Executive Summary

During 2003 the North West Region has seen the largest recorded number of new cases of HIV positive people accessing treatment and care since regional monitoring began. A total of 725 new HIV and AIDS cases (HIV positive individuals who had not previously been seen in North West statutory treatment centres prior to the year 2003) were reported during the year. This represents an 18% increase on last year's figure of 617. The total number of people treated for HIV in North West statutory treatment centres continues to rise at a rapid rate: during 2003 a total of 2,988 individuals accessed treatment and care, representing a 23% increase on the number reported in 2002 (2,429). Over the nine years since this level of monitoring began, there has been a three-fold increase in the HIV positive population in treatment in the North West (figure 1.12).

This is the eighth annual report of the North West HIV/AIDS Monitoring Unit, presenting data on HIV positive individuals accessing treatment and care in the North West Region. A total of 45 statutory centres within the North West provided treatment and care for HIV positive individuals resident throughout the region and beyond. We present analyses by treatment centre, as well as by primary care trust (PCT) and strategic health authority (SHA) of residence. It is not possible to present all possible breakdowns at PCT level, however, additional tables are available on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2003). This year, for the first time, we introduce a new chapter (see chapter 7), presenting trends in the epidemiology and treatment of HIV in the North West.

New cases represented 24% of all cases, a proportion similar to previous years. The predominant mode of exposure to HIV for new cases is heterosexual sex (53%); this route has overtaken homosexual sex (44%: table 2.3a) for the second year running, reflecting the trend that has been apparent nationally since 1999 (figure 1.6). The proportion of new cases exposed to HIV through homo/bisexual sex is higher in the North West (table 2.3a) than nationally (figure 1.6). The number of new cases who were exposed by other transmission routes (injecting drug use, blood or tissue and mother to child) remains relatively low. While the largest proportion of new cases presenting for treatment and care were categorised as asymptomatic (60%), the eleven new cases who died during 2003 all had an AIDS defining illness. This illustrates the continuing need to attract HIV positive people into services at an early stage of their HIV disease to maximise the efficacy of treatment and improve prognosis.

The predominant mode of exposure to HIV for those accessing treatment in the North West (new and existing cases) continues to be homosexual sex, accounting for 56% of all cases presenting to North West treatment centres in 2003 (table 3.2). There is, however, considerable variation across the three strategic health authorities, with 62% of the HIV positive residents of Cumbria and Lancashire having been infected by sex between men, compared to 47% of Cheshire and Merseyside residents (table 3.4a). The relatively high proportion of individuals infected by homosexual sex is reflected in the gender distribution of HIV and AIDS cases, with males representing 78% of all cases (table 3.5). Heterosexual sex continues to be the second largest exposure group, accounting for over a third of all cases in 2003 (table 3.2). This represents an increase on the proportion in 2002, reflecting trends for the United Kingdom as a whole. Greater Manchester SHA reports the highest number of HIV positive individuals in the North West, accounting for over half of all cases (table 3.3a) and new cases (table 2.2a) presenting to statutory treatment centres.

With regards to age distributions, the greatest proportion of cases are in the 30 to 44 age range (table 3.1.). The proportion of HIV positive people in the older age groups (50 years and over) continues to increase, from 7% in 1996 to 12% in 2003 (table 3.1). This ageing cohort effect is likely to be due to the effectiveness of antiretroviral therapies and subsequent improvement in prognosis of many HIV positive individuals. However, those aged 55 years or over are more likely to have died during 2003 from an AIDS-related condition (2%) than are those younger than 55 years, of whom only 1% died. The proportion of the HIV positive population dying from AIDS related conditions has decreased over the years, from 10% in 1995 to 0.8% in 2003 (figure 1.12).

The North West of England continues to be influenced by the global AIDS pandemic, as reflected in the number and pattern of HIV infections acquired abroad. Almost one third of all HIV positive individuals accessing treatment and care in the North West were reported to have been infected outside the United Kingdom (table 3.12). Heterosexual sex continues to be the major method of exposure to HIV in those infected abroad (74%), a significantly higher proportion than in those known to have been infected in the United Kingdom (13%). Of all the infections contracted outside the United Kingdom, 63% were in sub-Saharan Africa (figure 3.1). Western Europe accounted for a further 11% of infections contracted abroad, with Spain being the most frequently reported western European country of exposure. The role of exposure abroad was even more pronounced for cases who were new in 2003, where 43% were reported to have been infected abroad (table 2.11). The number of new cases exposed to HIV in Zimbabwe has increased by 51% on 2002, and this year accounts for 42% of new cases known to have been exposed abroad (figure 2.1). This high number of cases reflects both the high prevalence of HIV and the political situation in Zimbabwe.

