HIV & AIDS

In the North West of England 2010

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Executive Summary

In 2010, 6,576 HIV positive individuals accessed treatment and care from statutory treatment centres in north west England, representing a 5% increase on the number reported in 2009 (6,238 individuals). During 2010, there were 735 new cases of HIV, representing a 17% decrease from 2009 (881 cases) continuing the trend of declining numbers of new cases shown between 2008 and 2009 (5% decrease). New cases were classed as people who were new to the database in 2010, were not seen at a statutory treatment centre in north west England since 1994, and included transfers from elsewhere in the country.

This is the fifteenth annual report of the North West HIV/AIDS Monitoring Unit, presenting data on HIV positive individuals accessing treatment and care in north west England. A total of 40 statutory centres provided treatment and care for HIV positive individuals. Information is presented by local authority (LA), primary care trust (PCT) and treatment centre. Due to limited space, not all analyses by LA or PCT can be included. However, additional breakdowns can be found on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2010).

New cases represented 11% of all cases, a lower proportion than seen in previous years (from 23% in 2004 to 14% in 2009). The two dominant modes of exposure to HIV for new cases was heterosexual sex and sex between men (MSM) at 37% each (tables 2.1 and 2.2), reflecting the national trend (figure 1.2). The number of new cases infected through other routes (injecting drug use, blood/tissue and mother to child) remained relatively low. The largest proportion of new cases presenting for treatment and care were categorised as asymptomatic (64%). However, all eight deaths amongst individuals new to treatment services in the region in 2010 were due to an AIDS-related illness (table 2.3). This illustrates the continued need to ensure that people with HIV seek treatment at an early stage of their disease to maximise the effectiveness of treatment and improve prognosis.

Overall diagnosed prevalence was 142 per 100,000 population aged 15 to 59 years, and three areas (Manchester, Salford and Blackpool) had a diagnosed prevalence greater than the threshold whereby testing in general settings is recommended (2 per 1,000 population). The predominant mode of exposure to HIV for all individuals who accessed treatment in north west England continued to be MSM, accounting for 50% of all cases in 2010 (table 3.1). However, there is considerable variation at county level. Of those whose infection route was known, 61% of Lancashire's and 57% of Cheshire's HIV positive residents were infected through sex between men, compared with 38% of Merseyside's HIV positive population. There was greater variation across local authorities: 80% of HIV positive residents in Blackpool (compared with 28% in Hyndburn) were infected via MSM (table 3.2). In contrast, 63% of Liverpool's HIV positive residents were infected through heterosexual sex compared to only 15% of Rossendale's. Manchester had the largest number of HIV positive residents infected through MSM (948 individuals) and through heterosexual sex (786 individuals). Greater Manchester had the largest number of HIV positive people infected through injecting drug use (80 individuals) which accounted for 71% of all residents in north west England infected through this route. Greater Manchester had the largest number of HIV positive individuals in the region accounting for 61% of all cases (table 3.2) and 58% of new cases (table 2.2) presenting to statutory treatment centres in 2010.

North west England continued to be influenced by the global HIV situation, as reflected by the number and pattern of HIV infections acquired abroad. Amongst new cases, 28% were reported to have been acquired abroad (figure 2.2 and table 2.7). People reported to have been infected in Zimbabwe accounted for a third of new cases known to have been infected abroad (figure 2.2). When considering all HIV positive individuals accessing treatment and care in north west England, over a third (36%) were reported to have been infected outside the United Kingdom, the vast majority of whom were infected in sub-Saharan Africa (71%: figure 3.2 and table 3.8). Heterosexual sex was the most common route of infection for those infected abroad (81%), a much higher proportion than amongst those known to be infected in the United Kingdom (16%). Nine percent of individuals infected abroad were infected in South and South-East Asia (predominantly Thailand: 7% of all infections acquired abroad), with a similar proportion (7%) in Western Europe. Of those exposed in Western Europe, Spain accounted for 30% of cases (figure 3.2).

Ethnicity was recorded for almost all individuals accessing treatment and care in 2010, the majority of whom (65%) were of white ethnicity (table 3.1). An increasing number of individuals treated in north west England were from black and minority ethnic (BME) backgrounds (34% of those for whom ethnicity was known), a substantial over-representation when compared with the proportion of people from BME backgrounds in the general north west population (8%). A similar proportion (35%) of new cases whose ethnicity was known were from BME communities (table 2.1). There is a continuing burden of HIV on BME communities in north west England, and an ongoing need for effective HIV prevention activities. The characteristics of HIV positive individuals from BME communities, particularly amongst those of black African ethnicity, contrast with those of the white HIV positive population. Whereas white individuals with HIV were more likely to have been infected through MSM, heterosexual sex is the predominant route of infection amongst those of black African ethnicity (tables 2.1 and 3.1). There are proportionately more females from BME communities with HIV compared with white females (table 3.7), which potentially impacts on the number of mother to child transmissions.

This report includes information on the residency status of those in treatment and care for HIV (tables 2.9 and 3.13). This level of information is not available nationally, notwithstanding concern over the health of vulnerable groups

such as asylum seekers. The number of individuals classed as non-UK nationals represented 19% of all HIV positive individuals in the north west England. Over half (56%) of these individuals were asymptomatic, compared with 48% of UK nationals.

During 2010, the largest proportion (51%) of people accessing treatment and care services were using triple antiretroviral therapy (ART, table 3.6). Amongst residents of north west England who had received an AIDS diagnosis, 96% were on ART. Amongst those who were asymptomatic, 71% were on therapy, an increasing proportion compared to 2009. During the year, asymptomatic HIV positive people accumulated a total of 20,522 outpatient visits (table 3.12). People who had received an AIDS diagnosis had the highest mean number of outpatient visits (6.6 per person), whilst individuals who had died from an AIDS-related illness during the year required the most inpatient care (a mean number of 22.3 days per individual).

During 2010, 3,460 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by ten community sector organisations (previously known in this report as voluntary agencies) in north west England. The overall number of individuals seen by the community sector in 2010 was 10% higher than in 2009. Over a quarter of the individuals seen by voluntary agencies in 2010 did not attend a statutory sector service during the year (table 4.3), illustrating the continuing contribution of the organisations to the care of HIV positive individuals for whom these services may be the sole provider of care.

Information was requested from social service departments in north west England on the social care of HIV positive people. This year, five social service departments were able to contribute information on 98 individuals. The majority of people with HIV seen by social service departments also accessed statutory sector services in 2010 (table 5.1).

Information on trends for new and all cases of HIV in the North West from 2000 to 2010 are presented in chapter 6 and give an overall view of the changing pattern of HIV in north west England.

It is hoped that the tables and figures presented in this report, and the extra analysis available on the website (www.nwpho.org.uk/hiv2010) provide the relevant North West HIV/AIDS information needed. In recognition of the evolving and dynamic nature of HIV, any comments and suggestions for improving the usefulness of this report in future years are welcomed.

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1. Introduction

Over the past fifteen 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 of England [1-14]. This report aims to provide a comprehensive and timely summary of the epidemiology of HIV. It begins with a global and national overview before focussing on the north west of England. In chapter 2, we present analyses of new HIV cases in north west England and in chapter 3, analyses of all HIV cases. Information on the community sector (previously known in these reports as voluntary agencies) and social care are presented in chapters 4 and 5, followed by trend data in chapter 6.

Due to limited space, not all analyses by local authority (LA) or primary care trust (PCT) can be included here. However, additional tables can be found on the North West Public Health Observatory website: www.nwpho.org.uk/hiv2010.

We hope that the tables and figures presented within this report and the extra analysis available on the website provide the relevant HIV information required. In recognition of the evolving and dynamic nature of HIV, any comments and suggestions for improving the usefulness of this report in future years are welcomed.

Global Perspectives on HIV and AIDS[*15]

Globally, the proportion of individuals infected with HIV has stabilised in the first decade of the twenty first century. However, due to increases in new diagnoses and the effects of improved and more widely available antiretroviral therapy, the number of people living with HIV continues to rise. There were an estimated 33.3 [31.4 – 35.3] [†] million people infected with HIV globally at the end of 2009, of whom 2.6 [2.3—2.8] million were new HIV infections. An estimated 370,000 children aged under 15 years were infected in 2009, mostly from transmission in-utero, during delivery or post-partum through breastfeeding. There are thought to be 2.5 [1.7—3.4] million children aged under 15 years now living with HIV (an estimated 92% live in sub-Saharan Africa). The number of new infections in 2009 was around 24% lower than in 2004, due to expansion of services to prevent mother to child transmission.

Continued improvement in national HIV surveillance systems and estimates feed into the global epidemiological system. For example, anonymous HIV testing in national household surveys was conducted in 11 countries in 2007 and 2008, most in sub-Saharan Africa; such data help local governments better tailor their response as well as feeding more reliable information into the global system.

UNAIDS note that as we enter the fourth decade of the AIDS pandemic, there are signs of major progress in the response to HIV. This has been attributed in part to the substantial increase in access to HIV treatment in recent years. Coverage for services to prevent mother to child transmission rose from 10% in 2004 to 45% in 2008[16] and in 2009 51% of pregnant women who tested positive were reported as eligible to receive antiretroviral therapy for their own health[17]. In 2009, 1.2 million people received antiretroviral therapy for the first time, a 30% increase from 2008. Globally, 36% of 15 million people in need in low and middle income countries were receiving antiretroviral therapy and a fairly uniform increase in antiretroviral therapy coverage was seen (with slightly higher levels in eastern Europe (34%) and southern Africa (33%)). This increase is strongly contributing to the global decline in the number of HIV-related deaths. The annual number of AIDS deaths declined from 2.2 [1.9—2.6] million in 2005 to 1.8 [1.6—2.1] million in 2009. Amongst deaths reported in 2009, 250,000 were in children aged under 15 years.

Despite advances, action is still needed to reach HIV prevention and treatment and care targets[18,19]. UNAIDS reiterate that AIDS continues to be a major health priority and, despite improvements, AIDS-related illness is one of the leading causes of death globally and will contribute towards premature mortality in decades to come. Further, the number of persons living with HIV continues to increase. Global solidarity in the response to AIDS is thus called for.

Epidemiological patterns are evolving by region and country, with changing characteristics of populations at greatest risk of infection. This underscores the need for targeting prevention to local needs, and the importance of decentralising AIDS responses. In most regions the epidemic is stabilising, with sub-Saharan Africa remaining the most heavily affected with 68% of all new infections in 2009. While encouraging declines have been seen, between 2001 and 2009, seven countries, including five in Eastern Europe and Central Asia have seen HIV incidence increase by over 25% during this period. Further, resurgence of infections in men who have sex with men (MSM) in high income countries is well documented. Addressing the HIV epidemic amongst marginalised groups is particularly important. It was highlighted at the XVII International AIDS Conference, Mexico City in 2008, that in countries where there are no laws to protect sex workers, drug users and MSM, only a fraction of the population has access to prevention. This contrasts with access to services in countries where legal and human rights protection is available[20]. UNAIDS noted that programmes to prevent new infections among such key populations are an important part of national AIDS responses.

Important gaps in prevention programmes identified by UNAIDS include failure to match national AIDS strategies to documented national needs, or failures to prioritise focused HIV prevention programmes for key populations. Gaps in hyperendemic settings include lack of attention placed on HIV testing and counselling for serodiscordant couples,

[*] Unless otherwise stated, global data and information have been abstracted from UNAIDS Report on the Global AIDS Epidemic 2010 and UNAIDS factsheets, using 2009 data.

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

particularly amongst older heterosexual couples, and addressing intergenerational partnerships which increase vulnerability of young people. There is also a need to include people living with HIV in programme planning implementation and monitoring. To address these needs, UNAIDS has developed an outcome framework for 2009-2011 with nine priority areas (box 1)[21].

Box 1: UNAIDS Outcome Framework, 2009 – 2011

- Reduce sexual transmission of HIV;
- Prevent mothers from dying and babies becoming infected with HIV;
- Ensure people living with HIV receive treatment;
- Prevent people living with HIV from dying from TB;
- Protect drug users from becoming infected with HIV;
- Remove punitive laws, policing, practices, stigma and discrimination that block effective responses to AIDS;
- Stop violence against girls and women;
- Empower young people to protect themselves from HIV;
- Enhance social protection for people affected by HIV.

Sub-Saharan Africa

Sub-Saharan Africa remains the global epicentre of the HIV pandemic. There were an estimated 22.5 [20.9—24.2] million people living with HIV in 2009, 1.8 [1.6—2.0] million of these were new infections. These figures account for approximately two thirds (68%) of the global total of infection (33.3 [31.4—35.3] million) and nearly three quarters (72%) of the global number of AIDS-related deaths. The epidemic has orphaned around 14.8 million children in this region.

Although the epidemic in sub-Saharan Africa appears to be stabilising, this is often at high levels. In four of the five countries with the largest epidemics in sub-Saharan Africa, namely Ethiopia, South Africa, Zambia and Zimbabwe, new infections have been reduced by over 25% since 2001. National prevalence in Uganda, Kenya and Rwanda have stabilised at 6.5-7%, 5% and 3% respectively. Prevalence in West and Central Africa is lower than Southern Africa, and has fallen to 2% or less in 12 countries. But there is still cause for concern and nine countries in Southern Africa have an HIV prevalence of greater than 10%, including Swaziland with an adult prevalence of 26% and Lesotho with a stable 24% in 2009.

AIDS related deaths are declining in the region, with a 20% reduction since 2004. For example 610,000 [530,000 – 700,000] people died of AIDS related illness in southern Africa in 2009 compared with 740,000 [670,000 – 820,000] five years earlier. This decline in the number of AIDS related deaths is largely due to the scaling up of treatment. In 2009 an estimated 37% [34%-40%] of eligible adults and children received antiretroviral therapy, a substantial increase from the 2% receiving it in 2001. In Botswana, where antiretroviral treatment coverage exceeds 90%, there has been a 50% reduction in AIDS related deaths between 2002 and 2009, and a 40% reduction in the number of children orphaned by HIV. It is estimated that sustaining this level of antiretroviral therapy provision will avert a further 130,000 deaths in Botswana by 2016[22]. However, there is still progress to be made in the region and the majority of people receive antiretroviral therapy too late. Systems to monitor the health status of HIV positive individuals and provide access to treatment at the appropriate time need to be strengthened and expanded to ensure further reductions in AIDS related mortality.

Heterosexual intercourse remains the driving force behind the epidemic in sub-Saharan Africa and unprotected sex with multiple partners the greatest risk factor. Women and girls continue to be disproportionately affected, accounting for 60% of infections. Sub-Saharan Africa is home to 76% of HIV positive women in the world and 13 women in sub-Saharan Africa become infected for every 10 men. This results from social, legal and economic disadvantage, as well as their relatively greater physiological susceptibility to infection. In Southern Africa, young women aged 20-24 years have an almost three-fold higher rate of HIV than among men the same age. Marital status often relates to HIV infection, particularly among the widowed partners of infected men, and divorce following HIV diagnosis. Urban data in Zambia suggests that 60% of new infections through heterosexual transmission are within marriage or cohabitation.

Although the epidemic in sub-Saharan Africa is characterised by heterosexual transmission, it has become evident that the epidemic is becoming more varied. Unprotected paid sex, injecting drug users (IDUs) and sex between men (MSM) are becoming increasingly significant factors in the epidemics of many countries. In Kenya, for example, HIV infections in MSM and IDUs are an increasing concern, and along with unprotected paid sex account for 33% of new infections. An estimated 32% of new infections in Ghana and 14% in Kenya are associated with paid sex. Injecting drug use is the primary mode of transmission in Mauritius and a significant factor in Tanzania, Zanzibar and Kenya. Sex between men is illegal and stigmatised in many countries in sub-Saharan Africa, yet research shows that it is widespread and the needs of MSM in HIV prevention should be recognised[23]. More than 40% of the population of men who have sex with men in Mombasa (Kenya) and Cape Town (South Africa) are living with HIV and it is estimated that up to 15% of new infections in Senegal could be linked to sex between men. Evidence suggests that the majority of men who have sex with men in sub-Saharan Africa will also have sex with women. According to survey data, 82% of men who have sex with men in Senegal report also having sex with women[24] and in Malawi one third of men who have sex with men were married or cohabiting with a woman[25].

Prevention strategies do not always correctly target drivers of the national epidemics. Prevention programmes inadequately cover older people, those in stable relationships, drug users, and men who have sex with men. For example in Burkina

Faso, 0.4% of prevention expenditure is dedicated to programmes for IDUs, MSM and sex workers despite these groups accounting for 30% of new infections.

Asia

In Asia, there were an estimated 4.9 [4.5 – 5.5] million people living with HIV in 2009, of whom 360,000 [300,000 – 430,000] were newly infected, a fall from 450,000 in 2001. Around 300,000 [260,000 – 340,000] were reported to have died from AIDS-related illnesses in 2009. While the epidemic in the region overall appears stable, HIV prevalence is increasing in some parts, such as Bangladesh and Pakistan and the Philippines. There has been a long term decline in prevalence in Cambodia (0.5% in 2009 compared to 1.2% in 2001) and incidence of new infections from 2001 to 2009 has decreased by 25% in India, Nepal and Thailand. The overall trends also hide some variations within countries, for example in China, where five provinces account for 53% of all HIV infections within the country.

The proportion of women living with HIV in the region continues to rise from 19% in 2000 to 35% in 2009. While IDUs, sex workers and MSM remain the main population groups at risk, HIV transmission is expanding into lower-risk populations through transmission to sexual partners of those at most risk. Thus, in Thailand, the pattern of HIV transmission is changing to include people previously considered to be low risk, such as married women infected by their husbands who became infected through unprotected sex or use of contaminated equipment[26]. Heterosexual transmission has overtaken IDU as the main route of transmission in China, and it is that reported 60% of sex workers do not consistently use condoms. In Myanmar and Southern India 18% and 15% of female sex workers respectively, are infected. An estimated 16% of the 4.5 million IDUs in Asia are living with HIV and the overlap between IDU and buying or selling sex is a concern of many countries.

While MSM transmission is under-researched in this region, evidence suggests a rise in HIV prevalence amongst this group with high prevalence reported in several countries. China, Thailand, Myanmar and Indonesia have all seen rises in prevalence. Surveys suggest that a significant proportion of men who have sex with men in Asia will also have sex with women; however, the risk of living with HIV appears to be significantly higher for men who only have sex with men.

Eastern Europe and Central Asia

The estimated number of people living with HIV in Eastern Europe and Central Asia reached 1.4 [1.3—1.6] million in 2009; almost tripling since 2001 (760,000 [670,000-890,000]). Rising prevalence is particularly notable in Ukraine and the Russian Federation, where it exceeds 1%. AIDS related deaths are rising in the region, with an estimated 76,000 deaths in 2009 compared with 18,000 in 2001.

HIV infection in the region continues to be centred around injecting drugs use, paid sex work and, to a smaller degree, MSM. It is thought that around 37% of the 1.8 million IDUs in the region are living with HIV. The crossover with IDUs and sex work increases the risk of transmission further. In the Russian Federation, research shows that 30% of sex workers had injected drugs[18,27]. There is also increasing transmission among sexual partners of injecting drug users and the proportion of women living with HIV is growing. In 2009, 45% of those living with HIV in Ukraine were women (a rise from 41% in 2004). An estimated 35% were thought to be IDUs and 50% were likely to have been infected with HIV by partners who inject drugs.

A small proportion of new infections were due to unprotected sex between men; accounting for 1% of new HIV infections in 2009. Nevertheless, data from small surveys show that there are regional variations in the prevalence of HIV amongst men who have sex with men; ranging from zero in Belarus and Lithuania to 6% in the Russian Federation.

Caribbean

In 2009, there were an estimated 240,000 [220,000 – 270,000] people living with HIV in the Caribbean. The region has an HIV prevalence of 1%, with the second highest level of adult HIV infection outside sub-Saharan Africa. There were an estimated 17,000 new infections (a slight decline from 20,000 in 2001) and approximately 12,000 deaths due to AIDS-related illnesses in 2009. There are substantial variations in prevalence between countries; with a prevalence of 0.1% in Cuba rising to 3.1% in the Bahamas, the highest in the region. Treatment coverage in the region increased by 30% from 2009 to 2010.

The main mode of transmission of HIV in the Caribbean is unprotected heterosexual sex. The Caribbean is the only region outside sub-Saharan Africa where there is a higher proportion of women and girls (53%) living with HIV than men and boys. Paid sex contributes significantly to heterosexual transmission with surveys reporting an extremely high rate of infection in sex workers, with a prevalence ranging from 27% in Guyana to 9% in Jamaica. Transmission also occurs in MSM, despite sex between men being illegal in a number of countries. Surveys show that around 20% of men who have sex with men in Trinidad and Tobago, and 31% in Jamaica were infected. Evidence also indicates rising numbers of HIV infections among MSM in the Dominican Republic and Cuba. Injecting drug use makes a significant contribution to HIV incidence in Bermuda and Puerto Rico where it accounts for 40% of HIV incidence in males and 27% of new infections in females.

Latin America

An estimated 1.4 [1.2—2.6] million people were living with HIV in Latin America in 2009, a continued growth from 1.1 [1.0 to 1.3] million in 2001. This increase is largely due to the wider availability of antiretroviral therapy. An estimated 92,000 [70,000 – 120,000] new cases were reported along with an estimated 58,000 [43,000—70,000] AIDS-related deaths. Among children, an estimated 36,000 [25,000-50,000] were living with HIV compared to 30,000 [20,000 – 42,000] in 2001. The number of new cases among children under 15 years of

age was relatively low, at 4,000, and appears to be declining. Around 54% of pregnant mothers in 2009 were receiving antiretroviral therapy to prevent transmission to their unborn child.

The main mode of transmission continues to be MSM, although several countries continue to have fewer programmes targeting prevention among men who have sex with men. Surveys have found that prevalence among men who have sex with men in urban areas was at least 10% in 12 out of 14 countries[28]. An annual HIV incidence of 3.5% has been recorded among MSM attending health clinics in Peru, a higher rate than those observed in Europe and North America. One in five MSM in Central America reported also having sex with females[28]. Heterosexual HIV transmission is rising in some countries. This route now accounts for 43% of new infections in Peru and the majority are thought to occur during paid or other high risk forms of sex. Some 29% of two million Latin American IDUs are infected with HIV.

HIV prevention programmes among sex workers appear to be having an impact on transmission, with increasing use of condoms leading to a drop in HIV infections. Reported high condom use rates among female sex workers have coincided with low HIV prevalence in El Salvador and Guatemala[29]. High HIV prevalence among prisoners has lead some countries to move towards targeted prevention services in prisons.

North America, Western and Central Europe

In 2009 there were an estimated 2.3 [2.0 – 2.7] million people living with HIV in North America, Western and Central Europe. There were 100,000 [73,000 – 150,000] new HIV infections and an estimated 35,000 [29,000—56,000] people died from an AIDS-related illness in 2009. Progress in reducing the number of new HIV infections has stalled in high income countries.

The number of new infections amongst MSM increased while infections from IDUs fell. Data taken from 23 European countries shows an 86% rise in annual diagnoses among men who have sex with men.[30] In France MSM represent 1.6% of the total population and yet account for 50% of male HIV diagnoses. Levels of new infections amongst men who have sex with men have increased significantly in the United States of America, Canada, Spain, Germany, the Netherlands and the United Kingdom[31]. Thus, men outnumber women in both prevalence and new infections. In 2009 women accounted for 29% of infections in Western and Central Europe and 26% in North America.

Some racial and ethnic minorities are disproportionately impacted by HIV. For example, in the United States, African Americans accounted for 45% of new cases in 2006 but represented only 12% of the population. An African American female living in the United States is 19 times more likely to acquire HIV than her Caucasian counterpart. Immigrants living with HIV are also becoming a key feature of epidemics in a number of European countries. Heterosexual transmission accounts for around half people newly infected in Central Europe but many were infected abroad (mostly in Asia, sub-Saharan Africa and the Caribbean). In 2007, 17% of new diagnoses were from countries with a generalized epidemic[32].

Middle East and North Africa

Information for the Middle East and North Africa is limited however available data suggests increased HIV prevalence, new infections and AIDS related deaths in the past decade. An estimated 460,000 [400,000 – 530,000] people were living with HIV at the end of 2009 and, of these, 76,000 [61,000 – 91,000] were newly diagnosed, more than double the number of new diagnoses in 2001. AIDS related deaths have risen from 8,300 [6,300 – 11,000) in 2001 to 24,000 [20,000 – 27,000] in 2009. Epidemics in the region are relatively small scale, with the exception of southern Sudan and Djibouti, where HIV prevalence is growing in the general population and HIV prevalence among pregnant women is 1%. More generally, transmission has occurred through unprotected paid sex, MSM and IDU. IDU-related HIV infection is a concern in this region, with nearly a million people injecting drugs and a tendency to share injecting equipment[33]. The Isalmic Republic of Iran has the largest number of IDUs in the region and 14% of this population were believed to be living with HIV in 2007[34]. The criminalisation of same sex activities in many countries means services for MSM are rare. An estimated 6% of MSM in Egypt and between 8-9% of MSM in Sudan are HIV positive[35,36]. Many MSM also have sex with women. Evidence suggests that HIV transmission through paid sex networks is still limited; in 2006, an estimated 1% of female sex workers in Egypt and 2-4% in Morocco, Algeria and Yemen were living with HIV[33]. Insufficient data means it is not possible to determine the extent to which HIV is being transmitted to the male clients of sex workers and their respective partners.

Oceania

There were an estimated 57,000 [50,000 – 64,000] people living with HIV in Oceania in 2009, of which 4,500 [3,400 – 6,000] were newly infected. Epidemics in this area are mostly small, except in Papua New Guinea, the only generalized epidemic in the region, where the number of new diagnoses continues to rise. There were 1,400 AIDS related deaths in the region in 2009.

The HIV epidemics in this region are largely driven by sexual transmission. Heterosexual sex is the main driver in Papua New Guinea while men who have sex with men dominate the epidemics in Australia, New Zealand and smaller Pacific. Injecting drug use is a minor factor in the region as a whole but does feature significantly in some parts of the region. For example, 22% of HIV cases among Aboriginal and Torres Strait Islander people in the past five years have been due to injecting drug use[37]. In French Polynesia and Melanesia (not including Papua New Guinea) injecting drug users account for 11.7% and 16% of cumulative HIV cases respectively[38] .

An estimated 3,100 [1500-4800] children were living with HIV in this region in 2009. Mother to child transmission is a significant factor in Papua New Guinea where 10% of all new diagnoses acquired HIV through perinatal exposure. Targeted prevention programmes offering HIV testing to pregnant women have increased significantly in the second half of the

decade, with 17 sites offering testing in 2005 increasing to 178 sites in 2009.

Global access to treatment and prevention

At the second United National General Assembly High Level Meeting on HIV/AIDS in 2006, countries agreed to work towards the goal of "universal access to comprehensive prevention programmes, treatment, care and support" to be achieved by 2010. These global commitments supplement the health-related United Nations Millennium Development Goals[16], which established targets to combat HIV/AIDS as well as to reduce child mortality, improve maternal health, reduce deaths from malaria and other major diseases by 2015. By expanding the access to antiretroviral therapy there is evidence to suggest that morbidity and mortality rates are declining globally. Such programmes have resulted in behaviour change as well as a decreasing prevalence of HIV in highly burdened countries. However, many countries are far from achieving access goals. Some of the reasons for this include weak health systems, a critical shortage of human resources and a lack of long-term sustained financing.

Significant progress has been achieved in the prevention of HIV, with a 19% decline in HIV transmission over the past ten years and a 24% drop in mother to child transmission over the past five years. Condom availability has increased significantly, with international and non-governmental organisation funding providing 2.8 million female condoms in places of need in 2009. Correct knowledge of HIV has increased in the 12 months between 2008 and 2009, however with only 34% of young people having a comprehensive knowledge of HIV, there is still a long way to go to reach the United Nations General Assembly Special Session target of 95%.

UNAIDS feel that current investments in HIV prevention are insufficient and that national programmes should give priority to prevention programmes amongst the sectors of the population most in need. Paid sex workers and their clients, IDUs, transgender people and MSM continue to be neglected in many countries. They call for a scaling up of programmes to meet the trajectory of the epidemic through programmes that effectively combine structural, behavioural and biomedical responses. Focus should also be on the virtual elimination of mother-to-child transmission, advancing current progress through the integration of HIV services in antenatal settings. New prevention methods such as male circumcision are promising and should be scaled up in countries with general epidemics as part of a comprehensive HIV prevention package. Recent trials of a tenofovir based gel as a women orientated HIV prevention option are also promising and further steps need to be taken to confirm trial results at an international level[39] .

More people are receiving antiretroviral therapy than ever before. In 2009, an estimated 5.2 million people in low and middle income countries were receiving antiretroviral therapy; a 30% increase on the previous year. High treatment retention is also reported in many countries with 26 countries reporting that 95% of people are still receiving treatment 12 months after initiation. While extensive progress has been made, children and marginalized groups are still less likely to receive antiretroviral therapy. Only 28% of eligible children receive treatment compared with 34% of adults and only 15% of pregnant women receive treatment for their own health. Data for marginalized groups such as men who have sex with men, sex workers and injecting drug users are not collected in the majority of countries. Of the 21 countries with antiretroviral coverage data available, 14 report that less than 5% of injecting drug users were receiving treatment.

In 2010, the World Health Organisation revised their treatment guidelines, and this includes starting antiretroviral treatment earlier when CD4 count is <350 cells/mm^3. This means that the number of people eligible for antiretroviral treatment has increased by 50% to around 15 million people (based on 2009 data)[40]. In response to the new guidelines UNAIDS has produced its Treatment 2.0 framework which calls for a lowering of drug costs and optimizing drug treatment through the development of a "smarter, better pill". It couples this with adapting treatment delivery by mobilizing communities and providing access to point of care diagnostics[41].

HIV and AIDS in the United Kingdom

New diagnoses of HIV, AIDS and deaths of HIV positive individuals in the UK are reported to the Health Protection Agency (HPA) and the Scottish Centre for Infection and Environmental Health (SCIEH), who compile the data into six-monthly surveillance tables[42].

Table 1.1: Cumulative number of HIV diagnoses in the north west of England and the UK, by infection route to December 2010
Source: Adapted from table 4, United Kingdom New HIV Diagnoses to end of December 2010, HPA

	Infection route						
	MSM*	Injecting Drug Use	Heterosexual	Blood/Tissue**	Mother to Child†	Other/ Undetermined	Total
North West	4,340 (52.1%)	302 (3.6%)	3,125 (37.5%)	208 (2.5%)	122 (1.5%)	233 (2.8%)	8,330
Total UK††	50,137 (43.7%)	5,396 (4.7%)	51,372 (44.8%)	1,951 (1.7%)	1,940 (1.7%)	3,930 (3.4%)	114,726

**Includes 864 men who had also injected drugs.*
***All infections acquired through receipt of blood/tissue products diagnosed since 2002 were acquired outside the UK.*
†Includes individuals born outside but diagnosed in the UK.
†† Includes 40 cases were region is not stated but excludes 40 cases were sex is not stated

The HPA reports the cumulative total of reported new HIV infections for the UK reached 114,726 by the end of 2010 (table 1.1). Of these, 6,146 were newly diagnosed in 2010 (figure adjusted for underreporting; observed total 5,136). We anticipate the current unadjusted estimate of 5,136 new diagnoses for 2010 will also be upgraded as HPA refine the final year dataset. Figures 1.1 and table 1.1 compare the trend of new cases of HIV infection in the UK with those specific to the north west of England[42,43]. As with previous years, close to half of all individuals newly diagnosed with HIV reside in London (2,841 of 5,627 in England and of 6,136 in the UK). Similarly, over half of all cases diagnosed to date resided in London (58,191 of 106,040 in England and 114,766 in the UK)[42]. National policy will thus continue to be shaped by a strong bias towards the needs of London and the South East, with an under-representation of other parts of the UK[42-47]. For the epidemiology of HIV in north west England, see chapters 2 and 3 of this report, which are based on surveillance data of treatment and care of HIV positive individuals in north west England.

An additional tool for monitoring the HIV epidemic in the UK is provided by the unlinked anonymous HIV seroprevelance programme conducted by the HPA and the Institute of Child Health. Part of the programme involves the testing of blood samples that have been taken for other purposes (for example antenatal screening and syphilis serology) after having irreversibly removed patient identifying details. This allows estimations of the extent of undiagnosed HIV infection in high risk groups as well as in the general population. The monitoring programme has been operating throughout England and Wales since 1990 and provides low cost estimates of current HIV prevalence[42]. Results of the programme, combined with other HPA surveillance programmes, have been used to estimate that in 2010, there were 86,500 persons (diagnosed and undiagnosed) living with HIV in the UK, of whom, over a quarter (26%, 22,200) were unaware of their infection[48].

Men who have sex with men

Men who have sex with men (MSM) continue to be the group at greatest risk of acquiring HIV in the UK. The HPA recorded a cumulative total of 50,137 estimated cases of HIV acquired through sex between men. Amongst these, 2,534 were reported in 2009 and 2,363 in 2010. As noted previously, 2010 data are subject to reporting delays. To account for this, HPA have reported adjusted estimates, resulting in an estimate of 2,780 for 2009 and 3,080 for 2010. Using adjusted estimates, the HPA estimate around a 40% increase in the number of new diagnoses in MSM from 2001 to 2010 (from 1,810 to 3,080).

