HIV & AIDS

IN THE NORTH WEST OF ENGLAND 2008

Suzy C. Hargreaves Leighton Jones Hannah C.E. Madden Jennifer Daffin
Penelope A. Phillips-Howard Penny A. Cook Qutub Syed Mark A. Bellis

liverpool JMU
Centre for Public Health

HIV & AIDS

in the North West of England 2008

Suzy C. Hargreaves
Leighton Jones
Hannah C.E. Madden
Jennifer Daffin
Penelope A. Phillips-Howard
Penny A. Cook
Qutub Syed
Mark A. Bellis

Published by
North West HIV/AIDS Monitoring Unit
Centre for Public Health, Research Directorate
Faculty of Health and Applied Social Sciences
Liverpool John Moores University
Kingsway House
Hatton Garden
Liverpool
L3 2AJ

Tel: +44 (0)151 231 8782
Fax: +44 (0)151 231 8020
Email: sexualhealth@ljmu.ac.uk

Cover design: by Lee Tisdall, © Centre for Public Health, Liverpool John Moores University
Printing: Tech Litho Ltd

Executive Summary

In 2008, 5,767 HIV positive individuals accessed treatment and care from statutory treatment centres in the North West of England, representing an 11% increase on the number reported in 2007 (5,212 individuals). Prevalence in the region was 79 per 100,000 population. During 2008, there were 925 new cases of HIV, representing a 13% increase from 2007 (817 cases), a reversal in the downward trend observed in 2006 and 2007. New cases were classed as people who were new to the North West database in 2008, were not seen at a statutory treatment centre in the North West since 1994 and included transfers from outside the region.

This is the thirteenth 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 43 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/hiv2008).

New cases represented 16% of all cases, the same as in 2007, but a slightly lower proportion than seen in previous years (23%, 22% and 19% in 2004, 2005 and 2006, respectively). The predominant mode of exposure to HIV for new cases was heterosexual sex (48%), followed by sex between men (MSM) at 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 (64%). However, eight out of the 11 deaths amongst individuals new to treatment in 2008 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 MSM, accounting for 52% of all cases in 2008 (table 3.1). However, there is considerable variation at county level. Of those whose infection route was known, 53% of Lancashire's and 57% of Cheshire's HIV positive residents were infected through sex between men, compared with 40% of Merseyside's HIV positive population. There is greater variation across LAs: 81% of HIV positive residents in Blackpool (compared with 26% in Blackburn with Darwen) were infected via MSM. Manchester had the largest number of HIV positive residents infected through MSM (843 cases) and infected through heterosexual sex (727 cases). The Greater Manchester area had the largest number of HIV positive individuals infected through injecting drug use (77 individuals) which accounted for 69% of all residents of the North West infected through this route. However, heterosexual sex continued to be the second largest route of infection in the North West region, accounting for 41% of all cases in 2008 (tables 3.1 and 3.2). This is a similar proportion to that seen in 2007 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 over half of all cases (table 3.2) and new cases (table 2.2) presenting to statutory treatment centres in 2008.

The North West of England continued to be influenced by the global HIV situation, as reflected in the number and pattern of HIV infections acquired abroad. Over a third (36%) of all HIV positive individuals accessing treatment and care in the region were reported to have been infected outside the United Kingdom, the vast majority (82%) of home 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 were infected in South and South-East Asia, with a similar proportion (8%) in Western Europe. Of those exposed in Western Europe, the greatest number were infected in Spain (figure 3.2). The role of exposure abroad was even more marked amongst new cases where 42% were reported to have been acquired abroad (figure 2.2 and table 2.7). Individuals 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 2008, the majority of whom (66%) were of white ethnicity (table 3.1). An increasing number of individuals treated in the region were from black and minority ethnic (BME) backgrounds (34%), a substantial over-representation when compared to the proportion of people from BME backgrounds in the general North West population (8%). An even greater proportion (44%) of new cases whose ethnicity was known 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 black Africans, 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 black Africans (tables 2.1 and 3.1). There are proportionately more females from BME communities with HIV compared with white females, 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, notwithstanding growing concern over the health of vulnerable groups such as asylum seekers. The number of individuals classed as non-UK nationals represented 19% of all HIV positive individuals in the region. Over half (54%) these individuals were asymptomatic, compared with 46% of UK nationals (table 3.13).

During 2008, the largest proportion (47%) of people accessing treatment and care services were using triple therapy. Amongst those North West residents who had received an AIDS diagnosis, 94% were on antiretroviral therapy. Amongst those who were asymptomatic, 54% were on therapy, a greater proportion than in 2007. During the year, asymptomatic HIV positive people accumulated a total of 19,281 outpatient visits. People who had an AIDS-related illness had the highest mean number of outpatient visits (8.3 per person), whilst individuals who had died from an AIDS-related illness during the year required the most inpatient care (a mean number of 30 days per individual).

During 2008, 2,834 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by eight voluntary agencies in the region. The overall number of individuals seen by the voluntary sector in 2008 was 14% higher than in 2007. A third (34%) of the individuals seen by voluntary agencies in 2008, did not attend a statutory sector service during the year (table 4.3), illustrating the continuing contribution of the voluntary sector to the care of HIV positive individuals for whom voluntary agencies may be the sole provider of care. This also has particular significance for regional funding of HIV services, since individuals exclusively accessing voluntary agencies 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 seventh year running, information was requested from social service departments in the North West on the social care of HIV positive people. This year, five social service departments were able to contribute information on 219 individuals. Most individuals with HIV (74%) also accessed statutory sector services in 2008 (table 5.1). Renaissance, part of Manchester Methodist Housing Association, provided data for the fourth time in 2008 on 32 HIV positive individuals accessing their services, 88% of whom also accessed statutory sector services during the year.

Information on trends for new and all cases of HIV in the North West from 2000 to 2008 are presented in chapter 6 and give an overall view of the changing pattern of HIV in the North West region.

It is hoped that the tables and figures presented in this report, and the extra analysis available on the website (www.nwpho.org.uk/hiv2008) 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.

Acknowledgements

We are extremely grateful to all the staff in treatment centres, voluntary agencies, social services and other organisations who spend considerable time gathering the data for this report. Without their hard work, this report would not be possible.

Thanks are also due to staff in the Centre for Public Health, particularly, Lee Tisdall, Neil Potter, Sacha Wyke, Michela Morleo, Beccy Harrison, Corinne Harkins, Gill Elliott, Gemma Parry, Emma Pemberton and Sharon Schofield.

We would also like to acknowledge the continued support of Ruth Hussey (Regional Director of Public Health/Strategic Health Authority Medical Director), John Astbury (Consultant in Health Protection, Cumbria & Lancashire Health Protection Unit), Ken Mutton (Consultant Virologist, Health Protection Agency North West), Rod Thomson (Public Health Specialist, Central Liverpool Primary Care Trust), Simon Henning (Sexual Health Network Lead, Cheshire & Merseyside Sexual Health Network), Neil Jenkinson (Sexual Health Network Lead, Greater Manchester Sexual Health Network) and Stephen Woods (Programme Manager Sexual Health/Public Health Network Co-ordinator, Cumbria and Lancashire Public Health Network/Sexual Health Network).

Contents

Figures and Tables

Introduction

New Cases

All Cases

Voluntary Agencies

Social Services

Trends

1. Introduction

This is the thirteenth annual report of the North West HIV/AIDS Monitoring Unit. Over the past thirteen years, we have collected, collated, analysed and disseminated data on the treatment and care of HIV positive individuals in the region[1-12]. 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 and AIDS cases presenting for treatment and care in the region. Information on the voluntary sector and social care are presented in chapters four and five, followed by trend data in chapter 6. The relevant tables of information can be found at the end of each chapter. 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/hiv2008).

It is hoped that the tables and figures presented within this report, and the extra analysis available on the website, 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.

Global Perspectives on HIV and AIDS*[13]

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 million people infected with HIV globally in 2007, of whom 2.7 [2.2—3.2]† million were new HIV infections, compared with 3 [2.6—3.5] million in 2001. Half of these infections were in females. Young people aged 15-24 years accounted for almost half of all new infections. An estimated 370,000 children aged under 15 years were infected in 2007 and there are thought to be 2.0 [1.9—2.3] million children of this age now living with HIV (almost 90% live in sub-Saharan Africa). While this is a rise since 2001 when 1.6 [1.4—2.1] million were infected, the number of new infections has declined due to expansion of services to prevent mother to child transmission. Previous estimates on the number of deaths from HIV/AIDS in 2007 have remained, with an estimated 25 million deaths reported. The recent UNAIDS report noted since the recognition of AIDS nearly 30 years ago, there are signs of major progress in HIV response. The annual number of AIDS deaths declined from 2.2 [1.9—2.6] million in 2005 to 2 [1.8—2.3] million in 2007. This has been attributed in part to the substantial increase in access to HIV treatment in recent years.

The improvements in HIV sentinel surveillance data (especially in sub-Saharan Africa and Asia), along with the growing number of countries conducting national population-based surveys (including HIV testing), has led to more reliable epidemiological estimates. Subsequently, UNAIDS advises that comparisons with previously published reports are done so with caution and these changes kept in mind. It is these improvements and an increase in antiretroviral therapy uptake and provision that has led to the global decline in the number of HIV-related deaths.

Findings show that a decline in HIV prevalence exceeding 25% occurred in seven of the 17 countries with adequate survey data. In two of these countries (Botswana and Kenya) declines occurred in both urban and rural areas. In the other five (Benin, Burkina Faso, Cote d'Ivoire, Malawi, and Zimbabwe) declines were only significant in urban areas.

There was a six-fold increase in financing for HIV programmes in both low and middle income countries between 2001 and 2007. This is starting to show beneficial effects in a reduction in deaths from AIDS-related conditions and in the prevention of new infections. However, despite advances, action is still needed to reach HIV prevention and treatment and care targets[13]. Nearly 30 years into the epidemic, only about half of countries have national HIV prevention targets whereas nearly 90% have targets for AIDS treatment[14].

The rapid spread and high prevalence of HIV in southern Africa has been equated with concurrent multiple partnerships. However, there is, as yet, little evidence to suggest such relationships cause increased transmission compared with serial multiple partners. Condom use amongst young people (aged 15-24 years) is reported to have increased. Condom use in young males having more than one partner in the preceding 12 months increased in 12 countries, while in females use had only increased in eight countries. Whilst 70% of young men knew condoms could protect against HIV exposure only 55% of young women were so informed[13].

* Unless otherwise stated, global data and information have been sourced from the UNAIDS 2008 *Report on the global AIDS epidemic*. Please note, at the time of publication, no global figures for 2008 were available. Global figures refer to updated 2007 data.

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

Addressing the HIV epidemic amongst marginalised groups is particularly important. It was highlighted at the World Aids Conference, Mexico City 2008, that in countries where there are no laws to protect sex workers, drug users and men who have sex with men (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[15].

Sub-Saharan Africa

Sub-Saharan Africa remains the global epicentre of the HIV pandemic. There were an estimated 22 [20.5—23.6] million people infected with HIV in 2007, 1.7 million of these were new infections. These figures account for approximately two thirds (67%) of the global total of infection (33 million people) and nearly three quarters (72%) of the global number of AIDS-related deaths. The national prevalence for adult HIV infection is below 2% in several countries of West and Central Africa and in the horn of Africa. Previously it was above 5% in seven countries, mostly in Central and Eastern Africa. However, it exceeded 15% in seven other countries, all of which are located in southern Africa (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe). Regardless of the high prevalence in these countries, the epidemic appears to be stabilising in most African countries. Of particular interest is HIV infection trends amongst women attending antenatal clinics in Nigeria—the continent's most populous country—where transmission appears to be stabilising.

Heterosexual intercourse remains the driving force behind the epidemic in sub-Saharan Africa, resulting in the world's largest population of children living with HIV. In Botswana, a drop in HIV prevalence amongst pregnant 15-19 year olds suggests that the rate of new infections could be slowing. In Malawi and Zambia a similar trend appears, with a declining prevalence amongst females using antenatal services in some urban areas. In contrast, HIV prevalence is increasing amongst pregnant females in Lesotho and parts of Mozambique. In Uganda HIV prevalence appears to be stabilising at 5.4%. However, surveys have shown discordance in transmission, with over half of married or cohabiting women becoming infected by someone other than their current partner[13,16].

Characterisation of the African HIV epidemic as exclusively heterosexual is now incorrect, however, as methods of transmission and affected groups have become more varied. In Kenya, for example, HIV infections in MSM and injecting drug users (IDU) are an increasing concern. Half of injecting drug users tested in Mombasa and Nairobi were HIV positive, while 43% of males who only had sex with other males in Mombasa were HIV positive[17-18].

Nevertheless, in general the national epidemics appear to have stabilised or begun to decline, alongside the increase in resources provided to HIV/AIDS prevention. As antiretroviral treatments become more widely available in African countries a reduction in mortality rates can be found. In Malawi, for example, a 44% reduction in the mortality rate has been witnessed in workers of a national electric company after provision of treatment. In Botswana, which had an HIV prevalence of up to 30%, mortality has begun to fall as antiretroviral treatment has been introduced.

Asia

In Asia, there were an estimated 5 [4.1—6.2] million people living with HIV in 2007, of whom 380,000 were newly infected. A similar number (380,000) were reported to have died from AIDS-related illnesses in 2007. Infection levels are reported to be highest in South-East Asia where, in comparison to the rest of Asia, there are disparate epidemic trends. In Cambodia, Myanmar and Thailand there have been signs of decline in HIV prevalence, while there has been a rapid increase in prevalence in Indonesia, Pakistan and Vietnam. The Ministry of Health in Vietnam reported a doubling of cases between 2000 and 2005.

Injecting drug use and unprotected (commercial or otherwise) sex are reported to be the two main drivers of the HIV epidemic in Asia. Use of contaminated injecting equipment has been documented as a main driver of HIV transmission in China, Vietnam, Malaysia, and north eastern India. Unprotected sex amongst drug users and their partners further complicates the pattern of transmission. The overlap between IDU and buying or selling sex is a concern of many countries including China, India, Pakistan and Indonesia.

Sex-trafficked women are at high risk of infection. In Nepal, for example, the HIV prevalence amongst sex-trafficked females repatriated from Mumbai (India) was 38%. In other countries such as Cambodia, Thailand and in southern India, rates of infection in commercial sex workers have fallen, with an increase in consistent condom use. 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[19]. While MSM transmission is under-researched in this region, evidence suggests a rise in HIV prevalence between males. As many as one in five new infections in

Thailand are thought to be attributed to unprotected sex between males.

Eastern Europe and Central Asia

The estimated number of people living with HIV in Eastern Europe and Central Asia reached 1.5 [1.1—1.9] million in 2007. Almost 90% of those infected live in either the Ukraine (29%) or the Russian Federation (69%). It is estimated that there were 110,000 new cases in 2007 and 58,000 deaths due to AIDS-related illnesses. Annual diagnosis of HIV in Ukraine has doubled since 2001. Numbers of newly reported HIV diagnoses also rose in Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Tajikistan, and Uzbekistan. As with the rest of Asia, Eastern Europe and Central Asia's epidemic is largely amongst IDUs, sex workers and their partners. Of the new HIV cases in 2007, 62% were attributed to IDU. The prevalence of HIV in this group in the Russian Federation ranges from 3% in Volgograd to 70% in Biysk. There is an overlap of sex work and IDU as the predominant mode of transmission in this area. For example, nearly a third (30%) of sex workers participating in the research studies said that they had injected drugs[13,20].

About 40% of the newly infected cases of HIV in this area were amongst females, with a particularly high prevalence amongst pregnant females in regions of eastern and central Ukraine. About half of female HIV infection is through unprotected sex with IDU partners. In 2006, 1% of newly infected HIV cases were a result of unprotected sex between males.

Caribbean

In 2007, there were an estimated 230,000 people living with HIV in the Caribbean, three quarters of whom lived in the Dominican Republic and Haiti. There were an estimated 20,000 new infections and approximately 14,000 deaths due to AIDS-related illnesses. 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 the Dominican Republic and Haiti. The main mode of transmission in the Caribbean is unprotected heterosexual sex. Haiti has undergone the largest epidemic in the Caribbean, although prevalence amongst pregnant females attending antenatal clinics declined from 6% to 3% between 1991 and 2004. Surveys report that more sex workers are protecting themselves against infection especially in the main urban and tourist centres. Female sex workers account for 9% and 31% of infections in Jamaica and Guyana, respectively. Sex between men, while illegal in nine of the 24 countries, accounts for up to one in eight reported HIV infections and is a significant factor in a number of national epidemics. It is the main mode of transmission in Cuba, accounting for 80% of reported infections.

Latin America

An estimated 1.7 [1.5—2.1] million people live with HIV in Latin America. In 2007, 140,000 new cases were reported along with an estimated 63,000 [49,000—98,000] AIDS-related deaths. Trends appear to have changed little in the past decade. The main mode of transmission continues to be between males and sex workers and to a lesser extent IDUs. Heterosexual transmission accounts for two thirds of cases reported and an increasing number of females reported to have acquired HIV from their male partners, particularly in Argentina, Brazil, Peru and Uruguay. HIV infection amongst sex workers is lower than that amongst MSM, due to recent condom promotion aimed at sex workers. Injecting drug use features in several epidemics although they account for a small proportion of cases. IDUs constitute 5% of new infections in Buenos Aires, and a decreasing proportion in Brazil. Several countries (Peru, Argentina, Uruguay, Bolivia, and Colombia) have reported a high prevalence amongst MSM. A hidden HIV epidemic has been reported amongst MSM in other countries (Belize, Costa Rica, El Salvador, Guatemala, Mexico, Nicaragua, and Panama), and 57% of the HIV diagnoses in Mexico were amongst this group. Between a quarter and a third of MSM report also having sex with females, 30-40% of whom claim to have not used condoms in the previous month.

North America, Western and Central Europe

In 2007 there were an estimated 2 million people living with HIV in North America, Western and Central Europe, of which, 1.2 [0.69—1.9] million reside in the United States of America. An estimated 31,000 [16,000—67,000] people died from an AIDS-related illness in 2007, while 81,000 people were newly infected. Western Europe and the USA are the only regions in the world where the majority of people needing antiretrovirals can gain access to them. As a result, the death rate has remained comparatively low and stable over a number of years. The number of people living with HIV has thus increased despite a relatively stable number of new HIV cases. A similar rise in the number of people living with HIV is also seen in Western Europe although new cases are continuing to rise.

These high-income countries have witnessed diverse epidemics. In general, the proportion of infections from IDUs is low and falling (approximately 18% of new HIV diagnoses) alongside schemes to prevent needle sharing or reuse. Unprotected sex between males is the main

mode of transmission, with 40% of new diagnoses in Canada and 53% in the USA acquired this way. This form of transmission has risen sharply in Western Europe. For example, in Germany the number of new cases doubled (96%) between 2002 and 2006. A third of new cases of HIV in the USA and Canada result from unprotected heterosexual sex.

Middle East and North Africa

Information for the Middle East and North Africa is limited and sporadic. An estimated 380,000 people were living with HIV in 2007 and, of these, 40,000 were newly diagnosed. Epidemics in the region are relatively small scale, with the exception of Sudan which has an estimated prevalence of 1.4%, primarily spread through unprotected heterosexual sex. More generally, transmission has occurred through unprotected paid sex and IDU. There has been a serious IDU-related epidemic in Iran with an HIV prevalence of 15%-23% amongst males seeking services. This appears to be a main route of transmission in Libyan Arab Jamahiriya, Tunisia, Algeria, Morocco and Syria. 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 partner's paid sex or drug use. Since sex between males is illegal in the majority of countries in this region, treatment seeking is likely to be under-reported in this group.

Oceania

An estimated 74,000 people are living with HIV in Oceania, of which 13,000 were newly reported HIV infections in 2007. Epidemics in this area are mostly small, except in Papua New Guinea, where the number of new diagnoses recorded each year doubled between 2002 and 2006. HIV in this country is primarily transmitted through heterosexual sex, apparently driven by unprotected paid sex. Sex between males remains the primary mode of transmission in Australia and New Zealand. After a sharp decline in the 1990s, reports of new HIV infections have increased in Australia in recent years. 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[21], 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. At the end of 2007 the annual gap between available and required financial resources needed to achieve universal access goals was an estimated US$8.1 billion. If targets are going to be met, financial resources must be quadrupled by 2010 from the 2007 level.

By the end of 2007, an estimated 950,000 more people received antiretroviral therapy (ART) compared with the end of 2006, resulting in nearly three million people living with HIV receiving ART, of whom 2.1 million live in sub-Saharan Africa. Concurrently, major progress has occurred in expanding services to prevent mother to child transmission, with reports from low and middle income countries suggesting an increase from 9% to 33% between 2004 and 2007. Consequently, coverage of ART for women in most countries now exceeds, or is at least equal to, that of men. Global morbidity and mortality associated with co-infection with tuberculosis and HIV has yet to be adequately addressed, with too few persons living with dual infections receiving treatment for both conditions. Overall, some 22% of tuberculosis cases in Africa (within some countries, statistics report up to 70% of cases) occur in persons living with HIV.

Evidence that male circumcision is a valuable technology for reducing HIV risk in men is an important landmark in the history of HIV prevention[22]. 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.

UNAIDS recognise that stigma and discrimination have not been adequately addressed. Non-governmental reports suggest only a third of countries use performance indicators or benchmarks for reduction of HIV-related stigma[13]. Furthermore, no more than a quarter of countries are reported to have anti-discrimination legislation laws for sex workers, injecting drug users and

MSM. Evidence shows that countries with such laws reach a higher proportion of the population with HIV prevention services.

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) (HIV and STI Department, Centre for Infections) and the Scottish Centre for Infection and Environmental Health (SCIEH), who compile the data into quarterly surveillance tables[23].

HPA report the cumulative total of reported new HIV infections for the UK reached 102,333 by the end of 2008 (table 1.1). Of these, 7,370 were newly identified in 2008 of whom 4,670 (63.4%) were males (figures adjusted for reporting delay). It is noted that the downturn reported in 2007 (6,393 cases[12,24] was affected by a reporting delay, as the revised final estimate for 2007 was upgraded to 7,660). We anticipate the current unadjusted estimate of 6,706 new diagnoses for 2008 will also be upgraded as HPA refine the final year dataset. Figures 1.1 to 1.3 and table 1.1 compare the trend of new cases of HIV infection in the UK with those specific to the North West of the UK. As with previous years, approximately half of all individuals newly diagnosed with HIV reside in London (3,098 of 6,181 in England and of 6,706 in the UK). Similarly, over half of all cases living with HIV reside in London (52,984 of 94,465 in England and 102,333 in the UK). 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 [23,25-28]. For the epidemiology of HIV in the North West, see chapters two and three of this report, which are based on surveillance data of treatment and care of HIV positive individuals in the region.

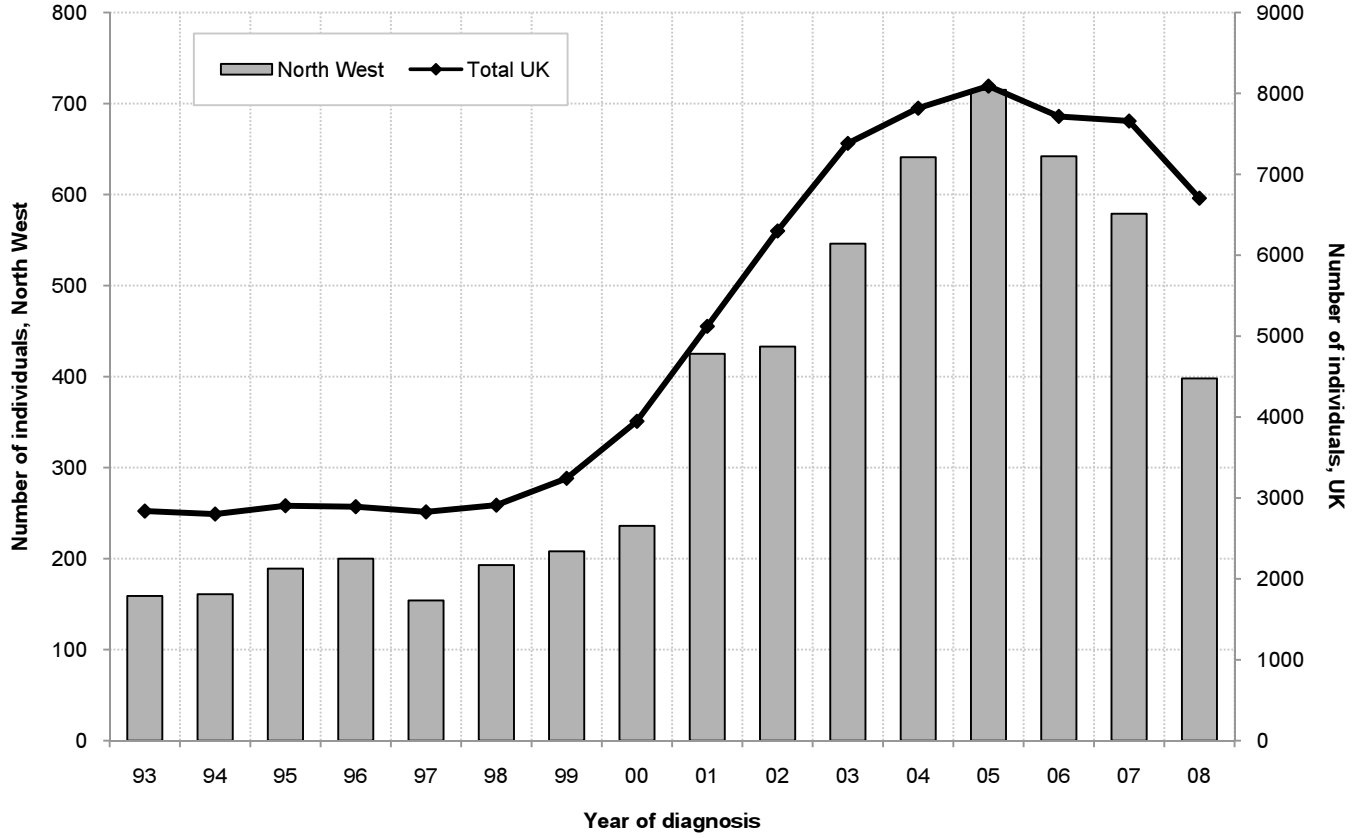
An additional tool for monitoring the HIV epidemic in the UK is provided by the unlinked anonymous HIV seroprevalence programme conducted by the HPA and the Institute of Child Health. Part of the programme involves the testing of blood samples that have been taken for other purposes (for example antenatal 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[29]. Results of the programme, combined with other HPA surveillance programmes, estimates that in 2007, there were an estimated 77,400 persons living with HIV (diagnosed and undiagnosed) in the UK. Amongst those aged 15-59 years living with HIV, just under a third (28%; 20,700 [16,300—25,800])were unaware of their infection[30].

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 44,537 estimated cases of HIV acquired through sex between men. Amongst these, 2,719 were reported in 2007 and 2,012 in 2008. As noted previously, 2008 data are prone to reporting delays. To account for this, HPA have reported adjusted estimates, resulting in an estimate of 3,050 and 2,830 cases in 2007 and 2008 respectively. Using adjusted estimates, the HPA estimate doubling in the number of new diagnoses in MSM from 1999 to 2007 (from 1,450 to 3,050). Where probable country of infection was reported, 74% were most likely infected in the UK[23]. Even though these figures as a whole remain high, the shape of the epidemic has changed in the UK over the past couple of decades. The overall proportion of new HIV diagnosis in the UK attributed to sex between males has decreased from 64% prior to 1992 to 30% (unadjusted figures) in 2008 (figure 1.2).

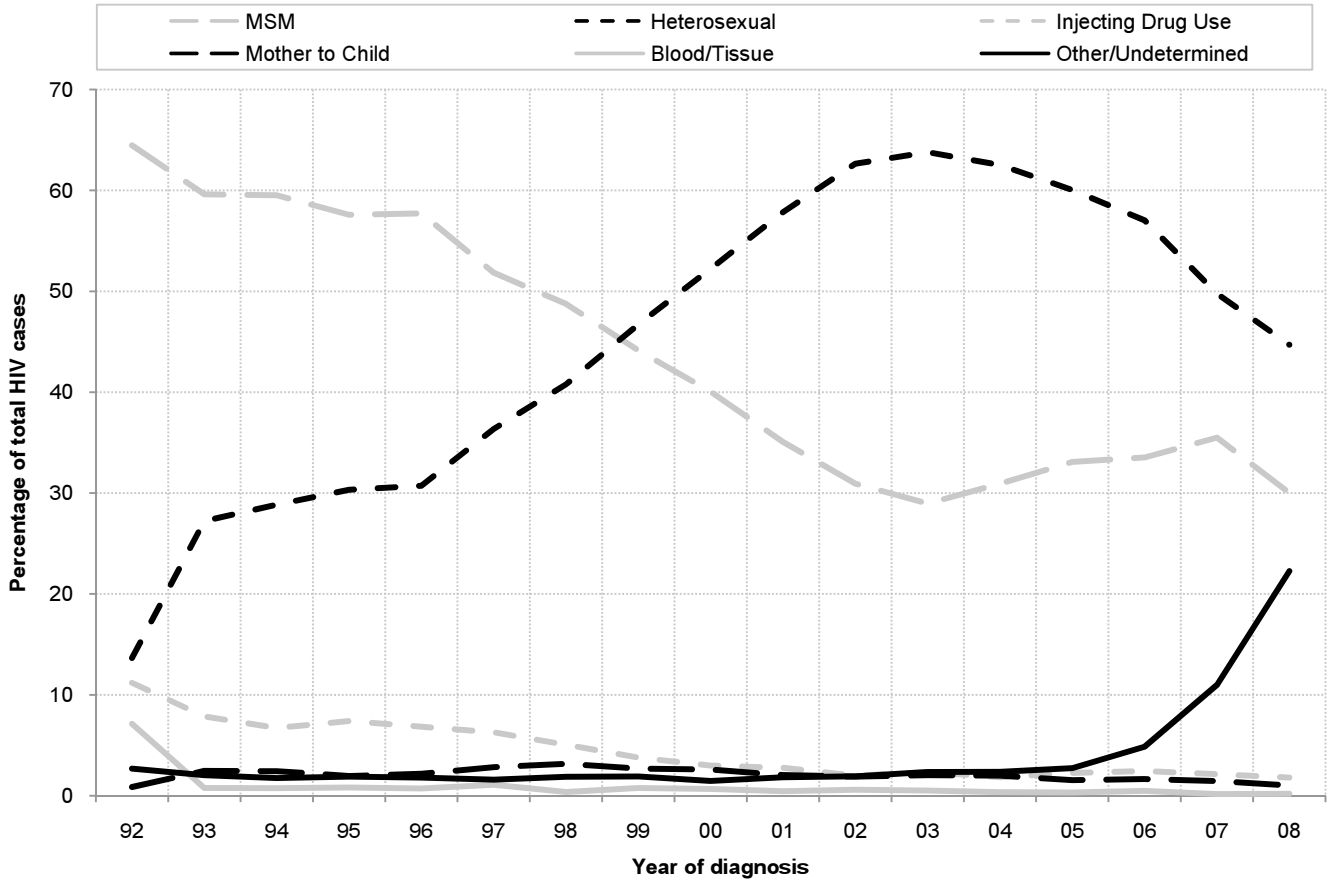
The 1980s saw substantial reductions in risky behaviours amongst MSM in response to the HIV/AIDS crisis. However, towards the end of the 1990s, the trends of sexual risk-taking behaviour appeared to increase again. Dougan and colleagues (2008) reported that twenty-five years after the first case of AIDS was reported, MSM remain the group at greatest risk of acquiring HIV in the United Kingdom[31].

