HIV & AIDS

in the North West of England 2006

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Executive Summary

In 2006, the North West Region has seen a total 4,761 HIV cases, representing a 13% increase on the number reported in 2005 (4,195). During 2006 there were 907 new cases of HIV: a 2% decrease on last year's figure of 928 (new HIV cases are defined as HIV positive individuals who have not previously been seen in North West statutory treatment centres prior to the year 2006). This reversal of the trend of steep year-on-year increases seen for the previous eight years suggests that the epidemic in the North West may be reaching a plateau.

This is the eleventh annual report of the North West HIV/AIDS Monitoring Unit, presenting data on HIV positive individuals accessing treatment and care in the North West Region. A total of 44 statutory centres within the North West provided treatment and care for HIV positive individuals resident in the region and beyond. We present analyses by treatment centre, as well as by local authority (LA) and primary care trust (PCT). Due to limited space it is not possible to present all possible breakdowns at LA or PCT level. However, additional tables are available on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2006).

New cases represented 19% of all cases, a proportion similar to previous years. The predominant mode of exposure to HIV for new cases was via heterosexual sex (48%). For the fifth year running this route has overtaken the percentage attributed to sex between men (42%: table 2.2), reflecting the trend that has been apparent nationally since 1999 (figure 1.4). The proportion of new cases infected through sex between men is higher in the North West (table 2.1) than nationally (figure 1.4). The number of new cases who were exposed by other transmission routes (injecting drug use, blood or tissue and mother to child) remains relatively low. The largest proportion of new cases presenting for treatment and care were categorised as asymptomatic (65%). However, 9 of the 11 new individuals who died during 2006 had an AIDS defining illness (table 2.3). This illustrates the continuing need to attract HIV positive people into services at an early stage of their HIV disease to maximise the efficacy of treatment and improve prognosis.

The predominant mode of exposure to HIV for those accessing treatment in the North West (all HIV cases) continues to be through sex between men, accounting for 53% of all cases presenting to North West treatment centres in 2006 (table 3.1). There is, however, considerable variation across the counties. Of those whose infection route was known, 62% of Lancashire's and 60% of Cheshire's HIV positive residents were men who have sex with men (MSM) compared to 39% of Merseyside's HIV positive residents. There is greater variation across LAs: 82% of Blackpool's HIV positive residents were infected through sex between men (table 3.2). The LA with the largest number of HIV positive residents infected through sex between men is Manchester, with 721 cases (table 3.2). The county of Greater Manchester accounted for the highest number of HIV positive injecting drug users with 68 individuals and accounts for 69% of all residents of the North West infected by this route. However, heterosexual sex continues to be the second largest exposure group, accounting for 40% of all cases in 2006 (table 3.2). This represents a similar proportion to 2005 and reflects trends for the United Kingdom as a whole. Greater Manchester reports the highest number of HIV positive individuals in the North West, accounting for over half of all cases (table 3.2) and new cases (table 2.2) presenting to statutory treatment centres.

The North West of England continues to be influenced by the global AIDS pandemic, as reflected in the number and pattern of HIV infections acquired abroad. Over a third (35%) of all HIV positive individuals accessing treatment and care in the North West were reported to have been infected outside the United Kingdom (table 3.7). The vast majority of those exposed abroad were infected via heterosexual sex (81%), a significantly higher proportion than in those known to have been infected in the United Kingdom (13%). Of all the infections contracted outside the United Kingdom, 70% were in sub-Saharan Africa (figure 3.2). Western Europe accounted for a further 9% of infections contracted abroad, with Spain being the most frequently reported western European country of exposure. The role of exposure abroad was even more pronounced for new cases in 2006, where 40% were reported to have been infected abroad (table 2.7). New cases exposed to HIV in Zimbabwe accounts for 32% of new cases known to have been exposed abroad whose country of infection is known (figure 2.2). This high number of cases reflects both the high prevalence of HIV and the political situation in Zimbabwe.

Ethnicity was recorded for 99% of individuals accessing treatment and care in 2006, most of whom (66%) were self-classified as white (table 3.1). However, an increasing proportion of individuals with HIV were from black and minority ethnic communities (33%); a substantial over-representation when considering the proportion of North West residents who are from minority ethnic communities (7%). An even higher proportion (46%) of new cases whose ethnicity was known were from minority ethnic communities (table 2.1), which demonstrates the increasing burden of HIV on these communities and the need for continuing and strengthening HIV prevention activities. The characteristics of HIV positive individuals from black and minority ethnic communities, particularly black Africans, are different to those of the white HIV positive population. Whereas white individuals were more likely to be MSM, heterosexual sex is the predominant method of exposure of black Africans (tables 2.1 and 3.1). This results in there being proportionally more females from black and minority ethnic communities with HIV compared to white females and more babies born with HIV infection (table 2.1 and 3.1).

This is the third year that we have included data on residency status. This level of information is not available nationally, despite growing concern over the health of vulnerable groups such as asylum seekers. The proportion of individuals who are non-UK nationals represent 19% of all HIV positive individuals. These individuals were more likely to be asymptomatic (48%) than were UK nationals (41%) (table 3.13).

During 2006, the proportion of North West residents with an AIDS diagnosis taking triple or more therapy rose to 94%, while only 40% of asymptomatic individuals were taking this level of therapy (table 3.6). The improved prognosis of HIV positive individuals across all clinical categories of HIV disease, together with relatively low numbers of individuals at early stages of HIV disease receiving combination therapy, has implications for a potential increase in demand for combination therapies. This has both planning and financial implications for the care of HIV positive individuals across the region. We also collected information on the level of inpatient and outpatient care for the whole of the region. During 2006, demand for outpatient care peaked for those with an AIDS diagnosis (a mean number of 8.5 per patient; table 3.12), while those who died during 2006 required the most inpatient care (a mean number of 39.9 days per patient). Home visits also formed a significant part of the care of HIV positive individuals (table 3.12), with those individuals who died during the year receiving the highest mean number of home visits.

During 2006, seven voluntary agencies in the North West reported care of 2,169 HIV positive individuals. Of these, 29% were not seen in North West statutory treatment centres during 2006 (table 4.3), illustrating the continuing contribution of the voluntary sector to the care of those HIV positive individuals for whom the voluntary agencies may be the sole provider of care. This also has particular significance for regional funding of HIV services, since individuals accessing voluntary agencies but not the statutory sector are not included in the regional statistics provided to the Department of Health. This is significant as regional statistics form the basis of the formula for the national distribution of funds for the care of HIV positive people.

This year, for the fifth time, we requested information from social service departments in the North West on the social care of HIV positive people. Ten social services departments were able to take part, and contributed data on 346 individuals. Most (82%) social service clients were also seen in the statutory sector in 2006 (table 5.1). Specialist drugs services contributed data on clients whom were known to be HIV positive (table 6.1). Nine individuals were reported by five drugs services. Additional analysis of all those infected by injecting drug use reported by the statutory sector highlights that, compared to other infection routes, IDUs were more likely to be at a advanced stage of disease, be on quadruple or more therapy and be admitted to hospital in 2006. They were also significantly more likely to get support from the voluntary sector (table 6.3). Renaissance, part of Manchester Methodist Housing Association, provided data for the second time in 2006 on 24 HIV positive individuals accessing their services, 88% of whom also accessed statutory treatment and care services.

We hope that the tables and figures provided in this report, together with additional analyses at LA and PCT level available on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2006), address most of your HIV-related information requirements. However, additional analyses and further breakdown of the data can be provided on request. As ever, we value your suggestions as to any developments that would improve the usefulness of the report in future years.

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.

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1. Introduction

This is the eleventh annual report of the North West HIV/AIDS Monitoring Unit. Over the past eleven years, we have collected, collated, analysed and disseminated data on the treatment and care of HIV positive individuals in the North West[1-10]. The aim of this report is to provide up to date epidemiology of HIV, starting with an overview of the global and national epidemiology, before focussing on the North West region. In chapter two, we present analyses of new HIV cases in the North West, and in chapter three analyses of all HIV and AIDS cases presenting for treatment and care in the North West. Voluntary sector care and social service care is dealt with in chapters four and five, followed by care from additional sources in chapter six. Chapter six also includes a focus on those infected through injecting drug use, comparing their characteristics, contact with health services and health status with those infected by other routes. The tables are placed at the end of the relevant chapter. Not all analyses by local authority (LA) or primary care trust (PCT) can be included here, due to limited space, but additional tables can be found on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2006).

We hope that the tables and figures provided within the report, and the extra analyses on the website, answer most of your HIV-related information requirements. We would value your suggestions as to what additions would improve the usefulness of the report in future years.

Global Perspectives on HIV and AIDS in 2006*

At the end of 2006 there were an estimated 39.5 million people infected with HIV globally. During 2006 AIDS an estimated 2.9 million people worldwide died of HIV/AIDS, including 380,000 children. UNAIDS reported that almost 4.3 million people were newly infected in 2006; 12% of whom were under 15 years of age. Prevalence appears to have levelled off in many countries as changes in incidence rates, increased mortality, longer life expectancies due to antiretroviral therapy, and population growth have kept the numbers of people living with HIV fairly stable. It is expected that prevalence rates will increase again if universal treatment access becomes a reality and HIV positive individuals live longer. Noticeable decreases have been seen in the Caribbean and North Africa and the Middle East regions. Sub-Saharan Africa continues to be the worst affected global region with 63% of all infections. Despite the number of infections only one in five people worldwide who are at risk of becoming infected with HIV have access to basic prevention services, such as condoms, therapy to limit mother to child transmission or general education to protect themselves.

More detailed information on each global region impacted by the pandemic can be found in the report '*Ten Years of Monitoring HIV & AIDS in the North West of England*'[12].

Sub-Saharan Africa

Sub–Saharan Africa remains the global epicentre of the HIV pandemic, with southern Africa being the worst affected area. The latest estimates state that almost 25 million people are infected with HIV across sub-Saharan Africa. The HIV epidemics in Mozambique, South Africa and Swaziland continue to grow. An estimated one in three (33%) adults in Swaziland was living with HIV in 2005 - the most intense epidemic in the world. In South Africa, which in terms of sheer numbers has one of the world's largest HIV epidemics, prevalence of HIV among women attending public antenatal clinics was more than one third (35%) higher in 2005 than it had been in 1999.

Although HIV incidence has decreased in some countries, death rates from AIDS continue to rise. The 2.1 million deaths related to AIDS in Africa in 2006 represent 72% of global AIDS deaths. Access to antiretroviral therapy (ART) has improved greatly in the last few years. In June 2006 an estimated one million people were taking ART, a ten-fold increase from December 2003. Problems with the procurement and the reliable distribution of drugs needed to maximise treatment outcome have meant that even with this improvement coverage is still low with less than one fifth of Africans in need of ART receiving it at the end of 2005[13].

East, South and South East Asia and Pacific

It is estimated that 8.6 million people were living with HIV across Asia in 2006. Main transmission routes vary between countries across the region but remain quite different to the sub-Saharan African epidemic. In most Asian countries HIV infection is mainly attributable to high risk behaviours such as intercourse with sex workers, injecting drug use (IDU) and sex between men. The exception is India, the country with the world's highest number of people living with HIV (5.7 million), where the main route of exposure is heterosexual sex. In China, 650,000 injecting drug users account for approximately half of the people living with HIV. The number of people receiving ART in Asia has increased more than threefold since 2003, and reached an estimated 235,000 by June 2006. This represents approximately 16% of the total number of people in need of antiretroviral treatment.

* *Unless otherwise stated global data and information taken from UNAIDS epidemic update, December 2006*[11]

Figure 1.1: Number of adults and children estimated to be living with HIV/AIDS as of end 2006
Source: UNAIDS/WHO AIDS epidemic update – December 2006

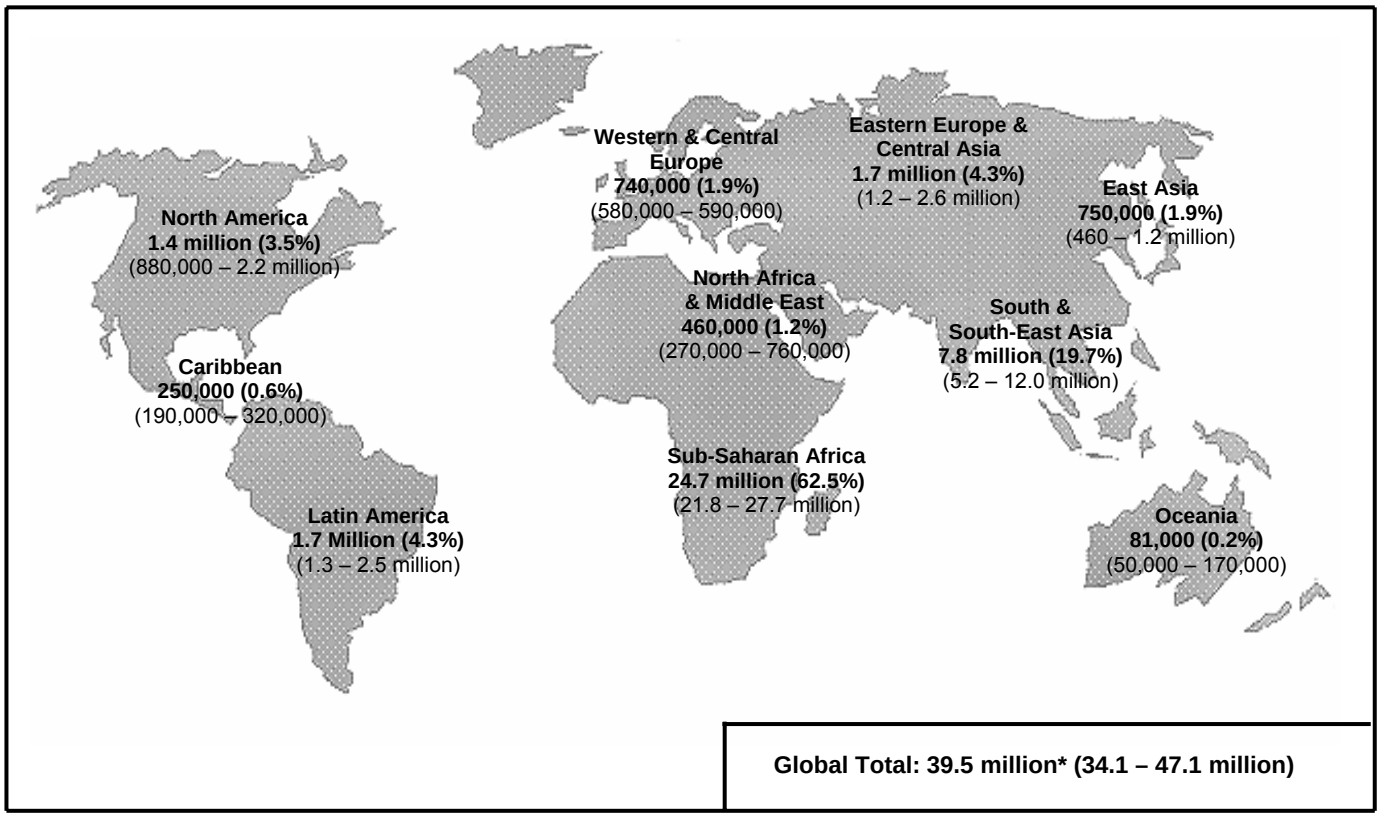
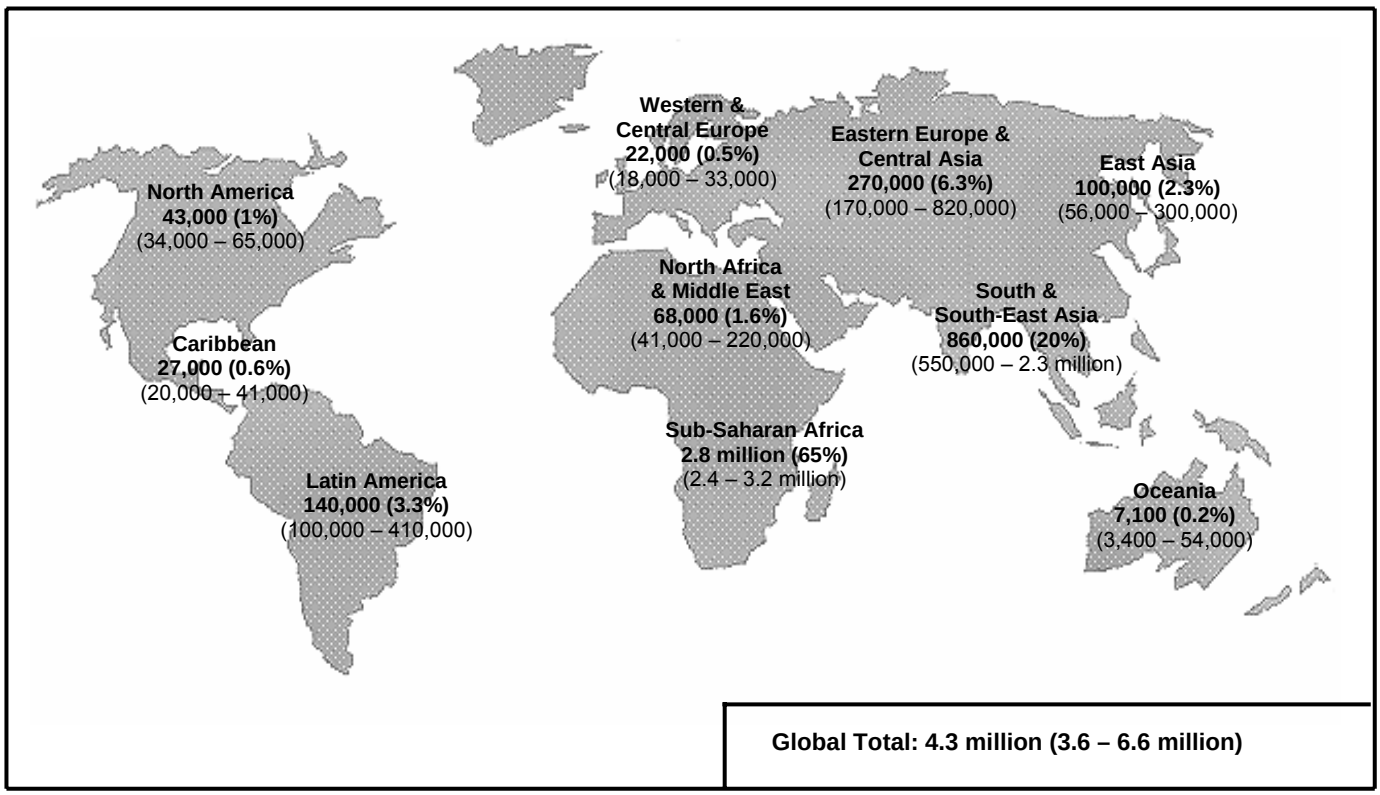


Figure 1.2: Number of adults and children estimated to be newly infected with HIV/AIDS during 2006
Source: UNAIDS/WHO AIDS Epidemic Update – December 2006



Eastern Europe and Central Asia

The epidemic across Eastern Europe and Central Asia is still in its infancy, but continues to grow rapidly in many areas. Ukraine has the highest HIV prevalence in Europe with injecting drug use accounting for the majority of new infections. The use of contaminated injecting drug equipment remains the main mode of transmission across the Russian Federation. The HIV epidemic is primarily affecting young people; in the Russian Federation, for example, some 80% of people with HIV are younger than 30 years of age. In the Russian Federation and Ukraine, women (many of them less than 25 years old) bear a growing proportion of the HIV burden, accounting for more than 40% of new HIV diagnoses in 2005.

Caribbean

The Caribbean has seen a decrease in the estimated number of HIV infected people since 2005. Nearly three quarters of the total infections in this region are confined to Dominican Republic and Haiti. An estimated 27,000 new infections were recorded in 2006. Women now account for 50% of all HIV positive adult cases in the Caribbean and in some countries young women have incidence rates of three to six times higher than young men[14]. Sex between men was estimated to account for only 10% of cases in 2006. However, this estimate may be unreliable as men who have sex with men (MSM) from this primarily conservative Catholic society often report 'heterosexual' or 'unknown' routes of transmission. Social constraints encourage people to keep same sex relationships secret. Cuba is the only country in the Caribbean that has managed to keep the developing epidemic in check. National prevalence is approximately 0.1% and although incidence is increasing every year, intensive efforts early on managed to keep it at a much lower level than its neighbouring countries.

Latin America

Changing patterns are noticeable in some Latin American countries. However, the epidemic in the region remains stable. An estimated 140,000 new infections were recorded in 2006 and 65,000 people were estimated to have died as a results of AIDS. Two thirds of the total HIV population in Latin America reside in Argentina, Brazil, Columbia or Mexico. However, the estimated HIV prevalence is highest in the smaller countries of Central America; less than 1% in El Salvador, Guatemala and Panama, 1.5% in Honduras and 2.5% in Belize in 2005. Unprotected sex between men accounts for as much as 25%–35% of reported AIDS cases in countries such as Argentina, Bolivia, Brazil, Guatemala and Peru[15]. Outbreaks of the virus continue to be found among injecting drug users and men who have sex with men in most countries of South America.

North America, Western and Central Europe

The number of people living with HIV in North America, Western and Central Europe rose to 2.1 million in 2006, with approximately 65,000 people newly acquiring the virus in the past year. Deaths caused by AIDS remain relatively low at 30,000 mainly due to the wide availability of ART. Western Europe and the USA are the only regions in the world where the majority of people who need it can access ART, and deaths due to AIDS have remained stable over a number of years.

The USA is estimated to have the eighth largest prevalence of HIV in the world, with 1.2 million people currently living with HIV. Unsafe sex between men remains the most common risk factor for HIV infection (44%), followed by unprotected heterosexual intercourse (34%), and the use of non-sterile injecting drug equipment (17%)[16]. About three quarters of heterosexually acquired HIV infections in Western and Central Europe were among immigrants and migrants[17]. Since 1998 there has been a substantial increase in HIV diagnoses across Western Europe from 42 cases per million to 74 cases per million in 2006.

Middle East and North Africa

HIV surveillance remains sporadic in the Middle East and North Africa but estimates show that there are currently 460,000 people living with HIV in this area. Estimates show that 68,000 became newly infected and approximately 36,000 people died of AIDS in the last year. Irregular and inadequate HIV surveillance systems make it difficult to gauge precisely the patterns and trends of the epidemics in many countries of this region and may account for the unstable estimates. Progress in providing antiretroviral therapy in this region remains slow, with only 4,000 people estimated to be on treatment at the end of 2005.

Global access to treatment and prevention

In the past three years, access to ART has greatly improved. The number of people receiving ART in low and middle-income countries has more than tripled since the end of 2001. Antiretroviral therapy is widely available in the wealthy countries of North America and Western Europe and treatment coverage in countries such as Argentina, Brazil, Chile and Cuba currently exceeds 80%. However, despite progress in many developed countries, the situation remains critical in the poorest countries of Latin America and the Caribbean, Eastern Europe, Asia and

virtually all of sub-Saharan Africa. At best, 17% of Africans and 15% of Asians in need of ART were receiving it at the end of 2005[13].

As well as treatment, provision prevention services need to be stepped up to stop the epidemic spreading even further. Condoms remain the most effective method of preventing sexual transmission of HIV. However, in the poorest countries where people do not have the resources for basics such a food and shelter, women often have no control over the sex that they have and condoms are not always available or appropriate. One study stressed the urgent need for female controlled physical and chemical barrier methods that allow women to take an active role in reducing their risks of contracting sexually transmitted infections (STIs) and HIV[18]. Increased funding has been provided in recent years to support the development of female controlled barrier methods such as microbicides. Many microbicides, which are designed to disrupt the viral membrane or block viral entry into and binding with the target cells, are currently undergoing clinical trials. These new developments offer hope that new products will be available in the near future. A recent study also found that male circumcision can greatly reduce the risk of HIV infection in men[19]. Authors stated that male circumcision is equivalent to a vaccine with 63% efficacy and concluded that circumcision must be recognised as an important means to fight the spread of HIV infection and one that the international community must promote accordingly.

HIV and AIDS in the United Kingdom – 2006

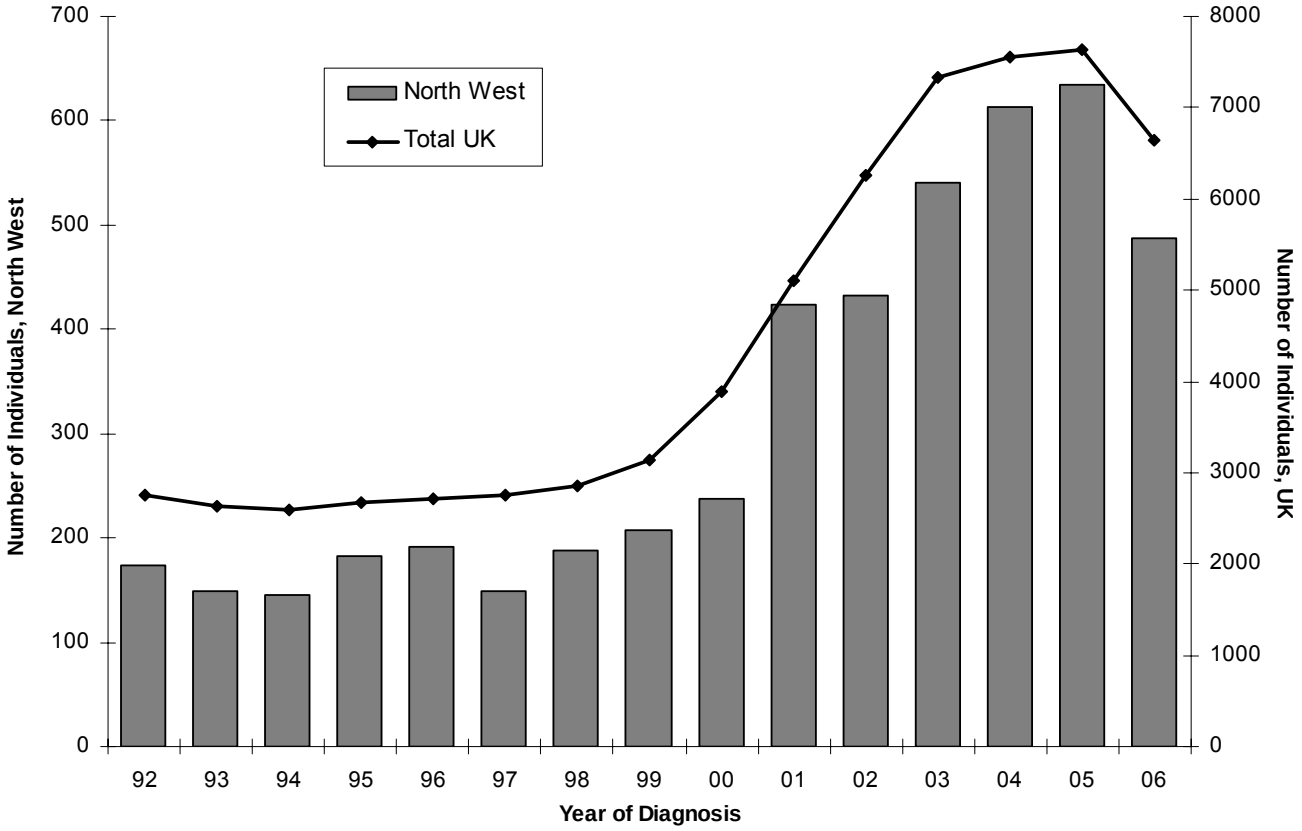
New diagnoses of HIV, AIDS diagnoses and deaths of HIV positive people are reported to the Health Protection Agency (HIV and STI Department) and the Scottish Centre for Infection and Environmental Health (SCIEH), who compile the data into quarterly surveillance tables[20].

Figures 1.3 to 1.5 and table 1.1 in this chapter give an overview of trends in the UK using these data. The majority of HIV positive people reside in London. This means that national policy is often shaped with a strong bias to the needs of London and the South East[20-23]. Additionally, the data may under represent some regions of the UK[20-23]. This section gives an overview of the UK and the North West for comparison. However, for the epidemiology of HIV in the North West, please see chapters two to five of this report, which are based on monitoring of treatment and care of individuals with HIV or AIDS in the North West, and provide the most accurate and detailed information available.

The cumulative total of reported HIV infections in the UK reached 86,084 by the end of 2006. Of these, 6,642 cases were newly identified in 2006 (figure 1.3). Note that the apparent down turn in the number of cases in 2006 is likely to be due to reporting delay. The epidemiology of HIV in England, Wales and Northern Ireland is shifting as a result of changing patterns in the route of transmission of new infections (figure 1.4).

