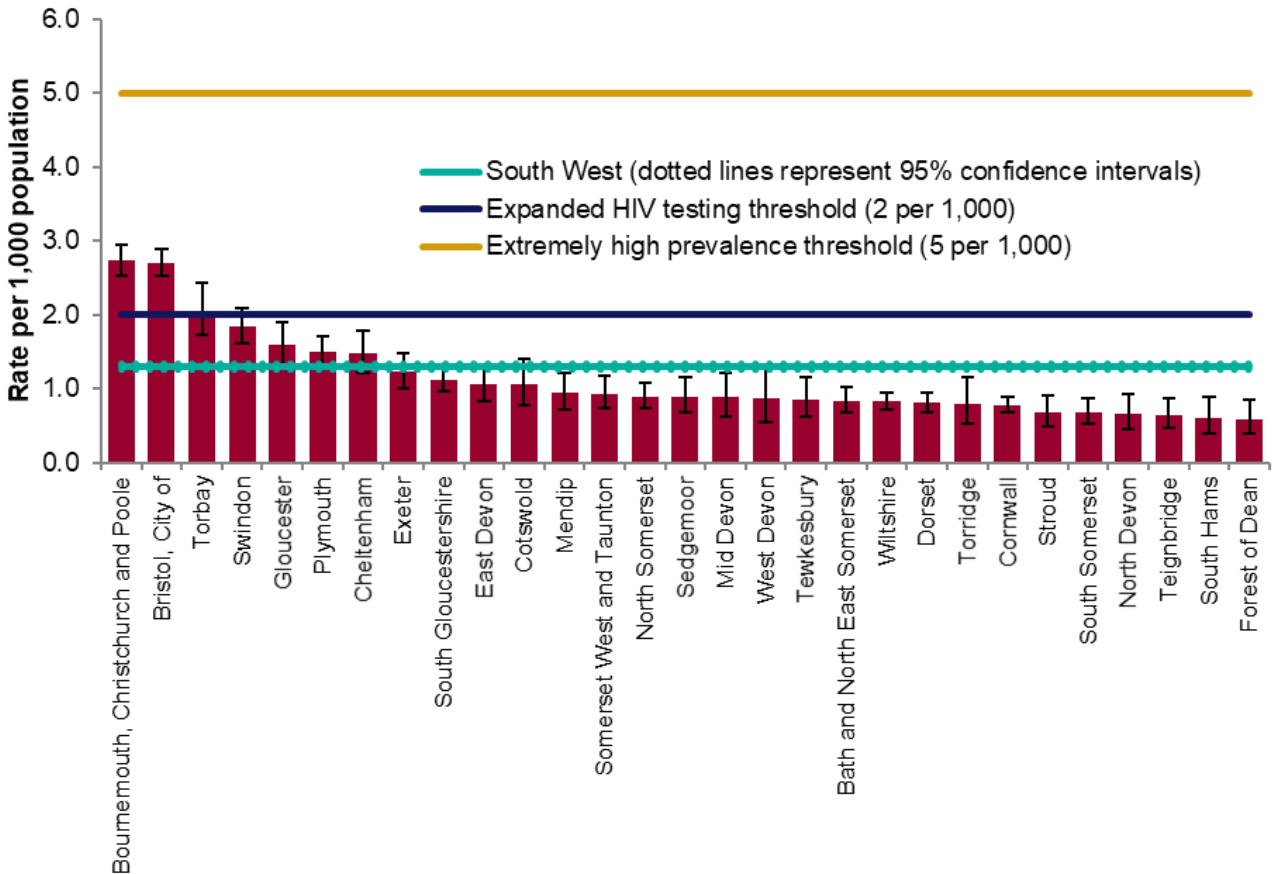
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 15: Diagnosed HIV prevalence per 1,000 residents by ethnic group aged 15-59 years, the South West, 2018