Figure 1.1: Number of new HIV diagnoses in the North West and the UK by year of diagnosis to December 2008
Source: UK HIV New Diagnoses to end of December 2008, 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 2008
Source: UK HIV New Diagnoses to end of December 2008, HPA



Changes in risky sexual behaviour were reported by the longitudinal study that recruited males in gyms in London. Between 1998 and 2003, the percentage of males reporting high-risk sexual behaviour with a causal 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.

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 (KC60 data), 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 diagnosis[32]. In 2007, the proportion of individuals diagnosed late (i.e. CD4 cell count <200 per mm^3 within three months of diagnosis) was lowest amongst MSM (19%) compared to other groups[30].

The most recent Sigma UK Gay Men's Sex Survey 2006 (conducted in partnership with 107 health promotion agencies across the UK, amongst men who had had sex with a man in the previous year and/or had a non-heterosexual sexual identity) revealed that 36% of all males surveyed in England, and 37% of all North West males surveyed, had never been tested for HIV[33]. The survey also revealed that 56% of males whose last HIV test was negative, 47% who had never had an HIV test and 67% who had tested HIV positive had participated in unprotected anal intercourse in the last year. Furthermore, 42% of all males surveyed engaged in unprotected anal intercourse with a casual male partner [33].

Heterosexual sex

Although there has been a doubling in the number of new diagnoses in MSM from 1999 to 2008, the increase in cases acquired through heterosexual sex was more marked. Since 1999, heterosexual sex has accounted for the largest number of new cases and outnumbered those acquired through sex between men, with the proportion rising from 47% to 57% of the total number of HIV diagnoses in the UK in 2008 (figure 1.2). Of those HIV positive individuals infected through heterosexual sex, the majority (61%) are female[23]. Figure 1.3 shows heterosexual sex cases categorised by whether they were exposed through sex with high-risk partners, exposed abroad or exposed 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. These preliminary data reveal that the prevalence of HIV amongst pregnant women in the North West has increased five-fold from 20 per 100,000 to 100 per 100,000 population (figure 1.4). In 2007, the overall prevalence of HIV in pregnant women in England was 220 per 100,000 population[34].

Africa is the predominant global region of transmission for HIV cases acquired abroad with 84% of all those HIV infections acquired through heterosexual sex (unadjusted figures) probably being acquired in the region[23]. 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[23]. 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 2007 reside[13]. However, HIV is often stigmatised within African communities, which can prevent individuals from accessing services[35] and disclosing their status to friends and family for extra support[36].

Injecting drug use

Injecting drug use (IDU) accounts for 4.9% of the total diagnosed HIV infections in the UK to date[23] (table 1.1). The proportion newly diagnosed by this route in 2008 remained stable at 1.8% (figure 1.2). Other blood borne infections, such as hepatitis B and C, are more infectious than HIV and are transmitted during episodes of indirect sharing (for example sharing of filters, spoons or water when preparing drugs). While HIV prevalence remains fairly low, hepatitis B and C have risen significantly. The North West has the highest prevalence of hepatitis B in IDUs outside London at 29% and the highest prevalence of hepatitis C in the country (60%)[37]. 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 [38]). Analyses have revealed that in the North West people infected by IDU tend to suffer poorer health[11,39].

Anonymous testing of IDUs attending services reveals that, outside London, the prevalence of HIV amongst injectors is low (1% in the North West compared to 4% in London in 2007). Although the prevalence in London increased slightly from 3.5% in 2004/05[37], low

prevalence amongst drug users in the UK compared to other countries in Europe has been attributed to harm reduction strategies such as needle exchange programmes[40].

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 0.2% in 2008 (figure 1.2)[23].

A small number of cases continue to be diagnosed as a result of transfusions or blood products received overseas[23]. 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[41]. 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[42].

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 mortality amongst these men[43]. A small proportion of the haemophilic men 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[43].

Mother to child

During 2007, 62% of females giving birth in England and Scotland in areas covered by anonymous surveillance, 0.21% (939/439, 698 individuals) were HIV positive. This is an estimated 1 per 468 females giving birth[30]. In the UK, this mode of transmission remains low at a prevalence of 0.05%, a gradual increase from figures in 2000. In 2008, 69 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 2007, 111 mother to child infections were reported, which was a decrease of 17 from 2006[23].

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[44]. HIV prevalence in mothers varies depends on global region and country of birth. Cumulative HIV data from HPA for 1995-2008 identified, of 1,444 total mother to child diagnoses, 1,143 (79%) were in persons of black African ethnicity, and 91 (6.3%) were white[23].

Interventions of ART for HIV infected mothers, caesarean section and avoidance of breast feeding have all been successful at reducing the rates of vertical transmission from around 32% to 4%[45]. The British HIV Association (BHIVA) updated their guidelines for the treatment of pregnant females in 2008[46]. 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 females in order to increase the uptake of the test to 90%[47-48]. The HPA North West's antenatal screening report for 2007[49], showed a regional HIV antenatal screening uptake rate of 86%, with the highest uptake (95%) in Cumbria and Lancashire. This regional figure is an increase of 5% on the uptake rate in 2006 but remains below the 90% government target.

In the UK in 2008 there were 9,512 births to HIV-infected women, of which 74% were uninfected (7,056 children), 9% were infected (838 children) and the remainder are currently of undetermined HIV status. In the North West, there were 515 births to HIV-infected women of which 58% (301 children) were uninfected and 9% were infected (46 children) and a third are currently of undetermined status[23].

Figure 1.3: Number of heterosexually acquired HIV cases in the UK by year of report to December 2008
Source: UK HIV New Diagnoses to end of December 2008, HPA

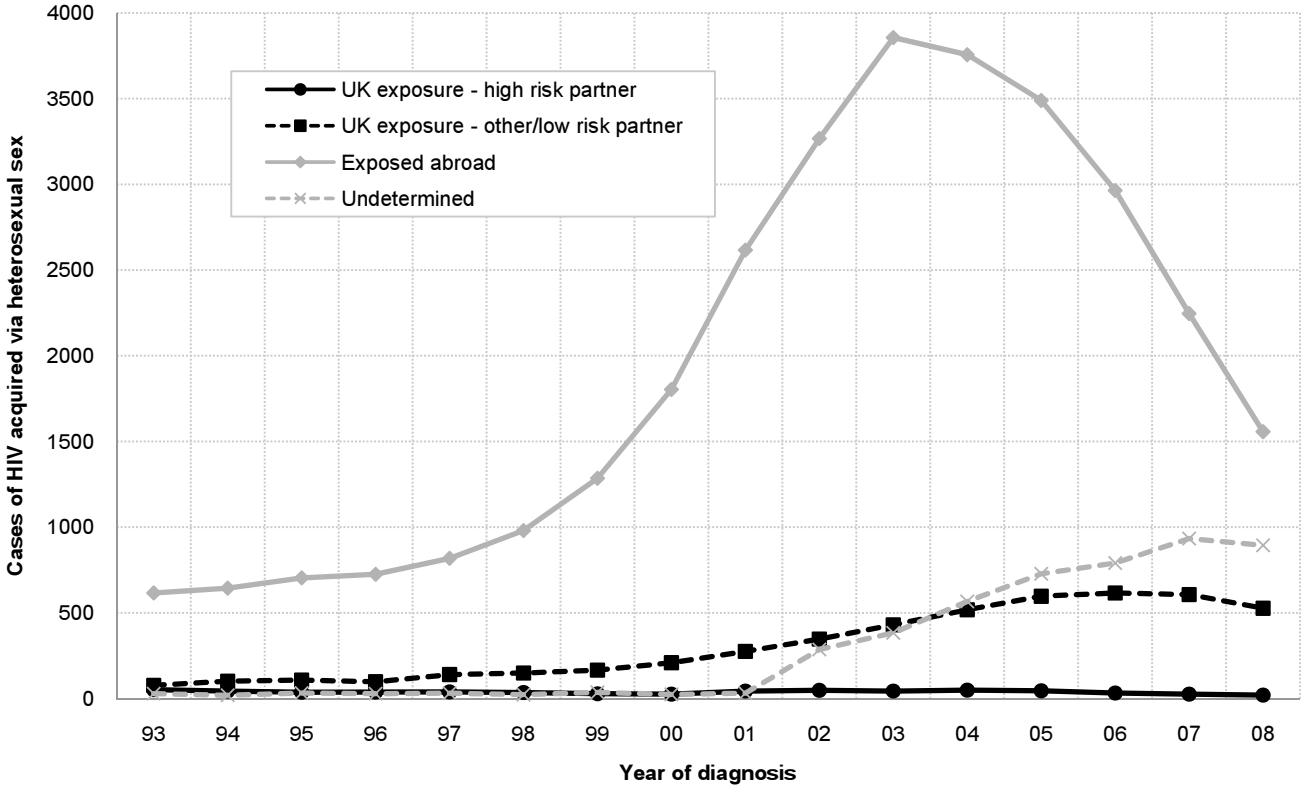
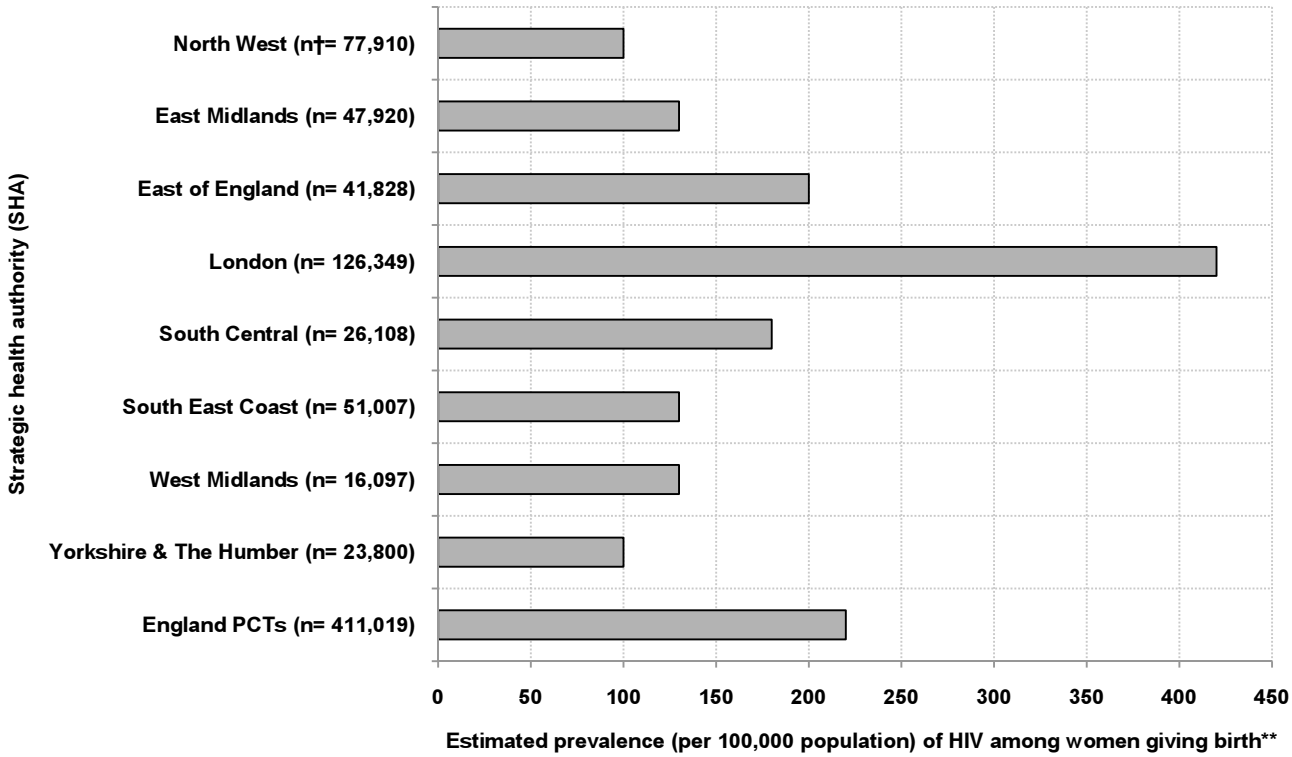


Figure 1.4: HIV prevalence amongst pregnant women in England, 2007 (newborn infant dried blood spots collected for metabolic screening)
Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: data from Dried Blood Spot Survey of Newborn infants and the National Study of HIV in Pregnancy in Childhood, 2007



** These data are preliminary and need to be considered with caution.*
*** Estimated prevalence of women giving birth who are HIV-infected in 2007 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. Consequently, services are being developed to address the needs of this group as they become young adults[50].

HIV in non-UK nationals

Globally, migrants are at greater risk of HIV infection than are resident populations, irrespective of their country of origin[51]. 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 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[52-53]. 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[54]. 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[55]. This is due to the 95% adherence to ART 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[56]. Further guidelines on the detention and removal of asylum seekers with HIV were published in June 2009 offering advice for healthcare and voluntary sector professionals[57].

During 2008, the UK received 25,670 asylum applications[58], 10% more than in 2007 (23,430)[59]. According to Home Office statistics, there are currently 6,485 asylum applicants residing in the North West receiving supported accommodation from NASS, with a further 365 receiving subsistence only support. Within the North West, the largest numbers of asylum seekers in supported accommodation are located in Liverpool (1,245), Manchester (1,050) and Salford (740)[58]. 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 2008

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 and AIDS in the North West, see the comprehensive overview in chapters 2 to 6 of this report.

By the end of 2008, a cumulative total of 7,090 HIV infections in the North West had been reported to the HPA[23], including 398 new diagnoses during 2008 (although this figure will increase as more reports are received) (figure 1.1). There were 52 newly diagnosed AIDS cases recorded in the North West in 2008, bringing the cumulative total to 1,652, 7% of the total number of AIDS cases reported in the UK[60].

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 (53%, compared with the UK figure of 44%), and a lower proportion of people infected through heterosexual sex (36% 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. Annual data for 2007 show an HIV prevalence of 220 per 100,000 population amongst women giving birth in the UK. The prevalence amongst pregnant women in the North West has decreased from 116 per 100,000 in 2006 to 100 per 100,000 in 2007[34].

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 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 genitor-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[61].

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[62]. This is likely to have risen as diagnoses and attendances have increased substantially since then[61]. 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. 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 [63].

Monitoring HIV and AIDS in the North West Region

Over the past 13 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 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[64]. 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[65].

We have collected data from over 40 statutory treatment centres including GUM clinics, infectious disease units, haematology clinics and a number of other specialist units and clinics[1-12]. The data collected form part of the national dataset— the Survey of Prevalent Diagnosed HIV Infections (SOPHID). In 2008, our fifth 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[66]. 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 2008. These data represent the most accurate and comprehensive source of information related to HIV and AIDS in the North West of England. The data collected by the North West HIV and AIDS Monitoring Unit, from across the region over the last 13 years, illustrate the increasing number of people accessing HIV services. There has been an increase (11%) in the number of HIV positive individuals attending treatment centres from 2007 to 2008. 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 voluntary organisations across the region (chapter 4). For the past seven years North West social service departments have also participated, providing data on HIV positive service users (chapter 5).

Methodology of monitoring HIV and AIDS in the North West

Clinics are prompted to complete and return forms 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 current 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.

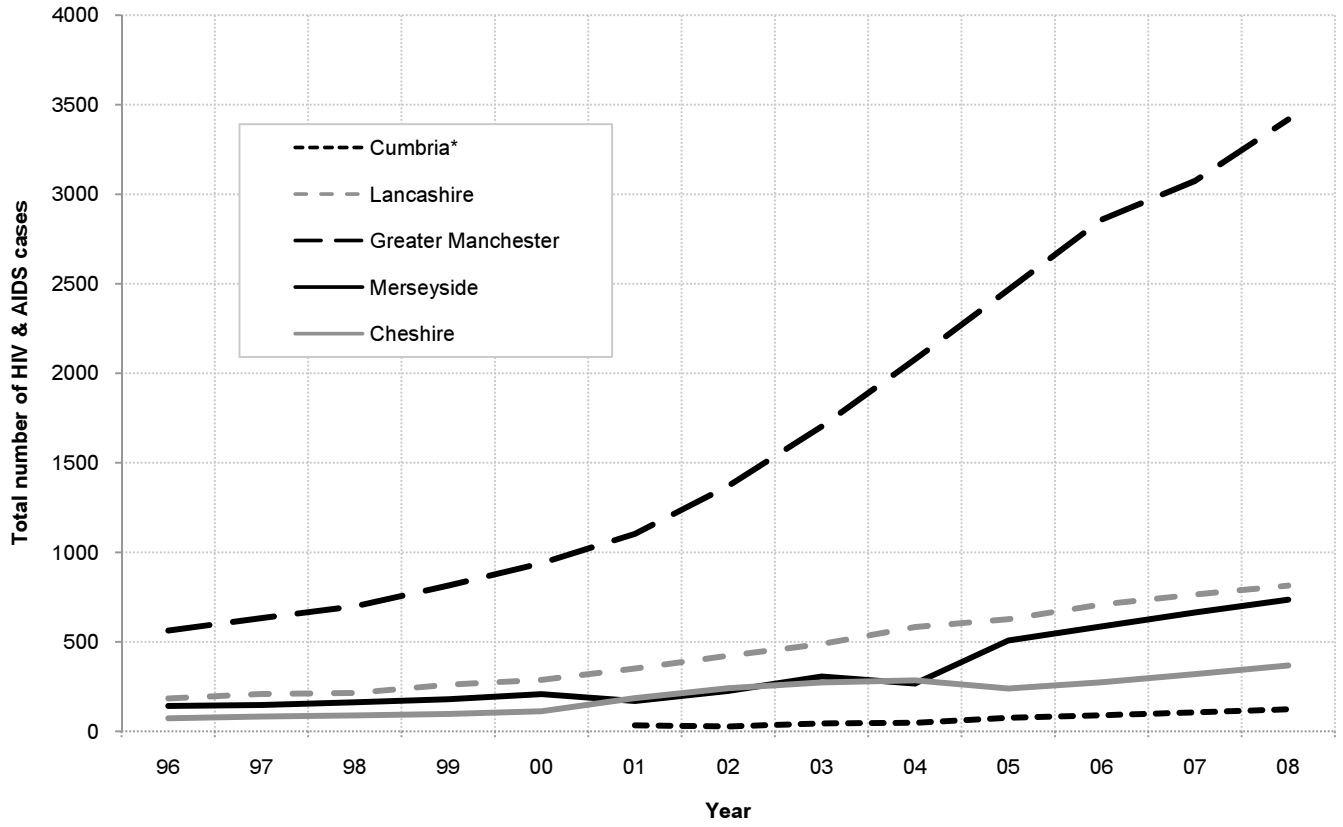
The demographic data collected for each person include: hospital number; soundex; date of birth; sex; postcode; ethnicity; residency status; transmission route of HIV; vital status; whether they were exposed abroad and country of exposure. Men who were exposed though sex with men (MSM) and who are also IDUs are included in the MSM category. Transsexuals who acquired HIV through sex between men are recorded as males for the purpose of our report. Age groups refer to the age of individuals at the end of December 2008, 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.

Table 1.1: Cumulative number of HIV diagnoses in the North West and the UK by infection route of HIV to December 2008
Source: UK HIV New Diagnoses to end of December 2008, HPA

	Infection route						
	MSM*	Injecting Drug Use	Heterosexual	Blood/Tissue	Mother to Child	Other/ Undetermined	Total
North West	3734 (52.7%)	267 (3.8%)	2579 (36.4%)	206 (2.9%)	99 (1.4%)	205 (2.9%)	7090
Total UK	**44537 (43.5%)**	**4997 (4.9%)**	**44610 (43.6%)**	**1903 (1.9%)**	**1762 (1.7%)**	**4482 (4.4%)**	**102333****

**Includes 821 men who had also injected drugs.*
***Row cannot be totalled as the UK total includes some people for whom region and/or sex is not yet known.*

Figure 1.5: Total number of HIV and AIDS cases seen in statutory treatment centres in the North West 1996-2008 by county
Source: HIV & AIDS in the North West of England annual reports[1-12]



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

'New cases' are classed as people who are new to the North West database in 2008, 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 data used in the annual and mid-year reports are comprehensive and, whilst slightly overestimating the number of new diagnoses, remain the most accurate indicator of new diagnoses in the North West.

Voluntary agencies and social services are also provided with forms to complete, although fewer data fields are requested from these providers. Individuals 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.

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 voluntary agencies and social service departments send their data via the document gateway.

All service providers are encouraged 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. 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/hiv2008).

This is the fifth year for which data have been collected from the statutory treatment centres divided into two periods (from January to June 2008[66] and July to December 2008). This is likely to have resulted in an improvement in data quality (an increase in the number of cases identified), although this will not be possible to quantify.

2. New Cases 2008

During 2008, 925 new HIV and AIDS cases presented to statutory treatment centres in the North West Region. This number represents a 13% increase from 2007 (817 cases)[12] and shows a reversal in the downward trend seen in 2006 and 2007. New cases are defined as individuals seen in the North West region in 2008 but not during the years 1995 to 2007 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 AIDS and its impact on treatment and care services in the North West of England. The aim of this chapter is to present information relating to new cases and, where appropriate, references are made to corresponding data from previous North West reports[1-12]. 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/hiv2008).

For the purposes of this report, men who acquired HIV through sex between men (MSM) and who are also injecting drug users (IDU) are included in the MSM category. Male to female transsexuals who acquired HIV through sex between men are recorded as males, and age groups refer to the age of individuals at the end of December 2008, or at death.

Figure 2.1 illustrates the number of new HIV and AIDS cases per 100,000 population in the North West who attended statutory centres and resided within the region during 2008‡. The population sizes for each LA used in the calculations are provided by the North West Public Health Observatory and are mid-2005 estimates based on 2001 census data. The rate per 100,000 population of diagnosed HIV in 2008 across the region (amongst individuals with known area of residence within the North West) is 12 per 100,000 population. Manchester LA has the highest rate (56 per 100,000), followed by Salford with 34, then Blackpool with 29 per 100,000. 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 2008. Forty two percent of new cases (389 individuals) were contracted abroad, three quarters (76%) of which were acquired in sub-Saharan Africa. A further 7% were exposed in South and South East Asia, followed by Western Europe (5%), then Eastern Europe and Central Asia (2%), and the Caribbean (2%). Of the 389 new cases who probably acquired their infection abroad, the probable country of exposure is available for 363 individuals (93%). Individuals reported to have been infected in Zimbabwe continue to dominate the statistics, accounting for 34% of newly reported infections thought to have been acquired abroad (133 cases). There were a high number of infections acquired in Malawi (29 cases; 8%) which is an increase of 12% from 2007 (26 cases). Overall, 295 new people presented for treatment and care in the North West who were thought to have been infected in 24 different countries across sub-Saharan Africa. Infections from South and South-East Asia were mostly acquired in Thailand, which accounts for the third largest number of new cases infected outside the UK (21, 5%). Infections in Western Europe were mostly from Spain and Portugal.

Table 2.1 illustrates the age distribution, stage of HIV disease and ethnicity of the new HIV and AIDS cases by infection route and sex. Sixteen percent of all reported cases in 2008 were seen for the first time in the region in this year. The majority of newly reported cases (70%) occur in people between the ages of 25 and 44 years, with the greatest proportion amongst those aged 25-29 years (19%). As seen in recent years, exposure through heterosexual sex accounts for the highest proportion of new cases (48%) followed by sex between men (41%). Ninety-nine 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 slightly from 11 in 2007 to 12 individuals in 2008. During the year, 16 new cases of vertical transmission (mother to child) were reported from North West treatment centres, which represents a decrease of 24% on 2007 (21 cases). Two new cases were attributed to having received contaminated blood or tissue. The infection route for 67 new cases (7%) has not yet been determined.

HIV positive individuals categorised as asymptomatic continue to represent the largest proportion of new cases (64%), maintaining the observation that many HIV positive individuals are contacting services at a relatively early stage of their HIV disease. Of the 11 new cases who died during 2008, eight had an AIDS-defining illness. Importantly, 14% of new cases first presented in the

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

region with AIDS. This shows that despite continued efforts to raise 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 and AIDS cases, for whom ethnicity is known, were of white ethnicity (56%), with 44% of cases occurring in a minority ethnic group. Black Africans account for 84% of minority ethnic cases, with black African females exposed through heterosexual sex making up 21% of all new cases reported in 2008. The proportion of females of white ethnicity who were infected heterosexually remained steady at 17% of new cases compared with 71% in females of black African ethnicity. Of all the individuals infected through MSM, 93% were of white ethnicity.

Table 2.2 shows the LA of residence and the infection route of new HIV and AIDS cases presenting in the North West for treatment and care in 2008. Although the infection route for 52% of all HIV positive individuals accessing treatment and care in 2008 was attributed to sex between men (chapter 3, table 3.1), this proportion was lower for new cases with 41% infected via this route. Across the counties there were large differences in the route of infection. Whilst the main route of infection in Cumbria is heterosexual (61%) with fewer men who have sex with men (MSM) (30%), Cheshire reveals the opposite, with 54% infected via MSM and 39% via heterosexual sex. Of those infected through MSM and residing in Lancashire, 49% reside in Blackpool, an area with a large gay community. Manchester also has a large gay community and correspondingly, Greater Manchester accounts for 54% of new cases resident in the North West exposed via sex between men, with the second highest proportion (15%) 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 (56%) 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 (22%; five out of 23 cases), while over four fifths (83%) of those with HIV living in Merseyside were asymptomatic. The majority of new cases who received care in the North West during 2008 (whose residential details were known) were resident within the region (96%). Of the 32 individuals known to live outside the region, 6% 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 2008, 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, 12% were symptomatic, and 15% presented with AIDS (including those who had died from an AIDS-related illness). The predominant route of HIV exposure amongst all women in treatment and care continues to be heterosexual sex (90%).

Table 2.5 shows new HIV and AIDS cases presenting in the North West for treatment and care in 2008 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 35 and 39 years represented the largest group of new cases accessing treatment and care (19%). Over half (55%) of those with HIV resident in the North West 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 2008 whose ethnicity was known were of white ethnicity (56%), a lower figure than the corresponding data for all cases (66%) (chapter 3, table 3.5). Of those HIV positive individuals whose ethnicity was known, 44% are from a black and minority ethnic (BME) group. This indicates a substantial over-representation of new HIV cases within BME communities, when compared to their overall proportion within the North West population (8%)[67]. The incidence of diagnosed HIV is ten times higher in BME communities than in the white population in the North West. This illustrates the need for specialist services such as the Black Health Agency (BHA) and specialist projects within the voluntary sector to provide care and support for communities that have already been identified as having shorter life expectancies, together with poorer physical and mental health[68].

Table 2.6 illustrates the sex, stage of HIV disease and infection abroad by ethnicity of new HIV and AIDS cases presenting in the North West for treatment and care in 2008. The majority of women for whom ethnicity was known and who were treated in the region for the first time in 2008 from a BME group (82%). Black Africans account for 72% of all new cases in women for whom ethnicity is known. Whilst in the white population the gender distribution is highly biased towards males (89%), 62% of the new cases in the BME group are female.

Considerable differences in presentation by stage of disease amongst 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 2008, as in more recent years, individuals from black and minority ethnic communities (for whom ethnicity and stage of disease were known) were almost as likely to present while still asymptomatic (66%) as were white individuals (73%). A similar proportion were symptomatic (16% compared to 12% of white individuals), or had AIDS (17% for BME groups compared with 13% 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 two percent all new cases of HIV and AIDS in 2008 were infections reported to have been contracted outside the UK. The exposure route for a further 109 cases is currently unknown, which could lead to an underestimation of the figures contracted abroad. For those whose exposure was known, 86% 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 and country of HIV exposure by infection route of HIV for new HIV and AIDS cases who presented in the North West for treatment and care in 2008. Of those infected abroad, the proportion who were infected through sex between men is 9%, a slight increase on 2007 (8%). For those new individuals reported to have been infected with HIV in the UK, and for whom infection route is known, sex between men is the predominant mode of exposure (77%). The vast majority (84%) of individuals with heterosexually acquired HIV, whose infections were contracted abroad, were acquired in sub-Saharan Africa, with a further 6% in South and South-East Asia.

Western Europe accounted for the largest proportion of new cases in MSM while abroad (27%). This could reflect the reported tendency of MSM to take risks while on holiday[69]. Five out of the 12 new cases who were infected by IDU were thought to be infected in the UK. IDU remains a major transmission route of HIV in many European countries[70]. Although the risk of contracting HIV through IDU is relatively low in the UK due to low prevalence of HIV amongst this group, sharing injecting equipment remains a significant risk.

Table 2.8 illustrates the distribution of new HIV and AIDS cases between North West treatment centres and by infection route. The treatment centre with the largest number of new cases in 2008 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). A stark increase in the number of new cases in 2008 compared to 2007 was recorded at Tameside and Glossop Centre for Sexual Health (TAMG) which saw a 400% increase (from 4 to 20 individuals). Conversely, several centres saw a reduction in their levels of new cases, for example, the department of sexual health at the Countess of Chester Hospital (CHR) had a 48% reduction in new cases (29 to 15); the department of GUM at St Helens Hospital (SHH) had a 46% decrease (from 13 to 7 individuals), and a specialist GP clinic in Manchester (MGP) had a 40% reduction (from 20 to 12 individuals).

Table 2.9 presents the residency status of new HIV and AIDS cases categorised by sex, age group, infection route, ethnicity, stage of disease and area of residence. Of the 925 new cases, 543 cases (59%) are known to be UK nationals, and 168 (18%) were non-UK nationals. Over two thirds (70%) of non-UK nationals were asymptomatic, a similar proportion to UK nationals (67%).

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 (27%), followed by Liverpool PCT with 9% (81 individuals).

Table 2.11 shows new HIV cases by stage of disease and PCT of residence. Amongst those that were asymptomatic, over a quarter (27%) resided in Manchester PCT, followed by the next largest proportion (12%) in Liverpool PCT. Further analyses by PCT can be found on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2008).