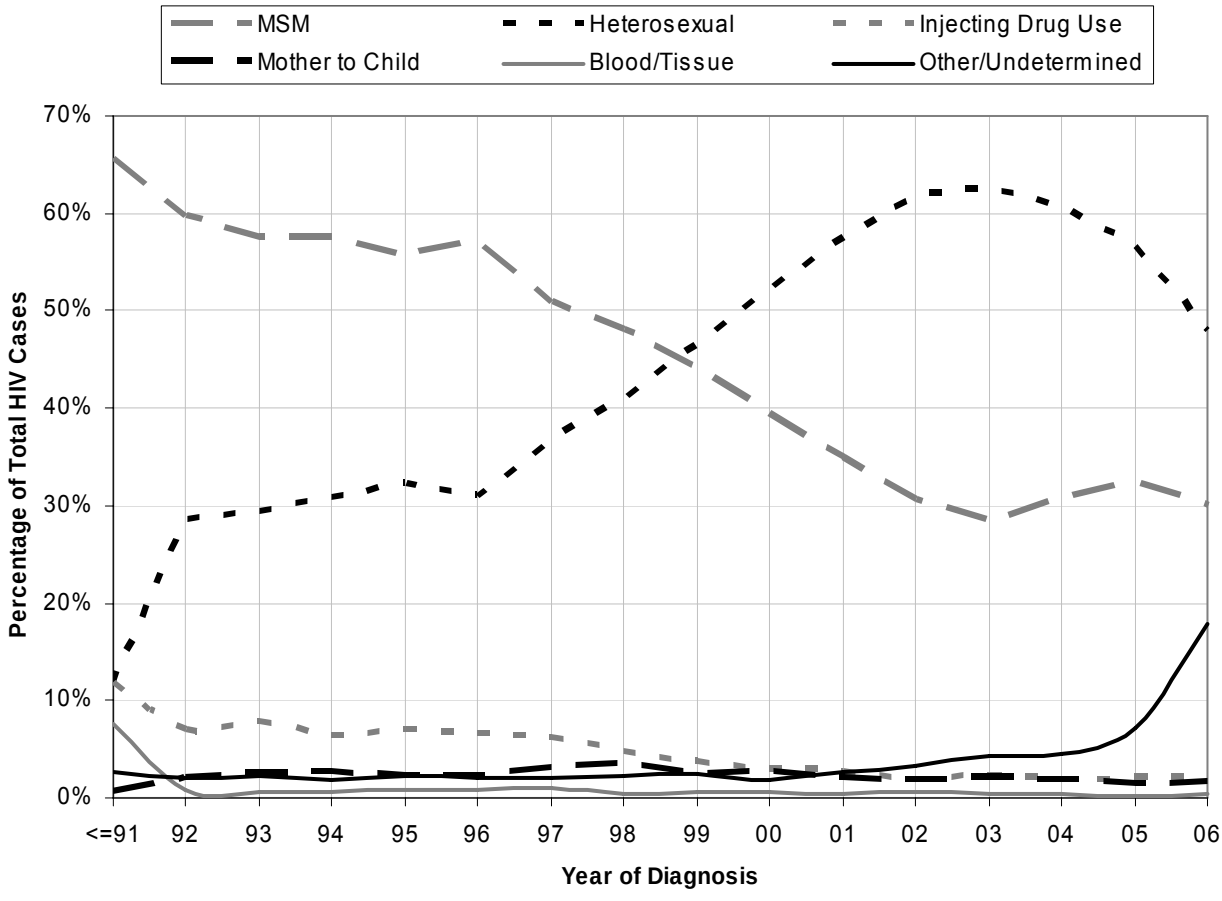
An additional tool for monitoring the HIV epidemic in the UK is provided by the unlinked anonymous HIV seroprevalence programme conducted by the Health Protection Agency (HPA) and the Institute of Child Health. Part of the programme involves the testing of blood samples that have been taken for other 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[25]. Results of the programme combined with the other HPA surveillance methods suggest that at the end of 2005 there were 63,500 (range: 59,500 – 68,800) adults infected with HIV in the UK, of whom 32% (range: 27% - 37%) were still undiagnosed[26].

Figure 1.3: Number of new HIV cases in the North West and the UK by year of diagnosis. *Source: AIDS/HIV Quarterly Surveillance Tables, No 74, HPA*



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

Figure 1.4: Infection route of HIV cases in the UK by year of diagnosis to December 2006
Source: AIDS/HIV Quarterly Surveillance Tables, No 74, HPA.



Men who have sex with men

Men who have sex with men (MSM) are the group at greatest risk of acquiring HIV infection within the UK. Of the 1,374 new diagnoses in MSM during 2005, where probable country of infection was reported, 84% were most likely infected in the UK[26]. However, the shape of the epidemic is changing, and the overall proportion of new HIV diagnoses attributed to sex between men has decreased from 66% prior to 1991 to 30% in 2006 (figure 1.4).

The 1980s saw substantial reductions in risky behaviour among gay men in response to the AIDS crisis. However, towards the end of the 1990s sexual risk-taking seemed to increase again. Changes in risky sexual behaviour were reported by one longitudinal study that recruited men in gyms in London. Between 1998 and 2003, the percentage of men reporting high risk sexual behaviour with a casual partner increased from 6.7% to 16.1%, however, there was no significant change in the percentage of men reporting high risk sexual behaviour with a main partner alone (7.8%). Similar results were seen in HIV positive, negative and never tested men regardless of age. This study recommends 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[27].

There is evidence that increases in HIV incidence in MSM in the UK are strongly influenced by an increase in uptake of HIV testing. Analysis of KC60 data, the unlinked anonymous screening programme and CD4 surveillance in the UK has revealed a substantial increase in the uptake of HIV testing which may explain the rise in HIV diagnoses[28]. There has also been an encouraging trend over recent years for MSM to be tested at an earlier stage of HIV infection, which may indicate an increased awareness of the risks among this group[26].

This change in self-reported risk behaviour is mirrored by increasing levels of MSM acquired infectious syphilis (primary, secondary and early latent) in the UK (an increase of over 2000%, from 84 cases in 1999 to 1,873 in 2006)[29-30] and is driven by a number of outbreaks, including outbreaks in UK cities[26,31], with parallel increases seen in the North West[30,32]. In addition to indicating increases in risky behaviour, sexually transmitted infections may also act as a co-factor in the transmission of HIV[33].

The Sigma UK Gay Men's Sex Survey 2005[34] (carried out in partnership with 107 health promotion agencies across the UK) revealed that in the past year three quarters of all men questioned had engaged in sex with a man of unknown serostatus. If these findings are representative of the whole MSM population they indicate a widespread lack of communication around HIV status among MSM. The survey also revealed that 11% of men who had anal intercourse in the last year never used a condom and inconsistent condom use was as common as consistent condom use. Furthermore, 19% of men whose last HIV test was negative or who had never been tested for HIV, had participated in receptive unprotected anal intercourse with a partner of unknown status in the last year. This figure rose to 32% of untested men with thirty or more partners.

At the end of 2005 there were an estimated 28,000 HIV positive men infected through sex between men living in the UK, of whom approximately 9,000 (32%) were undiagnosed[26]. In 2005, the prevalence of HIV among MSM was estimated to be 20.7% in London, compared to 5.6% elsewhere in England, Wales and Northern Ireland and 4.2% in Scotland[35].

Heterosexual sex

Although there has been a 52% increase in the number of new diagnoses in MSM since 1996, this increase is more marked in heterosexuals. There has been an almost five-fold increase in new diagnoses in heterosexuals in the last ten years and, since 1999, heterosexual diagnoses have outnumbered MSM diagnoses[26].

Sex between men and women now accounts for 41% of the total number of HIV diagnoses in the UK to the end of 2006. However, since 1999, heterosexual sex has accounted for the largest number of new cases, 48% in 2006 (figure 1.4). Of those HIV positive individuals infected through heterosexual sex, the majority (61%) are female[20]. Heterosexual cases are categorised by whether they were exposed through sex with high-risk partners, exposed abroad or exposed in the UK (figure 1.5). In 2006, 85% of all heterosexually acquired HIV cases were contracted abroad and of these, 89% were acquired in Africa. Despite the rapid increase in numbers of infections acquired abroad the proportion of heterosexual infections that were acquired in Africa has remained consistent over the last few years. The regions of Africa where infections were acquired have changed over the least ten years, in 1996 the majority were from Eastern Africa but in 2005 most were from South Eastern Africa[26].

Anonymous testing of all pregnant women can be used as an indicator of the prevalence of HIV in the general heterosexual population. These data reveal that the prevalence of HIV in the heterosexual population is four times higher in London than the North West (438 per 100,000 compared to 108 per 100,000: figure 1.6). Prevalence rates amongst pregnant women in the North West have increased almost six-fold from 17 per 100,000 in 2000[35]. In 2005, one in every 450 women giving birth in England and Scotland in was HIV positive[26].

Africa is the predominant global region of transmission for HIV cases acquired abroad with three-quarters of those HIV infections acquired through heterosexual sex probably being acquired in the region[20]. This is also reflected in the epidemiology of HIV in the North West, where, of those newly reported in 2006 and infected abroad, over three

quarters were exposed in sub-Saharan Africa (see chapter 2, figure 2.2). Individuals from black and minority ethnic communities make up the majority of heterosexually transmitted AIDS cases in the UK with black Africans constituting the largest group[20]. These communities have close connections with sub-Saharan countries, the region in which 63% of the global total of adults and children estimated to be living with HIV/AIDS at the end of 2006 reside (figure 1.1). However, HIV is often stigmatised within African communities, which can prevent individuals from accessing services[36] and disclosing their status to friends and family for extra support[37].

At the end of 2005, there were an estimated 33,600 individuals in the UK living with HIV that had been heterosexually acquired, a high proportion of whom (31%) were unaware of their HIV status. This was particularly the case among heterosexual males, where 37% were undiagnosed[26].

Injecting drug users

Injecting drug use accounts for 5.3% of the total diagnosed HIV infections in the UK to date[20]. The proportion newly diagnosed by this route in 2006 has remained stable at 2% (figure 1.4). 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 to alarming levels with the North West showing the highest prevalence of both at 28% and 58% respectively[38]. Since HIV is less infectious than hepatitis C, those individuals who have had sufficient high risk exposure via injecting drug use to acquire HIV are also likely to have been infected with hepatitis C. Having both infections makes the treatment of each more difficult to manage, increases the progression of hepatitis disease and, for women, increases the probability of transmission of HIV to an infant during pregnancy or birth (see review in the North West report on hepatitis B and C[39]). The recent report looking back over ten years of HIV epidemiology in the North West[12] reveals that people infected by injecting drug use tend to suffer poorer health. Chapter six of this report includes a focus on those infected through injecting drug use, comparing their characteristics, contact with health services and health status with those infected by other routes.

Anonymous testing of injecting drug users attending services reveals that, outside London, the prevalence of HIV among injectors is low; at 1.3% in the North West compared to 3.2% in London for 2005, although the prevalence in London has decreased slightly from 4% in 2001/02[38]. The low prevalence among drug users in the UK compared to other countries in Europe has been attributed to harm reduction strategies such as needle exchange programmes[40].

Blood or tissue

Since HIV screening and heat treatment were introduced for donated blood products in 1985, infection by these routes has been rare. This is clearly indicated by the abrupt decline from 8% of all infections reported before and during 1991 to just 0.5% in 2006 (figure 1.4)[20].

A small number of cases continue to be diagnosed as a result of transfusions or blood products received overseas[26]. 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; at less than one in 5,000[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 hepatitis C virus was also common and has contributed to mortality among these men. 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 related causes in this patient group as a consequence of co-infection with hepatitis C[43].

Figure 1.5: Number of heterosexually acquired HIV cases in the UK by year of report to December 2006
Source: AIDS/HIV Quarterly Surveillance Tables No 74, HPA

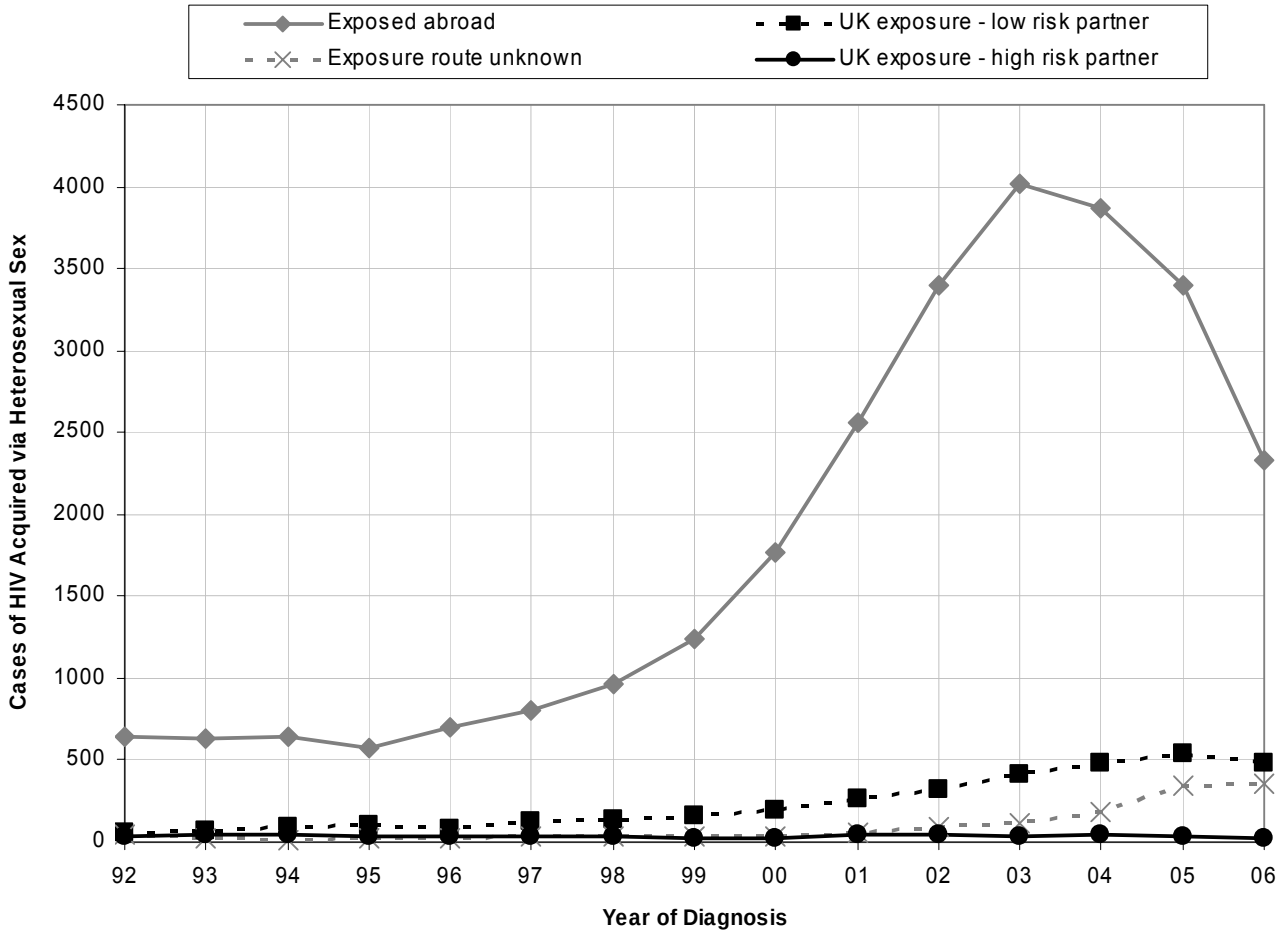
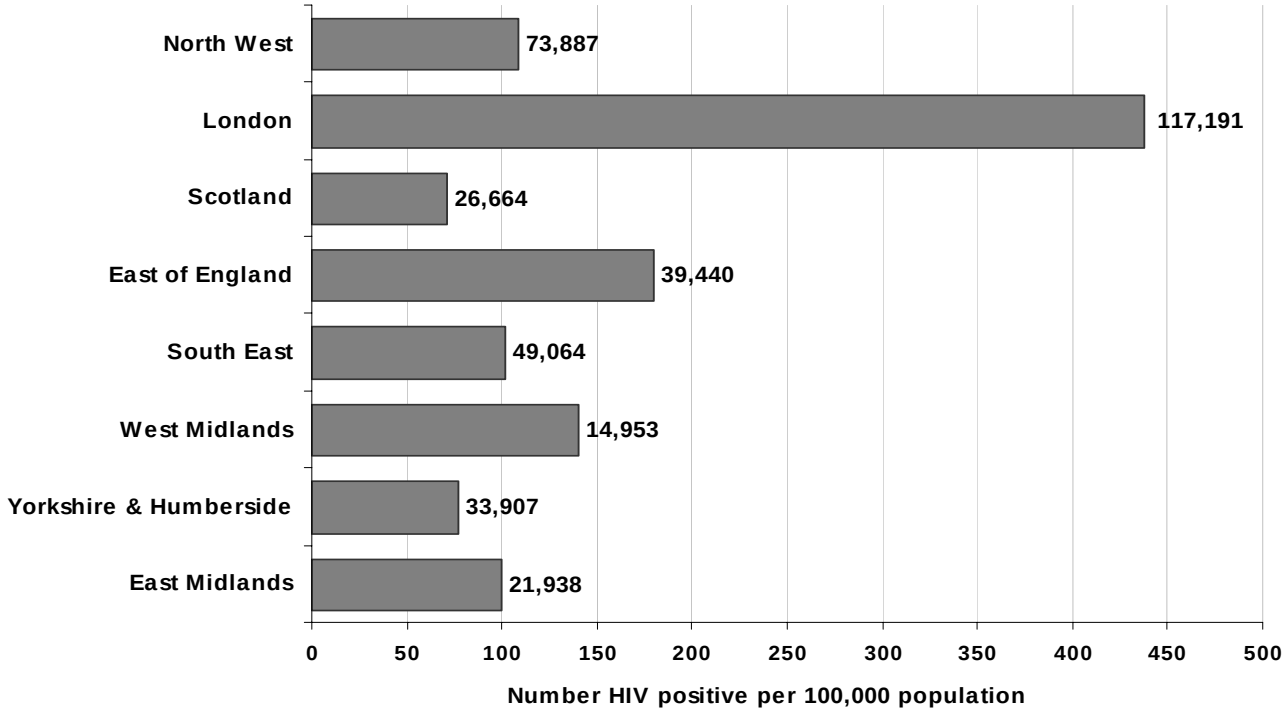


Figure 1.6: HIV prevalence among pregnant women in England, 2006 (newborn infant dried blood spots collected for metabolic screening)
Source: Unlinked Anonymous HIV Prevalence Monitoring Programme: England and Wales, 2006



NB. Numbers next to bars represent sample size.

Mother to child

During 2006, 106 infants were reported to have contracted HIV from their mothers[20]. This figure will inevitably increase as the year progresses as there is a delay in reporting vertically transmitted HIV, due to the presence of maternal antibodies for up to 18 months after birth that confound the diagnosis. For 2005, 117 mother to child infections were reported, which was a decrease of 27 from 2004.

Since 1994/95 the proportion of children presenting with HIV who were born abroad increased from 20% to 60% in 2000-2002[44]. HIV prevalence in mothers varies depending on global region and country of birth. The Unlinked anonymous screening program found an overall HIV prevalence of 0.26% in women giving birth in the UK, with a much higher prevalence (2.4%) in women born in sub-Saharan Africa [35].

Interventions of antiretroviral therapy for the mother, caesarean section and avoidance of breast feeding have been successful at reducing the rates of vertical transmission from around 32% to 4%[45]. The British HIV Association (BHIVA) updated their guidelines for the treatment of pregnant women in 2005[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 women in order to increase the uptake of the test to 90% of all pregnant women[47-48]. The HPA North West's antenatal screening report, for January to December 2005[49], showed a regional HIV antenatal screening uptake rate of 76%, with the highest uptake (91%) in Cumbria and Lancashire. This regional figure is an increase of 1% on the uptake rate in 2004 but is still far below the 90% governmental target.

Unlinked anonymous data for the North West (2004/05) estimates that 84% of all HIV infections in mothers were diagnosed prior to delivery. This is a decrease from the 100% reported in 2002/03. An estimated 224 babies in the UK in 2005 would have acquired HIV without screening and intervening measures. There were, in fact, an estimated 27 babies who acquired HIV infection from their mother; it is estimated 19 of these who would have acquired HIV even if all maternal infections had been diagnosed prior to delivery[35].

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[44]. 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 often 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 among this group is likely to reflect that of their country of origin. Currently asylum seekers have the right to HIV treatment whilst seeking asylum. Previously, 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[52]. 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 resistance to treatment if dispersed away from their source of treatment and support[53]. This is due to the 95% adherence to antiretroviral therapy (ART) that is required to have the greatest effect in treating the virus. As a result of this, there are 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[54]

During 2006, the UK received 23,520 asylum applications, 9% fewer than in 2005 (25,710)[55]. Of the applications received in 2006, 44% were from Africa, the global region with the highest prevalence of HIV. The most common origin of asylum seekers applying from African countries was Eritrea (25%), followed by Somalia (18%) and Zimbabwe (16%). According to Home Office statistics, there are currently 6,515 asylum applicants residing in the North West receiving supported accommodation from NASS and a further 585 receiving subsistence only support[55]. Within the North West, the largest numbers of asylum seekers are located in Manchester (1,355), Salford (945) and Liverpool (810). 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 and 2.10 (chapter 2), 3.13 and 3.14 (chapter 3).

HIV and AIDS in the North West of England – 2006

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

By the end of 2006, a cumulative total of 5,719 HIV infections in the North West had been reported to the Health Protection Agency[56], including 369 new diagnoses during 2006 (figure 1.3). There were 27 newly diagnosed AIDS

cases recorded in the North West over the first three quarters of 2006, bringing the cumulative total to 1,412, 6% of the total number of AIDS cases reported in the UK[57].

The pattern of HIV exposure among HIV positive people in the North West is broadly similar to that of the UK, with the largest number of people who have had an HIV diagnosis reported to be MSM (table 1.1). However, the North West has a lower proportion of people infected with HIV via heterosexual sex (34% compared to 42%) and a correspondingly higher percentage of men who were infected by having sex with men (54% compared to 45%) (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 twice the national average for both HIV and AIDS cases. At least part of this is likely to be due to patients from other areas attending specialist haematology units in the North West region and in some cases moving residence for convenience.

The data in figure 1.6 are derived from the anonymous seroprevalence survey conducted by the Health Protection Agency and show the level of HIV infection in pregnant women. Data for 2006 show an HIV prevalence of 0.22% amongst women giving birth in the UK[26]. The prevalence amongst pregnant women in the North West has increased from 89 per 100,000 in 2004 to 110 per 100,000 in 2005.

Table 1.1: Cumulative number of HIV cases in the North West and the UK by infection route of HIV to December 2007 Source: AIDS/HIV Quarterly Surveillance Tables, No 73, HPA

	Infection Route					
	MSM*	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Other/ Undetermined**	Total***
North West Region	3,102 (54.2%)	235 (4.1%)	1,939 (33.9%)	203 (3.5%)	240 (4.2%)	5,719
Total UK	**38,357 (45.2%)**	**4,582 (5.4%)**	**35,561 (41.9%)**	**1,846 (2.1%)**	**5,342 (6.3%)**	**84,730**

** Includes 786 men who had also injected drugs.*
***Includes 1,497 children born to HIV infected mothers.*
****Includes 42 patients with sex not stated on report.*

The sexual health of the North West

The epidemiology of HIV in the North West also needs to be set in the context of the deepening sexual health crisis in the region. In 2006, the North West saw 10% of all new episodes of the top five sexually transmitted infections (STIs) (chlamydia, gonorrhoea, syphilis, warts and herpes) diagnosed in GUM clinics, second only to London (14%)[29]. In addition, the North West has seen a large percentage increase in the number of new STIs diagnosed from 2002 to 2006 (22%), the second highest increase of any region in England[30]. Access to GUM clinics in the region has improved from 30% of individuals seen within the target time of 48 hours in May 2005 to 51% in the whole of 2006[58]. These waiting times are improving continuously and in May 2007 this figure had increased to 76%[59]. These improvements have continued despite an increase in attendees and diagnoses. However, the North West 48 hour access to GUM services remains poor compared to London, where 72% of GUM patients in 2006 were seen within 48 hours[58].

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[60] and this is likely to have increased as diagnoses and attendances have increased substantially since then[26]. 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 serve as an indicator of sexual risk-taking behaviour, but also increase the probability of HIV transmission, through weakening the defences of the genital tract[61].

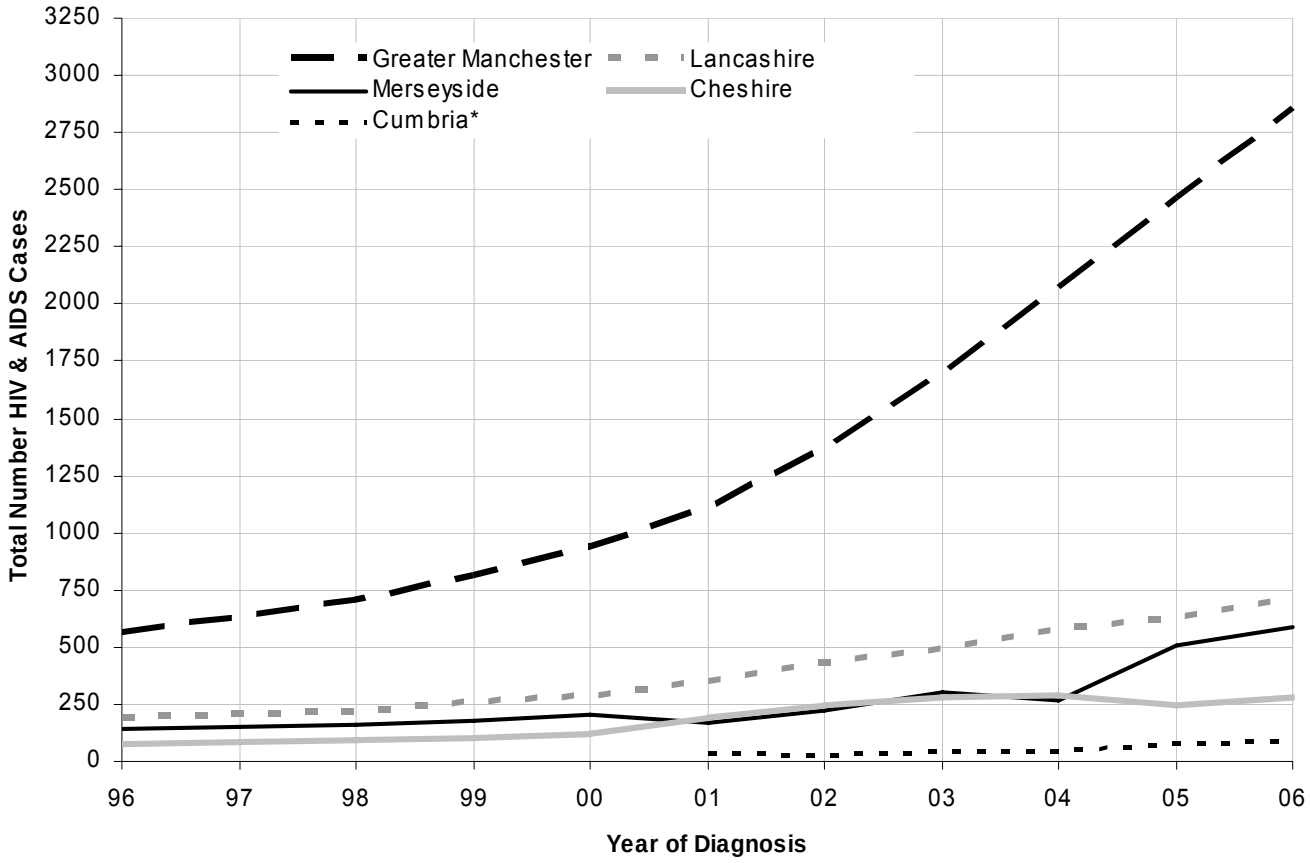
Monitoring HIV and AIDS in the North West Region

Over the past eleven 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[62]. 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[63].

We have collected data from over 40 statutory treatment centres including genito-urinary medicine clinics, infectious disease units, haematology clinics and a number of other specialist units and clinics[1-10]. The data collected form part of the national dataset - Survey of Prevalent Diagnosed HIV Infections (SOPHID). In 2006, our third 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[64]. In addition, data are used at a local authority (LA)

level as well as a primary care trust (PCT) and regional level to assist in service planning, development and evaluation in addition to providing analysis of the changing patterns of disease characteristics and prevalence.
Figure 1.7 shows the number of people with HIV and AIDS who contacted statutory treatment centres in the North West of England between 1996 and 2006. 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 ten years, illustrate the increasing number of people accessing HIV services. There has been an increase (13%) in the number of HIV positive individuals attending treatment centres. 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 also due to an increasing number of new cases. A full description of the epidemiology of HIV and AIDS in the North West is given in chapters two and three of this report.

Figure 1.7: Number of total HIV and AIDS cases in the North West 1996-2006 by county



**Prior to 2001, residency was by Health Authority and did not include Cumbria.*

Additional data providers also contribute to this report. The HIV/AIDS Monitoring Unit also continues to collect data from HIV/AIDS voluntary organisations across the region (chapter 4). For the fifth year North West social service departments have participated, all of which have HIV positive service users (chapter 5). For the eighth year, we have gathered data relating to HIV positive individuals accessing specialist drug services in the North West. Further analysis on injecting drug users accessing statutory treatment centres and specialist drug services in the region is provided in chapter six.