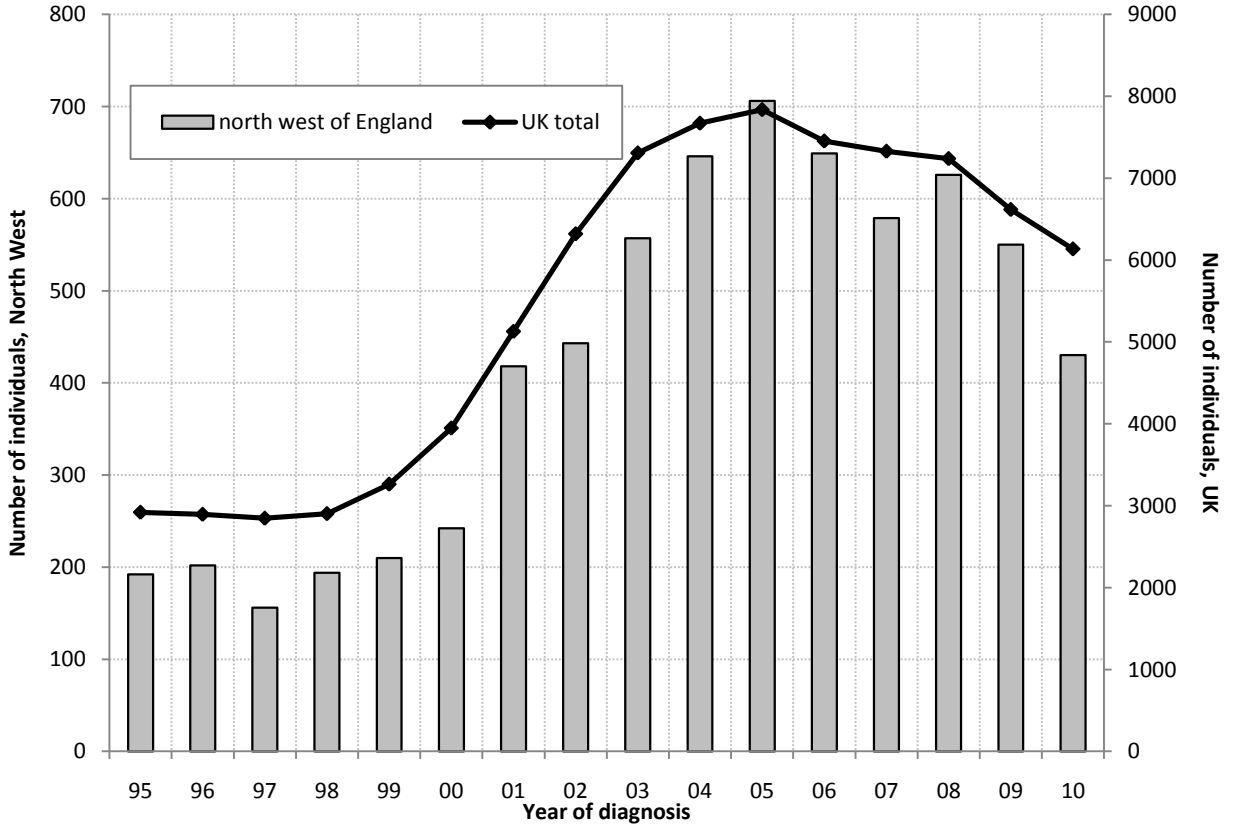
For those cases where the infection route was sex between men and where the probable country of infection had been reported, 64% were recorded as infected in the UK[42]. Even though these figures as a whole remain high, the shape of the epidemic has changed in the UK over the past two decades. The overall proportion of new HIV diagnoses in the UK attributed to sex between men has decreased from 63% prior to 1995 to 39% (based on observed figures) in 2010 (figure 1.2).

The 1980s saw substantial reductions in risky behaviours amongst MSM in response to HIV/AIDS. However, towards the end of the 1990s, the trends of increasing sexual risk-taking behaviour appeared to increase again. Changes in risky sexual behaviour were reported in Dougan *et al.*'s longitudinal study that recruited males in gyms in London[49]. Between 1998 and 2003, the percentage of males reporting high-risk sexual behaviour with a casual partner increased from 6.7% to 16.1%. This study recommended that sexual health promotion should target high-risk practices with casual partners since these, and not practices with steady partners, seem to account for the recent increase in high-risk behaviour[49].

There is evidence that the recent increase in diagnoses of HIV in MSM in the UK is strongly influenced by an increase in uptake of HIV testing. Analysis of routine data from GUM clinics, the unlinked anonymous screening programme and CD4 surveillance in the UK revealed a substantial increase in the uptake of HIV testing that may explain the rise in HIV diagnoses[50]. In 2009, the proportion of adults (aged over 15 years) diagnosed late (i.e. with a CD4 cell count less than 200 per mm^3 within three months of diagnosis) was lowest amongst MSM (20%) compared with heterosexual women (35%) and heterosexual men (42%). Over half (52%) of individuals were diagnosed with a CD4 cell count of less than 350 per mm^3 (the recommended threshold for commencing antiretroviral therapy)[48].

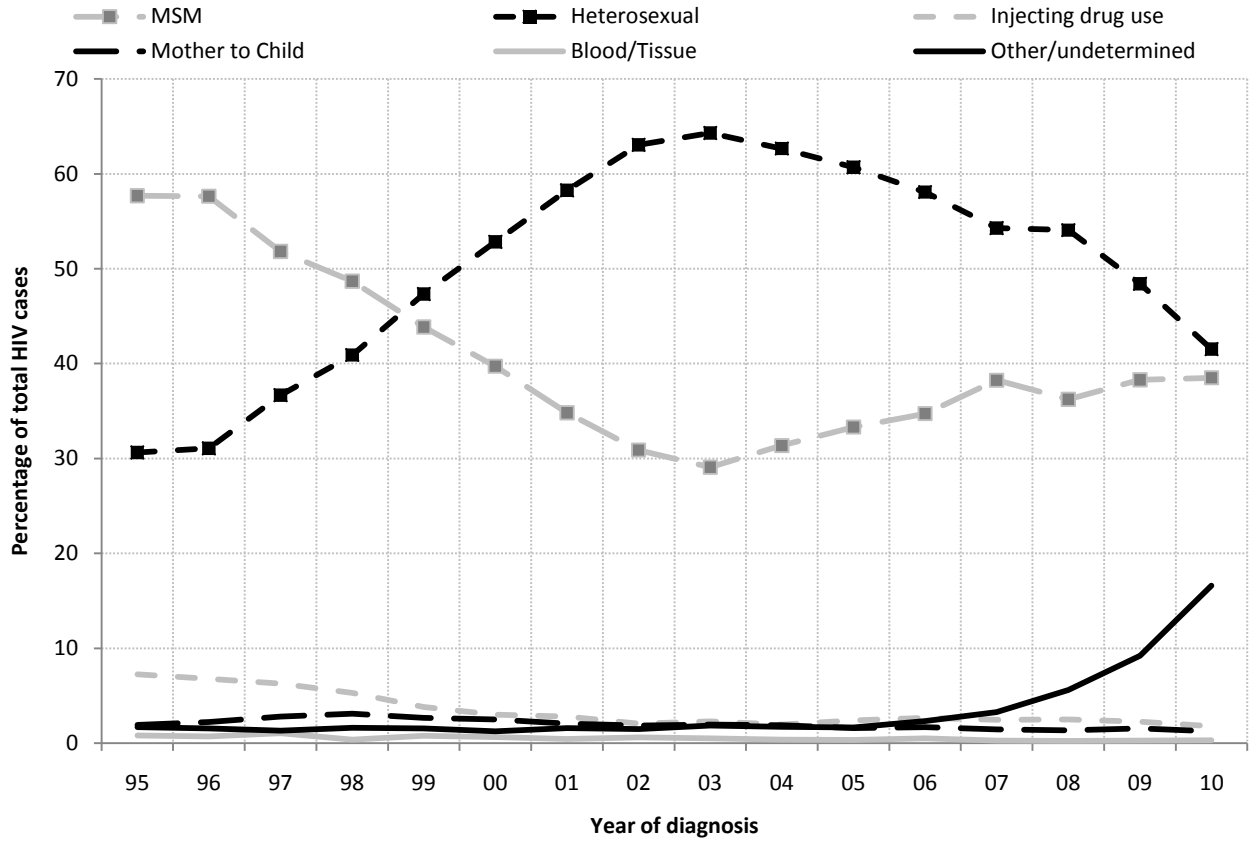
The most recent Sigma Research's Gay Men's Sex Survey was carried out in 2010 and conducted in partnership with health promotion agencies, organisations and websites across the UK, amongst men who reported having had sex with a man in the previous year and/or had a non-heterosexual sexual identity. The survey found that 30% of all males responding in England, and 36% of those in the north west of England, had never been tested for HIV[51].The survey also found that 64% of men had had intercourse with more than one partner in the past 12 months and 46% of men surveyed had not used a condom the last time they had anal sex with a male partner.

Figure 1.1: Number of new HIV diagnoses in the north west of England and the UK, by year of diagnosis to December 2010
Source: Adapted from table 3, United Kingdom New HIV Diagnoses to end of December 2010 HPA



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

Figure 1.2: Infection route of HIV cases in the UK, by year of diagnosis to December 2010
Source: Adapted from table 2, United Kingdom New HIV Diagnoses to end of December 2010, HPA



Heterosexual sex

From 1999, heterosexual sex accounted for the largest number of HIV diagnoses and outnumbered those acquired through sex between men, peaking in 2003 (64% of all UK diagnoses were acquired through heterosexual sex). Since 2003, the proportion infected through heterosexual sex has fallen and levelled off. However, even with reporting delay in 2009, 42% of individuals diagnosed acquired their infection through heterosexual sex, compared with 39% who had acquired HIV through sex between men (figure 1.2).

Of those HIV positive individuals infected through heterosexual sex in 2010, the majority (61%) were female[42]. Figure 1.3 shows the number of cases acquired through heterosexual sex categorised by whether they were exposed in the UK through sex with high risk or lower risk partners, or exposed abroad. The number of individuals exposed abroad peaked in 2002 and has since declined; the number is now becoming closer to the number of those infected through heterosexual sex within the UK.

Anonymous testing of all pregnant women can be used as an indicator of the prevalence of HIV in the general heterosexual population. Preliminary data reveal that the prevalence of HIV amongst pregnant women in England was 222 per 100,000 population in 2009 (figure 1.4)[52].

Africa is the predominant global region of transmission for HIV infections acquired abroad with 79% of all those HIV infections acquired through heterosexual sex (unadjusted 2009 figures) probably being acquired in the region[42]. This is also reflected in the epidemiology of HIV in north west England, of those new cases in 2010 that were infected abroad, around three quarters were exposed in sub-Saharan Africa (see chapter 2, figure 2.2). Individuals from black and minority ethnic (BME) communities make up a large proportion of heterosexually transmitted HIV cases in the UK, with black Africans constituting the largest proportion (around 63%)[42]. These communities have close connections with sub-Saharan countries, the region which is home to two thirds of the global total of adults and children estimated to be living with HIV/AIDS at the end of 2009[15]. However, HIV is often stigmatised within African communities, which can prevent individuals from accessing services[53] and disclosing their status to friends and family for extra support[54].

Injecting drug use

Injecting drug use (IDU) accounts for 4.7% of the total diagnosed HIV infections in the UK to date[42] (table 1.1). The proportion of new infections acquired by this route in 2010 remained stable at 2.2% (figure 1.2). Other blood borne infections, such as hepatitis B and C, are more infectious than HIV and can be transmitted during episodes of indirect sharing (for example, sharing of filters, spoons or water when preparing drugs). While HIV prevalence remains fairly low, hepatitis B and C have risen significantly. In 2009 north west England had the second highest prevalence of hepatitis B (25%) after London (32%). North west England also has the highest prevalence of hepatitis C in the country (62%)[55]. Since HIV is less infectious than hepatitis C, those individuals who have had sufficient high risk exposure via IDU to acquire HIV are also likely to have been infected with hepatitis C. Having both infections makes the treatment of each more difficult to manage, increases the progression of hepatic disease and, for women, increases the probability of transmission of HIV to an infant during pregnancy or birth (see review in the North West report on hepatitis C[56]). Analyses have revealed that in north west England people infected by IDU tend to suffer poorer health[11,57].

Anonymous testing of IDUs attending specialist agencies reveals that, outside London, the prevalence of HIV amongst injectors is low (1% outside London compared with 4.1% in London in 2009)[58]. Low prevalence amongst drug users in the UK compared with other countries in Europe has been attributed to harm reduction strategies such as needle exchange programmes[59].

Blood or tissue

Since HIV screening and heat treatment were introduced for donated blood products in 1985, infection by this route has been rare. Consequently there has been a decline from 8% of all infections reported before and during 1991 to just 0.3% in 2010. All infections in the UK acquired through blood/tissue products diagnosed since 2002 were acquired outside the UK. A small number of cases continue to be diagnosed as a result of transfusions or blood products received overseas[42]. After 1985, HIV infection via blood transfusions in the UK were rare occurrences and either the result of donations collected during the HIV infection window period (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[60]. 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[61].

Between 1979 and 1985 about a fifth of patients with haemophilia in the UK were infected with HIV after treatment with contaminated clotting factor concentrates. Co-infection with the hepatitis C virus was also common and has contributed to high mortality amongst these individuals[62]. A small proportion of individuals with haemophilia infected with HIV in the early 1980s are still alive and well, but there have been an increasing number of deaths from liver disease in this patient group as a consequence of co-infection with hepatitis C[62].

Mother to child

During 2009, 64% of women giving birth in England and Scotland lived in areas covered by an unlinked anonymous surveillance system. In these survey areas, an estimated 1 per 449 women giving birth were HIV positive. The prevalence of HIV in women giving birth is highest in London (390 per 100,000) and whilst increasing, the prevalence in the rest of England (despite a five-fold increase in the past decade) is relatively low (143 per 100,000)[48]. In 2009, 51 mother to child infections were reported. These figures will inevitably increase

as the year progresses due to reporting delays of vertically transmitted HIV because the presence of maternal antibodies for up to 18 months after birth confounds the diagnosis. In 2009, 77 mother to child infections were reported, a decrease of seven from 2008 [42].

Since 1994/95, the proportion of children presenting with HIV who were not born in the UK increased from 20% to 60% in 2000/02[63]. In 2009, 68% of children diagnosed with HIV in the UK were born outside of the country[48]. HIV prevalence in mothers varies by global region and country of birth. Cumulative HIV data from HPA for 1995-2010 identified that, of 1,624 total mother to child diagnoses, 1,311 (81%) were in persons of black African ethnicity, and 90 (6%) were white[42].

Interventions including the use of ART for pregnant women with HIV, Caesarean sections and avoidance of breast feeding have all been successful at reducing the rates of vertical transmission from around 32% to 4%[64]. The British HIV Association (BHIVA) updated their guidelines for the treatment of pregnant women in 2008[65]. Currently, the main obstacle that prevents successful intervention is lack of knowledge by the mother of her HIV status. For over ten years it has been policy to offer an HIV test to all pregnant women in order to increase the uptake of testing to 90%[66,67]. The report on antenatal screening on 2009 data by the Health Protection Agency North West showed an HIV antenatal screening uptake rate of 94%, above the 90% government target and an uptake has continued to rise with a further increase in uptake since 2008 (90%). The highest uptake was in Cumbria and Lancashire (98%) with Cheshire and Merseyside (94%) and Greater Manchester (91%) both achieving above the government target[68].

In the UK by 2010, there were 12,081 children born to HIV-infected women (cumulative total), of whom 75% (9,084 children) were uninfected, 7% (895 children) were infected and the remainder are currently of undetermined HIV status. In north west England, by the end of 2009 there were 709 births to HIV-infected women (cumulative total) of which 58% (413 children) were uninfected, 7% (53 children) were infected and a third are currently of undetermined status[42].

Figure 1.3: Number of heterosexually acquired HIV cases in the UK by year of report to December 2010
Source: Adapted from table 5, United Kingdom New HIV Diagnoses to end of December 2010, HPA

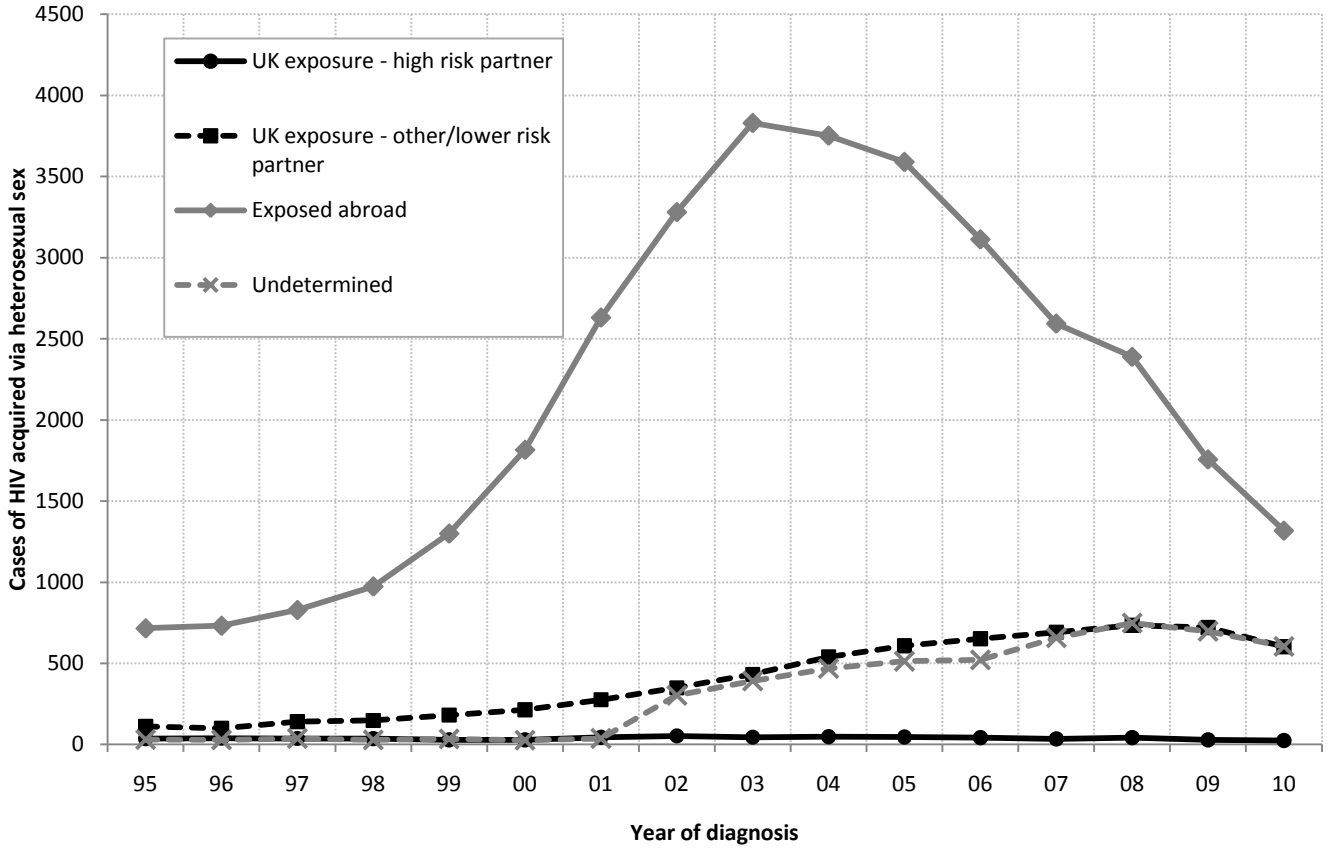
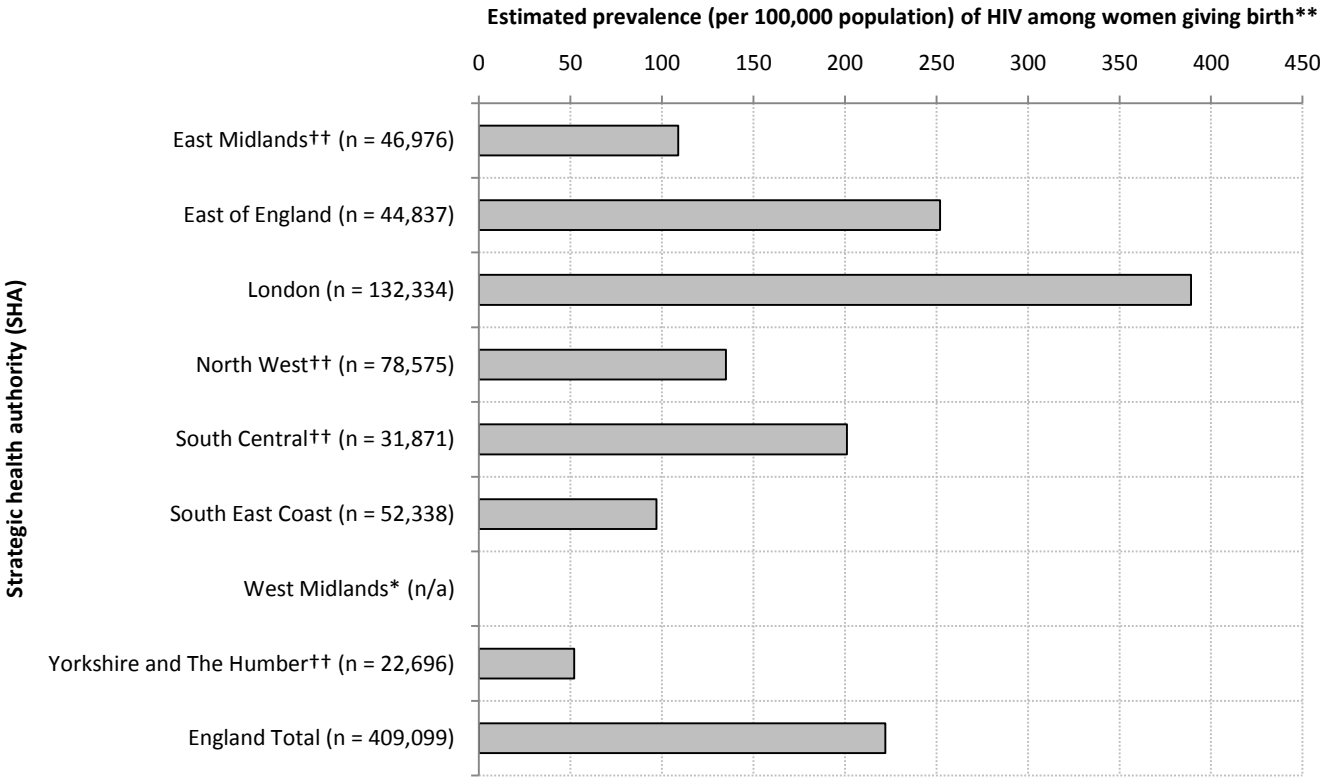


Figure 1.4: HIV prevalence amongst pregnant women in England, 2009 (newborn infant dried blood spots collected for metabolic screening)

Source: Adapted from data from the Unlinked Anonymous Dried Blood Spot Survey of newborn infants with NSHPC reports of live births to diagnosed HIV infected women, HPA[55]



These data are preliminary and need to be considered with caution.

**Data for West Midlands SHA were unavailable for 2009*

*** Estimated prevalence of women giving birth who are HIV-infected in 2009 in that SHA. These data should be interpreted as an estimated prevalence and the number of positives should not be considered as the definitive number of HIV-infected women giving birth in that SHA.*

† n = total tested; this is the total less insufficient samples and opt-outs.

††Data for East Midlands, North West, South Central and Yorkshire & The Humber were only collected between Jan-Sept. Data for the final three months of 2009 were imputed to provide estimates for the full year

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, as is the case in other developed countries[69]. Consequently, services are being developed to address the needs of this group as they become young adults[70].

HIV in non-UK nationals

Globally, migrants are at greater risk of HIV infection than are resident populations, irrespective of their country of origin [71]. In the UK, asylum seekers suffer the highest levels of absolute material deprivation, marginalisation and stigmatisation. The prevalence of HIV amongst this group is likely to reflect that of their country of origin. Asylum seekers in the UK currently have access to HIV care whilst seeking asylum. This is also the case for asylum seekers who have been refused asylum but are appealing. In 2008, a High Court ruling granted free HIV care to unsuccessful asylum seekers but following a Department of Health appeal this is no longer the case and failed asylum seekers are no longer considered exempt from charges[72,73]. In previous years, due to the policy of dispersal without reference to medical needs, many asylum seekers found themselves in areas where the medical services were unaware and unprepared for their health status and sometimes lacked sufficient expertise[74]. An inquiry by the All-Party Parliamentary Group on AIDS concluded that while resident in the UK, asylum seekers were at an increased risk of developing HIV that is resistant to treatment if dispersed away from their source of treatment and support[75]. This is due to the 95% adherence to antiretroviral therapy that is required to have the greatest effect in treating the virus. As a result of this, the National Asylum Support Service (NASS) produced new guidelines on 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[76]. Further guidelines on the detention and removal of asylum seekers with HIV were published in June 2009 offering advice for healthcare and community sector professionals on ensuring continuity of care and antiretroviral therapy[77].

During 2010, the UK received 22,090 asylum applications (including dependents), a 28% decrease compared with 2009 (30,675, including dependents). There are currently 5,205 asylum applicants residing in north west England receiving supported accommodation from NASS, with a further 165 receiving subsistence only support. The largest numbers of asylum seekers in supported accommodation are located in Liverpool (1,070), Manchester (855) and Salford (690)[78]. On a national level, no data are collected on how many asylum seekers seek treatment for HIV. Information for north west England about those known to be non-UK nationals is presented in tables 2.9 (chapter 2) and 3.13 (chapter 3).

HIV and AIDS in north west England 2010

Figure 1.1 and table 1.1 use data taken from the HPA New HIV Diagnoses Surveillance Tables to illustrate the status of the HIV/AIDS epidemic in the north west of England in comparison with the rest of the UK. This information is useful for monitoring trends both nationally and locally. For the most accurate and detailed information about people living with HIV in the north west of England, see the comprehensive overview in chapters 2 to 6 of this report.

By the end of 2010, a cumulative total of 8,830 HIV infections in the north west of England had been reported to the HPA (figure 1.1), including 430 new diagnoses during 2009 (although this figure will increase as more reports are received)[42]. There were 43 newly diagnosed AIDS cases recorded in 2010, bringing the cumulative total to 1,830, 7% of the total number of AIDS cases reported in the UK[42].

The pattern of HIV exposure amongst people living with HIV differs from that of the UK. North west England has a higher proportion of infections amongst MSM (52%, compared with the UK figure of 44%), and a lower proportion of people infected through heterosexual sex (38% compared with 45%) (table 1.1). As in previous years, the proportion of individuals exposed through the receipt of contaminated blood or blood products in north west England is approximately one third higher than the national figure. At least part of this is likely to be due to patients from other areas attending specialist haematology units in north west England and in some cases moving residence for convenience of treatment.

The data in figure 1.4 derived from the anonymous seroprevalence survey conducted by the HPA use newborn infant dried blood spots to show the level of HIV infection in pregnant women. Annual data for 2009 show an HIV prevalence of 222 per 100,000 population amongst women giving birth in England. The prevalence amongst pregnant women in north west England has remained stable at 135 per 100,000 population[79].

Sexual health in north west England

The epidemiology of HIV needs to be set in the context of general sexual health in north west England. Most recent data show that in 2009, 12% of all new episodes of the top five sexually transmitted infections (STIs; chlamydia, gonorrhoea, syphilis, genital warts and herpes) diagnosed in genito-urinary medicine (GUM) clinics in the UK were seen in north west England, second only to London (23%). In addition, there was a large percentage increase in the number of new STIs diagnosed from 2005 to 2009 (11%), the third highest increase in any part of England[80].

High rates of STIs also place a significant burden on the economy: it has been estimated that the direct medical cost of newly acquired STIs in north west England was almost £60 million in 2003[81]. 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. This is likely to have risen as diagnoses and attendances have increased substantially since then[80]. The presence of STIs in the population not only serves as an indicator of sexual risk-taking behaviour, but also increase the probability of HIV transmission[82].

Monitoring HIV and AIDS in north west England

Over the past 14 years, the North West HIV/AIDS Monitoring Unit has collected, collated, analysed and disseminated data on the treatment and care of HIV positive individuals in the North West. 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[83].

Data have been collected from over 40 statutory treatment centres including GUM clinics, haematology clinics, infectious disease units and a number of other specialist units and clinics. The data form part of the Survey of Prevalent Diagnosed HIV infections (SOPHID) national dataset. In 2010, midyear web tables were produced for the seventh consecutive year to provide a timely update of HIV epidemiology and treatment to provide analysis of the changing patterns of disease and characteristics of prevalence and inform funding and planning, development and evaluation[84]. In addition, data are used at Primary Care Trust (PCT) and Local Authority (LA) level to assist in service planning, development and evaluation. Figure 1.5 shows the number of people with HIV who contacted statutory treatment centres in north west England between 1996 and 2010 and represents the most accurate and comprehensive source of data related to HIV and AIDS in the North West of England. The data collected by the North West HIV/AIDS Monitoring Unit over the last 15 years illustrate the increasing number of people accessing HIV services. The number of HIV positive individuals attending treatment centres has increased (5%) from 2009-2010. The continuing increase in size of the HIV positive population is in part due to the decreased number of people dying from AIDS-related illness, but is also due to continuing high numbers of new cases. A full account of the epidemiology of HIV and AIDS in the North West is given in chapters 2 and 3 of this report.

The North West HIV/AIDS Monitoring Unit also collects data from HIV/AIDS community sector organisations (previously known as voluntary agencies in past reports, chapter 4). For one Manchester based centre, Body Positive North West (BPNW), this also includes a number of individuals diagnosed through their point of care testing (POCT) scheme. The BPNW POCT scheme delivers free HIV testing by staff and trained volunteers at five sites across north west England[85]. For the last seven years, data has also been included from social services departments from across the North West; providing data on HIV positive service users (chapter 5).

Methodology of monitoring HIV and AIDS in north west England

Statutory treatment centres are prompted twice a year to return forms or electronic data. Forms contain basic data on all HIV positive individuals at their clinic already known to the HIV/AIDS Monitoring Unit, with up to date details from the most recent reporting period. Clinics are also prompted to report all new cases either transferred from another clinic or newly diagnosed. The names of HIV positive individuals are not collected: a one-way encryption of the individual's surname, the soundex code, is used. This in combination with sex and date of birth defines a unique individual.

Demographic data collected for each person include: hospital number; soundex; date of birth; sex; postcode; ethnicity; residency status; transmission route of HIV; vital status; whether they were exposed abroad and country of exposure. For the purposes of this report, men who acquired HIV though sex with men (MSM) and who were also injecting drug users (IDUs) were included in the MSM category. Male to female transsexuals who acquired HIV through sex with men were recorded as male and age groups refer to the age of individuals at the end of December 2010, or at death. Ethnic group classifications are those used by the HPA HIV and STI Department, for SOPHID. Residency categories are adapted from the National Asylum Support Service (NASS) categories. The data requested on each individual for each six month period include: number of outpatient visits; inpatient stays; home visits; day cases; latest CD4 counts and viral loads and dates taken; details of any antiretroviral therapy (ART) they are being prescribed; if female, whether they are pregnant; clinical stage and the date they were last seen. Individuals are categorised as receiving the highest level of ART and as the most advanced stage of disease reported from any treatment centre during the period. Additionally, for those who died, information on cause and date of death is requested.

Community sector organisations are prompted annually to send basic data on the individuals attending their service. This information includes: soundex code, date of birth, sex, route of infection, ethnicity, residency status and pregnancy status. Information on the number of clients who were diagnosed through Manchester based Body Positive North West's point of care testing scheme (a rapid HIV test and completion of a short questionnaire[85]) is also included. Data are collected from social service departments in a similar way to community organisations. Individuals reported to community sector and social services 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.

New cases are classed as individuals who are new to the North West database in 2010 and have not been seen at a statutory treatment centre in the north west of England since 1994. These include transfers from outside north west England so new cases outside of the monitoring area are not necessarily new diagnoses. However, figures for new cases used in the annual and mid-year reports are based on a comprehensive survey and whilst slightly overestimating the number of new diagnoses, remain the most accurate indicator of new diagnoses in north west England.