Figure 2.1: Number of new cases of HIV per 100,000 population by local authority of residence, 2008
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

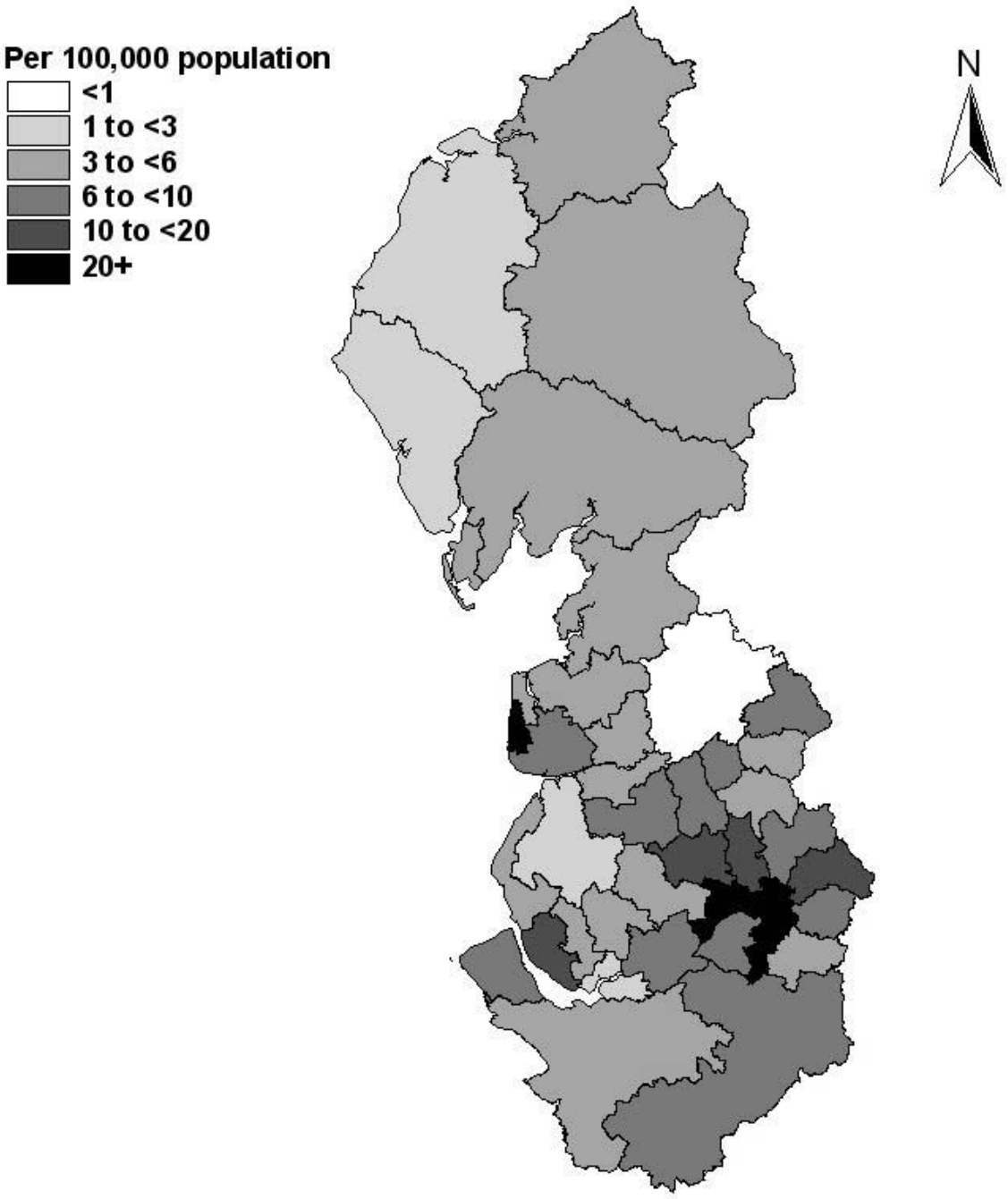
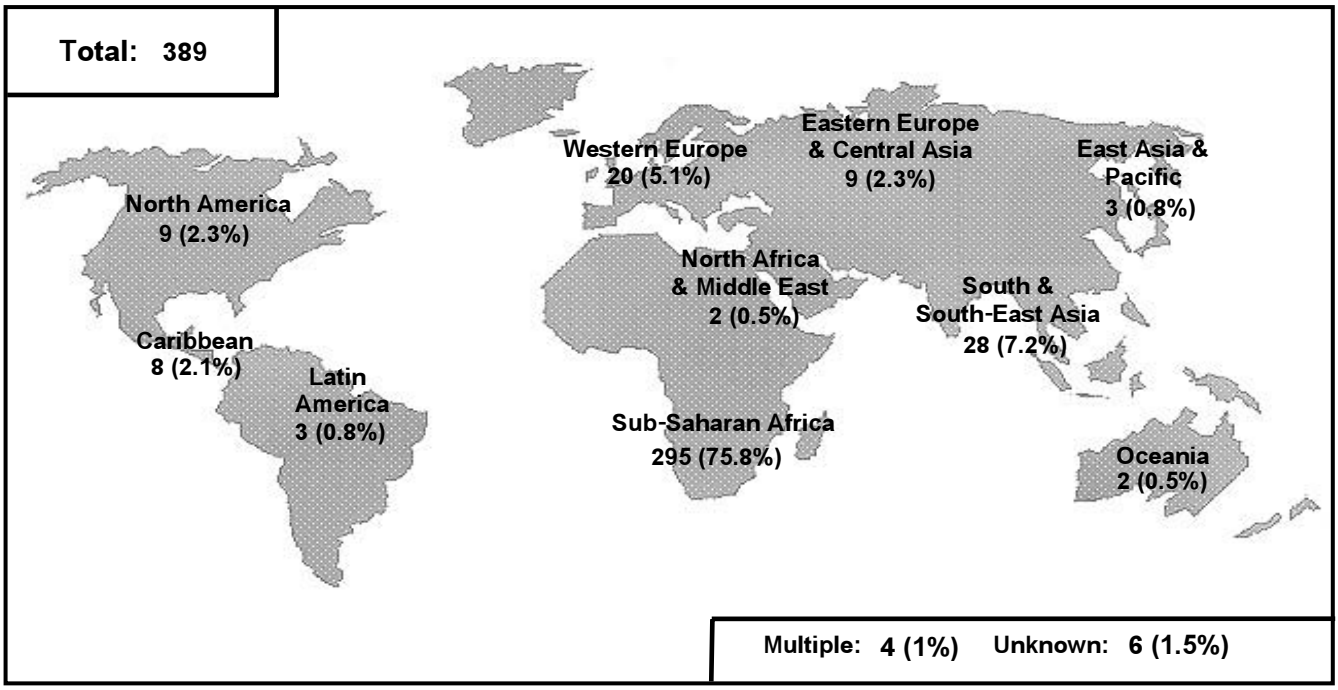


Figure 2.2: Global region and country of infection for new HIV and AIDS cases in the North West who probably acquired their infection outside the UK, 2008



Sub-Saharan Africa	295 (75.8%)
Angola	2 (0.5%)
Botswana	3 (0.8%)
Burundi	1 (0.3%)
Cameroon	11 (2.8%)
Congo	13 (3.3%)
Cote d'Ivoire	4 (1%)
Dem. Republic of Congo	4 (1%)
Equatorial Guinea	1 (0.3%)
Eritrea	5 (1.3%)
Ethiopia	7 (1.8%)
Ghana	6 (1.5%)
Guinea	1 (0.3%)
Kenya	11 (2.8%)
Liberia	1 (0.3%)
Malawi	29 (7.5%)
Nigeria	11 (2.8%)
Rwanda	2 (0.5%)
Sierra Leone	1 (0.3%)
Somalia	3 (0.8%)
South Africa	17 (4.4%)
Tanzania	2 (0.5%)
Uganda	5 (1.3%)
Zambia	8 (2.1%)
Zimbabwe	133 (34.2%)
Sub-Saharan Africa Unknown	13 (3.3%)
Sub-Saharan Africa Multiple	1 (0.3%)

Oceania	2 (0.5%)
Australia	1 (0.3%)
New Zealand	1 (0.3%)

South & South-East Asia	28 (7.2%)
Bangladesh	1 (0.3%)
India	3 (0.8%)
Pakistan	1 (0.3%)
Philippines	1 (0.3%)
Thailand	21 (5.4%)
Vietnam	1 (0.3%)

Eastern Europe & Central Asia	9 (2.3%)
Hungary	1 (0.3%)
Poland	8 (2.1%)

Western Europe	20 (5.1%)
Austria	1 (0.3%)
Canary Islands	2 (0.5%)
Germany	2 (0.5%)
Netherlands	1 (0.3%)
Portugal	5 (1.3%)
Slovenia	1 (0.3%)
Spain	7 (1.8%)
Western Europe Unknown	1 (0.3%)

East Asia & Pacific	3 (0.8%)
China	3 (0.8%)

North Africa & Middle East	2 (0.5%)
Bahrain	1 (0.3%)
Libyan Arab Jamahiriya	1 (0.3%)

North America	9 (2.3%)
United States of America	8 (2.1%)
North America Unknown	1 (0.3%)

Caribbean	8 (2.1%)
Jamaica	8 (2.1%)

Latin America	3 (0.8%)
Brazil	3 (0.8%)

Multiple	4 (1%)
Unknown	6 (1.5%)

Total	389

Table 2.1: Age distribution, stage of HIV disease and ethnic group of new HIV and AIDS cases by infection route and sex, 2008

		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								8	8			16
	15-19	3			1	7						1	12
	20-24	41		1	6	18					3	4	73
	25-29	73	1		15	70					7	6	172
	30-34	54	4		30	69					4	1	162
	35-39	63	4		39	50					5	6	167
	40-44	71	2		30	35					10	3	151
	45-49	29			23	9					7	1	69
	50-54	23			12	13					4		52
	55-59	15			6	2	1				3		27
	60+	10			9	2		1			2		24
Stage of HIV Disease	Asymptomatic	250	7	1	99	188	1	1	4	5	24	15	595
	Symptomatic	40	3		26	34			1	1	8	1	114
	AIDS	47			33	37			3	2	5	1	128
	AIDS Related Death	3			2	3							8
	Death Unrelated to AIDS				1	1					1		3
	Unknown	42	1		10	12					7	5	77
Ethnicity	White	357	9	1	60	47	1	1			24	4	504
	Black Caribbean	2			5	9					1	1	18
	Black African	3			95	195			8	7	7	10	325
	Black Other	3			2	1							6
	Indian/Pakistani/Bangladeshi	2			3	3					2		10
	Other Asian/Oriental	2	1		1	7						2	13
	Other/Mixed	7			1	4				1	2	2	17
	Unknown	6	1		4	9					9	3	32
	Total	**382**	**11**	**1**	**171**	**275**	**1**	**1**	**8**	**8**	**45**	**22**	**925**
	%	**41.3**	**1.2**	**0.1**	**18.5**	**29.7**	**0.1**	**0.1**	**0.9**	**0.9**	**4.9**	**2.4**	

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the age of individuals at the end of December 2008, or at death.

Table 2.2: Local authority of residence of new HIV and AIDS cases by infection route, 2008

	Local Authority of Residence	Infection Route						Total (100%)
		MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	Carlisle	1 (16.7%)		5 (83.3%)				6
	Allerdale	2 (100%)						2
	Eden	1 (33.3%)		2 (66.7%)				3
	Copeland	1 (50%)		1 (50%)				2
	South Lakeland	1 (16.7%)	1 (16.7%)	3 (50%)			1 (16.7%)	6
	Barrow-in-Furness	1 (25%)		3 (75%)				4
	Cumbria Total	**7 (30.4%)**	**1 (4.3%)**	**14 (60.9%)**			**1 (4.3%)**	**23**
Lancashire	Lancaster	4 (80%)			1 (20%)			5
	Wyre	2 (40%)		3 (60%)				5
	Fylde	2 (40%)		3 (60%)				5
	Blackpool	29 (70.7%)		12 (29.3%)				41
	Blackburn with Darwen	4 (30.8%)		9 (69.2%)				13
	Pendle	3 (50%)					3 (50%)	6
	Hyndburn	4 (50%)		4 (50%)				8
	Burnley	2 (40%)		1 (20%)			2 (40%)	5
	Rossendale			1 (50%)		1 (50%)		2
	Preston	1 (16.7%)		5 (83.3%)				6
	South Ribble	2 (40%)		2 (40%)			1 (20%)	5
	Chorley	5 (71.4%)		1 (14.3%)			1 (14.3%)	7
	West Lancashire	1 (50%)		1 (50%)				2
	Lancashire Total	**59 (53.6%)**		**42 (38.2%)**	**1 (0.9%)**	**1 (0.9%)**	**7 (6.4%)**	**110**
Greater Manchester	Wigan	2 (11.1%)		12 (66.7%)			4 (22.2%)	18
	Bolton	7 (14.6%)		34 (70.8%)		3 (6.3%)	4 (8.3%)	48
	Bury	10 (38.5%)		14 (53.8%)		1 (3.8%)	1 (3.8%)	26
	Rochdale	4 (20%)	2 (10%)	12 (60%)		1 (5%)	1 (5%)	20
	Oldham	15 (48.4%)		14 (45.2%)			2 (6.5%)	31
	Salford	41 (55.4%)		28 (37.8%)		1 (1.4%)	4 (5.4%)	74
	Manchester	97 (39%)	2 (0.8%)	133 (53.4%)		4 (1.6%)	13 (5.2%)	249
	Tameside	12 (60%)	2 (10%)	6 (30%)				20
	Trafford	13 (65%)		7 (35%)				20
	Stockport	4 (30.8%)		8 (61.5%)			1 (7.7%)	13
	Unknown Greater Manchester	2 (66.7%)		1 (33.3%)				3
	Greater Manchester Total	**207 (39.7%)**	**6 (1.1%)**	**269 (51.5%)**		**10 (1.9%)**	**30 (5.7%)**	**522**
Merseyside	Sefton	7 (53.8%)		6 (46.2%)				13
	Liverpool	18 (22.2%)	1 (1.2%)	47 (58%)		3 (3.7%)	12 (14.8%)	81
	Knowsley	4 (66.7%)		2 (33.3%)				6
	Wirral	9 (45%)	1 (5%)	10 (50%)				20
	St Helens	1 (14.3%)		5 (71.4%)			1 (14.3%)	7
	Unknown Merseyside						1 (100%)	1
	Merseyside Total	**39 (30.5%)**	**2 (1.6%)**	**70 (54.7%)**		**3 (2.3%)**	**14 (10.9%)**	**128**
Cheshire	Halton	1 (50%)		1 (50%)				2
	Warrington	6 (31.6%)		12 (63.2%)		1 (5.3%)		19
	Cheshire West and Chester	13 (72.2%)		3 (16.7%)			2 (11.1%)	18
	Cheshire East	18 (56.3%)	1 (3.1%)	12 (37.5%)			1 (3.1%)	32
	Cheshire Total	**38 (53.5%)**	**1 (1.4%)**	**28 (39.4%)**		**1 (1.4%)**	**3 (4.2%)**	**71**
	Total North West Residents	**350 (41%)**	**10 (1.2%)**	**423 (49.5%)**	**1 (0.1%)**	**15 (1.8%)**	**55 (6.4%)**	**854**
	Isle of Man			1 (50%)	1 (50%)			2
	Out of Region	11 (36.7%)	1 (3.3%)	10 (33.3%)		1 (3.3%)	7 (23.3%)	30
	Unknown*	21 (53.8%)	1 (2.6%)	12 (30.8%)			5 (12.8%)	39
	Total	**382 (41.3%)**	**12 (1.3%)**	**446 (48.2%)**	**2 (0.2%)**	**16 (1.7%)**	**67 (7.2%)**	**925**

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
** Includes two people of no fixed abode.*

Table 2.3: Local authority of residence of new HIV and AIDS cases by stage of HIV disease, 2008

	Local Authority of Residence	Stage of Disease						Total (100%)
		Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	Carlisle	2 (33.3%)	1 (16.7%)				3 (50%)	6
	Allerdale	1 (50%)					1 (50%)	2
	Eden	1 (33.3%)		1 (33.3%)			1 (33.3%)	3
	Copeland		1 (50%)	1 (50%)				2
	South Lakeland	3 (50%)	1 (16.7%)	2 (33.3%)				6
	Barrow-in-Furness	2 (50%)	1 (25%)	1 (25%)				4
	Cumbria Total	**9 (39.1%)**	**4 (17.4%)**	**5 (21.7%)**			**5 (21.7%)**	**23**
Lancashire	Lancaster	5 (100%)						5
	Wyre	4 (80%)		1 (20%)				5
	Fylde	4 (80%)					1 (20%)	5
	Blackpool	20 (48.8%)	4 (9.8%)	8 (19.5%)		1 (2.4%)	8 (19.5%)	41
	Blackburn with Darwen	11 (84.6%)	1 (7.7%)	1 (7.7%)				13
	Pendle	1 (16.7%)	3 (50%)	2 (33.3%)				6
	Hyndburn	4 (50%)	1 (12.5%)	2 (25%)			1 (12.5%)	8
	Burnley	3 (60%)	2 (40%)					5
	Rossendale		1 (50%)	1 (50%)				2
	Preston	4 (66.7%)	1 (16.7%)				1 (16.7%)	6
	South Ribble	4 (80%)		1 (20%)				5
	Chorley	4 (57.1%)	3 (42.9%)					7
	West Lancashire	1 (50%)	1 (50%)					2
	Lancashire Total	**65 (59.1%)**	**17 (15.5%)**	**16 (14.5%)**		**1 (0.9%)**	**11 (10%)**	**110**
Greater Manchester	Wigan	12 (66.7%)	3 (16.7%)	2 (11.1%)		1 (5.6%)		18
	Bolton	39 (81.3%)	5 (10.4%)	3 (6.3%)	1 (2.1%)			48
	Bury	15 (57.7%)	6 (23.1%)	4 (15.4%)			1 (3.8%)	26
	Rochdale	10 (50%)	4 (20%)	6 (30%)				20
	Oldham	22 (71%)	4 (12.9%)	2 (6.5%)	1 (3.2%)		2 (6.5%)	31
	Salford	37 (50%)	14 (18.9%)	20 (27%)	1 (1.4%)		2 (2.7%)	74
	Manchester	160 (64.3%)	24 (9.6%)	37 (14.9%)		1 (0.4%)	27 (10.8%)	249
	Tameside	17 (85%)	1 (5%)	1 (5%)	1 (5%)			20
	Trafford	9 (45%)	3 (15%)	6 (30%)			2 (10%)	20
	Stockport	10 (76.9%)	1 (7.7%)	2 (15.4%)				13
	Unknown Greater Manchester	3 (100%)						3
	Greater Manchester Total	**334 (64%)**	**65 (12.5%)**	**83 (15.9%)**	**4 (0.8%)**	**2 (0.4%)**	**34 (6.5%)**	**522**
Merseyside	Sefton	11 (84.6%)	1 (7.7%)	1 (7.7%)				13
	Liverpool	72 (88.9%)	2 (2.5%)	1 (1.2%)	1 (1.2%)		5 (6.2%)	81
	Knowsley	5 (83.3%)		1 (16.7%)				6
	Wirral	11 (55%)	4 (20%)	3 (15%)	1 (5%)		1 (5%)	20
	St Helens	6 (85.7%)					1 (14.3%)	7
	Unknown Merseyside	1 (100%)						1
	Merseyside Total	**106 (82.8%)**	**7 (5.5%)**	**6 (4.7%)**	**2 (1.6%)**		**7 (5.5%)**	**128**
Cheshire	Halton	2 (100%)						2
	Warrington	16 (84.2%)		2 (10.5%)	1 (5.3%)			19
	Cheshire West and Chester	10 (55.6%)	2 (11.1%)	4 (22.2%)			2 (11.1%)	18
	Cheshire East	13 (40.6%)	5 (15.6%)	6 (18.8%)			8 (25%)	32
	Cheshire Total	**41 (57.7%)**	**7 (9.9%)**	**12 (16.9%)**	**1 (1.4%)**		**10 (14.1%)**	**71**
	Total North West Residents	**555 (65%)**	**100 (11.7%)**	**122 (14.3%)**	**7 (0.8%)**	**3 (0.4%)**	**67 (7.8%)**	**854**
	Isle of Man	1 (50%)	1 (50%)					2
	Out of Region	13 (43.3%)	8 (26.7%)	4 (13.3%)	1 (3.3%)		4 (13.3%)	30
	Unknown*	26 (66.7%)	5 (12.8%)	2 (5.1%)			6 (15.4%)	39
	Total	**595 (64.3%)**	**114 (12.3%)**	**128 (13.8%)**	**8 (0.9%)**	**3 (0.3%)**	**77 (8.3%)**	**925**

** Includes two people of no fixed abode.*

Table 2.4: New HIV and AIDS cases by stage of HIV disease, infection route and sex, 2008

	Stage of disease	Infection Route											Total (100%)
		MSM	Injecting Drug Use		Heterosexual		Blood/ Tissue		Mother to Child		Undeter-mined		
		M	M	F	M	F	M	F	M	F	M	F	
Total North West Residents	Asymptomatic	229	7	1	95	182		1	4	5	18	13	555
	Symptomatic	38	2		23	28			1		7	1	100
	AIDS	43			33	35			3	2	5	1	122
	AIDS Related Death	3			2	2							7
	Death Unrelated to AIDS				1	1					1		3
	Unknown	37			9	12					6	3	67
	Total	**350**	**9**	**1**	**163**	**260**		**1**	**8**	**7**	**37**	**18**	**854**
	%	**41.0**	**1.1**	**0.1**	**19.1**	**30.4**		**0.1**	**0.9**	**0.8**	**4.3**	**2.1**	
All individuals treated in North West	Asymptomatic	250	7	1	99	188	1	1	4	5	24	15	595
	Symptomatic	40	3		26	34			1	1	8	1	114
	AIDS	47			33	37			3	2	5	1	128
	AIDS Related Death	3			2	3							8
	Death Unrelated to AIDS				1	1					1		3
	Unknown	42	1		10	12					7	5	77
	Total	**382**	**11**	**1**	**171**	**275**	**1**	**1**	**8**	**8**	**45**	**22**	**925**
	%	**41.3**	**1.2**	**0.1**	**18.5**	**29.7**	**0.1**	**0.1**	**0.9**	**0.9**	**4.9**	**2.4**	

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

.

Table 2.5: New HIV and AIDS cases by age category and ethnic group, 2008

	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			14				1		15
	15-19	6		5						11
	20-24	49	2	6	1		2	2	2	64
	25-29	80	4	54	1	4	2	5	7	157
	30-34	69	3	67	1	2	1	3	7	153
	35-39	70	3	80	1		4		2	160
	40-44	85	1	39	1	1	2	2	6	137
	45-49	39	2	20		1		2	1	65
	50-54	34		12	1					47
	55-59	16		5					1	22
	60+	20		2		1				23
	Total	**468**	**15**	**304**	**6**	**9**	**11**	**15**	**26**	**854**
	%	**54.8**	**1.8**	**35.6**	**0.7**	**1.1**	**1.3**	**1.8**	**3.0**	
All individuals treated in North West	0-14			15				1		16
	15-19	6	1	5						12
	20-24	54	3	7	1		3	2	3	73
	25-29	87	4	58	1	5	3	7	7	172
	30-34	74	4	69	1	2	1	3	8	162
	35-39	74	3	83	1		4		2	167
	40-44	93	1	44	1	1	2	2	7	151
	45-49	39	2	22		1		2	3	69
	50-54	35		15	1				1	52
	55-59	21		5					1	27
	60+	21		2		1				24
	Total	**504**	**18**	**325**	**6**	**10**	**13**	**17**	**32**	**925**
	%	**54.5**	**1.9**	**35.1**	**0.6**	**1.1**	**1.4**	**1.8**	**3.5**	

Age groups refer to the ages of individuals at the end of December 2008, or at death.

Table 2.6: Sex, stage of HIV disease and HIV exposure abroad of new HIV and AIDS cases by ethnic group, 2008

		Ethnicity								Total (100%)
		White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Sex	Male	451 (73%)	8 (1.3%)	113 (18.3%)	5 (0.8%)	7 (1.1%)	4 (0.6%)	10 (1.6%)	20 (3.2%)	618
	Female	53 (17.3%)	10 (3.3%)	212 (69.1%)	1 (0.3%)	3 (1%)	9 (2.9%)	7 (2.3%)	12 (3.9%)	307
Stage of Disease	Asymptomatic	334 (56.1%)	10 (1.7%)	203 (34.1%)	3 (0.5%)	7 (1.2%)	7 (1.2%)	12 (2%)	19 (3.2%)	595
	Symptomatic	53 (46.5%)	2 (1.8%)	51 (44.7%)		1 (0.9%)	3 (2.6%)	1 (0.9%)	3 (2.6%)	114
	AIDS	61 (47.7%)	2 (1.6%)	52 (40.6%)	1 (0.8%)	2 (1.6%)	2 (1.6%)	2 (1.6%)	6 (4.7%)	128
	AIDS Related Death	5 (62.5%)		3 (37.5%)						8
	Death Unrelated to AIDS	2 (66.7%)						1 (33.3%)		3
	Unknown	49 (63.6%)	4 (5.2%)	16 (20.8%)	2 (2.6%)		1 (1.3%)	1 (1.3%)	4 (5.2%)	77
HIV Exposure Abroad	No	391 (91.6%)	5 (1.2%)	13 (3%)	2 (0.5%)	5 (1.2%)		7 (1.6%)	4 (0.9%)	427
	Yes	64 (16.5%)	9 (2.3%)	286 (73.5%)	2 (0.5%)	5 (1.3%)	9 (2.3%)	5 (1.3%)	9 (2.3%)	389
	Unknown	49 (45%)	4 (3.7%)	26 (23.9%)	2 (1.8%)		4 (3.7%)	5 (4.6%)	19 (17.4%)	109
	Total	**504 (54.5%)**	**18 (1.9%)**	**325 (35.1%)**	**6 (0.6%)**	**10 (1.1%)**	**13 (1.4%)**	**17 (1.8%)**	**32 (3.5%)**	**925**

Table 2.7: Global region and country of exposure by infection route for new HIV and AIDS cases, 2008

Region of HIV Exposure	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Abroad	33 (8.5%)	5 (1.3%)	311 (79.9%)	2 (0.5%)	13 (3.3%)	25 (6.4%)	389
Caribbean	2		6				8
East Asia & Pacific	1		2				3
Eastern Europe & Central Asia	3	1	5				9
Latin America			2			1	3
North Africa & Middle East		1	1				2
North America	7		1			1	9
Oceania	1		1				2
South & South-East Asia	4		20			4	28
Sub-Saharan Africa	2	1	260	2	13	17	295
Western Europe	9	2	7			2	20
Multiple	2		2				4
Unknown	2		4				6
UK	316 (74%)	5 (1.2%)	85 (19.9%)		3 (0.7%)	18 (4.2%)	427
Undetermined	33 (30.3%)	2 (1.8%)	50 (45.9%)			24 (22%)	109
Total	**382 (41.3%)**	**12 (1.3%)**	**446 (48.2%)**	**2 (0.2%)**	**16 (1.7%)**	**67 (7.2%)**	**925**

Men who were exposed through sex with men (MSM) and are 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, 2008

Treatment Centre	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
AHC					5 (100%)		5
APH	5 (35.7%)	1 (7.1%)	8 (57.1%)				14
ARM	3 (60%)	1 (20%)				1 (20%)	5
BLAG	32 (59.3%)		22 (40.7%)				54
BLKG	7 (36.8%)		11 (57.9%)			1 (5.3%)	19
BOLG	14 (26.4%)		37 (69.8%)			2 (3.8%)	53
BOOT					5 (100%)		5
BURG	4 (50%)					4 (50%)	8
BURY	6 (37.5%)		9 (56.3%)			1 (6.3%)	16
CHR	9 (60%)		5 (33.3%)			1 (6.7%)	15
CUMB	4 (36.4%)		7 (63.6%)				11
FGH	2 (28.6%)	1 (14.3%)	4 (57.1%)				7
HAL	1 (100%)						1
LCN		1 (14.3%)	5 (71.4%)			1 (14.3%)	7
LEI	16 (69.6%)		6 (26.1%)			1 (4.3%)	23
MAC	5 (50%)	1 (10%)	3 (30%)			1 (10%)	10
MGP	12 (100%)						12
MRIG	104 (48.4%)	1 (0.5%)	97 (45.1%)			13 (6%)	215
NMG	41 (24.6%)	5 (3%)	94 (56.3%)	1 (0.6%)	12 (7.2%)	14 (8.4%)	167
NMGG	19 (55.9%)		15 (44.1%)				34
NOBL			1 (100%)				1
OLDG	10 (47.6%)		9 (42.9%)			2 (9.5%)	21
PG	9 (45%)		7 (35%)			4 (20%)	20
RLG	33 (27.3%)	1 (0.8%)	70 (57.9%)			17 (14%)	121
RLI	2 (40%)		2 (40%)	1 (20%)			5
ROCG	2 (22.2%)		6 (66.7%)			1 (11.1%)	9
SALG	18 (54.5%)		15 (45.5%)				33
SHH	1 (14.3%)	1 (14.3%)	4 (57.1%)			1 (14.3%)	7
SPG	4 (40%)		5 (50%)			1 (10%)	10
STP	2 (16.7%)		7 (58.3%)			3 (25%)	12
TAMG	14 (70%)	1 (5%)	5 (25%)				20
TRAG	1 (50%)					1 (50%)	2
WAR	5 (31.3%)		11 (68.8%)				16
WGH	1 (33.3%)		2 (66.7%)				3
WIGG	1 (16.7%)		5 (83.3%)				6
WITG	28 (71.8%)		11 (28.2%)				39
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 are also injecting drug users are included in the MSM category.