Methodology of Monitoring HIV and AIDS in the North West

Twice a year, clinics are prompted to complete and return forms, which 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 any individual for whom they have also submitted a new diagnosis form (buff coloured clinicians' reporting form) for the corresponding period and asked to report all other 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 includes hospital number, soundex, date of birth, sex, postcode, ethnicity, residency status, transmission route of HIV, vital status, whether they were exposed abroad and country

The demographic data collected for each person includes 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 injecting drug users 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 ranges refer to the age of individuals at the end of December 2006, or at death. Ethnic group classifications are those used by the Health Protection Agency HIV and STI Department, for SOPHID. Residency categories are adapted from the National Asylum Support Service 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 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 antiretroviral therapy 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 of death and date is requested.

'New cases' are classed as people who are new to the North West database in 2006, 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. In 2006, at least 23 of the 907 new cases were transfers from outside of the North West region who had been diagnosed positive and received HIV care in another part of the UK prior to 2006. The actual number of transfers will be higher than this since it was not possible to get the information from all clinics for the whole of 2006. Future reports will present data on all cases new to the region who have transferred from outside the North West in order to provide a more accurate number of newly diagnosed HIV cases within the region.

Voluntary agencies, social services and drug agencies 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 however, only a handful of the smaller centres submit data electronically. The remainder send details on paper forms. However, 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 local authority (LA) and primary care trust (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 greater than 90% of individual postcodes within a partial postcode area mapped to one LA or PCT. This method provides a good degree of accuracy when all but the last digit of the postcode available with 97% matching to a PCT. However, if only a first part postcode (e.g. M12) is provided, only 87% 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. Since the LAs in the North West are approximately co-terminus with PCTs, a table is given in appendix B showing the relationship between LAs and PCTs. 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/hiv2006).

This is the third year for which data have been collected from the statutory treatment centres in two periods (from January to June 2006 and July to December 2006). 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 2006

During 2006, 907 new HIV and AIDS cases presented to statutory treatment centres in the North West Region. This total represents a 2% decrease from 2005 (928 cases)[10] and is the first time since 1997 that a decrease has been recorded. New cases are defined as individuals seen in the North West Region in 2006 but not during the years 1995 to 2005 and include new cases who died during the year.

Data regarding newly reported cases of HIV infections assist in the identification of trends in incidence and represent the most up to date information on the characteristics of HIV infection and transmission. Such information is valuable not only for planning and evaluating the success of preventive activities, but also for predicting the future incidence of HIV and AIDS and its impact on treatment and care services in the North West of England. The aim of this chapter is to present information relating to new cases and, where appropriate, references are made to corresponding data from previous North West reports[1-10].

Analyses are given by local authority (LA) and primary care trust (PCT). Since the LAs in the North West are approximately co-terminus with PCTs, a table is given in appendix B showing the relationship between LAs and PCTs. For reasons of space, it is not possible to present all breakdowns at LA or PCT level, however, additional tables are available on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2006).

For the purposes of this report men who were exposed through sex between men and who are also injecting drug users are included in the MSM (men who have sex with men) category. Transsexuals who acquired HIV through sex between men are recorded as males and age ranges refer to the age of individuals at the end of December 2006, or at death.

Figure 2.1 illustrates the crude incidence of new HIV and AIDS cases in the North West who attended statutory centres within the region during 2006. The population sizes for each LA used in the incidence calculations are provided by the North West Public Health Observatory based on 2001 census data. The incidence of diagnosed HIV in 2006 throughout the North West is 13 per 100,000 people. Manchester LA has the highest incidence (65 per 100,000), followed by Salford with 42 per 100,000, then Blackpool with 29 per 100,000. The incidence of diagnosed HIV in Salford has superseded Blackpool since 2005 as the LA with the second highest incidence, and further demonstrates the dominance of Greater Manchester in North West HIV statistics.

Figure 2.2 shows the global region and country of HIV transmission for new cases acquired outside the UK who presented in the North West for treatment and care in 2006. Forty percent of new cases (367 individuals) were contracted abroad, over three quarters of which were acquired in sub-Saharan Africa (78%). A further 7% each were exposed in South & South East Asia and Western Europe, followed by Eastern Europe & Central Asia with 2%, then the Caribbean and North Africa & Middle East each with 1%. Of the 367 new cases who probably acquired their infection abroad, the exact single country of probable exposure is available for 304 individuals (83%). Individuals reported to have been infected in Zimbabwe continue to dominate the statistics, accounting for 27% of all infections thought to have been acquired abroad (100 cases). There were a high number of infections acquired in unspecified or unknown areas of sub-Saharan Africa (36 cases; 9.8%). Countries in sub-Saharan Africa also account for the next two largest numbers of new cases, South Africa (24 individuals; 7%) and Malawi (22 individuals; 6%). Overall, exposure in sub-Saharan Africa is spread across 28 different countries, reflecting the extent of the epidemic in that continent[11]. Infections from South & South East Asia were mostly acquired in Thailand, which accounted for 4.9% of total infections abroad and infections in Western Europe were most likely to be from Spain and Portugal.

Table 2.1 illustrates the age distribution, stage of HIV disease and ethnicity of new HIV and AIDS cases by infection route and sex. Nineteen percent of all reported cases in 2006 were seen for the first time in this year. The majority of newly reported cases fall between the ages of 25 and 44 (71%) years, with incidence being highest in those aged 30-34 years (19%), compared with 35-39 years recorded in 2005. As seen in recent years, exposure through heterosexual sex accounts for the highest proportion of new cases (48%) followed by sex between men (42%). The majority 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) (97%). Table 2.1 also shows that this age group is represented in the mother to child infection route category (3 individuals) but not in the injecting drug use category.

The number of new infections attributed to injecting drug use remains relatively low and dropped from 20 to 15 individuals between 2005 and 2006. During the year, 17 new cases of vertical transmission were reported from North West treatment centres, which represents an increase of 55% on 2005. Three new cases were attributed to having received contaminated blood or tissue. The infection route for 54 new cases (6%) has not yet been determined.

HIV positive individuals categorised as asymptomatic continue to represent the largest proportion of new cases (65%), maintaining the observation that many HIV positive individuals are contacting services at a relatively early stage of their HIV disease. Of the 11 new individuals who died during 2006, 9 individuals had an AIDS defining

illness. Furthermore, 16% of new cases first presented with AIDS, this shows that despite continued efforts to raise awareness, a minority of individuals are continuing 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 self-defined as white (54%), with 46% of cases being from a minority ethnic group. Black Africans account for 85% of minority ethnic cases, with black African females exposed through heterosexual sex making up 22% of all new cases reported in 2006. Of all the men infected through MSM, 89% 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 2006. Although the infection route for 53% of all HIV positive individuals accessing treatment and care in 2006 was attributed to sex between men (chapter 3, table 3.1), this proportion was lower for new cases with 42% infected via this route. Across the counties there were large differences in the route of infection. Whilst the main route of infection in Merseyside is heterosexual (59%) with fewer men who have sex with men (MSM) (29%), Lancashire reveals a more even split, with 45% infected via MSM and 40% via heterosexual sex. Of those infected through MSM and residing in Lancashire, 50% reside in Blackpool, an area with a large gay community. Manchester also has a large gay community[65] and correspondingly, Greater Manchester accounts for 68% of new cases resident in the North West exposed via sex between men, with the second highest proportion (13%) 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 almost a third (62%) of new HIV and AIDS cases presenting for treatment and care in the North West. Cheshire had the highest recorded proportion of AIDS cases with 21% and almost three quarters of those with HIV living in Merseyside were asymptomatic. For those whose residential details were known, the vast majority of new cases who received care in the North West during 2006 were resident within the region (97%). Of the 29 individuals known to live outside the region, 14% 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 2006, broken down by those resident in the North West, those residing out of region or of unknown residency 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 still asymptomatic and 16% presented with AIDS (including those who had died from an AIDS related illness). The predominant route of HIV exposure among women continues to be heterosexual sex (90%). The table shows that 29 individuals accessed treatment and care in the North West but are known to reside outside the region. Table 2.4 also shows that 50% of all individuals either resident outside the region, or whose residential details are unknown were infected through sex between men.

Table 2.5 shows the residential distribution of new HIV and AIDS cases presenting in the North West for treatment and care in 2006, categorised by ethnicity and age group. Of North West residents, those aged between 30 to 34 years represented the largest group of new cases accessing treatment and care. As would be expected, new cases tend to be younger (median age of 35 years) than all cases (median age 39 years), demonstrating the continuing need to encourage young people at risk of HIV exposure to access services. The majority of new cases in 2006 whose ethnicity was known were self-defined as white (54%), 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, 46% are self-defined as being from a minority ethnic group. This indicates a substantial over representation of new HIV cases within black and minority ethnic communities, when compared to their overall proportion within the North West population (7%)[66]. The incidence of diagnosed HIV is over 11 times higher in black and minority ethnic 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 which have already been identified as having shorter life expectancies, together with poorer physical and mental health[67].

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 2006. The majority of women seen in the region for the first time in 2006 are self-defined as being from a minority ethnic group (83%). Black Africans account for 78% of all female new cases for whom ethnicity is known. Whilst in the white population the gender distribution is highly biased towards males (91%), 57% of the new black and minority ethnic cases are female.

Overall, 65% of new HIV and AIDS cases presented while still asymptomatic, 17% were categorised as AIDS (including those who had died from an AIDS related illness) and 1% died during the year. Prior to 2002 considerable differences among ethnic groups were reported. For example, in 2001, 17% of white and 28% of non-white individuals presented for the first time already with AIDS, and in 2000 the margin was wider with 16% of white individuals already having AIDS compared to 34% of non-white ethnic communities. However, in 2006, as in more recent years, individuals from black and minority ethnic communities for whom ethnicity and stage were known were just as likely to present while still asymptomatic (64%) as were white individuals (69%) and similar proportions were symptomatic (17% compared to 16% of white individuals), or had AIDS (18% for minority ethnic groups compared with 14% for white individuals). This suggests that those from white and black and minority ethnic groups

are becoming more likely to access care at an early stage of their disease, and this will hopefully prolong their life expectancy.

Forty percent of all new cases of HIV and AIDS were reported to have been contracted outside the UK. However, the exposure route for a further 146 cases is currently unknown, which could lead to an underestimation of the figures contracted abroad. For those whose country of infection was known, 86% of all those self-defined as white were infected in the UK. However, 94% of all black Africans, for whom infection route abroad was known, were infected outside the UK.

Table 2.7 shows the global region of HIV exposure by infection route of HIV for new HIV and AIDS cases acquired outside the UK who presented in the North West for treatment and care in 2006. Of those infected abroad, the proportion who were infected via sex between men is 10%, a slight increase on 2005. 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 (86%) of individuals with heterosexually acquired HIV whose infections were contracted abroad were acquired in sub-Saharan Africa, with a further 6% in South & South East Asia.

Western Europe accounted for the largest number of new cases in MSM while abroad (46%). This could reflect the reported tendency of gay men to take risks while on holiday[68]. Three out of the 15 new cases who were infected by injecting drug use were thought to be infected abroad, primarily in Western Europe. Injecting drug use remains a major transmission route of HIV in many western European countries[17]. Although the risk of contracting HIV via injecting drug use is relatively low in the UK, due to low prevalence of HIV amongst this group, sharing injecting equipment abroad remains a significant risk.

Table 2.8 illustrates the distribution of new HIV and AIDS cases between North West treatment centres and infection route. The treatment centre with the largest number of new cases in 2006 was Manchester Royal Infirmary Department of Genito-Urinary Medicine (MRIG) with 24% 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 Genito-Urinary Medicine (RLG). Several treatment centres have seen increases in the number of new cases in 2006 compared to 2005, for example a specialist GP practice in Manchester (MGP) saw a 100% increase (from 17 to 34 individuals) and Withington Hospital (WITG) a 26% increase (from 34 to 43).

Table 2.9 presents the residency status of new HIV and AIDS cases categorised by their stage of disease. Of the 907 total new cases, 564 cases (62%) are known to be UK nationals, and 222 (24%) were non-UK nationals, a slight decrease on the figure from 2005 (233 individuals; 25%). Amongst non-UK nationals, similar to the case amongst UK nationals, two-thirds (66%) were asymptomatic.

Table 2.10 shows residency status of new cases known to be non-UK nationals broken down by sex, age group, infection route, ethnicity, stage of disease and area of residence. Amongst the non-UK nationals, over half (55%) were classified as asylum seekers. Females represent the majority (60%) of new cases and the predominant age range is between 25 and 39 years (64%). The ethnic distribution shows that black Africans make up the vast majority (90%) of cases. Furthermore, the primary source of infection amongst non-UK nationals is heterosexual sex, representing 90% of cases. Over two thirds of new cases (71%) resided in the Greater Manchester area, followed by 16% residing in Merseyside.

The largest percentage of infections through sex between men recorded within the non-UK national population was among temporary visitors to the region (31%). Overall, 34% of all non-UK nationals presented for the first time to treatment centres as symptomatic or AIDS (including those who died of AIDS related illnesses), similar to UK nationals (31%: table 2.9).

Table 2.11 displays new HIV cases by infection route and PCT of residence. The figures show that Manchester PCT has the largest proportion of new HIV cases in treatment and care in the North West (31%), and Liverpool PCT has the second largest population of new HIV cases with 7% (67 individuals).

Table 2.12 shows new HIV cases by stage of disease and PCT of residence. Amongst those that were asymptomatic, almost a third (31%) resided in Manchester PCT, followed by the next largest proportion (10%) in Salford PCT. Further analyses by PCT can be found on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2006).

Figure 2.1: Incidence of HIV by local authority, 2006
Crude rate based on the number of new cases of HIV and AIDS accessing North West treatment centres per 100,000 of the population

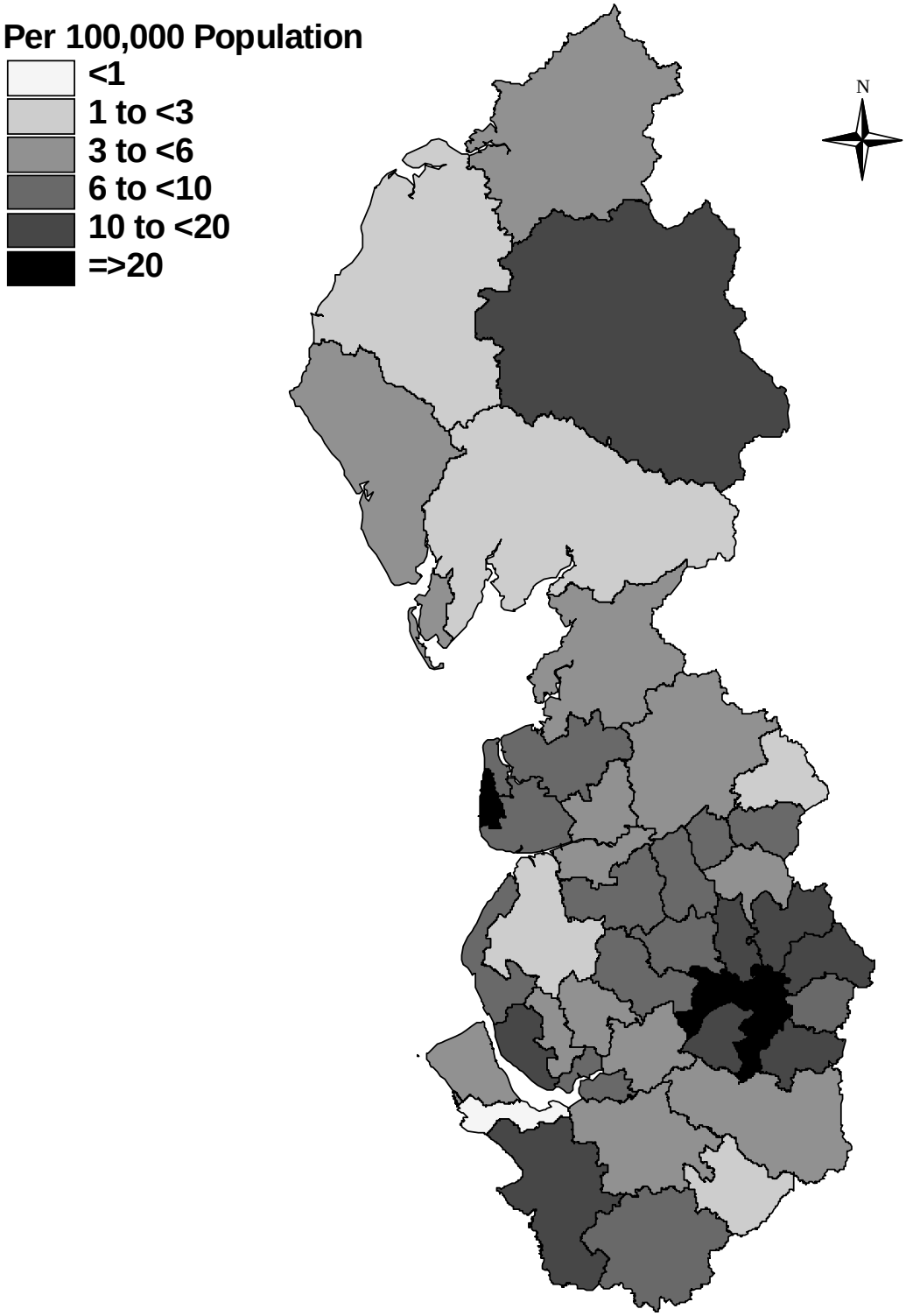
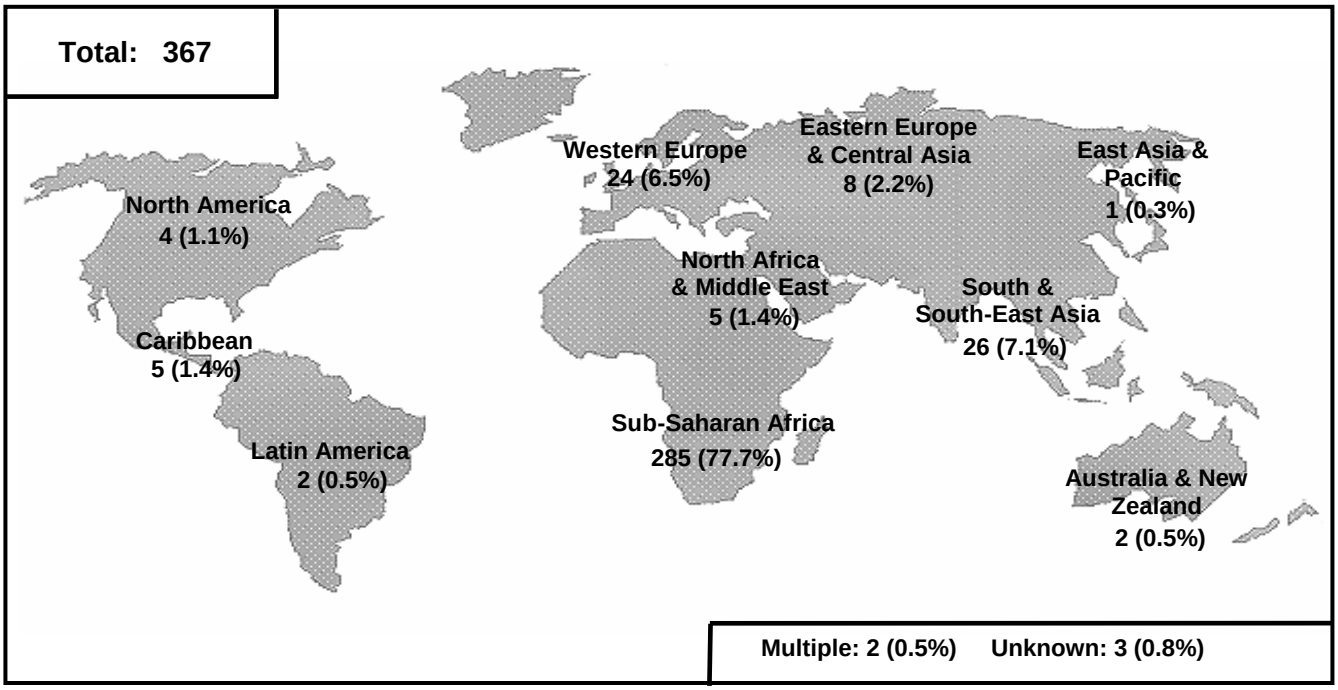


Figure 2.2: Global region and country of infection for new HIV and AIDS cases who probably acquired their infection outside the UK, 2006



Sub-Saharan Africa	285 (77.7%)
Angola	3 (0.8%)
Botswana	2 (0.5%)
Burundi	1 (0.3%)
Cameroon	8 (2.2%)
Central African Republic	2 (0.5%)
Chad	1 (0.3%)
Congo	6 (1.6%)
Dem. Republic of Congo	3 (0.8%)
Eritrea	7 (1.9%)
Ethiopia	3 (0.8%)
Ghana	3 (0.8%)
Guinea	1 (0.3%)
Kenya	8 (2.2%)
Liberia	1 (0.3%)
Malawi	22 (6%)
Mozambique	1 (0.3%)
Namibia	1 (0.3%)
Nigeria	17 (4.6%)
Rwanda	2 (0.5%)
Sierra Leone	3 (0.8%)
Somalia	3 (0.8%)
South Africa	24 (6.5%)
Tanzania	5 (1.4%)
The Gambia	1 (0.3%)
Togo	2 (0.5%)
Uganda	9 (2.5%)
Zambia	9 (2.5%)
Zimbabwe	100 (27.2%)
Unknown	36 (9.8%)
Multiple	1 (0.3%)

East Asia & Pacific	1 (0.3%)
Unknown	1 (0.3%)

Australia & New Zealand	2 (0.5%)
Australia	1 (0.3%)
Unknown	1 (0.3%)

South & South-East Asia	26 (7.1%)
India	2 (0.5%)
Pakistan	2 (0.5%)
Thailand	18 (4.9%)
Unknown	4 (1.1%)

Eastern Europe & Central Asia	8 (2.2%)
Latvia	2 (0.5%)
Poland	2 (0.5%)
Romania	3 (0.8%)
Unknown	1 (0.3%)

Western Europe	24 (6.5%)
Canary Islands	1 (0.3%)
France	1 (0.3%)
Italy	1 (0.3%)
Netherlands	3 (0.8%)
Portugal	6 (1.6%)
Spain	5 (1.4%)
Unknown	6 (1.6%)
Multiple	1 (0.3%)

North Africa & Middle East	5 (1.4%)
Jordan	1 (0.3%)
Libyan Arab Jamahiriya	2 (0.5%)
Saudi Arabia	1 (0.3%)
Sudan	1 (0.3%)

North America	4 (1.1%)
Canada	1 (0.3%)
United States of America	3 (0.8%)

Caribbean	5 (1.4%)
Jamaica	2 (0.5%)
Puerto Rico	1 (0.3%)
Unknown	2 (0.5%)

Latin America	2 (0.5%)
Brazil	1 (0.3%)
Mexico	1 (0.3%)

Multiple countries	2 (0.5%)
Unknown country	3 (0.8%)

Total	367 (100%)

Table 2.1: Age distribution, stage of HIV disease and ethnic group of new HIV and AIDS cases by infection route and sex, 2006

		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								4	10	1		15
	15-19	7			1	6			2	1	2	1	20
	20-24	44			13	25					5		87
	25-29	78	1		22	59					7	2	169
	30-34	64	3	2	37	62					6	2	176
	35-39	68	3	2	41	42	1				4	2	163
	40-44	63	1		35	25		1			8	3	136
	45-49	31	3		13	14					4	1	66
	50-54	19			9	11					3		42
	55-59	8			6	3					2		19
	60+	3			6	3		1			1		14
Stage of HIV Disease	Asymptomatic	265	5	3	115	163	1		1	8	23	7	591
	Symptomatic	53	5		28	43			3	2	7	2	143
	AIDS	46		1	35	42		2	2	1	11	2	142
	AIDS Related Death	3			4	2							9
	Death Unrelated to AIDS	1									1		2
	Unknown	17	1		1						1		20
Ethnicity	White	341	10	4	60	32	1		3	2	19	4	476
	Black Caribbean	2				7							9
	Black African	8			112	198		1	3	9	8	3	342
	Black Other					3							3
	Indian/Pakistani/Bangladeshi	4			4								8
	Other Asian/Oriental	6			2	5		1			2		16
	Other/Mixed	15	1		3	3					1		23
	Unknown	9			2	2					13	4	30
	Total	**385**	**11**	**4**	**183**	**250**	**1**	**2**	**6**	**11**	**43**	**11**	**907**
	%	**42.4**	**1.2**	**0.4**	**20.2**	**27.6**	**0.1**	**0.2**	**0.7**	**1.2**	**4.7**	**1.2**	

Men who have been exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age ranges refer to the age of individuals at the end of December 2006, or at death.