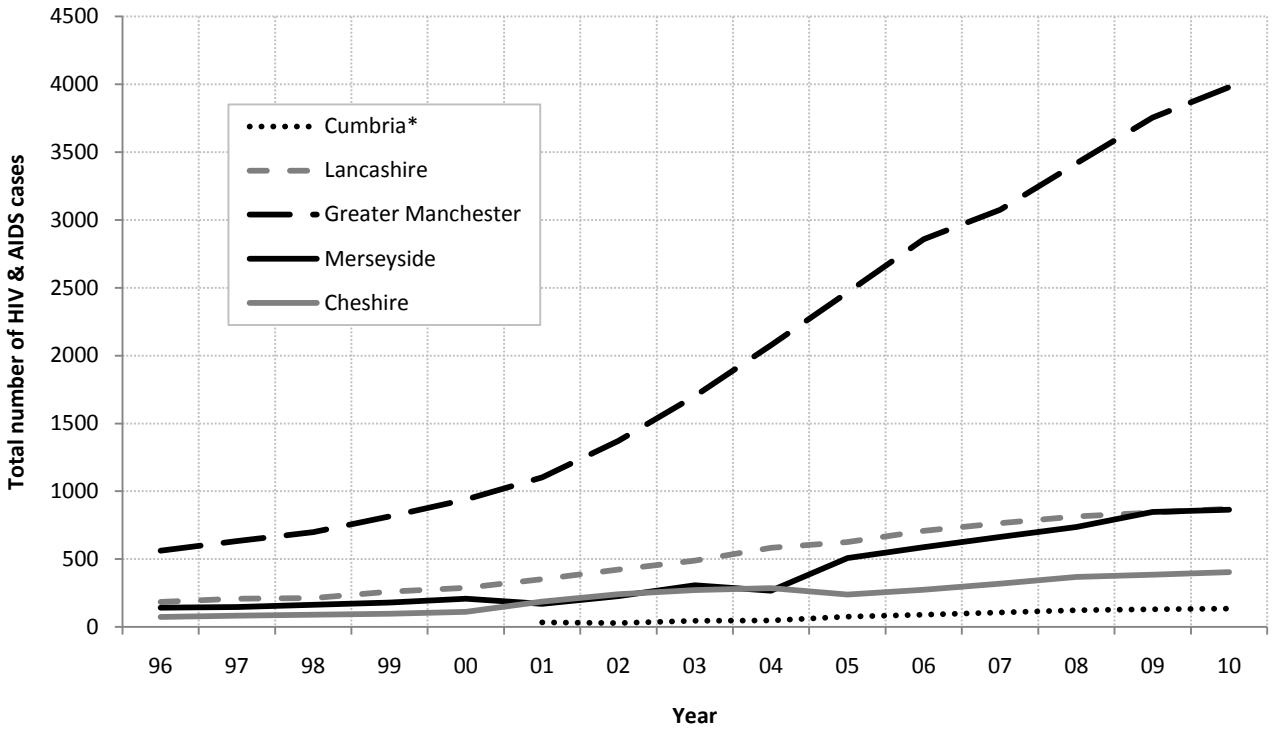
We encourage service providers to download a spreadsheet with pre-defined data collection fields from our secure document gateway and upload their completed data in the same way. All the large centres provide data this way and an increasing number of the smaller centres now submit data electronically. The remainder send details on paper forms. The vast majority of community sector organisations and social services departments send electronic data via the document gateway.

All service providers are asked to provide full postcodes to enable mapping to LA and PCT of residence (using postcode data supplied by the North West Public Health Observatory). Partial postcodes are mapped to a particular LA and PCT if more than 90% of individual postcodes within a partial postcode area map to one LA or PCT.
This method provides a good degree of accuracy when all but the last digit of the postcode is available with 97% matching to a PCT. However, if only the first part of the postcode (e.g. M12) is provided this allows only 86% to match to a PCT, and some first part postcodes do not even match to an area the size of north west England. Partial postcodes that could not be mapped to LA or PCT were allocated to a county if possible, or coded as unknown. Analyses are given by county, LA and PCT.

For reasons of space, it is not possible to present all breakdowns at LA and PCT level. However, additional tables are available on the North West Public Health Observatory website: www.nwpho.org.uk/hiv2010.

This is the seventh year for which data have been collected from the statutory treatment centres divided into two periods (from January to June 2010 and July to December 2010).

Figure 1.5: Total number of HIV and AIDS cases seen in statutory treatment centres in the North West, by county, 1996-2010
Source: HIV & AIDS in the North West of England annual reports [1-14]



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

2. New Cases 2010

During 2010, 735 new HIV and AIDS cases presented to statutory treatment centres in north west England. This number represents a 17% decrease from 2009 (881 cases[14]) showing a continuing downward trend in recent years. New cases are defined as individuals seen in north west England in 2010 but not during the years 1995 to 2009 and include new cases who died during the year.

Data on newly reported cases of HIV assist in the identification of trends and represent the most up to date information on the characteristics of HIV infection and transmission. Such information is valuable not only for planning and evaluating the success of prevention activities, but also for predicting future cases of HIV and its impact on treatment and care services. The aim of this chapter is to present information relating to new cases and, where appropriate, references are made to corresponding data from previous reports[1-14,84]. For reasons of confidentiality and space, it is not possible to present all breakdowns at local authority (LA) or primary care trust (PCT) level. However, additional tables are available on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2010).

For the purposes of this report, men who acquired HIV through sex between men (MSM) and who are also injecting drug users (IDU) are included in the MSM category. Male to female transsexuals who acquired HIV through sex with men are recorded as males, and age groups refer to the age of individuals at the end of December 2010, or at death.

Figure 2.1 illustrates the number of new HIV cases per 100,000 population who attended statutory centres and resided within north west England during 2010 [‡]. The population sizes for each LA used in the calculations are provided by the North West Public Health Observatory and are mid-2010 estimates based on 2001 census data. The rate per 100,000 population of diagnosed HIV in 2010 (amongst individuals with known area of residence within north west England) is 15 per 100,000 population. Manchester LA has the highest rate (59 per 100,000), followed by Salford with 44 and Blackpool with 39 new cases per 100,000 population.

Figure 2.2 shows the probable global region and country of HIV infection for new cases of HIV probably acquired outside the UK who presented in north west England for treatment and care in 2010. Twenty eight percent of new cases (203 individuals) were contracted abroad, nearly three quarters (74%) of which were acquired in sub-Saharan Africa. A further 8% were exposed in South and South-East Asia, followed by Eastern Europe and Central Asia (6%) and Western Europe (3%). Of the 203 new cases who probably acquired their infection abroad, the probable country of exposure is available for 189 individuals (93%). Individuals reported to have been infected in Zimbabwe continue to dominate the statistics, accounting for 33% of newly reported infections thought to have been acquired abroad (67 cases). There were a high number of infections acquired in South Africa (16 cases; 8%) and Nigeria (14 cases; 7%), figures have remained stable for South Africa and decreased by 42% for Nigeria from 2009. Overall, 151 new people presented for treatment and care in north west England who were thought to have been infected in 19 different countries across sub-Saharan Africa. Infections from South and South-East Asia were mostly acquired in Thailand, which (jointly with Nigeria) accounts for the fourth largest number of new cases infected outside the UK (14 cases; 7%). Infections in Western Europe were mostly from Portugal.

Table 2.1 illustrates the age distribution, stage of HIV disease and ethnicity of the new HIV and AIDS cases by infection route and sex. Eleven percent of all reported cases in 2010 had not previously been seen in north west England and were thus categorised as new cases. The majority of newly reported cases (68%) occur in people between the ages of 25 and 44 years, with the greatest proportion amongst those aged between 30 and 34 years (19%). Exposure through heterosexual sex (37%) and sex between men (37%) accounts for the highest proportion of new cases, a slightly lower proportion than seen in 2009. All young people aged 15-24 years, for whom route of exposure is known, were infected with HIV during sex (either sex between men or heterosexual sex).

The number of new infections attributed to IDU remains relatively low and has dropped from 15 individuals in 2009 to 6 individuals in 2010, all of whom were male. During the year, 6 new cases of vertical transmission (mother to child) were reported, a reduction of 63% from 2009. Two new cases were attributed to having received contaminated blood or tissue. The infection route for 177 new cases (24%) has not yet been determined.

HIV positive individuals categorised as asymptomatic continue to represent the largest proportion of new cases (64%), maintaining the observation that many HIV positive individuals are contacting services at a relatively early stage of their HIV disease. Of the 8 individuals classed as new cases who died during 2010, all had an AIDS-defining illness. Importantly, 14% of new cases first presented with AIDS

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

(including those who had died from an AIDS-related illness). This was a higher proportion than seen in 2009 and shows that despite continued efforts to raise awareness, a minority of individuals continue to present too late to benefit from life-prolonging treatment.

As in previous years, the majority of new HIV cases, for whom ethnicity is known, were of white ethnicity (65%), with 35% of cases occurring in a minority ethnic group. Black Africans account for 83% of minority ethnic cases, with black African females exposed through heterosexual sex making up 14% of all new cases reported in 2010. Of all the females infected through heterosexual sex, 21% were white, compared with 72% who were of black African ethnicity. Of all the individuals infected through MSM, 89% were of white ethnicity.

Table 2.2 shows the LA of residence and the infection route of new HIV cases presenting in north west England for treatment and care in 2010. Although the infection route for 50% of all HIV positive individuals accessing treatment and care in 2010 was attributed to sex between men (chapter 3, table 3.1), this proportion was lower for new cases with 37% infected via this route. Across the counties there were large differences in the route of infection. In Cumbria this year (as in 2009) there were more cases infected via MSM (7 individuals; 58%) than through heterosexual sex (4 individuals; 33%). In Greater Manchester, there were similar numbers of new cases infected via MSM and through heterosexual sex (158 and 137, respectively). In Cheshire almost half of new cases were infected through sex between men (44%) compared with 33% through heterosexual sex. Of those infected through MSM and residing in Lancashire, over half (54%) resided in Blackpool, an area with a large gay community. Manchester also has a large gay community and correspondingly, Greater Manchester accounted for 62% of new cases resident in north west England exposed via sex between men, with the second highest proportion (15%) in Merseyside.

Table 2.3 presents the breakdown of stage of HIV disease by LA. The widespread distribution of new HIV positive individuals demonstrates the importance of HIV prevention initiatives in every county. Residents of Greater Manchester accounted for over half (58%) of new HIV and AIDS cases presenting for treatment and care in north west England. Proportionately, Cheshire had the highest recorded percentage of AIDS cases (19%; seven out of 36 cases), while over four fifths (83%) of those with HIV living in Cumbria were asymptomatic. Nearly all new cases who received care in north west England during 2010 (whose residential details were known) were resident within north west England(95%).

Table 2.4 illustrates new HIV and AIDS cases by stage of HIV disease, infection route and sex presenting for treatment and care in 2010, by those resident in north west England, and total new cases treated in north west England. The figures show that 64% of new cases residing in north west England presented to services while asymptomatic, 10% were symptomatic, and 15% presented with AIDS (including those who had died from an AIDS-related illness). The predominant route of HIV exposure amongst all women in treatment and care continues to be heterosexual sex (80%).

Table 2.5 shows new HIV cases presenting for treatment and care in 2010 by ethnicity and age group, by those resident in north west England and total new cases treated in north west England. Of North West residents, those aged between 30 and 34 years represented the largest group of new cases accessing treatment and care (20%). Over half (52%) of those with HIV resident in north west England were aged between 25 and 39 years. New cases tend to be younger (median age of 38 years) than all cases (median age 41 years), demonstrating the continuing need to encourage younger people at risk of HIV exposure to access services. The majority of new cases treated in 2010 whose ethnicity was known were of white ethnicity (65%), the same level as the corresponding data for all cases (chapter 3, table 3.5). Of those HIV positive individuals whose ethnicity was known, 35% are from a black and minority ethnic (BME) group. This indicates a substantial over-representation of new HIV cases within BME communities, when compared to their overall proportion within north west England population (8%)[86]. The incidence of diagnosed HIV is nine times higher in BME communities than in the white population in north west England. This illustrates the need for specialist services such as the Black Health Agency (BHA) and specialist projects within the voluntary sector to provide care and support for communities that have already been identified as having shorter life expectancies, together with poorer physical and mental health [87].

Table 2.6 illustrates the sex, stage of HIV disease and infection abroad by ethnicity of new HIV cases presenting in north west England for treatment and care in 2010. The majority of women for whom ethnicity was known were from a BME group (78%). Black Africans account for 72% of all new cases in women for whom ethnicity is known. Whilst in the white population the gender distribution is highly biased towards males (92%), 55% of the new cases in the BME group are female.

Considerable differences in presentation by stage of disease amongst ethnic groups were reported prior to 2002. For example, in 2001, 17% of white and 28% of BME individuals presented for the first time with AIDS, and in 2000 the margin was wider with 16% of white individuals already having AIDS compared with 34% of BME communities. However, in 2010, as in more recent years, individuals from black and minority

ethnic communities (for whom ethnicity and stage of disease were known) were as likely to present while still asymptomatic as were white individuals (72%). The same proportion of white and BME were symptomatic (11% compared to 11% of white individuals), and the proportion with AIDS was similar (17% for BME groups compared with 16% for white individuals). This suggests that those from white and BME groups, are becoming more likely to access care at an earlier stage of their disease, which will hopefully increase their life expectancy.

Twenty eight percent all new cases of HIV and AIDS in 2010 were infections reported to have been contracted outside the UK. The exposure route for a further 235 cases is currently unknown, which could lead to an underestimation of the figures for HIV contracted abroad. For those whose exposure was known, 87% of those of white ethnicity were infected in the UK, while 96% of black Africans with HIV were infected outside the UK.

Table 2.7 shows the global region and country of HIV exposure by infection route of HIV for new HIV cases who presented in north west England for treatment and care in 2010. Of those infected abroad, the proportion who were infected through sex between men is 8%, a slight decrease on 2009 (11%). 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 (75%). The vast majority (81%) of individuals with heterosexually acquired HIV, whose infections were contracted abroad, were acquired in sub-Saharan Africa, with a further 10% in South and South-East Asia.

Western Europe accounted for the largest proportion of new cases acquired through sex between men abroad (31%). This could reflect the reported tendency of MSM to take risks while on holiday [88]. Three out of the 5 new cases who were infected by IDU were thought to be infected in the UK. However, a further two were infected in Eastern Europe and Central Asia. IDU remains a major transmission route of HIV in many European countries [89]. Although the risk of contracting HIV through IDU is relatively low in the UK due to low prevalence of HIV amongst this group, sharing injecting equipment remains a significant risk.

Table 2.8 illustrates the distribution of new HIV cases between North West treatment centres and by infection route. The treatment centre with the largest number of new cases in 2010 was Manchester Royal Infirmary GUM department (MRIG) with approximately 24% of all new cases (179/735). As in previous years, large numbers of new cases were also seen at North Manchester Regional Infectious Disease Unit (NMG) and Royal Liverpool University Hospital department of GUM and Tropical and Infectious Disease Unit (RLG) in line with the overall decrease in number of new cases. Many treatment centres had fewer cases in 2010 than they did in 2009. However, some still had an increase in numbers. Stepping Hill Hospital (STP) had an increase in new cases of 257% on 2009 figures (from 7 to 25; however, care should be taken when interpreting percentages based on small numbers).

Table 2.9 presents the residency status of new HIV cases categorised by sex, age group, infection route, ethnicity, stage of HIV disease and area of residence. Of the 735 new cases, 458 cases (62%) are known to be UK nationals, and 93 (13%) were non-UK nationals, a significant reduction from previous years. Nearly three quarters (74%) of non-UK nationals were asymptomatic, a greater proportion than UK nationals (64%).

Table 2.10 displays new HIV cases by infection route and PCT of residence. The figures show that Manchester PCT had the largest proportion of new HIV cases in treatment and care in north west England (29%; 211 individuals), followed by Liverpool PCT with 9% (67 individuals).

Table 2.11 shows new HIV cases by stage of disease and PCT of residence. Amongst those that were asymptomatic, 27% resided in Manchester PCT, followed by the next largest proportion (13%) in Liverpool PCT. Further analyses by PCT can be found on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2010).

Figure 2.1: Number of new cases of HIV, crude rate per 100,000 population by local authority of residence, 2010
Crude rate based on the number of cases of HIV and AIDS residing in, and accessing treatment in, north west England per 100,000 of the population

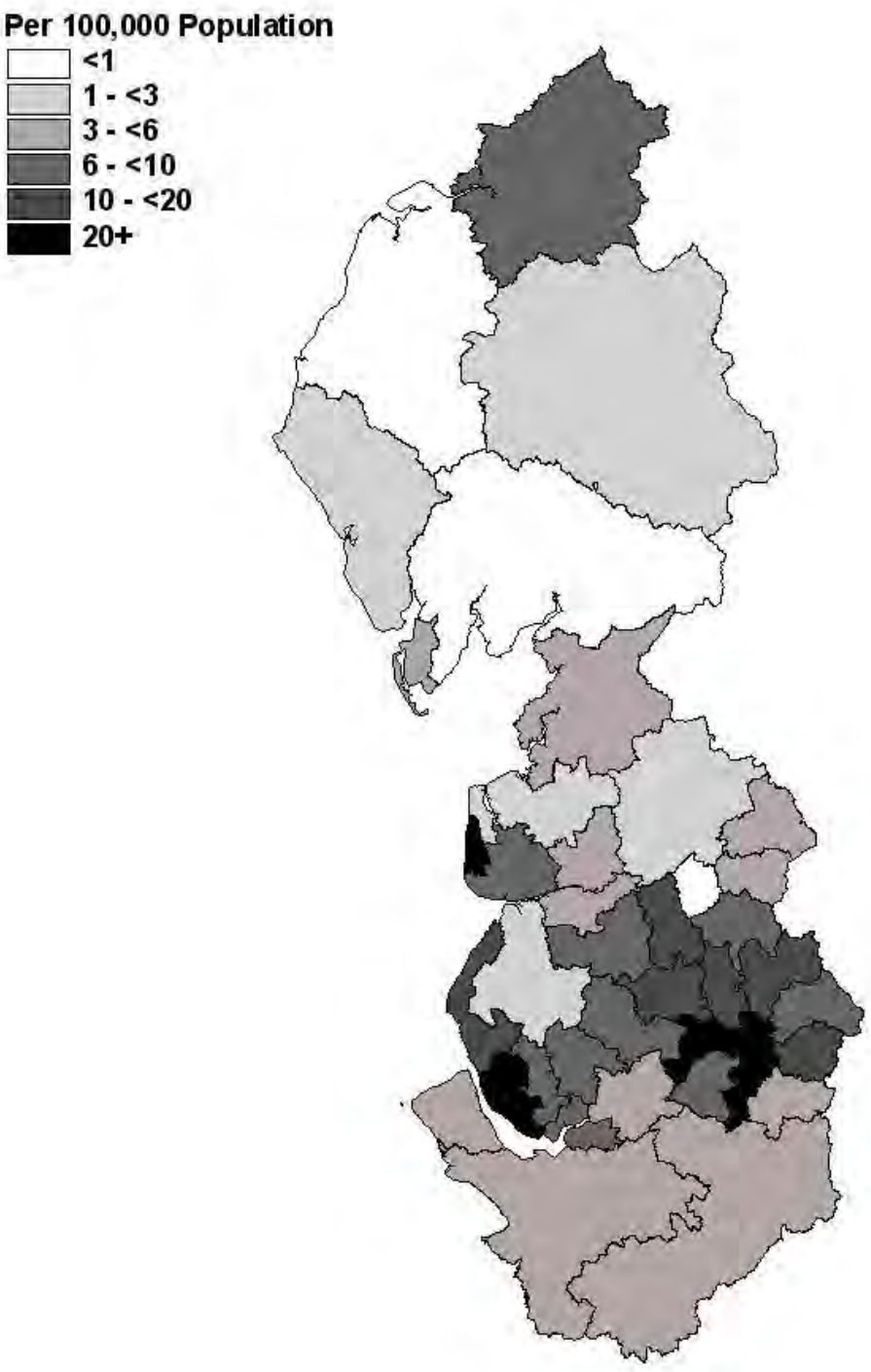
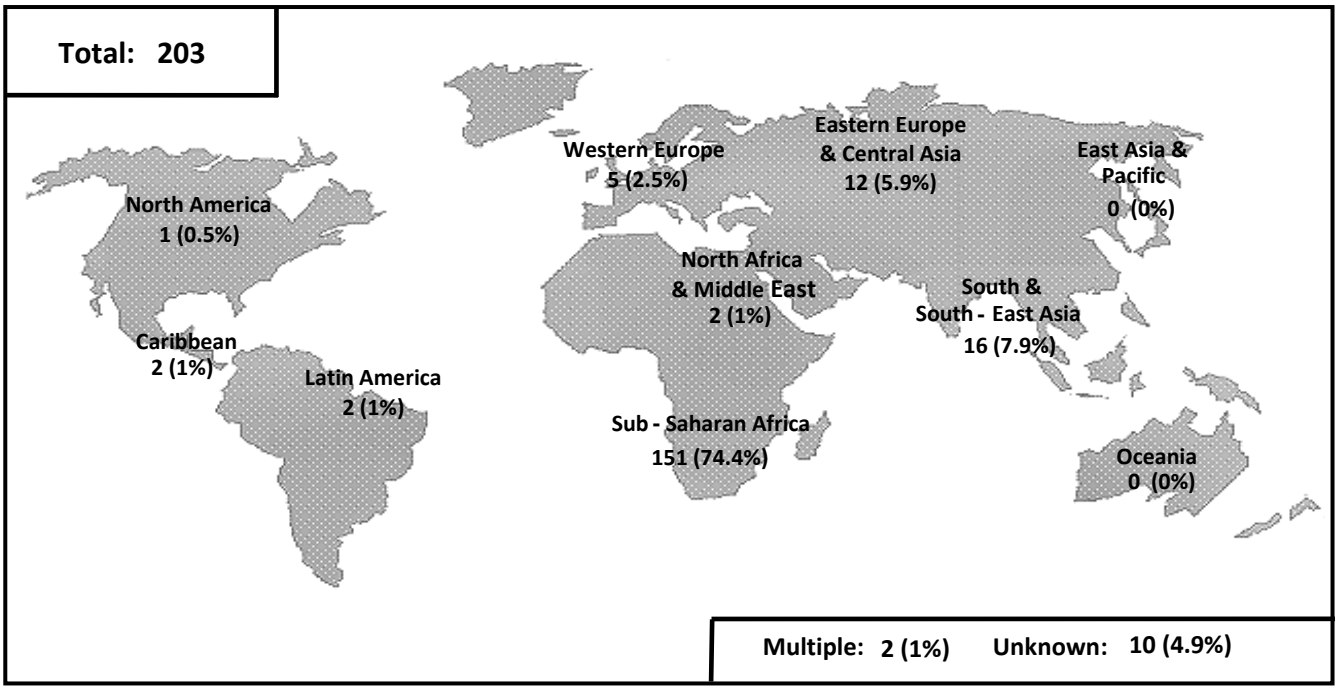


Figure 2.2: Global region and country of infection for new HIV and AIDS cases in north west England who probably acquired their infection outside the UK, 2010



Sub-Saharan Africa	151 (74.4%)
Angola	1 (0.5%)
Botswana	1 (0.5%)
Cameroon	5 (2.5%)
Congo	4 (2%)
Dem. Republic of Congo	1 (0.5%)
Eritrea	1 (0.5%)
Ethiopia	1 (0.5%)
Gambia	3 (1.5%)
Ghana	5 (2.5%)
Kenya	6 (3%)
Malawi	10 (4.9%)
Mozambique	2 (1%)
Nigeria	14 (6.9%)
Rwanda	1 (0.5%)
South Africa	16 (7.9%)
Tanzania	4 (2%)
Uganda	3 (1.5%)
Zambia	4 (2%)
Zimbabwe	67 (33%)
Unknown	2 (1%)

North America	1 (0.5%)
United States of America	1 (0.5%)

South & South-East Asia	16 (7.9%)
India	1 (0.5%)
Pakistan	1 (0.5%)
Thailand	14 (6.9%)

Eastern Europe & Central Asia	12 (5.9%)
Estonia	1 (0.5%)
Latvia	3 (1.5%)
Poland	6 (3%)
Romania	1 (0.5%)
Russian Federation	1 (0.5%)

Western Europe	5 (2.5%)
France	1 (0.5%)
Germany	1 (0.5%)
Portugal	2 (1%)
Spain	1 (0.5%)

Caribbean	2 (1%)
Jamaica	2 (1%)

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

Latin America	2 (1%)
Brazil	2 (1%)

Multiple	2 (1%)
Unknown	10 (4.9%)

Total (100%)	203

Table 2.1: Age distribution, stage of HIV disease and ethnic group of new HIV and AIDS cases by infection route and sex, 2010

		Infection Route										Total (100%)
		MSM	Injecting Drug Use		Hetero-sexual		Blood/ Tissue	Mother to Child		Undeter-mined		
		M	M	F	M	F	M	M	F	M	F	
Age Group	0-14							2	4			6
	15-19	1				1				4		6
	20-24	22			6	10				11	3	52
	25-29	45	1		14	23	1			22	2	108
	30-34	54	1		20	35				22	8	140
	35-39	47	2		22	26	1			28	5	131
	40-44	47	1		22	24				24	5	123
	45-49	24			12	16				17	6	75
	50-54	19	1		7	6				7	2	42
	55-59	7			10	3				1	1	22
	60+	9			8	4				9		30
Stage of HIV Disease	Asymptomatic	174	5		71	98	1	1	3	101	15	469
	Symptomatic	30	1		14	17		1	1	3	3	70
	AIDS	26			26	24				13	8	97
	AIDS Related Death	2			1	2				3		8
	Unknown	43			9	7	1			25	6	91
Ethnicity	White	244	4		60	31	2			101	7	449
	Black Caribbean	4			1	2					1	8
	Black African	5			52	106		2	4	16	12	197
	Black Other				1							1
	Indian/Pakistani/Bangladeshi	3			2					2		7
	Other Asian/Oriental	2				5				2		9
	Other/Mixed	6	1		2	1				5	1	16
	Unknown	11	1		3	3				19	11	48
	Total	**275**	**6**	**0**	**121**	**148**	**2**	**2**	**4**	**145**	**32**	**735**
	%	**37.4**	**0.8**	**0.0**	**16.5**	**20.1**	**0.3**	**0.3**	**0.5**	**19.7**	**4.4**	

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the age of individuals at the end of December 2010, or at death.

Table 2.2: Local authority of residence of new HIV and AIDS cases by infection route, 2010

	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%)		1 (33.3%)			1 (33.3%)	3
	Allerdale	3 (100%)						3
	Eden	1 (100%)						1
	Copeland			2 (100%)				2
	Barrow-in-Furness	2 (66.7%)		1 (33.3%)				3
	Cumbria Total	**7 (58.3%)**		**4 (33.3%)**			**1 (8.3%)**	**12**
Lancashire	Lancaster	1 (25%)		2 (50%)			1 (25%)	4
	Wyre	1 (33.3%)		2 (66.7%)				3
	Fylde			1 (100%)				1
	Blackpool	20 (60.6%)		12 (36.4%)			1 (3%)	33
	Blackburn with Darwen		1 (10%)	9 (90%)				10
	Ribble Valley	1 (100%)						1
	Pendle	2 (50%)		1 (25%)			1 (25%)	4
	Burnley	3 (75%)		1 (25%)				4
	Rossendale	3 (75%)		1 (25%)				4
	Preston	3 (33.3%)		5 (55.6%)			1 (11.1%)	9
	South Ribble	2 (66.7%)		1 (33.3%)				3
	Chorley	1 (33.3%)		1 (33.3%)			1 (33.3%)	3
	West Lancashire			1 (100%)				1
	Unknown Lancashire			1 (100%)				1
	Lancashire Total	**37 (45.7%)**	**1 (1.2%)**	**38 (46.9%)**			**5 (6.2%)**	**81**
Greater Manchester	Wigan	13 (54.2%)		8 (33.3%)			3 (12.5%)	24
	Bolton	5 (22.7%)		16 (72.7%)		1 (4.5%)		22
	Bury	5 (41.7%)		6 (50%)			1 (8.3%)	12
	Rochdale	5 (31.3%)	1 (6.3%)	6 (37.5%)			4 (25%)	16
	Oldham	6 (60%)		3 (30%)	1 (1%)			10
	Salford	26 (39.4%)	1 (1.5%)	18 (27.3%)		1 (1.5%)	20 (30.3%)	66
	Manchester	74 (35.1%)	1 (0.5%)	63 (29.9%)		1 (0.5%)	72 (34.1%)	211
	Tameside	5 (38.5%)		4 (30.8%)			4 (30.8%)	13
	Trafford	8 (30.8%)	1 (3.8%)	8 (30.8%)			9 (34.6%)	26
	Stockport	11 (45.8%)		4 (16.7%)		1 (4.2%)	8 (33.3%)	24
	Unknown Greater Manchester	0 (0%)		1 (50%)			1 (50%)	2
	Greater Manchester Total	**158 (37.1%)**	**4 (0.9%)**	**137 (32.2%)**	**1 (0.2%)**	**4 (0.9%)**	**122 (28.6%)**	**426**
Merseyside	Sefton	4 (44.4%)	1 (11.1%)	3 (33.3%)		1 (11.1%)		9
	Liverpool	22 (32.8%)		40 (59.7%)		1 (1.5%)	4 (6%)	67
	Knowsley	2 (28.6%)		2 (28.6%)			3 (42.9%)	7
	Wirral	7 (35%)		12 (60%)			1 (5%)	20
	St Helens	2 (66.7%)		1 (33.3%)				3
	Unknown Merseyside	1 (33.3%)		1 (33.3%)			1 (33.3%)	3
	Merseyside Total	**38 (34.9%)**	**1 (0.9%)**	**59 (54.1%)**		**2 (1.8%)**	**9 (8.3%)**	**109**
Cheshire	Halton	2(50%)		2 (50%)				4
	Warrington	1 (11.1%)		3 (33.3%)			5 (55.6%)	9
	Cheshire West and Chester	7 (77.8%)		2 (22.2%)				9
	Cheshire East	6 (42.9%)		5 (35.7%)			3 (21.4%)	14
	Cheshire Total	**16 (44.4%)**		**12 (33.3%)**			**8 (22.2%)**	**36**
	Total North West Residents	**256 (38.6%)**	**6 (0.9%)**	**250 (37.7%)**	**1 (0.2%)**	**6 (0.9%)**	**145 (21.8%)**	**664**
	Isle of Man	1 (100%)						1
	Out of Region	13 (41.9%)		9 (29%)	1 (3.2%)		8 (25.8%)	31
	Unknown*	5 (12.8%)		10 (25.6%)			24 (61.5%)	39
	Total	**275 (37.4%)**	**6 (0.8%)**	**269 (36.6%)**	**2 (0.3%)**	**6 (0.8%)**	**177 (24.1%)**	**735**

Men who were 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 one person who declined to give any residential information.*

Table 2.3: Local authority of residence of new HIV and AIDS cases by stage of HIV disease, 2010

	Local Authority of Residence	Stage of Disease					
		Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Unknown	Total (100%)
Cumbria	Carlisle	2 (66.7%)		1 (33.3%)			3
	Allerdale	2 (66.7%)	1 (33.3%)				3
	Eden	1 (100%)					1
	Copeland	2 (100%)					2
	Barrow-in-Furness	3 (100%)					3
	Cumbria Total	**10 (83.3)**	**1 (8.3%)**	**1 (8.3%)**			**12**
Lancashire	Lancaster	2 (50%)	1 (25%)	1 (25%)			4
	Wyre	2 (66.7%)				1 (33.3%)	3
	Fylde			1 (100%)			1
	Blackpool	16 (48.5%)	5 (15.2%)	4 (12.1%)		8 (24.2%)	33
	Blackburn with Darwen	6 (60%)	2 (20%)	1 (10%)		1 (10%)	10
	Ribble Valley				1 (100%)		1
	Pendle	3 (75%)			1 (25%)		4
	Burnley	2 (50%)		2 (50%)			4
	Rossendale	3 (75%)		1 (25%)			4
	Preston	7 (77.8%)	1 (11.1%)	1 (11.1%)			9
	South Ribble	2 (66.7%)	1 (33.3%)				3
	Chorley	3 (100%)					3
	West Lancashire	1 (100%)					1
	Unknown Lancashire	1 (100%)					1
	Lancashire Total	**48 (59.3%)**	**10 (12.3%)**	**11 (13.6%)**	**2 (2.5%)**	**10 (12.3%)**	**81**
Greater Manchester	Wigan	15 (62.5%)	4 (16.7%)	5 (20.8%)			24
	Bolton	14 (63.6%)	1 (4.5%)	5 (22.7%)	2 (9.1%)		22
	Bury	10 (83.3%)	1 (8.3%)	1 (8.3%)			12
	Rochdale	7 (43.8%)		3 (18.8%)	2 (12.5%)	4 (25%)	16
	Oldham	6 (60%)	2 (20%)	2 (20%)			10
	Salford	47 (71.2%)	6 (9.1%)	6 (9.1%)		7 (10.6%)	66
	Manchester	128 (60.7%)	25 (11.8%)	29 (13.7%)	1 (0.5%)	28 (13.3%)	211
	Tameside	4 (30.8%)		4 (30.8%)		5 (38.5%)	13
	Trafford	15 (57.7%)	4 (15.4%)	5 (19.2%)		2 (7.7%)	26
	Stockport	11 (45.8%)	4 (16.7%)	1 (4.2%)		8 (33.3%)	24
	Unknown Greater Manchester	2 (100%)					2
	Greater Manchester Total	**259 (60.8%)**	**47 (11%)**	**61 (14.3%)**	**5 (1.2%)**	**54 (12.7%)**	**426**
Merseyside	Sefton	8 (88.9%)		1 (11.1%)			9
	Liverpool	60 (89.6%)		3 (4.5%)		4 (6%)	67
	Knowsley	7 (100%)					7
	Wirral	8 (40%)	5 (25%)	6 (30%)		1 (5%)	20
	St Helens	1 (33.3%)				2 (66.7%)	3
	Unknown Merseyside	3 (100%)	**5 (4.6%)**	**10 (9.2%)**		**7 (6.4%)**	3
	Merseyside Total	**87 (79.8%)**					**109**
Cheshire	Halton	3 (75%)	1 (25%)				4
	Warrington	7 (77.8%)		1 (11.1%)		1 (11.1%)	9
	Cheshire West and Chester	2 (22.2%)		2 (22.2%)		5 (55.6%)	9
	Cheshire East	8 (57.1%)	1 (7.1%)	4 (28.6%)		1 (7.1%)	14
	Cheshire Total	**20 (55.6%)**	**2 (5.6%)**	**7 (19.4%)**		**7 (19.4%)**	**36**
	Total North West Residents	**424 (63.9%)**	**65 (9.8%)**	**90 (13.6%)**	**7 (1.1%)**	**78 (11.7%)**	**664**
	Isle of Man	1 (100%)					1
	Out of Region	19 (61.3%)	5 (16.1%)	4 (12.9%)		3 (9.7%)	31
	Unknown*	25 (64.1%)		3 (7.7%)	1 (2.6%)	10 (25.6%)	39
	Total	**469 (63.8%)**	**70 (9.5%)**	**97 (13.2%)**	**8 (1.1%)**	**91 (12.4%)**	**735**

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

Table 2.4: New HIV and AIDS cases by stage of HIV disease, infection route and sex, 2010

	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	M	F	M	F	
Total North West Residents	Asymptomatic	158	5		66	93	1	1	3	85	12	424
	Symptomatic	28	1		14	15		1	1	3	2	65
	AIDS	25			24	22				11	8	90
	AIDS Related Death	2			1	2				2		7
	Unknown	43			9	4				18	4	78
	Total	**256**	**6**		**114**	**136**	**1**	**2**	**4**	**119**	**26**	**664**
	%	**38.6%**	**0.9%**		**17.2%**	**20.5%**	**0.2%**	**0.3%**	**0.6%**	**17.9%**	**3.9%**	
All individuals treated in North West	Asymptomatic	174	5		71	98	1	1	3	101	15	469
	Symptomatic	30	1		14	17		1	1	3	3	70
	AIDS	26			26	24				13	8	97
	AIDS Related Death	2			1	2				3		8
	Unknown	43			9	7	1			25	6	91
	Total	**275**	**6**		**121**	**148**	**2**	**2**	**4**	**145**	**32**	**735**
	%	**37.4%**	**0.8%**		**16.5%**	**20.1%**	**0.3%**	**0.3%**	**0.5%**	**19.7%**	**4.4%**	

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

Table 2.5: New HIV and AIDS cases by age category and ethnic group, 2010

	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			6						6
	15-19	6								6
	20-24	31	3	8		1		1	5	49
	25-29	62	4	20		1	1	3	8	99
	30-34	70		47		2	3	2	7	131
	35-39	58		40		1	2	6	7	114
	40-44	70		29	1	1		3	8	112
	45-49	41		21					3	65
	50-54	30		6					1	37
	55-59	12		5		1				18
	60+	23		2			1		1	27
	Total	**403**	**7**	**184**	**1**	**7**	**7**	**15**	**40**	**664**
	%	**60.7%**	**1.1%**	**27.7%**	**0.2%**	**1.1%**	**1.1%**	**2.3%**	**6.0%**	**100%**
All individuals treated in North West	0-14			6						6
	15-19	6								6
	20-24	34	3	8		1		1	5	52
	25-29	67	4	24		1	1	3	8	108
	30-34	76		48		2	4	2	8	140
	35-39	70		43		1	2	6	9	131
	40-44	76		32	1	1		3	10	123
	45-49	46	1	22			1	1	4	75
	50-54	34		6					2	42
	55-59	14		6		1			1	22
	60+	26		2			1		1	30
	Total	**449**	**8**	**197**	**1**	**7**	**9**	**16**	**48**	**735**
	%	**61.1%**	**1.1%**	**26.8%**	**0.1%**	**1.0%**	**1.2%**	**2.2%**	**6.5%**	**100%**

Age groups refer to the ages of individuals at the end of December 2010, or at death.