Table 2.9: Residency status of new cases by sex, age group, infection route, ethnicity, stage of HIV disease and area of residence, 2008

		Residency Status							Total
		UK National	Asylum Seeker	Overseas Student	Temporary Visitor	Refugee	Other**	Unknown	
Sex	Male	441 (81.2%)	32 (30.5%)	5 (33.3%)	1 (11.1%)	3 (37.5%)	15 (48.4%)	121 (56.5%)	618 (66.8%)
	Female	102 (18.8%)	73 (69.5%)	10 (66.7%)	8 (88.9%)	5 (62.5%)	16 (51.6%)	93 (43.5%)	307 (33.2%)
Age Group	0-14	4 (0.7%)	2 (1.9%)					10 (4.7%)	16 (1.7%)
	15-19	11 (2%)						1 (0.5%)	12 (1.3%)
	20-24	60 (11%)	3 (2.9%)	1 (6.7%)			1 (3.2%)	8 (3.7%)	73 (7.9%)
	25-29	96 (17.7%)	24 (22.9%)	6 (40%)	3 (33.3%)	2 (25%)	8 (25.8%)	33 (15.4%)	172 (18.6%)
	30-34	80 (14.7%)	26 (24.8%)	3 (20%)	1 (11.1%)	2 (25%)	6 (19.4%)	44 (20.6%)	162 (17.5%)
	35-39	84 (15.5%)	29 (27.6%)	3 (20%)	1 (11.1%)	1 (12.5%)	9 (29%)	40 (18.7%)	167 (18.1%)
	40-44	90 (16.6%)	10 (9.5%)	2 (13.3%)	4 (44.4%)	2 (25%)	5 (16.1%)	38 (17.8%)	151 (16.3%)
	45-49	46 (8.5%)	5 (4.8%)				2 (6.5%)	16 (7.5%)	69 (7.5%)
	50-54	34 (6.3%)	4 (3.8%)			1 (12.5%)		13 (6.1%)	52 (5.6%)
	55-59	20 (3.7%)	2 (1.9%)					5 (2.3%)	27 (2.9%)
	60+	18 (3.3%)						6 (2.8%)	24 (2.6%)
Infection Route	MSM	333 (61.3%)	1 (1%)				10 (32.3%)	38 (17.8%)	382 (41.3%)
	Injecting drug use	7 (1.3%)						5 (2.3%)	12 (1.3%)
	Heterosexual	165 (30.4%)	95 (90.5%)	12 (80%)	9 (100%)	8 (100%)	20 (64.5%)	137 (64%)	446 (48.2%)
	Blood/tissue	2 (0.4%)							2 (0.2%)
	Mother to child	4 (0.7%)	2 (1.9%)					10 (4.7%)	16 (1.7%)
	Undetermined	32 (5.9%)	7 (6.7%)	3 (20%)			1 (3.2%)	24 (11.2%)	67 (7.2%)
Ethnicity	White	438 (80.7%)	1 (1%)				12 (38.7%)	53 (24.8%)	504 (54.5%)
	Black Caribbean	11 (2%)		2 (13.3%)	1 (11.1%)		1 (3.2%)	3 (1.4%)	18 (1.9%)
	Black African	59 (10.9%)	101 (96.2%)	13 (86.7%)	6 (66.7%)	8 (100%)	18 (58.1%)	120 (56.1%)	325 (35.1%)
	Black Other	5 (0.9%)						1 (0.5%)	6 (0.6%)
	Indian/Pakistani/Bangladeshi	7 (1.3%)	2 (1.9%)					1 (0.5%)	10 (1.1%)
	Other Asian/Oriental	8 (1.5%)			2 (22.2%)			3 (1.4%)	13 (1.4%)
	Other/Mixed	12 (2.2%)						5 (2.3%)	17 (1.8%)
	Unknown	3 (0.6%)	1 (1%)					28 (13.1%)	32 (3.5%)
Stage of Disease	Asymptomatic	364 (67%)	78 (74.3%)	8 (53.3%)	4 (44.4%)	4 (50%)	23 (74.2%)	114 (53.3%)	595 (64.3%)
	Symptomatic	59 (10.9%)	12 (11.4%)	2 (13.3%)	3 (33.3%)	2 (25%)	5 (16.1%)	31 (14.5%)	114 (12.3%)
	AIDS	61 (11.2%)	10 (9.5%)	1 (6.7%)	1 (11.1%)	1 (12.5%)	1 (3.2%)	53 (24.8%)	128 (13.8%)
	AIDS Related Death	5 (0.9%)						3 (1.4%)	8 (0.9%)
	Death Unrelated to AIDS	1 (0.2%)						2 (0.9%)	3 (0.3%)
	Unknown	53 (9.8%)	5 (4.8%)	4 (26.7%)	1 (11.1%)	1 (12.5%)	2 (6.5%)	11 (5.1%)	77 (8.3%)
Area of Residence	Cumbria	17 (3.1%)			4 (44.4%)		1 (3.2%)	1 (0.5%)	23 (2.5%)
	Lancashire	89 (16.4%)	5 (4.8%)		1 (11.1%)	2 (25%)	1 (3.2%)	12 (5.6%)	110 (11.9%)
	Greater Manchester	259 (47.7%)	63 (60%)	12 (80%)	3 (33.3%)	5 (62.5%)	23 (74.2%)	157 (73.4%)	522 (56.4%)
	Merseyside	78 (14.4%)	33 (31.4%)		1 (11.1%)		1 (3.2%)	15 (7%)	128 (13.8%)
	Cheshire	62 (11.4%)	1 (1%)				1 (3.2%)	7 (3.3%)	71 (7.7%)
	Out of Region***	14 (2.6%)	3 (2.9%)				1 (3.2%)	14 (6.5%)	32 (3.5%)
	Unknown*	24 (4.4%)		3 (20%)		1 (12.5%)	3 (9.7%)	8 (3.7%)	39 (4.2%)
	Total (100%)	**543**	**105**	**15**	**9**	**8**	**31**	**214**	**925**

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the age of individuals at the end of December 2008, or at death.
** Includes two people of no fixed abode.*
*** Includes residency status defined as 'Migrant Worker', 'Dependent', and 'Other'.*
**** Includes Isle of Man.*

Table 2.10: Primary care trust (PCT) of residence of new HIV and AIDS cases by infection route, 2008

PCT of Residence	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	7 (30.4%)	1 (4.3%)	14 (60.9%)			1 (4.3%)	23
North Lancashire	8 (53.3%)		6 (40%)	1 (6.7%)			15
Blackpool	29 (70.7%)		12 (29.3%)				41
Blackburn with Darwen	4 (30.8%)		9 (69.2%)				13
East Lancashire	9 (42.9%)		6 (28.6%)		1 (4.8%)	5 (23.8%)	21
Central Lancashire	9 (45%)		9 (45%)			2 (10%)	20
Ashton, Leigh & Wigan	2 (11.1%)		12 (66.7%)			4 (22.2%)	18
Bolton	7 (14.6%)		34 (70.8%)		3 (6.3%)	4 (8.3%)	48
Bury	10 (38.5%)		14 (53.8%)		1 (3.8%)	1 (3.8%)	26
Heywood, Middleton & Rochdale	4 (20%)	2 (10%)	12 (60%)		1 (5%)	1 (5%)	20
Oldham	15 (48.4%)		14 (45.2%)			2 (6.5%)	31
Salford	41 (55.4%)		28 (37.8%)		1 (1.4%)	4 (5.4%)	74
Manchester	97 (39%)	2 (0.8%)	133 (53.4%)		4 (1.6%)	13 (5.2%)	249
Tameside & Glossop	12 (60%)	2 (10%)	6 (30%)				20
Trafford	13 (65%)		7 (35%)				20
Stockport	4 (30.8%)		8 (61.5%)			1 (7.7%)	13
Unknown Greater Manchester	2 (66.7%)		1 (33.3%)				3
Sefton	7 (53.8%)		6 (46.2%)				13
Liverpool	18 (22.2%)	1 (1.2%)	47 (58%)		3 (3.7%)	12 (14.8%)	81
Knowsley	4 (66.7%)		2 (33.3%)				6
Wirral	9 (45%)	1 (5%)	10 (50%)				20
Halton & St Helens	2 (22.2%)		6 (66.7%)			1 (11.1%)	9
Unknown Merseyside						1 (100%)	1
Warrington	6 (31.6%)		12 (63.2%)		1 (5.3%)		19
Western Cheshire	8 (66.7%)		3 (25%)			1 (8.3%)	12
Central and Eastern Cheshire	23 (60.5%)	1 (2.6%)	12 (31.6%)			2 (5.3%)	38
Isle of Man			1 (50%)	1 (50%)			2
Out of Region	11 (36.7%)	1 (3.3%)	10 (33.3%)		1 (3.3%)	7 (23.3%)	30
Unknown*	21 (53.8%)	1 (2.6%)	12 (30.8%)			5 (12.8%)	39
Total	**382 (41.3%)**	**12 (1.3%)**	**446 (48.2%)**	**2 (0.2%)**	**16 (1.7%)**	**67 (7.2%)**	**925**

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
** Includes two people of no fixed abode.*

Table 2.11: Primary care trust (PCT) of residence of new HIV and AIDS cases by stage of disease, 2008

PCT of Residence	Stage of Disease						Total (100%)
	Asympto-matic	Sympto-matic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	9 (39.1%)	4 (17.4%)	5 (21.7%)			5 (21.7%)	23
North Lancashire	13 (86.7%)		1 (6.7%)			1 (6.7%)	15
Blackpool	20 (48.8%)	4 (9.8%)	8 (19.5%)		1 (2.4%)	8 (19.5%)	41
Blackburn with Darwen	11 (84.6%)	1 (7.7%)	1 (7.7%)				13
East Lancashire	8 (38.1%)	7 (33.3%)	5 (23.8%)			1 (4.8%)	21
Central Lancashire	13 (65%)	5 (25%)	1 (5%)			1 (5%)	20
Ashton, Leigh & Wigan	12 (66.7%)	3 (16.7%)	2 (11.1%)		1 (5.6%)		18
Bolton	39 (81.3%)	5 (10.4%)	3 (6.3%)	1 (2.1%)			48
Bury	15 (57.7%)	6 (23.1%)	4 (15.4%)			1 (3.8%)	26
Heywood, Middleton & Rochdale	10 (50%)	4 (20%)	6 (30%)				20
Oldham	22 (71%)	4 (12.9%)	2 (6.5%)	1 (3.2%)		2 (6.5%)	31
Salford	37 (50%)	14 (18.9%)	20 (27%)	1 (1.4%)		2 (2.7%)	74
Manchester	160 (64.3%)	24 (9.6%)	37 (14.9%)		1 (0.4%)	27 (10.8%)	249
Tameside & Glossop	17 (85%)	1 (5%)	1 (5%)	1 (5%)			20
Trafford	9 (45%)	3 (15%)	6 (30%)			2 (10%)	20
Stockport	10 (76.9%)	1 (7.7%)	2 (15.4%)				13
Unknown Greater Manchester	3 (100%)						3
Sefton	11 (84.6%)	1 (7.7%)	1 (7.7%)				13
Liverpool	72 (88.9%)	2 (2.5%)	1 (1.2%)	1 (1.2%)		5 (6.2%)	81
Knowsley	5 (83.3%)		1 (16.7%)				6
Wirral	11 (55%)	4 (20%)	3 (15%)	1 (5%)		1 (5%)	20
Halton & St Helens	8 (88.9%)					1 (11.1%)	9
Unknown Merseyside	1 (100%)						1
Warrington	16 (84.2%)		2 (10.5%)	1 (5.3%)			19
Western Cheshire	8 (66.7%)	1 (8.3%)	2 (16.7%)			1 (8.3%)	12
Central and Eastern Cheshire	15 (39.5%)	6 (15.8%)	8 (21.1%)			9 (23.7%)	38
Isle of Man	1 (50%)	1 (50%)					2
Out of Region	13 (43.3%)	8 (26.7%)	4 (13.3%)	1 (3.3%)		4 (13.3%)	30
Unknown*	26 (66.7%)	5 (12.8%)	2 (5.1%)			6 (15.4%)	39
Total	**595 (64.3%)**	**114 (12.3%)**	**128 (13.8%)**	**8 (0.9%)**	**3 (0.3%)**	**77 (8.3%)**	**925**

** Includes two people of no fixed abode.*

3. All Cases 2008

During 2008, a total of 5,767 individuals living with HIV and AIDS accessed treatment and care from statutory treatment centres in the North West, representing an 11% increase in the size of the HIV positive population (from 5,212 individuals in 2007). This is a slightly larger increase than that seen between 2006 and 2007 (9%). The aim of this chapter is to provide information on the demographics and characteristics of these 5,767 individuals and, where appropriate, references are made to corresponding data from previous North West reports[1-12]. 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/hiv2008).

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 2008[§]. The population sizes for each LA used in the prevalence calculations are provided by the North West Public Health Observatory and are mid-2005 estimates based on 2001 census data. Across the region, the prevalence of HIV was 79 per 100,000 population. There were considerable differences between LAs: the prevalence in Manchester LA was 378 per 100,000, Blackpool was 220 per 100,000 and Salford 231 per 100,000. The areas with the lowest prevalence were Allerdale (19 per 100,000), Copeland and Chorley (both 21 per 100,000 population).

Figure 3.2 illustrates the global region and country of infection for those 2,093 HIV positive individuals presenting for treatment in the North West in 2008 who were probably infected abroad. Of all the infections contracted outside the United Kingdom, 71% were exposed in sub-Saharan Africa. This high proportion reflects the impact of the pandemic in sub-Saharan Africa where the prevalence of HIV is extremely high[13]. 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 1,911 individuals (91%). The infections acquired outside the UK were spread across 101 different countries, with Zimbabwe representing the country where the largest number of infections were contracted (31%). Thailand represents the second largest number of infections acquired outside the UK (135 cases; 7%). Exposure in sub-Saharan Africa was spread across 34 countries. Of those exposed in Western Europe, the largest number were infected in Spain (52 individuals), reflecting the extent of the epidemic in that country[13], the large number of people who travel between the United Kingdom and Spain, and the increased propensity to take risks when on holiday[71-73].

Table 3.1 shows the infection route and sex of all HIV and AIDS cases presenting in the North West for treatment in 2008, 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 (52% of all cases). However the proportion of people infected through heterosexual sex continues to increase, from 15% in 1996 to 41% in 2008. On average, those who were infected through heterosexuals sex are younger (median age 38 years) than those infected through MSM (41 years) and injecting drug use (IDU) (also 41 years). The percentage of individuals exposed to HIV via IDU, those infected by contaminated blood or tissue and vertical transmission, all remain low at 2% or less per route.

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 (11%, see chapter 2, table 2.1) when compared to all cases (6%). Table 3.1 also shows that the proportion of HIV positive individuals in the older age groups (50 years and over) increased slightly each year (from 14% in 2006 and 15% in 2007 to 16% in 2008) which is a large increase from 7% 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 2008. Of the 55 individuals who died in 2008, 56% died of an AIDS-related condition (a decrease from 80% in 2007) and 24 (44%) died of other causes (a large increase from 20% in 2007).

Of those for whom ethnicity was known (5,721 individuals), 66% were of white ethnicity. Those from black and minority ethnic (BME) communities make up for 34% of the total HIV positive population 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 MSM continues to be the dominant mode of HIV transmission (52%) amongst those with HIV who

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

are resident in the North West region, there is considerable variation at county level. Of those whose infection route was known, 63% of Lancashire's and 57% of Cheshire's HIV positive residents were infected via MSM compared to 40% of Merseyside's HIV positive residents. There is greater variation across LAs: 81% of HIV positive residents in Blackpool (compared with 26% in Blackburn with Darwen) were infected through sex between men. Barrow-in-Furness in Cumbria was the LA with the greatest proportion of infections acquired via heterosexual sex (67%), although absolute numbers were low. Manchester LA had the largest number of HIV positive residents infected through MSM (843 cases) and through heterosexual sex (727 cases). The county of Greater Manchester had the highest number of HIV positive individuals infected through IDU (77 individuals) which accounts for 69% of all residents of the North West infected by this route.

Table 3.3 illustrates the LA, county of residence and clinical stage of HIV disease for all HIV and AIDS cases presenting to a North West treatment centre in 2008. The data refer to the clinical condition of individuals when last seen in 2008; individuals who died are presented in separate categories. The highest numbers of people with HIV live in Greater Manchester (59% 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 (95%). The proportion of people at different stages of HIV disease will impact on the funding of HIV treatment and care, since those at a more advanced stage require more hospital care[27]. There is variation between stages of disease across the counties; Merseyside had 58% presenting as asymptomatic whereas Cumbria had 35%, representing a decrease from 50% in 2007.

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 to 28% who were of white ethnicity. In contrast, of those infected via MSM, 96% 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 to their proportion in the North West population as a whole (8%)[67]. Prevalence in BME communities is seven times higher in the white population in the North West. The proportion of the HIV positive population from BME/mixed backgrounds varies between counties, with Greater Manchester and Merseyside having the largest proportion (40% and 39%, respectively) whilst Cumbria has the smallest proportion (15%).

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 (58% aged between 25 and 39 years) than white individuals (39% 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 (47%) were using triple therapy, followed by 28% using no ART. Amongst those North West residents with AIDS, 94% were on ART. Amongst those who were asymptomatic, 54% were on ART. There was little variation between the proportion of individuals on ART between counties, ranging from 70% in Merseyside to 77% 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, 66% were female and amongst those defined as other Asian/Oriental, 65% were female. The largest proportion of HIV positive individuals were asymptomatic (48%), followed by symptomatic individuals (27%). Amongst white HIV positive individuals, 45% 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 and country of exposure and route of infection of all HIV and AIDS cases. Over a third (36%) 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 (84%), South and South-East Asia (79%), North Africa and Middle East (63%) and Latin America (58%). In contrast, those infected in Oceania, North America and Western Europe were more likely to be via MSM (80%, 77% and 57% respectively).

Care of HIV positive people by North West statutory treatment centres

Table 3.9 presents the number of HIV positive people seeking care by North West treatment centres by infection route (for a definition of the abbreviated treatment centres, see the glossary). The Infectious Disease Unit at North Manchester General Hospital (NMG) provides care for the highest number of HIV

positive individuals in the North West (1,588). Manchester Centre for Sexual Health at Manchester Royal Infirmary (MRIG) provided treatment for 1,079 individuals, the Royal Liverpool University Hospital department of GUM and Tropical and Infectious Disease Unit (RLG) provided care for 702 individuals and Blackpool Victoria Hospital (BLAG) provided care for 412 individuals with HIV in 2008. There is considerable variation in the profile of HIV positive individuals between different treatment centres. Ninety seven percent of individuals attending a specialist general practice in Manchester (MGP) had been exposed to HIV via sex between men compared to the overall rate of 52% (table 3.1) of all HIV cases within the region. 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 specific treatment centres during 2008. 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 86% of their patients. The proportion taking triple or more therapy is higher in persons attending the specialist haematology centres at RLH and MRIH (92% each). There are few individuals on mono or dual therapy in accordance with the latest BHIVA guidelines[74].

Table 3.11 illustrates the distribution of all HIV and AIDS cases presenting in the North West for treatment in 2008 by LA of residence and the number of statutory treatment centres attended. The majority (90%) attended only one treatment centre. However, this varied across counties: residents of Cumbria and Lancashire were more likely to attend only one treatment centre (97% and 94% respectively), compared with people residing in Cheshire (91%), Greater Manchester (89%) and Merseyside (85%). 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 number of days, episodes or visits, and the mean number of days, episodes or visits per HIV positive individual treated by that centre. NMG provided the highest number of outpatient visits, accounting for 25% of all attendances across the region, with Manchester Centre for Sexual Health at Manchester Royal Infirmary (MRIG) reporting the second highest number of visits, and a higher mean number of outpatient visits per HIV positive person. NMG also provided the highest number of day cases (85% of the total), inpatient episodes (40% of the total) and inpatient days (49%), with the Department of GUM and Tropical and Infectious Disease Unit at RLG providing the next highest number of inpatient episodes (15%).

Some of the treatment centres provided a significant number of home visits, with Liverpool Community Nursing (LCN) providing 58% of the total home visits, followed by Alder Hey Children's Hospital in Liverpool (AHC; 23%), NMG (7%) and Blackpool Victoria Hospital (BLAG), with their HIV community nursing team (5%).This is the eighth year that data on home visits has been collected. Liverpool Community Nursing team provided the highest number of home visits per HIV positive person (9.5 per patient).

Asymptomatic HIV positive people accumulated a total of 19,281 outpatient visits. People with an AIDS-related illness had the highest mean number of outpatient visits (8.28). Individuals who died of an AIDS-related illness during 2008 spent the greatest mean number of days as inpatients (30 days).

HIV in non-UK nationals

Table 3.13 shows sex, age group, infection route, ethnicity, stage of disease and area of residence by residency status of all individuals who accessed treatment and care in the North West in 2008. A total of 1,118 (an increase of 36 from 2007) individuals were known to be non-UK nationals (19% of the total HIV positive population). The residency status of 6% was unknown. Over half the non-UK nationals were classified as asylum seekers (54%). Refugees (15%) and overseas students (12%) were the other main categories. Nearly two thirds (66%) 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 (26% compared to 91%). Non-UK nationals were younger (median age 37) than UK-national HIV positive population (median age 41 years). The majority (96%) of asylum seekers were black African. Most of the known HIV positive non-UK nationals were resident in Greater Manchester (71%), with the next largest number living in Merseyside (18% of the total).

Fifty four 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, 46% are classified as asymptomatic. The same proportion of non-UK and UK nationals had an AIDS diagnosis (22%). A similar proportion of non-UK nationals (0.5%) and UK nationals (1%) died in 2008.

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. Similar proportions of the HIV positive individuals living in Blackburn with Darwen PCT (64%) and Liverpool PCT (63%) were infected through heterosexual sex. Eighty one percent of those residing in Blackpool PCT were infected through sex between men and five percent of those individuals with HIV living in Tameside and Glossop 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 ten PCTs (Blackburn with Darwen; Ashton, Leigh & Wigan; Bolton; Oldham; Manchester; Sefton; 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/hiv2008).

Figure 3.1: Number of cases of HIV per 100,000 population by local authority of residence, 2008
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

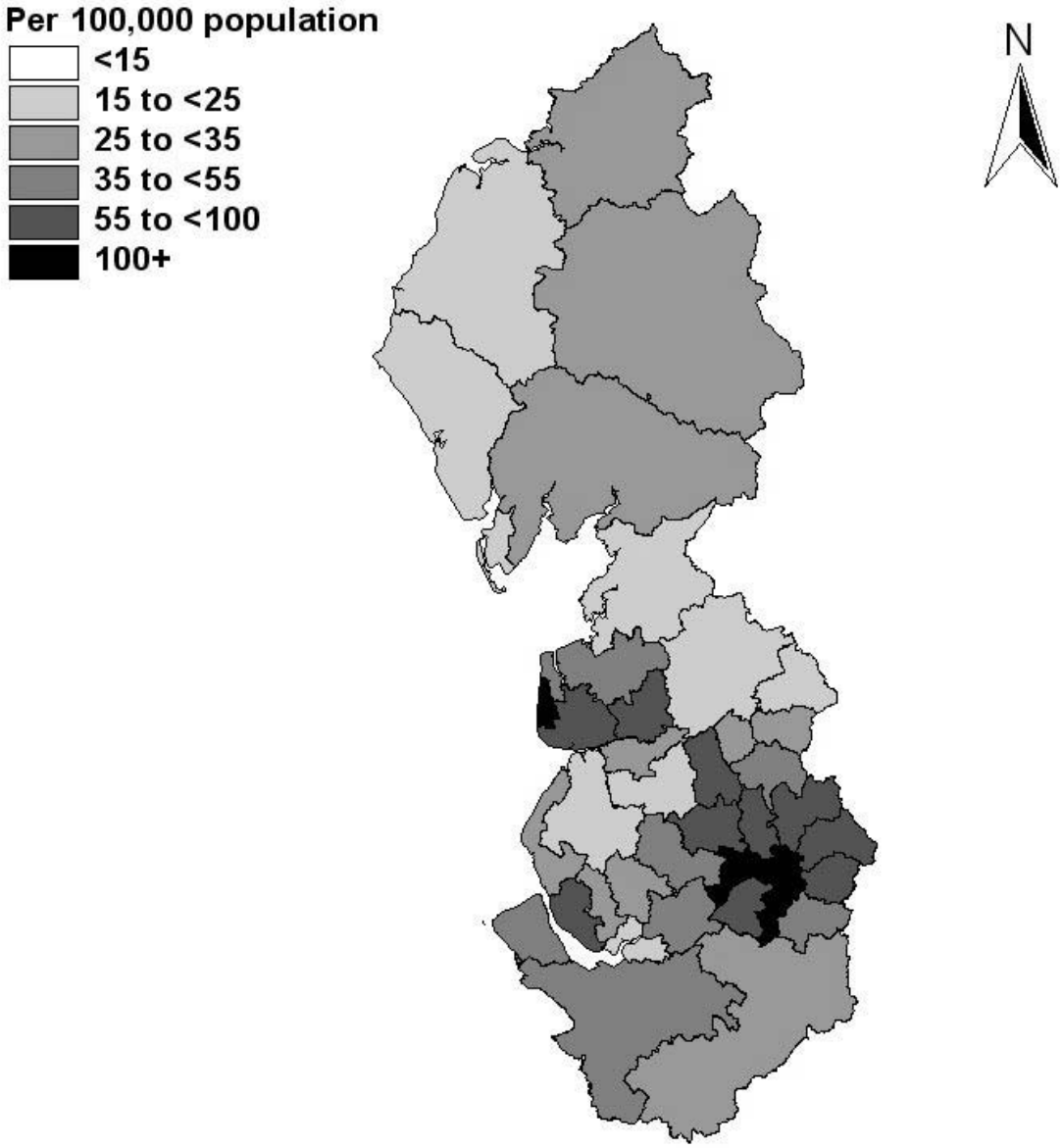
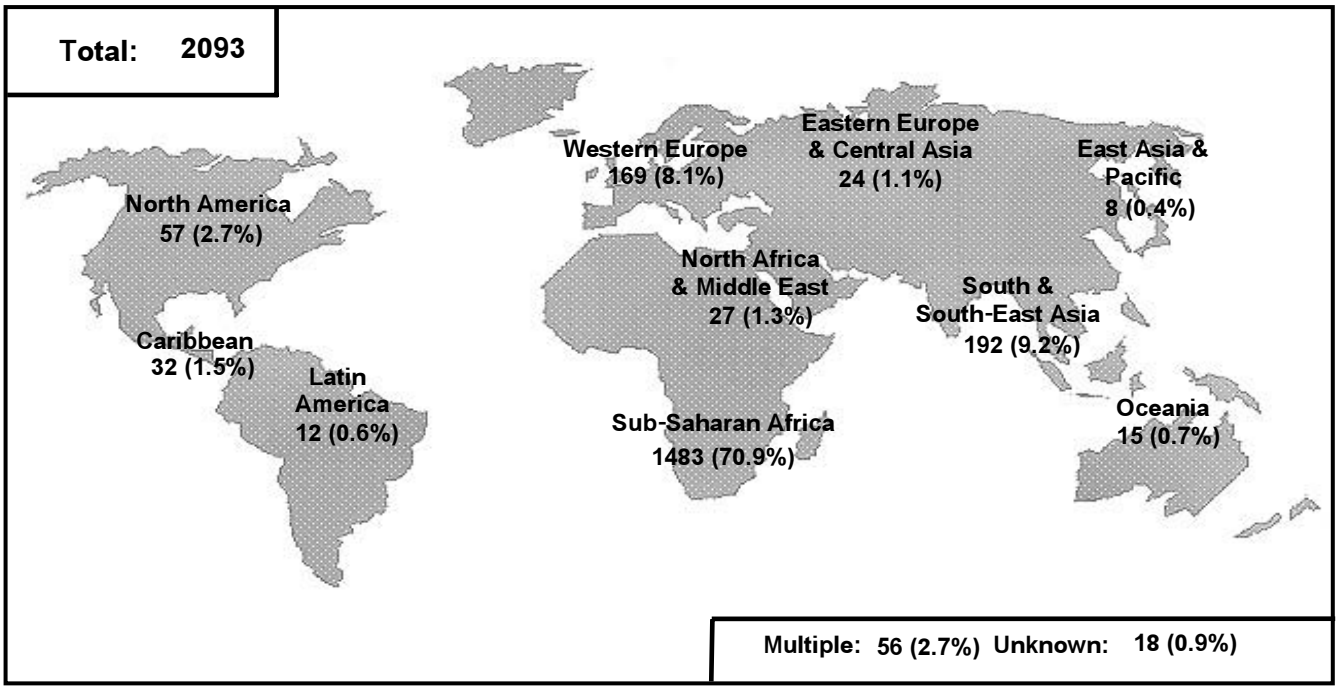


Figure 3.2: Global region and country of infection for all HIV and AIDS cases in the North West who probably acquired their infection outside the UK, 2008



Sub-Saharan Africa	1483 (70.9%)
Angola	13 (0.6%)
Botswana	21 (1%)
Burundi	14 (0.7%)
Cameroon	35 (1.7%)
Central African Republic	1 (0.05%)
Chad	1 (0.05%)
Congo	47 (2.2%)
Cote d'Ivoire	13 (0.6%)
Dem. Republic of Congo	9 (0.4%)
Equatorial Guinea	1 (0.05%)
Eritrea	20 (1%)
Ethiopia	14 (0.7%)
Gabon	1 (0.05%)
Gambia	8 (0.4%)
Ghana	17 (0.8%)
Guinea	3 (0.1%)
Kenya	47 (2.2%)
Lesotho	1 (0.05%)
Liberia	5 (0.2%)
Malawi	116 (5.5%)
Mozambique	3 (0.1%)
Namibia	2 (0.1%)
Niger	1 (0.05%)
Nigeria	72 (3.4%)
Rwanda	11 (0.5%)
Sierra Leone	4 (0.2%)
Somalia	18 (0.9%)
South Africa	125 (6%)
Swaziland	3 (0.1%)
Tanzania	19 (0.9%)
Togo	2 (0.1%)
Uganda	31 (1.5%)
Zambia	82 (3.9%)
Zimbabwe	641 (30.6%)
Sub-Saharan Africa Unknown	75 (3.6%)
Sub-Saharan Africa Multiple	7 (0.3%)

Latin America	12 (0.6%)
Brazil	7 (0.3%)
Colombia	1 (0.05%)
Guatemala	1 (0.05%)
Guyana	2 (0.1%)
Mexico	1 (0.05%)

Western Europe	169 (8.1%)
Austria	1 (0.05%)
Balearics	2 (0.1%)
Belgium	2 (0.1%)
Canary Islands	9 (0.4%)
Finland	2 (0.1%)
France	12 (0.6%)
Germany	13 (0.6%)
Gibraltar	1 (0.05%)
Greece	3 (0.1%)
Ireland	4 (0.2%)
Italy	13 (0.6%)
Malta	2 (0.1%)
Netherlands	12 (0.6%)
Portugal	25 (1.2%)
Slovenia	1 (0.05%)
Spain	52 (2.5%)
Sweden	1 (0.05%)
Switzerland	1 (0.05%)
Western Europe Unknown	8 (0.4%)
Western Europe Multiple	5 (0.2%)

Eastern Europe & Central Asia	24 (1.1%)
Belarus	1 (0.05%)
Croatia	1 (0.05%)
Estonia	1 (0.05%)
Georgia	1 (0.05%)
Hungary	1 (0.05%)
Latvia	4 (0.2%)
Poland	12 (0.6%)
Romania	2 (0.1%)
Russian Federation	1 (0.05%)

North America	57 (2.7%)
Canada	4 (0.2%)
United States of America	52 (2.5%)
North America Unknown	1 (0.05%)

Caribbean	32 (1.5%)
Dominican Republic	1 (0.05%)
Jamaica	28 (1.3%)
St Lucia	1 (0.05%)
Trinidad and Tobago	1 (0.05%)
Caribbean Unknown	1 (0.05%)

South & South-East Asia	192 (9.2%)
Bangladesh	1 (0.05%)
Brunei Darussalam	1 (0.05%)
Cambodia	1 (0.05%)
India	16 (0.8%)
Indonesia	2 (0.1%)
Iran	2 (0.1%)
Malaysia	2 (0.1%)
Pakistan	13 (0.6%)
Philippines	3 (0.1%)
Singapore	3 (0.1%)
Sri Lanka	1 (0.05%)
Thailand	135 (6.5%)
Vietnam	3 (0.1%)
South & South-East Asia Unknown	5 (0.2%)
South & South-East Asia Multiple	4 (0.2%)

North Africa & Middle East	27 (1.3%)
Bahrain	1 (0.05%)
Cyprus	2 (0.1%)
Egypt	2 (0.1%)
Israel	1 (0.05%)
Jordan	1 (0.05%)
Libyan Arab Jamahiriya	3 (0.1%)
Morocco	2 (0.1%)
Saudi Arabia	2 (0.1%)
Sudan	8 (0.4%)
Turkey	2 (0.1%)
United Arab Emirates	2 (0.1%)
North Africa & Middle East Unknown	1 (0.05%)

East Asia & Pacific	8 (0.4%)
China	6 (0.3%)
Hong Kong	1 (0.05%)
Taiwan	1 (0.05%)

Oceania	15 (0.7%)
Australia	13 (0.6%)
New Zealand	1 (0.05%)
Oceania Unknown	1 (0.05%)

Multiple	56 (2.7%)
Unknown	18 (0.9%)

Total	2093

Table 3.1: Age distribution, stage of HIV disease and ethnicity of total HIV & AIDS cases by infection route and sex 2008

		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								35	54			89
	15-19	7			1	13			9	13		1	44
	20-24	112	1	1	22	66	1		2		3	5	213
	25-29	277	7	2	52	230	7				9	6	590
	30-34	389	13	3	119	341	4				10	2	881
	35-39	563	19	6	193	336	11	1			14	6	1149
	40-44	618	23	4	192	235	13	2			17	5	1109
	45-49	464	19	5	126	122	6	3			15	3	763
	50-54	272	5	2	88	64	9	2			7		449
	55-59	164	1		51	31	2	1			5		255
	60+	111	7		68	22	4	4			8	1	225
Stage of HIV Disease	Asymptomatic	1375	33	12	429	814	9	1	9	27	37	19	2765
	Symptomatic	889	34	8	217	319	30	6	22	21	18	2	1566
	AIDS	611	25	3	242	303	17	5	15	18	25	2	1266
	AIDS Related Death	17			7	7							31
	Death Unrelated to AIDS	12	1		6	2	1	1			1		24
	Unknown	73	2		11	15				1	7	6	115
Ethnicity	White	2847	84	23	353	303	52	8	7	11	56	7	3751
	Black Caribbean	17	2		20	32	1			1	1	1	75
	Black African	17	2		487	1019	1		32	45	12	13	1628
	Black Other	8	1		3	9							21
	Indian/Pakistani/Bangladeshi	22	1		22	15	2	2		1	3	1	69
	Other Asian/Oriental	13	1		10	44	1	2	1	2	1	2	77
	Other/Mixed	41	2		13	26		1	6	7	2	2	100
	Unknown	12	2		4	12					13	3	46
	Total	**2977**	**95**	**23**	**912**	**1460**	**57**	**13**	**46**	**67**	**88**	**29**	**5767**
	%	**51.6**	**1.6**	**0.4**	**15.8**	**25.3**	**1.0**	**0.2**	**0.8**	**1.2**	**1.5**	**0.5**	

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the age of individuals at the end of December 2008, or at death.