Table 2.2: Local authority and county of residence of new HIV and AIDS cases by infection route, 2006

	Local Authority of Residence	Infection Route						Total (100%)
		MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	Carlisle	1 (33.3%)		2 (66.7%)				3
	Allerdale			1 (50%)			1 (50%)	2
	Eden	5 (100%)						5
	Copeland	1 (50%)			1 (50%)			2
	South Lakeland			1 (50%)			1 (50%)	2
	Barrow-in-Furness	1 (50%)		1 (50%)				2
	Total	**8 (50%)**		**5 (31.3%)**	**1 (6.3%)**		**2 (12.5%)**	**16**
Lancashire	Lancaster	2 (28.6%)	1 (14.3%)	3 (42.9%)			1 (14.3%)	7
	Wyre	7 (87.5%)		1 (12.5%)				8
	Fylde	2 (33.3%)	1 (16.7%)	1 (16.7%)			2 (33.3%)	6
	Blackpool	24 (57.1%)		13 (31%)		1 (2.4%)	4 (9.5%)	42
	Blackburn with Darwen	1 (12.5%)	1 (12.5%)	5 (62.5%)			1 (12.5%)	8
	Ribble Valley	1 (33.3%)		2 (66.7%)				3
	Pendle	1 (50%)		1 (50%)				2
	Hyndburn	1 (14.3%)		4 (57.1%)		1 (14.3%)	1 (14.3%)	7
	Burnley	1 (20%)		4 (80%)				5
	Rossendale			2 (100%)				2
	Preston	3 (60%)		2 (40%)				5
	South Ribble	2 (66.7%)		1 (33.3%)				3
	Chorley	2 (33.3%)		2 (33.3%)			2 (33.3%)	6
	West Lancashire	1 (50%)		1 (50%)				2
	Total	**48 (45.3%)**	**3 (2.8%)**	**42 (39.6%)**		**2 (1.9%)**	**11 (10.4%)**	**106**
Greater Manchester	Wigan	5 (27.8%)		12 (66.7%)			1 (5.6%)	18
	Bolton	7 (33.3%)	1 (4.8%)	13 (61.9%)				21
	Bury	11 (40.7%)		14 (51.9%)		1 (3.7%)	1 (3.7%)	27
	Rochdale	7 (30.4%)		12 (52.2%)		2 (8.7%)	2 (8.7%)	23
	Oldham	7 (33.3%)	1 (4.8%)	13 (61.9%)				21
	Salford	50 (54.9%)		34 (37.4%)		1 (1.1%)	6 (6.6%)	91
	Manchester	120 (42.4%)	5 (1.8%)	140 (49.5%)		6 (2.1%)	12 (4.2%)	283
	Tameside	8 (40%)	2 (10%)	10 (50%)				20
	Trafford	9 (30%)		17 (56.7%)		2 (6.7%)	2 (6.7%)	30
	Stockport	16 (59.3%)		11 (40.7%)				27
	Unknown Greater Manchester	1 (33.3%)		2 (66.7%)				3
	Total	**241 (42.7%)**	**9 (1.6%)**	**278 (49.3%)**		**12 (2.1%)**	**24 (4.3%)**	**564**
Merseyside	Sefton	5 (31.3%)	1 (6.3%)	9 (56.3%)			1 (6.3%)	16
	Liverpool	15 (22.4%)		43 (64.2%)		2 (3%)	7 (10.4%)	67
	Knowsley	1 (25%)	1 (25%)				2 (50%)	4
	Wirral	3 (17.6%)		14 (82.4%)				17
	St Helens	7 (77.8%)		2 (22.2%)				9
	Unknown Merseyside	2 (100%)						2
	Total	**33 (28.7%)**	**2 (1.7%)**	**68 (59.1%)**		**2 (1.7%)**	**10 (8.7%)**	**115**
Cheshire	Halton	4 (57.1%)		1 (14.3%)			2 (28.6%)	7
	Warrington	5 (71.4%)		2 (28.6%)				7
	Chester	7 (43.8%)		8 (50%)			1 (6.3%)	16
	Vale Royal	1 (25%)		3 (75%)				4
	Macclesfield	4 (66.7%)		1 (16.7%)			1 (16.7%)	6
	Congleton	1 (100%)						1
	Crewe & Nantwich	4 (57.1%)		3 (42.9%)				7
	Total	**26 (54.2%)**		**18 (37.5%)**			**4 (8.3%)**	**48**
	Total North West Residents	**356 (41.9%)**	**14 (1.6%)**	**411 (48.4%)**	**1 (0.1%)**	**16 (1.9%)**	**51 (6%)**	**849**
	Isle of Man	3 (75%)		1 (25%)				4
	Out of Region	15 (60%)	1 (4%)	7 (28%)	1 (4%)	1 (4%)		25
	Unknown*	11 (37.9%)		14 (48.3%)	1 (3.4%)		3 (10.3%)	29
	Total	**385 (42.4%)**	**15 (1.7%)**	**433 (47.7%)**	**3 (0.3%)**	**17 (1.9%)**	**54 (6%)**	**907**

Men who have been exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
** Includes one person of no fixed abode and two who declined to give any residential information.*

Table 2.3: Local authority and county of residence of new HIV and AIDS cases by stage of HIV disease, 2006

	Local Authority of Residence	Stage of Disease						Total (100%)
		Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	Carlisle	1 (33.3%)	2 (66.7%)					3
	Allerdale	2 (100%)						2
	Eden	3 (60%)	2 (40%)					5
	Copeland	1 (50%)		1 (50%)				2
	South Lakeland		1 (50%)	1 (50%)				2
	Barrow-in-Furness	2 (100%)						2
	Total	**9 (56.3%)**	**5 (31.3%)**	**2 (12.5%)**				**16**
Lancashire	Lancaster	4 (57.1%)	2 (28.6%)		1 (14.3%)			7
	Wyre	2 (25%)	2 (25%)	4 (50%)				8
	Fylde	3 (50%)		1 (16.7%)		1 (16.7%)	1 (16.7%)	6
	Blackpool	31 (73.8%)	4 (9.5%)	5 (11.9%)	2 (4.8%)			42
	Blackburn with Darwen	2 (25%)	4 (50%)	2 (25%)				8
	Ribble Valley	1 (33.3%)		2 (66.7%)				3
	Pendle	2 (100%)						2
	Hyndburn	5 (71.4%)		2 (28.6%)				7
	Burnley	3 (60%)	2 (40%)					5
	Rossendale		1 (50%)	1 (50%)				2
	Preston	4 (80%)			1 (20%)			5
	South Ribble	2 (66.7%)					1 (33.3%)	3
	Chorley	3 (50%)	2 (33.3%)				1 (16.7%)	6
	West Lancashire	2 (100%)						2
	Total	**64 (60.4%)**	**17 (16%)**	**17 (16%)**	**4 (3.8%)**	**1 (0.9%)**	**3 (2.8%)**	**106**
Greater Manchester	Wigan	13 (72.2%)	2 (11.1%)	3 (16.7%)				18
	Bolton	17 (81%)	1 (4.8%)	3 (14.3%)				21
	Bury	18 (66.7%)	9 (33.3%)					27
	Rochdale	12 (52.2%)	6 (26.1%)	5 (21.7%)				23
	Oldham	13 (61.9%)	5 (23.8%)	3 (14.3%)				21
	Salford	59 (64.8%)	14 (15.4%)	14 (15.4%)	1 (1.1%)		3 (3.3%)	91
	Manchester	182 (64.3%)	50 (17.7%)	37 (13.1%)	2 (0.7%)		12 (4.2%)	283
	Tameside	14 (70%)	1 (5%)	5 (25%)				20
	Trafford	18 (60%)	7 (23.3%)	5 (16.7%)				30
	Stockport	11 (40.7%)	9 (33.3%)	6 (22.2%)			1 (3.7%)	27
	Unknown Greater Manchester	2 (66.7%)		1 (33.3%)				3
	Total	**359 (63.7%)**	**104 (18.4%)**	**82 (14.5%)**	**3 (0.5%)**		**16 (2.8%)**	**564**
Merseyside	Sefton	9 (56.3%)	2 (12.5%)	5 (31.3%)				16
	Liverpool	58 (86.6%)	2 (3%)	7 (10.4%)				67
	Knowsley	3 (75%)		1 (25%)				4
	Wirral	9 (52.9%)	2 (11.8%)	5 (29.4%)	1 (5.9%)			17
	St Helens	8 (88.9%)		1 (11.1%)				9
	Unknown Merseyside	2 (100%)						2
	Total	**89 (77.4%)**	**6 (5.2%)**	**19 (16.5%)**	**1 (0.9%)**			**115**
Cheshire	Halton	3 (42.9%)	1 (14.3%)	2 (28.6%)	1 (14.3%)			7
	Warrington	6 (85.7%)		1 (14.3%)				7
	Chester	13 (81.3%)	1 (6.3%)	2 (12.5%)				16
	Vale Royal	4 (100%)						4
	Macclesfield	4 (66.7%)	1 (16.7%)	1 (16.7%)				6
	Congleton			1 (100%)				1
	Crewe & Nantwich	3 (42.9%)	1 (14.3%)	3 (42.9%)				7
	Total	**33 (68.8%)**	**4 (8.3%)**	**10 (20.8%)**	**1 (2.1%)**			**48**
	Total North West Residents	**554 (65.3%)**	**136 (16%)**	**130 (15.3%)**	**9 (1.1%)**	**1 (0.1%)**	**19 (2.2%)**	**849**
	Isle of Man	1 (25%)	2 (50%)	1 (25%)				4
	Out of Region	18 (72%)	3 (12%)	4 (16%)				25
	Unknown*	18 (62.1%)	2 (6.9%)	7 (24.1%)		1 (3.4%)	1 (3.4%)	29
	Total	**591 (65.2%)**	**143 (15.8%)**	**142 (15.7%)**	**9 (1%)**	**2 (0.2%)**	**20 (2.2%)**	**907**

** Includes one person of no fixed abode and two who declined to give any residential information.*

Table 2.4: New HIV and AIDS cases by stage of HIV disease, infection route and sex, 2006

	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	245	5	3	106	158			1	7	22	7	554
	Symptomatic	50	5		25	42			3	2	7	2	136
	AIDS	40			32	41		1	2	1	11	2	130
	AIDS Related Death	3			4	2							9
	Death Unrelated to AIDS	1											1
	Unknown	17	1		1								19
	Total	**356**	**11**	**3**	**168**	**243**		**1**	**6**	**10**	**40**	**11**	**849**
	%	**41.9**	**1.3**	**0.4**	**19.8**	**28.6**		**0.1**	**0.7**	**1.2**	**4.7**	**1.3**	
Out of Region/ Unknown	Out of Region**	18		1	4	4	1			1			29
	Unknown*	11			11	3		1			3		29
	Total	**29**		**1**	**15**	**7**	**1**	**1**		**1**	**3**		**58**
	%	**50.0**		**1.7**	**25.9**	**12.1**	**1.7**	**1.7**		**1.7**	**5.2**		
All individuals treated in North West	Asymptomatic	265	5	3	115	163	1		1	8	23	7	591
	Symptomatic	53	5		28	43			3	2	7	2	143
	AIDS	46		1	35	42		2	2	1	11	2	142
	AIDS Related Death	3			4	2							9
	Death Unrelated to AIDS	1									1		2
	Unknown	17	1		1						1		20
	Total	**385**	**11**	**4**	**183**	**250**	**1**	**2**	**6**	**11**	**43**	**11**	**907**
	%	**42.4**	**1.2**	**0.4**	**20.2**	**27.6**	**0.1**	**0.2**	**0.7**	**1.2**	**4.7**	**1.2**	

Men who have been exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
*** Includes Isle of Man.*
** Includes one person of no fixed abode and two who declined to give any residential information.*

Table 2.5: New HIV and AIDS cases by age category and ethnic group, 2006

	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	3		11						14
	15-19	11	2	7						20
	20-24	45	3	22	1		2	1		74
	25-29	74	3	66	1	1	4	6	4	159
	30-34	74		78		2	2	6	6	168
	35-39	78		67		3	2	4	3	157
	40-44	72		41	1	1	2	2	5	124
	45-49	44	1	16				1	2	64
	50-54	24		11				1	4	40
	55-59	14		2					2	18
	60+	6		4					1	11
	Total	**445**	**9**	**325**	**3**	**7**	**12**	**21**	**27**	**849**
	%	**52.4%**	**1.1%**	**38.3%**	**0.4%**	**0.8%**	**1.4%**	**2.5%**	**3.2%**	
Out of Region/ Unknown	Out of Region**	19		6		1	3			29
	Unknown*	12		11			1	2	3	29
	Total	**31**		**17**		**1**	**4**	**2**	**3**	**58**
	%	**53.4%**		**29.3%**		**1.7%**	**6.9%**	**3.4%**	**5.2%**	
All individuals treated in North West	0-14	3		12						15
	15-19	11	2	7						20
	20-24	52	3	25	1		3	2	1	87
	25-29	80	3	69	1	1	4	7	4	169
	30-34	75		83		2	4	6	6	176
	35-39	83		67		3	2	4	4	163
	40-44	80		42	1	2	3	2	6	136
	45-49	46	1	16				1	2	66
	50-54	25		12				1	4	42
	55-59	14		3					2	19
	60+	7		6					1	14
	Total	**476**	**9**	**342**	**3**	**8**	**16**	**23**	**30**	**907**
	%	**52.5%**	**1.0%**	**37.7%**	**0.3%**	**0.9%**	**1.8%**	**2.5%**	**3.3%**	

Age ranges refer to the ages of individuals at the end of December 2006, or at death.
*** Includes Isle of Man.*
** Includes one person of no fixed abode and two who declined to give any residential information.*

Table 2.6: Sex, stage of HIV disease and HIV exposure abroad of new HIV and AIDS cases by ethnic group, 2006

		Ethnicity								Total (100%)
		White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Sex	Male	434 (69%)	2 (0.3%)	131 (20.8%)		8 (1.3%)	10 (1.6%)	20 (3.2%)	24 (3.8%)	629
	Female	42 (15.1%)	7 (2.5%)	211 (75.9%)	3 (1.1%)		6 (2.2%)	3 (1.1%)	6 (2.2%)	278
Stage of Disease	Asymptomatic	317 (53.6%)	9 (1.5%)	215 (36.4%)	3 (0.5%)	5 (0.8%)	12 (2%)	12 (2%)	18 (3%)	591
	Symptomatic	73 (51%)		63 (44.1%)				6 (4.2%)	1 (0.7%)	143
	AIDS	64 (45.1%)		60 (42.3%)		2 (1.4%)	3 (2.1%)	5 (3.5%)	8 (5.6%)	142
	AIDS Related Death	6 (66.7%)		3 (33.3%)						9
	Death Unrelated to AIDS	1 (50%)							1 (50%)	2
	Unknown	15 (75%)		1 (5%)		1 (5%)	1 (5%)		2 (10%)	20
HIV Exposure Abroad	No	348 (88.3%)	7 (1.8%)	18 (4.6%)	1 (0.3%)	1 (0.3%)	4 (1%)	8 (2%)	7 (1.8%)	394
	Yes	59 (16.1%)	2 (0.5%)	276 (75.2%)	2 (0.5%)	6 (1.6%)	8 (2.2%)	12 (3.3%)	2 (0.5%)	367
	Unknown	69 (47.3%)		48 (32.9%)		1 (0.7%)	4 (2.7%)	3 (2.1%)	21 (14.4%)	146
	Total	**476 (52.5%)**	**9 (1%)**	**342 (37.7%)**	**3 (0.3%)**	**8 (0.9%)**	**16 (1.8%)**	**23 (2.5%)**	**30 (3.3%)**	**907**

Table 2.7: Global region and country of exposure by infection route for new HIV and AIDS cases who probably acquired their infection outside the UK, 2006

Region of Exposure	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Abroad	35 (9.5%)	3 (0.8%)	309 (84.2%)	2 (0.5%)	9 (2.5%)	9 (2.5%)	367
Australia & New Zealand	2						2
Caribbean			4			1	5
East Asia & Pacific	1						1
Eastern Europe & Central Asia			5		2	1	8
Latin America	2						2
North Africa & Middle East	1		3			1	5
North America	2	1	1				4
South & South-East Asia	5		20	1			26
Sub-Saharan Africa	5		266	1	7	6	285
Western Europe	16	2	6				24
Multiple			2				2
Unknown	1		2				3
UK	287 (72.8%)	12 (3%)	68 (17.3%)	1 (0.3%)	6 (1.5%)	20 (5.1%)	394
Undetermined	63 (43.2%)		56 (38.4%)		2 (1.4%)	25 (17.1%)	146
Total	**385 (42.4%)**	**15 (1.7%)**	**433 (47.7%)**	**3 (0.3%)**	**17 (1.9%)**	**54 (6%)**	**907**

Men who have been 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, 2006

Treatment Centre	Infection Route						Total
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
AHC					2 (66.7%)	1 (33.3%)	3
APH	4 (28.6%)		10 (71.4%)				14
ARM	3 (100%)						3
BLAG	35 (57.4%)	1 (1.6%)	15 (24.6%)		1 (1.6%)	9 (14.8%)	61
BLKG	2 (14.3%)	1 (7.1%)	11 (78.6%)				14
BOLG	3 (12%)	1 (4%)	21 (84%)				25
BOOT					9 (100%)		9
BURG	2 (33.3%)		4 (66.7%)				6
BURY	3 (42.9%)		4 (57.1%)				7
CHR	11 (44%)		13 (52%)			1 (4%)	25
CUMB	7 (58.3%)		4 (33.3%)			1 (8.3%)	12
FGH			1 (100%)				1
HAL	3 (75%)		1 (25%)				4
LCN			5 (100%)				5
LEI	3 (42.9%)		4 (57.1%)				7
LEII	2 (100%)						2
MAC	4 (100%)						4
MGP	31 (91.2%)		2 (5.9%)			1 (2.9%)	34
MRIG	125 (51.4%)		117 (48.1%)	1 (0.4%)			243
MRIH				1 (100%)			1
NMG	61 (31.1%)	9 (4.6%)	87 (44.4%)		14 (7.1%)	25 (12.8%)	196
NMGG	13 (48.1%)		14 (51.9%)				27
NOBL	3 (75%)		1 (25%)				4
OLDG	8 (53.3%)		7 (46.7%)				15
PG	6 (35.3%)		9 (52.9%)			2 (11.8%)	17
RLG	26 (24.5%)	3 (2.8%)	64 (60.4%)			13 (12.3%)	106
RLI	2 (40%)	1 (20%)	2 (40%)				5
ROCG			11 (100%)				11
SALG	8 (29.6%)		19 (70.4%)				27
SHH	9 (81.8%)		2 (18.2%)				11
SPG	5 (41.7%)	1 (8.3%)	6 (50%)				12
STP	9 (45%)		11 (55%)				20
TAMG	5 (38.5%)	2 (15.4%)	6 (46.2%)				13
TRAG	3 (42.9%)		4 (57.1%)				7
WAR	4 (80%)		1 (20%)				5
WGH	2 (66.7%)		1 (33.3%)				3
WIGG	2 (28.6%)		4 (57.1%)			1 (14.3%)	7
WITG	26 (60.5%)		17 (39.5%)				43
WORK				1 (100%)			1

For a definition of the abbreviated statutory treatment centres please refer to appendix A 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 have had exposure through sex with men and are also injecting drug users are included in the MSM category.

Table 2.9: Residency status by stage of HIV disease, 2006

Residency Status	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
UK national	379 (67.2%)	83 (14.7%)	85 (15.1%)	7 (1.2%)	1 (0.2%)	9 (1.6%)	564
Non UK national	147 (66.2%)	36 (16.2%)	38 (17.1%)	1 (0.5%)			222
Unknown	65 (53.7%)	24 (19.8%)	19 (15.7%)	1 (0.8%)	1 (0.8%)	11 (9.1%)	121
Total	**591 (65.2%)**	**143 (15.8%)**	**142 (15.7%)**	**9 (1%)**	**2 (0.2%)**	**20 (2.2%)**	**907**

Table 2.10: Residency status of individuals known to be non-UK nationals by sex, age group, infection route and stage of HIV disease, 2006

		Residency Status							Total
		Asylum Seeker	Overseas Student	Migrant Worker	Temporary Visitor	Refugee	Dependent	Other	
Sex	Male	45 (36.6%)	14 (48.3%)	5 (38.5%)	10 (76.9%)	8 (34.8%)	1 (50%)	6 (31.6%)	89 (40.1%)
	Female	78 (63.4%)	15 (51.7%)	8 (61.5%)	3 (23.1%)	15 (65.2%)	1 (50%)	13 (68.4%)	133 (59.9%)
Age Group	0-14	1 (0.8%)							1 (0.5%)
	15-19	5 (4.1%)	1 (3.4%)			1 (4.3%)			7 (3.2%)
	20-24	10 (8.1%)	4 (13.8%)	2 (15.4%)	1 (7.7%)	2 (8.7%)		1 (5.3%)	20 (9%)
	25-29	25 (20.3%)	9 (31%)	2 (15.4%)	4 (30.8%)	4 (17.4%)		5 (26.3%)	49 (22.1%)
	30-34	30 (24.4%)	2 (6.9%)	3 (23.1%)	1 (7.7%)	5 (21.7%)		4 (21.1%)	45 (20.3%)
	35-39	27 (22%)	4 (13.8%)	2 (15.4%)	2 (15.4%)	7 (30.4%)		5 (26.3%)	47 (21.2%)
	40-44	13 (10.6%)	8 (27.6%)		1 (7.7%)	2 (8.7%)	1 (50%)	1 (5.3%)	26 (11.7%)
	45-49	6 (4.9%)		1 (7.7%)	1 (7.7%)	1 (4.3%)	1 (50%)	2 (10.5%)	12 (5.4%)
	50-54	4 (3.3%)	1 (3.4%)	1 (7.7%)	1 (7.7%)	1 (4.3%)		1 (5.3%)	9 (4.1%)
	55-59			1 (7.7%)	1 (7.7%)				2 (0.9%)
	60+	2 (1.6%)		1 (7.7%)	1 (7.7%)				4 (1.8%)
Infection Route	MSM	2 (1.6%)	2 (6.9%)	3 (23.1%)	4 (30.8%)			2 (10.5%)	13 (5.9%)
	Injecting Drug Use							1 (5.3%)	1 (0.5%)
	Heterosexual	118 (95.9%)	25 (86.2%)	9 (69.2%)	9 (69.2%)	22 (95.7%)	1 (50%)	16 (84.2%)	200 (90.1%)
	Blood/Tissue			1 (7.7%)			1 (50%)		2 (0.9%)
	Mother to Child	2 (1.6%)							2 (0.9%)
	Undetermined	1 (0.8%)	2 (6.9%)			1 (4.3%)			4 (1.8%)
Ethnicity	White		1 (3.4%)	2 (15.4%)	2 (15.4%)			2 (10.5%)	7 (3.2%)
	Black Caribbean		1 (3.4%)						1 (0.5%)
	Black African	121 (98.4%)	25 (86.2%)	9 (69.2%)	8 (61.5%)	23 (100%)	1 (50%)	13 (68.4%)	200 (90.1%)
	Black Other							1 (5.3%)	1 (0.5%)
	Indian/Pakistani/Bangladeshi			1 (7.7%)	1 (7.7%)			1 (5.3%)	3 (1.4%)
	Other Asian/Oriental		1 (3.4%)				1 (50%)	1 (5.3%)	3 (1.4%)
	Other/Mixed	2 (1.6%)	1 (3.4%)	1 (7.7%)	2 (15.4%)			1 (5.3%)	7 (3.2%)
Stage of Disease	Asymptomatic	83 (67.5%)	19 (65.5%)	10 (76.9%)	9 (69.2%)	16 (69.6%)		10 (52.6%)	147 (66.2%)
	Symptomatic	21 (17.1%)	5 (17.2%)		1 (7.7%)	5 (21.7%)		4 (21.1%)	36 (16.2%)
	AIDS	19 (15.4%)	5 (17.2%)	3 (23.1%)	2 (15.4%)	2 (8.7%)	2 (100%)	5 (26.3%)	38 (17.1%)
	AIDS Related Death				1 (7.7%)				1 (0.5%)
Area of Residence	Cumbria			1 (7.7%)			1 (50%)		2 (0.9%)
	Lancashire	6 (4.9%)	1 (3.4%)	1 (7.7%)		1 (4.3%)		1 (5.3%)	10 (4.5%)
	Greater Manchester	80 (65%)	24 (82.8%)	8 (61.5%)	8 (61.5%)	20 (87%)		17 (89.5%)	157 (70.7%)
	Merseyside	34 (27.6%)	1 (3.4%)		1 (7.7%)				36 (16.2%)
	Cheshire		1 (3.4%)	1 (7.7%)	1 (7.7%)	1 (4.3%)	1 (50%)		5 (2.3%)
	Out of Region	3 (2.4%)						1 (5.3%)	4 (1.8%)
	Isle of Man				1 (7.7%)				1 (0.5%)
	Unknown*		2 (6.9%)	2 (15.4%)	2 (15.4%)	1 (4.3%)			7 (3.2%)
	Total	**123**	**29**	**13**	**13**	**23**	**2**	**19**	**222**

Men who have been exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age ranges refer to the age of individuals at the end of December 2006, or at death.
** Includes one person of no fixed abode and two who declined to give any residential information.*

Table 2.11: Primary care trust of residence of new HIV and AIDS cases by infection route, 2006

PCT of Residence	Infection Route						Total
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	8 (50%)		5 (31.3%)	1 (6.3%)		2 (12.5%)	16
North Lancashire	11 (52.4%)	2 (9.5%)	5 (23.8%)			3 (14.3%)	21
Blackpool	24 (57.1%)		13 (31%)		1 (2.4%)	4 (9.5%)	42
Blackburn with Darwen	1 (12.5%)	1 (12.5%)	5 (62.5%)			1 (12.5%)	8
East Lancashire	4 (21.1%)		13 (68.4%)		1 (5.3%)	1 (5.3%)	19
Central Lancashire	8 (50%)		6 (37.5%)			2 (12.5%)	16
Ashton, Leigh & Wigan	5 (27.8%)		12 (66.7%)			1 (5.6%)	18
Bolton	7 (33.3%)	1 (4.8%)	13 (61.9%)				21
Bury	11 (40.7%)		14 (51.9%)		1 (3.7%)	1 (3.7%)	27
Heywood, Middleton & Rochdale	7 (30.4%)		12 (52.2%)		2 (8.7%)	2 (8.7%)	23
Oldham	7 (33.3%)	1 (4.8%)	13 (61.9%)				21
Salford	50 (54.9%)		34 (37.4%)		1 (1.1%)	6 (6.6%)	91
Manchester	120 (42.4%)	5 (1.8%)	140 (49.5%)		6 (2.1%)	12 (4.2%)	283
Tameside & Glossop	9 (42.9%)	2 (9.5%)	10 (47.6%)				21
Trafford	9 (30%)		17 (56.7%)		2 (6.7%)	2 (6.7%)	30
Stockport	16 (59.3%)		11 (40.7%)				27
Unknown Greater Manchester	1 (33.3%)		2 (66.7%)				3
Sefton	5 (31.3%)	1 (6.3%)	9 (56.3%)			1 (6.3%)	16
Liverpool	15 (22.4%)		43 (64.2%)		2 (3%)	7 (10.4%)	67
Knowsley	1 (25%)	1 (25%)				2 (50%)	4
Wirral	3 (17.6%)		14 (82.4%)				17
Halton & St Helens	11 (68.8%)		3 (18.8%)			2 (12.5%)	16
Unknown Merseyside	2 (100%)						2
Warrington	5 (71.4%)		2 (28.6%)				7
West Cheshire	8 (42.1%)		10 (52.6%)			1 (5.3%)	19
Central and Eastern Cheshire	9 (60%)		5 (33.3%)			1 (6.7%)	15
Out of Region	14 (58.3%)	1 (4.2%)	7 (29.2%)	1 (4.2%)	1 (4.2%)		24
Isle of Man	3 (75%)		1 (25%)				4
Unknown*	11 (37.9%)		14 (48.3%)	1 (3.4%)		3 (10.3%)	29
Total	**385 (42.4%)**	**15 (1.7%)**	**433 (47.7%)**	**3 (0.3%)**	**17 (1.9%)**	**54 (6%)**	**907**

Men who have been exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
** Includes one person of no fixed abode and two who declined to give any residential information.*

Table 2.12: Primary care trust of residence of new HIV and AIDS cases by stage of disease, 2006

PCT of Residence	Stage of Disease						Total
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	9 (56.3%)	5 (31.3%)	2 (12.5%)				16
North Lancashire	9 (42.9%)	4 (19%)	5 (23.8%)	1 (4.8%)	1 (4.8%)	1 (4.8%)	21
Blackpool	31 (73.8%)	4 (9.5%)	5 (11.9%)	2 (4.8%)			42
Blackburn with Darwen	2 (25%)	4 (50%)	2 (25%)				8
East Lancashire	11 (57.9%)	3 (15.8%)	5 (26.3%)				19
Central Lancashire	11 (68.8%)	2 (12.5%)		1 (6.3%)		2 (12.5%)	16
Ashton, Leigh & Wigan	13 (72.2%)	2 (11.1%)	3 (16.7%)				18
Bolton	17 (81%)	1 (4.8%)	3 (14.3%)				21
Bury	18 (66.7%)	9 (33.3%)					27
Heywood, Middleton & Rochdale	12 (52.2%)	6 (26.1%)	5 (21.7%)				23
Oldham	13 (61.9%)	5 (23.8%)	3 (14.3%)				21
Salford	59 (64.8%)	14 (15.4%)	14 (15.4%)	1 (1.1%)		3 (3.3%)	91
Manchester	182 (64.3%)	50 (17.7%)	37 (13.1%)	2 (0.7%)		12 (4.2%)	283
Tameside & Glossop	15 (71.4%)	1 (4.8%)	5 (23.8%)				21
Trafford	18 (60%)	7 (23.3%)	5 (16.7%)				30
Stockport	11 (40.7%)	9 (33.3%)	6 (22.2%)			1 (3.7%)	27
Unknown Greater Manchester	2 (66.7%)		1 (33.3%)				3
Sefton	9 (56.3%)	2 (12.5%)	5 (31.3%)				16
Liverpool	58 (86.6%)	2 (3%)	7 (10.4%)				67
Knowsley	3 (75%)		1 (25%)				4
Wirral	9 (52.9%)	2 (11.8%)	5 (29.4%)	1 (5.9%)			17
Halton & St Helens	11 (68.8%)	1 (6.3%)	3 (18.8%)	1 (6.3%)			16
Unknown Merseyside	2 (100%)						2
Warrington	6 (85.7%)		1 (14.3%)				7
West Cheshire	16 (84.2%)	1 (5.3%)	2 (10.5%)				19
Central and Eastern Cheshire	8 (53.3%)	2 (13.3%)	5 (33.3%)				15
Out of Region	17 (70.8%)	3 (12.5%)	4 (16.7%)				24
Isle of Man	1 (25%)	2 (50%)	1 (25%)				4
Unknown*	18 (62.1%)	2 (6.9%)	7 (24.1%)		1 (3.4%)	1 (3.4%)	29
Total %	**591 (65.2%)**	**143 (15.8%)**	**142 (15.7%)**	**9 (1%)**	**2 (0.2%)**	**20 (2.2%)**	**907**

** Includes one person of no fixed abode and two who declined to give any residential information.*

3. All Cases 2006

During 2006, a total of 4,761 individuals living with HIV or AIDS accessed treatment and care from statutory treatment centres in the North West, representing a 13% increase in the size of the HIV positive population (from 4,195 individuals in 2005[10]). This is a slightly smaller increase than between 2004 and 2005 (17%). The aim of this chapter is to provide information on the demographics and characteristics of these 4,761 individuals and, where appropriate, references are made to corresponding data from previous North West reports[1-10].

Analyses are given by LA and PCT. Since the LAs in the North West are approximately co-terminus with PCTs, a table is given in appendix B showing the relationship between LA and PCTs. For reasons of space, it is not possible to present all breakdowns at LA or PCT level, however, additional tables are available on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2006).

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 attended statutory treatment centres within the region during 2006. The population sizes for each LA used in the prevalence calculations are provided by the North West Public Health Observatory based on 2001 census data.

Across the region, the prevalence of HIV was 70 per 100,000 population. There were considerable differences between LAs, with the prevalence in Manchester LA being 325 per 100,000, that of Liverpool being 75 per 100,000 and Congleton and Barrow-in-Furness both being 11 per 100,000

Figure 3.2 illustrates the global region and country of infection for those 1,660 HIV positive individuals presenting for treatment in the North West in 2006 who were probably infected abroad. Of all the infections contracted outside the United Kingdom, 70% 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[11]. Nine percent of people who were infected abroad were infected in Western Europe and the same proportion in South and South East Asia. The exact single country of infection is known for 1,495 individuals (90%). A total of 90 different countries have been named, with Zimbabwe representing the country where the largest number of infections were contracted (29%). Exposure in sub-Saharan Africa was spread across 33 countries. Of those exposed in Western Europe, the largest number were infected in Spain (40 individuals), reflecting the extent of the epidemic in that country[11], the large number of people that travel between the United Kingdom and Spain, and the increased propensity to take risks when on holiday[69-71].