Table 2.6: Sex, stage of HIV disease and HIV exposure abroad of new HIV and AIDS cases by ethnic group, 2010

		Ethnicity								Total (100%)
		White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Sex	Male	411 (74.6%)	5 (0.9%)	75 (13.6%)	1 (0.2%)	7 (1.3%)	4 (0.7%)	14 (2.5%)	34 (6.2%)	551
	Female	38 (20.7%)	3 (1.6%)	122 (66.3%)			5 (2.7%)	2 (1.1%)	14 (7.6%)	184
Stage of Disease	Asymptomatic	275 (58.6%)	6 (1.3%)	134 (28.6%)		6 (1.3%)	6 (1.3%)	11 (2.3%)	31 (6.6%)	469
	Symptomatic	43 (61.4%)		24 (34.3%)				1 (1.4%)	2 (2.9%)	70
	AIDS	56 (57.7%)		31 (32%)	1 (1%)		3 (3.1%)	1 (1%)	5 (5.2%)	97
	AIDS Related Death	6 (75%)		2 (25%)						8
	Unknown	69 (75.8%)	2 (2.2%)	6 (6.6%)		1 (1.1%)		3 (3.3%)	10 (11%)	91
HIV Exposure Abroad	UK	271 (91.2%)	4 (1.3%)	6 (2%)		3 (1%)	4 (1.3%)	4 (1.3%)	5 (1.7%)	297
	Abroad	40 (19.7%)	2 (1%)	145 (71.4%)	1 (0.5%)	1 (0.5%)	4 (2%)	5 (2.5%)	5 (2.5%)	203
	Unknown	138 (58.7%)	2 (0.9%)	46 (19.6%)		3 (1.3%)	1 (0.4%)	7 (3.0%)	38 (16.2%)	235
	Total	**449 (61.1%)**	**8 (1.1%)**	**197 (26.8%)**	**1 (0.1%)**	**7 (1%)**	**9 (1.2%)**	**16 (2.2%)**	**48 (6.5%)**	**735**

Table 2.7: Global region and country of exposure by infection route for new HIV and AIDS cases, 2010

Region of HIV Exposure	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Abroad	16 (7.9%)	2 (1%)	169 (83.3%)	1 (0.5%)	4 (2%)	11 (5.4%)	203
Caribbean			1	1			2
Eastern Europe & Central Asia	3	2	6			1	12
Latin America	2						2
North Africa & Middle East	1		1				2
North America	1						1
South & South-East Asia			16				16
Sub-Saharan Africa	3		137		4	7	151
Western Europe	5						5
Multiple			1			1	2
Unknown	1		7			2	10
UK	199 (67%)	3 (1%)	63 (21.2%)			32 (10.8%)	297
Unknown	60 (25.5%)	1 (0.4%)	37 (15.7%)	1 (0.4%)	2 (0.9%)	134 (57.0%)	235
Total	**275 (37.4%)**	**6 (0.8%)**	**269 (36.6%)**	**2 (0.3%)**	**6 (0.8%)**	**177 (24.1%)**	**735**

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

Table 2.8: Distribution of treatment for new HIV and AIDS cases by infection route, 2010

Treatment Centre	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
AHC					2 (100%)		2
APH	7 (43.8%)		9 (56.3%)				16
ARM	3 (100%)						3
BLAG	22 (57.9%)		15 (39.5%)			1 (2.6%)	38
BLKG	3 (20%)	1 (6.7%)	9 (60%)			2 (13.3%)	15
BOLG	16 (47.1%)		18 (52.9%)				34
BURG	5 (55.6%)		4 (44.4%)				9
BURY	3 (42.9%)		4 (57.1%)				7
CHR	8 (80%)		2 (20%)				10
CUMB	2 (33.3%)		3 (50%)			1 (16.7%)	6
FGH	2 (66.7%)		1 (33.3%)				3
HAL	1 (50%)		1 (50%)				2
LCN	5 (83.3%)		1 (16.7%)				6
LEI	6 (60%)		3 (30%)			1 (10%)	10
MAC			3 (75%)			1 (25%)	4
MGP	25 (89.3%)					3 (10.7%)	28
MRIG	31 (17.3%)	1 (0.6%)	21 (11.7%)	1 (0.6%)		125 (69.8%)	179
NMG	35 (32.7%)	3 (2.8%)	53 (49.5%)		4 (3.7%)	12 (11.2%)	107
NMGG	18 (58.1%)		11 (35.5%)			2 (6.5%)	31
OLDG	6 (60%)		4 (40%)				10
PG	4 (25%)		10 (62.5%)			2 (12.5%)	16
RLG	31 (29.5%)		58 (55.2%)			16 (15.2%)	105
RLI	1 (20%)		3 (60%)			1 (20%)	5
ROCG	2 (22.2%)	1 (11.1%)	5 (55.6%)	1 (11.1%)			9
SALG	8 (34.8%)		15 (65.2%)				23
SHH	4 (57.1%)		3 (42.9%)				7
SPG	3 (30%)	1 (10%)	6 (60%)				10
STP	10 (40%)		10 (40%)			5 (20%)	25
TAMG	6 (75%)		1 (12.5%)			1 (12.5%)	8
TRAG	5 (71.4%)		2 (28.6%)				7
WAR	1 (11.1%)		4 (44.4%)			4 (44.4%)	9
WGH	1 (100%)						1
WITG	30 (71.4%)		9 (21.4%)			3 (7.1%)	42
WORK	3 (100%)						3
WYTH	2 (25%)		6 (75%)				8

For a definition of the abbreviated statutory treatment centres please refer to the glossary at the back of the report.
Columns cannot be totalled as some individuals may attend two or more treatment locations, thus exaggerating the totals.
Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.

Table 2.9: Residency status of new cases by sex, age group, infection route, ethnicity, stage of HIV disease and area of residence, 2010

		Residency Status							Total
		UK National	Asylum Seeker	Overseas Student	Temporary Visitor	Refugee	Other*	Unknown	
Sex	Male	398 (86.9%)	16 (29.6%)	3 (33.3%)	1 (25%)	9 (56.3%)	6 (60%)	118 (64.1%)	551 (75%)
	Female	60 (13.1%)	38 (70.4%)	6 (66.7%)	3 (75%)	7 (43.8%)	4 (40%)	66 (35.9%)	184 (25%)
Age Group	0-14	1 (0.2%)				1 (6.3%)		4 (2.2%)	6 (0.8%)
	15-19	5 (1.1%)						1 (0.5%)	6 (0.8%)
	20-24	37 (8.1%)	3 (5.6%)	2 (22.2%)		1 (6.3%)		9 (4.9%)	52 (7.1%)
	25-29	75 (16.4%)	7 (13%)	1 (11.1%)	2 (50%)	1 (6.3%)	1 (10%)	21 (11.4%)	108 (14.7%)
	30-34	81 (17.7%)	15 (27.8%)	5 (55.6%)	1 (25%)	4 (25%)	4 (40%)	30 (16.3%)	140 (19%)
	35-39	69 (15.1%)	13 (24.1%)			2 (12.5%)	3 (30%)	44 (23.9%)	131 (17.8%)
	40-44	77 (16.8%)	7 (13%)			1 (6.3%)	1 (10%)	37 (20.1%)	123 (16.7%)
	45-49	47 (10.3%)	4 (7.4%)	1 (11.1%)	1 (25%)	3 (18.8%)	1 (10%)	18 (9.8%)	75 (10.2%)
	50-54	30 (6.6%)	3 (5.6%)			2 (12.5%)		7 (3.8%)	42 (5.7%)
	55-59	16 (3.5%)	2 (3.7%)			1 (6.3%)		3 (1.6%)	22 (3%)
	60+	20 (4.4%)						10 (5.4%)	30 (4.1%)
Infection Route	MSM	219 (47.8%)	3 (5.6%)				1 (10%)	52 (28.3%)	275 (37.4%)
	Injecting Drug Use	3 (0.7%)						3 (1.6%)	6 (0.8%)
	Heterosexual	116 (25.3%)	48 (88.9%)	6 (66.7%)	4 (100%)	13 (81.3%)	6 (60%)	76 (41.3%)	269 (36.6%)
	Blood/Tissue	2 (0.4%)							2 (0.3%)
	Mother to Child	1 (0.2%)				1 (6.3%)		4 (2.2%)	6 (0.8%)
	Unknown	117 (25.5%)	3 (5.6%)	3 (33.3%)		2 (12.5%)	3 (30%)	49 (26.6%)	177 (24.1%)
Ethnicity	White	376 (82.1%)	1 (1.9%)	1 (11.1%)			5 (50%)	66 (35.9%)	449 (61.1%)
	Black Caribbean	6 (1.3%)			1 (25%)			1 (0.5%)	8 (1.1%)
	Black African	40 (8.7%)	52 (96.3%)	7 (77.8%)	2 (50%)	15 (93.8%)	5 (50%)	76 (41.3%)	197 (26.8%)
	Black Other							1 (0.5%)	1 (0.1%)
	Indian/Pakistani/ Bangladeshi	6 (1.3%)						1 (0.5%)	7 (1%)
	Other Asian/Oriental	6 (1.3%)			1 (25%)			2 (1.1%)	9 (1.2%)
	Other/Mixed	11 (2.4%)	1 (1.9%)					4 (2.2%)	16 (2.2%)
	Unknown	13 (2.8%)		1 (11.1%)		1 (6.3%)		33 (17.9%)	48 (6.5%)
Stage of HIV Disease	Asymptomatic	291 (63.5%)	41 (75.9%)	9 (100%)	4 (100%)	11 (68.8%)	4 (40%)	109 (59.2%)	469 (63.8%)
	Symptomatic	38 (8.3%)	3 (5.6%)			2 (12.5%)	3 (30%)	24 (13%)	70 (9.5%)
	AIDS	50 (10.9%)	6 (11.1%)			3 (18.8%)	2 (20%)	36 (19.6%)	97 (13.2%)
	AIDS Related Death	3 (0.7%)	1 (1.9%)					4 (2.2%)	8 (1.1%)
	Unknown	76 (16.6%)	3 (5.6%)				1 (10%)	11 (6%)	91 (12.4%)
Area of Residence	Cumbria	10 (2.2%)			1 (25%)		1 (10%)		12 (1.6%)
	Lancashire	62 (13.5%)	2 (3.7%)	1 (11.1%)		3 (18.8%)	1 (10%)	12 (6.5%)	81 (11%)
	Greater Manchester	234 (51.1%)	19 (35.2%)	6 (66.7%)	1 (25%)	13 (81.3%)	7 (70%)	146 (79.3%)	426 (58%)
	Merseyside	70 (15.3%)	30 (55.6%)	1 (11.1%)	1 (25%)			7 (3.8%)	109 (14.8%)
	Cheshire	32 (7%)	1 (1.9%)				1 (10%)	2 (1.1%)	36 (4.9%)
	Out of Region**	24 (5.2%)			1 (25%)			7 (3.8%)	32 (4.4%)
	Unknown***	26 (5.7%)	2 (3.7%)	1 (11.1%)				10 (5.4%)	39 (5.3%)
	Total (100%)	**458**	**54**	**9**	**4**	**16**	**10**	**184**	**735**

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the age of individuals at the end of December 2010, or at death.
** Includes residency status defined as 'Migrant Worker', 'Dependent', and 'Other'.*
*** Includes Isle of Man.*
**** Includes one person of no fixed abode and one person who declined to give any residential information.*

Table 2.10: Primary care trust (PCT) of residence of new HIV and AIDS cases by infection route, 2010

PCT of Residence	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	7 (58.3%)		4 (33.3%)			1 (8.3%)	12
North Lancashire	2 (25%)		5 (62.5%)			1 (12.5%)	8
Blackpool	20 (60.6%)		12 (36.4%)			1 (3%)	33
Blackburn with Darwen		1 (10%)	9 (90%)				10
East Lancashire	9 (69.2%)		3 (23.1%)			1 (7.7%)	13
Central Lancashire	6 (37.5%)		8 (50%)			2 (12.5%)	16
Unknown Lancashire			1 (100%)				1
Ashton, Leigh & Wigan	13 (54.2%)		8 (33.3%)			3 (12.5%)	24
Bolton	5 (22.7%)		16 (72.7%)		1 (4.5%)		22
Bury	5 (41.7%)		6 (50%)			1 (8.3%)	12
Heywood, Middleton & Rochdale	5 (31.3%)	1 (6.3%)	6 (37.5%)			4 (25%)	16
Oldham	6 (60%)		3 (30%)	1 (10%)			10
Salford	26 (39.4%)	1 (1.5%)	18 (27.3%)		1 (1.5%)	20 (30.3%)	66
Manchester	74 (35.1%)	1 (0.5%)	63 (29.9%)		1 (0.5%)	72 (34.1%)	211
Tameside & Glossop	5 (38.5%)		4 (30.8%)			4 (30.8%)	13
Trafford	8 (30.8%)	1 (3.8%)	8 (30.8%)			9 (34.6%)	26
Stockport	11 (45.8%)		4 (16.7%)		1 (4.2%)	8 (33.3%)	24
Unknown Greater Manchester			1 (50%)			1 (50%)	2
Sefton	4 (44.4%)	1 (11.1%)	3 (33.3%)		1 (11.1%)		9
Liverpool	22 (32.8%)		40 (59.7%)		1 (1.5%)	4 (6%)	67
Knowsley	2 (28.6%)		2 (28.6%)			3 (42.9%)	7
Wirral	7 (35%)		12 (60%)			1 (5%)	20
Halton & St Helens	4 (57.1%)		3 (42.9%)				7
Unknown Merseyside	1 (33.3%)		1 (33.3%)			1 (33.3%)	3
Warrington	1 (11.1%)		3 (33.3%)			5 (55.6%)	9
Western Cheshire	6 (100%)						6
Central and Eastern Cheshire	7 (41.2%)		7 (41.2%)			3 (17.6%)	17
Isle of Man	1 (100%)						1
Out of Region	13 (41.9%)		9 (29%)	1 (3.2%)		8 (25.8%)	31
Unknown*	5 (12.8%)		10 (25.6%)			24 (61.5%)	39
Total	**275**	**6**	**269**	**2**	**6**	**177**	**735**

Men who were 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 one person who declined to give any residential information.*

Table 2.11: Primary care trust (PCT) of residence of new HIV and AIDS cases by stage of disease, 2010

PCT of Residence	Stage of Disease					Total (100%)
	Asympto-matic	Sympto-matic	AIDS	AIDS Related Death	Unknown	
Cumbria	10 (83.3%)	1 (8.3%)	1 (8.3%)			12
North Lancashire	4 (50%)	1 (12.5%)	2 (25%)		1 (12.5%)	8
Blackpool	16 (48.5%)	5 (15.2%)	4 (12.1%)		8 (24.2%)	33
Blackburn with Darwen	6 (60%)	2 (20%)	1 (10%)		1 (10%)	10
East Lancashire	8 (61.5%)		3 (23.1%)	2 (15.4%)		13
Central Lancashire	13 (81.3%)	2 (12.5%)	1 (6.3%)			16
Unknown Lancashire	1 (100%)					1
Ashton, Leigh & Wigan	15 (62.5%)	4 (16.7%)	5 (20.8%)			24
Bolton	14 (63.6%)	1 (4.5%)	5 (22.7%)	2 (9.1%)		22
Bury	10 (83.3%)	1 (8.3%)	1 (8.3%)			12
Heywood, Middleton & Rochdale	7 (43.8%)		3 (18.8%)	2 (12.5%)	4 (25%)	16
Oldham	6 (60%)	2 (20%)	2 (20%)			10
Salford	47 (71.2%)	6 (9.1%)	6 (9.1%)		7 (10.6%)	66
Manchester	128 (60.7%)	25 (11.8%)	29 (13.7%)	1 (0.5%)	28 (13.3%)	211
Tameside & Glossop	4 (30.8%)		4 (30.8%)		5 (38.5%)	13
Trafford	15 (57.7%)	4 (15.4%)	5 (19.2%)		2 (7.7%)	26
Stockport	11 (45.8%)	4 (16.7%)	1 (4.2%)		8 (33.3%)	24
Unknown Greater Manchester	2 (100%)					2
Sefton	8 (88.9%)		1 (11.1%)			9
Liverpool	60 (89.6%)		3 (4.5%)		4 (6%)	67
Knowsley	7 (100%)					7
Wirral	8 (40%)	5 (25%)	6 (30%)		1 (5%)	20
Halton & St Helens	4 (57.1%)	1 (14.3%)			2 (28.6%)	7
Unknown Merseyside	3 (100%)					3
Warrington	7 (77.8%)		1 (11.1%)		1 (11.1%)	9
Western Cheshire	3 (50%)		1 (16.7%)		2 (33.3%)	6
Central and Eastern Cheshire	7 (41.2%)	1 (5.9%)	5 (29.4%)		4 (23.5%)	17
Isle of Man	1 (100%)					1
Out of Region	19 (61.3%)	5 (16.1%)	4 (12.9%)		3 (9.7%)	31
Unknown*	25 (64.1%)		3 (7.7%)	1 (2.6%)	10 (25.6%)	39
Total	**469 (63.8%)**	**70 (9.5%)**	**97 (13.2%)**	**8 (1.1%)**	**91 (12.4%)**	**735**

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

3. All Cases 2010

During 2010, a total of 6,576 individuals living with HIV accessed treatment and care from statutory treatment centres in north west England, representing an 5% increase in the size of the HIV positive population (from 6,238 individuals in 2009). This is a slightly smaller increase than that seen between 2008 and 2009 (8%). The aim of this chapter is to provide information on the demographics and characteristics of these 6,576 individuals and, where appropriate, references are made to corresponding data from previous reports [1-14]. For reasons of confidentiality and space, it is not possible to present all breakdowns at local authority (LA) and primary care trust (PCT) level. However, additional tables are available on the North West Public Health Observatory website: (www.nwpho.org.uk/hiv2010).

Epidemiology of HIV in north west England

Figure 3.1 illustrates the crude population prevalence of HIV based on all cases who resided in north west England and attended statutory treatment centres within in north west England during 2010[§]. The population sizes for each LA used in the prevalence calculations are provided by the North West Public Health Observatory and are mid-2010 estimates based on 2001 census data. Across north west England, the prevalence of HIV was 142 per 100,000 population aged 15 to 59 years. There were considerable differences between LAs: the prevalence in Manchester was 527 per 100,000, Salford 399 per 100,000 and Blackpool 360 per 100,000. These three areas all had prevalence above the threshold whereby testing is recommended in general settings including all medical admissions and all new registrations in general practice (2 per 1,000, i.e. 200 per 100,000). This threshold (based on analysis from the USA) is deemed to be that at which it is cost effective to screen the whole population[90]. The areas with the lowest prevalence were Copeland (32 per 100,000), Allerdale (34 per 100,000) and West Lancashire (36 per 100,000 population).

Figure 3.2 illustrates the global region and country of infection for those 2,348 HIV positive individuals presenting for treatment in north west England in 2010 who were probably infected abroad. Of all the infections contracted outside the United Kingdom, 71% were exposed in sub-Saharan Africa. This high proportion reflects the impact of the pandemic in sub-Saharan Africa where the prevalence of HIV is extremely high[15]. Nine percent of people who were infected abroad were infected in South and South-East Asia, with a similar proportion (7%) in Western Europe. The exact country of infection is known for 2,259 individuals (96%). The infections acquired outside the UK were spread across 105 different countries, with Zimbabwe representing the country where the largest number of infections were contracted (32%). Thailand represents the second largest number of infections acquired outside the UK (156 cases; 7%). Exposure in sub-Saharan Africa was spread across 36 countries. Of those exposed in Western Europe, the largest number were infected in Spain (51 individuals), reflecting the extent of the epidemic in that country [15], the large number of people who travel between the United Kingdom and Spain, and the increased propensity to take risks when on holiday [91-93].

Table 3.1 shows the infection route and sex of all HIV and AIDS cases presenting in north west England for treatment in 2010, categorised by age group, stage of HIV disease and ethnicity. Sex between men (MSM) remains the most common route of infection amongst people with HIV (50% of all cases). However the proportion of people infected through heterosexual sex has increased over the past 15 years, from 15% in 1996 to 41% in 2010. The percentage of individuals exposed to HIV via injecting drug use (IDU), those infected by contaminated blood or tissue and vertical transmission all remain low at up to 2% per route.

On average, those who were infected through heterosexual sex were younger (median age 41 years) than those infected through MSM (43 years) and IDU (also 42 years). The overall age distribution remained concentrated in the 30-44 year age range, accounting for more than half of all cases (52%) and shows little deviation from previous years. New cases were more likely to be under 25 years (9%, see chapter 2, table 2.1) compared to all cases (5%). The proportion of HIV positive individuals in the older age groups (50 years and over) has increased slightly each year (16% in 2008 and 17% in 2009 to 19% in 2010) and is a large increase from 7% in 1996. This ageing cohort effect is likely to be due to the effectiveness of antiretroviral therapy and subsequent improved prognosis and longevity of many HIV positive individuals.

The proportion of individuals with HIV who died during the year decreased from 9% in 1996 to under 1% in 2010. Of the 40 individuals who died in 2010, 68% died of an AIDS-related condition (an increase from 51% in 2009) and 23 (32%) died of other causes.

Amongst those for whom ethnicity was known (6,502 individuals), 66% were of white ethnicity. Those from black and minority ethnic (BME) communities make up for 34% of the total HIV positive population accessing care in north west England, with black Africans representing the greatest proportion within BME groups (83%).

Table 3.2 shows LA and county of residence by infection route. Although MSM continues to be the dominant mode of HIV transmission (50%) amongst those with HIV who are resident in north west England, there is considerable variation at county level. Of those whose infection route was known, 60% of Lancashire's and 56% of Cheshire's HIV positive residents were infected via MSM compared to 37% of Merseyside's HIV positive residents. There is greater variation across LAs: the proportion infected through sex between men ranged from 80% in Blackpool to 27% in Hyndburn. Barrow-in-Furness in Cumbria was the LA with the greatest proportion of infections acquired via heterosexual sex (67%), although absolute numbers were low (14/21, therefore the percentage

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

should be interpreted with caution). Nearly two thirds (63%; 297 individuals) of the HIV positive population living in Liverpool LA were infected through heterosexual sex. Manchester LA had the largest number of HIV positive residents infected through MSM (948 cases) and through heterosexual sex (786 cases). The county of Greater Manchester had the highest number of HIV positive individuals infected through IDU (80 individuals) which accounts for 67% of all residents of north west England infected by this route.

Table 3.3 illustrates the LA, county of residence and clinical stage of HIV disease for all HIV and AIDS cases presenting to a treatment centre in north west England in 2010. The data refer to the clinical condition of individuals when last seen in 2010; 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 seen in north west England). As in previous years, the vast majority of people treated in north west England were also resident in north west England (95%). The proportion of people at different stages of HIV disease will impact on the funding of HIV treatment and care, since those at a more advanced stage require more hospital care [46]. There is variation between stages of disease across the counties, from 42% of Lancashire's residents presenting as asymptomatic to 63% for Merseyside.

Table 3.4 gives a breakdown of ethnicity and county by infection route and sex. Of those infected through heterosexual sex who were treated in north west England 70% were from BME/mixed background, compared to 29% who were of white ethnicity. In contrast, of those infected via MSM, 95% were of white ethnicity and only 4% were from BME/mixed ethnic backgrounds. Individuals from black and minority ethnic or of mixed ethnicity are substantially over-represented amongst the HIV positive population when compared to their proportion in the population as a whole (34% of all cases, compared to 8% of north west England population)[86]. Prevalence in BME communities is seven times higher in the white population. The proportion of the HIV positive population from BME/mixed backgrounds varies between counties, with Greater Manchester and Merseyside having the largest proportion (both at 40%) whilst Cumbria has the smallest proportion (13%).

Table 3.5 shows a breakdown of age by ethnicity for all residents of north west England and for all those individuals treated for HIV in north west England. Of all those who accessed treatment and care in north west England, black African individuals tended to be younger (50% aged between 25 and 39 years) than white individuals (37% aged 25 to 39 years).

Table 3.6 shows the distribution of total HIV and AIDS cases by stage of HIV disease, county and level of antiretroviral therapy (ART). The largest proportion of individuals (51%) were using triple therapy, followed by 29% using quadruple or more. Amongst those residents of north west England with AIDS, 96% were on ART. Amongst those who were asymptomatic, 71% were on ART. There was little variation between the proportion of individuals on ART between counties, ranging from 80% in Greater Manchester to 85% in Cumbria.

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, 65% were female and amongst those defined as other Asian/Oriental, 62% were female. The largest proportion of HIV positive individuals were asymptomatic (50%), followed by symptomatic individuals (23%). Amongst white HIV positive individuals, 47% were asymptomatic and the majority of Black Africans (55%) were asymptomatic. In contrast to the 13% of white individuals infected abroad, 79% of those classed as from BME groups were exposed to HIV abroad.

Table 3.8 illustrates the global region and country of exposure and route of infection of all HIV cases. Over a third (36%) of all cases reported were 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 were infected in sub-Saharan Africa (81%). Heterosexual sex was the most common route of infection in those infected in sub-Saharan Africa (93%), the Caribbean (84%), South and South-East Asia (79%), East Asia and Pacific (63%), North Africa and Middle East (61%), Eastern Europe and Central Asia (57%). In contrast, those infected in Oceania, North America and Western Europe were more likely to be via MSM (81%, 79% and 63% respectively).

Care of HIV positive people by statutory treatment centres

Table 3.9 presents the number of HIV positive people seeking care by infection route and treatment centre (for a definition of the abbreviated treatment centres, see the glossary). The Infectious Disease Unit at North Manchester General Hospital (NMG) provides care for the greatest number of HIV positive individuals (1,668). Manchester Centre for Sexual Health at Manchester Royal Infirmary (MRIG) provided treatment for 1,314 individuals, the Royal Liverpool University Hospital department of GUM and Tropical and Infectious Disease Unit (RLG) provided care for 790 individuals and Blackpool Victoria Hospital (BLAG) provided care for 404 individuals with HIV in 2010. There is considerable variation in the profile of HIV positive individuals between different treatment centres. Ninety five 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 50% (table 3.1) of all HIV cases. Treatment of individuals exposed through contaminated blood or blood products is primarily undertaken by specialist haematology units at Manchester Royal Infirmary (MRIH) and Royal Liverpool University Hospital (RLH).

Table 3.10 refers to the highest level of ART prescribed by specific treatment centres during 2010. The Infectious Disease Unit at North Manchester General Hospital (NMG, which sees the most individuals) prescribed triple or more ART to 89% of their patients. The proportion taking triple or more therapy is higher in persons attending the specialist haematology

centres at RLH and MRIH (90% and 100% respectively). There are few individuals prescribed mono or dual therapy in accordance with the latest British HIV Association guidelines[94].

Table 3.11 illustrates the distribution of all HIV cases presenting in north west England for treatment in 2010 by LA of residence and the number of statutory treatment centres attended. The majority (92%) attended only one treatment centre. However, this varied across counties: residents of Cumbria, Cheshire and Lancashire were more likely to attend only one treatment centre (96%), compared with people residing in Greater Manchester (90%) and Merseyside (89%). It should be noted that these numbers refer only to treatment centres within north west England. Attendance at multiple treatment centres could be due to a change in residence or simultaneously accessing treatment and care from more than one treatment centre.

Table 3.12 shows the total and mean number of outpatient visits, day cases, inpatient episodes, inpatient days and home visits per HIV positive individual treated at each centre. MRIG and NMG provided the highest number of outpatient visits, each accounting for over a fifth (22% and 21% respectively) of all attendances. NMG also provided the highest number of day cases (94% of the total), inpatient episodes (45% of the total) and inpatient days (54%), with the Department of GUM and Tropical and Infectious Disease Unit at RLG providing the next highest number of inpatient episodes (15%).

Some of the treatment centres provided a significant number of home visits, with Liverpool Community Nursing (LCN) providing 56% of the total home visits, followed by Alder Hey Children's Hospital in Liverpool (AHC; 31%) and NMG (8%). AHC provided the highest number of home visits per HIV positive person (18.4 per patient).

Asymptomatic HIV positive people accumulated a total of 20,522 outpatient visits. People with an AIDS-related illness had the highest mean number of outpatient visits (6.6). Individuals who died of an AIDS-related illness during 2010 spent the greatest mean number of days as inpatients (22.3 days).

HIV in non-UK nationals

Table 3.13 shows the residency status of all individuals who accessed treatment and care in north west England in 2010 by sex, age group, infection route, ethnicity, stage of HIV disease and area of residence. A total of 1,234 (slightly fewer than the 1,242 individuals seen in 2009) individuals were known to be non-UK nationals (19% of the total HIV positive population). The residency status of 8% was unknown. Over half the non-UK nationals were classified as asylum seekers (54%). Refugees (16%) and overseas students (10%) were the other main categories. Nearly two thirds (65%) of HIV positive non-UK nationals were female, compared with 16% of UK-national HIV positive individuals. There is also a large difference in the proportion of heterosexual cases between UK national and non-UK nationals (27% compared with 91%). Non-UK nationals were younger (median age 38) than UK-national HIV positive population (median age 42 years). The majority (96%) of asylum seekers were black African. Most of the known HIV positive non-UK nationals were resident in Greater Manchester (71%), with the next largest number living in Merseyside (19% of the total).

Fifty six percent of non-UK nationals were reported to be asymptomatic, suggesting that individuals usually access treatment while still healthy and thus may benefit from life-prolonging treatment. In UK nationals, 48% are classified as asymptomatic. A similar proportion of non-UK and UK nationals had an AIDS diagnosis (22% and 21%, respectively). A similar proportion of non-UK nationals (0.3%) and UK nationals (0.6%) died in 2009.

Table 3.14 shows PCT of residence by infection route. Several PCTs have a larger proportion of individuals infected through heterosexual sex than through MSM. The highest proportions of individuals infected through heterosexual sex lived in Blackburn with Darwen PCT (63%) and Liverpool PCT (63%), the same proportions seen in 2009. Eighty percent of those residing in Blackpool PCT were infected through sex between men. Six percent of HIV positive people living in Sefton PCT were infected through IDU, substantially higher than the north west average of 2%. Amongst those residing outside north west England, those infected through blood/tissue and mother to child were over represented (5% mother to child compared to 2% overall and 3% blood/tissue compared to 1% overall), suggesting that these individuals are travelling from elsewhere to specialist treatment centres[95].