Table 3.2: Local authority of residence of total HIV and AIDS cases by infection route, 2008

	Local Authority of Residence	Infection Route						Total (100%)
		MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	Carlisle	14 (46.7%)	2 (6.7%)	12 (40%)	1 (3.3%)		1 (3.3%)	30
	Allerdale	10 (55.6%)		7 (38.9%)		1 (5.6%)		18
	Eden	11 (73.3%)		4 (26.7%)				15
	Copeland	7 (46.7%)		5 (33.3%)	1 (6.7%)	1 (6.7%)	1 (6.7%)	15
	South Lakeland	11 (37.9%)	2 (6.9%)	13 (44.8%)	1 (3.4%)	1 (3.4%)	1 (3.4%)	29
	Barrow-in-Furness	5 (33.3%)		10 (66.7%)				15
	Unknown Cumbria	1 (100%)						1
	Cumbria Total	**59 (48%)**	**4 (3.3%)**	**51 (41.5%)**	**3 (2.4%)**	**3 (2.4%)**	**3 (2.4%)**	**123**
Lancashire	Lancaster	19 (55.9%)		14 (41.2%)	1 (2.9%)			34
	Wyre	36 (73.5%)		13 (26.5%)				49
	Fylde	34 (69.4%)	1 (2%)	12 (24.5%)	1 (2%)	1 (2%)		49
	Blackpool	255 (81%)	3 (1%)	51 (16.2%)	5 (1.6%)	1 (0.3%)		315
	Blackburn with Darwen	20 (25.6%)	2 (2.6%)	50 (64.1%)	4 (5.1%)		2 (2.6%)	78
	Ribble Valley	6 (46.2%)		6 (46.2%)			1 (7.7%)	13
	Pendle	12 (60%)	1 (5%)	3 (15%)	1 (5%)		3 (15%)	20
	Hyndburn	8 (28.6%)		17 (60.7%)	1 (3.6%)	1 (3.6%)	1 (3.6%)	28
	Burnley	9 (33.3%)		14 (51.9%)	1 (3.7%)	1 (3.7%)	2 (7.4%)	27
	Rossendale	19 (76%)	1 (4%)	4 (16%)		1 (4%)		25
	Preston	42 (43.8%)	1 (1%)	48 (50%)		4 (4.2%)	1 (1%)	96
	South Ribble	14 (48.3%)	1 (3.4%)	11 (37.9%)	1 (3.4%)	1 (3.4%)	1 (3.4%)	29
	Chorley	14 (63.6%)	1 (4.5%)	5 (22.7%)			2 (9.1%)	22
	West Lancashire	15 (55.6%)		11 (40.7%)	1 (3.7%)			27
	Unknown Lancashire		1 (50%)	1 (50%)				2
	Lancashire Total	**503 (61.8%)**	**12 (1.5%)**	**260 (31.9%)**	**16 (2%)**	**10 (1.2%)**	**13 (1.6%)**	**814**
Greater Manchester	Wigan	41 (33.3%)	1 (0.8%)	72 (58.5%)	3 (2.4%)	2 (1.6%)	4 (3.3%)	123
	Bolton	72 (30.9%)	7 (3%)	135 (57.9%)	5 (2.1%)	9 (3.9%)	5 (2.1%)	233
	Bury	92 (55.4%)	3 (1.8%)	61 (36.7%)	3 (1.8%)	3 (1.8%)	4 (2.4%)	166
	Rochdale	53 (39.6%)	5 (3.7%)	66 (49.3%)	4 (3%)	4 (3%)	2 (1.5%)	134
	Oldham	48 (35%)	3 (2.2%)	80 (58.4%)	2 (1.5%)	2 (1.5%)	2 (1.5%)	137
	Salford	351 (70.1%)	11 (2.2%)	125 (25%)	1 (0.2%)	3 (0.6%)	10 (2%)	501
	Manchester	843 (50.5%)	34 (2%)	727 (43.6%)	3 (0.2%)	36 (2.2%)	26 (1.6%)	1669
	Tameside	71 (55%)	7 (5.4%)	48 (37.2%)		2 (1.6%)	1 (0.8%)	129
	Trafford	103 (56%)	6 (3.3%)	62 (33.7%)	4 (2.2%)	3 (1.6%)	6 (3.3%)	184
	Stockport	82 (61.2%)		43 (32.1%)	3 (2.2%)	4 (3%)	2 (1.5%)	134
	Unknown Greater Manchester	5 (62.5%)		3 (37.5%)				8
	Greater Manchester Total	**1761 (51.5%)**	**77 (2.3%)**	**1422 (41.6%)**	**28 (0.8%)**	**68 (2%)**	**62 (1.8%)**	**3418**
Merseyside	Sefton	36 (44.4%)	2 (2.5%)	39 (48.1%)	3 (3.7%)		1 (1.2%)	81
	Liverpool	121 (28.6%)	5 (1.2%)	267 (63.1%)	5 (1.2%)	11 (2.6%)	14 (3.3%)	423
	Knowsley	22 (57.9%)	1 (2.6%)	14 (36.8%)			1 (2.6%)	38
	Wirral	65 (47.8%)	5 (3.7%)	60 (44.1%)	2 (1.5%)	3 (2.2%)	1 (0.7%)	136
	St Helens	37 (74%)		11 (22%)	1 (2%)		1 (2%)	50
	Unknown Merseyside	3 (37.5%)		4 (50%)			1 (12.5%)	8
	Merseyside Total	**284 (38.6%)**	**13 (1.8%)**	**395 (53.7%)**	**11 (1.5%)**	**14 (1.9%)**	**19 (2.6%)**	**736**
Cheshire	Halton	13 (50%)	1 (3.8%)	11 (42.3%)		1 (3.8%)		26
	Warrington	45 (57%)		31 (39.2%)	1 (1.3%)	2 (2.5%)		79
	Cheshire West and Chester	83 (55.3%)	3 (2%)	52 (34.7%)	3 (2%)	6 (4%)	3 (2%)	150
	Cheshire East	67 (59.3%)	1 (0.9%)	41 (36.3%)	2 (1.8%)		2 (1.8%)	113
	Cheshire Total	**208 (56.5%)**	**5 (1.4%)**	**135 (36.7%)**	**6 (1.6%)**	**9 (2.4%)**	**5 (1.4%)**	**368**
	Total North West Residents	**2815 (51.6%)**	**111 (2%)**	**2263 (41.5%)**	**64 (1.2%)**	**104 (1.9%)**	**102 (1.9%)**	**5459**
	Isle of Man	9 (39.1%)		13 (56.5%)	1 (4.3%)			23
	Out of Region	113 (54.6%)	5 (2.4%)	65 (31.4%)	5 (2.4%)	9 (4.3%)	10 (4.8%)	207
	Abroad			1 (100%)				1
	Unknown*	40 (51.9%)	2 (2.6%)	30 (39%)			5 (6.5%)	77
	Total	**2977 (51.6%)**	**118 (2%)**	**2372 (41.1%)**	**70 (1.2%)**	**113 (2%)**	**117 (2%)**	**5767**

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
** Includes three people of no fixed abode and five people who declined to give any residential information.*

Table 3.3: Local authority of residence of total HIV and AIDS cases by stage of HIV disease, 2008

	Local Authority of Residence	Stage of HIV Disease						Total (100%)
		Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	Carlisle	6 (20%)	11 (36.7%)	6 (20%)			7 (23.3%)	30
	Allerdale	4 (22.2%)	8 (44.4%)	3 (16.7%)	1 (5.6%)		2 (11.1%)	18
	Eden	7 (46.7%)	3 (20%)	2 (13.3%)			3 (20%)	15
	Copeland	4 (26.7%)	4 (26.7%)	7 (46.7%)				15
	South Lakeland	12 (41.4%)	9 (31%)	8 (27.6%)				29
	Barrow-in-Furness	9 (60%)	2 (13.3%)	4 (26.7%)				15
	Unknown Cumbria	1 (100%)						1
	Cumbria Total	**43 (35%)**	**37 (30.1%)**	**30 (24.4%)**	**1 (0.8%)**		**12 (9.8%)**	**123**
Lancashire	Lancaster	21 (61.8%)	6 (17.6%)	5 (14.7%)		2 (5.9%)		34
	Wyre	15 (30.6%)	18 (36.7%)	13 (26.5%)	2 (4.1%)	1 (2%)		49
	Fylde	19 (38.8%)	17 (34.7%)	10 (20.4%)	1 (2%)	1 (2%)	1 (2%)	49
	Blackpool	112 (35.6%)	115 (36.5%)	77 (24.4%)	2 (0.6%)	1 (0.3%)	8 (2.5%)	315
	Blackburn with Darwen	44 (56.4%)	18 (23.1%)	16 (20.5%)				78
	Ribble Valley	5 (38.5%)	1 (7.7%)	7 (53.8%)				13
	Pendle	6 (30%)	9 (45%)	5 (25%)				20
	Hyndburn	9 (32.1%)	10 (35.7%)	8 (28.6%)			1 (3.6%)	28
	Burnley	17 (63%)	7 (25.9%)	2 (7.4%)		1 (3.7%)		27
	Rossendale	5 (20%)	16 (64%)	4 (16%)				25
	Preston	38 (39.6%)	34 (35.4%)	23 (24%)			1 (1%)	96
	South Ribble	12 (41.4%)	7 (24.1%)	9 (31%)		1 (3.4%)		29
	Chorley	9 (40.9%)	10 (45.5%)	3 (13.6%)				22
	West Lancashire	10 (37%)	11 (40.7%)	5 (18.5%)			1 (3.7%)	27
	Unknown Lancashire		2 (100%)					2
	Lancashire Total	**322 (39.6%)**	**281 (34.5%)**	**187 (23%)**	**5 (0.6%)**	**7 (0.9%)**	**12 (1.5%)**	**814**
Greater Manchester	Wigan	66 (53.7%)	34 (27.6%)	22 (17.9%)		1 (0.8%)		123
	Bolton	139 (59.7%)	48 (20.6%)	44 (18.9%)	1 (0.4%)	1 (0.4%)		233
	Bury	65 (39.2%)	66 (39.8%)	34 (20.5%)			1 (0.6%)	166
	Rochdale	56 (41.8%)	37 (27.6%)	40 (29.9%)		1 (0.7%)		134
	Oldham	69 (50.4%)	33 (24.1%)	32 (23.4%)	1 (0.7%)		2 (1.5%)	137
	Salford	230 (45.9%)	155 (30.9%)	99 (19.8%)	5 (1%)	2 (0.4%)	10 (2%)	501
	Manchester	815 (48.8%)	440 (26.4%)	361 (21.6%)	6 (0.4%)	6 (0.4%)	41 (2.5%)	1669
	Tameside	64 (49.6%)	38 (29.5%)	25 (19.4%)	1 (0.8%)	1 (0.8%)		129
	Trafford	75 (40.8%)	57 (31%)	49 (26.6%)		1 (0.5%)	2 (1.1%)	184
	Stockport	60 (44.8%)	46 (34.3%)	27 (20.1%)		1 (0.7%)		134
	Unknown Greater Manchester	5 (62.5%)	1 (12.5%)	2 (25%)				8
	Greater Manchester Total	**1644 (48.1%)**	**955 (27.9%)**	**735 (21.5%)**	**14 (0.4%)**	**14 (0.4%)**	**56 (1.6%)**	**3418**
Merseyside	Sefton	42 (51.9%)	20 (24.7%)	18 (22.2%)			1 (1.2%)	81
	Liverpool	275 (65%)	58 (13.7%)	76 (18%)	4 (0.9%)	1 (0.2%)	9 (2.1%)	423
	Knowsley	20 (52.6%)	7 (18.4%)	10 (26.3%)			1 (2.6%)	38
	Wirral	53 (39%)	41 (30.1%)	37 (27.2%)	2 (1.5%)	1 (0.7%)	2 (1.5%)	136
	St Helens	29 (58%)	11 (22%)	9 (18%)			1 (2%)	50
	Unknown Merseyside	5 (62.5%)		3 (37.5%)				8
	Merseyside Total	**424 (57.6%)**	**137 (18.6%)**	**153 (20.8%)**	**6 (0.8%)**	**2 (0.3%)**	**14 (1.9%)**	**736**
Cheshire	Halton	14 (53.8%)	5 (19.2%)	6 (23.1%)	1 (3.8%)			26
	Warrington	54 (68.4%)	12 (15.2%)	11 (13.9%)	2 (2.5%)			79
	Cheshire West and Chester	85 (56.7%)	32 (21.3%)	30 (20%)			3 (2%)	150
	Cheshire East	39 (34.5%)	29 (25.7%)	37 (32.7%)			8 (7.1%)	113
	Cheshire Total	**192 (52.2%)**	**78 (21.2%)**	**84 (22.8%)**	**3 (0.8%)**		**11 (3%)**	**368**
	Total North West Residents	**2625 (48.1%)**	**1488 (27.3%)**	**1189 (21.8%)**	**29 (0.5%)**	**23 (0.4%)**	**105 (1.9%)**	**5459**
	Isle of Man	8 (34.8%)	9 (39.1%)	6 (26.1%)				23
	Out of Region	82 (39.6%)	59 (28.5%)	60 (29%)	1 (0.5%)	1 (0.5%)	4 (1.9%)	207
	Abroad			1 (100%)				1
	Unknown*	50 (64.9%)	10 (13%)	10 (13%)	1 (1.3%)		6 (7.8%)	77
	Total	**2765 (47.9%)**	**1566 (27.2%)**	**1266 (22%)**	**31 (0.5%)**	**24 (0.4%)**	**115 (2%)**	**5767**

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

Table 3.4: Total HIV and AIDS cases by infection route, sex, county of residence and ethnicity, 2008

	Ethnicity	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	
Cumbria	White	59	3	1	18	17	2			2	1	1	104
	BME/mixed				2	14		1	1		1		19
	Total	**59**	**3**	**1**	**20**	**31**	**2**	**1**	**1**	**2**	**2**	**1**	**123**
	%	**48.0**	**2.4**	**0.8**	**16.3**	**25.2**	**1.6**	**0.8**	**0.8**	**1.6**	**1.6**	**0.8**	
Lancashire	White	489	9		73	68	9	3		3	9		663
	BME/mixed	12	3		41	76	2	2	3	4	1	3	147
	Unknown	2				2							4
	Total	**503**	**12**		**114**	**146**	**11**	**5**	**3**	**7**	**10**	**3**	**814**
	%	**61.8**	**1.5**		**14.0**	**17.9**	**1.4**	**0.6**	**0.4**	**0.9**	**1.2**	**0.4**	
Greater Manchester	White	1674	56	14	111	102	21	2	5	3	34	4	2026
	BME/mixed	81	5		393	809	3	2	24	36	10	7	1370
	Unknown	6	2		3	4					5	2	22
	Total	**1761**	**63**	**14**	**507**	**915**	**24**	**4**	**29**	**39**	**49**	**13**	**3418**
	%	**51.5**	**1.8**	**0.4**	**14.8**	**26.8**	**0.7**	**0.1**	**0.8**	**1.1**	**1.4**	**0.4**	
Merseyside	White	275	7	5	70	63	8	3		1	7	2	441
	BME/mixed	7	1		81	176			4	9	3	4	285
	Unknown	2			1	4					3		10
	Total	**284**	**8**	**5**	**152**	**243**	**8**	**3**	**4**	**10**	**13**	**6**	**736**
	%	**38.6**	**1.1**	**0.7**	**20.7**	**33.0**	**1.1**	**0.4**	**0.5**	**1.4**	**1.8**	**0.8**	
Cheshire	White	204	3	2	47	31	6			1	2		296
	BME/mixed	4			22	33			4	4	1	2	70
	Unknown					2							2
	Total	**208**	**3**	**2**	**69**	**66**	**6**		**4**	**5**	**3**	**2**	**368**
	%	**56.5**	**0.8**	**0.5**	**18.8**	**17.9**	**1.6**		**1.1**	**1.4**	**0.8**	**0.5**	
Out of region*	White	111	4	1	29	21	6		2	1	2		177
	BME/mixed	9			8	20			3	3	2		45
	Unknown	2									5	1	8
	Total	**122**	**4**	**1**	**37**	**41**	**6**		**5**	**4**	**9**	**1**	**230**
	%	**53.0**	**1.7**	**0.4**	**16.1**	**17.8**	**2.6**		**2.2**	**1.7**	**3.9**	**0.4**	
Abroad	White				1								1
	Total				**1**								**1**
	%				**100.0**								
Unknown **	White	35	2		4	1					1		43
	BME/mixed	5			8	17					1	3	34
	Total	**40**	**2**		**12**	**18**					**2**	**3**	**77**
	%	**51.9**	**2.6**		**15.6**	**23.4**					**2.6**	**3.9**	
Total	White	2847	84	23	353	303	52	8	7	11	56	7	3751
	BME/mixed	118	9		555	1145	5	5	39	56	19	19	1970
	Unknown	12	2		4	12					13	3	46
	Total	**2977**	**95**	**23**	**912**	**1460**	**57**	**13**	**46**	**67**	**88**	**29**	**5767**
	%	**51.6**	**1.6**	**0.4**	**15.8**	**25.3**	**1.0**	**0.2**	**0.8**	**1.2**	**1.5**	**0.5**	

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
** Includes Isle of Man.*
*** Includes three people of no fixed abode and five who declined to give any residential information.*

Table 3.5: Age group of total HIV and AIDS cases by ethnicity, 2008

	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	9	1	60			2	8		80
	15-19	14	1	23		1	1	3		43
	20-24	141	7	40	2	1	2	3	2	198
	25-29	318	13	190	1	7	9	15	7	560
	30-34	438	10	329	7	12	15	21	9	841
	35-39	646	13	392	2	11	20	18	6	1108
	40-44	719	11	275	3	16	10	11	7	1052
	45-49	537	9	140	5	6	5	8	3	713
	50-54	331	2	72	1	8	5	6	2	427
	55-59	198	1	27		1	1	1	1	230
	60+	179	2	21		3	1		1	207
	Total	**3530**	**70**	**1569**	**21**	**66**	**71**	**94**	**38**	**5459**
	%	**64.7**	**1.3**	**28.7**	**0.4**	**1.2**	**1.3**	**1.7**	**0.7**	
All individuals treated in North West	0-14	12	1	64			2	10		89
	15-19	14	2	23		1	1	3		44
	20-24	152	8	41	2	1	3	3	3	213
	25-29	335	15	197	1	8	10	17	7	590
	30-34	462	11	341	7	12	16	22	10	881
	35-39	670	13	405	2	12	21	18	8	1149
	40-44	764	11	283	3	17	11	12	8	1109
	45-49	576	9	148	5	6	6	8	5	763
	50-54	348	2	76	1	8	5	6	3	449
	55-59	221	1	29		1	1	1	1	255
	60+	197	2	21		3	1		1	225
	Total	**3751**	**75**	**1628**	**21**	**69**	**77**	**100**	**46**	**5767**
	%	**65.0**	**1.3**	**28.2**	**0.4**	**1.2**	**1.3**	**1.7**	**0.8**	

Age groups refer to the ages of individuals at the end of December 2008, or at death.

Table 3.6: Total HIV and AIDS cases by stage of HIV disease, level of antiretroviral therapy and county of residence, 2008

	Stage of HIV Disease	Level of Antiretroviral Therapy					Total (100%)
		None	Mono	Dual	Triple	Quadruple or More	
Cumbria	Asymptomatic	23			14	6	43
	Symptomatic	2			23	12	37
	AIDS	1			18	11	30
	AIDS Related Death	1					1
	Unknown	7			4	1	12
	Cumbria Total	**34 (27.6%)**			**59 (48%)**	**30 (24.4%)**	**123**
Lancashire	Asymptomatic	139			129	54	322
	Symptomatic	28			167	86	281
	AIDS	6			115	66	187
	AIDS Related Death	1			2	2	5
	Death Unrelated to AIDS	2			3	2	7
	Unknown	8			2	2	12
	Lancashire Total	**184 (22.6%)**			**418 (51.4%)**	**212 (26%)**	**814**
Greater Manchester	Asymptomatic	800	2		583	259	1644
	Symptomatic	91		1	528	335	955
	AIDS	48			370	317	735
	AIDS Related Death	3			5	6	14
	Death Unrelated to AIDS	3		1	6	4	14
	Unknown	48			2	6	56
	Greater Manchester Total	**993 (29.1%)**	**2 (0.1%)**	**2 (0.1%)**	**1494 (43.7%)**	**927 (27.1%)**	**3418**
Merseyside	Asymptomatic	183	2	7	178	54	424
	Symptomatic	12	1	2	90	32	137
	AIDS	10		4	100	39	153
	AIDS Related Death	3			3		6
	Death Unrelated to AIDS				2		2
	Unknown	10			3	1	14
	Merseyside Total	**218 (29.6%)**	**3 (0.4%)**	**13 (1.8%)**	**376 (51.1%)**	**126 (17.1%)**	**736**
Cheshire	Asymptomatic	67		1	105	19	192
	Symptomatic	13			44	21	78
	AIDS	5			53	26	84
	AIDS Related Death	2				1	3
	Unknown	3			5	3	11
	Cheshire Total	**90 (24.5%)**		**1 (0.3%)**	**207 (56.3%)**	**70 (19%)**	**368**
Total North West Residents	Asymptomatic	1212	4	8	1009	392	2625
	Symptomatic	146	1	3	852	486	1488
	AIDS	70		4	656	459	1189
	AIDS Related Death	10			10	9	29
	Death Unrelated to AIDS	5		1	11	6	23
	Unknown	76			16	13	105
	Total North West Residents	**1519 (27.8%)**	**5 (0.1%)**	**16 (0.3%)**	**2554 (46.8%)**	**1365 (25%)**	**5459**
	Isle of Man	5	1		9	8	23
	Out of Region	38		4	103	62	207
	Abroad				1		1
	Unknown*	49		2	15	11	77
	Total	**1611 (27.9%)**	**6 (0.1%)**	**22 (0.4%)**	**2682 (46.5%)**	**1446 (25.1%)**	**5767**

** Includes three people of no fixed abode and five 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 total HIV and AIDS cases by sex, stage of HIV disease and exposure abroad, 2008

		Ethnicity								Total
		White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Sex	Male	3399 (90.6%)	41 (54.7%)	551 (33.8%)	12 (57.1%)	50 (72.5%)	27 (35.1%)	64 (64%)	31 (67.4%)	4175
	Female	352 (9.4%)	34 (45.3%)	1077 (66.2%)	9 (42.9%)	19 (27.5%)	50 (64.9%)	36 (36%)	15 (32.6%)	1592
Stage of HIV Disease	Asymptomatic	1694 (45.2%)	49 (65.3%)	856 (52.6%)	13 (61.9%)	36 (52.2%)	34 (44.2%)	58 (58%)	25 (54.3%)	2765
	Symptomatic	1110 (29.6%)	10 (13.3%)	373 (22.9%)	2 (9.5%)	16 (23.2%)	21 (27.3%)	26 (26%)	8 (17.4%)	1566
	AIDS	824 (22%)	10 (13.3%)	368 (22.6%)	4 (19%)	16 (23.2%)	21 (27.3%)	14 (14%)	9 (19.6%)	1266
	AIDS Related Death	22 (0.6%)	1 (1.3%)	8 (0.5%)						31
	Death Unrelated to AIDS	19 (0.5%)	1 (1.3%)	2 (0.1%)		1 (1.4%)		1 (1%)		24
	Unknown	82 (2.2%)	4 (5.3%)	21 (1.3%)	2 (9.5%)		1 (1.3%)	1 (1%)	4 (8.7%)	115
Exposure Abroad	UK	2916 (77.7%)	31 (41.3%)	55 (3.4%)	5 (23.8%)	21 (30.4%)	12 (15.6%)	43 (43%)	6 (13%)	3089
	Abroad	511 (13.6%)	29 (38.7%)	1393 (85.6%)	11 (52.4%)	43 (62.3%)	54 (70.1%)	40 (40%)	12 (26.1%)	2093
	Unknown	324 (8.6%)	15 (20%)	180 (11.1%)	5 (23.8%)	5 (7.2%)	11 (14.3%)	17 (17%)	28 (60.9%)	585
	Total	**3751**	**75**	**1628**	**21**	**69**	**77**	**100**	**46**	**5767**

Table 3.8: Global region and country of HIV exposure by infection route of total HIV and AIDS cases, 2008

Region of HIV Exposure	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Abroad	267 (12.8%)	28 (1.3%)	1683 (80.4%)	16 (0.8%)	61 (2.9%)	38 (1.8%)	2093
Caribbean	*5*		*27*				*32*
East Asia & Pacific	*3*		*5*				*8*
Eastern Europe & Central Asia	*5*	*3*	*14*	*1*	*1*		*24*
Latin America	*4*		*7*			*1*	*12*
North Africa & Middle East	*6*	*2*	*17*		*1*	*1*	*27*
North America	*44*	*3*	*7*	*1*	*1*	*1*	*57*
Oceania	*12*		*3*				*15*
South & South-East Asia	*29*	*1*	*152*	*4*	*1*	*5*	*192*
Sub-Saharan Africa	*18*	*3*	*1376*	*8*	*55*	*23*	*1483*
Western Europe	*97*	*16*	*48*	*2*	*1*	*5*	*169*
Unknown	*7*		*11*				*18*
Multiple	*37*		*16*		*1*	*2*	*56*
UK	2423 (78.4%)	77 (2.5%)	451 (14.6%)	54 (1.7%)	41 (1.3%)	43 (1.4%)	3089
Undetermined	287 (49.1%)	13 (2.2%)	238 (40.7%)		11 (1.9%)	36 (6.2%)	585
Total	**2977 (51.6%)**	**118 (2%)**	**2372 (41.1%)**	**70 (1.2%)**	**113 (2%)**	**117 (2%)**	**5767**

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

Table 3.9: Distribution of treatment for total HIV and AIDS cases by infection route, 2008

Treatment Centre	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
AHC					28 (100%)		28
APH	34 (43.6%)	1 (1.3%)	42 (53.8%)			1 (1.3%)	78
ARM	33 (82.5%)	4 (10%)	1 (2.5%)			2 (5%)	40
BLAG	325 (78.9%)	4 (1%)	78 (18.9%)	3 (0.7%)	2 (0.5%)		412
BLK	2 (100%)						2
BLKG	27 (27.8%)	2 (2.1%)	64 (66%)	1 (1%)		3 (3.1%)	97
BOLG	93 (32.7%)	7 (2.5%)	180 (63.4%)	2 (0.7%)		2 (0.7%)	284
BOOT					34 (100%)		34
BURG	18 (48.6%)	1 (2.7%)	14 (37.8%)			4 (10.8%)	37
BURY	23 (44.2%)	1 (1.9%)	27 (51.9%)			1 (1.9%)	52
CHR	78 (55.7%)	3 (2.1%)	57 (40.7%)		1 (0.7%)	1 (0.7%)	140
CPED					1 (100%)		1
CUMB	30 (53.6%)	2 (3.6%)	21 (37.5%)	1 (1.8%)	1 (1.8%)	1 (1.8%)	56
FGH	7 (38.9%)	1 (5.6%)	9 (50%)	1 (5.6%)			18
HAL	5 (83.3%)		1 (16.7%)				6
LCN	21 (32.8%)	3 (4.7%)	36 (56.3%)	3 (4.7%)		1 (1.6%)	64
LEI	34 (63%)		18 (33.3%)	1 (1.9%)		1 (1.9%)	54
MAC	32 (65.3%)	1 (2%)	13 (26.5%)	1 (2%)		2 (4.1%)	49
MGP	187 (96.9%)	1 (0.5%)	5 (2.6%)				193
MRIG	613 (56.8%)	11 (1%)	418 (38.7%)	20 (1.9%)		17 (1.6%)	1079
MRIH	1 (2.7%)		3 (8.1%)	33 (89.2%)			37
NMG	784 (49.4%)	63 (4%)	614 (38.7%)	7 (0.4%)	76 (4.8%)	44 (2.8%)	1588
NMGG	100 (57.5%)	1 (0.6%)	73 (42%)				174
NOBL	9 (52.9%)		8 (47.1%)				17
OLDG	34 (47.2%)		36 (50%)			2 (2.8%)	72
PG	77 (45.3%)	3 (1.8%)	80 (47.1%)		3 (1.8%)	7 (4.1%)	170
PP					4 (100%)		4
RLG	258 (36.8%)	16 (2.3%)	395 (56.3%)	7 (1%)	4 (0.6%)	22 (3.1%)	702
RLH				12 (100%)			12
RLI	17 (50%)		16 (47.1%)	1 (2.9%)			34
ROCG	33 (46.5%)		37 (52.1%)			1 (1.4%)	71
SALG	76 (57.1%)	1 (0.8%)	56 (42.1%)				133
SHH	42 (72.4%)	2 (3.4%)	13 (22.4%)			1 (1.7%)	58
SPG	25 (37.9%)	1 (1.5%)	38 (57.6%)			2 (3%)	66
STP	76 (58.5%)		51 (39.2%)			3 (2.3%)	130
TAMG	26 (66.7%)	1 (2.6%)	12 (30.8%)				39
TRAG	1 (50%)					1 (50%)	2
WAR	28 (58.3%)		20 (41.7%)				48
WGH	10 (47.6%)	1 (4.8%)	10 (47.6%)				21
WHIT			1 (50%)			1 (50%)	2
WIGG	1 (16.7%)		5 (83.3%)				6
WITG	198 (75.3%)	4 (1.5%)	58 (22.1%)	1 (0.4%)		2 (0.8%)	263
WORK	12 (60%)		7 (35%)	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 are also injecting drug users are included in the MSM category.