Table 3.1 shows the infection route and sex of all HIV and AIDS cases presenting in the North West for treatment in 2006, categorised by age group, stage of HIV disease and ethnicity. Sex between men remains the most common route of infection among people with HIV in the North West (53% of all cases). The proportion of people infected through heterosexual sex continues to increase, from 15% in 1996 to 40% in 2006. On average, HIV positive heterosexuals are younger (median age 37 years) than MSM (40 years) and injecting drug users (also 40 years). The percentage of individuals exposed to HIV via injecting drug use, those infected by contaminated blood or tissue and vertical transmission all remain low at 2%.

The overall age distribution remained concentrated in the 30-44 year age range, accounting for more than half of all cases (56%) and, as would be expected, shows little deviation from previous years. New cases were more likely to be under 25 years (13%, see chapter 2, table 2.1) when compared to all cases (7%). Table 3.1 also shows that the proportion of HIV positive individuals in the older age groups (50 years and over) has increased slightly from 13% in 2004 and 2005 to 14% in 2006 and this is a large increase from 7% in 1996. This ageing cohort effect is likely to be due to the effectiveness of anti-HIV treatment and subsequent improved prognosis of many HIV positive individuals.

The proportion of individuals with HIV who died during the year decreased from 9% in 1996 to less than 1% in 2006. Of the 41 individuals who died in 2006, 73% died of an AIDS related condition (a slight decrease from 76% in 2005) and 11 (27%) died of other causes (an increase from 24% in 2005).

Of those for whom ethnicity was known (4,721 individuals), 66% were self-defined as white. Those belonging to black and minority ethnic communities make up 33% of the total HIV positive population in the North West, with black Africans representing the greatest proportion of black and minority ethnic groups with 83% of cases.

Table 3.2 shows LA and county of residence by infection route. Although MSM continues to be the dominant mode of HIV transmission (53%) amongst those with HIV resident in the North West region, there is considerable variation at county level. Of those whose infection route was known, 62% of Lancashire's and 60% of Cheshire's HIV positive residents were infected via MSM compared to 39% of Merseyside's HIV positive residents. There is greater variation across LAs: 82% of Blackpool's HIV positive residents were infected through MSM. The LA with

the largest number of HIV positive residents infected through MSM is Manchester, with 721 cases. The county of Greater Manchester had the highest number of HIV positive injecting drug users with 68 individuals and accounts for 69% of all residents of the North West infected by this route.

Table 3.3 illustrates the LA and county of residence and clinical stage of HIV disease for all HIV and AIDS cases presenting to a North West treatment centre in 2006. The figures refer to the clinical condition of individuals when last seen in 2006; individuals who died are presented in separate categories. The highest numbers of people with HIV live in Greater Manchester (60% of the total number of people). As in previous years, the vast majority of people treated in the North West were also resident in the North West (95%). The proportion of people at different stages of HIV disease has consequences for the funding of HIV treatment and care, since those at a more advanced stage require more hospital care[23]. Overall, there was a slight decrease in those classed as asymptomatic (43% compared to 47% in 2005). There was an increase in the proportion of those who were symptomatic from 29% in 2005 to 32% in 2006 and also in those classified as having AIDS from 22% in 2005 to 24% in 2006. There is variation between stages of disease among the counties; Cumbria had 48% (a slight decrease from the previous year) presenting as asymptomatic, whereas Lancashire had 35% (a slight increase from the previous year).

Table 3.4 gives a breakdown of ethnicity and county by infection route and sex. Nearly three quarters (72%) of those infected through heterosexual sex treated in the North West region were from BME/mixed ethnicity backgrounds, compared to 28% who were of white ethnicity. In contrast, of those infected via MSM, 95% were of white ethnicity and only 5% were from BME/mixed ethnicity backgrounds. Individuals from black and minority ethnic communities are substantially over represented among the HIV positive population when compared to their proportion in the North West population as a whole (7%)[66]. Thus, the prevalence in black and minority ethnic communities is 7 times higher than in the white population in the North West. The proportion of the HIV positive population from BME/mixed ethnicity backgrounds varies between counties, with Merseyside having the largest proportion (40%), followed by Greater Manchester (39%) and Cumbria has the smallest proportion (11%).

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, a larger proportion of black African individuals (77%) than those who were white (64%) were aged between 25 and 44 years.

Table 3.6 shows the distribution of total HIV and AIDS cases by stage of HIV disease, county and level of antiretroviral therapy. The largest proportion of individuals (44%) were using triple therapy, followed by a third using no antiretroviral therapy. Amongst those North West residents with AIDS, 95% were on antiretroviral therapy. Amongst those who were asymptomatic, 40% were on antiretroviral therapy. There was little variation between the proportion of individuals on antiretroviral therapy between counties, ranging from 66% in Merseyside to 71% in both Cumbria and 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 (73%) than females with HIV, amongst black Africans, 66% were female and amongst those defined as other Asian/Oriental, 60% were female. The largest proportion of HIV positive individuals were asymptomatic (43%), followed by symptomatic individuals (32%). Amongst white HIV positive individuals, 40% were asymptomatic. In contrast to the 14% of white individuals infected abroad, 77% of those classed as black and minority ethnic individuals were exposed to HIV abroad.

Table 3.8 illustrates global region and country of exposure and route of infection of all HIV and AIDS cases. Over a third (35%) of all cases were reported to have been exposed to HIV abroad, up from 19% in 1998. The majority (81%) of those infected abroad were infected through heterosexual sex, the vast majority of these being infected in sub-Saharan Africa (81%). Heterosexual sex was the most common route of infection in those infected in sub-Saharan Africa (94%), the Caribbean (85%), South and South East Asia (78%), North Africa and Middle East (72%) and Eastern Europe and Central Asia (67%). In contrast, those infected in Australia and New Zealand, North America and Western Europe were more likely to be via MSM (92%, 74% and 57% respectively).

Care of HIV positive people by North West statutory treatment centres

Table 3.9 lists the North West treatment centres (for a definition of the abbreviated treatment centres, please see appendix A), broken down by infection route. The Infectious Disease Unit at North Manchester General Hospital (NMG) provides care for the highest number of HIV positive individuals in the North West (1,448). Manchester Royal Infirmary GUM (MRIG) provided treatment for 857 individuals, the Royal Liverpool University Hospital GUM (RLG) provided care for 563 individuals and Blackpool Victoria Hospital (BLAG) provided care for 360 individuals with HIV in 2006. There are considerable variations in the profile of HIV positive patients between different treatment centres. Ninety six 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 53% (table 3.1) of all HIV and AIDS 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 antiretroviral therapy prescribed by specific treatment centres during 2006. The Infectious Disease Unit at North Manchester General Hospital (NMG), the treatment centre that sees the most individuals in the North West, prescribed triple or more antiretroviral therapy to 81% of their patients. The proportion taking triple or more therapy is yet higher out of those attending the specialist haematology centres at the Royal Liverpool (RLH) and Manchester Royal Infirmary (MRIH) (83% and 87% respectively). There are few individuals on mono or dual therapy in accordance with the latest BHIVA guidelines[72].

Table 3.11 illustrates the residential distribution of all HIV and AIDS cases presenting in the North West for treatment in 2006 by the number of statutory treatment centres attended. The majority (88%) attended only one treatment centre. However, this varied across counties, with residents of Cumbria and residents of Lancashire being more likely to attend only one treatment centre (98% and 94% respectively) than those of Cheshire (89%), Greater Manchester (87%) 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 seen as a result of moving treatment centre because of 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. North Manchester General Infectious Disease Unit (NMG) provided the highest number of outpatient visits, accounting for 24% of all attendances across the region, with Manchester Royal Infirmary GUM (MRIG) department reporting the second highest number of visits, and a higher mean number of outpatient visits per HIV positive person. North Manchester General Infectious Disease Unit (NMG) also provided the highest number of day cases (79% of the total), inpatient episodes (45% of the total) and inpatient days (53%), with the Department of GUM and Tropical and Infectious Disease Unit at the Royal Liverpool University Hospital (RLG) providing the next highest numbers of inpatient episodes at 23% of the total.

Some of the treatment centres provided a significant number of home visits, with Liverpool Community Nursing (LCN) providing 37% of the total home visits, followed by NMG (15%), Blackpool Victoria Hospital (BLAG) with their HIV community nursing team (15%) and Withington Hospital Department of GUM (WITG) (13% of the total). This is the sixth year that we have collected data on home visits. The haematology department at Alder Hey Children's Hospital (AHC) provided the highest number of home visits per HIV positive person (8 per patient), followed by Liverpool Community Nursing team (7 per patient).

Although those categorised as asymptomatic accounted for the highest number of outpatient visits (12,857) it is those with an AIDS defining illness who had the highest mean number of outpatient visits (8.46). Individuals who died of an AIDS related illness during 2006 had the highest mean number of inpatient days (39.87).

HIV among non-UK nationals

Table 3.13 presents a breakdown of residency status by stage of HIV disease for all those individuals who presented for treatment in the North West in 2006. A total of 917 (an increase of 184 from 2005) individuals were known to be non-UK nationals (19% of the total HIV positive population). Residency status for 6% was unknown. Nearly 50% of non-UK nationals were reported to be asymptomatic, suggesting that individuals usually access treatment while still healthy and thus may benefit by life-prolonging treatment. This compares to the population classified as UK nationals, where 41% are classified as asymptomatic. Of those known to be non-UK nationals, a quarter had an AIDS diagnosis, slightly more than the 24% of UK nationals. A similar proportion of non-UK nationals (0.2%) and UK nationals (1%) died in 2006.

Table 3.14 shows the sex, age group, infection route, ethnicity, stage of disease and area of residence by residency status of those individuals known to be non-UK nationals who accessed treatment and care in the North West in 2006. Over half the non-UK nationals were classified as asylum seekers (54%), with overseas students (13%) and refugee (12%) being the other significant categories. Two thirds of HIV positive non-UK nationals were female; this differs from the proportion of all HIV positive individuals where only 27% are female (table 3.1). There is also a large difference in the proportion of heterosexual cases between non-UK nationals and all cases (92% compared to 40%; see chapter 3, table 3.1). Non-UK nationals were younger than the general HIV positive population (table 3.1), with most (78%) being aged between 25 and 44 years. The majority (96%) of asylum seekers were self-defined as black African. Most of the known HIV positive non-UK nationals were resident in Greater Manchester (72%), with the next largest number living in Merseyside (17% of the total).

HIV & AIDS data by primary care trust

Table 3.15 shows primary care trust (PCT) of residence by infection route using the primary care trust boundaries introduced in 2006. Several PCTs have a larger proportion of individuals infected through heterosexual sex than through MSM. Nearly two thirds of the HIV positive individuals residing in Liverpool PCT and 60% of those infected living in Blackburn with Darwen were infected through heterosexual sex. Eighty two percent of those residing in Blackpool PCT were infected through sex between men and 8% of those individuals with HIV living in Knowsley were infected through injecting drug use. Amongst those residing in regions outside the North West being treated in the region, 4% were infected through blood or tissue and 4% through mother to child, suggesting that these individuals are travelling to specialist treatment centres in the region.

Table 3.16 displays PCT of residence by stage of HIV disease. There are four PCTs (Bolton, Liverpool, Warrington and West Cheshire) where asymptomatic individuals represent a larger proportion than those who are symptomatic or have an AIDS defining illness. In all other PCTs, there are fewer individuals recorded as asymptomatic than as symptomatic or having an AIDS defining illness. Further analyses by PCT can be found on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2006).

Figure 3.1: Population prevalence of HIV by local authority, 2006
Crude prevalence based on total number of HIV and AIDS cases accessing North West treatment centres per 100,000 of the population

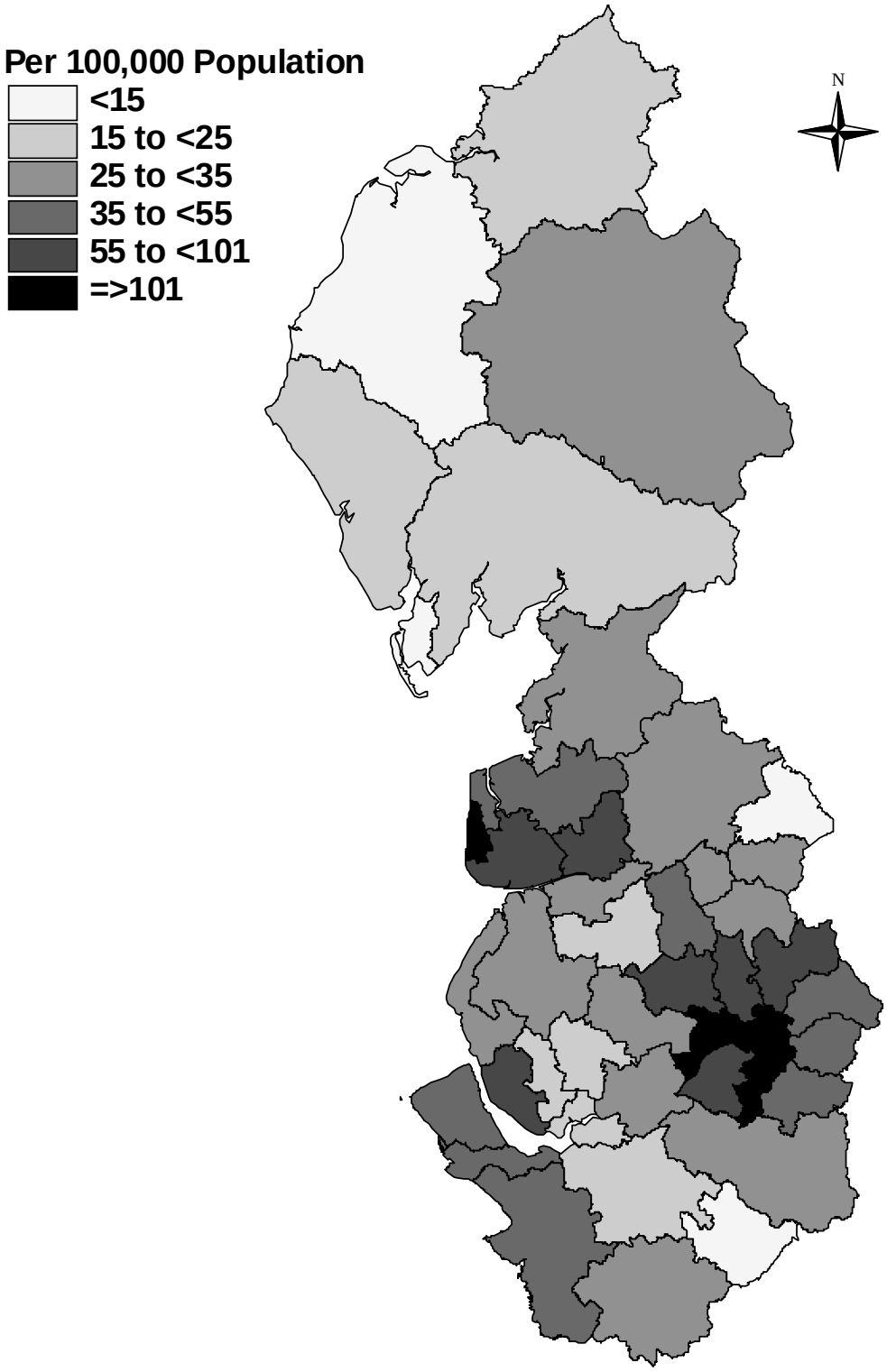
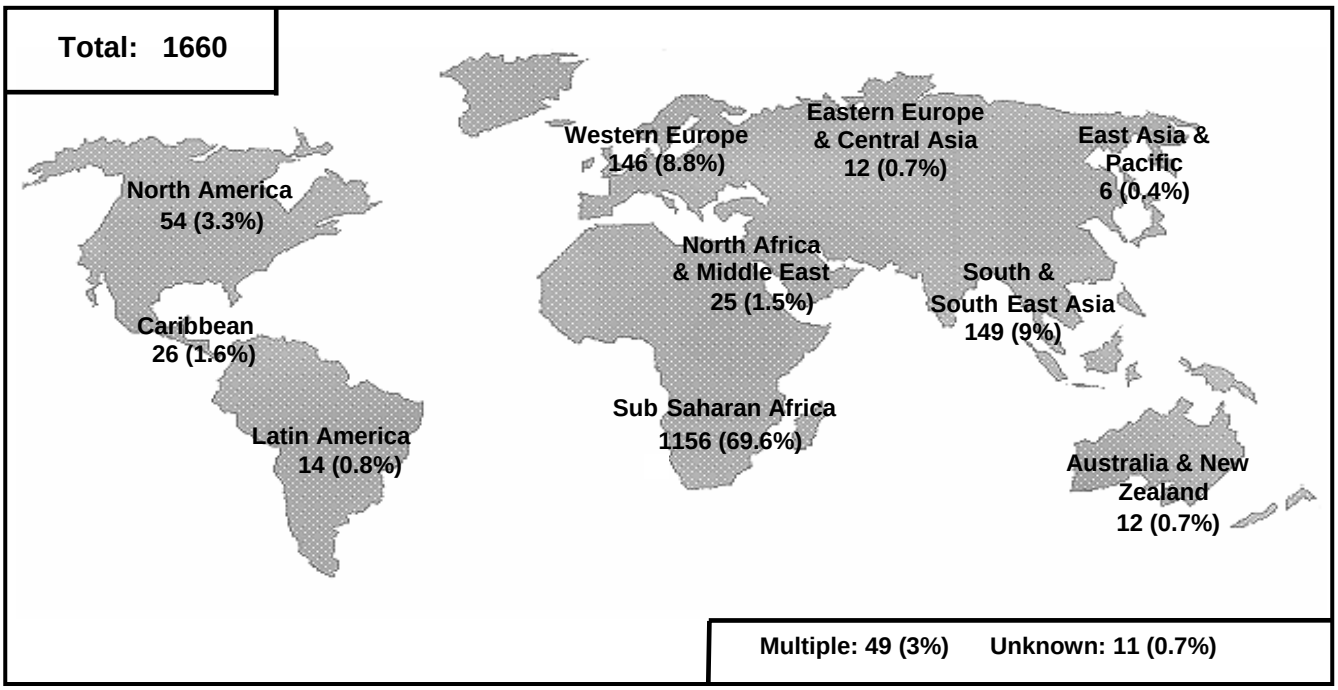


Figure 3.2: Global region and country of infection for all HIV and AIDS cases who probably acquired their infection outside the UK, 2006



Sub-Saharan Africa	1156 (69.6%)
Angola	13 (0.8%)
Botswana	22 (1.3%)
Burundi	13 (0.8%)
Cameroon	22 (1.3%)
Central African Republic	2 (0.1%)
Chad	1 (0.1%)
Congo	32 (1.9%)
Cote d'Ivoire	8 (0.5%)
Dem. Republic of Congo	7 (0.4%)
Eritrea	14 (0.8%)
Ethiopia	9 (0.5%)
Gabon	1 (0.1%)
Ghana	13 (0.8%)
Guinea	2 (0.1%)
Kenya	42 (2.5%)
Lesotho	2 (0.1%)
Liberia	3 (0.2%)
Malawi	91 (5.5%)
Mozambique	2 (0.1%)
Namibia	4 (0.2%)
Nigeria	50 (3%)
Rwanda	10 (0.6%)
Senegal	1 (0.1%)
Sierra Leone	7 (0.4%)
Somalia	13 (0.8%)
South Africa	111 (6.7%)
Swaziland	3 (0.2%)
Tanzania	17 (1%)
The Gambia	9 (0.5%)
Togo	3 (0.2%)
Uganda	29 (1.7%)
Zambia	58 (3.5%)
Zimbabwe	474 (28.6%)
Unknown	62 (3.7%)
Multiple	6 (0.4%)

East Asia & Pacific	6 (0.4%)
China	3 (0.2%)
Hong Kong	1 (0.1%)
Taiwan	1 (0.1%)
Unknown	1 (0.1%)

Australia & New Zealand	12 (0.7%)
Australia	11 (0.7%)
Unknown	1 (0.1%)

South & South-East Asia	149 (9%)
India	9 (0.5%)
Indonesia	2 (0.1%)
Iran	2 (0.1%)
Malaysia	2 (0.1%)
Pakistan	13 (0.8%)
Philippines	2 (0.1%)
Singapore	2 (0.1%)
Thailand	102 (6.1%)
Vietnam	2 (0.1%)
Unknown	8 (0.5%)
Multiple	5 (0.3%)

Eastern Europe & Central Asia	12 (0.7%)
Belarus	1 (0.1%)
Croatia	1 (0.1%)
Georgia	1 (0.1%)
Latvia	2 (0.1%)
Poland	2 (0.1%)
Romania	3 (0.2%)
Unknown	2 (0.1%)

Western Europe	146 (8.8%)
Balearics	1 (0.1%)
Belgium	2 (0.1%)
Canary Islands	6 (0.4%)
Eire	2 (0.1%)
Finland	1 (0.1%)
France	12 (0.7%)
Germany	14 (0.8%)
Gibraltar	1 (0.1%)
Greece	2 (0.1%)
Italy	12 (0.7%)
Malta	2 (0.1%)
Netherlands	11 (0.7%)
Portugal	21 (1.3%)
Spain	40 (2.4%)
Sweden	2 (0.1%)
Unknown	12 (0.7%)
Multiple	5 (0.3%)

North Africa and Middle East	25 (1.5%)
Cyprus	1 (0.1%)
Egypt	3 (0.2%)
Israel	1 (0.1%)
Jordan	1 (0.1%)
Libyan Arab Jamahiriya	3 (0.2%)
Morocco	2 (0.1%)
Saudi Arabia	2 (0.1%)
Sudan	7 (0.4%)
Turkey	2 (0.1%)
United Arab Emirates	2 (0.1%)
Unknown	1 (0.1%)

North America	54 (3.3%)
Canada	6 (0.4%)
United States of America	48 (2.9%)

Caribbean	26 (1.6%)
Dominican Republic	1 (0.1%)
Jamaica	20 (1.2%)
Puerto Rico	1 (0.1%)
St Lucia	2 (0.1%)
Unknown	2 (0.1%)

Latin America	14 (0.8%)
Brazil	6 (0.4%)
Chile	1 (0.1%)
Colombia	1 (0.1%)
Guatemala	1 (0.1%)
Guyana	2 (0.1%)
Mexico	2 (0.1%)
Peru	1 (0.1%)

Multiple	49 (3%)
Unknown	11 (0.7%)

Total	1660 (100%)

Table 3.1: Age distribution, stage of HIV disease and ethnic group of total HIV and AIDS cases by infection route and sex, 2006

		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								29	41	1		71
	15-19	8			1	16			5	7	2	1	40
	20-24	105	2		21	68	3		1		5		205
	25-29	260	3	3	56	217	3				11	3	556
	30-34	365	17	3	114	274	6	1			11	2	793
	35-39	501	18	4	175	260	17	1			7	4	987
	40-44	538	18	6	134	180	11	3			14	5	909
	45-49	351	16	4	78	78	7	1			7	1	543
	50-54	199	2	2	61	33	5	2			6		310
	55-59	107	4		47	28	2	1			5		194
	60+	75	2		49	16	2	4			5		153
Stage of HIV Disease	Asymptomatic	1027	18	7	321	581	7		6	18	30	11	2026
	Symptomatic	877	38	9	206	319	30	6	18	18	15	2	1538
	AIDS	554	22	6	199	265	18	7	11	12	25	3	1122
	AIDS Related Death	14	1		9	5					1		30
	Death Unrelated to AIDS	7	2				1				1		11
	Unknown	30	1		1						2		34
Ethnicity	White	2378	74	22	282	244	52	7	10	9	45	6	3129
	Black Caribbean	14	2		9	21	1				1		48
	Black African	21			401	828	1	2	18	33	10	5	1319
	Black Other	3	1		3	9			1	1			18
	Indian/Pakistani/Bangladeshi	22	1		15	11	2	2		1	1	1	56
	Other Asian/Oriental	13			8	33		2	1	1	2		60
	Other/Mixed	43	3		16	20			5	3	1		91
	Unknown	15	1		2	4					14	4	40
	Total	**2509**	**82**	**22**	**736**	**1170**	**56**	**13**	**35**	**48**	**74**	**16**	**4761**
	%	**52.7**	**1.7**	**0.5**	**15.5**	**24.6**	**1.2**	**0.3**	**0.7**	**1**	**1.5**	**0.3**	

Men who have been exposed through sex with men and are also injecting drug users are included in the MSM category.
Age ranges refer to the age of individuals at the end of December 2006, or at death.

Table 3.2: Local authority of residence of total HIV and AIDS cases by infection route, 2006

	Local Authority of Residence	Infection Route						Total (100%)
		MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	Carlisle	11 (50%)	2 (9.1%)	8 (36.4%)			1 (4.5%)	22
	Allerdale	6 (50%)		5 (41.7%)			1 (8.3%)	12
	Eden	11 (78.6%)		3 (21.4%)				14
	Copeland	4 (36.4%)		4 (36.4%)	1 (9.1%)	1 (9.1%)	1 (9.1%)	11
	South Lakeland	9 (45%)		9 (45%)			2 (10%)	20
	Barrow-in-Furness	4 (50%)		4 (50%)				8
	Unknown Cumbria	1 (50%)					1 (50%)	2
	Total	**46 (51.7%)**	**2 (2.2%)**	**33 (37.1%)**	**1 (1.1%)**	**1 (1.1%)**	**6 (6.7%)**	**89**
Lancashire	Lancaster	15 (44.1%)	1 (2.9%)	16 (47.1%)			2 (5.9%)	34
	Wyre	31 (70.5%)		13 (29.5%)				44
	Fylde	26 (61.9%)	2 (4.8%)	9 (21.4%)	1 (2.4%)	1 (2.4%)	3 (7.1%)	42
	Blackpool	221 (82.2%)	4 (1.5%)	33 (12.3%)	5 (1.9%)	2 (0.7%)	4 (1.5%)	269
	Blackburn with Darwen	15 (25%)	2 (3.3%)	36 (60%)	4 (6.7%)	1 (1.7%)	2 (3.3%)	60
	Ribble Valley	7 (50%)		7 (50%)				14
	Pendle	6 (50%)	1 (8.3%)	4 (33.3%)	1 (8.3%)			12
	Hyndburn	5 (19.2%)	1 (3.8%)	16 (61.5%)	1 (3.8%)	1 (3.8%)	2 (7.7%)	26
	Burnley	7 (29.2%)	2 (8.3%)	14 (58.3%)	1 (4.2%)			24
	Rossendale	16 (76.2%)	1 (4.8%)	4 (19%)				21
	Preston	42 (48.8%)		39 (45.3%)	1 (1.2%)	3 (3.5%)	1 (1.2%)	86
	South Ribble	15 (48.4%)	1 (3.2%)	12 (38.7%)	1 (3.2%)	2 (6.5%)		31
	Chorley	10 (55.6%)		6 (33.3%)			2 (11.1%)	18
	West Lancashire	15 (55.6%)		11 (40.7%)	1 (3.7%)			27
	Unknown Lancashire			1 (100%)				1
	Total	**431 (60.8%)**	**15 (2.1%)**	**221 (31.2%)**	**16 (2.3%)**	**10 (1.4%)**	**16 (2.3%)**	**709**
Greater Manchester	Wigan	31 (36%)		50 (58.1%)	2 (2.3%)	1 (1.2%)	2 (2.3%)	86
	Bolton	64 (35.4%)	8 (4.4%)	99 (54.7%)	4 (2.2%)	5 (2.8%)	1 (0.6%)	181
	Bury	74 (53.2%)	3 (2.2%)	52 (37.4%)	4 (2.9%)	2 (1.4%)	4 (2.9%)	139
	Rochdale	53 (43.1%)	5 (4.1%)	56 (45.5%)	3 (2.4%)	4 (3.3%)	2 (1.6%)	123
	Oldham	33 (37.1%)	3 (3.4%)	49 (55.1%)	2 (2.2%)	2 (2.2%)		89
	Salford	301 (71%)	8 (1.9%)	106 (25%)	1 (0.2%)	1 (0.2%)	7 (1.7%)	424
	Manchester	721 (51.4%)	30 (2.1%)	607 (43.2%)	2 (0.1%)	27 (1.9%)	17 (1.2%)	1404
	Tameside	58 (52.3%)	3 (2.7%)	48 (43.2%)		2 (1.8%)		111
	Trafford	83 (51.9%)	6 (3.8%)	59 (36.9%)	3 (1.9%)	4 (2.5%)	5 (3.1%)	160
	Stockport	86 (63.7%)	2 (1.5%)	38 (28.1%)	3 (2.2%)	4 (3%)	2 (1.5%)	135
	Unknown Greater Manchester	4 (66.7%)		2 (33.3%)				6
	Total	**1508 (52.8%)**	**68 (2.4%)**	**1166 (40.8%)**	**24 (0.8%)**	**52 (1.8%)**	**40 (1.4%)**	**2858**
Merseyside	Sefton	28 (37.3%)	3 (4%)	38 (50.7%)	4 (5.3%)		2 (2.7%)	75
	Liverpool	103 (31.2%)	1 (0.3%)	207 (62.7%)	6 (1.8%)	5 (1.5%)	8 (2.4%)	330
	Knowsley	14 (53.8%)	2 (7.7%)	7 (26.9%)			3 (11.5%)	26
	Wirral	50 (45.5%)	4 (3.6%)	50 (45.5%)	2 (1.8%)	3 (2.7%)	1 (0.9%)	110
	St Helens	28 (70%)		11 (27.5%)	1 (2.5%)			40
	Unknown Merseyside	2 (33.3%)		3 (50%)			1 (16.7%)	6
	Total	**225 (38.3%)**	**10 (1.7%)**	**316 (53.8%)**	**13 (2.2%)**	**8 (1.4%)**	**15 (2.6%)**	**587**
Cheshire	Halton	14 (48.3%)	1 (3.4%)	10 (34.5%)	1 (3.4%)	1 (3.4%)	2 (6.9%)	29
	Warrington	35 (66%)		16 (30.2%)	1 (1.9%)	1 (1.9%)		53
	Ellesmere Port & Neston	10 (35.7%)		15 (53.6%)		3 (10.7%)		28
	Chester	32 (56.1%)	3 (5.3%)	19 (33.3%)	2 (3.5%)		1 (1.8%)	57
	Vale Royal	18 (72%)		5 (20%)	1 (4%)		1 (4%)	25
	Macclesfield	28 (65.1%)		11 (25.6%)	2 (4.7%)		2 (4.7%)	43
	Congleton	8 (80%)		2 (20%)				10
	Crewe & Nantwich	16 (57.1%)		12 (42.9%)				28
	Unknown Cheshire			1 (100%)				1
	Total	**161 (58.8%)**	**4 (1.5%)**	**91 (33.2%)**	**7 (2.6%)**	**5 (1.8%)**	**6 (2.2%)**	**274**
	Total North West Residents	**2371 (52.5%)**	**99 (2.2%)**	**1827 (40.4%)**	**61 (1.4%)**	**76 (1.7%)**	**83 (1.8%)**	**4517**
	Isle of Man	10 (52.6%)		9 (47.4%)				19
	Out of Region	97 (58.8%)	5 (3%)	45 (27.3%)	7 (4.2%)	7 (4.2%)	4 (2.4%)	165
	Abroad	2 (66.7%)		1 (33.3%)				3
	Unknown*	29 (50.9%)		24 (42.1%)	1 (1.8%)		3 (5.3%)	57
	Total	**2509 (52.7%)**	**104 (2.2%)**	**1906 (40%)**	**69 (1.4%)**	**83 (1.7%)**	**90 (1.9%)**	**4761**