Table 3.15 displays PCT of residence of all HIV and AIDS cases by stage of HIV disease. There are 12 PCTs where asymptomatic individuals represent a larger proportion than those who are symptomatic or have an AIDS-related illness, including five where the proportion who are asymptomatic is 65% or more (Bolton; Sefton; Liverpool; Warrington; and Western Cheshire). In all other PCTs, proportionately fewer individuals were recorded as asymptomatic. Further analyses by PCT can be found on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2010).

Figure 3.1: Number of cases of HIV, crude rate per 100,000 population by local authority of residence, 2010
Crude rate based on the number of cases of HIV and AIDS residing in, and accessing treatment in, north west England per 100,000 of the population

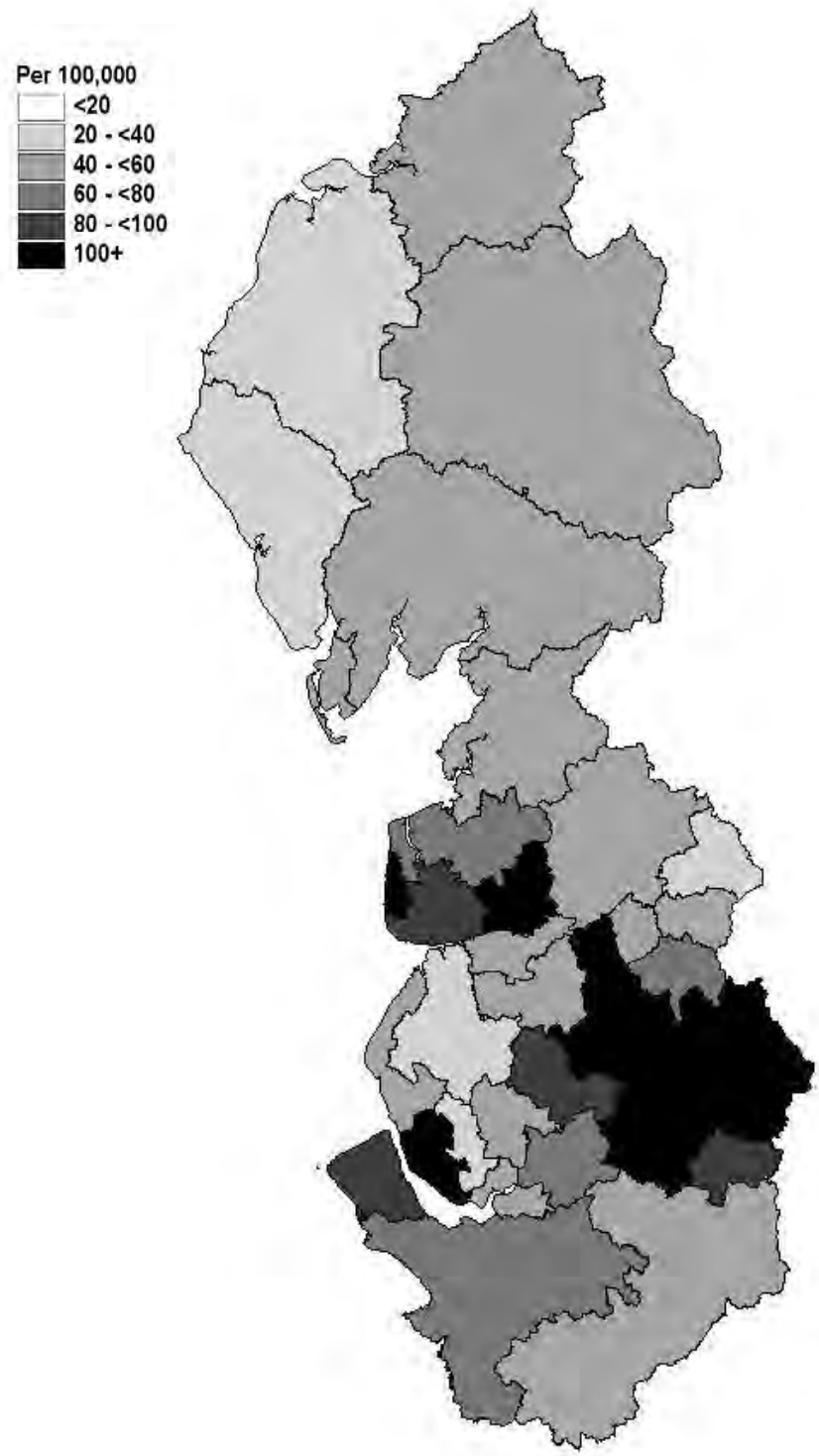
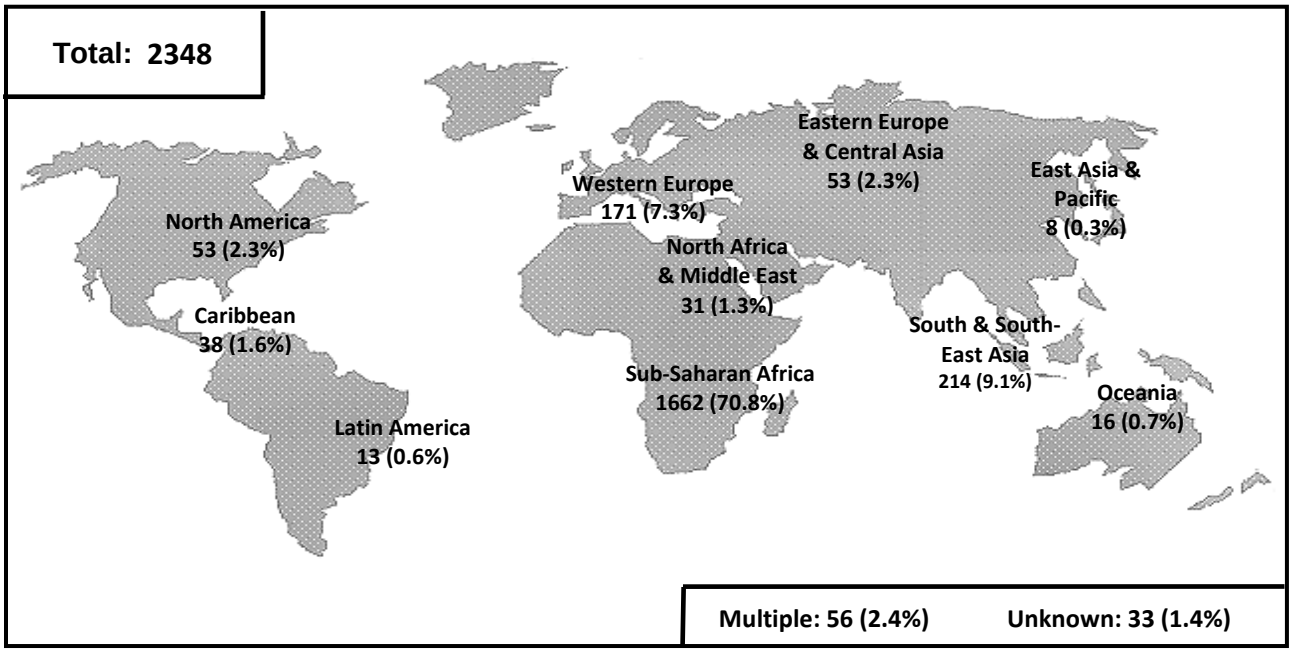


Figure 3.2: Global region and country of infection for all HIV and AIDS cases in north west England who probably acquired their infection outside the UK, 2010



Sub-Saharan Africa	1662 (70.8%)
Angola	13 (0.6%)
Botswana	23 (1%)
Burundi	11 (0.5%)
Cameroon	38 (1.6%)
Cape Verde	1 (0%)
Central African Republic	1 (0%)
Chad	1 (0%)
Congo	48 (2%)
Cote d'Ivoire	13 (0.6%)
Dem. Republic of Congo	10 (0.4%)
Equatorial Guinea	1 (0%)
Eritrea	18 (0.8%)
Ethiopia	18 (0.8%)
Gabon	1 (0%)
Gambia	11 (0.5%)
Ghana	25 (1.1%)
Guinea	5 (0.2%)
Kenya	53 (2.3%)
Lesotho	1 (0%)
Liberia	5 (0.2%)
Malawi	124 (5.3%)
Mozambique	4 (0.2%)
Namibia	3 (0.1%)
Niger	1 (0%)
Nigeria	103 (4.4%)
Rwanda	13 (0.6%)
Senegal	1 (0.04%)
Sierra Leone	9 (0.4%)
Somalia	17 (0.7%)
South Africa	119 (5.1%)
Swaziland	5 (0.2%)
Tanzania	21 (0.9%)
Togo	2 (0.1%)
Uganda	40 (1.7%)
Zambia	81 (3.4%)
Zimbabwe	759 (32.3%)
Unknown	59 (2.5%)
Multiple	4 (0.2%)

East Asia & Pacific	8 (0.3%)
China	6 (0.3%)
Hong Kong	1 (0%)
Taiwan	1 (0%)

South & South-East Asia	214 (9.1%)
Bangladesh	1 (0%)
Brunei Darussalam	1 (0%)
Cambodia	1 (0%)
Dem. Republic of Timor-Leste	1 (0%)
India	17 (0.7%)
Indonesia	2 (0.1%)
Iran	3 (0.1%)
Malaysia	2 (0.1%)
Nepal	1 (0%)
Pakistan	14 (0.6%)
Philippines	2 (0.1%)
Singapore	3 (0.1%)
Sri Lanka	1 (0%)
Thailand	156 (6.6%)
Vietnam	2 (0.1%)
Unknown	5 (0.2%)
Multiple	2 (0.1%)

Eastern Europe & Central Asia	53 (2.3%)
Croatia	1 (0%)
Estonia	3 (0.1%)
Georgia	1 (0%)
Hungary	1 (0%)
Latvia	13 (0.6%)
Poland	24 (1%)
Romania	4 (0.2%)
Russian Federation	5 (0.2%)
Unknown	1 (0%)

Oceania	16 (0.7%)
Australia	15 (0.6%)
New Zealand	1 (0%)

North America	53 (2.3%)
Canada	5 (0.2%)
United States of America	48 (2%)

Caribbean	38 (1.6%)
Barbados	1 (0%)
Jamaica	33 (1.4%)
St Lucia	1 (0%)
Trinidad and Tobago	1 (0%)
Unknown	2 (0.1%)

Western Europe	171 (7.3%)
Austria	1 (0%)
Balearics	2 (0.1%)
Belgium	3 (0.1%)
Canary Islands	9 (0.4%)
Finland	2 (0.1%)
France	13 (0.6%)
Germany	17 (0.7%)
Gibraltar	1 (0%)
Greece	6 (0.3%)
Italy	14 (0.6%)
Malta	2 (0.1%)
Netherlands	12 (0.5%)
Norway	1 (0%)
Portugal	22 (0.9%)
Republic of Ireland	3 (0.1%)
Slovenia	1 (0%)
Spain	51 (2.2%)
Sweden	1 (0%)
Unknown	7 (0.3%)
Multiple	3 (0.1%)

North Africa & Middle East	31 (1.3%)
Cyprus	2 (0.1%)
Egypt	3 (0.1%)
Israel	1 (0%)
Kuwait	1 (0%)
Libyan Arab Jamahiriya	3 (0.1%)
Morocco	2 (0.1%)
Saudi Arabia	1 (0%)
Sudan	11 (0.5%)
Turkey	3 (0.1%)
United Arab Emirates	3 (0.1%)
Unknown	1 (0%)

Latin America	13 (0.6%)
Brazil	9 (0.4%)
Colombia	1 (0%)
Guatemala	1 (0%)
Guyana	1 (0%)
Mexico	1 (0%)

Multiple	56 (2.4%)
Unknown	33 (1.4%)

Total	2348

Table 3.1: Age distribution, stage of HIV disease and ethnicity of all HIV and AIDS cases by infection route and sex 2010

		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								38	56			94
	15-19	3			1	7			13	12	4		40
	20-24	92		1	17	56			2	6	12	3	189
	25-29	260	5	4	60	183	6		1		26	2	547
	30-34	442	12	3	137	353	4				33	10	994
	35-39	542	20	5	194	368	10	1			36	9	1,185
	40-44	647	21	1	230	320	11	1			35	6	1,272
	45-49	589	16	5	178	177	6	5			26	9	1,011
	50-54	351	14	4	103	90	6	1			15	4	588
	55-59	198	2		74	46	4	2			3	1	330
	60+	166	6		91	37	6	4			16		326
Stage of HIV Disease	Asymptomatic	1572	35	14	538	950	9	3	13	32	125	23	3,314
	Symptomatic	881	33	7	218	305	23	6	27	23	14	6	1,543
	AIDS	656	26	2	281	327	18	5	14	19	38	9	1,395
	AIDS Related Death	14	1		4	4	1				3		27
	Death Unrelated to AIDS	7			5	1							13
	Unknown	160	1		39	50	2				26	6	284
Ethnicity	White	3132	85	23	441	357	50	7	7	12	150	11	4,275
	Black Caribbean	21	1		22	37				1		1	83
	Black African	23	3		561	1136		1	40	52	21	17	1,854
	Black Other	9	1		4	9							23
	Indian/Pakistani/Bangladeshi	28	1		24	15	2	2		1	3	1	77
	Other Asian/Oriental	16			12	47	1	2	1	2	2	1	84
	Other/Mixed	41	3		17	25		2	6	6	5	1	106
	Unknown	20	2		4	11					25	12	74
	Total	**3,290**	**96**	**23**	**1,085**	**1,637**	**53**	**14**	**54**	**74**	**206**	**44**	**6,576**
	%	**50.0**	**1.5**	**0.3**	**16.5**	**24.9**	**0.8**	**0.2**	**0.8**	**1.1**	**3.1**	**0.7**	

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the age of individuals at the end of December 2010, or at death.

Table 3.2: Local authority of residence of all HIV and AIDS cases by infection route, 2010

	Local Authority of Residence	Infection Route						Total (100%)
		MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	Carlisle	21 (55.3%)	1 (2.6%)	12 (31.6%)	1 (2.6%)		3 (7.9%)	38
	Allerdale	14 (70.0%)		5 (25.0%)		1 (5.0%)		20
	Eden	10 (76.9%)		3 (23.1%)				13
	Copeland	5 (35.7%)		6 (42.9%)	1 (7.1%)	1 (7.1%)	1 (7.1%)	14
	South Lakeland	13 (46.4%)	1 (3.6%)	11 (39.3%)	1 (3.6%)	1 (3.6%)	1 (3.6%)	28
	Barrow-in-Furness	7 (33.3%)		14 (66.7%)				21
	Unknown Cumbria	1 (100%)						1
	Cumbria Total	**71 (52.6%)**	**2 (1.5%)**	**51 (37.8%)**	**3 (2.2%)**	**3 (2.2%)**	**5 (3.7%)**	**135**
Lancashire	Lancaster	22 (48.9%)		20 (44.4%)	1 (2.2%)	1 (2.2%)	1 (2.2%)	45
	Wyre	33 (70.2%)		14 (29.8%)				47
	Fylde	32 (66.7%)	1 (2.1%)	13 (27.1%)		1 (2.1%)	1 (2.1%)	48
	Blackpool	251 (80.4%)	3 (1.0%)	51 (16.3%)	4 (1.3%)	1 (0.3%)	2 (0.6%)	312
	Blackburn with Darwen	28 (28.6%)	2 (2.0%)	62 (63.3%)	3 (3.1%)		3 (3.1%)	98
	Ribble Valley	6 (35.3%)		10 (58.8%)			1 (5.9%)	17
	Pendle	14 (58.3%)	2 (8.3%)	4 (16.7%)	1 (4.2%)		3 (12.5%)	24
	Hyndburn	7 (26.9%)		17 (65.4%)		1 (3.8%)	1 (3.8%)	26
	Burnley	9 (36.0%)		15 (60.0%)	1 (4.0%)			25
	Rossendale	27 (79.4%)	1 (2.9%)	5 (14.7%)		1 (2.9%)		34
	Preston	47 (45.6%)	1 (1.0%)	50 (48.5%)		3 (2.9%)	2 (1.9%)	103
	South Ribble	18 (56.3%)	1 (3.1%)	11 (34.4%)		1 (3.1%)	1 (3.1%)	32
	Chorley	14 (48.3%)	1 (3.4%)	12 (41.4%)			2 (6.9%)	29
	West Lancashire	15 (60.0%)		8 (32.0%)	2 (8.0%)			25
	Unknown Lancashire	2 (33.3%)		4 (66.7%)				6
	Lancashire Total	**525 (60.3%)**	**12 (1.4%)**	**296 (34.0%)**	**12 (1.4%)**	**9 (1.0%)**	**17 (2.0%)**	**871**
Greater Manchester	Wigan	66 (39.3%)	1 (0.6%)	90 (53.6%)	3 (1.8%)	3 (1.8%)	5 (3.0%)	168
	Bolton	82 (31.1%)	8 (3.0%)	156 (59.1%)	4 (1.5%)	12 (4.5%)	2 (0.8%)	264
	Bury	104 (56.5%)	2 (1.1%)	68 (37.0%)		3 (1.6%)	7 (3.8%)	184
	Rochdale	58 (34.7%)	8 (4.8%)	86 (51.5%)	3 (1.8%)	6 (3.6%)	6 (3.6%)	167
	Oldham	49 (34.8%)	3 (2.1%)	84 (59.6%)	3 (2.1%)	1 (0.7%)	1 (0.7%)	141
	Salford	391 (64.8%)	10 (1.7%)	169 (28.0%)	1 (0.2%)	4 (0.7%)	28 (4.6%)	603
	Manchester	948 (49.8%)	38 (2.0%)	786 (41.3%)	5 (0.3%)	40 (2.1%)	88 (4.6%)	1905
	Tameside	77 (49.0%)	3 (1.9%)	69 (43.9%)		3 (1.9%)	5 (3.2%)	157
	Trafford	106 (51.2%)	5 (2.4%)	79 (38.2%)	4 (1.9%)	3 (1.4%)	10 (4.8%)	207
	Stockport	101 (60.5%)	2 (1.2%)	46 (27.5%)	2 (1.2%)	6 (3.6%)	10 (6.0%)	167
	Unknown Greater Manchester	11 (64.7%)		5 (29.4%)			1 (5.9%)	17
	Greater Manchester Total	**1,993 (50.1%)**	**80 (2%)**	**1,638 (41.2%)**	**25 (0.6%)**	**81 (2.0%)**	**163 (4.1%)**	**3,980**
Merseyside	Sefton	36 (37.9%)	6 (6.3%)	45 (47.4%)	3 (3.2%)	1 (1.1%)	4 (4.2%)	95
	Liverpool	153 (32.2%)	5 (1.1%)	297 (62.5%)	3 (0.6%)	11 (2.3%)	6 (1.3%)	475
	Knowsley	20 (55.6%)	1 (2.8%)	11 (30.6%)			4 (11.1%)	36
	Wirral	67 (42.9%)	1 (0.6%)	81 (51.9%)	2 (1.3%)	3 (1.9%)	2 (1.3%)	156
	St Helens	33 (62.3%)		18 (34.0%)	1 (1.9%)		1 (1.9%)	53
	Unknown Merseyside	11 (22.4%)		37 (75.5%)			1 (2.0%)	49
	Merseyside Total	**320 (37.0%)**	**13 (1.5%)**	**489 (56.6%)**	**9 (1.0%)**	**15 (1.7%)**	**18 (2.1%)**	**864**
Cheshire	Halton	19 (55.9%)		13 (38.2%)		1 (2.9%)	1 (2.9%)	34
	Warrington	37 (45.7%)	1 (1.2%)	35 (43.2%)	1 (1.2%)	2 (2.5%)	5 (6.2%)	81
	Cheshire West and Chester	90 (57.3%)	3 (1.9%)	55 (35.0%)	3 (1.9%)	6 (3.8%)		157
	Cheshire East	79 (59.8%)	2 (1.5%)	43 (32.6%)	4 (3.0%)		4 (3.0%)	132
	Cheshire Total	**225 (55.7%)**	**6 (1.5%)**	**146 (36.1%)**	**8 (2.0%)**	**9 (2.2%)**	**10 (2.5%)**	**404**
	Total North West Residents	**3,134 (50.1%)**	**113 (1.8%)**	**2,620 (41.9%)**	**57 (0.9%)**	**117 (1.9%)**	**213 (3.4%)**	**6,254**
	Isle of Man	11 (37.9%)	1 (3.4%)	15 (51.7%)	2 (6.9%)			29
	Out of Region	112 (54.4%)	2 (1.0%)	65 (31.6%)	6 (2.9%)	11 (5.3%)	10 (4.9%)	206
	Abroad	2 (66.7%)		1 (33.3%)				3
	Unknown*	31 (36.9%)	3 (3.6%)	21 (25.0%)	2 (2.4%)		27 (32.1%)	84
	Total	**3,290 (50.0%)**	**119 (1.8%)**	**2,722 (41.4%)**	**67 (1.0%)**	**128 (1.9%)**	**250 (3.8%)**	**6,576**

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

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

Table 3.3: Local authority of residence of all HIV and AIDS cases by stage of HIV disease, 2010

	Local Authority of Residence	Stage of HIV Disease						Total (100%)
		Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	Carlisle	16 (42.1%)	7 (18.4%)	12 (31.6%)			3 (7.9%)	38
	Allerdale	7 (35.0%)	9 (45.0%)	3 (15.0%)			1 (5.0%)	20
	Eden	9 (69.2%)	2 (15.4%)	1 (7.7%)			1 (7.7%)	13
	Copeland	3 (21.4%)	6 (42.9%)	4 (28.6%)			1 (7.1%)	14
	South Lakeland	12 (42.9%)	8 (28.6%)	8 (28.6%)				28
	Barrow-in-Furness	14 (66.7%)	1 (4.8%)	6 (28.6%)				21
	Unknown Cumbria	1 (100%)						1
	Cumbria Total	**62 (45.9%)**	**33 (24.4%)**	**34 (25.2%)**			**6 (4.4%)**	**135**
Lancashire	Lancaster	28 (62.2%)	8 (17.8%)	9 (20.0%)				45
	Wyre	16 (34.0%)	14 (29.8%)	16 (34.0%)			1 (2.1%)	47
	Fylde	19 (39.6%)	18 (37.5%)	11 (22.9%)				48
	Blackpool	117 (37.5%)	111 (35.6%)	71 (22.8%)	3 (1.0%)		10 (3.2%)	312
	Blackburn with Darwen	53 (54.1%)	24 (24.5%)	18 (18.4%)		1 (1.0%)	2 (2.0%)	98
	Ribble Valley	6 (35.3%)	4 (23.5%)	6 (35.3%)	1 (5.9%)			17
	Pendle	8 (33.3%)	10 (41.7%)	4 (16.7%)	1 (4.2%)		1 (4.2%)	24
	Hyndburn	9 (34.6%)	8 (30.8%)	8 (30.8%)		1 (3.8%)		26
	Burnley	14 (56.0%)	4 (16.0%)	7 (28.0%)				25
	Rossendale	8 (23.5%)	16 (47.1%)	4 (11.8%)			6 (17.6%)	34
	Preston	42 (40.8%)	35 (34.0%)	25 (24.3%)	1 (1.0%)			103
	South Ribble	17 (53.1%)	9 (28.1%)	6 (18.8%)				32
	Chorley	16 (55.2%)	8 (27.6%)	4 (13.8%)			1 (3.4%)	29
	West Lancashire	7 (28.0%)	12 (48.0%)	6 (24.0%)				25
	Unknown Lancashire	2 (33.3%)	2 (33.3%)	1 (16.7%)			1 (16.7%)	6
	Lancashire Total	**362 (41.6%)**	**283 (32.5%)**	**196 (22.5%)**	**6 (0.7%)**	**2 (0.2%)**	**22 (2.5%)**	**871**
Greater Manchester	Wigan	108 (64.3%)	32 (19.0%)	28 (16.7%)				168
	Bolton	181 (68.6%)	27 (10.2%)	52 (19.7%)	2 (0.8%)	2 (0.8%)		264
	Bury	84 (45.7%)	63 (34.2%)	35 (19.0%)		2 (1.1%)		184
	Rochdale	65 (38.9%)	23 (13.8%)	36 (21.6%)	3 (1.8%)		40 (24.0%)	167
	Oldham	69 (48.9%)	35 (24.8%)	31 (22.0%)			6 (4.3%)	141
	Salford	312 (51.7%)	153 (25.4%)	117 (19.4%)		2 (0.3%)	19 (3.2%)	603
	Manchester	934 (49.0%)	466 (24.5%)	425 (22.3%)	7 (0.4%)	1 (0.1%)	72 (3.8%)	1905
	Tameside	54 (34.4%)	35 (22.3%)	36 (22.9%)			32 (20.4%)	157
	Trafford	86 (41.5%)	59 (28.5%)	54 (26.1%)	1 (0.5%)		7 (3.4%)	207
	Stockport	70 (41.9%)	56 (33.5%)	31 (18.6%)		1 (0.6%)	9 (5.4%)	167
	Unknown Greater Manchester	10 (58.8%)	3 (17.6%)	3 (17.6%)		1 (5.9%)		17
	Greater Manchester Total	**1,973 (49.6%)**	**952 (23.9%)**	**848 (21.3%)**	**13 (0.3%)**	**9 (0.2%)**	**185 (4.6%)**	**3,980**
Merseyside	Sefton	63 (66.3%)	17 (17.9%)	12 (12.6%)	2 (2.1%)		1 (1.1%)	95
	Liverpool	345 (72.6%)	52 (10.9%)	64 (13.5%)	1 (0.2%)	1 (0.2%)	12 (2.5%)	475
	Knowsley	21 (58.3%)	5 (13.9%)	6 (16.7%)			4 (11.1%)	36
	Wirral	57 (36.5%)	45 (28.8%)	51 (32.7%)	1 (0.6%)	1 (0.6%)	1 (0.6%)	156
	St Helens	17 (32.1%)	9 (17.0%)	9 (17.0%)			18 (34.0%)	53
	Unknown Merseyside	37 (75.5%)	3 (6.1%)	9 (18.4%)				49
	Merseyside Total	**540 (62.5%)**	**131 (15.2%)**	**151 (17.5%)**	**4 (0.5%)**	**2 (0.2%)**	**36 (4.2%)**	**864**
Cheshire	Halton	22 (64.7%)	4 (11.8%)	6 (17.6%)			2 (5.9%)	34
	Warrington	58 (71.6%)	8 (9.9%)	13 (16.0%)			2 (2.5%)	81
	Cheshire West and Chester	86 (54.8%)	30 (19.1%)	33 (21.0%)	1 (0.6%)		7 (4.5%)	157
	Cheshire East	52 (39.4%)	35 (26.5%)	42 (31.8%)	1 (0.8%)		2 (1.5%)	132
	Cheshire Total	**218 (54%)**	**77 (19.1%)**	**94 (23.3%)**	**2 (0.5%)**		**13 (3.2%)**	**404**
	Total North West Residents	**3,155 (50.4%)**	**1,476 (23.6%)**	**1,323 (21.2%)**	**25 (0.4%)**	**13 (0.2%)**	**262 (4.2%)**	**6,254**
	Isle of Man	12 (41.4%)	9 (31.0%)	8 (27.6%)				29
	Out of Region	90 (43.7%)	51 (24.8%)	56 (27.2%)	1 (0.5%)		8 (3.9%)	206
	Abroad	2 (66.7%)		1 (33.3%)				3
	Unknown*	55 (65.5%)	7 (8.3%)	7 (8.3%)	1 (1.2%)		14 (16.7%)	84
	Total	**3,314 (50.4%)**	**1,543 (23.5%)**	**1,395 (21.2%)**	**27 (0.4%)**	**13 (0.2%)**	**284 (4.3%)**	**6,576**

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

Table 3.4: All HIV and AIDS cases by infection route, sex, county of residence and ethnicity, 2010

	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	71	2		20	16	2			2	4	1	118
	BME/mixed				3	12		1	1				17
	Unknown												
	Total	**71**	**2**		**23**	**28**	**2**	**1**	**1**	**2**	**4**	**1**	**135**
	%	**52.6**	**1.5**		**17.0**	**20.7**	**1.5**	**0.7**	**0.7**	**1.5**	**3.0**	**0.7**	
Lancashire	White	509	10	1	95	75	6	3		3	13		715
	BME/mixed	13	1		41	84	1	2	3	3	1	1	150
	Unknown	3				1					2		6
	Total	**525**	**11**	**1**	**136**	**160**	**7**	**5**	**3**	**6**	**16**	**1**	**871**
	%	**60.3**	**1.3**	**0.1**	**15.6**	**18.4**	**0.8**	**0.6**	**0.3**	**0.7**	**1.8**	**0.1**	
Greater Manchester	White	1,883	56	15	155	115	19	1	5	3	92	6	2350
	BME/mixed	94	8		463	898	2	3	30	43	23	15	1579
	Unknown	16	1		2	5					17	10	51
	Total	**1,993**	**65**	**15**	**620**	**1018**	**21**	**4**	**35**	**46**	**132**	**31**	**3,980**
	%	**50.1**	**1.6**	**0.4**	**15.6**	**25.6**	**0.5**	**0.1**	**0.9**	**1.2**	**3.3**	**0.8**	
Merseyside	White	305	8	4	87	80	6	2		1	16	1	510
	BME/mixed	15			98	220		1	5	9		1	349
	Unknown	0	1		2	2							5
	Total	**320**	**9**	**4**	**187**	**302**	**6**	**3**	**5**	**10**	**16**	**2**	**864**
	%	**37.00**	**1.00**	**0.50**	**21.60**	**35.00**	**0.70**	**0.30**	**0.60**	**1.20**	**1.90**	**0.20**	
Cheshire	White	220	3	3	55	40	8			1	7	1	338
	BME/mixed	5			21	29			4	4		1	64
	Unknown					1					1		2
	Total	**225**	**3**	**3**	**76**	**70**	**8**		**4**	**5**	**8**	**2**	**404**
	%	**55.7**	**0.7**	**0.7**	**18.8**	**17.3**	**2.0**		**1.0**	**1.2**	**2.0**	**0.5**	
Out of region*	White	116	3		24	27	8		2	2	5	1	188
	BME/mixed	6			11	18			4	3	2		44
	Unknown	1									1	1	3
	Total	**123**	**3**		**35**	**45**	**8**		**6**	**5**	**8**	**2**	**235**
	%	**52.3**	**1.3**		**14.9**	**19.1**	**3.4**		**2.6**	**2.1**	**3.4**	**0.9**	
Abroad	White	2			1								3
	Total	**2**			**1**								**3**
	%	**66.7**			**33.3**								
Unknown**	White	26	3		4	4	1	1			13	1	53
	BME/mixed	5			3	8					5	3	24
	Unknown					2					4	1	7
	Total	**31**	**3**		**7**	**14**	**1**	**1**			**22**	**5**	**84**
	%	**36.9**	**3.6**		**8.3**	**16.7**	**1.2**	**1.2**			**26.2**	**6.0**	
Total	White	3,132	85	23	441	357	50	7	7	12	150	11	4,275
	BME/mixed	138	9		640	1,269	3	7	47	62	31	21	2,227
	Unknown	20	2	0	4	11	0	0	0	0	25	12	74
	Total	**3,290**	**96**	**23**	**1,085**	**1,637**	**53**	**14**	**54**	**74**	**206**	**44**	**6,576**
	%	**50.0**	**1.5**	**0.3**	**16.5**	**24.9**	**0.8**	**0.2**	**0.8**	**1.1**	**3.1**	**0.7**	

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

Table 3.5: Age distribution of all HIV and AIDS cases by ethnicity, 2010

	Age Group	Ethnicity								Total
		White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Total North West Residents	0-14	9	1	64			2	8		84
	15-19	13		23		1	1	1		39
	20-24	123	8	38	1	2		4	5	181
	25-29	334	19	130	3	6	7	9	11	519
	30-34	508	18	360	3	16	12	21	11	949
	35-39	630	12	407	4	9	27	23	13	1,125
	40-44	764	8	387	5	19	11	18	13	1,225
	45-49	707	8	215	5	5	6	8	5	959
	50-54	430	2	105	2	8	5	5	4	561
	55-59	250	3	48		5	2	3		311
	60+	263	1	28		4	3		2	301
	Total	**4,031**	**80**	**1,805**	**23**	**75**	**76**	**100**	**64**	**6,254**
	%	**64.5**	**1.3**	**28.9**	**0.4**	**1.2**	**1.2**	**1.6**	**1.0**	
All individuals treated in North West	0-14	12	1	69			2	10		94
	15-19	14		23		1	1	1		40
	20-24	129	9	38	1	2	1	4	5	189
	25-29	356	19	135	3	6	8	9	11	547
	30-34	542	18	366	3	17	14	22	12	994
	35-39	669	13	422	4	9	30	23	15	1,185
	40-44	800	8	394	5	19	11	19	16	1,272
	45-49	749	9	220	5	6	7	9	6	1,011
	50-54	452	2	107	2	8	5	6	6	588
	55-59	264	3	52		5	2	3	1	330
	60+	288	1	28		4	3		2	326
	Total	**4,275**	**83**	**1,854**	**23**	**77**	**84**	**106**	**74**	**6,576**
	%	**65.0**	**1.3**	**28.2**	**0.3**	**1.2**	**1.3**	**1.6**	**1.1**	

Age groups refer to the ages of individuals at the end of December 2010, or at death.