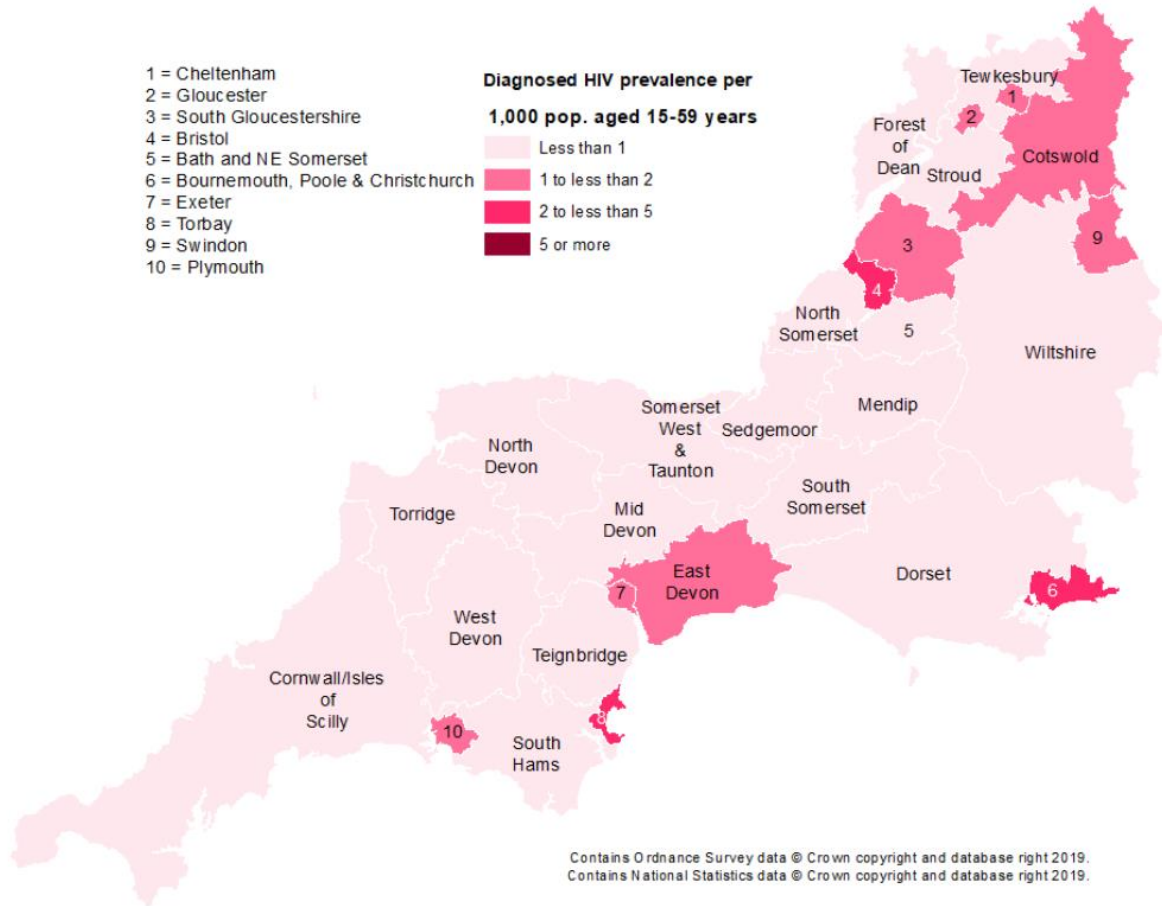
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 16: Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by local authority, the South West, 2018



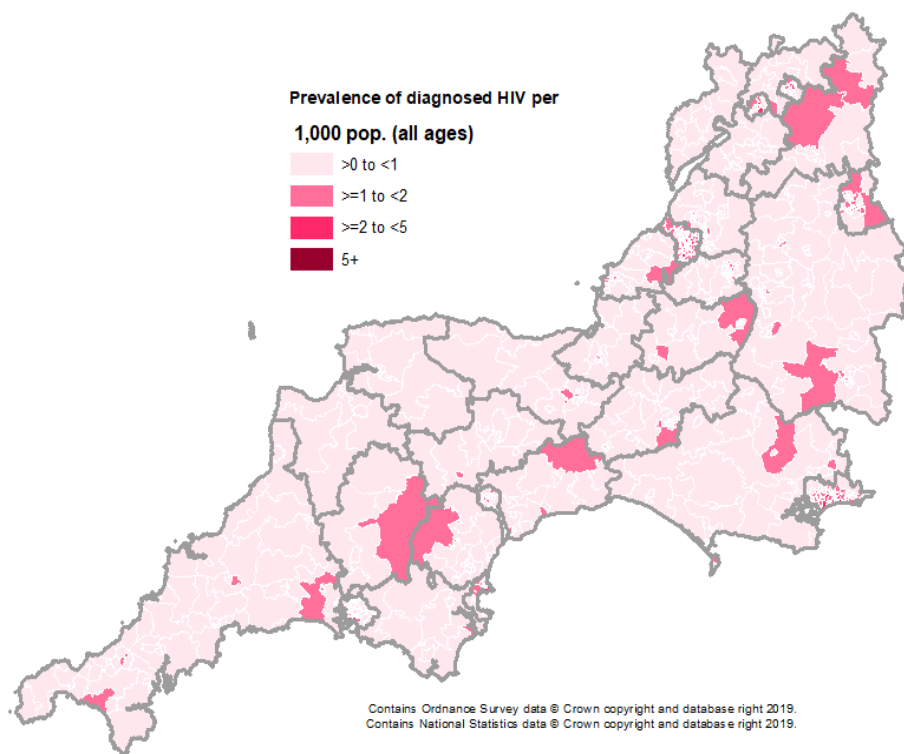
Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 17: Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by local authority, the South West, 2018



Source: Public Health England, HIV & AIDS Reporting System (HARS).