Men who have been exposed through sex with men and are also injecting drug users are included in the MSM category.
** Includes three people of no fixed abode and four 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, 2006

	Local Authority of Residence	Stage of HIV Disease						Total (100%)
		Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	Carlisle	7 (31.8%)	10 (45.5%)	5 (22.7%)				22
	Allerdale	7 (58.3%)	1 (8.3%)	4 (33.3%)				12
	Eden	10 (71.4%)	4 (28.6%)					14
	Copeland	6 (54.5%)		5 (45.5%)				11
	South Lakeland	6 (30%)	9 (45%)	5 (25%)				20
	Barrow-in-Furness	5 (62.5%)	1 (12.5%)	2 (25%)				8
	Unknown Cumbria	2 (100%)						2
	Total	**43 (48.3%)**	**25 (28.1%)**	**21 (23.6%)**				**89**
Lancashire	Lancaster	16 (47.1%)	13 (38.2%)	3 (8.8%)	2 (5.9%)			34
	Wyre	13 (29.5%)	15 (34.1%)	16 (36.4%)				44
	Fylde	12 (28.6%)	15 (35.7%)	13 (31%)		1 (2.4%)	1 (2.4%)	42
	Blackpool	87 (32.3%)	103 (38.3%)	72 (26.8%)	3 (1.1%)	4 (1.5%)		269
	Blackburn with Darwen	26 (43.3%)	21 (35%)	13 (21.7%)				60
	Ribble Valley	5 (35.7%)	3 (21.4%)	6 (42.9%)				14
	Pendle	5 (41.7%)	5 (41.7%)	2 (16.7%)				12
	Hyndburn	9 (34.6%)	10 (38.5%)	6 (23.1%)		1 (3.8%)		26
	Burnley	14 (58.3%)	7 (29.2%)	3 (12.5%)				24
	Rossendale	5 (23.8%)	12 (57.1%)	4 (19%)				21
	Preston	29 (33.7%)	33 (38.4%)	22 (25.6%)	2 (2.3%)			86
	South Ribble	10 (32.3%)	12 (38.7%)	8 (25.8%)			1 (3.2%)	31
	Chorley	8 (44.4%)	7 (38.9%)	2 (11.1%)			1 (5.6%)	18
	West Lancashire	8 (29.6%)	13 (48.1%)	5 (18.5%)			1 (3.7%)	27
	Unknown Lancashire			1 (100%)				1
	Total	**247 (34.8%)**	**269 (37.9%)**	**176 (24.8%)**	**7 (1%)**	**6 (0.8%)**	**4 (0.6%)**	**709**
Greater Manchester	Wigan	42 (48.8%)	28 (32.6%)	16 (18.6%)				86
	Bolton	97 (53.6%)	48 (26.5%)	36 (19.9%)				181
	Bury	57 (41%)	58 (41.7%)	24 (17.3%)				139
	Rochdale	48 (39%)	36 (29.3%)	38 (30.9%)	1 (0.8%)			123
	Oldham	38 (42.7%)	25 (28.1%)	26 (29.2%)				89
	Salford	193 (45.5%)	136 (32.1%)	82 (19.3%)	6 (1.4%)	2 (0.5%)	5 (1.2%)	424
	Manchester	583 (41.5%)	481 (34.3%)	316 (22.5%)	5 (0.4%)		19 (1.4%)	1404
	Tameside	47 (42.3%)	40 (36%)	22 (19.8%)	2 (1.8%)			111
	Trafford	62 (38.8%)	58 (36.3%)	40 (25%)				160
	Stockport	43 (31.9%)	58 (43%)	31 (23%)	2 (1.5%)		1 (0.7%)	135
	Unknown Greater Manchester	4 (66.7%)		2 (33.3%)				6
	Total	**1214 (42.5%)**	**968 (33.9%)**	**633 (22.1%)**	**16 (0.6%)**	**2 (0.1%)**	**25 (0.9%)**	**2858**
Merseyside	Sefton	35 (46.7%)	18 (24%)	21 (28%)			1 (1.3%)	75
	Liverpool	175 (53%)	69 (20.9%)	82 (24.8%)	2 (0.6%)		2 (0.6%)	330
	Knowsley	11 (42.3%)	5 (19.2%)	10 (38.5%)				26
	Wirral	38 (34.5%)	39 (35.5%)	31 (28.2%)	2 (1.8%)			110
	St Helens	19 (47.5%)	11 (27.5%)	10 (25%)				40
	Unknown Merseyside	4 (66.7%)		1 (16.7%)	1 (16.7%)			6
	Total	**282 (48%)**	**142 (24.2%)**	**155 (26.4%)**	**5 (0.9%)**		**3 (0.5%)**	**587**
Cheshire	Halton	12 (41.4%)	6 (20.7%)	10 (34.5%)	1 (3.4%)			29
	Warrington	30 (56.6%)	11 (20.8%)	11 (20.8%)	1 (1.9%)			53
	Ellesmere Port & Neston	16 (57.1%)	9 (32.1%)	3 (10.7%)				28
	Chester	37 (64.9%)	12 (21.1%)	8 (14%)				57
	Vale Royal	7 (28%)	8 (32%)	10 (40%)				25
	Macclesfield	17 (39.5%)	13 (30.2%)	11 (25.6%)		2 (4.7%)		43
	Congleton	3 (30%)	5 (50%)	2 (20%)				10
	Crewe & Nantwich	6 (21.4%)	7 (25%)	15 (53.6%)				28
	Unknown Cheshire			1 (100%)				1
	Total	**128 (46.7%)**	**71 (25.9%)**	**71 (25.9%)**	**2 (0.7%)**	**2 (0.7%)**		**274**
	Total North West Residents	**1914 (42.4%)**	**1475 (32.7%)**	**1056 (23.4%)**	**30 (0.7%)**	**10 (0.2%)**	**32 (0.7%)**	**4517**
	Isle of Man	6 (31.6%)	8 (42.1%)	5 (26.3%)				19
	Out of Region	70 (42.4%)	45 (27.3%)	50 (30.3%)				165
	Abroad		2 (66.7%)	1 (33.3%)				3
	Unknown*	36 (63.2%)	8 (14%)	10 (17.5%)		1 (1.8%)	2 (3.5%)	57
	Total	**2026 (42.6%)**	**1538 (32.3%)**	**1122 (23.6%)**	**30 (0.6%)**	**11 (0.2%)**	**34 (0.7%)**	**4761**

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

Table 3.4: Total HIV and AIDS cases by infection route, sex, county of residence and ethnicity, 2006

	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	46	2		13	12				1	3	2	79
	BME/Mixed				1	7		1			1		10
	Total	**46**	**2**		**14**	**19**		**1**		**1**	**4**	**2**	**89**
	%	**51.7**	**2.2**		**15.7**	**21.3**		**1.1**		**1.1**	**4.5**	**2.2**	
Lancashire	White	420	11		68	54	9	2	1	3	9		577
	BME/Mixed	9	4		35	63	3	2	3	3	4		126
	Unknown	2				1					3		6
	Total	**431**	**15**		**103**	**118**	**12**	**4**	**4**	**6**	**16**		**709**
	%	**60.8**	**2.1**		**14.5**	**16.6**	**1.7**	**0.6**	**0.6**	**0.8**	**2.3**		
Greater Manchester	White	1416	49	15	96	83	20	2	7	3	21	3	1715
	BME/Mixed	83	3		311	673	1	1	15	27	7	1	1122
	Unknown	9	1		1	2					7	1	21
	Total	**1508**	**53**	**15**	**408**	**758**	**21**	**3**	**22**	**30**	**35**	**5**	**2858**
	%	**52.8**	**1.9**	**0.5**	**14.3**	**26.5**	**0.7**	**0.1**	**0.8**	**1**	**1.2**	**0.2**	
Merseyside	White	217	8	2	46	57	10	3			4		347
	BME/Mixed	7			72	141			2	6	2	3	233
	Unknown	1									3	3	7
	Total	**225**	**8**	**2**	**118**	**198**	**10**	**3**	**2**	**6**	**9**	**6**	**587**
	%	**38.3**	**1.4**	**0.3**	**20.1**	**33.7**	**1.7**	**0.5**	**0.3**	**1**	**1.5**	**1**	
Cheshire	White	154	2	2	36	20	7			1	3	1	226
	BME/Mixed	6			16	19			2	2	0	2	47
	Unknown	1											1
	Total	**161**	**2**	**2**	**52**	**39**	**7**		**2**	**3**	**3**	**3**	**274**
	%	**58.8**	**0.7**	**0.7**	**19**	**14.2**	**2.6**		**0.7**	**1.1**	**1.1**	**1.1**	
Out of region*	White	99	2	3	17	17	6		2	1	4		151
	BME/Mixed	7			7	13		1	3	1			32
	Unknown	1											1
	Total	**107**	**2**	**3**	**24**	**30**	**6**	**1**	**5**	**2**	**4**		**184**
	%	**58.2**	**1.1**	**1.6**	**13**	**16.3**	**3.3**	**0.5**	**2.7**	**1.1**	**2.2**		
Abroad	White	1											1
	BME/Mixed	1			1								2
	Total	**2**			**1**								**3**
	%	**66.7**			**33.3**								
Unknown**	White	25			6	1					1		33
	BME/Mixed	3			9	6		1			1		20
	Unknown	1			1	1					1		4
	Total	**29**			**16**	**8**		**1**			**3**		**57**
	%	**50.9**			**28.1**	**14**		**1.8**			**5.3**		
Total	White	2378	74	22	282	244	52	7	10	9	45	6	3129
	BME/Mixed	116	7		452	922	4	6	25	39	15	6	1592
	Unknown	15	1		2	4					14	4	40
	Total	**2509**	**82**	**22**	**736**	**1170**	**56**	**13**	**35**	**48**	**74**	**16**	**4761**
	%	**52.7**	**1.7**	**0.5**	**15.5**	**24.6**	**1.2**	**0.3**	**0.7**	**1**	**1.6**	**0.3**	

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

Table 3.5: Total HIV and AIDS cases by age category and ethnic group, 2006

	Age Group	Ethnicity								Total
		White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Total North West Residents	0-14	10		43	1	1	2	7		64
	15-19	16	2	21						39
	20-24	119	6	50	2	1	5	5		188
	25-29	274	8	207	3	8	7	16	7	530
	30-34	414	9	283	3	9	15	18	8	759
	35-39	590	4	311	2	13	9	21	4	954
	40-44	615	10	193	4	7	7	12	6	854
	45-49	398	3	97	1	4	6	4	2	515
	50-54	238	3	38		8	2	3	4	296
	55-59	152	1	19			1		3	176
	60+	118	1	18	1	2	1		1	142
	Total	**2944**	**47**	**1280**	**17**	**53**	**55**	**86**	**35**	**4517**
	%	**65.2**	**1.0**	**28.3**	**0.4**	**1.2**	**1.2**	**1.9**	**0.8**	
Out of Region /Unknown	Out of Region*	151		23	1	1	4	3	1	184
	Abroad	1		1		1				3
	Unknown**	33	1	15		1	1	2	4	57
	Total	**185**	**1**	**39**	**1**	**3**	**5**	**5**	**5**	**244**
	%	**75.8**	**0.4**	**16**	**0.4**	**1.2**	**2.0**	**2.0**	**2.0**	
All individuals treated in North West	0-14	13		45	2	1	2	8		71
	15-19	16	2	21					1	40
	20-24	129	6	54	2	1	6	6	1	205
	25-29	291	9	213	3	9	7	17	7	556
	30-34	436	9	293	3	9	17	18	8	793
	35-39	615	4	315	2	13	10	22	6	987
	40-44	661	10	199	4	8	8	12	7	909
	45-49	425	3	98	1	4	6	4	2	543
	50-54	249	3	39		9	2	4	4	310
	55-59	167	1	22			1		3	194
	60+	127	1	20	1	2	1		1	153
	Total	**3129**	**48**	**1319**	**18**	**56**	**60**	**91**	**40**	**4761**
	%	**65.7**	**1.1**	**27.7**	**0.4**	**1.2**	**1.3**	**1.9**	**0.8**	

Men who have been exposed through sex with men and are also injecting drug users are included in the MSM category.
Age ranges refer to the ages of individuals at the end of December 2006, or at death.
** Includes Isle of Man.*
*** Includes three people of no fixed abode and four who declined to give any residential information.*

Table 3.6: Total HIV and AIDS cases by stage of HIV disease and level of antiretroviral therapy, 2006

	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			16	7	25
	AIDS	1			13	7	21
	Total	**26 (29.2%)**			**43 (48.3%)**	**20 (22.5%)**	**89**
Lancashire	Asymptomatic	154			71	22	247
	Symptomatic	35			160	74	269
	AIDS	12		1	108	55	176
	AIDS Related Death	3			2	2	7
	Death Unrelated to AIDS	1			1	4	6
	Unknown	4					4
	Total	**209 (29.5%)**		**1 (0.1%)**	**342 (48.2%)**	**157 (22.1%)**	**709**
Greater Manchester	Asymptomatic	737			343	134	1214
	Symptomatic	157	1		516	294	968
	AIDS	31	1	1	343	257	633
	AIDS Related Death	5			5	6	16
	Death Unrelated to AIDS	1				1	2
	Unknown	24				1	25
	Total	**955 (33.4%)**	**2 (0.1%)**	**1 (0.1%)**	**1207 (42.2%)**	**693 (24.2%)**	**2858**
Merseyside	Asymptomatic	160			83	39	282
	Symptomatic	28			75	39	142
	AIDS	9			84	62	155
	AIDS Related Death	2			1	2	5
	Unknown	3					3
	Total	**202 (34.4%)**			**243 (41.4%)**	**142 (24.2%)**	**587**
Cheshire	Asymptomatic	69		1	50	8	128
	Symptomatic	9			47	15	71
	AIDS	4		1	44	22	71
	AIDS Related Death	2					2
	Death Unrelated to AIDS	1			1		2
	Total	**85 (31%)**		**2 (0.7%)**	**142 (51.8%)**	**45 (16.4%)**	**274**
Total North West Residents	Asymptomatic	1143		1	561	209	1914
	Symptomatic	231	1		814	429	1475
	AIDS	57	1	3	592	403	1056
	AIDS Related Death	12			8	10	30
	Death Unrelated to AIDS	3			2	5	10
	Unknown	31				1	32
	Total	**1477 (32.7%)**	**2 (0%)**	**4 (0.1%)**	**1977 (43.8%)**	**1057 (23.4%)**	**4517**
	Isle of Man	7			10	2	19
	Out of Region	38		1	77	49	165
	Abroad	1			1	1	3
	Unknown*	37			15	5	57
	Total	**1560 (32.8%)**	**2 (0.1%)**	**5 (0.1%)**	**2080 (43.7%)**	**1114 (23.4%)**	**4761**

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

Table 3.7: Ethnic distribution of total HIV and AIDS cases by sex, clinical stage of HIV disease and exposure abroad, 2006

		Ethnicity								Total
		White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Sex	Male	2841 (90.8%)	27 (56.3%)	451 (34.2%)	8 (44.4%)	41 (73.2%)	24 (40%)	68 (74.7%)	32 (80%)	3492 (73.3%)
	Female	288 (9.2%)	21 (43.8%)	868 (65.8%)	10 (55.6%)	15 (26.8%)	36 (60%)	23 (25.3%)	8 (20%)	1269 (26.7%)
Stage of HIV Disease	Asymptomatic	1245 (39.8%)	27 (56.3%)	631 (47.8%)	10 (55.6%)	25 (44.6%)	28 (46.7%)	40 (44%)	20 (50%)	2026 (42.6%)
	Symptomatic	1085 (34.7%)	15 (31.3%)	365 (27.7%)	4 (22.2%)	18 (32.1%)	14 (23.3%)	32 (35.2%)	5 (12.5%)	1538 (32.3%)
	AIDS	739 (23.6%)	6 (12.5%)	316 (24%)	4 (22.2%)	12 (21.4%)	17 (28.3%)	19 (20.9%)	9 (22.5%)	1122 (23.6%)
	AIDS Related Death	24 (0.8%)		6 (0.5%)						30 (0.6%)
	Death Unrelated to AIDS	10 (0.3%)							1 (2.5%)	11 (0.2%)
	Unknown	26 (0.8%)		1 (0.1%)		1 (1.8%)	1 (1.7%)		5 (12.5%)	34 (0.7%)
HIV Exposure Abroad	No	2373 (75.8%)	18 (37.5%)	55 (4.2%)	7 (38.9%)	16 (28.6%)	12 (20%)	32 (35.2%)	10 (25%)	2523 (53%)
	Yes	437 (14%)	19 (39.6%)	1078 (81.7%)	9 (50%)	36 (64.3%)	37 (61.7%)	41 (45.1%)	3 (7.5%)	1660 (34.9%)
	Unknown	319 (10.2%)	11 (22.9%)	186 (14.1%)	2 (11.1%)	4 (7.1%)	11 (18.3%)	18 (19.8%)	27 (67.5%)	578 (12.1%)
	Total	**3129**	**48**	**1319**	**18**	**56**	**60**	**91**	**40**	**4761**

Table 3.8: Global region and country of HIV exposure by infection route of total HIV and AIDS cases who probably acquired their infection outside the UK, 2006

Region of HIV Exposure	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Abroad	236 (14.2%)	18 (1.1%)	1336 (80.5%)	12 (0.7%)	39 (2.3%)	19 (1.1%)	1660
Australia & New Zealand	*11*		*1*				*12*
Caribbean	*2*		*22*			*2*	*26*
East Asia & Pacific	*3*		*3*				*6*
Eastern Europe & Central Asia	*1*		*8*		*2*	*1*	*12*
Latin America	*7*		*7*				*14*
North Africa & Middle East	*5*		*18*		*1*	*1*	*25*
North America	*40*	*4*	*9*	*1*			*54*
South & South-East Asia	*27*	*1*	*116*	*3*		*2*	*149*
Sub-Saharan Africa	*20*		*1086*	*6*	*34*	*10*	*1156*
Western Europe	*83*	*13*	*45*	*2*	*1*	*2*	*146*
Multiple	*32*		*15*		*1*	*1*	*49*
Unknown	*5*		*6*				*11*
UK	1986 (78.7%)	74 (2.9%)	331 (13.1%)	56 (2.2%)	35 (1.4%)	41 (1.6%)	2523
Undetermined	287 (49.7%)	12 (2.1%)	239 (41.3%)	1 (0.2%)	9 (1.6%)	30 (5.2%)	578
Total	**2509 (52.7%)**	**104 (2.2%)**	**1906 (40%)**	**69 (1.4%)**	**83 (1.7%)**	**90 (1.9%)**	**4761**

Men who have been 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, 2006

Treatment Centre	Infection Route						Total
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother To Child	Undeter-mined	
AHC					17 (94.4%)	1 (5.6%)	18
APH	28 (47.5%)		30 (50.8%)			1 (1.7%)	59
ARM	19 (86.4%)	1 (4.5%)	2 (9.1%)				22
BLAG	287 (79.7%)	7 (1.9%)	50 (13.9%)	3 (0.8%)	3 (0.8%)	10 (2.8%)	360
BLK	3 (100%)						3
BLKG	18 (24%)	2 (2.7%)	52 (69.3%)	2 (2.7%)		1 (1.3%)	75
BOLG	74 (35.6%)	6 (2.9%)	126 (60.6%)	1 (0.5%)		1 (0.5%)	208
BOOT					50 (100%)		50
BURG	13 (43.3%)	3 (10%)	14 (46.7%)				30
BURY	16 (47.1%)		18 (52.9%)				34
CHR	59 (52.7%)	3 (2.7%)	48 (42.9%)			2 (1.8%)	112
CPED							1
CUMB	25 (53.2%)	3 (6.4%)	15 (31.9%)	1 (2.1%)		3 (6.4%)	47
FGH	5 (55.6%)		3 (33.3%)			1 (11.1%)	9
HAL	5 (83.3%)		1 (16.7%)				6
LCN	15 (26.3%)		40 (70.2%)	2 (3.5%)			57
LEI	14 (60.9%)		8 (34.8%)	1 (4.3%)			23
LEII	7 (70%)		3 (30%)				10
MAC	25 (71.4%)		9 (25.7%)	1 (2.9%)			35
MGP	178 (95.7%)	2 (1.1%)	4 (2.2%)			2 (1.1%)	186
MRIG	499 (58.2%)	6 (0.7%)	347 (40.5%)	5 (0.6%)			857
MRIH	1 (2.6%)		3 (7.7%)	35 (89.7%)			39
NMG	757 (52.3%)	58 (4%)	528 (36.5%)	7 (0.5%)	58 (4%)	40 (2.8%)	1448
NMGG	82 (57.3%)		61 (42.7%)				143
NOBL	9 (60%)		6 (40%)				15
OLDG	20 (52.6%)		18 (47.4%)				38
PG	71 (48.3%)	1 (0.7%)	68 (46.3%)		3 (2%)	4 (2.7%)	147
PP					4 (100%)		4
RLG	206 (36.6%)	15 (2.7%)	313 (55.6%)	10 (1.8%)		19 (3.4%)	563
RLH				12 (100%)			12
RLI	13 (48.1%)	1 (3.7%)	12 (44.4%)			1 (3.7%)	27
ROCG	28 (47.5%)		31 (52.5%)				59
SALG	53 (54.6%)		44 (45.4%)				97
SHH	37 (75.5%)	1 (2%)	11 (22.4%)				49
SPG	19 (32.8%)	2 (3.4%)	36 (62.1%)			1 (1.7%)	58
STP	75 (61.5%)	2 (1.6%)	45 (36.9%)				122
TAMG	9 (37.5%)	2 (8.3%)	13 (54.2%)				24
TRAG	5 (45.5%)		6 (54.5%)				11
WAR	18 (75%)		6 (25%)				24
WGH	8 (53.3%)		7 (46.7%)				15
WHIT			2 (66.7%)			1 (33.3%)	3
WIGG	2 (28.6%)		4 (57.1%)			1 (14.3%)	7
WITG	158 (74.2%)	3 (1.4%)	49 (23%)	1 (0.5%)		2 (0.9%)	213
WORK	8 (50%)		7 (43.8%)	1 (6.3%)			16

For a definition of the abbreviated treatment centres please refer to appendix A 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 have been exposed through sex with men 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, 2006

Treatment Centre	Level of Antiretroviral Therapy					Total
	None	Mono	Dual	Triple	Quadruple or More	
AHC	5 (27.8%)			8 (44.4%)	5 (27.8%)	18
APH	24 (40.7%)			16 (27.1%)	19 (32.2%)	59
ARM*	22 (100%)					22
BLAG	131 (36.4%)			161 (44.7%)	68 (18.9%)	360
BLK			1 (33.3%)	1 (33.3%)	1 (33.3%)	3
BLKG	22 (29.3%)		1 (1.3%)	33 (44%)	19 (25.3%)	75
BOLG	81 (38.9%)			98 (47.1%)	29 (13.9%)	208
BOOT	8 (16%)			32 (64%)	10 (20%)	50
BURG	14 (46.7%)			11 (36.7%)	5 (16.7%)	30
BURY	15 (44.1%)			14 (41.2%)	5 (14.7%)	34
CHR	41 (36.6%)			64 (57.1%)	7 (6.3%)	112
CPED					1 (100%)	1
CUMB	17 (36.2%)			23 (48.9%)	7 (14.9%)	47
FGH	2 (22.2%)			4 (44.4%)	3 (33.3%)	9
HAL	4 (66.7%)			1 (16.7%)	1 (16.7%)	6
LCN*	57 (100%)					57
LEI	9 (39.1%)		1 (4.3%)	12 (52.2%)	1 (4.3%)	23
LEII	2 (20%)			6 (60%)	2 (20%)	10
MAC	10 (28.6%)			17 (48.6%)	8 (22.9%)	35
MGP*	186 (100%)					186
MRIG	409 (47.7%)	1 (0.1%)		279 (32.6%)	168 (19.6%)	857
MRIH	5 (12.8%)			19 (48.7%)	15 (38.5%)	39
NMG	270 (18.6%)		1 (0.1%)	710 (49%)	467 (32.3%)	1448
NMGG	42 (29.4%)	1 (0.7%)		72 (50.3%)	28 (19.6%)	143
NOBL	6 (40%)			7 (46.7%)	2 (13.3%)	15
OLDG	19 (50%)			13 (34.2%)	6 (15.8%)	38
PG	43 (29.3%)			73 (49.7%)	31 (21.1%)	147
PP	1 (25%)			3 (75%)		4
RLG	182 (32.3%)	2 (0.4%)		254 (45.1%)	125 (22.2%)	563
RLH	2 (16.7%)			6 (50%)	4 (33.3%)	12
RLI	5 (18.5%)			17 (63%)	5 (18.5%)	27
ROCG	22 (37.3%)			28 (47.5%)	9 (15.3%)	59
SALG	41 (42.3%)			37 (38.1%)	19 (19.6%)	97
SHH	18 (36.7%)			17 (34.7%)	14 (28.6%)	49
SPG	26 (44.8%)			24 (41.4%)	8 (13.8%)	58
STP	35 (28.7%)			53 (43.4%)	34 (27.9%)	122
TAMG	24 (100%)					24
TRAG	9 (81.8%)			2 (18.2%)		11
WAR	10 (41.7%)		1 (4.2%)	11 (45.8%)	2 (8.3%)	24
WGH	4 (26.7%)			7 (46.7%)	4 (26.7%)	15
WHIT				2 (66.7%)	1 (33.3%)	3
WIGG	7 (100%)					7
WITG	109 (51.2%)			73 (34.3%)	31 (14.6%)	213
WORK	5 (31.3%)			7 (43.8%)	4 (25%)	16

** ARM, LCN, & MGP are support services and do not prescribe ART.*
NB. Some individuals who are on unusually high or low ART combinations are taking part in clinical trials.