Table 3.10: Distribution of treatment for total HIV and AIDS cases by level of antiretroviral therapy, 2008

Treatment Centre	Level of Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or More	
AHC	8 (28.6%)			11 (39.3%)	9 (32.1%)	28
APH	30 (38.5%)			25 (32.1%)	23 (29.5%)	78
ARM	40 (100%)					40
BLAG	108 (26.2%)			199 (48.3%)	105 (25.5%)	412
BLK			1 (50%)	1 (50%)		2
BLKG	24 (24.7%)			48 (49.5%)	25 (25.8%)	97
BOLG	83 (29.2%)			148 (52.1%)	53 (18.7%)	284
BOOT	4 (11.8%)			14 (41.2%)	16 (47.1%)	34
BURG	10 (27%)			21 (56.8%)	6 (16.2%)	37
BURY	13 (25%)			28 (53.8%)	11 (21.2%)	52
CHR	19 (13.6%)			98 (70%)	23 (16.4%)	140
CPED					1 (100%)	1
CUMB	14 (25%)			31 (55.4%)	11 (19.6%)	56
FGH	7 (38.9%)			7 (38.9%)	4 (22.2%)	18
HAL	5 (83.3%)			1 (16.7%)		6
LCN	64 (100%)					64
LEI	21 (38.9%)			22 (40.7%)	11 (20.4%)	54
MAC	16 (32.7%)			27 (55.1%)	6 (12.2%)	49
MGP	193 (100%)					193
MRIG	538 (49.9%)	1 (0.1%)		339 (31.4%)	201 (18.6%)	1079
MRIH	3 (8.1%)			18 (48.6%)	16 (43.2%)	37
NMG	217 (13.7%)	1 (0.1%)	4 (0.3%)	752 (47.4%)	614 (38.7%)	1588
NMGG	64 (36.8%)			83 (47.7%)	27 (15.5%)	174
NOBL	3 (17.6%)			6 (35.3%)	8 (47.1%)	17
OLDG	28 (38.9%)			28 (38.9%)	16 (22.2%)	72
PG	33 (19.4%)			91 (53.5%)	46 (27.1%)	170
PP	1 (25%)			3 (75%)		4
RLG	208 (29.6%)	7 (1%)	18 (2.6%)	362 (51.6%)	107 (15.2%)	702
RLH	1 (8.3%)			6 (50%)	5 (41.7%)	12
RLI	8 (23.5%)			19 (55.9%)	7 (20.6%)	34
ROCG	16 (22.5%)			35 (49.3%)	20 (28.2%)	71
SALG	40 (30.1%)			68 (51.1%)	25 (18.8%)	133
SHH	11 (19%)			33 (56.9%)	14 (24.1%)	58
SPG	20 (30.3%)			35 (53%)	11 (16.7%)	66
STP	34 (26.2%)			68 (52.3%)	28 (21.5%)	130
TAMG	29 (74.4%)			9 (23.1%)	1 (2.6%)	39
TRAG	1 (50%)				1 (50%)	2
WAR	16 (33.3%)		1 (2.1%)	27 (56.3%)	4 (8.3%)	48
WGH	6 (28.6%)			10 (47.6%)	5 (23.8%)	21
WHIT				1 (50%)	1 (50%)	2
WIGG	6 (100%)					6
WITG	80 (30.4%)			130 (49.4%)	53 (20.2%)	263
WORK	6 (30%)			9 (45%)	5 (25%)	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 total HIV and AIDS cases by number of treatment centres attended, 2008

	Local Authority of Residence	Treatment Centres Attended			Total (100%)
		One	Two	Three	
Cumbria	Carlisle	30 (100%)			30
	Allerdale	18 (100%)			18
	Eden	14 (93.3%)	1 (6.7%)		15
	Copeland	13 (86.7%)	2 (13.3%)		15
	South Lakeland	28 (96.6%)	1 (3.4%)		29
	Barrow-in-Furness	15 (100%)			15
	Unknown Cumbria	1 (100%)			1
	Cumbria Total	**119 (96.7%)**	**4 (3.3%)**		**123**
Lancashire	Lancaster	30 (88.2%)	4 (11.8%)		34
	Wyre	46 (93.9%)	3 (6.1%)		49
	Fylde	46 (93.9%)	3 (6.1%)		49
	Blackpool	303 (96.2%)	11 (3.5%)	1 (0.3%)	315
	Blackburn with Darwen	70 (89.7%)	8 (10.3%)		78
	Ribble Valley	13 (100%)			13
	Pendle	18 (90%)	2 (10%)		20
	Hyndburn	25 (89.3%)	3 (10.7%)		28
	Burnley	25 (92.6%)	2 (7.4%)		27
	Rossendale	21 (84%)	4 (16%)		25
	Preston	92 (95.8%)	3 (3.1%)	1 (1%)	96
	South Ribble	27 (93.1%)	2 (6.9%)		29
	Chorley	21 (95.5%)	1 (4.5%)		22
	West Lancashire	25 (92.6%)	2 (7.4%)		27
	Unknown Lancashire	2 (100%)			2
	Lancashire Total	**764 (93.9%)**	**48 (5.9%)**	**2 (0.2%)**	**814**
Greater Manchester	Wigan	111 (90.2%)	11 (8.9%)	1 (0.8%)	123
	Bolton	228 (97.9%)	5 (2.1%)		233
	Bury	153 (92.2%)	11 (6.6%)	2 (1.2%)	166
	Rochdale	118 (88.1%)	14 (10.4%)	2 (1.5%)	134
	Oldham	133 (97.1%)	4 (2.9%)		137
	Salford	437 (87.2%)	64 (12.8%)		501
	Manchester	1448 (86.8%)	211 (12.6%)	10 (0.6%)	1669
	Tameside	122 (94.6%)	7 (5.4%)		129
	Trafford	171 (92.9%)	12 (6.5%)	1 (0.5%)	184
	Stockport	118 (88.1%)	15 (11.2%)	1 (0.7%)	134
	Unknown Greater Manchester	8 (100%)			8
	Greater Manchester Total	**3047 (89.1%)**	**354 (10.4%)**	**17 (0.5%)**	**3418**
Merseyside	Sefton	72 (88.9%)	9 (11.1%)		81
	Liverpool	346 (81.8%)	65 (15.4%)	12 (2.8%)	423
	Knowsley	36 (94.7%)		2 (5.3%)	38
	Wirral	123 (90.4%)	13 (9.6%)		136
	St Helens	39 (78%)	11 (22%)		50
	Unknown Merseyside	6 (75%)	2 (25%)		8
	Merseyside Total	**622 (84.5%)**	**100 (13.6%)**	**14 (1.9%)**	**736**
Cheshire	Halton	25 (96.2%)	1 (3.8%)		26
	Warrington	69 (87.3%)	10 (12.7%)		79
	Cheshire West and Chester	136 (90.7%)	14 (9.3%)		150
	Cheshire East	104 (92%)	9 (8%)		113
	Cheshire Total	**334 (90.8%)**	**34 (9.2%)**		**368**
	Total North West Residents	**4886 (89.5%)**	**540 (9.9%)**	**33 (0.6%)**	**5459**
	Isle of Man	21 (91.3%)	2 (8.7%)		23
	Out of Region	194 (93.7%)	13 (6.3%)		207
	Abroad	1 (100%)			1
	Unknown*	74 (96.1%)	3 (3.9%)		77
	Total	**5176 (89.8%)**	**558 (9.7%)**	**33 (0.6%)**	**5767**

** Includes three people of no fixed abode and five 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, 2008

		Outpatient Visits		Day Cases		Inpatient Episodes		Inpatient Days		Home Visits	
		Total	Mean	Total	Mean	Total	Mean	Total	Mean	Total	Mean
Treatment Centre	AHC	140	5.00			14	0.50	110	3.93	241	8.61
	APH	550	7.05			12	0.15	54	0.69	2	0.03
	ARM	1311	32.78								
	BLAG	3413	8.28	24	0.06	41	0.10	526	1.28	56	0.14
	BLK	8	4.00								
	BLKG	755	7.78	13	0.13	24	0.25	158	1.63	6	0.06
	BOLG	1778	6.26			6	0.02	172	0.61	2	0.01
	BOOT	46	1.35	6	0.18	10	0.29	121	3.56		
	BURG	308	8.32	1	0.03	5	0.14	23	0.62	5	0.14
	BURY	248	4.77								
	CHR	781	5.58	1	0.01	17	0.12	143	1.02		
	CPED	13	13.00							9	9.00
	CUMB	279	4.98	3	0.05	1	0.02	1	0.02	2	0.04
	FGH	51	2.83			3	0.17	51	2.83		
	HAL	52	8.67							3	0.50
	LCN	334	5.22							610	9.53
	LEI	437	8.09	3	0.06	4	0.07	30	0.56		
	MAC	420	8.57			10	0.20	12	0.24	6	0.12
	MGP	849	4.40								
	MRIG	8049	7.46	43	0.04	88	0.08	1524	1.41		
	MRIH	189	5.11	8	0.22	12	0.32	151	4.08		
	NMG	10549	6.64	1053	0.66	271	0.17	4429	2.79	73	0.05
	NMGG	615	3.53								
	NOBL	153	9.00			4	0.24	11	0.65		
	OLDG	434	6.03	1	0.01	3	0.04	14	0.19		
	PG	900	5.29	3	0.02	10	0.06	129	0.76	2	0.01
	PP	7	1.75								
	RLG	4416	6.29			102	0.15	830	1.18		
	RLH	64	5.33	1	0.08	3	0.25	17	1.42		
	RLI	109	3.21			5	0.15	75	2.21	2	0.06
	ROCG	335	4.72								
	SALG	878	6.60			2	0.02	16	0.12		
	SHH	382	6.59	11	0.19	5	0.09	63	1.09	3	0.05
	SPG	593	8.98	1	0.02	3	0.05	59	0.89	8	0.12
	STP	625	4.81	45	0.35	6	0.05	101	0.78	4	0.03
	TAMG	342	8.77								
	TRAG	7	3.50			2	1.00	32	16.00		
	WAR	320	6.67	1	0.02	4	0.08	127	2.65	1	0.02
	WGH	64	3.05			1	0.05	20	0.95		
	WHIT	7	3.50								
	WIGG	8	1.33								
	WITG	2033	7.73	9	0.03	3	0.01	16	0.06		
	WORK	104	5.20	5	0.25	4	0.20	37	1.85	12	0.60
Stage of HIV Disease	Asymptomatic	19281	6.97	66	0.02	165	0.06	1773	0.64	181	0.07
	Symptomatic	12116	7.74	729	0.47	154	0.10	1394	0.89	256	0.16
	AIDS	10484	8.28	395	0.32	280	0.22	4515	3.57	492	0.39
	AIDS Related Death	166	5.35	29	1.26	41	1.32	930	30.00	14	0.61
	Death Unrelated to AIDS	163	6.79	10	0.45	30	1.25	359	14.96	72	3.27
	Unknown	746	6.49	3	0.03	5	0.04	81	0.70	32	0.29
	Total	**42956**	**7.45**	**1232**	**0.22**	**675**	**0.12**	**9052**	**1.57**	**1047**	**0.19**

Table 3.13: Residency status of individuals by sex, age group, infection route and stage of HIV disease, 2008

		Residency Status							Total
		UK National	Asylum Seeker	Overseas Student	Temporary Visitor	Refugee	Other***	Unknown	
Sex	Male	3616 (84.3%)	192 (32%)	52 (38.5%)	21 (43.8%)	50 (30.9%)	65 (37.6%)	179 (49.7%)	4175 (72.4%)
	Female	673 (15.7%)	408 (68%)	83 (61.5%)	27 (56.3%)	112 (69.1%)	108 (62.4%)	181 (50.3%)	1592 (27.6%)
Age Group	0-14	43 (1%)	12 (2%)				13 (7.5%)	21 (5.8%)	89 (1.5%)
	15-19	27 (0.6%)	8 (1.3%)			2 (1.2%)	5 (2.9%)	2 (0.6%)	44 (0.8%)
	20-24	164 (3.8%)	15 (2.5%)	7 (5.2%)	2 (4.2%)	7 (4.3%)	5 (2.9%)	13 (3.6%)	213 (3.7%)
	25-29	389 (9.1%)	79 (13.2%)	32 (23.7%)	5 (10.4%)	14 (8.6%)	22 (12.7%)	49 (13.6%)	590 (10.2%)
	30-34	559 (13%)	150 (25%)	23 (17%)	6 (12.5%)	32 (19.8%)	34 (19.7%)	77 (21.4%)	881 (15.3%)
	35-39	814 (19%)	151 (25.2%)	33 (24.4%)	10 (20.8%)	39 (24.1%)	33 (19.1%)	69 (19.2%)	1149 (19.9%)
	40-44	844 (19.7%)	95 (15.8%)	24 (17.8%)	14 (29.2%)	36 (22.2%)	34 (19.7%)	62 (17.2%)	1109 (19.2%)
	45-49	629 (14.7%)	51 (8.5%)	15 (11.1%)	3 (6.3%)	16 (9.9%)	18 (10.4%)	31 (8.6%)	763 (13.2%)
	50-54	388 (9%)	24 (4%)	1 (0.7%)	3 (6.3%)	11 (6.8%)	4 (2.3%)	18 (5%)	449 (7.8%)
	55-59	227 (5.3%)	9 (1.5%)		4 (8.3%)	3 (1.9%)	3 (1.7%)	9 (2.5%)	255 (4.4%)
	60+	205 (4.8%)	6 (1%)		1 (2.1%)	2 (1.2%)	2 (1.2%)	9 (2.5%)	225 (3.9%)
Infection Route	MSM	2886 (67.3%)	10 (1.7%)	5 (3.7%)	6 (12.5%)	1 (0.6%)	21 (12.1%)	48 (13.3%)	2977 (51.6%)
	Injecting drug use	110 (2.6%)					2 (1.2%)	6 (1.7%)	118 (2%)
	Heterosexual	1098 (25.6%)	564 (94%)	125 (92.6%)	41 (85.4%)	159 (98.1%)	129 (74.6%)	256 (71.1%)	2372 (41.1%)
	Blood/tissue	65 (1.5%)	2 (0.3%)	1 (0.7%)			2 (1.2%)		70 (1.2%)
	Mother to child	57 (1.3%)	16 (2.7%)			1 (0.6%)	18 (10.4%)	21 (5.8%)	113 (2%)
	Undetermined	73 (1.7%)	8 (1.3%)	4 (3%)	1 (2.1%)	1 (0.6%)	1 (0.6%)	29 (8.1%)	117 (2%)
Ethnicity	White	3639 (84.8%)	6 (1%)	3 (2.2%)	6 (12.5%)	2 (1.2%)	27 (15.6%)	68 (18.9%)	3751 (65%)
	Black Caribbean	56 (1.3%)	2 (0.3%)	5 (3.7%)	1 (2.1%)	1 (0.6%)	4 (2.3%)	6 (1.7%)	75 (1.3%)
	Black African	367 (8.6%)	576 (96%)	125 (92.6%)	36 (75%)	156 (96.3%)	129 (74.6%)	239 (66.4%)	1628 (28.2%)
	Black Other	16 (0.4%)	1 (0.2%)			1 (0.6%)	2 (1.2%)	1 (0.3%)	21 (0.4%)
	Indian/Pakistani/Bangladeshi	55 (1.3%)	4 (0.7%)	1 (0.7%)	1 (2.1%)		6 (3.5%)	2 (0.6%)	69 (1.2%)
	Other Asian/Oriental	61 (1.4%)	3 (0.5%)	1 (0.7%)	3 (6.3%)	1 (0.6%)	3 (1.7%)	5 (1.4%)	77 (1.3%)
	Other/Mixed	80 (1.9%)	7 (1.2%)		1 (2.1%)	1 (0.6%)	2 (1.2%)	9 (2.5%)	100 (1.7%)
	Unknown	15 (0.3%)	1 (0.2%)					30 (8.3%)	46 (0.8%)
Stage of Disease	Asymptomatic	1988 (46.4%)	344 (57.3%)	78 (57.8%)	19 (39.6%)	73 (45.1%)	91 (52.6%)	172 (47.8%)	2765 (47.9%)
	Symptomatic	1251 (29.2%)	114 (19%)	23 (17%)	15 (31.3%)	48 (29.6%)	41 (23.7%)	74 (20.6%)	1566 (27.2%)
	AIDS	920 (21.5%)	132 (22%)	29 (21.5%)	13 (27.1%)	38 (23.5%)	37 (21.4%)	97 (26.9%)	1266 (22%)
	AIDS Related Death	24 (0.6%)	2 (0.3%)			1 (0.6%)	1 (0.6%)	3 (0.8%)	31 (0.5%)
	Death Unrelated to AIDS	20 (0.5%)	1 (0.2%)	1 (0.7%)				2 (0.6%)	24 (0.4%)
	Unknown	86 (2%)	7 (1.2%)	4 (3%)	1 (2.1%)	2 (1.2%)	3 (1.7%)	12 (3.3%)	115 (2%)
Area of Residence	Cumbria	112 (2.6%)			5 (10.4%)		4 (2.3%)	2 (0.6%)	123 (2.1%)
	Lancashire	740 (17.3%)	25 (4.2%)	3 (2.2%)	2 (4.2%)	8 (4.9%)	17 (9.8%)	19 (5.3%)	814 (14.1%)
	Greater Manchester	2345 (54.7%)	361 (60.2%)	121 (89.6%)	36 (75%)	147 (90.7%)	134 (77.5%)	274 (76.1%)	3418 (59.3%)
	Merseyside	514 (12%)	188 (31.3%)	4 (3%)	1 (2.1%)	1 (0.6%)	6 (3.5%)	22 (6.1%)	736 (12.8%)
	Cheshire	336 (7.8%)	9 (1.5%)	2 (1.5%)		3 (1.9%)	5 (2.9%)	13 (3.6%)	368 (6.4%)
	Out of Region*	192 (4.5%)	11 (1.8%)		3 (6.3%)	1 (0.6%)	2 (1.2%)	21 (5.8%)	230 (4%)
	Abroad						1 (0.6%)		1 (0.02%)
	Unknown**	50 (1.2%)	6 (1%)	5 (3.7%)	1 (2.1%)	2 (1.2%)	4 (2.3%)	9 (2.5%)	77 (1.3%)
	Total (100%)	**4289**	**600**	**135**	**48**	**162**	**173**	**360**	**5767**

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the ages of individuals at the end of December 2008, or at death.
** Includes Isle of Man.*
*** Includes three people of no fixed abode and five 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 total HIV and AIDS cases by infection route, 2008

PCT of Residence	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Heterosexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	59 (48%)	4 (3.3%)	51 (41.5%)	3 (2.4%)	3 (2.4%)	3 (2.4%)	123
North Lancashire	89 (67.4%)	1 (0.8%)	39 (29.5%)	2 (1.5%)	1 (0.8%)		132
Blackpool	255 (81%)	3 (1%)	51 (16.2%)	5 (1.6%)	1 (0.3%)		315
Blackburn with Darwen	20 (25.6%)	2 (2.6%)	50 (64.1%)	4 (5.1%)		2 (2.6%)	78
East Lancashire	54 (47.8%)	2 (1.8%)	44 (38.9%)	3 (2.7%)	3 (2.7%)	7 (6.2%)	113
Central Lancashire	85 (48.9%)	3 (1.7%)	75 (43.1%)	2 (1.1%)	5 (2.9%)	4 (2.3%)	174
Unknown Lancashire		1 (50%)	1 (50%)				2
Ashton, Leigh & Wigan	41 (33.3%)	1 (0.8%)	72 (58.5%)	3 (2.4%)	2 (1.6%)	4 (3.3%)	123
Bolton	72 (30.9%)	7 (3%)	135 (57.9%)	5 (2.1%)	9 (3.9%)	5 (2.1%)	233
Bury	92 (55.4%)	3 (1.8%)	61 (36.7%)	3 (1.8%)	3 (1.8%)	4 (2.4%)	166
Heywood, Middleton & Rochdale	53 (39.6%)	5 (3.7%)	66 (49.3%)	4 (3%)	4 (3%)	2 (1.5%)	134
Oldham	48 (35%)	3 (2.2%)	80 (58.4%)	2 (1.5%)	2 (1.5%)	2 (1.5%)	137
Salford	351 (70.1%)	11 (2.2%)	125 (25%)	1 (0.2%)	3 (0.6%)	10 (2%)	501
Manchester	843 (50.5%)	34 (2%)	727 (43.6%)	3 (0.2%)	36 (2.2%)	26 (1.6%)	1669
Tameside & Glossop	74 (54.8%)	7 (5.2%)	51 (37.8%)		2 (1.5%)	1 (0.7%)	135
Trafford	103 (56%)	6 (3.3%)	62 (33.7%)	4 (2.2%)	3 (1.6%)	6 (3.3%)	184
Stockport	82 (61.2%)		43 (32.1%)	3 (2.2%)	4 (3%)	2 (1.5%)	134
Unknown Greater Manchester	5 (62.5%)		3 (37.5%)				8
Sefton	36 (44.4%)	2 (2.5%)	39 (48.1%)	3 (3.7%)		1 (1.2%)	81
Liverpool	121 (28.6%)	5 (1.2%)	267 (63.1%)	5 (1.2%)	11 (2.6%)	14 (3.3%)	423
Knowsley	22 (57.9%)	1 (2.6%)	14 (36.8%)			1 (2.6%)	38
Wirral	65 (47.8%)	5 (3.7%)	60 (44.1%)	2 (1.5%)	3 (2.2%)	1 (0.7%)	136
Halton & St Helens	50 (65.8%)	1 (1.3%)	22 (28.9%)	1 (1.3%)	1 (1.3%)	1 (1.3%)	76
Unknown Merseyside	3 (37.5%)		4 (50%)			1 (12.5%)	8
Warrington	45 (57%)		31 (39.2%)	1 (1.3%)	2 (2.5%)		79
Western Cheshire	64 (50.8%)	3 (2.4%)	50 (39.7%)	2 (1.6%)	6 (4.8%)	1 (0.8%)	126
Central and Eastern Cheshire	86 (62.8%)	1 (0.7%)	43 (31.4%)	3 (2.2%)		4 (2.9%)	137
Isle of Man	9 (39.1%)		13 (56.5%)	1 (4.3%)			23
Out of Region	110 (54.7%)	5 (2.5%)	62 (30.8%)	5 (2.5%)	9 (4.5%)	10 (5%)	201
Abroad			1 (100%)				1
Unknown*	40 (51.9%)	2 (2.6%)	30 (39%)			5 (6.5%)	77
Total	**2977 (51.6%)**	**118 (2%)**	**2372 (41.1%)**	**70 (1.2%)**	**113 (2%)**	**117 (2%)**	**5767**

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
** Includes three people of no fixed abode and five who declined to give any residential information.*

Table 3.15: Primary care trust of residence of total HIV and AIDS cases by stage of disease, 2008

PCT of Residence	Infection Route						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	43 (35%)	37 (30.1%)	30 (24.4%)	1 (0.8%)		12 (9.8%)	123
North Lancashire	55 (41.7%)	41 (31.1%)	28 (21.2%)	3 (2.3%)	4 (3%)	1 (0.8%)	132
Blackpool	112 (35.6%)	115 (36.5%)	77 (24.4%)	2 (0.6%)	1 (0.3%)	8 (2.5%)	315
Blackburn with Darwen	44 (56.4%)	18 (23.1%)	16 (20.5%)				78
East Lancashire	42 (37.2%)	43 (38.1%)	26 (23%)		1 (0.9%)	1 (0.9%)	113
Central Lancashire	69 (39.7%)	62 (35.6%)	40 (23%)		1 (0.6%)	2 (1.1%)	174
Unknown Lancashire		2 (100%)					2
Ashton, Leigh & Wigan	66 (53.7%)	34 (27.6%)	22 (17.9%)		1 (0.8%)		123
Bolton	139 (59.7%)	48 (20.6%)	44 (18.9%)	1 (0.4%)	1 (0.4%)		233
Bury	65 (39.2%)	66 (39.8%)	34 (20.5%)			1 (0.6%)	166
Heywood, Middleton & Rochdale	56 (41.8%)	37 (27.6%)	40 (29.9%)		1 (0.7%)		134
Oldham	69 (50.4%)	33 (24.1%)	32 (23.4%)	1 (0.7%)		2 (1.5%)	137
Salford	230 (45.9%)	155 (30.9%)	99 (19.8%)	5 (1%)	2 (0.4%)	10 (2%)	501
Manchester	815 (48.8%)	440 (26.4%)	361 (21.6%)	6 (0.4%)	6 (0.4%)	41 (2.5%)	1669
Tameside & Glossop	65 (48.1%)	42 (31.1%)	26 (19.3%)	1 (0.7%)	1 (0.7%)		135
Trafford	75 (40.8%)	57 (31%)	49 (26.6%)		1 (0.5%)	2 (1.1%)	184
Stockport	60 (44.8%)	46 (34.3%)	27 (20.1%)		1 (0.7%)		134
Unknown Greater Manchester	5 (62.5%)	1 (12.5%)	2 (25%)				8
Sefton	42 (51.9%)	20 (24.7%)	18 (22.2%)			1 (1.2%)	81
Liverpool	275 (65%)	58 (13.7%)	76 (18%)	4 (0.9%)	1 (0.2%)	9 (2.1%)	423
Knowsley	20 (52.6%)	7 (18.4%)	10 (26.3%)			1 (2.6%)	38
Wirral	53 (39%)	41 (30.1%)	37 (27.2%)	2 (1.5%)	1 (0.7%)	2 (1.5%)	136
Halton & St Helens	43 (56.6%)	16 (21.1%)	15 (19.7%)	1 (1.3%)		1 (1.3%)	76
Unknown Merseyside	5 (62.5%)		3 (37.5%)				8
Warrington	54 (68.4%)	12 (15.2%)	11 (13.9%)	2 (2.5%)			79
Western Cheshire	81 (64.3%)	24 (19%)	19 (15.1%)			2 (1.6%)	126
Central and Eastern Cheshire	43 (31.4%)	37 (27%)	48 (35%)			9 (6.6%)	137
Isle of Man	8 (34.8%)	9 (39.1%)	6 (26.1%)				23
Out of Region	81 (40.3%)	55 (27.4%)	59 (29.4%)	1 (0.5%)	1 (0.5%)	4 (2%)	201
Abroad			1 (100%)				1
Unknown*	50 (64.9%)	10 (13%)	10 (13%)	1 (1.3%)		6 (7.8%)	77
Total	**2765 (47.9%)**	**1566 (27.2%)**	**1266 (22%)**	**31 (0.5%)**	**24 (0.4%)**	**115 (2%)**	**5767**

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
** Includes three people of no fixed abode and five who declined to give any residential information.*

4. Voluntary Agencies 2008

Voluntary organisations have long played a fundamental role in the recognition of HIV/AIDS and in addressing the needs of HIV positive individuals[75-76]. They are identified in the Department of Health's AIDS Service Grant circular as key providers of social care[77] and the Department of Health anticipates an increasing role for the voluntary 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 services*[78]. In the North West Region, voluntary agencies 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. The majority of agencies 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 services 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 the voluntary and statutory services and those accessing the statutory services alone[79]. These data show that the voluntary 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 voluntary agencies annually contribute one million pounds worth of services over and above those purchased by the statutory sector[27]. During 2008, 2,834 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by eight voluntary organisations in the region. The overall number of individuals seen by the voluntary sector in 2008 is 14% higher than in 2007 (2,834 compared with 2,494).

It is important to note that not all HIV/AIDS voluntary 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 and Body Positive Blackpool are not included in the tables, but nonetheless make a valuable contribution to the provision of care. Similarly, the amount of attributable data provided by each voluntary organisation do not necessarily reflect the overall service provision since agencies provide support for all those affected by HIV (including families, partners and carers of HIV positive people). For all voluntary 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 voluntary 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 individuals accessing care from individual voluntary agencies, whilst table 4.3 is concerned with those HIV positive individuals accessing voluntary care as a whole. Where appropriate, references are made to corresponding data from previous North West reports[1-12].

Voluntary agencies have contributed data to the North West HIV/AIDS Monitoring Unit since 1995 and consistently appear to provide services to a broader constituency than the statutory sector alone[1-12]. This year two organisations which are part of Drugline Lancs in Lancashire contributed data for the first time. Central Lancashire HIV Advice and Support Services (CLASS) are based in Preston and Sexual Health, HIV, Education and Responses (SHIVER) are based in Blackpool and the Fylde coast. CLASS offer holistic support and advice to individuals on issues including diagnosis and discrimination. SHIVER encompasses a number of sexual health focussed projects. In 2008 34% of individuals seen by voluntary organisations did not access care in the statutory sector and 24% of individuals have never been treated by the statutory sector in the North West.

Table 4.1 illustrates demographic information on the number of HIV positive individuals presenting to voluntary agencies in the North West during 2008, and the number who also presented at statutory agencies in the North West during 2008 or prior to 2008 (but not in 2008). Most agencies reporting recorded an increase in their client numbers compared with the previous year: Body Positive Cheshire and North Wales (BP Cheshire; 20% increase), Body Positive North West (BP North West; 16%), George House Trust (GHT; 16%) and Barnardo's in Manchester (BARM; 12%). Black Health Agency (BHA) saw a substantial decrease (63%) and Sahir House saw a small decrease (3%) on the previous year.

There is variation in the proportion of voluntary sector clients also seen by the statutory sector in 2008, ranging from three quarters (75%) at Sahir House to 39% at Barnardo's in Manchester. The vast majority of clients not in contact with statutory treatment centres in 2008 reside in the North West of England (99% for BARM, 48% BP Cheshire, 84% BP North West, 92% GHT, 94% Sahir and 100% for the remaining agencies; data not shown). A significant number of individuals have never been seen at statutory centres, for example, up to 324 individuals at GHT have apparently never been seen by the statutory sector. These data suggest that the voluntary sector may

be the sole provider of care and support for a substantial number of HIV positive individuals.

Table 4.1 also categorises individuals accessing voluntary care in 2008 according to infection route, sex, age group, ethnicity and residency. For half the voluntary services that provided data for 2008, the largest proportion of individuals presenting for support acquired HIV through sex between men (BP North West 66%, BP Cheshire 62%, GHT 57% and SHIVER 33%). The main route of infection for the other services was heterosexual sex (BHA 95%, BARM 75%, CLASS 50% and Sahir 47%) with a high proportion of female service users (76%, 80%, 60% and 43% respectively). BARM provides support for families with young people affected by HIV. In some cases the HIV positive client is a parent, in other cases the young person. Two voluntary organisations (BHA and CLASS) had no clients infected via injecting drug use. One organisation had a similar proportion to those attending statutory centres (2% at BP North West) (also 2% of all those seen by the statutory sector; chapter 3, table 3.2). Two organisations had higher proportions infected through injecting drug use than the statutory centres (3% at Sahir and BP Cheshire).

The majority of clients at all voluntary organisations were aged between 25 and 49 years. BARM treated the most clients aged 14 years or under (31 individuals, 16%), 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 voluntary agencies 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 voluntary services, the majority of individuals seen in 2008 were of white ethnicity, ranging from 89% at BP Cheshire to 63% each at GHT and 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 (612 individuals) an increase of 20% since 2007 (511 individuals).

For all the voluntary agencies, the majority of clients seen in 2008 were resident in the North West, ranging from 100% at CLASS and SHIVER to 80% at BP Cheshire. BP Cheshire was the only voluntary organisation with a significant proportion of HIV positive clients from outside the region (20%), reflecting the proximity of the organisation to Wales and the West Midlands.

Table 4.2 illustrates the crossover of care of HIV positive individuals between North West based voluntary agencies and the statutory organisations during 2008. The distribution of statutory treatment and care of voluntary agency clients reflects the geographical location of the voluntary agencies. However, the Infectious Disease Unit at North Manchester General Hospital (NMG), the largest HIV and AIDS treatment centre in the North West (chapter 3, table 3.9), accounts for a significant number of presentations by individuals accessing voluntary organisations across the whole region. In addition, MRIG saw 611 individuals who also visited the voluntary sector.

Table 4.3 illustrates the infection route, sex, ethnicity and residency status of HIV positive individuals accessing the voluntary sector in the North West in 2008 by attendance at the statutory sector during the year. 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 of those for whom the information is known. The predominant method of exposure to HIV amongst voluntary sector clients during 2008 was sex between men, accounting for 55% of cases. This is comparable to the 52% of individuals accessing the statutory sector for which method of exposure has been determined (chapter 3, table 3.2). A similar proportion of heterosexually exposed clients were seen at the voluntary sector (40%) compared to the statutory sector (41%: chapter 3, table 3.2). This has increased since 2001 when only 19% of voluntary sector clients were heterosexually exposed. In 2008, the vast majority of voluntary sector clients were male (71%), primarily due to the relatively high rates of HIV infection in MSM. As with HIV positive individuals accessing the statutory sector, the majority of voluntary sector clients are of white ethnicity (both 64%) but this varies between services (table 4.1).

Table 4.3 also shows that 34% of individuals (958 out of 2,834) using voluntary services did not attend a statutory sector service during 2008 and 24% 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 (39% compared to 60% accessing both the voluntary and statutory sector in 2008 and those individuals seen prior to but not in 2008) and more likely to be heterosexually infected (53% compared to 36%). They are more likely to be black African (44% compared to 26%) and more likely to be an asylum seeker (15% compared to 9%). Those who have attended the statutory sector in the past but not in 2008 are more likely to be male (79%), MSM (68%), white (70%) and a UK national (76%).