Table 3.6: All HIV and AIDS cases by stage of HIV disease, level of antiretroviral therapy and county of residence, 2010

	Stage of HIV Disease	Level of Antiretroviral Therapy					Total (100%)
		None	Mono	Dual	Triple	Quadruple or More	
Cumbria	Asymptomatic	17			35	10	62
	Symptomatic	1		1	23	8	33
	AIDS				19	15	34
	AIDS Related Death						
	Death Unrelated to AIDS						
	Unknown	2			4		6
	Cumbria Total	**20 (14.8%)**		**1 (0.7%)**	**81 (60.0%)**	**33 (24.4%)**	**135**
Lancashire	Asymptomatic	118			164	80	362
	Symptomatic	15			169	99	283
	AIDS	7			112	77	196
	AIDS Related Death	4			2		6
	Death Unrelated to AIDS	2					2
	Unknown	11			6	5	22
	Lancashire Total	**157 (18.0%)**			**453 (52.0%)**	**261 (30.0%)**	**871**
Greater Manchester	Asymptomatic	593		4	955	421	1973
	Symptomatic	55		2	552	343	952
	AIDS	35			462	351	848
	AIDS Related Death	2			6	5	13
	Death Unrelated to AIDS	2			3	4	9
	Unknown	95	1	1	60	28	185
	Greater Manchester Total	**782 (19.6%)**	**1 (0.03%)**	**7 (0.2%)**	**2,038 (51.2%)**	**1152 (28.9%)**	**3,980**
Merseyside	Asymptomatic	133	2	4	251	150	540
	Symptomatic	12		2	68	49	131
	AIDS	4		6	88	53	151
	AIDS Related Death	2			1	1	4
	Death Unrelated to AIDS				1	1	2
	Unknown	14		1	13	8	36
	Merseyside Total	**165 (19.1%)**	**2 (0.2%)**	**13 (1.5%)**	**422 (48.8%)**	**262 (30.3%)**	**864**
Cheshire	Asymptomatic	61		1	111	45	218
	Symptomatic	5			50	22	77
	AIDS	2			57	35	94
	AIDS Related Death	2					2
	Death Unrelated to AIDS						
	Unknown	8			4	1	13
	Cheshire Total	**78 (19.3%)**		**1 (0.2%)**	**222 (55.0%)**	**103 (25.5%)**	**404**
Total North West Residents	Asymptomatic	922	2	9	1516	706	3155
	Symptomatic	88		5	862	521	1476
	AIDS	48		6	738	531	1323
	AIDS Related Death	10			9	6	25
	Death Unrelated to AIDS	4			4	5	13
	Unknown	130	1	2	87	42	262
	Total North West Residents	**1,202 (19.2%)**	**3 (0.05%)**	**22 (0.4%)**	**3,216 (51.4%)**	**1811 (29.0%)**	**6,254**
	Isle of Man	3	1	0	15	10	29
	Out of Region	31	1	2	103	69	206
	Abroad	1	0	0	2	0	3
	Unknown*	44	2	0	24	14	84
	Total	**1,281 (19.5%)**	**7 (0.1%)**	**24 (0.4%)**	**3,360 (51.1%)**	**1,904 (29.0%)**	**6,576**

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

NB. Some individuals who are on unusually high or low ART combinations may be taking part in clinical trials.

Table 3.7: Ethnic distribution of all HIV and AIDS cases by sex, stage of HIV disease and exposure abroad, 2010

		Ethnicity								Total
		White	Black Caribbean	Black African	Black Other	Indian/ Pakistani/ Bangladeshi	Other Asian/ Oriental	Other/ Mixed	Unknown	
Sex	Male	3,865 (80.8%)	44 (0.9%)	648 (13.5%)	14 (0.3%)	58 (1.2%)	32 (0.7%)	72 (1.5%)	51 (1.1%)	4,784
	Female	410 (22.9%)	39 (2.2%)	1,206 (67.3%)	9 (0.5%)	19 (1.1%)	52 (2.9%)	34 (1.9%)	23 (1.3%)	1,792
Stage of HIV Disease	Asymptomatic	2,021 (61.0%)	61 (1.8%)	1,026 (31.0%)	12 (0.4%)	39 (1.2%)	43 (1.3%)	65 (2%)	47 (1.4%)	3,314
	Symptomatic	1,100 (71.3%)	8 (0.5%)	369 (23.9%)	4 (0.3%)	17 (1.1%)	18 (1.2%)	21 (1.4%)	6 (0.4%)	1,543
	AIDS	910 (65.2%)	10 (0.7%)	402 (28.8%)	7 (0.5%)	19 (1.4%)	23 (1.6%)	14 (1.0%)	10 (0.7%)	1,395
	AIDS Related Death	22 (81.5%)		5 (18.5%)						27
	Death Unrelated to AIDS	11 (84.6%)		2 (15.4%)						13
	Unknown	211 (74.3%)	4 (1.4%)	50 (17.6%)		2 (0.7%)		6 (2.1%)	11 (3.9%)	284
Exposure Abroad	UK	3,271 (94.6%)	36 (1.0%)	55 (1.6%)	6 (0.2%)	27 (0.8%)	15 (0.4%)	39 (1.1%)	10 (0.3%)	3,459
	Abroad	573 (24.4%)	33 (1.4%)	1,579 (67.2%)	12 (0.5%)	41 (1.7%)	59 (2.5%)	44 (1.9%)	7 (0.3%)	2,348
	Unknown	431 (56.0%)	14 (1.8%)	220 (28.6%)	5 (0.7%)	9 (1.2%)	10 (1.3%)	23 (3.0%)	57 (7.4%)	769
	Total	**4,275 (65.0%)**	**83 (1.3%)**	**1,854 (28.2%)**	**23 (0.3%)**	**77 (1.2%)**	**84 (1.3%)**	**106 (1.6%)**	**74 (1.1%)**	**6,576**

Table 3.8: Global region and country of HIV exposure by infection route of all HIV and AIDS cases, 2010

Region of HIV Exposure	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Abroad	290 (12.4%)	29 (1.2%)	1,900 (80.9%)	20 (0.9%)	74 (3.2%)	35 (1.5%)	2,348
Caribbean	*5*		*32*	*1*			*38*
East Asia & Pacific	*3*		*5*				*8*
Eastern Europe & Central Asia	*12*	*8*	*30*	*1*	*1*	*1*	*53*
Latin America	*7*		*6*				*13*
North Africa & Middle East	*8*	*2*	*19*		*2*		*31*
North America	*42*	*2*	*7*	*1*	*1*		*53*
Oceania	*13*		*3*				*16*
South & South-East Asia	*31*	*1*	*170*	*5*	*1*	*6*	*214*
Sub-Saharan Africa	*20*	*4*	*1542*	*9*	*67*	*20*	*1,662*
Western Europe	*107*	*12*	*45*	*3*	*1*	*3*	*171*
Multiple	*34*		*18*		*1*	*3*	*56*
Unknown	*8*		*23*			*2*	*33*
UK	2,690 (77.8%)	79 (2.3%)	542 (15.7%)	46 (1.3%)	41 (1.2%)	61 (1.8%)	3,459
Unknown	310 (40.3%)	11 (1.4%)	280 (36.4%)	1 (0.1%)	13 (1.7%)	154 (20.0%)	769
Total	**3,290 (50.0%)**	**119 (1.8%)**	**2,722 (41.4%)**	**67 (1.0%)**	**128 (1.9%)**	**250 (3.8%)**	**6,576**

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

Table 3.9: Distribution of treatment for all HIV and AIDS cases by infection route, 2010

Treatment Centre	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Hetero-sexual	Blood/ Tissue	Mother to Child	Undeter-mined	
AHC					28 (100%)		28
APH	44 (44.4%)		54 (54.5%)			1 (1.0%)	99
ARM	27 (90.0%)	1 (3.3%)	1 (3.3%)			1 (3.3%)	30
BLAG	320 (79.2%)	6 (1.5%)	72 (17.8%)	2 (0.5%)	2 (0.5%)	2 (0.5%)	404
BLK	2 (100%)						2
BLKG	31 (27.0%)	2 (1.7%)	76 (66.1%)	1 (0.9%)		5 (4.3%)	115
BOLG	110 (32.6%)	8 (2.4%)	218 (64.7%)	1 (0.3%)			337
BURG	20 (44.4%)	2 (4.4%)	21 (46.7%)			2 (4.4%)	45
BURY	28 (45.2%)		34 (54.8%)				62
CHR	87 (58.4%)	3 (2.0%)	58 (38.9%)		1 (0.7%)		149
CUMB	32 (54.2%)	1 (1.7%)	21 (35.6%)	1 (1.7%)	1 (1.7%)	3 (5.1%)	59
FGH	8 (34.8%)	1 (4.3%)	13 (56.5%)	1 (4.3%)			23
HAL	8 (72.7%)		3 (27.3%)				11
LCN	26 (40.6%)	2 (3.1%)	35 (54.7%)	1 (1.6%)			64
LEI	41 (64.1%)		21 (32.8%)	1 (1.6%)		1 (1.6%)	64
MAC	33 (66.0%)	1 (2.0%)	13 (26.0%)	1 (2%)		2 (4.0%)	50
MGP	200 (95.2%)	2 (1.0%)	5 (2.4%)			3 (1.4%)	210
MRIG	691 (52.6%)	11 (0.8%)	461 (35.1%)	19 (1.4%)		132 (10%)	1,314
MRIH			2 (6.9%)	27 (93.1%)			29
NMG	795 (47.7%)	63 (3.8%)	667 (40.0%)	8 (0.5%)	89 (5.3%)	46 (2.8%)	1,668
NMGG	132 (59.2%)		84 (37.7%)		1 (0.4%)	6 (2.7%)	223
NOBL	7 (43.8%)		9 (56.3%)				16
OLDG	36 (42.9%)		47 (56.0%)			1 (1.2%)	84
PG	91 (46.7%)	3 (1.5%)	90 (46.2%)	1 (0.5%)	3 (1.5%)	7 (3.6%)	195
RLG	283 (35.8%)	13 (1.6%)	461 (58.4%)	5 (0.6%)	5 (0.6%)	23 (2.9%)	790
RLH				10 (100%)			10
RLI	20 (46.5%)		20 (46.5%)	1 (2.3%)	1 (2.3%)	1 (2.3%)	43
ROCG	31 (37.8%)	1 (1.2%)	49 (59.8%)	1 (1.2%)			82
SALG	97 (53.6%)	1 (0.6%)	83 (45.9%)				181
SHH	32 (62.7%)		19 (37.3%)				51
SPG	27 (35.1%)	6 (7.8%)	41 (53.2%)			3 (3.9%)	77
STP	87 (58.8%)	1 (0.7%)	54 (36.5%)			6 (4.1%)	148
TAMG	31 (63.3%)		17 (34.7%)			1 (2%)	49
TRAG	6 (66.7%)	1 (11.1%)	2 (22.2%)				9
WAR	28 (52.8%)		21 (39.6%)			4 (7.5%)	53
WGH	15 (62.5%)		8 (33.3%)			1 (4.2%)	24
WHIT			1 (50.0%)			1 (50.0%)	2
WITG	245 (75.4%)	4 (1.2%)	71 (21.8%)	1 (0.3%)		4 (1.2%)	325
WORK	14 (66.7%)		5 (23.8%)	1 (4.8%)	1 (4.8%)		21
WYTH	3 (27.3%)		8 (72.7%)				11

For a definition of the abbreviated treatment centres please refer to the glossary at the back of the report.
Columns cannot be totalled vertically as some individuals may appear in more than one row (i.e. those attending two or more treatment locations), thus exaggerating the totals.
Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.

Table 3.10: Distribution of treatment for all HIV and AIDS cases by level of antiretroviral therapy, 2010

Treatment Centre	Level of Antiretroviral Therapy					Total (100%)
	None	Mono	Dual	Triple	Quadruple or More	
AHC	6 (21.4%)		1 (3.6%)	13 (46.4%)	8 (28.6%)	28
APH	27 (27.3%)		5 (5.1%)	41 (41.4%)	26 (26.3%)	99
ARM	30 (100%)					30
BLAG	85 (21.0%)			190 (47%)	129 (31.9%)	404
BLK				2 (100%)		2
BLKG	27 (23.5%)			53 (46.1%)	35 (30.4%)	115
BOLG	61 (18.1%)			220 (65.3%)	56 (16.6%)	337
BURG	9 (20%)			22 (48.9%)	14 (31.1%)	45
BURY	11 (17.7%)			37 (59.7%)	14 (22.6%)	62
CHR	16 (10.7%)		1 (0.7%)	94 (63.1%)	38 (25.5%)	149
CUMB	11 (18.6%)			40 (67.8%)	8 (13.6%)	59
FGH	4 (17.4%)			12 (52.2%)	7 (30.4%)	23
HAL	8 (72.7%)			2 (18.2%)	1 (9.1%)	11
LCN	64 (100%)					64
LEI	18 (28.1%)			27 (42.2%)	19 (29.7%)	64
MAC	11 (22.0%)			34 (68.0%)	5 (10.0%)	50
MGP	210 (100%)					210
MRIG	392 (29.8%)		3 (0.2%)	560 (42.6%)	359 (27.3%)	1,314
MRIH				14 (48.3%)	15 (51.7%)	29
NMG	178 (10.7%)	1 (0.1%)	5 (0.3%)	864 (51.8%)	620 (37.2%)	1,668
NMGG	63 (28.3%)			124 (55.6%)	36 (16.1%)	223
NOBL	2 (12.5%)			7 (43.8%)	7 (43.8%)	16
OLDG	19 (22.6%)			43 (51.2%)	22 (26.2%)	84
PG	28 (14.4%)			111 (56.9%)	56 (28.7%)	195
RLG	131 (16.6%)	6 (0.8%)	9 (1.1%)	396 (50.1%)	248 (31.4%)	790
RLH	1 (10.0%)			5 (50.0%)	4 (40.0%)	10
RLI	6 (14.0%)			29 (67.4%)	8 (18.6%)	43
ROCG	19 (23.2%)	1 (1.2%)		42 (51.2%)	20 (24.4%)	82
SALG	52 (28.7%)		1 (0.6%)	85 (47.0%)	43 (23.8%)	181
SHH	14 (27.5%)		1 (2.0%)	22 (43.1%)	14 (27.5%)	51
SPG	23 (29.9%)	1 (1.3%)		39 (50.6%)	14 (18.2%)	77
STP	25 (16.9%)			85 (57.4%)	38 (25.7%)	148
TAMG	25 (51.0%)			18 (36.7%)	6 (12.2%)	49
TRAG	8 (88.9%)				1 (11.1%)	9
WAR	17 (32.1%)		1 (1.9%)	30 (56.6%)	5 (9.4%)	53
WGH	3 (12.5%)			15 (62.5%)	6 (25.0%)	24
WHIT				1 (50.0%)	1 (50.0%)	2
WITG	67 (20.6%)		1 (0.3%)	198 (60.9%)	59 (18.2%)	325
WORK	3 (14.3%)			11 (52.4%)	7 (33.3%)	21
WYTH	1 (9.1%)			6 (54.5%)	4 (36.4%)	11

ARM, LCN, & MGP are support services and do not prescribe ART.
NB. Some individuals who are on unusually high or low ART combinations may be taking part in clinical trials.
Columns cannot be totalled vertically as some individuals may appear in more than one row (i.e., those attending two or more treatment locations), thus exaggerating the totals.

Table 3.11: Local authority of residence of all HIV and AIDS cases by number of treatment centres attended, 2010

	Local Authority of Residence	Treatment Centres Attended			Total (100%)
		One	Two	Three	
Cumbria	Carlisle	37 (97.4%)	1 (2.6%)		38
	Allerdale	19 (95.0%)	1 (5.0%)		20
	Eden	13 (100%)			13
	Copeland	14 (100%)			14
	South Lakeland	26 (92.9%)	2 (7.1%)		28
	Barrow-in-Furness	19 (90.5%)	2 (9.5%)		21
	Unknown Cumbria	1 (100%)			1
	Cumbria Total	**129 (95.6%)**	**6 (4.4%)**		**135**
Lancashire	Lancaster	45 (100%)			45
	Wyre	45 (95.7%)	2 (4.3%)		47
	Fylde	47 (97.9%)	1 (2.1%)		48
	Blackpool	302 (96.8%)	10 (3.2%)		312
	Blackburn with Darwen	89 (90.8%)	9 (9.2%)		98
	Ribble Valley	16 (94.1%)	1 (5.9%)		17
	Pendle	22 (91.7%)	2 (8.3%)		24
	Hyndburn	23 (88.5%)	3 (11.5%)		26
	Burnley	22 (88.0%)	3 (12.0%)		25
	Rossendale	33 (97.1%)	1 (2.9%)		34
	Preston	102 (99.0%)	1 (1.0%)		103
	South Ribble	32 (100%)			32
	Chorley	28 (96.6%)	1 (3.4%)		29
	West Lancashire	25 (100%)			25
	Unknown Lancashire	6 (100%)			6
	Lancashire Total	**837 (96.1%)**	**34 (3.9%)**		**871**
Greater Manchester	Wigan	165 (98.2%)	3 (1.8%)		168
	Bolton	254 (96.2%)	10 (3.8%)		264
	Bury	172 (93.5%)	11 (6.0%)	1 (0.5%)	184
	Rochdale	152 (91.0%)	15 (9.0%)		167
	Oldham	132 (93.6%)	9 (6.4%)		141
	Salford	530 (87.9%)	70 (11.6%)	3 (0.5%)	603
	Manchester	1672 (87.8%)	222 (11.7%)	11 (0.6%)	1905
	Tameside	151 (96.2%)	6 (3.8%)		157
	Trafford	194 (93.7%)	13 (6.3%)		207
	Stockport	153 (91.6%)	14 (8.4%)		167
	Unknown Greater Manchester	16 (94.1%)	1 (5.9%)		17
	Greater Manchester Total	**3,591 (90.2%)**	**374 (9.4%)**	**15 (0.4%)**	**3,980**
Merseyside	Sefton	88 (92.6%)	7 (7.4%)		95
	Liverpool	410 (86.3%)	58 (12.2%)	7 (1.5%)	475
	Knowsley	31 (86.1%)	4 (11.1%)	1 (2.8%)	36
	Wirral	149 (95.5%)	7 (4.5%)		156
	St Helens	44 (83.0%)	8 (15.1%)	1 (1.9%)	53
	Unknown Merseyside	48 (98.0%)	1 (2.0%)		49
	Merseyside Total	**770 (89.1%)**	**85 (9.8%)**	**9 (1.0%)**	**864**
Cheshire	Halton	32 (94.1%)	2 (5.9%)		34
	Warrington	78 (96.3%)	3 (3.7%)		81
	Cheshire West and Chester	152 (96.8%)	5 (3.2%)		157
	Cheshire East	124 (93.9%)	8 (6.1%)		132
	Cheshire Total	**386 (95.5%)**	**18 (4.5%)**		**404**
	Total North West Residents	**5,713 (91.3%)**	**517 (8.3%)**	**24 (0.4%)**	**6,254**
	Isle of Man	25 (86.2%)	4 (13.8%)		29
	Out of Region	198 (96.1%)	8 (3.9%)		206
	Abroad	3 (100%)			3
	Unknown*	81 (96.4%)	3 (3.6%)		84
	Total	**6,020 (91.5%)**	**532 (8.1%)**	**24 (0.4%)**	**6,576**

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

Table 3.12: Distribution of total and mean number of outpatient visits, day cases, inpatient episodes, inpatient days and home visits by treatment centre and stage of HIV disease, 2010

		Outpatient Visits		Day Cases		Inpatient Episodes		Inpatient Days		Home Visits	
		Total	Mean	Total	Mean	Total	Mean	Total	Mean	Total	Mean
Treatment Centre	AHC	159	5.68							515	18.39
	APH	456	4.61	4	0.04	12	0.12	103	1.04	12	0.12
	ARM	562	18.73								
	BLAG	2,368	5.86	9	0.02	37	0.09	346	0.86	19	0.05
	BLK	7	3.50								
	BLKG	525	4.57	14	0.12	26	0.23	251	2.18	6	0.05
	BOLG	2,170	6.44	3	0.01	14	0.04	340	1.01		
	BURG	396	8.80	1	0.02	5	0.11	8	0.18	7	0.16
	BURY	222	3.58			3	0.05	7	0.11		
	CHR	668	4.48	1	0.01	16	0.11	130	0.92	8	0.06
	CUMB	297	5.03	1	0.02	8	0.14	60	1.02	1	0.02
	FGH	78	3.39			2	0.09	35	1.52	1	0.04
	HAL	41	3.73								
	LCN	382	5.97							916	14.31
	LEI	500	7.81	1	0.02	9	0.14	34	0.53		
	MAC	346	6.92								
	MGP	1,035	4.93								
	MRIG	8,786	6.69			47	0.04	627	0.48		
	MRIH	118	4.07	5	0.17	1	0.03	2	0.07		
	NMG	8,514	5.10	645	0.39	261	0.16	3957	2.37	139	0.08
	NMGG	602	2.70								
	NOBL	163	10.19								
	OLDG	543	6.46			1	0.01	10	0.12	1	0.01
	PG	928	4.76			13	0.07	255	1.31	6	0.03
	RLG	4,647	5.88			89	0.11	633	0.80		
	RLH	53	5.30			1	0.10	3	0.30		
	RLI	169	3.93			1	0.02	10	0.23		
	ROCG	326	3.98								
	SALG	1,190	6.57	1	0.01	8	0.04	41	0.23		
	SHH	351	6.88			5	0.10	25	0.49		
	SPG	525	6.82								
	STP	678	4.58								
	TAMG	318	6.49							5	0.10
	TRAG	30	3.33			4	0.44	115	12.78		
	WAR	226	4.26							5	0.09
	WGH	84	3.50								
	WHIT	6	3.00								
	WITG	2,243	6.90								
	WORK	114	5.43			5	0.24	27	1.29	7	0.33
	WYTH	36	3.27	1	0.09	10	0.91	367	33.36		
Stage of HIV Disease	Asymptomatic	20,522	6.19	35	0.01	158	0.05	1,285	0.39	722	0.22
	Symptomatic	9,371	6.07	352	0.23	115	0.07	1,139	0.74	340	0.22
	AIDS	9,159	6.57	282	0.20	243	0.17	3,894	2.79	456	0.33
	AIDS Related Death	85	3.15	16	0.59	34	1.26	602	22.30	13	0.48
	Death Unrelated to AIDS	108	8.31	1	0.08	17	1.31	131	10.08	1	0.08
	Unknown	1,617	5.69			11	0.04	335	1.19	116	0.41
	Total	**40,862**	**6.21**	**686**	**0.10**	**578**	**0.09**	**7,386**	**1.12**	**1,648**	**0.25**

Table 3.13: Residency status of all cases of HIV and AIDS by sex, age group, infection route, ethnicity, stage of HIV disease and area of residence, 2010

		Residency Status							Total
		UK National	Asylum Seeker	Overseas Student	Temporary Visitor	Refugee	Other***	Unknown	
Sex	Male	4,046 (84.2%)	220 (32.9%)	48 (39.7%)	23 (50.0%)	64 (31.7%)	75 (38.3%)	308 (57.2%)	4,784 (72.7%)
	Female	758 (15.8%)	449 (67.1%)	73 (60.3%)	23 (50.0%)	138 (68.3%)	121 (61.7%)	230 (42.8%)	1,792 (27.3%)
Age Group	0-14	38 (0.8%)	11 (1.6%)			2 (1.0%)	13 (6.6%)	30 (5.6%)	94 (1.4%)
	15-19	24 (0.5%)	7 (1.0%)			1 (0.5%)	7 (3.6%)	1 (0.2%)	40 (0.6%)
	20-24	142 (3.0%)	13 (1.9%)	7 (5.8%)		8 (4.0%)	3 (1.5%)	16 (3.0%)	189 (2.9%)
	25-29	387 (8.1%)	53 (7.9%)	13 (10.7%)	6 (13.0%)	17 (8.4%)	19 (9.7%)	52 (9.7%)	547 (8.3%)
	30-34	644 (13.4%)	147 (22%)	28 (23.1%)	6 (13.0%)	35 (17.3%)	39 (19.9%)	95 (17.7%)	994 (15.1%)
	35-39	787 (16.4%)	168 (25.1%)	25 (20.7%)	8 (17.4%)	41 (20.3%)	36 (18.4%)	120 (22.3%)	1,185 (18.0%)
	40-44	895 (18.6%)	144 (21.5%)	22 (18.2%)	11 (23.9%)	40 (19.8%)	41 (20.9%)	119 (22.1%)	1,272 (19.3%)
	45-49	820 (17.1%)	65 (9.7%)	21 (17.4%)	6 (13.0%)	27 (13.4%)	25 (12.8%)	47 (8.7%)	1,011 (15.4%)
	50-54	490 (10.2%)	35 (5.2%)	4 (3.3%)	1 (2.2%)	21 (10.4%)	8 (4.1%)	29 (5.4%)	588 (8.9%)
	55-59	285 (5.9%)	19 (2.8%)	1 (0.8%)	7 (15.2%)	5 (2.5%)	3 (1.5%)	10 (1.9%)	330 (5.0%)
	60+	292 (6.1%)	7 (1%)		1 (2.2%)	5 (2.5%)	2 (1.0%)	19 (3.5%)	326 (5.0%)
Infection Route	MSM	3,135 (65.3%)	11 (1.6%)	2 (1.7%)	7 (15.2%)	1 (0.5%)	25 (12.8%)	109 (20.3%)	3290 (50%)
	Injecting Drug Use	105 (2.2%)	1 (0.1%)				2 (1.0%)	11 (2.0%)	119 (1.8%)
	Heterosexual	1,280 (26.6%)	633 (94.6%)	115 (95%)	38 (82.6%)	195 (96.5%)	143 (73.0%)	318 (59.1%)	2,722 (41.4%)
	Blood/Tissue	61 (1.3%)	2 (0.3%)				3 (1.5%)	1 (0.2%)	67 (1.0%)
	Mother to Child	56 (1.2%)	18 (2.7%)			4 (2.0%)	20 (10.2%)	30 (5.6%)	128 (1.9%)
	Undetermined	167 (3.5%)	4 (0.6%)	4 (3.3%)	1 (2.2%)	2 (1.0%)	3 (1.5%)	69 (12.8%)	250 (3.8%)
Ethnicity	White	4,065 (84.6%)	8 (1.2%)	6 (5%)	8 (17.4%)	3 (1.5%)	37 (18.9%)	148 (27.5%)	4,275 (65%)
	Black Caribbean	66 (1.4%)	2 (0.3%)	3 (2.5%)	2 (4.3%)	1 (0.5%)	3 (1.5%)	6 (1.1%)	83 (1.3%)
	Black African	429 (8.9%)	641 (95.8%)	109 (90.1%)	30 (65.2%)	194 (96.0%)	143 (73%)	308 (57.2%)	1,854 (28.2%)
	Black Other	16 (0.3%)	2 (0.3%)			1 (0.5%)	2 (1.0%)	2 (0.4%)	23 (0.3%)
	Indian/Pakistani/ Bangladeshi	62 (1.3%)	3 (0.4%)	1 (0.8%)	1 (2.2%)		5 (2.6%)	5 (0.9%)	77 (1.2%)
	Other Asian/Oriental	62 (1.3%)	7 (1.0%)		4 (8.7%)	1 (0.5%)	2 (1.0%)	8 (1.5%)	84 (1.3%)
	Other/Mixed	82 (1.7%)	6 (0.9%)	1 (0.8%)	1 (2.2%)	1 (0.5%)	4 (2.0%)	11 (2%)	106 (1.6%)
	Unknown	22 (0.5%)		1 (0.8%)		1 (0.5%)		50 (9.3%)	74 (1.1%)
Stage of HIV Disease	Asymptomatic	2,324 (48.4%)	397 (59.3%)	69 (57%)	20 (43.5%)	105 (52%)	101 (51.5%)	298 (55.4%)	3,314 (50.4%)
	Symptomatic	1,227 (25.5%)	112 (16.7%)	23 (19%)	12 (26.1%)	39 (19.3%)	39 (19.9%)	91 (16.9%)	1,543 (23.5%)
	AIDS	993 (20.7%)	144 (21.5%)	27 (22.3%)	13 (28.3%)	43 (21.3%)	48 (24.5%)	127 (23.6%)	1,395 (21.2%)
	AIDS Related Death	19 (0.4%)	1 (0.1%)	1 (0.8%)			1 (0.5%)	5 (0.9%)	27 (0.4%)
	Death Unrelated to AIDS	11 (0.2%)	1 (0.1%)					1 (0.2%)	13 (0.2%)
	Unknown	230 (4.8%)	14 (2.1%)	1 (0.8%)	1 (2.2%)	15 (7.4%)	7 (3.6%)	16 (3.0%)	284 (4.3%)
Area of Residence	Cumbria	126 (2.6%)			5 (10.9%)		3 (1.5%)	1 (0.2%)	135 (2.1%)
	Lancashire	782 (16.3%)	26 (3.9%)	4 (3.3%)	2 (4.3%)	13 (6.4%)	16 (8.2%)	28 (5.2%)	871 (13.2%)
	Greater Manchester	2,677 (55.7%)	395 (59.0%)	107 (88.4%)	30 (65.2%)	184 (91.1%)	159 (81.1%)	428 (79.6%)	3,980 (60.5%)
	Merseyside	588 (12.2%)	221 (33%)	6 (5%)	3 (6.5%)	3 (1.5%)	7 (3.6%)	36 (6.7%)	864 (13.1%)
	Cheshire	372 (7.7%)	13 (1.9%)	2 (1.7%)		1 (0.5%)	5 (2.6%)	11 (2.0%)	404 (6.1%)
	Out of Region*	196 (4.1%)	10 (1.5%)	1 (0.8%)	5 (10.9%)	1 (0.5%)	4 (2.0%)	18 (3.3%)	235 (3.6%)
	Abroad	2 (0.04%)					1 (0.5%)		3 (0.04%)
	Unknown**	61 (1.3%)	4 (0.6%)	1 (0.8%)	1 (2.2%)		1 (0.5%)	16 (3.0%)	84 (1.3%)
	Total (100%)	**4,804**	**669**	**121**	**46**	**202**	**196**	**538**	**6,576**

Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the ages of individuals at the end of December 2010, or at death.
** Includes Isle of Man.*
*** Includes six people of no fixed abode and two people who declined to give any residential information..*
****Includes residency status defined as 'Migrant worker', 'Dependant' and 'Other'.*

Table 3.14: Primary care trust of residence of all HIV and AIDS cases by infection route, 2010

PCT of Residence	Infection Route						Total (100%)
	MSM	Injecting Drug Use	Heterosexual	Blood/ Tissue	Mother to Child	Undeter-mined	
Cumbria	71 (52.6%)	2 (1.5%)	51 (37.8%)	3 (2.2%)	3 (2.2%)	5 (3.7%)	135
North Lancashire	87 (62.1%)	1 (0.7%)	47 (33.6%)	1 (0.7%)	2 (1.4%)	2 (1.4%)	140
Blackpool	251 (80.4%)	3 (1%)	51 (16.3%)	4 (1.3%)	1 (0.3%)	2 (0.6%)	312
Blackburn with Darwen	28 (28.6%)	2 (2%)	62 (63.3%)	3 (3.1%)		3 (3.1%)	98
East Lancashire	63 (50%)	3 (2.4%)	51 (40.5%)	2 (1.6%)	2 (1.6%)	5 (4%)	126
Central Lancashire	94 (49.7%)	3 (1.6%)	81 (42.9%)	2 (1.1%)	4 (2.1%)	5 (2.6%)	189
Unknown Lancashire	2 (33.3%)		4 (66.7%)				6
Ashton, Leigh & Wigan	66 (39.3%)	1 (0.6%)	90 (53.6%)	3 (1.8%)	3 (1.8%)	5 (3%)	168
Bolton	82 (31.1%)	8 (3%)	156 (59.1%)	4 (1.5%)	12 (4.5%)	2 (0.8%)	264
Bury	104 (56.5%)	2 (1.1%)	68 (37%)		3 (1.6%)	7 (3.8%)	184
Heywood, Middleton & Rochdale	58 (34.7%)	8 (4.8%)	86 (51.5%)	3 (1.8%)	6 (3.6%)	6 (3.6%)	167
Oldham	49 (34.8%)	3 (2.1%)	84 (59.6%)	3 (2.1%)	1 (0.7%)	1 (0.7%)	141
Salford	391 (64.8%)	10 (1.7%)	169 (28%)	1 (0.2%)	4 (0.7%)	28 (4.6%)	603
Manchester	948 (49.8%)	38 (2%)	786 (41.3%)	5 (0.3%)	40 (2.1%)	88 (4.6%)	1,905
Tameside & Glossop	83 (49.7%)	3 (1.8%)	72 (43.1%)		4 (2.4%)	5 (3.0%)	167
Trafford	106 (51.2%)	5 (2.4%)	79 (38.2%)	4 (1.9%)	3 (1.4%)	10 (4.8%)	207
Stockport	101 (60.5%)	2 (1.2%)	46 (27.5%)	2 (1.2%)	6 (3.6%)	10 (6%)	167
Unknown Greater Manchester	11 (64.7%)		5 (29.4%)			1 (5.9%)	17
Sefton	36 (37.9%)	6 (6.3%)	45 (47.4%)	3 (3.2%)	1 (1.1%)	4 (4.2%)	95
Liverpool	153 (32.2%)	5 (1.1%)	297 (62.5%)	3 (0.6%)	11 (2.3%)	6 (1.3%)	475
Knowsley	20 (55.6%)	1 (2.8%)	11 (30.6%)			4 (11.1%)	36
Wirral	67 (42.9%)	1 (0.6%)	81 (51.9%)	2 (1.3%)	3 (1.9%)	2 (1.3%)	156
Halton & St Helens	52 (59.8%)		31 (35.6%)	1 (1.1%)	1 (1.1%)	2 (2.3%)	87
Unknown Merseyside	11 (22.4%)		37 (75.5%)			1 (2%)	49
Warrington	37 (45.7%)	1 (1.2%)	35 (43.2%)	1 (1.2%)	2 (2.5%)	5 (6.2%)	81
Western Cheshire	70 (54.7%)	3 (2.3%)	47 (36.7%)	2 (1.6%)	6 (4.7%)		128
Central and Eastern Cheshire	99 (61.5%)	2 (1.2%)	51 (31.7%)	5 (3.1%)		4 (2.5%)	161
Out of Region	106 (54.1%)	2 (1%)	62 (31.6%)	6 (3.1%)	10 (5.1%)	10 (5.1%)	196
Isle of Man	11 (37.9%)	1 (3.4%)	15 (51.7%)	2 (6.9%)			29
Abroad	2 (66.7%)		1 (33.3%)				3
Unknown*	31 (36.9%)	3 (3.6%)	21 (25%)	2 (2.4%)		27 (32.1%)	84
Total	**3,290 (50%)**	**119 (1.8%)**	**2,722 (41.4%)**	**67 (1%)**	**128 (1.9%)**	**250 (3.8%)**	**6,576**