Table 3.11: Local authority of residence of total HIV and AIDS cases by number of treatment centres attended, 2006

	Local Authority of Residence	Treatment Centres Attended			Total (100%)
		One	Two	Three	
Cumbria	Carlisle	22 (100%)			22
	Allerdale	12 (100%)			12
	Eden	13 (92.9%)		1 (7.1%)	14
	Copeland	10 (90.9%)	1 (9.1%)		11
	South Lakeland	20 (100%)			20
	Barrow-in-Furness	8 (100%)			8
	Unknown Cumbria	2 (100%)			2
	Total	**87 (97.8%)**	**1 (1.1%)**	**1 (1.1%)**	**89**
Lancashire	Lancaster	33 (97.1%)	1 (2.9%)		34
	Wyre	43 (97.7%)	1 (2.3%)		44
	Fylde	39 (92.9%)	3 (7.1%)		42
	Blackpool	251 (93.3%)	15 (5.6%)	3 (1.1%)	269
	Blackburn with Darwen	58 (96.7%)	2 (3.3%)		60
	Ribble Valley	13 (92.9%)	1 (7.1%)		14
	Pendle	11 (91.7%)	1 (8.3%)		12
	Hyndburn	23 (88.5%)	3 (11.5%)		26
	Burnley	22 (91.7%)	2 (8.3%)		24
	Rossendale	21 (100%)			21
	Preston	84 (97.7%)	2 (2.3%)		86
	South Ribble	27 (87.1%)	4 (12.9%)		31
	Chorley	17 (94.4%)	1 (5.6%)		18
	West Lancashire	26 (96.3%)	1 (3.7%)		27
	Unknown Lancashire	1 (100%)			1
	Total	**669 (94.4%)**	**37 (5.2%)**	**3 (0.4%)**	**709**
Greater Manchester	Wigan	77 (89.5%)	9 (10.5%)		86
	Bolton	169 (93.4%)	12 (6.6%)		181
	Bury	130 (93.5%)	9 (6.5%)		139
	Rochdale	108 (87.8%)	15 (12.2%)		123
	Oldham	82 (92.1%)	7 (7.9%)		89
	Salford	351 (82.8%)	72 (17%)	1 (0.2%)	424
	Manchester	1199 (85.4%)	200 (14.2%)	5 (0.4%)	1404
	Tameside	99 (89.2%)	12 (10.8%)		111
	Trafford	144 (90%)	13 (8.1%)	3 (1.9%)	160
	Stockport	113 (83.7%)	21 (15.6%)	1 (0.7%)	135
	Unknown Greater Manchester	6 (100%)			6
	Total	**2478 (86.7%)**	**370 (12.9%)**	**10 (0.3%)**	**2858**
Merseyside	Sefton	69 (92%)	6 (8%)		75
	Liverpool	267 (80.9%)	59 (17.9%)	4 (1.2%)	330
	Knowsley	21 (80.8%)	5 (19.2%)		26
	Wirral	102 (92.7%)	8 (7.3%)		110
	St Helens	34 (85%)	6 (15%)		40
	Unknown Merseyside	6 (100%)			6
	Total	**499 (85%)**	**84 (14.3%)**	**4 (0.7%)**	**587**
Cheshire	Halton	29 (100%)			29
	Warrington	49 (92.5%)	4 (7.5%)		53
	Ellesmere Port & Neston	25 (89.3%)	3 (10.7%)		28
	Chester	49 (86%)	7 (12.3%)	1 (1.8%)	57
	Vale Royal	20 (80%)	5 (20%)		25
	Macclesfield	40 (93%)	3 (7%)		43
	Congleton	5 (50%)	5 (50%)		10
	Crewe & Nantwich	27 (96.4%)	1 (3.6%)		28
	Unknown Cheshire	1 (100%)			1
	Total	**245 (89.4%)**	**28 (10.2%)**	**1 (0.4%)**	**274**
	Total NW residents	**3978 (88.1%)**	**520 (11.5%)**	**19 (0.4%)**	**4517**
	Isle of Man	17 (89.5%)	2 (10.5%)		19
	Out of Region	153 (92.7%)	11 (6.7%)	1 (0.6%)	165
	Abroad	3 (100%)			3
	Unknown*	55 (96.5%)	2 (3.5%)		57
	Total	**4206 (88.3%)**	**535 (11.2%)**	**20 (0.4%)**	**4761**

** Includes three people of no fixed abode and four 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 clinical stage of HIV disease, 2006

		Outpatient Visits		Day Cases		Inpatient Episodes		Inpatient Days		Home Visits	
		Total	Mean	Total	Mean	Total	Mean	Total	Mean	Total	Mean
Treatment Centre	AHC	102	5.67	2	0.11	5	0.28	24	1.33	145	8.06
	APH	516	8.75	191	3.24	14	0.24	190	3.22	2	0.03
	ARM	879	39.95								
	BLAG	3067	8.52	28	0.8	52	0.14	530	1.47	185	0.51
	BLK	15	5								
	BLKG	501	6.68	10	0.13	15	0.20	86	1.15	1	0.01
	BOLG	1580	7.60			3	0 1	10	0.05		
	BOOT	117	2.34	4	0.08	6	0.12	117	2.34		
	BURG	222	7.40			5	0.17	15	0.50	15	0.50
	BURY	203	5.97			1	0.03	7	0.21		
	CHR	589	5.26	2	0.02	7	0.06	23	0.21		
	CPED	4	4							4	4
	CUMB	242	5.15	2	0.04	3	0.06	9	0.19	1	0.02
	FGH	33	3.67								
	HAL	52	8.67			1	0.17	21	3.50		
	LCN	278	4.88							454	7.96
	LEI	212	9.22								
	LEII	41	4.10	1	0.10	4	0.40	52	5.20		
	MAC	324	9.26	3	0.09	2	0 6	12	0.34		
	MGP	858	4.61								
	MRIG	5991	6.99			4	0.01	229	0.27		
	MRIH	190	4.87	5	0.13	11	0.28	44	1.13		
	NMG	8421	5.82	1110	0.77	289	0.20	4125	2.85	188	0.13
	NMGG	416	2.91								
	NOBL	145	9.67	3	0.20	3	0.20	14	0.93		
	OLDG	331	8.71	5	0.13	6	0.16	25	0.66		
	PG	885	6.02			10	0.07	171	1.16	2	0.01
	PP	11	2.75								
	RLG	3754	6.67	2	0.01	144	0.26	1592	2.83		
	RLH	125	10.42	7	0.58	4	0.33	17	1.42		
	RLI	108	4			7	0.26	55	2.04	6	0.22
	ROCG	295	5								
	SALG	370	3.81	2	0.02	9	0.09	117	1.21	10	0.10
	SHH	282	5.76	5	0.10	4	0.08	64	1.31	3	0.06
	SPG	457	7.88			4	0.07	10	0.17	13	0.22
	STP	711	5.83	5	0.04	15	0.12	58	0.48	37	0.30
	TAMG	139	5.79							2	0.08
	TRAG	51	4.64			2	0.18	51	4.64		
	WAR	209	8.71			3	0.13	24	1		
	WGH	52	3.47								
	WHIT	8	2.67								
	WIGG	18	2.57			1	0.14	10	1.43		
	WITG	1636	7.68	12	0.06	2	0.01	42	0.20	159	0.75
	WORK	129	8.06			1	0.06	3	0.19	6	0.38
Stage of HIV Disease	Asymptomatic	12857	6.35	108	0.05	110	0.05	720	0.36	239	0.12
	Symptomatic	11734	7.63	628	0.41	160	0.10	1739	1.13	229	0.15
	AIDS	9490	8.46	628	0.56	303	0.27	3983	3.55	636	0.57
	AIDS Related Death	180	6	35	1.17	53	1.77	1196	39.87	94	3.13
	Death Unrelated to AIDS	81	7.36			11	1	109	9.91	35	3.18
	Unknown	227	6.68								
	Total	**34569**	**7.26**	**1399**	**0.29**	**637**	**0.13**	**7747**	**1.63**	**1233**	**0.26**

Table 3.13: Residency status by stage of HIV disease, 2006

Residency status	Stage of HIV Disease						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
UK national	1460 (40.8%)	1218 (34%)	847 (23.7%)	26 (0.7%)	10 (0.3%)	18 (0.5%)	3579
Non UK national	440 (48%)	248 (27%)	227 (24.8%)	2 (0.2%)			917
Unknown	126 (47.5%)	72 (27.2%)	48 (18.1%)	2 (0.8%)	1 (0.4%)	16 (6%)	265
Total	**2026 (42.6%)**	**1538 (32.3%)**	**1122 (23.6%)**	**30 (0.6%)**	**11 (0.2%)**	**34 (0.7%)**	**4761**

Table 3.14: Residency status of individuals known to be non-UK nationals by sex, age group, infection route and stage of HIV disease, 2006

		Residency Status							Total
		Asylum Seeker	Overseas Student	Migrant Worker	Temporary Visitor	Refugee	Dependent	Other	
Sex	Male	156 (31.4%)	46 (39%)	14 (35.9%)	26 (55.3%)	35 (32.4%)	4 (36.4%)	29 (29.9%)	310 (33.8%)
	Female	341 (68.6%)	72 (61%)	25 (64.1%)	21 (44.7%)	73 (67.6%)	7 (63.6%)	68 (70.1%)	607 (66.2%)
Age Group	0-14	5 (1%)					5 (45.5%)	9 (9.3%)	19 (2.1%)
	15-19	11 (2.2%)	1 (0.8%)	1 (2.6%)		1 (0.9%)		2 (2.1%)	16 (1.7%)
	20-24	28 (5.6%)	8 (6.8%)	4 (10.3%)	3 (6.4%)	3 (2.8%)		3 (3.1%)	49 (5.3%)
	25-29	81 (16.3%)	33 (28%)	5 (12.8%)	6 (12.8%)	14 (13%)		17 (17.5%)	156 (17%)
	30-34	128 (25.8%)	22 (18.6%)	7 (17.9%)	8 (17%)	22 (20.4%)	1 (9.1%)	13 (13.4%)	201 (21.9%)
	35-39	117 (23.5%)	28 (23.7%)	11 (28.2%)	9 (19.1%)	36 (33.3%)	1 (9.1%)	21 (21.6%)	223 (24.3%)
	40-44	72 (14.5%)	21 (17.8%)	2 (5.1%)	5 (10.6%)	19 (17.6%)	2 (18.2%)	18 (18.6%)	139 (15.2%)
	45-49	35 (7%)	4 (3.4%)	5 (12.8%)	6 (12.8%)	7 (6.5%)	2 (18.2%)	5 (5.2%)	64 (7%)
	50-54	12 (2.4%)	1 (0.8%)	1 (2.6%)	2 (4.3%)	1 (0.9%)		6 (6.2%)	23 (2.5%)
	55-59	4 (0.8%)		1 (2.6%)	5 (10.6%)	4 (3.7%)		2 (2.1%)	16 (1.7%)
	60+	4 (0.8%)		2 (5.1%)	3 (6.4%)	1 (0.9%)		1 (1%)	11 (1.2%)
Infection Route	MSM	8 (1.6%)	10 (8.5%)	4 (10.3%)	12 (25.5%)			4 (4.1%)	38 (4.1%)
	Injecting Drug Use							1 (1%)	1 (0.1%)
	Heterosexual	479 (96.4%)	105 (89%)	33 (84.6%)	35 (74.5%)	107 (99.1%)	5 (45.5%)	82 (84.5%)	846 (92.3%)
	Blood/Tissue	1 (0.2%)		1 (2.6%)			1 (9.1%)		3 (0.3%)
	Mother to Child	7 (1.4%)		1 (2.6%)			5 (45.5%)	10 (10.3%)	23 (2.5%)
	Undetermined	2 (0.4%)	3 (2.5%)			1 (0.9%)			6 (0.7%)
Ethnicity	White	5 (1%)	9 (7.6%)	3 (7.7%)	11 (23.4%)	1 (0.9%)		3 (3.1%)	32 (3.5%)
	Black Caribbean	5 (1%)	1 (0.8%)					1 (1%)	7 (0.8%)
	Black African	479 (96.4%)	104 (88.1%)	32 (82.1%)	33 (70.2%)	107 (99.1%)	10 (90.9%)	83 (85.6%)	848 (92.5%)
	Black Other			1 (2.6%)				1 (1%)	2 (0.2%)
	Indian/Pakistani/Bangladeshi	1 (0.2%)	1 (0.8%)	1 (2.6%)	1 (2.1%)			4 (4.1%)	8 (0.9%)
	Other Asian/Oriental	2 (0.4%)	1 (0.8%)				1 (9.1%)	3 (3.1%)	7 (0.8%)
	Other/Mixed	5 (1%)	2 (1.7%)	2 (5.1%)	2 (4.3%)			2 (2.1%)	13 (1.4%)
Stage of Disease	Asymptomatic	248 (49.9%)	58 (49.2%)	23 (59%)	25 (53.2%)	48 (44.4%)	1 (9.1%)	37 (38.1%)	440 (48%)
	Symptomatic	128 (25.8%)	29 (24.6%)	8 (20.5%)	10 (21.3%)	36 (33.3%)	6 (54.5%)	31 (32%)	248 (27%)
	AIDS	120 (24.1%)	31 (26.3%)	8 (20.5%)	11 (23.4%)	24 (22.2%)	4 (36.4%)	29 (29.9%)	227 (24.8%)
	AIDS Related Death	1 (0.2%)			1 (2.1%)				2 (0.2%)
Area of Residence	Cumbria			3 (7.7%)	1 (2.1%)		1 (9.1%)		5 (0.5%)
	Lancashire	27 (5.4%)	3 (2.5%)	2 (5.1%)	4 (8.5%)	7 (6.5%)	2 (18.2%)	6 (6.2%)	51 (5.6%)
	Greater Manchester	314 (63.2%)	107 (90.7%)	28 (71.8%)	33 (70.2%)	94 (87%)	7 (63.6%)	79 (81.4%)	662 (72.2%)
	Merseyside	144 (29%)	3 (2.5%)	1 (2.6%)	1 (2.1%)	1 (0.9%)		6 (6.2%)	156 (17%)
	Cheshire	3 (0.6%)	2 (1.7%)	3 (7.7%)	2 (4.3%)	4 (3.7%)	1 (9.1%)	3 (3.1%)	18 (2%)
	Out of Region*	6 (1.2%)	1 (0.8%)		4 (8.5%)	1 (0.9%)		2 (2.1%)	14 (1.5%)
	Abroad							1 (1%)	1 (0.1%)
	Unknown**	3 (0.6%)	2 (1.7%)	2 (5.1%)	2 (4.3%)	1 (0.9%)			10 (1.1%)
	Total	**497**	**118**	**39**	**47**	**108**	**11**	**97**	**917**

Men who have been exposed through sex with men and are also injecting drug users are included in the MSM category.
Age ranges refer to the ages of individuals at the end of December 2006, or at death.
** Includes Isle of Man.*
*** Includes three people of no fixed abode and four who declined to give any residential information.*

Table 3.15: Primary care trust of residence of total HIV and AIDS cases by infection route and sex, 2006

PCT of Residence	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	46 (51.7%)	2 (2.2%)	33 (37.1%)	1 (1.1%)	1 (1.1%)	6 (6.7%)	89
North Lancashire	72 (60%)	3 (2.5%)	38 (31.7%)	1 (0.8%)	1 (0.8%)	5 (4.2%)	120
Blackpool	221 (82.2%)	4 (1.5%)	33 (12.3%)	5 (1.9%)	2 (0.7%)	4 (1.5%)	269
Blackburn with Darwen	15 (25%)	2 (3.3%)	36 (60%)	4 (6.7%)	1 (1.7%)	2 (3.3%)	60
East Lancashire	41 (42.3%)	5 (5.2%)	45 (46.4%)	3 (3.1%)	1 (1%)	2 (2.1%)	97
Central Lancashire	82 (50.6%)	1 (0.6%)	68 (42%)	3 (1.9%)	5 (3.1%)	3 (1.9%)	162
Unknown Lancashire			1 (100%)				1
Ashton, Leigh & Wigan	31 (36%)		50 (58.1%)	2 (2.3%)	1 (1.2%)	2 (2.3%)	86
Bolton	64 (35.4%)	8 (4.4%)	99 (54.7%)	4 (2.2%)	5 (2.8%)	1 (0.6%)	181
Bury	74 (53.2%)	3 (2.2%)	52 (37.4%)	4 (2.9%)	2 (1.4%)	4 (2.9%)	139
Heywood, Middleton & Rochdale	53 (43.1%)	5 (4.1%)	56 (45.5%)	3 (2.4%)	4 (3.3%)	2 (1.6%)	123
Oldham	33 (37.1%)	3 (3.4%)	49 (55.1%)	2 (2.2%)	2 (2.2%)		89
Salford	301 (71%)	8 (1.9%)	106 (25%)	1 (0.2%)	1 (0.2%)	7 (1.7%)	424
Manchester	721 (51.4%)	30 (2.1%)	607 (43.2%)	2 (0.1%)	27 (1.9%)	17 (1.2%)	1404
Tameside & Glossop	61 (52.1%)	3 (2.6%)	51 (43.6%)		2 (1.7%)		117
Trafford	83 (51.9%)	6 (3.8%)	59 (36.9%)	3 (1.9%)	4 (2.5%)	5 (3.1%)	160
Stockport	86 (63.7%)	2 (1.5%)	38 (28.1%)	3 (2.2%)	4 (3%)	2 (1.5%)	135
Unknown Greater Manchester	4 (66.7%)		2 (33.3%)				6
Sefton	28 (37.3%)	3 (4%)	38 (50.7%)	4 (5.3%)		2 (2.7%)	75
Liverpool	103 (31.2%)	1 (0.3%)	207 (62.7%)	6 (1.8%)	5 (1.5%)	8 (2.4%)	330
Knowsley	14 (53.8%)	2 (7.7%)	7 (26.9%)			3 (11.5%)	26
Wirral	50 (45.5%)	4 (3.6%)	50 (45.5%)	2 (1.8%)	3 (2.7%)	1 (0.9%)	110
Halton & St Helens	42 (60.9%)	1 (1.4%)	21 (30.4%)	2 (2.9%)	1 (1.4%)	2 (2.9%)	69
Unknown Merseyside	2 (33.3%)		3 (50%)			1 (16.7%)	6
Warrington	35 (66%)		16 (30.2%)	1 (1.9%)	1 (1.9%)		53
West Cheshire	46 (49.5%)	3 (3.2%)	38 (40.9%)	2 (2.2%)	3 (3.2%)	1 (1.1%)	93
Central and Eastern Cheshire	66 (67.3%)		26 (26.5%)	3 (3.1%)		3 (3.1%)	98
Unknown Cheshire			1 (100%)				1
Out of Region	94 (59.1%)	5 (3.1%)	42 (26.4%)	7 (4.4%)	7 (4.4%)	4 (2.5%)	159
Isle of Man	10 (52.6%)		9 (47.4%)				19
Abroad	2 (66.7%)		1 (33.3%)				3
Unknown*	29 (50.9%)		24 (42.1%)	1 (1.8%)		3 (5.3%)	57
Total	**2509**	**104**	**1906**	**69**	**83**	**90**	**4761**
%	**(52.7%)**	**(2.2%)**	**(40%)**	**(1.4%)**	**(1.7%)**	**(1.9%)**	

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

Table 3.16: Primary care trust of residence of total HIV and AIDS cases by stage of disease, 2006

PCT of Residence	Stage of Disease						Total
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	43 (48.3%)	25 (28.1%)	21 (23.6%)				89
North Lancashire	41 (34.2%)	43 (35.8%)	32 (26.7%)	2 (1.7%)	1 (0.8%)	1 (0.8%)	120
Blackpool	87 (32.3%)	103 (38.3%)	72 (26.8%)	3 (1.1%)	4 (1.5%)		269
Blackburn with Darwen	26 (43.3%)	21 (35%)	13 (21.7%)				60
East Lancashire	38 (39.2%)	37 (38.1%)	21 (21.6%)		1 (1%)		97
Central Lancashire	55 (34%)	65 (40.1%)	37 (22.8%)	2 (1.2%)		3 (1.9%)	162
Unknown Lancashire			1 (100%)				1
Ashton, Leigh & Wigan	42 (48.8%)	28 (32.6%)	16 (18.6%)				86
Bolton	97 (53.6%)	48 (26.5%)	36 (19.9%)				181
Bury	57 (41%)	58 (41.7%)	24 (17.3%)				139
Heywood, Middleton & Rochdale	48 (39%)	36 (29.3%)	38 (30.9%)	1 (0.8%)			123
Oldham	38 (42.7%)	25 (28.1%)	26 (29.2%)				89
Salford	193 (45.5%)	136 (32.1%)	82 (19.3%)	6 (1.4%)	2 (0.5%)	5 (1.2%)	424
Manchester	583 (41.5%)	481 (34.3%)	316 (22.5%)	5 (0.4%)		19 (1.4%)	1404
Tameside & Glossop	49 (41.9%)	42 (35.9%)	24 (20.5%)	2 (1.7%)			117
Trafford	62 (38.8%)	58 (36.3%)	40 (25%)				160
Stockport	43 (31.9%)	58 (43%)	31 (23%)	2 (1.5%)		1 (0.7%)	135
Unknown Greater Manchester	4 (66.7%)		2 (33.3%)				6
Sefton	35 (46.7%)	18 (24%)	21 (28%)			1 (1.3%)	75
Liverpool	175 (53%)	69 (20.9%)	82 (24.8%)	2 (0.6%)		2 (0.6%)	330
Knowsley	11 (42.3%)	5 (19.2%)	10 (38.5%)				26
Wirral	38 (34.5%)	39 (35.5%)	31 (28.2%)	2 (1.8%)			110
Halton & St Helens	31 (44.9%)	17 (24.6%)	20 (29%)	1 (1.4%)			69
Unknown Merseyside	4 (66.7%)		1 (16.7%)	1 (16.7%)			6
Warrington	30 (56.6%)	11 (20.8%)	11 (20.8%)	1 (1.9%)			53
West Cheshire	58 (62.4%)	23 (24.7%)	12 (12.9%)				93
Central and Eastern Cheshire	28 (28.6%)	31 (31.6%)	37 (37.8%)		2 (2%)		98
Unknown Cheshire			1 (100%)				1
Out of Region	68 (42.8%)	43 (27%)	48 (30%)				159
Isle of Man	6 (31.6%)	8 (42.1%)	5 (26.3%)				19
Abroad		2 (66.7%)	1 (33.3%)				3
Unknown*	36 (63.2%)	8 (14%)	10 (17.5%)		1 (1.8%)	2 (3.5%)	57
Total	**2026**	**1538**	**1122**	**30**	**11**	**34**	**4761**
%	**(42.6%)**	**(32.3%)**	**(23.6%)**	**(0.6%)**	**(0.2%)**	**(0.7%)**	

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

4. Voluntary Agencies 2006

Voluntary organisations have long played a fundamental role in the recognition of HIV/AIDS and in addressing the needs of HIV positive individuals[73-74]. They are identified in the Department of Health's AIDS Service Grant circular as key providers of social care[75] 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*[76]. In the North West Region, voluntary agencies continue to provide a wide range of services including counselling, information services, 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 appointments with 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[12]. 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 North West of England has established that seven voluntary agencies annually contribute £1 million pounds worth of services over and above those purchased by the statutory sector[3]. During 2006, 2,169 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by seven voluntary organisations in the North West.

It is important to note that not all HIV/AIDS voluntary organisations are able to provide attributable data for the report. Organisations such as South Lancashire HEAL are not included in the tables, but nonetheless make a valuable contribution to the provision of care. Similarly, the amount of attributable data provided by each voluntary organisation does not necessarily reflect the overall service provision 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 (where available). Tables 4.1 to 4.3 illustrate key characteristics of individuals accessing care from individual voluntary agencies, whilst table 4.4 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[1-10].

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[1-10]. The year 2006 was no exception, and 29% of individuals seen by voluntary organisations did not access care in the statutory sector in 2006, with 18% never having been known to the statutory sector in the North West.

Table 4.1 illustrates the number of HIV positive individuals presenting to voluntary agencies in the North West during 2006 and the number who had also presented at statutory agencies in the North West, either during 2006 or prior to 2006. Most agencies who reported in 2006 recorded an increase in their client base compared with 2005 figures: Barnardo's in Manchester (BARM) increased by 41%, George House Trust (GHT) by 22%, Body Positive Cheshire by 21%, Black Health Agency (BHA) increased by 16%, and Body Positive North West by 2%. The exceptions were Body Positive Blackpool and Sahir House whose numbers went down by 18% and 5% respectively from last year. The overall number of individuals seen by the voluntary sector in 2006 is 11% higher than in 2005 (2,169 compared with 1,947).

There is variation in the proportion of voluntary sector clients also seen within the statutory sector in 2006, with 80% at BP Cheshire, 78% at GHT and 76% at Sahir House, to 53% at BP Blackpool. The vast majority of clients not in contact with statutory treatment centres in 2006 reside in the North West of England (33% for BP Cheshire, 91% for BP North West and Sahir House, 93% for GHT, 98% for BHA and 100% for the remaining agencies). A significant number of individuals have never been seen at statutory centres: up to 208 individuals at GHT. These data suggest that the voluntary sector may be the sole provider of care and support for a substantial number of these HIV positive individuals who do not access statutory care.

Table 4.1 also categorises individuals accessing voluntary care in 2006 according to infection route, sex, age group, ethnicity and residency. Apart from those attending the BHA, BARM and Sahir House, the majority of individuals presenting to voluntary agencies were men who have sex with men (MSM), ranging from 57% at Body Positive Cheshire to 94% at BP Blackpool. The main route of infection for BHA, BARM and Sahir clients was heterosexual sex (95%, 82% and 38% respectively) with a high proportion of female service users (81%, 80% and 34% respectively). BARM provides support for families with children affected by HIV. In some cases the HIV positive client is a parent, in other cases the child. A similar proportion of BP Blackpool and BP Cheshire were injecting drug users (at 2% each) compared to 2.2% for those attending statutory services (chapter three, table 3.2).

The majority of clients at all voluntary organisations were aged between 25 and 49 years. The organisation that saw the highest number and proportion of children was BARM (22 individuals, 14% of clients were aged 14 years or under), as would be expected for an organisation specialising in the needs of children. The numbers of service

users aged 14 years or under has increased in three voluntary organisations since 2005. The differing profiles and characteristics of HIV positive clients accessing North West voluntary agencies may in part reflect the different range of services provided and the varying strategies used to encourage HIV positive people to use services.

The vast majority of presentations to voluntary sector organisations were by individuals self-defined as white, for example 100% of those attending BP Blackpool, 87% BP Cheshire, 81% BP North West and 65% of GHT. However, BHA, a specialist service for black and minority ethnic communities, provided care for high proportions of HIV positive individuals from black African communities (98%), as did BARM (82%). GHT provided care for the largest number of HIV positive black Africans (457 individuals), an increase since 2005 (362 individuals).

Presentations at most North West voluntary agencies were predominantly by residents of the North West Region. The proportion of clients known to be resident within the North West ranges from 87% of BP Cheshire clients, to 100% at BP Blackpool. BP Cheshire was the only voluntary organisation with a significant proportion of HIV positive clients from outside the region (13%), 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 2006. 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.

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 2006 by attendance at the statutory sector during the year. Due to the relatively high proportion of individuals for whom infection route is unknown (particularly among those who have never attended the statutory sector), the percentages in the table are calculated as percentages of those individuals for whom the information is known. The predominant method of exposure to HIV amongst voluntary sector clients during 2006 was sex between men, accounting for 58% of cases where infection route has been determined. This is comparable to the 53% 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 (39%) compared to the statutory sector (40%: chapter 3, table 3.2). This has increased since 2001 when only 19% of voluntary sector clients were heterosexually exposed. The vast majority of voluntary sector clients were male (72%), primarily due to the relatively high rates of HIV infection in MSM. As in those HIV positive individuals accessing the statutory sector (chapter 3, table 3.5), the majority of voluntary sector clients where ethnicity is known are self-defined as white (66%); a similar percentage as those who accessed statutory services (65%).