Table 4.1: Attendance by HIV positive individuals at voluntary organisations in the North West, by statutory sector attendance, sex, age group, infection route, ethnicity, residency status and North West residency, 2008

		Voluntary Agency							
		BARM	BHA	BP Cheshire	BP North West	CLASS	GHT	Sahir	SHIVER
Statutory Sector Attendance	Never Seen	119 (59.5%)	28 (47.5%)	37 (24.7%)	144 (14.7%)	2 (20%)	324 (17%)	31 (21.5%)	24 (55.8%)
	Seen in 2008	78 (39%)	28 (47.5%)	110 (73.3%)	715 (73%)	7 (70%)	1388 (72.9%)	108 (75%)	19 (44.2%)
	Seen Prior to 2008	3 (1.5%)	3 (5.1%)	3 (2%)	121 (12.3%)	1 (10%)	191 (10%)	5 (3.5%)	
Sex	Male	41 (20.5%)	14 (23.7%)	120 (80%)	790 (80.6%)	4 (40%)	1379 (72.5%)	82 (56.9%)	28 (65.1%)
	Female	159 (79.5%)	45 (76.3%)	30 (20%)	190 (19.4%)	6 (60%)	524 (27.5%)	62 (43.1%)	15 (34.9%)
Age Group	0-14	31 (15.5%)		1 (0.7%)	3 (0.3%)		19 (1%)	1 (0.7%)	
	15-19	17 (8.5%)			3 (0.3%)		15 (0.8%)		
	20-24	4 (2%)	2 (3.4%)	10 (6.7%)	17 (1.7%)		48 (2.5%)	6 (4.2%)	4 (9.3%)
	25-29	21 (10.5%)	7 (11.9%)	20 (13.3%)	64 (6.5%)	2 (20%)	172 (9%)	13 (9%)	5 (11.6%)
	30-34	34 (17%)	10 (16.9%)	23 (15.3%)	129 (13.2%)		315 (16.6%)	31 (21.5%)	7 (16.3%)
	35-39	42 (21%)	9 (15.3%)	25 (16.7%)	186 (19%)	1 (10%)	401 (21.1%)	28 (19.4%)	9 (20.9%)
	40-44	28 (14%)	13 (22%)	27 (18%)	230 (23.5%)	4 (40%)	398 (20.9%)	21 (14.6%)	8 (18.6%)
	45-49	16 (8%)	10 (16.9%)	20 (13.3%)	165 (16.8%)	1 (10%)	281 (14.8%)	27 (18.8%)	6 (14%)
	50-54	4 (2%)	1 (1.7%)	9 (6%)	96 (9.8%)		145 (7.6%)	9 (6.3%)	1 (2.3%)
	55-59	3 (1.5%)	2 (3.4%)	7 (4.7%)	58 (5.9%)		70 (3.7%)	7 (4.9%)	2 (4.7%)
	60+		5 (8.5%)	8 (5.3%)	29 (3%)	2 (20%)	39 (2%)	1 (0.7%)	1 (2.3%)
Infection Route	MSM	2 (1%)		93 (62%)	650 (66.3%)	3 (30%)	1089 (57.2%)	38 (26.4%)	14 (32.6%)
	Injecting drug use	2 (1%)		4 (2.7%)	18 (1.8%)		25 (1.3%)	4 (2.8%)	
	Heterosexual	150 (75%)	56 (94.9%)	48 (32%)	249 (25.4%)	5 (50%)	762 (40%)	68 (47.2%)	5 (11.6%)
	Blood/tissue	1 (0.5%)	1 (1.7%)	1 (0.7%)	23 (2.3%)			2 (1.4%)	
	Mother to child	45 (22.5%)			4 (0.4%)		25 (1.3%)	1 (0.7%)	
	Undetermined		2 (3.4%)	4 (2.7%)	36 (3.7%)	2 (20%)	2 (0.1%)	31 (21.5%)	24 (55.8%)
Ethnicity	White	14 (7%)		134 (89.3%)	747 (76.2%)	7 (70%)	1192 (62.6%)	91 (63.2%)	38 (88.4%)
	Black Caribbean		1 (1.7%)		9 (0.9%)		12 (0.6%)	1 (0.7%)	
	Black African	178 (89%)	58 (98.3%)	14 (9.3%)	124 (12.7%)	3 (30%)	612 (32.2%)	46 (31.9%)	2 (4.7%)
	Black Other			1 (0.7%)	23 (2.3%)		28 (1.5%)	1 (0.7%)	
	Indian/Pakistani/Bangladeshi	1 (0.5%)			7 (0.7%)		31 (1.6%)		
	Other Asian/Oriental	2 (1%)		1 (0.7%)	6 (0.6%)			5 (3.5%)	
	Other/Mixed	5 (2.5%)			64 (6.5%)		28 (1.5%)		2 (4.7%)
	Unknown								1 (2.3%)
Residency	UK National	28 (14%)	3 (5.1%)	124 (82.7%)	833 (85%)	9 (90%)	1221 (64.2%)	103 (71.5%)	43 (100%)
	Asylum Seeker	76 (38%)	38 (64.4%)	2 (1.3%)	75 (7.7%)	1 (10%)	135 (7.1%)	28 (19.4%)	
	Overseas Student		2 (3.4%)	1 (0.7%)	9 (0.9%)		49 (2.6%)		
	Migrant Worker		1 (1.7%)	14 (9.3%)	4 (0.4%)		101 (5.3%)		
	Temporary Visitor	11 (5.5%)	3 (5.1%)		19 (1.9%)		11 (0.6%)		
	Other	6 (3%)	4 (6.8%)	2 (1.3%)	11 (1.1%)		165 (8.7%)	1 (0.7%)	
	Refugee	51 (25.5%)	6 (10.2%)	2 (1.3%)	21 (2.1%)		221 (11.6%)	2 (1.4%)	
	Dependent	28 (14%)	2 (3.4%)	4 (2.7%)					
	Unknown			1 (0.7%)	8 (0.8%)			10 (6.9%)	
North West Resident	Resident outside North West	1 (0.5%)	1 (1.7%)	30 (20%)	57 (5.8%)		56 (2.9%)	3 (2.1%)	
	North West Resident	199 (99.5%)	58 (98.3%)	120 (80%)	923 (94.2%)	10 (100%)	1847 (97.1%)	141 (97.9%)	43 (100%)
	Total (100%)	**200**	**59**	**150**	**980**	**10**	**1903**	**144**	**43**

For a definition of the abbreviated voluntary agencies, please refer to the glossary at the back of the report.
Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the ages of individuals at the end of December 2008, or at death.

Table 4.2: Distribution of statutory treatment for HIV and AIDS cases presenting to voluntary organisations, 2008

Treatment Centre	Voluntary Agency							
	BARM	BHA	BP Cheshire	BP North West	CLASS	GHT	Sahir	SHIVER
AHC	1					1		
APH							10	
ARM				4		4	15	
BLAG			1	13	1	31	1	19
BLKG				5		26		
BOLG	3	1		19		52		
BOOT	6			1		5		
BURG				5	1	9		
BURY	2	2		5		11		
CHR			47	5		4	1	
CPED						1		
CUMB						4		
HAL			1			1		
LCN						6	33	
LEI			20	3		5		
MAC	1		11	2		7		
MGP			1	59		77		
MRIG	26	11	2	185		386	1	
MRIH				6		6		
NMG	42	12	9	346		593	3	
NMGG		2		20		38	1	
NOBL						1	1	
OLDG	1			33		18		
PG				5	7	27		
PP	1							
RLG	1		8	16		36	93	
RLH						1	1	
RLI	1			1		5		
ROCG	2			5		32		
SALG	1	1		14		55		
SHH			2	6		13	4	
SPG				3		5	2	
STP	1			22		40		
TAMG				9		11		
TRAG						1		
WAR			18	6		6		
WGH						2		
WIGG						1		
WITG	1	1		56		68		
WORK						4		

For a definition of the abbreviated treatment centres and voluntary agencies 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 voluntary agencies), thus exaggerating the totals.

Table 4.3: HIV and AIDS cases presenting to the voluntary sector and statutory sector by sex, infection route, ethnicity and residency status, 2008

		Statutory Sector Attendance			Total
		Never Seen	Seen in 2008	Seen Prior to 2008	
Sex	Male	386 (57.3%)	1387 (73.9%)	225 (79.2%)	1998 (70.5%)
	Female	288 (42.7%)	489 (26.1%)	59 (20.8%)	836 (29.5%)
Infection Route	MSM	225 (38.8%)	1094 (58.4%)	194 (68.3%)	1513 (55.3%)
	Injecting drug use	4 (0.7%)	38 (2%)	6 (2.1%)	48 (1.8%)
	Heterosexual	307 (52.9%)	705 (37.6%)	83 (29.2%)	1095 (40%)
	Blood/tissue	4 (0.7%)	10 (0.5%)	1 (0.4%)	15 (0.5%)
	Mother to child	40 (6.9%)	27 (1.4%)		67 (2.4%)
	Sub Total (100%)	**580**	**1874**	**284**	**2738**
	Undetermined	94	2		96
Ethnicity	White	324 (48.1%)	1280 (68.2%)	200 (70.4%)	1804 (63.7%)
	Black Caribbean	6 (0.9%)	13 (0.7%)	2 (0.7%)	21 (0.7%)
	Black African	299 (44.4%)	510 (27.2%)	56 (19.7%)	865 (30.5%)
	Black Other	9 (1.3%)	20 (1.1%)	9 (3.2%)	38 (1.3%)
	Indian/Pakistani/Bangladeshi	7 (1%)	24 (1.3%)	4 (1.4%)	35 (1.2%)
	Other Asian/Oriental	6 (0.9%)	5 (0.3%)	1 (0.4%)	12 (0.4%)
	Other/Mixed	22 (3.3%)	24 (1.3%)	12 (4.2%)	58 (2%)
	Sub Total (100%)	**673**	**1876**	**284**	**2833**
	Unknown	1			1
Residency	UK National	352 (53.4%)	1373 (73.3%)	215 (76%)	1940 (68.9%)
	Asylum Seeker	100 (15.2%)	178 (9.5%)	18 (6.4%)	296 (10.5%)
	Overseas Student	12 (1.8%)	29 (1.5%)	11 (3.9%)	52 (1.8%)
	Migrant Worker	32 (4.9%)	66 (3.5%)	8 (2.8%)	106 (3.8%)
	Temporary Visitor	18 (2.7%)	8 (0.4%)	4 (1.4%)	30 (1.1%)
	Other	51 (7.7%)	88 (4.7%)	7 (2.5%)	146 (5.2%)
	Refugee	75 (11.4%)	123 (6.6%)	20 (7.1%)	218 (7.7%)
	Dependent	19 (2.9%)	8 (0.4%)		27 (1%)
	Sub Total (100%)	**659**	**1873**	**283**	**2815**
	Unknown	15	3	1	19
	Total (100%)	**674**	**1876**	**284**	**2834**

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

5. Social Care Providers 2008

This is the seventh year that the North West HIV/AIDS Monitoring Unit has collected data related to the care and support of HIV positive individuals who access social service departments in the North West. Five social service departments were able to participate in this report. Data were collected on 219 individuals accessing HIV care and support in 2008. Information was also collected from Renaissance, part of the Manchester Methodist Housing Association, who provide housing and support services for individuals living with HIV in Manchester region.

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 2008/2009, £19.8 million was made available for English local authorities through the AIDS Support Grant. Of this, £1.7 million was allocated to North West local authorities (9% of the national allocation)[77]. It is important to note that not all individuals with HIV seen by each social service department may be reported as HIV positive. 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 service department who provided us with data by sex, infection route, residency status and statutory sector attendance. More men were reported to use social services than women, though a lower proportion than those accessing the statutory sector care (61% in social services compared to 72% in statutory; chapter 3, table 3.7). There was also a smaller percentage of people known to be HIV positive accessing social service care infected through sex between men (MSM)(26%) than in the statutory sector (52%) (chapter 3, table 3.2).

Within this dataset, a total of 101 individuals known to be non-UK nationals received care from social service departments. Nearly two thirds (64%; 16 individuals) of those with HIV seen by Stockport social service department were non-UK nationals, followed by 57% (61 individuals) by Manchester social services and 54% (14 individuals) by Bolton social service department. Table 5.1 also shows that 23% of individuals had not been seen in the statutory sector in the North West region since monitoring began in 1995. This indicates that social service departments may be the sole provider of care and support to those individuals who do not access statutory services.

Table 5.2 illustrates those social service attendees who also accessed North West voluntary organisations in 2008. Every social service department, with the exception of Blackburn with Darwen (who saw very few individuals) had at least one service user who also used voluntary services.

Table 5.3 illustrates the care provided by Renaissance, part of the Manchester Methodist Housing Association, categorised by infection route, and attendance in the statutory and voluntary sector. Data have been collected from Renaissance for the last four years and, for comparison, data for all four years is presented. The table shows that 84% of individuals using Renaissance housing in 2008 also accessed the voluntary services in 2008, with only five people not accessing the voluntary sector. The predominant route of infection for residents was MSM (63%), which is a slightly smaller proportion than seen in 2007 (73%). This is also much greater than the proportion of cases infected through MSM in the statutory sector (52%; chapter 3, table 3.2).

Table 5.1: HIV and AIDS cases presenting to five social service departments by sex, infection route, residency status and statutory sector attendance, 2008

		Social Service Department					Total
		Blackburn with Darwen	Bolton	Manchester	Salford	Stockport	
Sex	Male	1 (50%)	13 (50%)	58 (54.2%)	48 (81.4%)	14 (56%)	134 (61.2%)
	Female	1 (50%)	13 (50%)	49 (45.8%)	11 (18.6%)	11 (44%)	85 (38.8%)
Infection Route	MSM		5 (19.2%)	6 (5.6%)	40 (67.8%)	6 (24%)	57 (26%)
	Injecting Drug Use		2 (7.7%)	6 (5.6%)	2 (3.4%)		10 (4.6%)
	Heterosexual		16 (61.5%)	63 (58.9%)	17 (28.8%)	17 (68%)	113 (51.6%)
	Mother to Child		1 (3.8%)			1 (4%)	2 (0.9%)
	Undetermined	2 (100%)	2 (7.7%)	32 (29.9%)		1 (4%)	37 (16.9%)
Residency	UK National	2 (100%)	12 (46.2%)	43 (40.2%)	49 (83.1%)	7 (28%)	113 (51.6%)
	Asylum Seeker		5 (19.2%)	32 (29.9%)	7 (11.9%)	8 (32%)	52 (23.7%)
	Overseas Student			7 (6.5%)			7 (3.2%)
	Migrant Worker		1 (3.8%)	4 (3.7%)	1 (1.7%)	2 (8%)	8 (3.7%)
	Temporary Visitor		1 (3.8%)	8 (7.5%)			9 (4.1%)
	Dependent		7 (26.9%)	3 (2.8%)	2 (3.4%)	5 (20%)	17 (7.8%)
	Refugee			3 (2.8%)		1 (4%)	4 (1.8%)
	Other			4 (3.7%)			4 (1.8%)
	Unknown			3 (2.8%)		2 (8%)	5 (2.3%)
Statutory Sector Attendance	Never Seen		13 (50%)	19 (17.8%)	11 (18.6%)	7 (28%)	50 (22.8%)
	Seen in 2008	2 (100%)	13 (50%)	86 (80.4%)	44 (74.6%)	17 (68%)	162 (74%)
	Seen prior to 2008			2 (1.9%)	4 (6.8%)	1 (4%)	7 (3.2%)
	Total (100%)	**2**	**26**	**107**	**59**	**25**	**219**

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

Table 5.2: Distribution of social service care for HIV and AIDS cases presenting to voluntary organisations, 2008

	Voluntary Agency					
Social Service Department	**BARM**	**BHA**	**BP Cheshire**	**BP North West**	**GHT**	**Sahir**
Bolton	1			3	8	
Manchester	10	6	1	32	62	1
Salford	1			21	32	
Stockport	2			4	12	

Table 5.3: HIV and AIDS care provided by Renaissance housing association by statutory and voluntary sector attendance and infection route, 2008

		Year			
		2005	**2006**	**2007**	**2008**
Statutory sector attendance	Never seen		1 (4.2%)	2 (7.7%)	4 (12.5%)
	Seen prior to year of report		2 (8.3%)	1 (3.8%)	
	Seen in year of report	18 (100%)	21 (87.5%)	23 (88.5%)	28 (87.5%)
Voluntary sector attendance in same year	Not seen in year of report	5 (27.8%)	1 (4.2%)	2 (7.7%)	5 (15.6%)
	Seen in year of report	13 (72.2%)	23 (95.8%)	24 (92.3%)	27 (84.4%)
Infection Route	MSM	12 (66.7%)	16 (66.7%)	19 (73.1%)	20 (62.5%)
	Injecting Drug Use	1 (5.6%)	2 (8.3%)	2 (7.7%)	1 (3.1%)
	Heterosexual	5 (27.8%)	6 (25%)	5 (19.2%)	4 (12.5%)
	Unknown				7 (21.9%)
	Total (100%)	**18**	**24**	**26**	**32**

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 from 1996 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 469% since 1996 (from 1,014 individuals in 1996 to 5,767 individuals in 2008) (not shown). There has been a continued increase (11%) in the size of the HIV positive population from 2007 to 2008. This is slightly larger than the increase seen between 2006 and 2007 (9%), but not as large as those seen in previous years (2002 to 2003: 23%; 2003 to 2004: 20%; 2004 to 2005: 17%: 2005 to 2006: 13%; 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%). Between 2005 and 2006, new cases fell by 2%, followed by a larger decrease (10%) between 2006 and 2007. However, new cases increased again between 2007 and 2008 by 13% (table 6.1).

Figure 6.1 shows proportional changes in the number of new cases from 2000 to 2008 by route of HIV infection. Overall there has been an increase in new cases by 176% since 2000. However, the most striking change is the 401% increase in heterosexual infections. This is a trend that has been noted nationally[30] 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 103% between 2000 and 2008. This stresses the need to maintain and develop prevention strategies amongst this group. The number of infections acquired through IDU has declined over the years; this may partly be due to the early implementation of syringe exchange programmes across the North West. The data from 2008 show a 20% increase since 2000 of new cases of HIV transmitted through injecting drug use but also a 40% 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 2008 compared with 2000. The absolute numbers are relatively low (16 in 2008), therefore, care needs to be taken when interpreting a large percentage change 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).

Table 6.1 shows the infection route of new HIV and AIDS cases presenting in the North West from 2000 to 2008 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 2008. By 2008, almost half of new cases were infected via heterosexual sex (48%).

Across counties, Merseyside saw the largest increase in new cases since 2000 (220%), followed by Greater Manchester, which saw a 185% increase over the same period. Cumbria saw the greatest increase (35%) between 2007 and 2008, compared with a smaller increase in Merseyside (7%) and Greater Manchester (13%). The overall number of new heterosexual and MSM cases has risen since 2000 (401% and 103% respectively). All counties, with the exception of Lancashire, reported an increase in the number of new heterosexual infections since 2007. Only Merseyside and Cumbria reported a percentage decrease (9% and 13%, respectively) in the number of new MSM cases compared to 2007. The highest overall number of MSM cases remains in Greater Manchester. This is consistent with the fact that the Manchester area has a large gay community[80] and evidence of high levels of sexual risk behaviour (as revealed in investigations of the syphilis outbreak[81-85]). Despite decreases in the number of new cases infected through MSM overall between 2006 and 2007, this year there was an increase of 11%.

Figure 6.2 illustrates proportional changes in the level of antiretroviral therapy (ART) prescribed to HIV positive individuals attending treatment and care in the North West from 2000 to 2008. 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 drug, have all increased in line

with the increasing number of HIV cases. Mono and dual therapy use have declined, in line with research[86] and guidelines[74], which define triple or more antiretroviral drugs as the most effective form of therapy. The recent small increase in 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 2007 and 2008 show recent increases 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 2008 by county of residence. Between 2000 and 2008, those receiving triple or more therapy have varied between 63% and 70% of all cases. From 2000 to date, around one third of HIV positive individuals did not receive ART at the reporting time. Relatively few people are prescribed mono therapy and the number prescribed this level of therapy has decreased (by 75%) since 2007. 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[87], and remains a valid option for treatment during pregnancy (although the latest BHIVA guidelines are more complex)[46]. With the increase in the number of females with HIV infection, the use of mono therapy may continue to fluctuate in the future. The proportion taking dual therapy in 2008 remained constant since 2001 (less than 1% of all cases). Between 2000 and 2008, the largest percentage increase in the number of people in treatment for HIV was seen in Cumbria, rising from 12 to 123 (925%), followed by Greater Manchester (269%), Merseyside (257%), Cheshire (235%) and Lancashire (198%).

Table 6.3 shows the number of new cases of HIV and AIDS from 2003 to 2008 subdivided by LA of residence. In order to review six years of data, the LA of residence was reassigned for those seen in treatment and care in 2003 and 2004 (as data were presented by PCT prior to 2005). 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 2003 to 2008 (e.g. St Helens, Warrington and Pendle) are those that had very few cases in 2003.

Table 6.4 shows data for all cases of HIV and AIDS presenting to North West treatment centres from 2003 to 2008, 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 in cases since 2003 at 108%, followed by an increase of 102% in Greater Manchester, 93% in Merseyside, 92% in Cheshire and 74% in Lancashire. Manchester LA had the largest number of HIV positive residents in 2008 (1,669 individuals; a 99% increase since 2003). None of the LAs had fewer than ten cases of HIV in 2008. The largest percentage increases on 2003 were seen in Barrow-in-Furness (from 3 to 15; 400%), Ribble Valley (from 4 to 13; 225%); Wigan (from 41 to 123; 200%) and in Knowsley (from 13 to 38; 192%). Since 2003 the number of HIV positive people seen at North West treatment centres who reside outside the region has increased to 78% (from 116 to 207 individuals).

Figure 6.1: Percentage change in new cases of HIV and AIDS by infection route of HIV, 2000-2008

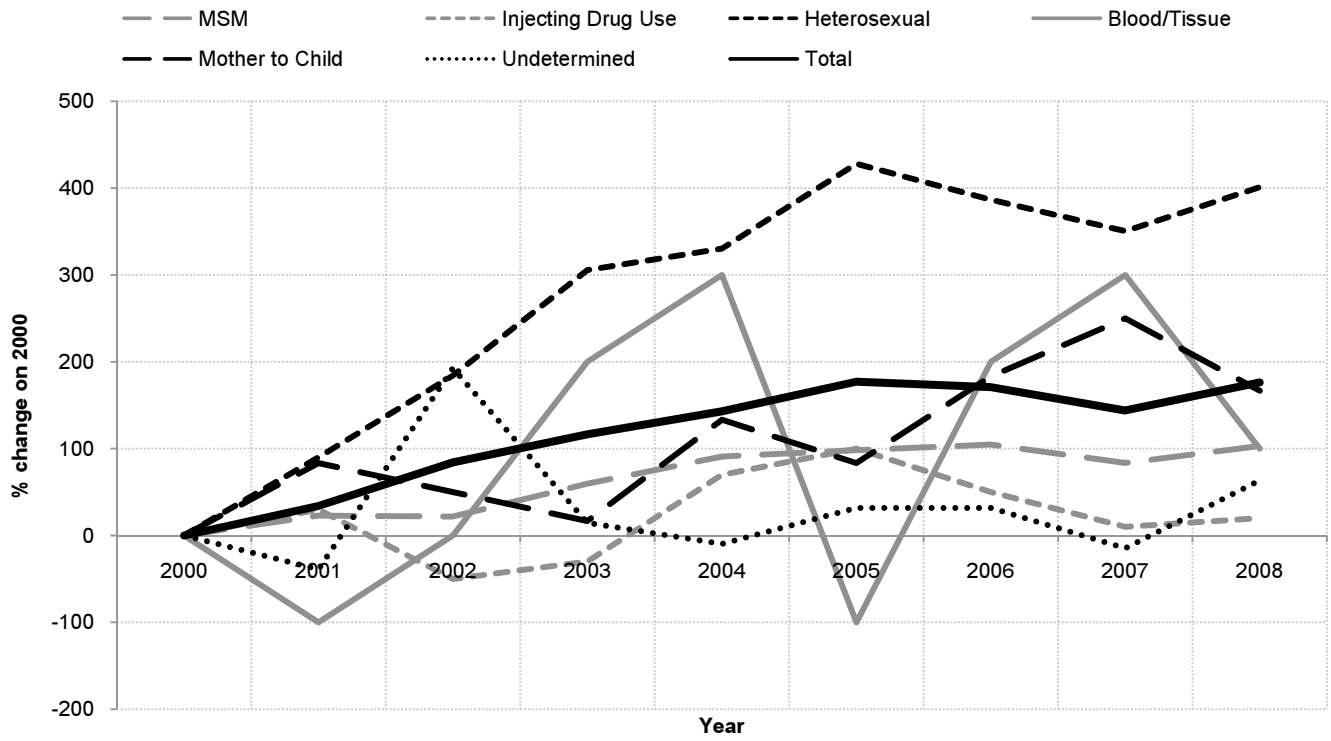


Figure 6.2: Percentage change in total HIV and AIDS cases by level of antiretroviral therapy, 2000-2008

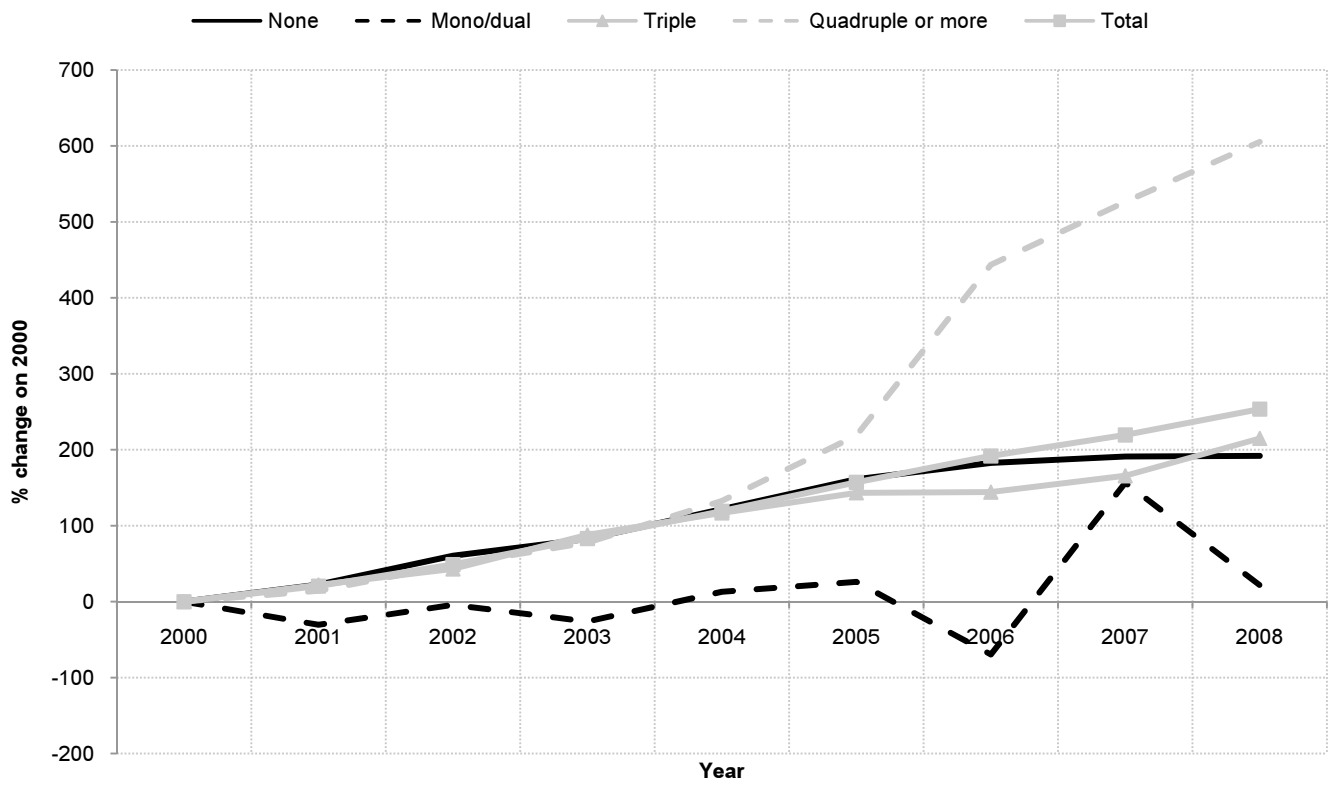


Table 6.1: Number of new HIV and AIDS cases by infection route of HIV and county of residence, 2000-2008

	Infection Route	Year									% Change 2000-2008	% Change 2007-2008
		2000	2001	2002	2003	2004	2005	2006	2007	2008		
Cumbria	MSM		3	5	4	6	10	8	8	7		-13
	Injecting Drug Use			1		1			1	1		
	Heterosexual		6	4	4	3	1	5	6	14		133
	Blood/Tissue							1	1			-100
	Mother to Child								1			-100
	Undetermined				2	1	1	2		1		
	Cumbria Total		**9**	**10**	**10**	**11**	**12**	**16**	**17**	**23**		**35**
Lancashire	MSM	32	47	24	58	64	68	48	38	59	84	55
	Injecting Drug Use		5	2		1	3	3	1			-100
	Heterosexual	13	18	35	31	39	33	42	44	42	223	-5
	Blood/Tissue					1				1		
	Mother to Child	2	3					2	1	1	-50	0
	Undetermined	1	5	26		1	5	11	5	7	600	40
	Lancashire Total	**48**	**78**	**87**	**89**	**106**	**109**	**106**	**89**	**110**	**129**	**24**
Greater Manchester	MSM	112	127	144	168	209	208	241	190	207	85	9
	Injecting Drug Use	3	4		3	11	9	9	7	6	100	-14
	Heterosexual	37	93	145	219	226	288	278	239	269	627	13
	Blood/Tissue			1	3	1			2			-100
	Mother to Child		7	8	6	10	6	12	10	10		0
	Undetermined	31	11	57	18	23	26	24	13	30	-3	131
	Greater Manchester Total	**183**	**242**	**355**	**417**	**480**	**537**	**564**	**461**	**522**	**185**	**13**
Merseyside	MSM	10	18	17	21	31	18	33	43	39	290	-9
	Injecting Drug Use	4	1		1	2	5	2	1	2	-50	100
	Heterosexual	24	19	50	68	65	81	68	63	70	192	11
	Blood/Tissue	1									-100	
	Mother to Child			1	1	1	3	2	5	3		-40
	Undetermined	1	2	15	18	1	12	10	8	14	1300	75
	Merseyside Total	**40**	**40**	**83**	**109**	**100**	**119**	**115**	**120**	**128**	**220**	**7**
Cheshire	MSM	16	14	23	20	10	25	26	29	38	138	31
	Injecting Drug Use	1	2	2	2	1	1			1	0	
	Heterosexual	6	11	8	13	17	18	18	25	28	367	12
	Blood/Tissue					1			1			-100
	Mother to Child	1	1				2		3	1	0	-67
	Undetermined	1	1	7	4	1	2	4	1	3	200	200
	Cheshire Total	**25**	**29**	**40**	**39**	**30**	**48**	**48**	**59**	**71**	**184**	**20**
Total North West Residents	MSM	172	209	213	271	321	329	356	308	350	103	14
	Injecting Drug Use	8	12	5	6	16	18	14	10	10	25	0
	Heterosexual	80	147	243	335	351	421	411	377	423	429	12
	Blood/Tissue	1		1	3	2		1	4	1	0	-75
	Mother to Child	3	11	9	7	12	11	16	20	15	400	-25
	Undetermined	34	19	105	42	27	46	51	27	55	62	104
	Total	**298**	**398**	**576**	**664**	**729**	**825**	**849**	**746**	**854**	**187**	**14**
Total	MSM	188	231	229	300	359	373	385	345	382	103	11
	Injecting Drug Use	10	13	5	7	17	20	15	11	12	20	9
	Heterosexual	89	169	253	361	383	470	433	401	446	401	11
	Blood/Tissue	1		1	3	4		3	4	2	100	-50
	Mother to Child	6	11	9	7	14	11	17	21	16	167	-24
	Undetermined	41	25	120	47	37	54	54	35	67	63	91
	Total	**335**	**449**	**617**	**725**	**814**	**928**	**907**	**817**	**925**	**176**	**13**

