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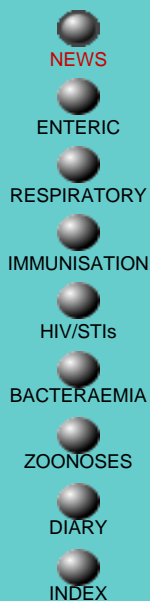
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PHLS Communicable Disease Surveillance Centre



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Patients notified of exposure to HIV-infected dental health care worker in North East London

Over 1300 patients treated by an HIV-infected dental health care worker (HCW) in North East London between July 1997 and July 1999 are being contacted by Barking and Havering Health Authority (HA) and East London and City HA (1). Each patient was sent a letter on 19 March informing them of their exposure, providing details of a confidential help-line, and offering a salivary HIV test. Experienced HIV counsellors are being made available from 0900 to 2000hrs for two weeks to provide a dedicated counselling service and to facilitate HIV testing. Patients have been given the option of receiving negative results in person, by telephone, or in the post. Presumptive positive results will be confirmed by a blood test with arrangements for follow-up via the local genitourinary medicine service.

The diagnosis of HIV infection in the dental HCW, who stopped working in 1999, was confirmed in December 2000. The dental HCW had provided dental care for patients in two NHS practices. Possibly exposed patients were identified by searching the records of all patients registered with the practices. The majority of patients contacted are still resident in area where the dental HCW worked. A significant number, however, have moved elsewhere. The NHS tracing service was used to identify the addresses of those who had moved. Information and salivary swabs have been provided to 37 other HAs to facilitate follow-up and testing of patients near their present place of residence.

Health care workers who have any reason to believe they may have been exposed to infection with HIV, in whatever circumstances, must promptly seek and follow confidential professional advice on whether they should be tested for HIV (2). Examples of how a person in the United Kingdom may have been exposed to HIV infection include a) engaging in unprotected sexual intercourse between men; b) sharing injecting equipment whilst misusing drugs; c) unprotected sexual intercourse in, or with a person who had been exposed in, a country where transmission of HIV through sexual intercourse between men and women is common; d) engaging in invasive medical, surgical, dental or midwifery procedures in parts of the world where infection control precautions may have been inadequate; or e) have had significant occupational exposure to HIV infected material in any circumstances. Additionally, a person who is aware they had unprotected sexual intercourse with someone in any of categories a to e above may also have been exposed to HIV infection. HCWs who find themselves to be HIV-infected must promptly seek and follow expert medical and occupational health advice. HIV-infected HCWs who undertake exposure prone invasive procedures should cease doing so as soon as they become aware of their infection.

1. *Patients notified of dental health care worker with HIV in North East London* [Press Release]. London: Barking and Havering Health Authority, 19 March 2001.

2. UK Health Departments. *AIDS/HIV infected health care workers: guidance on the management of infected health care workers and patient notification*. London: Department of Health, December 1998. Available online from <www.open.gov.uk/doh/aids.htm>.

Report on Leicestershire vCJD cluster published

The inquiry team at Leicestershire Health Authority has reported on the results of the investigation into the geographical cluster of five cases of variant Creutzfeldt-Jakob Disease (vCJD) around the village of Queniborough. The investigators have concluded that the purchase and consumption of beef in the early 1980's from butcher's shops where the meat could have been contaminated with brain tissue from cattle affected with bovine spongiform encephalopathy (BSE) provides a plausible explanation for the cluster (1). A case control study, in which relatives of the five cases and relatives of 30 age-matched controls were interviewed, found that cases were 15 times more likely than controls to have purchased and consumed beef from a butcher who removed brains from cattle ($p = 0.0058$, 95% confidence intervals for odds ratio 1.6 – 140).

The two butchers linked to four of the five cases removed the brains from cattle that were slaughtered

either by the butchers themselves or in a nearby small abattoir. Pithing rods were used during slaughtering, and the carcasses were cleaned by wiping rather than by hosing. Removal of the brain was difficult and messy and the meninges were often ruptured either at removal or by the pithing rod. This led to a risk of cross contamination of carcass meat with brain tissue. Reasons are also given as to why during the early 1980's the cattle in mixed dairy-beef herds used for the local meat trade may have had higher levels of BSE agent at slaughter than cattle raised for beef alone.

The practice of removing and selling the brains of cattle as food was legal in the United Kingdom throughout the 1980's. Since 1989 it has been illegal for cattle brains to be used for human consumption and since 1996 the whole head of cattle over six months must be disposed of in a slaughterhouse as specified risk material.

The current number of definite and probable cases of vCJD in the UK is 97 (2). Of these, seven are probable cases who are still alive. Although there are other geographical areas with more than one case, to date Queniborough is the only area where statistical analysis suggests the association between the cases is unlikely to have occurred by chance. A national steering group comprising representatives from the Public Health Medicine Environmental Group, the National CJD Surveillance Unit, the London School of Hygiene and Tropical Medicine, the PHLS, and the Department of Health developed a protocol to guide the investigation of geographically associated cases of vCJD. This protocol is being made available to CCDC who are investigating associated cases in collaboration with the national steering group. The protocol will be reviewed as experience accrues.