Table 4.3 also shows that 29% of individuals (619 out of 2,169) using voluntary services did not attend a statutory sector service during 2006 and 18% have never been seen by the statutory sector. The profile of those who have never presented to the statutory sector is quite distinct: compared to those who access both voluntary and statutory services they are much less likely to be MSM (40% compared to 60% of people accessing both the voluntary and statutory sector in 2006) and more likely to be heterosexually infected (57% compared to 37%). They are more likely to be black African (43% compared to 26%) and more likely to be an asylum seeker (24% compared to 9%). Those who have attended the statutory sector in the past but not in 2006 are different again, being much more likely to be male (81%), MSM (70%) and white (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 and ethnicity, 2006

		Voluntary Agency						
		BARM	BHA	BP Blackpool*	BP Cheshire	BP North West	GHT	SAHIR
Statutory Sector Attendance	Never Seen	62 (39.5%)	35 (26.5%)		6 (13%)	77 (10.6%)	208 (13.9%)	32 (21.9%)
	Seen Prior to 2006	4 (2.5%)	20 (15.2%)	25 (47.2%)	3 (6.5%)	83 (11.4%)	127 (8.5%)	3 (2.1%)
	Seen 2006	91 (58%)	77 (58.3%)	28 (52.8%)	37 (80.4%)	568 (78%)	1161 (77.6%)	111 (76%)
Sex	Male	31 (19.7%)	25 (18.9%)	51 (96.2%)	36 (78.3%)	609 (83.7%)	1089 (72.8%)	96 (65.8%)
	Female	126 (80.3%)	107 (81.1%)	2 (3.8%)	10 (21.7%)	119 (16.3%)	407 (27.2%)	50 (34.2%)
Age Group	0-14	22 (14%)	2 (1.5%)			2 (0.3%)	20 (1.3%)	
	15-19	8 (5.1%)	1 (0.8%)			2 (0.3%)	10 (0.7%)	3 (2.1%)
	20-24	8 (5.1%)	4 (3%)		1 (2.2%)	14 (1.9%)	54 (3.6%)	7 (4.8%)
	25-29	23 (14.6%)	15 (11.4%)	5 (9.4%)	6 (13%)	53 (7.3%)	165 (11%)	18 (12.3%)
	30-34	27 (17.2%)	32 (24.2%)	10 (18.9%)	9 (19.6%)	110 (15.1%)	247 (16.5%)	21 (14.4%)
	35-39	31 (19.7%)	31 (23.5%)	7 (13.2%)	9 (19.6%)	167 (22.9%)	322 (21.5%)	38 (26%)
	40-44	17 (10.8%)	28 (21.2%)	10 (18.9%)	9 (19.6%)	172 (23.6%)	324 (21.7%)	28 (19.2%)
	45-49	13 (8.3%)	9 (6.8%)	13 (24.5%)	2 (4.3%)	102 (14%)	180 (12%)	17 (11.6%)
	50-54	4 (2.5%)	4 (3%)	3 (5.7%)	6 (13%)	54 (7.4%)	93 (6.2%)	6 (4.1%)
	55-59	2 (1.3%)	5 (3.8%)	3 (5.7%)	2 (4.3%)	40 (5.5%)	52 (3.5%)	7 (4.8%)
	60+	2 (1.3%)	1 (0.8%)	2 (3.8%)	2 (4.3%)	12 (1.6%)	29 (1.9%)	1 (0.7%)
Infection Route	MSM	1 (0.6%)	3 (2.3%)	50 (94.3%)	26 (56.5%)	516 (70.9%)	887 (59.3%)	49 (33.6%)
	Injecting Drug Use	2 (1.3%)		1 (1.9%)	1 (2.2%)	9 (1.2%)	7 (0.5%)	2 (1.4%)
	Heterosexual	128 (81.5%)	125 (94.7%)	2 (3.8%)	19 (41.3%)	158 (21.7%)	572 (38.2%)	56 (38.4%)
	Blood/Tissue					14 (1.9%)	3 (0.2%)	3 (2.1%)
	Mother to Child	26 (16.6%)	1 (0.8%)			2 (0.3%)	14 (0.9%)	
	Undetermined		3 (2.3%)			29 (4%)	13 (0.9%)	36 (24.7%)
Ethnicity	White	17 (10.8%)		53 (100%)	40 (87%)	586 (80.5%)	970 (64.8%)	99 (67.8%)
	Black Caribbean	2 (1.3%)	3 (2.3%)		1 (2.2%)	3 (0.4%)	10 (0.7%)	
	Black African	128 (81.5%)	129 (97.7%)		4 (8.7%)	86 (11.8%)	457 (30.5%)	20 (13.7%)
	Black Other	2 (1.3%)				35 (4.8%)	2 (0.1%)	22 (15.1%)
	Indian/Pakistani/Bangladeshi	4 (2.5%)				4 (0.5%)	5 (0.3%)	
	Other Asian/Oriental	1 (0.6%)			1 (2.2%)	1 (0.1%)	14 (0.9%)	2 (1.4%)
	Other/Mixed	3 (1.9%)				10 (1.4%)	37 (2.5%)	3 (2.1%)
	Unknown					3 (0.4%)	1 (0.1%)	
Residency	UK National	29 (18.5%)	1 (0.8%)	53 (100%)	44 (95.7%)	596 (81.9%)	1009 (67.4%)	111 (76%)
	Asylum Seeker	62 (39.5%)	67 (50.8%)		2 (4.3%)	42 (5.8%)	128 (8.6%)	20 (13.7%)
	Overseas Student	5 (3.2%)	4 (3%)			5 (0.7%)	37 (2.5%)	
	Migrant Worker	3 (1.9%)	7 (5.3%)			5 (0.7%)	33 (2.2%)	
	Temporary Visitor	3 (1.9%)	1 (0.8%)			9 (1.2%)	10 (0.7%)	
	Refugee	23 (14.6%)	31 (23.5%)			34 (4.7%)	118 (7.9%)	
	Dependent	10 (6.4%)	1 (0.8%)			1 (0.1%)	5 (0.3%)	
	Other	21 (13.4%)	20 (15.2%)			25 (3.4%)	156 (10.4%)	2 (1.4%)
	Unknown	1 (0.6%)				11 (1.5%)		13 (8.9%)
NW Resident	Resident outside NW	1 (0.6%)	1 (0.8%)		6 (13%)	26 (3.6%)	39 (2.6%)	6 (4.1%)
	NW Resident	156 (99.4%)	131 (99.2%)	53 (100%)	40 (87%)	702 (96.4%)	1457 (97.4%)	140 (95.9%)
	Total	**157**	**132**	**53**	**46**	**728**	**1496**	**146**

For a definition of the abbreviated voluntary agencies, please refer to appendix A at the back of the report.
**Blackpool HEAL merged with BP Blackpool at the end of 2005.*

Table 4.2: Distribution of statutory treatment for HIV and AIDS cases presenting to voluntary organisations, 2006

Treatment Centre	Voluntary Agency						
	BARM	BHA	BP Cheshire	BP Blackpool*	BP North West	GHT	Sahir
APH							11
ARM						3	8
BLAG				21	7	27	1
BLKG		1			2	10	
BOLG	2	1		1	12	34	
BOOT	15	1			2	15	
BURG	1				4	6	
BURY	2	1			3	6	
CHR			20		4	3	2
CPED						1	
CUMB						2	
HAL						1	1
LCN						7	28
LEI			5			2	
LEII			1				
MAC			2			5	
MGP				1	52	80	
MRIG	28	19	3		117	303	2
MRIH					4	4	
NMG	52	43	2	3	309	573	
NMGG		6			21	40	
NOBL						2	1
OLDG	2	1			19	9	
PG	2			2	2	16	
PP	1						
RLG	2	1	7	2	14	39	97
RLH						1	2
RLI				1	2	7	
ROCG	1	2			7	21	
SALG	3	4			9	38	
SHH			2	2	4	8	8
SPG							1
STP	4				21	41	
TAMG	1	1			11	6	
TRAG						1	
WAR			4		3	5	
WGH						3	1
WIGG						2	
WITG	1	3			47	50	1
WORK						4	

For definitions of the abbreviated treatment centres please refer to appendix A at the back of the report. Columns cannot be totalled vertically 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.
**Blackpool HEAL merged with BP Blackpool at the end of 2005.*

Table 4.3: HIV and AIDS cases presenting to the voluntary sector and statutory sector by sex, infection route, ethnicity and residency status: 2006

		Statutory Sector Attendance			Total
		Never Seen	Seen Prior to 2006	Seen in 2006	
Sex	Male	223 (57%)	184 (80.7%)	1148 (74.1%)	1555 (71.7%)
	Female	168 (43%)	44 (19.3%)	402 (25.9%)	614 (28.3%)
Infection Route	MSM	132 (39.6%)	158 (69.9%)	920 (60%)	1210 (57.8%)
	Injecting Drug Use	1 (0.3%)	1 (0.4%)	14 (0.9%)	16 (0.8%)
	Heterosexual	189 (56.8%)	65 (28.8%)	565 (36.9%)	819 (39.1%)
	Blood/Tissue	2 (0.6%)	2 (0.9%)	11 (0.7%)	15 (0.7%)
	Mother to Child	9 (2.7%)		23 (1.5%)	32 (1.5%)
	Sub Total (100%)	**333**	**226**	**1533**	**2092**
	Undetermined	58	2	17	77
Ethnicity	White	182 (46.7%)	173 (76.2%)	1064 (68.7%)	1419 (65.5%)
	Black Caribbean	6 (1.5%)	1 (0.4%)	8 (0.5%)	15 (0.7%)
	Black African	166 (42.6%)	43 (18.9%)	395 (25.5%)	604 (27.9%)
	Black Other	18 (4.6%)	5 (2.2%)	32 (2.1%)	55 (2.5%)
	Indian/Pakistani/Bangladeshi	2 (0.5%)		6 (0.4%)	8 (0.4%)
	Other Asian/Oriental	4 (1%)		13 (0.8%)	17 (0.8%)
	Other/Mixed	12 (3.1%)	5 (2.2%)	30 (1.9%)	47 (2.2%)
	Sub Total (100%)	**390**	**227**	**1548**	**2165**
	Unknown	1	1	2	4
Residency	UK National	198 (52.9%)	176 (77.5%)	1113 (72.1%)	1487 (69.4%)
	Asylum Seeker	88 (23.5%)	24 (10.6%)	134 (8.7%)	246 (11.5%)
	Overseas Student	8 (2.1%)	1 (0.4%)	31 (2%)	40 (1.9%)
	Migrant Worker	11 (2.9%)		27 (1.7%)	38 (1.8%)
	Temporary Visitor	7 (1.9%)	2 (0.9%)	11 (0.7%)	20 (0.9%)
	Other	31 (8.3%)	11 (4.8%)	120 (7.8%)	162 (7.6%)
	Refugee	28 (7.5%)	13 (5.7%)	99 (6.4%)	140 (6.5%)
	Dependent	3 (0.8%)		8 (0.5%)	11 (0.5%)
	Sub Total (100%)	**374**	**227**	**1543**	**2144**
	Unknown	17	1	7	25
	Total	**391**	**228**	**1550**	**2169**

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

5. Social Services 2006

This is the fifth year that the North West HIV/AIDS Monitoring Unit has collected data related to the care and support of HIV positive individuals who access social service departments in the North West. All social service departments in the North West were contacted and 10 were able to participate in this report. Data were obtained on 346 individuals accessing HIV care and support in 2006.

Social services provide essential care to HIV positive people by ensuring that their needs are assessed and met with respect to welfare, benefits, housing, advocacy and other necessary community based practical support. This is a crucial service to those affected by and infected with HIV and, for some, may be the only source of care (table 5.1). In 2006/2007, £16.5million was made available for English local authorities through the AIDS Support Grant. Of this, £1.2million has been allocated to North West local authorities (7% of the national allocation)[75]. It is important to note that not all individuals with HIV seen by each social services department may be reported as HIV positive as 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 by sex, infection route, residency status and statutory sector attendance. More men were reported by social services than women: the percentage was similar to that accessing the statutory sector for care (72% compared to 73%: chapter 3, table 3.7). However, there was a slightly smaller percentage of people accessing social service care infected via MSM (49%) than in the statutory sector (53%) (chapter 3, table 3.2).

A total of 73 individuals known to be non-UK nationals received care from social service departments. Liverpool saw 60% of these and just over half of all individuals seen by Liverpool social services were non-UK nationals (55%). Three social service departments, all of whom only saw a small number of people, state that no non-UK nationals accessed their services in 2006. Table 5.1 also shows that 15% 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 2006. Every social service department had at least one service user who also used voluntary services. In addition, every voluntary organisation was accessed by at least one individual who also presented to social services.

Table 5.1: HIV and AIDS cases presenting to social service departments by sex, infection route, residency and statutory sector attendance, 2006

		Social Service Department										
		Blackpool	Bolton	Cheshire	Cumbria	Knowsley	Liverpool	Preston	Salford	Stockport	Trafford	Total*
Sex	Male	67 (94.4%)	8 (36.4%)	3 (75%)	6 (75%)	4 (100%)	41 (51.3%)	34 (64.2%)	56 (93.3%)	8 (57.1%)	24 (77.4%)	250 (72.3%)
	Female	4 (5.6%)	14 (63.6%)	1 (25%)	2 (25%)		39 (48.8%)	19 (35.8%)	4 (6.7%)	6 (42.9%)	7 (22.6%)	96 (27.7%)
Infection Route	MSM	57 (80.3%)	4 (18.2%)	1 (25%)	3 (37.5%)		15 (18.8%)	19 (35.8%)	52 (86.7%)	5 (35.7%)	16 (51.6%)	171 (49.4%)
	Injecting Drug Use	6 (8.5%)	2 (9.1%)			2 (50%)	1 (1.3%)	2 (3.8%)	2 (3.3%)		3 (9.7%)	18 (5.2%)
	Heterosexual	5 (7%)	10 (45.5%)	2 (50%)	3 (37.5%)	1 (25%)	34 (42.5%)	28 (52.8%)	6 (10%)	8 (57.1%)	10 (32.3%)	107 (30.9%)
	Blood/Tissue	2 (2.8%)					2 (2.5%)				2 (6.5%)	6 (1.7%)
	Mother to Child		1 (4.5%)	1 (25%)	1 (12.5%)			2 (3.8%)		1 (7.1%)		6 (1.7%)
	Undetermined	1 (1.4%)	5 (22.7%)		1 (12.5%)	1 (25%)	28 (35%)	2 (3.8%)				38 (11%)
Residency	UK National	69 (97.2%)	12 (54.5%)	4 (100%)	8 (100%)	4 (100%)	36 (45%)	48 (90.6%)	55 (91.7%)	8 (57.1%)	29 (93.5%)	272 (78.6%)
	Asylum Seeker		5 (22.7%)				38 (47.5%)	1 (1.9%)	2 (3.3%)	4 (28.6%)	1 (3.2%)	51 (14.7%)
	Overseas Student							2 (3.8%)				2 (0.6%)
	Migrant Worker	1 (1.4%)	2 (9.1%)				2 (2.5%)	1 (1.9%)				6 (1.7%)
	Temporary Visitor	1 (1.4%)										1 (0.3%)
	Refugee		3 (13.6%)				3 (3.8%)		3 (5%)		1 (3.2%)	10 (2.9%)
	Dependent									1 (7.1%)		1 (0.3%)
	Other						1 (1.3%)	1 (1.9%)				2 (0.6%)
	Unknown									1 (7.1%)		1 (0.3%)
Statutory Sector Attendance	Never Seen	3 (4.2%)	2 (9.1%)	1 (25%)			27 (33.8%)	7 (13.2%)	9 (15%)	1 (7.1%)	2 (6.5%)	52 (15%)
	Seen Prior to 2006	3 (4.2%)			1 (12.5%)		1 (1.3%)	2 (3.8%)	3 (5%)		2 (6.5%)	11 (3.2%)
	Seen in 2006	65 (91.5%)	20 (90.9%)	3 (75%)	7 (87.5%)	4 (100%)	52 (65%)	44 (83%)	48 (80%)	13 (92.9%)	27 (87.1%)	283 (81.8%)
	Total	**71**	**22**	**4**	**8**	**4**	**80**	**53**	**60**	**14**	**31**	**346**

**Column total excludes double counting of individuals who accessed care from more than one social service department.*
Men who have had exposure through sex with men and who are also injecting drug users are included in the MSM (men who have sex with men) category.

Table 5.2: Distribution of social service care for HIV and AIDS cases presenting to voluntary organisations, 2006

	Voluntary Agency						
Social Service Department	**BARM**	**BHA**	**BP Blackpool**	**BP Cheshire**	**BP North West**	**GHT**	**SAHIR**
Blackpool			8		2	8	
Bolton	3	2			1	12	
Cheshire				1			
Cumbria						2	
Knowsley							2
Liverpool						6	31
Preston	1					9	
Salford					20	29	
Stockport	1				4	8	
Trafford	1	1			11	15	

6. Additional providers of HIV treatment and care 2006

This is the eighth year that the North West HIV/AIDS Monitoring unit has collected data relating to the case of HIV positive individuals attending specialist drug services in the North West. Community Drug Teams and Drug Dependency Units in the North West were asked to provide brief attributable data (soundex, date of birth, sex) on individuals they knew to be HIV positive who had accessed their services during 2006. For the second year running Renaissance, part of the Manchester Methodist Housing Association, has provided information on the number of HIV positive individuals using their service.

Table 6.1 displays the care provided by North West specialist drug agencies for HIV positive individuals, categorised by county of residence, sex and age group by year of report. Data relating to drug service clients who are known to be HIV positive were provided by five agencies in the North West (contributing drug services are listed at the end of this report). Although this year's figures suggest a reduction in HIV positive individuals accessing the drug services, the figures are limited due to incomplete data from the service providers. However, an increase has been recorded amongst residents in Merseyside.

Table 6.2 illustrates the care provided by Renaissance, part of the Manchester Methodist Housing Association, categorised by infection route, and attendance of the statutory and voluntary sector. The table shows that 96% of individuals using Renaissance housing in 2006 also accessed the voluntary services in 2006, with only one person not accessing the voluntary sector. The predominant route of infection for residents is MSM (67%), which represents the same proportion as last year, and reflects the regional trend (see chapter 3; table 3.2).

Focus on those infected by injecting drug use

Unlinked anonymous testing of injecting drug users in 2005 showed a North West HIV prevalence of 1.3%[38]. This low prevalence is attributed to harm reduction strategies such as needle exchange schemes. In the North West the proportion of new cases infected through injecting drug use has reduced to around 2% per annum. Often successful prevention interventions risk disinvestment. However, new HIV infections via this route continue to present each year and overall IDU represents the third most common route of HIV infection in the North West (see chapter 3). Findings from the North West ten year HIV report[12] show that compared to other groups, injecting drug users (IDUs) were more likely to demonstrate poor health indicators and have a higher risk of mortality. This section provides further detailed analysis using the latest HIV data and highlights demographic and clinical characteristics of those likely to be infected via injecting drug use by comparison with those infected by all other routes, or whose route of infection is unknown.

Table 6.3 shows that a high proportion of injecting drug users had symptomatic HIV (45%) in contrast with those infected via other routes (32%) and a corresponding low proportion was asymptomatic (P<0.001). There was also a tendency for injecting drug users to have been more likely to die (3%) compared to other infection routes (fewer than 1% of whom died), although this needs to be interpreted with caution as the number of deaths (three drug users) was too low for statistical analysis. As expected from the fact that IDUs were at more advanced stage of disease, significantly more were taking therapy (P=0.002), and in particular there was a high rate of use of quadruple or more therapy (38% of IDUs, compared to 23% of those infected by other routes). Correspondingly, IDUs were significantly more likely to be admitted to hospital for at least one episode of inpatient care (21% compared to 8%; P<0.001). Injecting drug users also accessed the voluntary sector to a greater extent, since 44% of those seen in the statutory sector were also seen in the voluntary sector, compared to 32% of those infected by other routes (P=0.01).

Table 6.4 shows that IDUs were marginally older at 41 years on average compared to 39 years (P=0.45) for all others. The average number of visits to outpatient clinics was seven in 2006. IDUs did not differ in their use of HIV outpatient services from those infected via other routes. Due to the relationship between deprivation and ill health and the probability of admission to hospital[12], IDUs were compared to those infected by other routes in order to determine whether poverty was a significant issue for those with IDU-acquired HIV. However, there were no significant differences between IDUs and non-IDUs in the mean index of multiple deprivation score. In common with others with HIV in the North West, the majority of IDUs (60%) lived in the most deprived quintile compared to England average deprivation (compared to 65% of non-IDUs; difference not statistically significant; data not shown).

Table 6.1: HIV and AIDS care provided by North West drug services by county of residence, sex and age group 1999-2006

	Age Group	Year of Report							
		1999	2000	2001	2002	2003	2004	2005	2006
County of Residence	Cumbria								
	Lancashire		1		1	1			
	Greater Manchester	22	10	3	2	2	10	10	2
	Merseyside	8	8		9	4	5	4	7
	Cheshire	2	1		1	1	1	1	
	No Fixed Abode							2	
	Unknown			10					
Sex	Male	25	14	9	11	4	13	12	5
	Female	7	6	4	2	4	3	5	4
Age Group	0-14								
	15-19	2							
	20-24		1	1		1	1	3	1
	25-29	2	1	2	1		2	1	3
	30-34	11	4	2	1	4	3	6	1
	35-39	10	7	4	4	1	4	3	2
	40-44	2	5	1	2		4	1	1
	45-49	2	1		2			1	
	50-54	3	1	2	1	1	1		
	55-59			1	2	1	1	2	1
	60+								
	Total	**32**	**20**	**13**	**13**	**8**	**16**	**17**	**9**

Table 6.2: HIV and AIDS care provided by Renaissance housing association by statutory and voluntary sector attendance and infection route

		Year	
		2005	2006
Statutory sector attendance	Never Seen		1 (4.2%)
	Seen prior to 2006		2 (8.3%)
	Seen in 2006	18 (100%)	21 (87.5%)
Voluntary sector attendance in same year	Seen in 2006	13 (72.2%)	23 (95.8%)
	Not Seen in 2006	5 (27.8%)	1 (4.2%)
Infection Route	MSM	12 (66.7%)	16 (66.7%)
	Injecting Drug Use	1 (5.6%)	2 (8.3%)
	Heterosexual	5 (27.8%)	6 (25%)
	Total (100%)	**18**	**24**

Table 6.3: Stage of disease, use of antiretroviral therapy, admission to hospital and use of voluntary services of injecting drug users (IDUs) compared to those infected though other routes

	IDUs % (n)	Other infection routes % (n)	Chi square	df	P
Stage of disease			**19.6**	**3**	**<0.001[#]**
Asymptomatic	24% (25)	43% (2001)			
Symptomatic	45.2% (47)	32% (1491)			
AIDS	26.9% (28)	23.5% (1094)			
AIDS Related Death	1% (1)	0.6% (29)			
Death Unrelated to AIDS	1.9% (2)	0.2% (9)			
Unknown	1% (1)	0.7% (33)			
ART level			**12.6**	**2**	**0.002[†]**
None	23.1% (24)	33% (1536)			
Mono		0% (2)			
Dual		0.1% (5)			
Triple	39.4% (41)	43.8% (2039)			
Quadruple or more	37.5% (39)	23.1% (1075)			
Hospital stay >1night			**20.7**	**1**	**<0.001**
	21.2% (22)	8.4% (393)			
Accessed voluntary sector			**6.6**	**1**	**0.010**
	44.2% (46)	32.3% (1504)			
Total	**100% (104)**	**100% (4657)**			

[#]chi-square test was carried out with death categories merged and unknowns excluded.
[†]chi-square test was carried out with triple/dual/mono categories merged.

Table 6.4: Index of multiple deprivation, number of outpatient attendances and age of injecting users compared to those infected through other routes

	n	Mean (SD)	t	df[#]	P
Age (years)			**2.0**	**111.2**	**0.045**
Injecting drug users	104	40.6 (8.03)			
Other infection routes	4657	39.0 (10.63)			
Number of outpatient attendances			**0.6**	**106.7**	**0.554**
Injecting drug users	104	6.8 (7.21)			
Other infection routes	4657	7.3 (6.43)			
Index of multiple deprivation[†]			**1.3**	**100.2**	**0.213**
Injecting drug users	96	42.2 (19.94)			
Other infection routes	4226	44.8 (21.73)			

[#]degrees of freedom adjusted for unequal variances
[†]those with area of residence not supplied were therefore excluded from the analysis (8% of IDU and 9% of other)

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Appendix A

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: (01254) 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) 390 772

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

BURG Burnley General Hospital, Department of GUM, St Peter's Centre, Church St., Burnley, Lancashire, BB11 2DL. Tel: (01282) 644 300

BURY Fairfield General Hospital, Bury GUM Clinic, Rochdale Old Road, Bury, BL9 7TD. Tel: (0161) 764 6081

CHR The Countess of Chester Hospital, Department of GUM, Liverpool Road, Chester, Cheshire, CH2 1HJ. Tel: (01244) 365 000

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

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

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

LEII Leighton Hospital, Ward 5, Middlewich Road, Crewe, Cheshire, CW1 4QJ. Tel: (01270) 255 141

MAC Macclesfield District General Hospital, Department of GUM, Victoria Road, Macclesfield, Cheshire, SK10 3BL. Tel: (01625) 421 000

MGP 'The Docs' General Practice, Manchester, 55-59 Bloom Street, Manchester, M1 3LY. Tel: (0161) 237 9490

MRIG Manchester Royal Infirmary, Manchester Centre for Sexual Health, Oxford Road, Manchester, M13 9WL. Tel: (0161) 276 1234

MRIH Manchester Royal Infirmary, Department of Haematology, Oxford Road, Manchester, M13 9WL. Tel: (0161) 276 4810

NMG North Manchester General Hospital, Infectious Disease Unit, Monsall Wing, Crumpsall, Manchester, M8 6RB. Tel: (0161) 795 4567

NMGG North Manchester General Hospital, Department of GUM, Crumpsall, Manchester, M8 6RB. Tel: (0161) 795 4567

NOBL Noble's Isle of Man Hospital, Department of GUM, Strang, Douglas, Isle of Man, IM4 4RJ. Tel: (01624) 650 710

OLDG Royal Oldham Hospital, Department of GUM, Phoenix Health Centre, Rochdale Road, Oldham, Lancashire, OL1 2JH. Tel: (0161) 627 8394

PG	Royal Preston Hospital, Department of GUM, Sharoe Green Lane North, Fulwood, Preston, PR2 9HT. Tel: (01772) 522 814
PP	Royal Preston Hospital, Paediatric Department, Sharoe Green Lane North, Fulwood, Preston, PR2 9HT. Tel: (01772) 522 551
RLG	Royal Liverpool University Hospital, Department of GUM, 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	Baillie Street Health Centre, Department of GUM, Baillie Street, Rochdale, OL16 1XS. Tel: (01706) 517 686
SALG	Capio Oakland Hospital, Sexual Health Clinic, 19 Lancaster Road, Salford, M6 8AQ. Tel: (0161) 212 5717
SHH	St Helens General Hospital, Department of GUM, Marshalls Cross Road, St Helens, WA9 3DA. Tel: (01744) 458 383
SPG	Southport and 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, Crickets Lane Clinic, Crickets Lane, Ashton-under-Lyne, Lancashire, OL6 6NG. Tel: (0161) 339 2222
TRAG	Trafford General Hospital, Department of GUM, Moorside Road, Urmston, Manchester, M41 5SL. Tel: (0161) 746 2621
WAR	Warrington Hospital, Department of GUM, Lovely Lane, Warrington, Cheshire, WA5 1QG. Tel: (01925) 635 911
WGH	Westmorland General Hospital, Outpatient Department, Burton Road, Kendal, Cumbria, LA9 7RG. Tel: (01539) 732 288
WHIT	West Cumberland Hospital, Department of Haematology, Hensingham, Whitehaven, Cumbria, CA28 8JG. Tel: (01946) 693 181
WIGG	Royal Albert Edward Infirmary, Department of GUM, Wigan Lane, Wigan, WN1 2NN. Tel: (01942) 244 000
WITG	South Manchester Centre for Sexual Health, Withington Hospital, 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 Blackpool	Body Positive Blackpool	Tel: (01253) 292 803
BP Cheshire	Body Positive Cheshire and North Wales	Tel: (01270) 653 150
BP North West	Body Positive North West	Tel: (0161) 873 8100
GHT	George House Trust	Tel: (0161) 274 4499
SAHIR	Sahir House	Tel: (0151) 708 9080

Social Service Departments

Blackpool Borough Council	Tel: (01253) 477 933
Bolton	Tel: 01204 337 2820
Cheshire	Tel: (01244) 602 915
Cumbria	Tel: (01229) 894 345
Oldham	Tel: (0161) 911 4800
Knowsley	Tel: 0151 430 1764
Liverpool	Tel: 0151 706 2854
Preston	Tel: (01772) 263 689
Salford	Tel: (0161) 607 6999
Stockport	Tel: (0161) 476 4628
Trafford	Tel: (0161) 912 1213

Additional providers of HIV care

Chester Community Drugs Team	Tel: (01244) 344 999
Liverpool Drug Dependency Unit	Tel: (0151) 709 0516
Southport Lighthouse Project	Tel: (0151) 530 2566 (head office)
Tameside Community Drugs Team	Tel: (0161) 339 4141
Wirral Drug Service	Tel: (0151) 604 7330
Renaissance, Manchester Methodist Housing Association	Tel: (01204) 365 711

Appendix B

Local Authorities to Primary Care Trust

Due to recent changes in primary care trust (PCT) boundaries, data are presented by local authority (LA) in chapters two and three. To calculate PCT total from the tables, sum the LAs as shown in the table below.

Table B1: Relationship between local authority areas and primary care trust areas in the North West

Local Authority	PCT
Carlisle Allerdale Eden Copeland South Lakeland Barrow-in-Furness	Cumbria
Lancaster Wyre Fylde	North Lancashire
Blackpool	Blackpool
Blackburn with Darwen	Blackburn with Darwen
Ribble Valley Pendle Hyndburn Burnley Rossendale	East Lancashire
Preston South Ribble Chorley West Lancashire	Central Lancashire
Wigan	Ashton, Leigh & Wigan
Bolton	Bolton
Bury	Bury
Rochdale	Rochdale, Heywood & Middleton
Oldham	Oldham
Salford	Salford
Manchester	Manchester
Tameside	Tameside & Glossop
Trafford	Trafford
Stockport	Stockport
Sefton	Sefton
Liverpool	Liverpool
Knowsley	Knowsley
Wirral	Wirral
St Helens Halton	St Helens & Halton
Warrington	Warrington
Ellesmere Port & Neston Chester	West Cheshire
Vale Royal Crewe & Nantwich *	Central and Eastern Cheshire
Macclesfield Congleton	

** All North West LA boundaries match approximately with PCTs except Vale Royal and Crewe and Nantwich, which both split between Central and Eastern and West Cheshire PCTs.*

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