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

Table 6.2: Total number of HIV and AIDS cases by level of antiretroviral therapy and county of residence, 2000-2008

	ART	Year									% Change 2000-2008	% Change 2007-2008
		2000	2001	2002	2003	2004	2005	2006	2007	2008		
Cumbria	None	2	11	16	21	28	27	26	29	34	1600	17
	Mono				1							
	Triple	10	35	31	31	29	36	43	51	59	490	16
	Quadruple or more		5	4	6	8	13	20	26	30		15
	Cumbria Total	**12**	**51**	**51**	**59**	**65**	**76**	**89**	**106**	**123**	**925**	**16**
Lancashire	None	77	104	122	129	304	207	209	190	184	139	-3
	Mono				2		1					
	Dual	13	8	8	3	1	4	1	4		-100	-100
	Triple	142	181	223	283	211	319	342	385	418	194	9
	Quadruple or more	41	43	55	52	42	95	157	185	212	417	15
	Lancashire Total	**273**	**336**	**408**	**469**	**558**	**626**	**709**	**764**	**814**	**198**	**7**
Greater Manchester	None	328	397	537	566	753	840	955	988	993	203	1
	Mono			1	1	8	6	2	4	2		-50
	Dual	3	1	7	2	5	4	1	21	2	-33	-90
	Triple	468	566	660	932	1091	1264	1207	1240	1494	219	20
	Quadruple or more	127	132	158	192	223	353	693	822	927	630	13
	Greater Manchester Total	**926**	**1096**	**1363**	**1693**	**2080**	**2467**	**2858**	**3075**	**3418**	**269**	**11**
Merseyside	None	69	77	96	149	155	181	202	211	218	216	3
	Mono			1	3	2	4		17	3		-82
	Dual	1	3	2	1	3	2		5	13	1200	160
	Triple	120	118	146	169	180	203	243	301	376	213	25
	Quadruple or more	16	22	48	59	86	118	142	130	126	688	-3
	Merseyside Total	**206**	**220**	**293**	**381**	**426**	**508**	**587**	**664**	**736**	**257**	**11**
Cheshire	None	38	43	53	63	64	73	85	95	90	137	-5
	Mono			1			1		1			-100
	Dual	2	1				2	2	1	1	-50	0
	Triple	60	74	87	99	106	128	142	166	207	245	25
	Quadruple or more	10	14	23	30	28	35	45	57	70	600	23
	Cheshire Total	**110**	**132**	**164**	**192**	**198**	**239**	**274**	**320**	**368**	**235**	**15**
Total North West Residents	None	516	632	825	929	1306	1328	1477	1513	1519	194	0
	Mono			3	7	10	12	2	22	5		-77
	Dual	19	13	17	6	9	12	4	31	16	-16	-48
	Triple	805	975	1147	1514	1625	1950	1977	2143	2554	217	19
	Quadruple or more	198	216	288	339	389	614	1057	1220	1365	589	12
	Total	**1538**	**1836**	**2280**	**2795**	**3339**	**3916**	**4517**	**4929**	**5459**	**255**	**11**
Total	None	552	675	885	1007	1224	1441	1560	1606	1611	192	0
	Mono			3	9	12	15	2	24	6		-75
	Dual	23	16	19	8	14	14	5	35	22	-4	-37
	Triple	852	1039	1218	1600	1847	2072	2080	2263	2682	215	19
	Quadruple or more	205	234	304	364	477	653	1114	1284	1446	605	13
	Total	**1632**	**1964**	**2429**	**2988**	**3574**	**4195**	**4761**	**5212**	**5767**	**253**	**11**

Table 6.3: New cases of HIV and AIDS by local authority of residence, 2003-2008

	Local Authority of Residence	Year						% change 2003-2008	% change 2007-2008
		2003	2004	2005	2006	2007	2008		
Cumbria	Carlisle	4	4	1	3	3	6	50	100
	Allerdale	3	1	3	2	3	2	-33	-33
	Eden	3	1	3	5		3	0	
	Copeland		2	3	2	2	2		0
	South Lakeland		2	2	2	5	6		20
	Barrow-in-Furness		1		2	4	4		0
	Cumbria Total	**10**	**11**	**12**	**16**	**17**	**23**	**130**	**35**
Lancashire	Lancaster	2	4	5	7	3	5	150	67
	Wyre	4	1	3	8	3	5	25	67
	Fylde	5	8	7	6	7	5	0	-29
	Blackpool	36	40	55	42	29	41	14	41
	Blackburn with Darwen	10	12	9	8	15	13	30	-13
	Ribble Valley	2	3	5	3	1		-100	-100
	Pendle	2	1	1	2	4	6	200	50
	Hyndburn	3	3	2	7	1	8	167	700
	Burnley	2	3	3	5	6	5	150	-17
	Rossendale		4	2	2	1	2		100
	Preston	14	11	11	5	14	6	-57	-57
	South Ribble	3	5	4	3		5	67	
	Chorley	3	1	2	6	1	7	133	600
	West Lancashire	2	5		2	4	2	0	-50
	Unknown Lancashire	1	5					-100	
	Lancashire Total	**89**	**106**	**109**	**106**	**89**	**110**	**24**	**24**
Greater Manchester	Wigan	10	18	18	18	18	18	80	0
	Bolton	28	27	53	21	41	48	71	17
	Bury	24	14	24	27	9	26	8	189
	Rochdale	7	22	20	23	27	20	186	-26
	Oldham	17	13	13	21	27	31	82	15
	Salford	66	67	72	91	68	74	12	9
	Manchester	212	241	268	283	209	249	17	19
	Tameside	13	18	24	20	11	20	54	82
	Trafford	21	26	32	30	32	20	-5	-38
	Stockport	17	18	12	27	13	13	-24	0
	Unknown Greater Manchester	2	16	1	3	6	3	50	-50
	Greater Manchester Total	**417**	**480**	**537**	**564**	**461**	**522**	**25**	**13**
Merseyside	Sefton	14	8	18	16	13	13	-7	0
	Liverpool	73	59	74	67	74	81	11	9
	Knowsley	3		2	4	4	6	100	50
	Wirral	7	21	20	17	22	20	186	-9
	St Helens	1	5	4	9	6	7	600	17
	Unknown Merseyside	11	7	1	2	1	1	-91	0
	Merseyside Total	**109**	**100**	**119**	**115**	**120**	**128**	**17**	**7**
Cheshire	Halton	2	1	6	7	4	2	0	-50
	Warrington	6	4	9	7	11	19	217	73
	Cheshire West and Chester*	14	16	17	20	26	18	29	-31
	Cheshire East**	17	7	16	14	18	32	88	78
	Unknown Cheshire		4						
	Cheshire Total	**39**	**32**	**48**	**48**	**59**	**71**	**82**	**20**
	Total North West Residents	**664**	**729**	**825**	**849**	**746**	**854**	**29**	**14**
	Isle of Man	5	5	2	4	2	2	-60	0
	Out of Region	14	32	20	25	39	30	114	-23
	Abroad		4			2			-100
	Unknown	42	44	81	29	28	39	-7	39
	Total	**725**	**814**	**928**	**907**	**817**	**925**	**28**	**13**

**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, 2003-2008

	Local Authority of Residence	Year						% change 2003-2008	% change 2007-2008
		2003	2004	2005	2006	2007	2008		
Cumbria	Carlisle	20	21	20	22	26	30	50	15
	Allerdale	10	10	12	12	16	18	80	13
	Eden	7	7	10	14	13	15	114	15
	Copeland	8	11	13	11	13	15	88	15
	South Lakeland	11	13	17	20	24	29	164	21
	Barrow-in-Furness	3	3	4	8	13	15	400	15
	Unknown Cumbria				2	1	1		0
	Cumbria Total	**59**	**65**	**76**	**89**	**106**	**123**	**108**	**16**
Lancashire	Lancaster	15	21	26	34	35	34	127	-3
	Wyre	31	35	38	44	46	49	58	7
	Fylde	24	30	35	42	46	49	104	7
	Blackpool	175	206	249	269	291	315	80	8
	Blackburn with Darwen	38	50	53	60	70	78	105	11
	Ribble Valley	4	7	12	14	14	13	225	-7
	Pendle	9	9	11	12	16	20	122	25
	Hyndburn	20	19	21	26	21	28	40	33
	Burnley	11	13	16	24	27	27	145	0
	Rossendale	13	18	17	21	24	25	92	4
	Preston	77	79	83	86	96	96	25	0
	South Ribble	15	23	24	31	29	29	93	0
	Chorley	13	12	13	18	17	22	69	29
	West Lancashire	19	24	26	27	26	27	42	4
	Unknown Lancashire	5	13	2	1	6	2	-60	-67
	Lancashire Total	**469**	**559**	**626**	**709**	**764**	**814**	**74**	**7**
Greater Manchester	Wigan	41	55	70	86	105	123	200	17
	Bolton	117	136	177	181	208	233	99	12
	Bury	86	92	123	139	151	166	93	10
	Rochdale	63	82	98	123	133	134	113	1
	Oldham	55	65	74	89	110	137	149	25
	Salford	238	283	354	424	443	501	111	13
	Manchester	838	1037	1227	1404	1505	1669	99	11
	Tameside	64	77	96	111	108	129	102	19
	Trafford	95	120	144	160	179	184	94	3
	Stockport	86	94	98	135	123	134	56	9
	Unknown Greater Manchester	11	39	6	6	10	8	-27	-20
	Greater Manchester Total	**1694**	**2080**	**2467**	**2858**	**3075**	**3418**	**102**	**11**
Merseyside	Sefton	49	46	72	75	83	81	65	-2
	Liverpool	203	205	278	330	375	423	108	13
	Knowsley	13	13	19	26	29	38	192	31
	Wirral	74	90	103	110	126	136	84	8
	St Helens	24	26	33	40	44	50	108	14
	Unknown Merseyside	18	48	3	6	7	8	-56	14
	Merseyside Total	**381**	**428**	**508**	**587**	**664**	**736**	**93**	**11**
Cheshire	Halton	16	15	25	29	30	26	63	-13
	Warrington	33	34	48	53	65	79	139	22
	Cheshire West and Chester*	72	85	93	110	135	150	108	11
	Cheshire East**	66	60	70	81	90	113	71	26
	Unknown Cheshire	5	11	3	1			-100	
	Cheshire Total	**192**	**205**	**239**	**274**	**320**	**368**	**92**	**15**
	Total North West Residents	**2795**	**3339**	**3916**	**4517**	**4929**	**5459**	**95**	**11**
	Isle of Man	16	19	18	19	21	23	44	10
	Out of Region	116	134	135	165	191	207	78	8
	Abroad	1	8	2	3	3	1	0	-67
	Unknown	60	74	124	57	68	77	28	13
	Total	**2988**	**3574**	**4195**	**4761**	**5212**	**5767**	**93**	**11**

**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, 1st Floor, Musker Buildings, 1 Stanley St, Liverpool, L1 6AA. Tel: (0151) 227 1893

BLAG Blackpool Victoria Hospital, Department of GUM, Whinney Heys Road, Blackpool, Lancashire, FY3 8NR. Tel: (01253) 300 000

BLK Blackburn Royal Infirmary, Haslingden Road, Blackburn, BB2 3HH. Tel: (0154) 263 555

BLKG Blackburn Royal Infirmary, Department of GUM, Haslingden Road, Blackburn, BB2 3HH. Tel: (01254) 734 207

BOLG Royal Bolton Hospital, Bolton Centre for Sexual Health, Minerva Road, Farnworth, Bolton, BL4 0JR. Tel: (01204) 390 390

BOOT Booth Hall Children's Hospital, Charlestown Road, Blackley, Manchester, M9 7AA. Tel: (0161) 795 7000

BURG GUM Clinic, St Peter's Centre, Church St, Burnley, Lancashire, BB11 2DL. Tel: (01282) 646 297

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) 365 000

CPED West Cumberland Hospital, Department of Paediatrics, Hensingham, Whitehaven, Cumbria, CA28 8JG. Tel: (01946) 693 181

CUMB Cumberland Infirmary, Department of GUM, Newtown Road, Carlisle, CA2 7HY. Tel: (01228) 523 444

FGH Furness General Hospital, Dalton Lane, Barrow in Furness, Cumbria, LA14 4LF. Tel: (01229) 870 870

HAL Halton General Hospital, Department of GUM, Hospital Way, Runcorn, Cheshire. WA7 2DA, Tel: (01928) 714 567

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) 255 141

MAC Macclesfield GUM, Assura Health & Wellbeing Centre, Sunderland Street, Macclesfield, Cheshire, SK11 6JL. Tel: (01625) 264 116

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, Heathersage Centre, Oxford Road, Manchester, M13 9WL. Tel: (0161) 276 1234

MRIH Manchester Royal Infirmary, Department of Haematology, Oxford Road, Manchester, M13 9WL. Tel: (0161) 276 1234

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) 650 000

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, Prescot Street, Liverpool, L7 8XP. Tel: (0151) 706 2000

RLH Royal Liverpool University Hospital, Roald Dahl Haemostasis and Thrombosis Centre, Prescot 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, Baillie Street Health Centre, Baillie Street, Rochdale, OL16 1XS. Tel: (01706) 517 655

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) 458 383

SPG Southport & Formby District General Hospital, Department of GUM, Town Lane, Southport, Merseyside, PR8 6PN. Tel: (01704) 547 471

STP Stepping Hill Hospital, Department of GUM, Poplar Grove, Stockport, Cheshire SK2 7JE. Tel: (0161) 483 1010

TAMG Tameside 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) 635 911

WGH Westmorland General Hospital, Outpatients Department, Burton Road, Kendal, Cumbria, LA9 7RG. Tel: (01539) 732 288

WHIT West Cumberland Hospital, Department of Haematology, Hensingham, Whitehaven, Cumbria, CA28 8JG. Tel: (01946) 693 181

WIGG Wigan Health Centre, Department of GUM, Boston House, Frog Lane, Wigan, WN6 7BL. Tel: (01942) 244 000

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) 705 000

Voluntary Agencies

BARM	Barnardo's (Manchester)	Tel: (0161) 273 2901
BHA	The Black Health Agency	Tel: (0161) 226 9145
BP Cheshire	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

Social Service Departments

Blackburn with Darwen	Tel: (01254) 585585
Bolton	Tel: (01204) 337 2820
Manchester	Tel: (0161) 255 8250
Salford	Tel: (0161) 607 6999
Stockport	Tel: (0161) 443 4320

Additional providers of HIV care

Renaissance, Manchester Methodist Housing Association	Tel: (01204) 365 711

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

References

1. McCullagh J, Syed Q, and Bellis MA (1997) HIV and AIDS in the North West of England 1996. University of Liverpool, Department of Public Health.

2. McVeigh J, Rimmer P, Syed Q and Bellis MA (1998) HIV and AIDS in the North West of England 1997. Liverpool John Moores University, Public Health Sector.

3. McVeigh J, Rimmer P, Syed Q and Bellis MA (1999) HIV and AIDS in the North West of England 1998. Liverpool John Moores University, Public Health Sector.

4. McVeigh J, Cook PA, Rimmer P, Syed Q and Bellis MA (2000) HIV and AIDS in the North West of England 1999. Liverpool John Moores University, Public Health Sector.

5. Cook PA, Rimmer P, Towle A, Syed, Q and Bellis MA (2001) HIV and AIDS in the North West of England 2000. Liverpool John Moores University, Public Health Sector.

6. Cook PA, Towle A, Rimmer P, Mitchell SC, Syed Q and Bellis MA (2002) HIV and AIDS in the North West of England 2001. Liverpool John Moores University, Public Health Sector.

7. Cook PA, Downing J, Hunt G, Syed Q and Bellis MA (2003) HIV and AIDS in the North West of England 2002. Liverpool John Moores University, Centre for Public Health.

8. Cook, PA, Downing J, Duckett A, Clark P, Syed Q and Bellis MA (2004) HIV and AIDS in the North West of England 2003. Liverpool John Moores University, Centre for Public Health.

9. Cook PA, Downing J, Rimmer P, Hargreaves SC, Jones A, Ashton M, Syed Q and Bellis MA (2005) HIV and AIDS in the North West of England 2004. Liverpool John Moores University, Centre for Public Health.

10. Cook PA, Downing J, Hargreaves SC, Madden H, Syed Q and Bellis MA (2006) HIV and AIDS in the North West of England 2005. Liverpool John Moores University, Centre for Public Health.

11. Downing J, Cook PA, Madden H, Hargreaves SC, Jones L, Syed Q and Bellis MA (2007) HIV and AIDS in the North West of England 2006. Liverpool John Moores University, Centre for Public Health.

12. Downing, J, Madden H, Jones L, Hargreaves SC, Cook PA, Phillips-Howard PA, Syed Q and Bellis MA (2008) HIV and AIDS in the North West of England 2007. Liverpool John Moores University, Centre for Public Health.

13. Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008) Report on the global AIDS epidemic 2008. UNAIDS.

14. Piot P, Kazatchkine M, Dybul M and Lob-Levyt J (2009) AIDS: lessons learnt and myths dispelled. Lancet, (09): p. 60321-4.

15. Smart T (2009) Appropriate prevention and care services for men who have sex with men and transgender people in resource-limited settings. HIV & AIDS Treatment in Practice (HATiP). 138: p. 2-8.

16. de Walque D (2007) Sero-discordant couples in five African countries: implications for prevention strategies. Population and Development Review. 33(3): p. 501-523.

17. Smart T (2009) HIV prevalence among South African MSM twice as high as general population. HIV & AIDS Treatment in Practice (HATiP). 138: p. 8-11.

18. Sanders E, Graham S, Okuhu H, van der Elst E, Muhaaru A, Davies A, Peshu N, Price M and McClelland R (2007) HIV-1 infection in high risk men who have sex with men in Mombasa, Kenya. AIDS. 21: p. 2513-2520.

19. Piot P, Bartos M, Larson H, Zewdie D and Mane P (2008) Coming to terms with complexity: a call to action for HIV prevention. Lancet. 372(9641): p. 845-59.

20. Rhodes T, Sarang A, Bobrik A, Bobkov E and Platt L (2004) HIV transmission and HIV prevention associated with injecting drug use in the Russian Federation. International Journal of Drug Policy. 15(1): p. 1-16.

21. World Health Organisation (WHO) (2007)Towards Universal Access. Scaling up priority HIV/AIDS Interventions in the Health Sector; Progress Report. WHO.

22. World Health Organisation (WHO) (2007) New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications.WHO/UNAIDS.

23. Health Protection Agency (HPA) (2009) Centre for Infections and Health Protection Scotland, Unpublished HIV Diagnoses Surveillance Tables 02:2008. Centre for Infections, HPA.

24. Health Protection Agency (HPA) (2007) New HIV Diagnosis Surveillance Tables. UK Data to the End of December 2007. No.77:07/4. Centre for Infections, HPA.

25. Bellis MA, McCullagh J, Thomson R, Regan D, Syed Q and Kelly T (1997) Inequality in funding for AIDS across England threatens regional services. British Medical Journal, (315): p. 950-1.

26. Bellis MA, McVeigh J, Thomson R and Syed Q (1999) The National Lottery. Health Service Journal: p. 22-3.

27. Cosgrove P, Lyons M and Bellis MA (2001) Economics of HIV and AIDS in the North West of England. Liverpool John Moores University, Public Health Sector.

28. Cosgrove P, Thomson R and Bellis MA (2000) Equitable Strife. Health Service Journal, (4): p. 23.

29. Nicoll A, Gill O, Peckham C, Ades A, Parry J and Mortimer P (2000) The public health applications of Unliked Anonymous Seroprevalence Monitoring for HIV in the United Kingdom. International Journal of Epidemiology, (29): p. 1-10.

30. Health Protection Agency (HPA) (2008) HIV in the United Kingdom: 2008 Report. Centre for Infections, HPA.

31. Dougan S, Evans B, MacDonald N, Goldberg D, Gill O, Fenton K, et al. (2008) HIV in gay and bisexual men in the United Kingdom: 25 years of public health surveliance. Epidemiology and Infection, (136): p. 145-56.

32. Dougan S, Elford J, Chadborn T, Brown A, Roy K, Murphy G, et al. (2007) Does the recent increase in HIV diagnoses among men who have sex with men in the UK reflect a rise in HIV incidence or increased uptake of HIV testing? Sexually Transmitted Infections, (83): p. 120-5.

33. Weatherburn P, Hickson F, Reid D, Jessup K and Hammond G (2008) Multiple Chances: Findings from the United Kingdom Gay Men's Sex Survey 2006. Sigma Research.

34. Health Protection Agency (HPA) (2009) Unlinked Anonymous HIV Prevalence Monitoring Programme, England. Alignment of data from Dried Blood Spot Survey of newborn infants with RCOG reports of live births to HIV infected women to end of 2007. Preliminary data.Centre for Infections, HPA.

35. Goldin C (1994) Stigmatization and AIDS: critical issues in public health. Social Science and Medicine, (39): p. 1359-66.

36. Dodds C (2006) HIV-related stigma in England: experiences of gay men and heterosexual African migrants living with HIV. Journal of Community & Applied Social Psychology, (16): p. 472-80.

37. Health Protection Agency (HPA) (2008) Supplementary data tables of the Unlinked Anonymous Prevalence Monitoring Programme: data to the end of 2007 IDUs Survey: Surveillance Update 2008. Centre for Infections, HPA.

38. Cook PA, McVeigh J, Patel A, Syed Q, Mutton K and Bellis MA (2000) Hepatitis C in injecting drug users in the North West: a multi-agency study. Liverpool John Moores University, Public Health Sector.

39. Cook PA and Hargreaves SC (2007) Inequalities in HIV, in: Downing J, Cook PA and Bellis MA Ten Years of Mointoring HIV and AIDS in the North West of England. Liverpool John Moores University, Centre for Public Health.

40. Stimson G (1998) Harm reduction in action: putting theory into practice. International Journal of Drug Policy, (9): p. 401-409.

41. Mortimer J and Spooner R (1997) HIV infection transmitted through blood product treatment, blood transfusion and tissue transplantation. Communicable Disease Review CDR Review, (7): p. R130-R132.

42. Regan F, Hewitt P, Barbara J and Contreras M (2000) Prospective investigation of transfusion transmitted infection in recipients of over 20,000 units of blood. British Medical Journal, (320): p. 403-406.

43. Sabin C, Phillips A, Yee T, Griffioen A and Lee C (2005) Twenty five years of HIV infection in haemophilic men in Britain: an observational study. British Medical Journal, (331): p. 997-998.

44. Gibb D, Duong T, Tookey P, Sharland M, Tudor-Williams G, Novelli et al. (2003) Decline in mortality, AIDS, and hospital admissions in perinatally HIV-1 infected children in the United Kingdom and Ireland. British Medical Journal, (327): p. 1019-0.

45. Duong T, Ades A, Gibb D, Tookey P and Masters J (1999) Vertical transmission rates for HIV in the British Isles: estimates based on surveillance data. British Medical Journal, (319): p. 1227-9.

46. de Ruiter A, Mercey D, Anderson J, Chakraborty R, Clayden P, Foster G, et al. (2008) British HIV Association and Children's HIV Association guidelines for the management of HIV infection in pregnant women 2008. HIV Medicine, 9: p. 452-502.

47. NHS Executive (1999) Reducing mother baby transmission of HIV. Health Service Circular HSC 1999/183.

48. Communicable Disease Surveillance Centre (2002) Proportions of maternal HIV infections diagnosed: monitoring performance towards national targets. CDR Weekly; 12(17).

49. Health Protection Agency (HPA) (2008) North West Regional Epidemiology, Antenatal Screening of Infectious Diseases in the North West Annual Report 2007.

50. Prime K, Jungmann E and Edwards S (2004) Decline in mortality in children with HIV in the UK and Ireland: HIV positive adolescents urgently need dedicated services British Medical Journal, (328): p. 524.

51. Salama P and Dondero T (2001) HIV surveillance in complex emergencies. AIDS, (15): p. S4-S12.

52. Department of Health (DH) (2009) Letter to Chief Executive from David Flory, Director General NHS Finance, Performance and Operations. Gateway Reference Number 11628. DH.

53. Department of Health (DH) (2009) Table of entitlement to NHS treatment, updated 3rd April 2009. DH.

54. Creighton S, Sethi G, Edwards S and Miller R (2004) Dispersal of HIV positive asylum seekers: national survey of UK healthcare providers. British Medical Journal, (329): p. 322-3.

55. All Party Parliamentary Group on AIDS (APPGA) (2003) Migration and HIV: improving lives in Britain. An inquiry into the impact of the UK nationality and immigration system on people living with HIV. APPGA.

56. National AIDS Trust (NAT) (2006) Dispersal of asylum seekers. NAT.

57. British HIV Association (BHIVA) and National AIDS Trust (NAT) (2009) Detention, Removal, and People Living with HIV, BHIVA and NAT.

58. Home Office and Office for National Statistics (ONS) (2009) Control of immigration: quarterly statistical summary, United Kingdom. Home Office.

59. Home Office (2008) Home Office Asylum Statistics: 1st quarter 2008 United Kingdom. Home Office.

60. Health Protection Agency (HPA) (2009) North West HIV New Diagnoses to end of December 2008, 2:2008. Centre for Infections, HPA.

61. Health Protection Agency (HPA) (2009) Selected STI diagnoses (numbers and rates) from GUM clinics in the UK: 2004-2008. Centre for Infections, HPA.

62. Lamont J and Ashton M (2005) Counting the cost: economics of sexually transmitted infections. North West Public Health Observatory Synthesis Report, Issue 02. Liverpool John Moores University, Centre for Public Health.

63. Royce R, Sena A, Cates W and Cohen M (1997) Sexual transmission of HIV. New England Journal of Medicine, (336): p. 1072-8.

64. Burns F (1998) Information for health: an information strategy for the modern NHS 1998-2005. NHS Executive.

65. Walker P (1999) Proctecting and using patient information: a national framework. Consultation Paper. NHS Executive.

66. Hargreaves SC, Jones L, Madden H, Phillips-Howard PA, Cook PA, Downing J, Syed Q and Bellis MA (2008) HIV and AIDS in the North West of England Mid Year 2008. Liverpool John Moores University, Centre for Public Health.

67. Office for National Statistics (ONS) (2009) Local Area Labour Markets: statistical indicators July 2009. ONS.

68. Lee B, Syed Q and Bellis MA (1998) Improving the health of black and ethnic minority communities: a North West of England perspective. University of Liverpool.

69. Whittier D, Lawrence J and Seeley S (2005) Sexual risk behaviour of men who have sex with men: comparison of behaviour at home and at a gay resort. Archives of Sexual Behaviour, (34): p. 95-102.

70. Euro HIV (2007) HIV/AIDS surveillance in Europe. Mid year report 2007, No 76. Saint-Maurice: Institut de veille sanitaire.

71. Clift S and Forrest S (1999) Factors associated with gay men's sexual behaviours and risk on holiday. AIDS Care, (11): p. 281-95.

72. Bellis MA, Hale G, Bennett A, Chaudry M and Kilfoyle M (2000) Ibiza uncovered: changes in substance use and sexual behaviour amoungst young people visiting an international night-life resort. International Journal of Drug Policy, (11): p. 235-44.

73. Bellis MA, Hughes K, Thomson R and Bennett A (2004) Sexual behaviour of young people in international tourist resorts. Sexually Transmitted Infections, (80): p. 43-7.

74. Gazzard B, British HIV Association (BHIVA) (2008) guidelines for the treatment of HIV-1 infected adults with antiretroviral therapy 2008. BHIVA.

75. Alcorn K and Fieldhouse R (2000) AIDS Reference Manual: December 2000. National AIDS Manual Publications.

76. Poultney M and Partridge N (1998) The voluntary sector: a providers' perspective. HIV/AIDS Strategy Conference Report, 27 October 1998. NHS Executive.

77. Department of Health (DH) (2009) Local Authority Circular: AIDS support grant for social care for people with HIV/AIDS: financial year 2008/2009. DH.

78. Department of Health (DH) (2006) Our health, our care, our say: a new direction for community services. DH.

79. Madden H (2007) Support from voluntary agencies for people with HIV, in: Downing J, Cook PA and Bellis MA Ten Years of Monitoring HIV and AIDS in the North West of England. Liverpool John Moores University, Centre for Public Health.

80. Truman C, Keenaghan L and Gudgion G (1996) Men who have sex with men in the North West. Lancaster Univerisity and Healthy Gay Manchester.

81. Ashton M, Sopwith W, Clark P, McKelvey D, Lighton L and Mandal D (2003) An outbreak no longer: factors contributing to the return of syphilis in Greater Manchester. Sexually Transmitted Infections, (79): p. 291-3.

82. Clark P, Cook PA, Syed Q, Ashton J and Bellis MA (2001) Re-emerging syphilis in the North West: lessons from the Manchester Outbreak. Liverpool John Moores University, Public Health Sector.

83. Cook PA, Clark P, Bellis MA, Ashton J, Syed Q and Hoskins A (2001) Re-emerging syphilis: a behavioural analysis of infected individuals. Communicable Disease and Public Health (4): p. 253-8.

84. Clark P, Cook PA, Wheater CP, Syed Q, Ashton J and Bellis MA (2001) Re-emerging syphilis: a case control study based on the Manchester outbreak. Liverpool John Moores University, Public Health Sector.

85. Bellis MA, Cook PA, Clark P, Syed Q and Hoskins A (2002) Re-emerging syphilis in gay men: a case control study behavioural risk factors and HIV status. Journal of Epidemiology and Community Health, (56): p. 235-6.

86. Jordon R, Gold L, Cummings C and Hyde C (2002) Systematic review and meta-analysis of evidence for increasing numbers of drugs in antiretrovial combination therapy. British Medical Journal, (324): p. 757-67.

87. Gottleib S (2002) Drug therapy reduces birth rate of HIV infected babies from 19% to 3%. British Medical Journal, (324): p. 381.

HIV & AIDS

IN THE NORTH WEST OF ENGLAND 2008

Suzy C. Hargreaves Leighton Jones Hannah C.E. Madden Jennifer Daffin
Penelope A. Phillips-Howard Penny A. Cook Qutub Syed Mark A. Bellis

Published by the

North West HIV/AIDS Monitoring Unit,
Centre for Public Health, Research Directorate,
Faculty of Health and Applied Social Sciences,
Liverpool John Moores University,
Kingsway House, Hatton Garden,
Liverpool L3 2AJ

Tel: +44 (0) 151 231 8782
Fax: +44 (0) 151 231 8020

August 2009

ISBN: 978-1-906591-90-8 (printed version)

ISBN: 978-1-906591-91-5 (web version)

www.cph.org.uk/sexualhealth.asp

liverpool JMU Centre for Public Health

Health Protection Agency North West Office

NorthWest Public Health Observatory