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

Table 3.15: Primary care trust of residence of all HIV and AIDS cases by stage of disease, 2010

PCT of Residence	Infection Route						Total (100%)
	Asymptomatic	Symptomatic	AIDS	AIDS Related Death	Death Unrelated to AIDS	Unknown	
Cumbria	62 (45.9%)	33 (24.4%)	34 (25.2%)			6 (4.4%)	135
North Lancashire	63 (45%)	40 (28.6%)	36 (25.7%)			1 (0.7%)	140
Blackpool	117 (37.5%)	111 (35.6%)	71 (22.8%)	3 (1%)		10 (3.2%)	312
Blackburn with Darwen	53 (54.1%)	24 (24.5%)	18 (18.4%)		1 (1%)	2 (2%)	98
East Lancashire	45 (35.7%)	42 (33.3%)	29 (23%)	2 (1.6%)	1 (0.8%)	7 (5.6%)	126
Central Lancashire	82 (43.4%)	64 (33.9%)	41 (21.7%)	1 (0.5%)		1 (0.5%)	189
Unknown Lancashire	2 (33.3%)	2 (33.3%)	1 (16.7%)			1 (16.7%)	6
Ashton, Leigh & Wigan	108 (64.3%)	32 (19%)	28 (16.7%)				168
Bolton	181 (68.6%)	27 (10.2%)	52 (19.7%)	2 (0.8%)	2 (0.8%)		264
Bury	84 (45.7%)	63 (34.2%)	35 (19%)		2 (1.1%)		184
Heywood, Middleton & Rochdale	65 (38.9%)	23 (13.8%)	36 (21.6%)	3 (1.8%)		40 (24%)	167
Oldham	69 (48.9%)	35 (24.8%)	31 (22%)			6 (4.3%)	141
Salford	312 (51.7%)	153 (25.4%)	117 (19.4%)		2 (0.3%)	19 (3.2%)	603
Manchester	934 (49%)	466 (24.5%)	425 (22.3%)	7 (0.4%)	1 (0.1%)	72 (3.8%)	1,905
Tameside & Glossop	56 (33.5%)	40 (24.0%)	38 (22.8%)			33 (19.8%)	167
Trafford	86 (41.5%)	59 (28.5%)	54 (26.1%)	1 (0.5%)		7 (3.4%)	207
Stockport	70 (41.9%)	56 (33.5%)	31 (18.6%)		1 (0.6%)	9 (5.4%)	167
Unknown Greater Manchester	10 (58.8%)	3 (17.6%)	3 (17.6%)		1 (5.9%)		17
Sefton	63 (66.3%)	17 (17.9%)	12 (12.6%)	2 (2.1%)		1 (1.1%)	95
Liverpool	345 (72.6%)	52 (10.9%)	64 (13.5%)	1 (0.2%)	1 (0.2%)	12 (2.5%)	475
Knowsley	21 (58.3%)	5 (13.9%)	6 (16.7%)			4 (11.1%)	36
Wirral	57 (36.5%)	45 (28.8%)	51 (32.7%)	1 (0.6%)	1 (0.6%)	1 (0.6%)	156
Halton & St Helens	39 (44.8%)	13 (14.9%)	15 (17.2%)			20 (23%)	87
Unknown Merseyside	37 (75.5%)	3 (6.1%)	9 (18.4%)				49
Warrington	58 (71.6%)	8 (9.9%)	13 (16%)			2 (2.5%)	81
Western Cheshire	83 (64.8%)	20 (15.6%)	21 (16.4%)	1 (0.8%)		3 (2.3%)	128
Central and Eastern Cheshire	55 (34.2%)	45 (28%)	54 (33.5%)	1 (0.6%)		6 (3.7%)	161
Out of Region	88 (44.9%)	46 (23.5%)	54 (27.6%)	1 (0.5%)		7 (3.6%)	196
Isle of Man	12 (41.4%)	9 (31%)	8 (27.6%)				29
Abroad	2 (66.7%)		1 (33.3%)				3
Unknown*	55 (65.5%)	7 (8.3%)	7 (8.3%)	1 (1.2%)		14 (16.7%)	84
Total	**3,314 (50.4%)**	**1,543 (23.5%)**	**1,395 (21.2%)**	**27 (0.4%)**	**13 (0.2%)**	**284 (4.3%)**	**6,576**

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

4. Community Sector 2010

Community sector organisations have long played a fundamental role in the recognition of HIV/AIDS and in addressing the needs of HIV positive individuals[96,97]. They are identified in the Department of Health's AIDS Service Grant circular as key providers of social care[98]. In north west England, community sector organisations continue to provide a wide range of services including counselling, information, training, awareness-raising campaigns, complementary therapies, advocacy, free condoms, financial assistance, fundraising, support groups and help lines. Some also offer medical services such as nurse-led sessions run by local PCT staff. The majority of organisations 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 organisations also provide care and support to the friends and families of those affected by HIV. Recent research has shown that those not known to the statutory sector were significantly more likely to reside in an area of high deprivation than those accessing both community sector and statutory services and those accessing the statutory services alone[99,100]. These data show that the community sector provide services to some of the most vulnerable HIV positive people. Research carried out in 2001 into the economics of HIV in north west England established that seven community sector organisations annually contribute one million pounds worth of services over and above those purchased by the statutory sector[101]. During 2010, 3,460 HIV positive individuals were reported to the North West HIV/AIDS Monitoring Unit by ten community sector organisations. The overall number of individuals seen by the ten organisations in 2010 was 10% higher than in 2009 (3,460 compared with 3,108).

It is important to note that not all HIV/AIDS community sector organisations are able to provide attributable data (soundex, date of birth and sex) for the report. Organisations such as South Lancashire HEAL/Lancashire AIDS Line are not included in the tables provided in this report, but nonetheless make a valuable contribution to the provision of care. Similarly, the amount of attributable data provided by each community sector organisation do not necessarily reflect the overall service provision since organisations provide support for all those affected by HIV (including families, partners and carers of HIV positive people). For all community sector organisations, where information relating to infection route and ethnicity was not available, data have been updated from that provided from the statutory care providers. Matching between databases relies on the same attributable data being provided by the community and statutory sector, underlining the need for accuracy in recording of soundex codes, dates of birth and sex. Tables 4.1 and 4.2 illustrate key characteristics of all individuals accessing care from individual community sector organisations, and will include duplicate information on some individuals as some attend more than one organisation. Table 4.3 is concerned with those HIV positive individuals accessing community sector care as a whole and contains only unique individuals. Where appropriate, references are made to corresponding data from previous reports[1-14].

Community sector organisations 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[1-14,99]. In 2010, 28% of individuals seen by community sector organisations did not access care in the statutory sector and 17% of individuals have never been treated by the statutory sector in north west England (table 4.3).

Table 4.1 illustrates demographic information on the number of HIV positive individuals presenting to 10 community sector organisations during 2010, and the number who also presented at statutory agencies in the north west of England during 2010 or prior to 2010. Over half of organisations recorded a decline in their client numbers compared with the previous year: Banardo's in Manchester (BARM, 30%); CLASS (24%); SHIVER (21%) George House Trust (GHT 17%); Body Positive Blackpool (BP Blackpool, 8%). Sahir House (Sahir, 9%), Body Positive Cheshire and North Wales (BP Cheshire N Wales, 4%), the Black Health Agency (BHA, 4%) and Body Positive North West (BP North West, 1%) saw a slight increase in client numbers compared with the previous year.

There is variation in the proportion of community sector clients also seen by the statutory sector in 2010, ranging from 91% at SHIVER in Blackpool to 50% at BARM. The vast majority of clients not in contact with statutory treatment centres in 2010 reside in the north west of England. A significant number of individuals have never been seen at statutory centres, for example, 255 individuals at GHT have never been seen by the statutory sector. These data suggest that the community sector may be the sole provider of care and support for a substantial number of HIV positive individuals.

Table 4.1 also categorises individuals accessing community sector organisations in 2010 according to infection route, sex, age group, ethnicity and residency. For over half of the community sector organisations that provided data for 2010, the largest proportion of individuals presenting for support acquired HIV through sex between men (BP North West, 79%; BP Blackpool, 73%; SHIVER, 73%; Signposts, 57%; BP Cheshire and North Wales, 55%; GHT, 52%.) The main route of infection for those seen at the other organisations was heterosexual sex (BHA 92%, BARM 56%, and CLASS 53%) with a high proportion of female service users in two of these organisations (BHA, 74% and BARM, 82%). BARM provides support for families with young people affected by HIV. In some cases the HIV positive client is a parent, in other cases the young person. Four out of the ten community sector organisations reporting in 2010 (BARM, BP North West, BP Cheshire and North Wales and GHT) had clients infected via injecting drug use.

The majority of clients at all community sector organisations were aged between 25 and 49 years. BARM treated the most clients aged 14 years or under (24 individuals, 19% of all those seen at BARM), as would be expected for an organisation specialising in the needs of young people.

The differing profiles and characteristics of HIV positive clients accessing community sector organisations in part reflects the different range of services provided and the varying strategies used to encourage HIV positive people to use the services.

For most community sector organisations, the majority of individuals seen in 2010 were of white ethnicity, ranging from 89% at BP Blackpool to 54% at Sahir. BHA, a specialist service for black and minority ethnic communities, provided care for a high proportion of HIV positive black Africans (95%), as did BARM (89%). GHT provided care for the largest number of HIV positive black Africans (643 individuals) a decrease of 5% since 2009 (678 individuals).

For all the community sector organisations, the majority of clients seen in 2010 were resident in the north west of England, ranging from 100% at Signposts and SHIVER to 71% at BP Cheshire and North Wales. BP Cheshire and North Wales was the only community sector organisation with a significant proportion of HIV positive clients from outside the north west of England (30%), reflecting the proximity of the organisation to Wales and the West Midlands and the specific services it provides in North Wales.

Table 4.2 illustrates the crossover of care of HIV positive individuals between the community sector organisations and the statutory organisations during 2010. The distribution of statutory treatment and care of community sector clients in part reflects the geographical location of the community sector organisations. 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 community sector organisations. For example, 20% of clients seen by BP North West also attended NMG, as did 24% of GHT clients.

Table 4.3 illustrates the infection route, sex, ethnicity and residency status of HIV positive individuals accessing the community sector in 2010 by attendance at the statutory sector during the year. Unlike table 4.1 and 4.2, this table only contains one record for each individual and represents information on unique individuals rather than all those attending all organisations. Due to the relatively high proportion of individuals for whom infection route is unknown the percentages in the table are calculated of those for whom the information is known. The predominant route of exposure to HIV amongst community sector clients during 2010 was sex between men, accounting for 59% of cases. This is higher than the 50% of individuals accessing the statutory sector for whom route of exposure has been determined (chapter 3, table 3.2). Thirty six percent of clients seen in the community sector were heterosexually exposed compared to 43% in the statutory sector (chapter 3, table 3.2). This has increased since 2001 when only 19% of community sector clients were heterosexually exposed. In 2010, the majority of community sector clients were male (66%), primarily due to the relatively high rates of HIV infection in MSM. As with HIV positive individuals accessing the statutory sector (65%), the majority of community sector clients are of white ethnicity (60%) but this varies between services (table 4.1).

Table 4.3 also shows that 28% of individuals (965 out of 3,460) using community sector organisations did not attend a statutory sector service during 2010 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: they are less likely to be MSM (46% compared to 62% accessing both the community and statutory sector in 2010 or prior to this) and more likely to be heterosexually infected (47% compared to 34%). They are more likely to be black African (49% compared to 32%) and more likely to be an asylum seeker (15% compared to 8%). Those who have attended the statutory sector in the past but not in 2010 are more likely to be male (75%), MSM (69%), white (66%) and a UK national (68%).

Table 4.1: Attendance by HIV positive individuals at community sector organisation in north west England, by statutory sector attendance, sex, age group, infection route, ethnicity and residency status, 2010

		Community Sector Organisation									
		BARM	**BHA**	**BP Blackpool**	**BP Cheshire N. Wales**	**BP North West**	**CLASS**	**GHT**	**Sahir**	**SHIVER**	**Signposts**
Statutory Sector Attendance	Never seen	63 (49.2%)	37 (43%)	39 (54.9%)	46 (21.2%)	141 (13.5%)	4 (21.1%)	255 (15.2%)	35 (15.9%)	1 (9.1%)	1 (14.3%)
	Seen in 2010	64 (50%)	45 (52.3%)	24 (33.8%)	157 (72.4%)	747 (71.7%)	14 (73.7%)	1277 (76%)	172 (78.2%)	10 (90.9%)	4 (57.1%)
	Seen prior to 2010	1 (0.8%)	4 (4.7%)	8 (11.3%)	14 (6.5%)	154 (14.8%)	1 (5.3%)	149 (8.9%)	13 (5.9%)		2 (28.6%)
Sex	Male	23 (18%)	22 (25.6%)	59 (83.1%)	173 (79.7%)	834 (80%)	16 (84.2%)	1163 (69.2%)	127 (57.7%)	10 (90.9%)	5 (71.4%)
	Female	105 (82%)	64 (74.4%)	12 (16.9%)	44 (20.3%)	208 (20%)	3 (15.8%)	518 (30.8%)	93 (42.3%)	1 (9.1%)	2 (28.6%)
Age Group	0-14	24 (18.8%)		5 (7%)		2 (0.2%)		17 (1.0%)	1 (0.5%)		
	15-19	17 (13.3%)	1 (1.2%)			2 (0.2%)		16 (1.0%)	4 (1.8%)		
	20-24	3 (2.3%)		1 (1.4%)	9 (4.1%)	13 (1.2%)	1 (5.3%)	36 (2.1%)	7 (3.2%)		
	25-29	10 (7.8%)	6 (7%)	5 (7%)	22 (10.1%)	50 (4.8%)	1 (5.3%)	136 (8.1%)	15 (6.8%)	2 (18.2%)	
	30-34	27 (21.1%)	11 (12.8%)	15 (21.1%)	29 (13.4%)	119 (11.4%)	2 (10.5%)	280 (16.7%)	42 (19.1%)		
	35-39	18 (14.1%)	20 (23.3%)	11 (15.5%)	29 (13.4%)	199 (19.1%)	3 (15.8%)	337 (20%)	43 (19.5%)		4 (57.1%)
	40-44	19 (14.8%)	17 (19.8%)	16 (22.5%)	37 (17.1%)	209 (20.1%)	6 (31.6%)	345 (20.5%)	36 (16.4%)	2 (18.2%)	
	45-49	6 (4.7%)	16 (18.6%)	11 (15.5%)	36 (16.6%)	211 (20.2%)	2 (10.5%)	251 (14.9%)	37 (16.8%)	4 (36.4%)	2 (28.6%)
	50-54	2 (1.6%)	6 (7%)	5 (7%)	22 (10.1%)	114 (10.9%)	3 (15.8%)	140 (8.3%)	21 (9.5%)	2 (18.2%)	
	55-59	2 (1.6%)	4 (4.7%)		16 (7.4%)	79 (7.6%)	1 (5.3%)	75 (4.5%)	10 (4.5%)	1 (9.1%)	1 (14.3%)
	60+		5 (5.8%)	2 (2.8%)	17 (7.8%)	44 (4.2%)		48 (2.9%)	4 (1.8%)		
Infection Route	MSM	2 (1.6%)		52 (73.2%)	119 (54.8%)	821 (78.8%)	8 (42.1%)	868 (51.6%)		8 (72.7%)	4 (57.1%)
	Injecting Drug Use	1 (0.8%)			5 (2.3%)	19 (1.8%)		15 (0.9%)			
	Heterosexual	71 (55.5%)	79 (91.9%)	10 (14.1%)	69 (31.8%)	163 (15.6%)	10 (52.6%)	756 (45%)			1 (14.3%)
	Blood/Tissue	1 (0.8%)	1 (1.2%)		1 (0.5%)	26 (2.5%)				3 (27.3%)	
	Mother to Child	40 (31.3%)			1 (0.5%)	10 (1.0%)	1 (5.3%)	23 (1.4%)			
	Undetermined	13 (10.2%)	6 (7.0%)	9 (12.7%)	22 (10.1%)	3 (0.3%)		19 (1.1%)	220 (100%)		2 (28.6%)
Ethnicity	White	10 (7.8%)	2 (2.3%)	63 (88.7%)	188 (86.6%)	581 (55.8%)	15 (78.9%)	948 (56.4%)	118 (53.6%)	10 (90.9%)	5 (71.4%)
	Black Caribbean	1 (0.8%)	2 (2.3%)		1 (0.5%)	9 (0.9%)		6 (0.4%)	3 (1.4%)		
	Black African	114 (89.1%)	82 (95.3%)	7 (9.9%)	20 (9.2%)	192 (18.4%)	2 (10.5%)	643 (38.3%)	89 (40.5%)		2 (28.6%)
	Black Other					24 (2.3%)		22 (1.3%)	4 (1.8%)		
	Indian/Pakistani/ Bangladeshi					3 (0.3%)		30 (1.8%)	2 (0.9%)		
	Other Asian/Oriental	1 (0.8%)			6 (2.8%)				4 (1.8%)		
	Other/Mixed	2 (1.6%)		1 (1.4%)	2 (0.9%)		2 (10.5%)	24 (1.4%)		1 (9.1%)	
	Unknown					233 (22.4%)		8 (0.5%)			
Residency	UK National	13 (10.2%)	5 (5.8%)	65 (91.5%)	187 (86.2%)	841 (80.7%)	18 (94.7%)	949 (56.5%)		11 (100%)	6 (85.7%)
	Asylum Seeker	48 (37.5%)	56 (65.1%)	1 (1.4%)	4 (1.8%)	80 (7.7%)		107 (6.4%)			
	Overseas Student	2 (1.6%)	2 (2.3%)		1 (0.5%)	6 (0.6%)		28 (1.7%)			
	Migrant Worker		1 (1.2%)		8 (3.7%)	6 (0.6%)		103 (6.1%)			
	Temporary Visitor	7 (5.5%)	1 (1.2%)			17 (1.6%)		8 (0.5%)			
	Other	3 (2.3%)	4 (4.7%)		11 (5.1%)	14 (1.3%)		128 (7.6%)			
	Refugee	38 (29.7%)	14 (16.3%)	2 (2.8%)	1 (0.5%)	61 (5.9%)		336 (20%)			1 (14.3%)
	Dependent	17 (13.3%)	3 (3.5%)		4 (1.8%)						
	Unknown			3 (4.2%)	1 (0.5%)	17 (1.6%)	1 (5.3%)	22 (1.3%)	220 (100%)		
North West	Resident Outside North West	1 (0.8%)	2 (2.3%)	2 (2.8%)	64 (29.5%)	67 (6.4%)		58 (3.5%)	5 (2.3%)	0 (0%)	0 (0%)
	North West Resident	127 (99.2%)	84 (97.7%)	69 (97.2%)	153 (70.5%)	975 (93.6%)	19 (100%)	1,623 (96.5%)	215 (97.7%)	11 (100%)	7 (100%)
	Total (100%)	**128**	**86**	**71**	**217**	**1,042**	**19**	**1681**	**220**	**11**	**7**

For a definition of the abbreviated community sector organisation, please refer to the glossary at the back of the report.
Men who were exposed through sex with men (MSM) and are also injecting drug users are included in the MSM category.
Age groups refer to the ages of individuals at the end of December 2010, or at death.
Rows cannot be totalled horizontally as some individuals may appear in more than one row or column (i.e. those attending two or more organisations), thus exaggerating the totals.

Table 4.2: Distribution of statutory treatment for HIV and AIDS cases presenting to community sector organisations, 2010

Treatment Centre	Community Sector Organisation									
	BARM	BHA	BP Blackpool	BP Cheshire N.Wales	BP North West	CLASS	GHT	Sahir	SHIVER	Signposts
AHC	3				1		1	3		
APH				1			2	9		
ARM				1	2		6	17		
BLAG			20		8	1	15		10	
BLKG	1				8		19			1
BOLG		1			20		58			
BURG					4		5			
BURY		3			7		20	1		
CHR				78	3		3	1		
CUMB							1			
FGH							1			
HAL				4						
LCN				1			6	32		
LEI				32			1			
MAC				16	2		7			
MGP					62		59	1		
MRIG	16	19		3	211	1	399	7	2	
MRIH					3		2	1		
NMG	40	14		1	336		489	2		
NMGG	1	3			23		37	1		
OLDG	2				25		21			
PG			4		5	13	22		1	
RLG	2			9	14		49	140		
RLI					1		6			1
ROCG		3			4		25			
SALG	1	2	1	1	20		63	1		
SHH					3		8	11		
SPG					3	1	2	4		
STP	1	1		1	23		31			
TAMG					10		10			
TRAG							2			
WAR				19	5		5	1		
WGH							3			1
WITG	1	1		1	57		54	1		
WORK							1			1
WYTH							2			

For a definition of the abbreviated treatment centres and community sector organisations please refer to the glossary at the back of the report.
Columns cannot be totalled vertically or horizontally as some individuals may appear in more than one row or column (i.e. those attending two or more treatment locations or community sector organisations), thus exaggerating the totals.

Table 4.3: HIV and AIDS cases presenting to the community and statutory sector by sex, infection route, ethnicity and residency status, 2010

		Statutory Sector Attendance			Total
		Never Seen	Seen in 2010	Seen Prior to 2010	
Sex	Male	357 (57.6%)	1,795 (71.9%)	271 (78.6%)	2,423 (70%)
	Female	263 (42.4%)	700 (28.1%)	74 (21.4%)	1,037 (30%)
Infection Route	MSM	259 (46%)	1,395 (61.4%)	227 (68.8%)	1881 (59.4%)
	Injecting Drug Use	6 (1.1%)	31 (1.4%)	3 (0.9%)	40 (1.3%)
	Heterosexual	265 (47.1%)	782 (34.4%)	91 (27.6%)	1,138 (35.9%)
	Blood/Tissue	5 (0.9%)	19 (0.8%)	8 (2.4%)	32 (1.0%)
	Mother to Child	28 (5.0%)	46 (2.0%)	1 (0.3%)	75 (2.4%)
	Sub Total (100%)	**563**	**2,273**	**330**	**3,166**
	Undetermined	57	222	15	294
Ethnicity	White	272 (46.8%)	1,465 (62.8%)	201 (66.1%)	1,938 (60.2%)
	Black Caribbean	5 (0.9%)	14 (0.6%)	3 (1.0%)	22 (0.7%)
	Black African	284 (48.9%)	761 (32.6%)	86 (28.3%)	1,131 (35.1%)
	Black Other	6 (1.0%)	39 (1.7%)	5 (1.6%)	50 (1.6%)
	Indian/Pakistani/Bangladeshi	3 (0.5%)	27 (1.2%)	5 (1.6%)	35 (1.1%)
	Other Asian/Oriental	1 (0.2%)	9 (0.4%)	1 (0.3%)	11 (0.3%)
	Other/Mixed	10 (1.7%)	19 (0.8%)	3 (1.0%)	32 (1.0%)
	Sub Total (100%)	**581**	**2,334**	**304**	**3,219**
	Unknown	39	161	41	241
Residency	UK	285 (49.5%)	1,584 (69.2%)	224 (67.9%)	2,093 (65.5%)
	Asylum Seeker	86 (14.9%)	178 (7.8%)	23 (7.0%)	287 (9.0%)
	Overseas Student	11 (1.9%)	15 (0.7%)	13 (3.9%)	39 (1.2%)
	Migrant Worker	28 (4.9%)	79 (3.4%)	11 (3.3%)	118 (3.7%)
	Temporary Visitor	15 (2.6%)	11 (0.5%)	7 (2.1%)	33 (1.0%)
	Other	44 (7.6%)	94 (4.1%)	22 (6.7%)	160 (5.0%)
	Refugee	99 (17.2%)	313 (13.7%)	30 (9.1%)	442 (13.8%)
	Dependent	8 (1.4%)	16 (0.7%)	0 (0%)	24 (0.8%)
	Sub Total (100%)	**576**	**2,290**	**330**	**3,196**
	Unknown	44	205	15	264
	Total	**620**	**2,495**	**345**	**3,460**

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

5. Social Care Providers 2010

This is the ninth year that the North West HIV/AIDS Monitoring Unit has collected data relating to the care and support of HIV positive individuals who access social service departments in north west England. Five social service departments were able to participate in this report. Data were collected on 98 individuals accessing HIV care and support in 2010.

Social services provide essential care to HIV positive people by ensuring that their needs are assessed and met with regard to welfare, benefits, housing, advocacy and other necessary community-based practical support. This is a crucial service to those affected by and infected with HIV and, for some, may be the only source of care (table 5.1). In 2009/2010, £21.8 million was made available for English local authorities through the AIDS Support Grant. Of this, £1.9 million was allocated to local authorities in north west England (9% of the national allocation)[102].

It is important to note that 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 participating social service department by sex, infection route, residency status and statutory sector attendance. Knowsley, Liverpool and Stockport reported more men who use social services than women (83%, 64.1% and 52%, respectively). In Stockport the majority (52%) of individuals accessing social care were infected through heterosexual sex whereas in Knowsley sex between men was the predominant route of infection (50%).

At all social service departments the residency category with the largest proportion was UK nationals. However, a large proportion (23.4%) of individuals seen by Liverpool were refugees and 27% seen by Stockport social service department were asylum seekers.

The majority of individuals seen by each social service department had been seen at statutory services since monitoring began in 1995. This indicates that social service departments may be the sole provider of care and support to some individuals who do not access statutory services.

Table 5.2 illustrates those social service attendees who also accessed North West voluntary organisations in 2010. Every social service department aside from Blackburn had service users who also used voluntary organisations, with at least one individual from each social service department attending the largest voluntary organisation; GHT.

Table 5.3 illustrates the care provided by Renaissance, part of the Manchester Methodist Housing Association, categorised by infection route, and attendance in the statutory and voluntary sector. Data have been collected from Renaissance for four of the last five years and, for comparison, data for all four years is presented. The table shows that 40% of individuals using Renaissance housing in 2010 also accessed the voluntary services in 2010. The predominant route of infection for residents was MSM (60%), which is a slightly smaller proportion than seen in 2008 (63%). This is also much greater than the proportion of cases infected through sex between men in the statutory sector (50%; chapter 3, table 3.2).

Table 5.1: HIV and AIDS cases presenting to five social service departments by sex, infection route, residency status and statutory sector attendance, 2010

		Social Service Department				
		Blackburn	**Knowsley**	**Liverpool**	**Stockport**	**Warrington**
Sex	Male		5 (83.3%)	41 (64.1%)	13 (52%)	1 (50%)
	Female	1 (100%)	1 (16.7%)	23 (35.9%)	12 (48%)	1 (50%)
Infection Route	MSM		3 (50%)	1 (1.6%)	9 (36%)	1 (50%)
	Injecting Drug Use		1 (16.7%)			
	Heterosexual	1 (100%)	2 (33.3%)	1 (1.6%)	13 (52%)	1 (50%)
	Mother to child				3 (12%)	
	Undetermined			62 (96.9%)		
Residency	UK National	1 (100%)	6 (100%)	41 (64.1%)	12 (48%)	1 (50%)
	Asylum Seeker			5 (7.8%)	7 (28%)	1 (50%)
	Migrant Worker			2 (3.1%)		
	Other			1 (1.6%)		
	Refugee			15 (23.4%)	6 (24%)	
Statutory Sector Attendance	Never seen			12 (18.8%)	6 (24%)	
	Seen in 2010	1 (100%)	6 (100%)	47 (73.4%)	18 (72%)	2 (100%)
	Seen prior to 2010			5 (7.8%)	1 (4%)	
	Total (100%)	1	6	64	25	2

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

Table 5.2: Distribution of social service care for HIV and AIDS cases presenting to voluntary organisations, 2010

	Voluntary Agency				
	BARM	**BP Cheshire N. Wales**	**BPNW**	**GHT**	**SAHIR**
Knowsley				1	1
Liverpool				1	2
Stockport	2	1	6	13	
Warrington		1		1	1

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

		Year					
		2005	**2006**	**2007**	**2008**	**2009***	**2010**
Statutory sector attendance	Never seen		1 (4.2%)	2 (7.7%)	4 (12.5%)		5 (25%)
	Seen in year of report		2 (8.3%)	1 (3.8%)			14 (70%)
	Seen prior to year of report	18 (100%)	21 (87.5%)	23 (88.5%)	28 (87.5%)		1 (5%)
Voluntary sector attendance in same year	Seen in year of report	5 (27.8%)	1 (4.2%)	2 (7.7%)	5 (15.6%)		12 (60%)
	Not seen in year of report	13 (72.2%)	23 (95.8%)	24 (92.3%)	27 (84.4%)		8 (40%)
Infection Route	MSM	12 (66.7%)	16 (66.7%)	19 (73.1%)	20 (62.5%)		12 (60%)
	Injecting Drug Use	1 (5.6%)	2 (8.3%)	2 (7.7%)	1 (3.1%)		1 (5%)
	Heterosexual	5 (27.8%)	6 (25%)	5 (19.2%)	4 (12.5%)		7 (35%)
	Unknown				7 (21.9%)		
	Total (100%)	**18**	**24**	**26**	**32**		**20**

***** *Data not available for 2009*

6. HIV Trends

The North West HIV/AIDS Monitoring Unit has been collecting and collating data on the treatment and care of HIV positive individuals since 1996. This chapter presents trends broken down by county and local authority of residence. Data from 1996 cannot be presented here due to space restrictions and it should be noted that some variables were introduced to the surveillance system in later years.

The number of people accessing HIV services in north west England has increased year on year since recording began, and has risen by 649% since 1996 (from 1,014 individuals in 1996 to 6,576 individuals in 2010). There has been a continued increase (5%) in the size of the HIV positive population from 2009 to 2010. This is slightly smaller than the increase seen between 2008 and 2009 (8%). The rate of increase has been slowing from its peak between 2002-2003 (23%).

The number of new cases rose annually between 2000 and 2005, with the most dramatic increase in new cases seen between 2001 and 2002 (a rise of 37%). Since 2005, the numbers of new cases have fluctuated. Between 2009 and 2010, there was a decrease of 17%.

Figure 6.1 shows proportional changes in the number of new cases from 2000 to 2010 by sexual route of HIV infection. Overall there has been an increase in new cases by 119% since 2000. However, the most striking change is the 202% increase in heterosexual infections. This is a trend that has been noted nationally [48] and is accompanied by an increasing proportion of infections contracted overseas and amongst BME individuals.

It should be noted that although heterosexual cases now dominate the statistics, the annual number of new cases acquired through MSM has shown a 46% increase between 2000 and 2010. This stresses the need to maintain and develop prevention strategies amongst this group.

Table 6.1 shows the infection route of new HIV and AIDS cases from 2001 to 2010 subdivided by county of residence. The most common route of infection has altered over the years. In 2001, MSM still accounted for the majority of new HIV infections (51%) but by 2002 heterosexual sex overtook MSM for the first time as the main mode of HIV exposure and this continued until 2009. In 2010 the gap between MSM and heterosexual cases has closed with both categories accounting for 37% of the total new cases. The number of infections acquired through IDU has remained low over the years; this may partly be due to the early implementation of syringe exchange programmes across north west England. The data from 2010 show a 54% decrease since 2001 of new cases of HIV transmitted through injecting drug use but also a 70% decrease since its peak in 2005 (20 new cases). The number of cases due to mother to child transmission had gradually increased from 2001 to 2009 but in 2010 has returned to the level seen in 2000; a decrease of 63% from 2009 to 2010. The absolute numbers are relatively low (6 in 2010), therefore, care needs to be taken when interpreting a large percentage change based on a low number. The continuing occurrence of new cases in mother to child transmission is linked to the high number of heterosexually infected HIV positive females, which in turn is linked to migration from high prevalence countries. Were it not for large improvements in diagnosis during pregnancy and effective prevention of HIV transmission to the infant (see chapter 1), the number of infected children would be much higher. The majority of cases of mother to child transmission have occurred overseas prior to arrival in the UK (see table 2.7).