1. Bryant G, Monk P. *Summary of the final report of the investigation into the North Leicestershire cluster of variant Creutzfeld-Jakob disease*. Leicester: Leicestershire NHS Health Authority, 2001. Available online at <www.leics-ha.org.uk>.

2. *Queniborough vCJD cluster report - Department of Health Statement* [press release 2001/0141]. London: Department of Health, 21 March 2001. Available online at <<http://tap.ccta.gov.uk/doh/intpress.nsf/page/2001-0141?OpenDocument>>

Meningococcal infection in pilgrims returning from Hajj

Four cases of infection with *Neisseria meningitidis* group W135 have been confirmed in travellers returning to the United Kingdom (UK) from the 2001 Hajj in Saudi Arabia. Two further confirmed cases of meningococcal infection of unknown serogroup and two probable cases of meningococcal disease have been reported in other pilgrims. Isolates from two of confirmed cases have been identified as subtype 2a:P1.2, 1.5, the same subtype found in the world-wide outbreak of W135 meningococcal disease associated with Hajj in 2000 (1). In 2000 eight pilgrims were affected by the outbreak strain in the UK, with most dates of onset in the three weeks following Hajj. This spread to contacts of pilgrims and also to people with no history of such contact (47 cases in 2000) (2) (data updated March 2001). Sustained transmission of the strain is suggested by the appearance of cases more than nine months after Hajj and the detection of carriers among people visiting a Mosque. Characteristics of Hajj such as crowding in a dry, dusty environment probably explain the increased transmission observed.

The 2001 Hajj took place from 4 to 8 March (week 10), and all pilgrims are expected to return to the UK before 4 April. Based on last year's outbreak, most cases in pilgrims are expected in weeks 11, 12, and 13, but cases will continue to be seen in contacts. The PHLS Communicable Disease Surveillance Centre has contacted both the World Health Organization and the European network but are not yet aware of any cases reported from other countries.

Following large outbreaks of group A meningococcal disease in association with the Hajj in 1987 and 1992 (3,4), all pilgrims to Mecca are required to produce a certificate of vaccination against meningococcal infection before a visa is issued by the Saudi Arabian embassy. In the UK, quadrivalent vaccine was recommended against meningococcal groups A,C,W135 and Y for pilgrims on Hajj in 2001 (2). The vaccination status of the cases is being sought, but failure of the quadrivalent vaccine to prevent meningococcal disease was reported in two Hajj associated cases in the United States last year (5).

Clinicians and microbiologists should be aware of the diagnosis of meningococcal disease in returning pilgrims and their contacts and to ensure that samples and isolates are sent promptly to the PHLS Meningococcal Reference Unit. Supplies of ACWYVax quadrivalent vaccine are now available from the usual pharmaceutical wholesaler/suppliers (SmithKline Beecham Pharmaceuticals, Mundells, Welwyn Garden City AL7 1EY, orders: 080 8100 9997, enquiries: 080 8100 2228).

Please report any cases linked with Hajj to CDSC (tel 020 8200 6868, Mary Ramsay ext 4085 or Susan Hahné ext 3651).

1. Taha MK, Achtman A, Alonso JM, Greenwood B, Ramsay M, Fox A et al. Serogroup W135 meningococcal disease in Hajj pilgrims. *Lancet* 2000; **356**: 2159.
2. CDSC. Meningococcal infection and Hajj. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited on 22 March 2001]; **11**(2): news. Available from <www.phls.co.uk/publications/>
3. Jones DM and Sutcliffe EM. Group A meningococcal disease in England associated with the Haj. *Journal of Infection* 1990; **21**: 21-5.
4. Al-Gahtani YM, El Bushra HE, Al-Qarawi SM, Al-Zubaidi AA, Fontaine RE. Epidemiological investigation of an outbreak of meningococcal disease in Makkah (Mecca), Saudi Arabia, 1992. *Epidemiol Infect* 1995; **115**: 399-409

5. Popovic T, Sacchi CT, Reeves MW, Whitney AM, Mayer LW, Noble CA, et al. *Neisseria meningitidis* serogroup W135 isolates associated with the ET-37 complex. *Emerging Infectious Diseases* 2000; 6 (4): 428-9.

Mandatory bacteraemia surveillance from April 2001

The Government announced in October (1) that every NHS Trust in the country must monitor levels of hospital-acquired infection (HAI), and that this would focus on infections that pose a serious threat to the health of patients, such as methicillin-resistant *Staphylococcus aureus* (MRSA). It was stated that a system would be in place by April 2001, with results being published the following year. A team of health professionals would be formed to drive the initiative, fronted by a trust chief executive - this team is the Healthcare Acquired Infection Surveillance Steering Group (HAISSG), chaired by Mr Graham Elderfield, Chief Executive, Isle of Wight Healthcare NHS Trust.