Ethnicity was recorded for 98% of individuals accessing treatment and care in 2003, most of whom (74%) were self-classified as white (table 3.8). However, an increasing proportion of individuals with HIV were from black and minority ethnic communities (26%); a substantial over-representation when considering the proportion of North West residents who are from minority ethnic communities (5.6%). An even higher proportion (46%) of new cases whose ethnicity was known were from minority ethnic communities (table 2.7), which has increased from 40% of new cases in 2002, demonstrating the increasing burden of HIV on these communities and the need for continuing and strengthening HIV prevention activities. The characteristics of HIV positive individuals from black and minority ethnic communities, particularly black Africans, are different to those of the white HIV positive population. Whereas white individuals were more likely to have been infected by homosexual sex, heterosexual sex is the predominant method of exposure of black Africans (tables 2.8 and 3.10). This results in there being proportionally more females from black and minority ethnic communities with HIV compared to white females (table 2.9 and 3.9) and more babies born with HIV infection (tables 2.8 and 3.10). Individuals from minority ethnic groups presenting for the first time during 2003 were no more likely to be at an advanced stage of disease than were white individuals.

We are now in our third year of collecting information on asylum seeker status of HIV positive individuals accessing HIV related care. This level of information is not available nationally, despite growing concern over the health of this vulnerable population. Since collection of this information began, the proportion of individuals who are asylum seekers has almost quadrupled, and this year represented 11% of all HIV positive individuals. During 2003, there were 316 individuals who were identified as being asylum seekers, an increase of 107% on last year's total of 153 (table 3.27). These individuals were more likely to be asymptomatic (58%) than were those who were known not to be asylum seekers (38%). The majority of those known to be asylum seekers resided in Greater Manchester SHA (69%) and most (96%) were black Africans (table 3.28).

During 2003, two thirds of individuals received triple or more combination therapy, including 12% who were taking quadruple or more therapy when they last attended treatment centres in the year (table 3.15). The level of triple or more therapy rose to 91% when considering those with an AIDS diagnosis, while only 39% of asymptomatic individuals were taking this level of therapy (table 3.16). The improved prognosis of HIV positive individuals across all clinical categories of HIV disease, together with relatively low numbers of individuals at early stages of HIV disease receiving combination therapy, has implications for a potential increase in demand for combination therapies. This has both planning and financial implications for the care of HIV positive individuals across the region.

We also collected information on the level of inpatient and outpatient care for the whole of the region. During 2003, North Manchester General Infectious Disease Unit, the treatment centre with the highest number of HIV positive attendees (table 3.19), provided the highest number of outpatient visits, day cases, inpatient episodes and inpatient days (table 3.25). Demand for outpatient care peaked for those with an AIDS diagnosis (table 3.26), while those who died during 2003 required the most inpatient care. Home visits also formed a significant part of the care of HIV positive individuals (table 3.25), with those individuals who died during the year receiving the highest mean number of home visits.

During 2003, eight voluntary agencies in the North West reported care of 1,216 HIV positive individuals. Of these, 14% were not seen in North West statutory treatment centres during 2003, illustrating the continuing contribution of the voluntary sector to the care of those HIV positive individuals for whom the voluntary agencies may be the sole provider of care. This also has particular significance for regional funding of HIV services, since individuals accessing voluntary agencies but not the statutory sector are not included in the regional statistics provided to the Department of Health, the basis of the formula for the national distribution of funds for the care of HIV positive people.

This year, for the second time, we requested information from social services departments in the North West on the social care of HIV positive people. Twelve social services departments were able to take part, and contributed data on 272 individuals. Most (79%) social services' clients were also seen in the statutory sector in 2003. Services were provided for 34 individuals known to be asylum seekers.

Four hospices reported providing palliative care for HIV positive individuals during 2003. Four HIV positive individuals residing in three strategic health authorities received hospice care, accounting for 57 inpatient days (table 6.1). All four individuals also received care from the statutory sector during 2003. In addition, specialist drugs services contributed data on clients whom were known to be HIV positive (table 6.2). Eight individuals were reported by five drugs services, all of whom also received HIV treatment from elsewhere in the statutory sector in 2003.

We hope that the tables and figures provided in this report, together with additional analyses at PCT level available on the North West Public Health Observatory website (www.nwpho.org.uk/hiv2003), address most of your HIV-related information requirements. However, additional analyses and further breakdown of the data can be provided on request. As ever, we value your suggestions as to any developments that would improve the usefulness of the report in future years.