



# HIV & AIDS

in the North West of England 2006

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© August 2007  
Published by  
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ISBN 978-1-902051-95-5

British Library Cataloguing in Publication Data

A Catalogue record for this book is available from the British Library

Cover photograph: © STOCKFOLIO / Alamy  
Cover Design: Lee Tisdall



## 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](http://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 an 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](http://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.

Thanks are also due to staff in the Centre for Public Health, particularly Alyson Jones, Karl Witty, Layla English, Zara Anderson, Charlie Gibbons, Sacha Wyke, Neil Potter, Karen Tocque, Diana Leighton, Jim McVeigh, Karen Hughes, Helen Casstles, Lynn Deacon, Michela Morleo and Sharon Schofield.

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