Figure 18: Diagnosed HIV prevalence per 1,000 residents (all ages) by middle super output area of residence, the South West, 2018



Source: Public Health England, HIV & AIDS Reporting System (HARS).

3 Information on data sources

HIV & AIDS New Diagnoses and Deaths (HANDD) collects information on new HIV diagnoses, AIDS at diagnosis and deaths among people diagnosed with HIV. Information is received from laboratories, specialist SHSs, GPs and other services where HIV testing takes place in England, Wales and Northern Ireland. The Recent Infection Testing Algorithm (RITA) and CD4 surveillance scheme are linked to HANDD to assess trends in recent and late diagnoses. Data is deduplicated across regions and therefore figures may differ from country-specific data.

The Survey of Prevalent HIV Infections Diagnosed (SOPHID) began in 1995 and was a cross-sectional survey of all adults living with diagnosed HIV infection who attend for HIV care in England, Wales and Northern Ireland. SOPHID collected information about the individual's place of residence along with epidemiological data including clinical stage and antiretroviral therapy (ART). In 2015, SOPHID reporting in England was replaced by the HIV & AIDS Reporting System (HARS) which captures information at every attendance for HIV care.

Date of data extract: September 2019. Updates to HANDD and SOPHID/HARS made after this date will not be reflected in this report.

Confidence intervals for rates in the figures have been calculated to the 95% level using the Byar's method; confidence intervals for percentages have been calculated to the 95% level using the Wilson Score method (see www.apho.org.uk/resource/item.aspx?RID=48457) . Confidence intervals presented in the text are produced by Bayesian analysis.

ONS mid-year estimates for 2018 were used as a denominator for rates for 2018.

The data behind charts showing absolute numbers has been adjusted for missing information; however, unless stated otherwise, the numbers in the summary section are the numbers as reported, that is unadjusted counts. Where charts are displaying adjusted data, this is indicated in the chart title.

The denominators for all percentages exclude records for which information was unknown, that is the proportion of new diagnoses where probable route of infection was sex between men would be calculated using new diagnoses for which route of infection was known as the denominator.

With the exception of Figure 3, all analyses in this report are residence-based. Information about a patient's place of residence is not collected by HANDD. Reports to this database are cross-linked to the database of people accessing care for HIV, HARS.

If a report could not be linked to a corresponding HARS report, the patient's PHEC of residence (but not their LA of residence) was imputed using the location of the centre at which they were diagnosed where sufficient information about the latter was available.

Imputation was not used to supplement the linkage process in the HIV Spotlight report produced in 2014. This means that the numbers in the new diagnosis section of the report for that year cannot be compared directly with the numbers in this report.

Numbers may change as more information becomes available to assign area of residence to cases and historical data is refreshed accordingly.

Data are rounded to the nearest whole number.

4 Further information

Please access the online 'Sexual and Reproductive Health Profiles' for further information on a whole range of sexual health indicators:

<http://fingertips.phe.org.uk/profile/sexualhealth>

National and PHE centre HIV data tables:

www.gov.uk/government/statistics/hiv-annual-data-tables

Guide to sexual health, reproductive health and HIV data sources:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770945/sexual_health_reproductive_health_and_HIV_in_England_a_guide_to_local_and_national_data.pdf

For the annual epidemiological spotlight on STIs in the South West: 2018 data, please access:

www.gov.uk/government/publications/sexually-transmitted-infections-south-west-data

For the national HIV report: 2018 data, please access:

www.gov.uk/government/publications/hiv-in-the-united-kingdom

Local authorities have access to LA HIV, sexual and reproductive health epidemiology reports (LASERs) and other HIV and STI intelligence via the HIV and STI portal. They should contact fes.southwest@phe.gov.uk if they do not have access to this information.

5 About the Field Service

The Field Service was established in 2018 as a national service comprising geographically dispersed multi-disciplinary teams integrating expertise in Field Epidemiology, Real-time Syndromic Surveillance, Public Health Microbiology and Food, Water and Environmental Microbiology to strengthen the surveillance, intelligence and response functions of PHE. The Field Service also leads and coordinates the Global Health work of PHE's National Infection Service working with the Global Public Health Team and will lead and coordinate the national aspects of PHE's port health functions.

You can contact your local FS team at fes.southwest@phe.gov.uk

If you have any comments or feedback regarding this report or the FS, please contact fes.southwest@phe.gov.uk

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