In 2005, for the first time, the North West Region has seen over 4,000 cases of HIV. In total there were 4,195 individuals accessing treatment and care, representing a 17% increase on the number reported in 2004 (3,574). During 2005 there were 928 new cases of HIV, the largest recorded number of new cases of HIV positive people accessing treatment and care since regional monitoring began (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 2005). This represents a 14% increase on last year’s figure of 814.

This is the tenth 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 43 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/hiv2005).

New cases represented 22% of all cases, a proportion similar to previous years. However, the number of female new cases has increased dramatically by 23% from 269 new female cases in 2004 to 331 in 2005 (table 2.4). The predominant mode of exposure to HIV for new cases was heterosexual sex (51%); this route has overtaken the percentage attributed to sex between men (40%: table 2.1) for the fourth year running, 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. While the largest proportion of new cases presenting for treatment and care were categorised as asymptomatic (69%), of the 14 new individuals who died during 2005, 13 had an AIDS defining illness (table 2.1). This illustrates the continuing need to attract HIV positive people into services at an early stage of their HIV disease to maximise the efficacy of treatment and improve prognosis.

The predominant mode of exposure to HIV for those accessing treatment in the North West (new and existing cases) continues to be through sex between men, accounting for 53% of all cases presenting to North West treatment centres in 2005 (table 3.1). There is, however, considerable variation across the counties. Of those whose infection route was known, 64% of Lancashire’s and 62% of Cumbria’s HIV positive residents were men who have sex with men (MSM) compared to 40% of Merseyside’s HIV positive residents. There is greater variation across LAs: 84% of Blackpool’s HIV positive residents were infected through sex between men. The LA with the largest number of HIV positive residents infected through sex between men is Manchester, with 650 cases (table 3.2). The county of Greater Manchester accounted for the highest number of HIV positive injecting drug users with 61 individuals and accounts for 64% of all residents of the North West infected by this route. However, heterosexual sex continues to be the second largest exposure group, accounting for over a third of all cases in 2005 (table 3.2). This represents a similar proportion to 2004 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. A third of all HIV positive individuals accessing treatment and care in the North West were reported to have been infected outside the United Kingdom (table 3.10). The vast majority of those exposed abroad were infected via heterosexual sex (80%), 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, 68% were in sub-Saharan Africa (figure 3.2). Western Europe accounted for a further 10% 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 2005, where 34% were reported to have been infected abroad (table 2.9). New cases exposed to HIV in Zimbabwe accounts for 31% of new cases known to have been exposed abroad (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 2005, most of whom (68%) were self-classified as white (table 3.5). However, an increasing proportion of individuals with HIV were from black and minority ethnic communities (32%); a substantial over-representation when considering the proportion of North West residents who are from minority ethnic communities (6%). An even higher proportion (47%) of new cases whose ethnicity was known were from minority ethnic communities (table 2.5), which represents an increase from 42% in 2004 and 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 second 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 residents represent 17% of all HIV positive individuals. These individuals were more likely to be asymptomatic (56%) than were UK residents (44%) (table 3.17).

During 2005, the level of triple or more therapy rose to 92% when considering those with an AIDS diagnosis, while only 42% of asymptomatic individuals were taking this level of therapy (table 3.8). 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 2005, demand for outpatient care peaked for those with an AIDS diagnosis (table 3.15), while those who died during 2005 required the most inpatient care. Home visits also formed a significant part of the care of HIV positive individuals (table 3.15), with those individuals who died during the year receiving the highest mean number of home visits.

During 2005, eight voluntary agencies in the North West reported care of 1,947 HIV positive individuals. Of these, 27% were not seen in North West statutory treatment centres during 2005 (table 4.4), illustrating the continuing contribution of the voluntary sector to the care of those HIV positive individuals for whom the voluntary agencies may be the sole provider of care. This also has particular significance for regional funding of HIV services, since individuals accessing voluntary agencies but not the statutory sector are not included in the regional statistics provided to the Department of Health, the basis of the formula for the national distribution of funds for the care of HIV positive people.

This year, for the fourth time, we requested information from social service departments in the North West on the social care of HIV positive people. Thirteen social services departments were able to take part, and contributed data on 380 individuals. Most (82%) social service clients were also seen in the statutory sector in 2005 (table 5.1). Specialist drugs services contributed data on clients whom were known to be HIV positive (table 6.1). Seventeen individuals were reported by four drugs services, and all of these people also received HIV treatment from elsewhere in the statutory sector in 2005. In addition, Renaissance, part of Manchester Methodist Housing Association, provided data for the first time in 2005 on 18 HIV positive individuals accessing their services, all 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/hiv2005), address most of your HIV-related information requirements. However, additional analyses and further breakdown of the data can be provided on request. As ever, we value your suggestions as to any developments that would improve the usefulness of the report in future years.

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