Across counties, Merseyside saw the largest increase in new cases since 2001 (173%), followed by Greater Manchester, which saw a 76% increase over the same period. All counties saw a decrease in numbers of new cases between 2009 and 2010. Merseyside had the greatest decrease (33%), followed by Cumbria (25%). The overall number of new MSM and heterosexual cases has risen since 2001 (19% and 59% respectively). However, all counties, with the exception of Cumbria where there was no change, saw a decrease in the number of new cases infected through heterosexual sex since 2009. All counties saw a decline in the number of new MSM cases. The greatest overall number of MSM cases remains in Greater Manchester (158 individuals). This is consistent with the fact that the Manchester area has a large gay community and evidence of high levels of sexual risk behaviour (as revealed in investigations of the syphilis outbreak). There was, however, a decrease of 22% in the overall number of new cases infected through MSM between 2009 and 2010.

Figure 6.2 illustrates proportional changes in the level of antiretroviral therapy (ART) prescribed to HIV positive individuals attending treatment and care between 2000 and 2010. Individuals are categorised by the highest level of combination therapy they received in a given year. Since 2000, the number of individuals on triple and quadruple or more therapy and the number not taking any antiretroviral drugs, have all increased in line with the increasing number of HIV cases. Mono and dual therapy use have remained low, in line with research [103] and guidelines which define triple or more antiretroviral drugs as the most effective form of therapy[94]. The small increase in 2007 in the use of mono and dual therapy may be due to data anomalies arising from the development of electronic reporting systems. Data from 2010 show that there has been a continued increase in the proportion of individuals prescribed triple and quadruple or more therapy.

Table 6.2 refers to the level of ART received by all HIV positive individuals accessing treatment and care in between 2001 and 2010 by county of residence. Between 2001 and 2010, those receiving triple or more therapy has increased from 65% to 80% of all cases. From 2001 to 2007, around one third of HIV positive individuals did not receive ART at the reporting time. Since then, this proportion has decreased to 25% in 2009 and 19% in 2010. Relatively few people are in receipt of monotherapy and the number prescribed this level of therapy

decreased from its highest in 2007 to 2010 (by 71%). This type of therapy is preferred during pregnancy and so its use continues to fluctuate over time. Giving HIV positive pregnant women a single antiretroviral drug (e.g. Zidovudine) during pregnancy significantly reduces the chance of the infant becoming infected [104], and remains a valid option for treatment during pregnancy (although the latest BHIVA guidelines are more complex) [65]. With the ongoing high number of females with HIV infection, the use of mono therapy may continue to fluctuate in the future. The proportion taking dual therapy has remained constant since 2001 (less than 1% of all cases). Between 2001 and 2010, the largest percentage increase in the number of people in treatment for HIV was seen in Merseyside, rising from 220 to 864 (293%), followed by Greater Manchester (263%), Cheshire (206%), Cumbria (165%) and Lancashire (159%).

Table 6.3 shows the number of new cases of HIV from 2005 to 2010 subdivided by local authority (LA) of residence. Caution is needed when interpreting the percentage change for LAs with a small number of new cases. For example, the LAs with the largest proportional increases from 2005 to 2010 (e.g. Carlisle, Pendle and Knowsley) are those that had very few cases in 2005.

Table 6.4 shows data for all cases of HIV presenting for treatment between 2005 and 2010, subdivided by LA of residence. Again, caution is needed when interpreting the percentage changes for those LAs with relatively small numbers of HIV cases. The total numbers of HIV cases have increased annually. Of the five counties, Cumbria has seen the largest percentage increase in cases since 2005 at 78%, followed by an increase of 70% in Merseyside, 69% in Cheshire, 61% in Greater Manchester and 39% in Lancashire. Manchester LA had the largest number of HIV positive residents in 2010 (1,905 individuals; a 55% increase since 2005). None of the LAs had fewer than 13 cases of HIV in 2010. The largest percentage increases since 2005 were seen in Barrow-in-Furness (from 4 to 21; 425%), Wigan (from 70 to 168; 140%), Chorley (13 to 29 individuals; 123%) and Pendle (11 to 24 individuals; 118%). Since 2005 the number of HIV positive people seen in treatment centres in north west England who reside outside north west England has increased by 54% (from 155 to 238 individuals).

Figure 6.1: Percentage change in new cases of HIV by selected infection route of HIV, 2000-2010

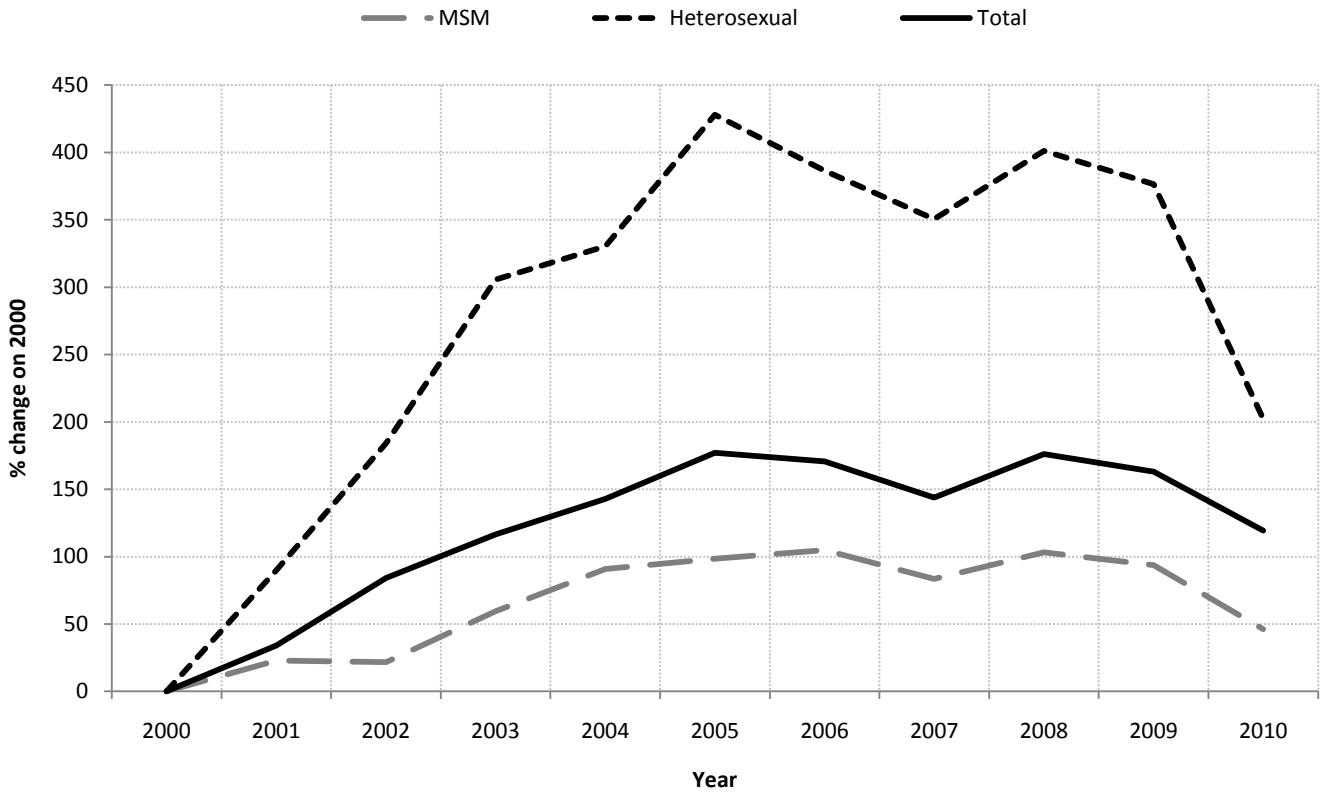


Figure 6.2: Percentage change in total cases of HIV by level of antiretroviral therapy, 2000-2010

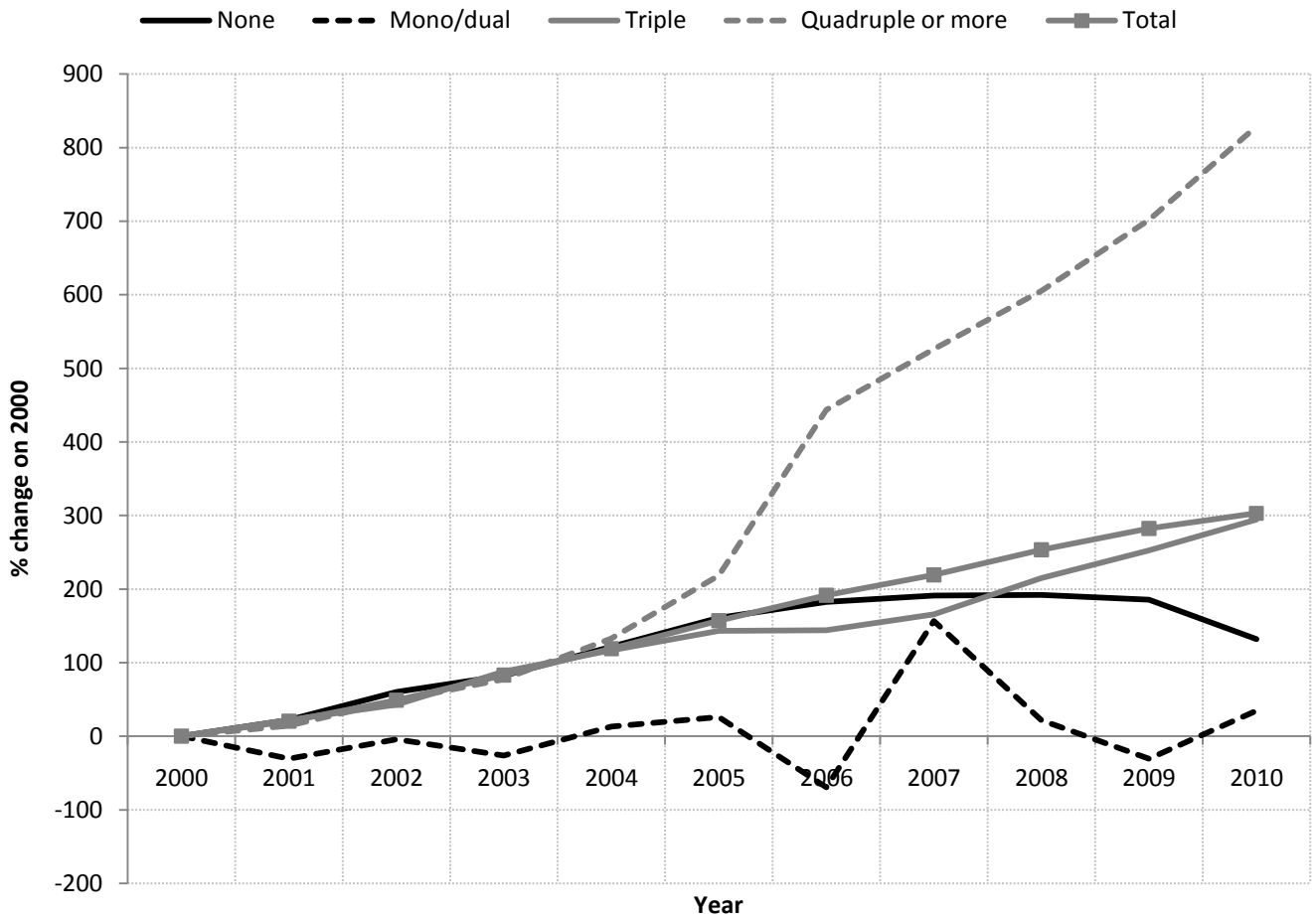


Table 6.1: Number of new HIV and AIDS cases by infection route of HIV and county of residence, 2001-2010

	Infection Route	Year										% Change 2001-2010	% Change 2009-2010
		2001	2002	2003	2004	2005	2006	2007	2008	2009	2010		
Cumbria	MSM	3	5	4	6	10	8	8	7	11	7	133	-36
	Injecting Drug Use		1		1			1	1				
	Heterosexual	6	4	4	3	1	5	6	14	4	4	-33	0
	Blood/Tissue						1	1					
	Mother to Child							1					
	Undetermined			2	1	1	2		1	1	1		0
	Cumbria Total	**9**	**10**	**10**	**11**	**12**	**16**	**17**	**23**	**16**	**12**	**33**	**-25**
Lancashire	MSM	47	24	58	64	68	48	38	59	53	37	-21	-30
	Injecting Drug Use	5	2		1	3	3	1		1	1	-80	0
	Heterosexual	18	35	31	39	33	42	44	42	46	38	111	-17
	Blood/Tissue				1				1				
	Mother to Child	3					2	1	1	2		-100	-100
	Undetermined	5	26		1	5	11	5	7	4	5	0	25
	Lancashire Total	**78**	**87**	**89**	**106**	**109**	**106**	**89**	**110**	**106**	**81**	**4**	**-24**
Greater Manchester	MSM	127	144	168	209	208	241	190	207	202	158	24	-22
	Injecting Drug Use	4		3	11	9	9	7	6	6	4	0	-33
	Heterosexual	93	145	219	226	288	278	239	269	250	137	47	-45
	Blood/Tissue		1	3	1			2		1	1		0
	Mother to Child	7	8	6	10	6	12	10	10	10	4	-43	-60
	Undetermined	11	57	18	23	26	24	13	30	29	122	1009	321
	Greater Manchester Total	**242**	**355**	**417**	**480**	**537**	**564**	**461**	**522**	**498**	**426**	**76**	**-14**
Merseyside	MSM	18	17	21	31	18	33	43	39	49	38	111	-22
	Injecting Drug Use	1		1	2	5	2	1	2	6	1	0	-83
	Heterosexual	19	50	68	65	81	68	63	70	91	59	211	-35
	Blood/Tissue												
	Mother to Child		1	1	1	3	2	5	3	3	2		-33
	Undetermined	2	15	18	1	12	10	8	14	14	9	350	-36
	Merseyside Total	**40**	**83**	**109**	**100**	**119**	**115**	**120**	**128**	**163**	**109**	**173**	**-33**
Cheshire	MSM	14	23	20	10	25	26	29	38	24	16	14	-33
	Injecting Drug Use	2	2	2	1	1			1	1		-100	-100
	Heterosexual	11	8	13	17	18	18	25	28	21	12	9	-43
	Blood/Tissue				1			1					
	Mother to Child	1				2		3	1			-100	
	Undetermined	1	7	4	1	2	4	1	3		8	700	
	Cheshire Total	**29**	**40**	**39**	**30**	**48**	**48**	**59**	**71**	**46**	**36**	**24**	**-22**
Total North West Residents*	MSM	209	213	271	321	329	356	308	350	339	256	22	-24
	Injecting Drug Use	12	5	6	16	18	14	10	10	14	6	-50	-57
	Heterosexual	147	243	335	351	421	411	377	423	412	250	70	-39
	Blood/Tissue		1	3	2		1	4	1	1	1		0
	Mother to Child	11	9	7	12	11	16	20	15	15	6	-45	-60
	Undetermined	19	105	42	27	46	51	27	55	48	145	663	202
	Total	**398**	**576**	**664**	**729**	**825**	**849**	**746**	**854**	**829**	**664**	**67**	**-20**
Total	MSM	231	229	300	359	373	385	345	382	364	275	19	-24
	Injecting Drug Use	13	5	7	17	20	15	11	12	15	6	-54	-60
	Heterosexual	169	253	361	383	470	433	401	446	424	269	59	-37
	Blood/Tissue		1	3	4		3	4	2	1	2		100
	Mother to Child	11	9	7	14	11	17	21	16	16	6	-45	-63
	Undetermined	25	120	47	37	54	54	35	67	61	177	608	190
	Total	**449**	**617**	**725**	**814**	**928**	**907**	**817**	**925**	**881**	**735**	**64**	**-17**

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

**Individual county totals may not add up to Total North West Residents due to some individuals being categorised as living in north west England but unknown area.*

Table 6.2: Total number of HIV and AIDS cases by level of antiretroviral therapy and county of residence, 2001-2010

	ART	Year										% Change 2000-2010	% Change 2009-2010
		2001	2002	2003	2004	2005	2006	2007	2008	2009	2010		
Cumbria	None	11	16	21	28	27	26	29	34	29	20	82	-31
	Mono			1									
	Dual										1		
	Triple	35	31	31	29	36	43	51	59	70	81	131	16
	Quadruple or more	5	4	6	8	13	20	26	30	32	33	560	3
	Cumbria Total	**51**	**51**	**59**	**65**	**76**	**89**	**106**	**123**	**131**	**135**	**165**	**3**
Lancashire	None	104	122	129	304	207	209	190	184	163	157	51	-4
	Mono			2		1							
	Dual	8	8	3	1	4	1	4				-100	
	Triple	181	223	283	211	319	342	385	418	447	453	150	1
	Quadruple or more	43	55	52	42	95	157	185	212	233	261	507	12
	Lancashire Total	**336**	**408**	**469**	**558**	**626**	**709**	**764**	**814**	**843**	**871**	**159**	**3**
Greater Manchester	None	397	537	566	753	840	955	988	993	1007	782	97	-22
	Mono		1	1	8	6	2	4	2		1		
	Dual	1	7	2	5	4	1	21	2	7	7	600	0
	Triple	566	660	932	1091	1264	1207	1240	1494	1670	2038	260	22
	Quadruple or more	132	158	192	223	353	693	822	927	1070	1152	773	8
	Greater Manchester Total	**1,096**	**1,363**	**1,693**	**2,080**	**2,467**	**2,858**	**3,075**	**3,418**	**3,754**	**3,980**	**263**	**6**
Merseyside	None	77	96	149	155	181	202	211	218	217	165	114	-24
	Mono		1	3	2	4		17	3	2	2		0
	Dual	3	2	1	3	2		5	13	3	13	333	333
	Triple	118	146	169	180	203	243	301	376	471	422	258	-10
	Quadruple or more	22	48	59	86	118	142	130	126	155	262	1091	69
	Merseyside Total	**220**	**293**	**381**	**426**	**508**	**587**	**664**	**736**	**848**	**864**	**293**	**2**
Cheshire	None	43	53	63	64	73	85	95	90	86	78	81	-9
	Mono		1			1		1			0		
	Dual	1				2	2	1	1		1	0	
	Triple	74	87	99	106	128	142	166	207	218	222	200	2
	Quadruple or more	14	23	30	28	35	45	57	70	80	103	636	29
	Cheshire Total	**132**	**164**	**192**	**198**	**239**	**274**	**320**	**368**	**384**	**404**	**206**	**5**
Total North West Residents*	None	632	825	929	1306	1328	1477	1513	1519	1502	1202	90	-20
	Mono		3	7	10	12	2	22	5	2	3		50
	Dual	13	17	6	9	12	4	31	16	10	22	69	120
	Triple	975	1147	1514	1625	1950	1977	2143	2554	2876	3216	230	12
	Quadruple or more	216	288	339	389	614	1057	1220	1365	1570	1811	738	15
	Total	**1,836**	**2,280**	**2,795**	**3,339**	**3,916**	**4,517**	**4,929**	**5,459**	**5,960**	**6,254**	**241**	**5**
Total	None	675	885	1007	1224	1441	1560	1606	1611	1575	1281	90	-19
	Mono		3	9	12	15	2	24	6	6	7		17
	Dual	16	19	8	14	14	5	35	22	10	24	50	140
	Triple	1039	1218	1600	1847	2072	2080	2263	2682	3004	3360	223	12
	Quadruple or more	234	304	364	477	653	1114	1284	1446	1643	1904	714	16
	Total	**1,964**	**2,429**	**2,988**	**3,574**	**4,195**	**4,761**	**5,212**	**5,767**	**6,238**	**6,576**	**235**	**5**

**Individual county totals may not add up to Total North West Residents due to some individuals being categorised as living in north west England but unknown area.*

Table 6.3: New cases of HIV and AIDS by local authority of residence, 2005-2010

	Local Authority of Residence	Year						% change 2005-2010	% change 2009-2010
		2005	2006	2007	2008	2009	2010		
Cumbria	Carlisle	1	3	3	6	7	3	200	-57
	Allerdale	3	2	3	2	1	3	0	200
	Eden	3	5		3	1	1	-67	0
	Copeland	3	2	2	2	2	2	-33	0
	South Lakeland	2	2	5	6	1		-100	-100
	Barrow-in-Furness		2	4	4	4	3		-25
	Cumbria Total	**12**	**16**	**17**	**23**	**16**	**12**	**0**	**-25**
Lancashire	Lancaster	5	7	3	5	9	4	-20	-56
	Wyre	3	8	3	5	3	3	0	0
	Fylde	7	6	7	5	7	1	-86	-86
	Blackpool	55	42	29	41	32	33	-40	3
	Blackburn with Darwen	9	8	15	13	18	10	11	-44
	Ribble Valley	5	3	1		1	1	-80	0
	Pendle	1	2	4	6	4	4	300	0
	Hyndburn	2	7	1	8			-100	
	Burnley	3	5	6	5	5	4	33	-20
	Rossendale	2	2	1	2	5	4	100	-20
	Preston	11	5	14	6	8	9	-18	13
	South Ribble	4	3		5	4	3	-25	-25
	Chorley	2	6	1	7	7	3	50	-57
	West Lancashire		2	4	2	2	1		-50
	Unknown Lancashire					1	1		0
	Lancashire Total	**109**	**106**	**89**	**110**	**106**	**81**	**-26**	**-24**
Greater Manchester	Wigan	18	18	18	18	21	24	33	14
	Bolton	53	21	41	48	36	22	-58	-39
	Bury	24	27	9	26	24	12	-50	-50
	Rochdale	20	23	27	20	24	16	-20	-33
	Oldham	13	21	27	31	23	10	-23	-57
	Salford	72	91	68	74	75	66	-8	-12
	Manchester	268	283	209	249	214	211	-21	-1
	Tameside	24	20	11	20	26	13	-46	-50
	Trafford	32	30	32	20	18	26	-19	44
	Stockport	12	27	13	13	10	24	100	140
	Unknown Greater Manchester	1	3	6	3	27	2	100	-93
	Greater Manchester Total	**537**	**564**	**461**	**522**	**498**	**426**	**-21**	**-14**
Merseyside	Sefton	18	16	13	13	31	9	-50	-71
	Liverpool	74	67	74	81	97	67	-9	-31
	Knowsley	2	4	4	6	11	7	250	-36
	Wirral	20	17	22	20	11	20	0	82
	St Helens	4	9	6	7	13	3	-25	-77
	Unknown Merseyside	1	2	1	1		3	200	
	Merseyside Total	**119**	**115**	**120**	**128**	**163**	**109**	**-8**	**-33**
Cheshire	Halton	6	7	4	2	8	4	-33	-50
	Warrington	9	7	11	19	9	9	0	0
	Cheshire West and Chester*	17	20	26	18	15	9	-47	-40
	Cheshire East**	16	14	18	32	14	14	-13	0
	Cheshire Total	**48**	**48**	**59**	**71**	**46**	**36**	**-25**	**-22**
	Total North West Residents	**825**	**849**	**746**	**854**	**829**	**664**	**-20**	**-20**
	Isle of Man	2	4	2	2	1	1	-50	0
	Out of Region	20	25	39	30	19	31	55	63
	Abroad			2					
	Unknown	81	29	28	39	32	39	-52	22
	Total	**928**	**907**	**817**	**925**	**881**	**735**	**-21**	**-17**

**Formerly Ellesmere Port & Neston, Chester and Vale Royal local authorities*

***Formerly Macclesfield, Congleton and Crewe & Nantwich local authorities*

Table 6.4: All cases of HIV and AIDS by local authority of residence, 2005-2010

	Local Authority of Residence	Year						% change 2005-2010	% change 2009-2010
		2005	2006	2007	2008	2009	2010		
Cumbria	Carlisle	20	22	26	30	36	38	90	6
	Allerdale	12	12	16	18	19	20	67	5
	Eden	10	14	13	15	14	13	30	-7
	Copeland	13	11	13	15	15	14	8	-7
	South Lakeland	17	20	24	29	27	28	65	4
	Barrow-in-Furness	4	8	13	15	19	21	425	11
	Unknown Cumbria		2	1	1	1	1		0
	Cumbria Total	**76**	**89**	**106**	**123**	**131**	**135**	**78**	**3**
Lancashire	Lancaster	26	34	35	34	41	45	73	10
	Wyre	38	44	46	49	45	47	24	4
	Fylde	35	42	46	49	52	48	37	-8
	Blackpool	249	269	291	315	310	312	25	1
	Blackburn with Darwen	53	60	70	78	89	98	85	10
	Ribble Valley	12	14	14	13	16	17	42	6
	Pendle	11	12	16	20	23	24	118	4
	Hyndburn	21	26	21	28	26	26	24	0
	Burnley	16	24	27	27	28	25	56	-11
	Rossendale	17	21	24	25	31	34	100	10
	Preston	83	86	96	96	99	103	24	4
	South Ribble	24	31	29	29	27	32	33	19
	Chorley	13	18	17	22	28	29	123	4
	West Lancashire	26	27	26	27	26	25	-4	-4
	Unknown Lancashire	2	1	6	2	2	6	200	200
	Lancashire Total	**626**	**709**	**764**	**814**	**843**	**871**	**39**	**3**
Greater Manchester	Wigan	70	86	105	123	148	168	140	14
	Bolton	177	181	208	233	260	264	49	2
	Bury	123	139	151	166	178	184	50	3
	Rochdale	98	123	133	134	161	167	70	4
	Oldham	74	89	110	137	146	141	91	-3
	Salford	354	424	443	501	542	603	70	11
	Manchester	1227	1404	1505	1669	1790	1905	55	6
	Tameside	96	111	108	129	148	157	64	6
	Trafford	144	160	179	184	198	207	44	5
	Stockport	98	135	123	134	145	167	70	15
	Unknown Greater Manchester	6	6	10	8	38	17	183	-55
	Greater Manchester Total	**2,467**	**2,858**	**3,075**	**3,418**	**3,754**	**3,980**	**61**	**6**
Merseyside	Sefton	72	75	83	81	106	95	32	-10
	Liverpool	278	330	375	423	491	475	71	-3
	Knowsley	19	26	29	38	47	36	89	-23
	Wirral	103	110	126	136	138	156	51	13
	St Helens	33	40	44	50	60	53	61	-12
	Unknown Merseyside	3	6	7	8	6	49	1533	717
	Merseyside Total	**508**	**587**	**664**	**736**	**848**	**864**	**70**	**2**
Cheshire	Halton	25	29	30	26	28	34	36	21
	Warrington	48	53	65	79	80	81	69	1
	Cheshire West and Chester*	93	110	135	150	153	157	69	3
	Cheshire East**	70	81	90	113	123	132	89	7
	Unknown Cheshire	3	1					-100	
	Cheshire Total	**239**	**274**	**320**	**368**	**384**	**404**	**69**	**5**
	Total North West Residents	**3,916**	**4,517**	**4,929**	**5,459**	**5,960**	**6,254**	**60**	**5**
	Isle of Man	18	19	21	23	22	29	61	32
	Out of Region	135	165	191	207	191	206	53	8
	Abroad	2	3	3	1	1	3	50	200
	Unknown	124	57	68	77	64	84	-32	31
	Total	**4,195**	**4,761**	**5,212**	**5,767**	**6,238**	**6,576**	**57**	**5**

**Formerly Ellesmere Port & Neston, Chester and Vale Royal local authorities*

***Formerly Macclesfield, Congleton and Crewe & Nantwich local authorities*

Glossary of Service Providers

Statutory Treatment Centres

AHC Alder Hey Children's Hospital, Haematology Treatment Centre, Eaton Road, Liverpool, L12 2AP. Tel: (0151) 228 4811

APH Arrowe Park Hospital, Department of GUM, Arrowe Park Road, Upton, Wirral, Merseyside, CH49 5PE. Tel: (0151) 678 5111

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

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

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

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

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

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

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

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

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

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

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

LCN Liverpool Community HIV Specialist Nursing Team, Hartington Road Clinic, Hartington Road, Liverpool, L8 0SG. Tel: (0151) 285 2802

LEI Leighton Hospital, Department of GUM, Middlewich Road, Crewe, Cheshire, CW1 4QJ. Tel: (01270) 255 141

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

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

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

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

NMG North Manchester General Hospital, Infectious Disease Unit, Delaunays Road, Crumpsall, Manchester, M8 5RB. Tel: (0161) 795 4567

NMGG North Manchester General Hospital, Department of GUM, Delaunays Road, Crumpsall, Manchester, M8 5RB. Tel: (0161) 795 4567

NOBL Noble's Isle of Man Hospital, Department of GUM, Strang, Douglas, Isle of Man, IM4 4RJ. Tel: (01624) 650 000

OLDG Royal Oldham Hospital, Department of GUM, Rochdale Road, Oldham, Lancashire, OL1 2JH. Tel: (0161) 624 0420

PG Royal Preston Hospital, Department of GUM, Sharoe Green Lane North, Fulwood, Preston, PR2 9HT. Tel: (01772) 716 565

RLG	Royal Liverpool University Hospital, Department of GUM and Tropical and Infectious Disease Unit, Prescot Street, Liverpool, L7 8XP. Tel: (0151) 706 2000
RLH	Royal Liverpool University Hospital, Roald Dahl Haemostasis and Thrombosis Centre, Prescot Street, Liverpool, L7 8XP. Tel: (0151) 706 2000
RLI	Royal Lancaster Infirmary, Ashton Road, Lancaster, LA1 4RP. Tel: (01524) 65944
ROCG	Bridge Sexual Health Centre, Baillie Street Health Centre, Baillie Street, Rochdale, OL16 1XS. Tel: (01706) 517 655
SALG	The Goodman Centre for Sexual Health, Lance Burn Clinic, Churchill Way, Salford, Manchester, M6 5AX. Tel: (0161) 212 5717
SHH	St Helens Hospital, Department of GUM, Marshalls Cross Road, St Helens, WA9 3DA. Tel: (01744) 458 383
SPG	Southport & Formby District General Hospital, Department of GUM, Town Lane, Southport, Merseyside, PR8 6PN. Tel: (01704) 547 471
STP	Stepping Hill Hospital, Department of GUM, Poplar Grove, Stockport, Cheshire SK2 7JE. Tel: (0161) 483 1010
TAMG	Tameside and Glossop Centre for Sexual Health, Orange Suite, Ashton Primary Care Centre, 193 Old Street, Ashton-under-Lyne, OL6 7SR. Tel: (0161) 331 6000
TRAG	Trafford General Hospital, Department of GUM, Moorside Road, Urmston, Manchester, M41 5SL. Tel: (0161) 748 4022
WAR	Warrington Hospital, Department of GUM, Lovely Lane, Warrington, Cheshire, WA5 1QG. Tel: (01925) 635 911
WGH	Westmorland General Hospital, Outpatients Department, Burton Road, Kendal, Cumbria, LA9 7RG. Tel: (01539) 732 288
WHIT	West Cumberland Hospital, Department of Haematology, Hensingham, Whitehaven, Cumbria, CA28 8JG. Tel: (01946) 693 181
WITG	Withington Hospital, South Manchester Centre for Sexual Health, Nell Lane, West Didsbury, Manchester, M20 2LR. Tel: (0161) 434 5555
WORK	Workington Community Hospital, Department of GUM, Park Lane, Workington, Cumbria, CA14 2RW, Tel: (01900) 705 000
WYTH	University Hospital of South Manchester, Wythenshawe Hospital, Southmoor Road, Manchester, M23 9LT, Tel: (07751) 270 936

Community Sector Organisations

BARM	Barnardo's (Manchester)	Tel: (0161) 273 2901
BHA	The Black Health Agency	Tel: (0161) 226 9145
BP Cheshire	Body Positive Cheshire and North Wales	Tel: (01270) 653150
BP North West	Body Positive North West	Tel: (0161) 882 2200
CLASS	Central Lancashire HIV Advice and Support Services	Tel: (01772) 253840
GHT	George House Trust	Tel: (0161) 274 4499
Sahir	Sahir House	Tel: (0151) 708 9080
SHIVER	Sexual Health, HIV, Education and Responses	Tel: (01253) 311431
Signposts	Signposts	Tel: (01524) 411541

Social Service Departments

Blackburn with Darwen	Tel: (01254) 585585
Knowsley	Tel: (0151) 443 5626
Liverpool	Tel: (0151) 706 2854
Stockport	Tel: (0161) 443 4320
Warrington	

Additional providers of HIV care

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

List of Abbreviations

AIDS - Acquired immunodeficiency syndrome

ART – Antiretroviral therapy

BME – Black and minority ethnic groups

CHR – Clinician HIV report

CPH – The Centre for Public Health based at Liverpool John Moores University

GUM - Genito-Urinary Medicine

HIV - Human immunodeficiency virus

HPA – Health Protection Agency

IDU – Injecting drug use/user

LA – Local authority

LSOA – Lower super output area

MSM – Men who have sex with men

NASS – National Asylum Support Service

NAT – National AIDS trust

ONS – Office of national statistics

PCT – Primary care trust

SCIEH – Scottish Centre for Infection and Environmental Health

SOPHID - Survey of Prevalent HIV Infections Diagnosed

STI – Sexually transmitted infection

UNAIDS – Joint United Nations Programme on HIV/AIDS

WHO – World Health Organisation

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