Following deliberations by this committee, the Department of Health has confirmed that compulsory universal bacteraemia surveillance, focussing on MRSA in the first instance, will be the first step in improving surveillance of antimicrobial resistance and healthcare associated infections, through a two-tier approach. Firstly, there will be a universal and comprehensive approach to MRSA bacteraemia surveillance. This will be complemented by a selective added value bacteraemia module, which is being developed.

Information required for universal bacteraemia surveillance (2)

First tier/primary bacteraemia surveillance

- Data is to be reported quarterly from 1 April 2001 by hospital by the Trust. This will be the responsibility of Chief Executives. Data to go from Trusts to Regions, and then to the centre. Trusts are to be responsible for tidying up their own data, in consultation with the Regional Office.
- The main aim is for Trusts to identify hospitals that are outliers or where there is an observable trend (either increasing or decreasing).
- MRSA needs to be seen in the context of methicillin susceptible *S. aureus* (MSSA) and other micro-organisms causing HAI, including those resistant to antimicrobials. *S. aureus* is considered to be a marker of infection control practice/HAI rates. MRSA bacteraemia is a marker of the prevalence of MRSA infection within that hospital.

Hospital activity data will be extracted from the standard data sets already collected by the centre from all Trusts.

The dataset

This comprises:

- The total number of blood culture sets taken, both positive and negative
- The total number of positive blood culture sets (clinically significant isolates as well as sets with contaminants)
- The total number of *S. aureus* positive blood cultures
- MRSA positive blood cultures expressed as a proportion of all *Staph. aureus* positive blood cultures

Each of these data are to be expressed as a proportion of all hospital activity. Individual trust data will be expressed and then aggregated to provide the regional rates of reported MSSA and MRSA bacteraemias.

How will this information be gathered?

Regional Offices are likely to be contacting Trust Chief Executives about how this data will be collected. For acute trusts whose laboratories participate in CDR reporting, the information on the clinically significant bacteraemias could be obtained directly from their reports to CDSC. In addition, changes have been made to the new version of CoSurv, LabMod3, which has more automated data capture from microbiology systems, to allow microbiologists to indicate whether the bacteraemia was acquired in their hospital or elsewhere, should they wish to provide this extra information at this stage. Trusts which do not participate in CDR reporting will need to agree their reporting arrangements with their Regional Office. Regional Offices will discuss data collection in more detail with Trusts.

Starting in July, there will be quarterly feedback of *S. aureus* bacteraemia rates to appropriate members of individual Trusts (Chair of Infection Control Committee, Infection Control Doctor and Chief Executive) and Health Authorities (CCDC) from Regional Offices. Trust rates will initially be mainly based on the bed availability and occupancy (KH03) hospital activity data and should be examined carefully as changes in trust activity (such as recent mergers), may affect the activity denominator. Trusts should confirm whether their rates are correct or give reasoned justification for their modification. Trusts will also need to provide the activity information and rates for their constituent hospitals, as this information is not available in the KH03 dataset.

The information will then be corrected, as necessary, and returned to trusts, taking into account their feedback. This should initiate a continuing process of feedback to and from trusts, with continuing validation of the data throughout the rest of the financial year, to ensure that the data is robust and bacteraemia reporting consolidated across English acute trusts by April 2002, when trust results will be published.

Each region was allocated £100,000 of Public Health Development Fund money in the financial year 2000/1 to ensure delivery of the first level of surveillance. This will form part of the Government's response to the Public Accounts Committee's report on management and control of hospital-acquired infections (3,4), particularly in relation to surveillance, following the National Audit Office study on hospital-acquired infection. Regional Offices should use these funds to meet local and regional priorities to deliver this surveillance, negotiating with acute Trusts on how the funding is put to most effective use. It is likely that there will be further funding in 2001/2.

A second level of bacteraemia surveillance to show whether high rates of infection are a result of ascertainment, case-mix, or reflect a genuine infection control problem is being developed. Trusts wishing to continue to participate in the current Nosocomial Infection National Surveillance Scheme (NINSS) should do so for the time being, until the arrangements for the second level of surveillance are properly in place.

1. Department of Health Press Release, Monday 16 October 2000. *All hospitals to monitor hospital acquired infection*. London: Department of Health, 2000.
2. Department of Health, February 2001. HAB surveillance: Statement
3. Public Accounts Committee. *The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England*. (HC 306). London: House of Commons, 2000. ISBN 0 10 269500 8. <www.publications.parliament.uk/pa/cm/cmpublic.htm>
4. Treasury Minute on the Forty-Second Report from the Committee of Public Accounts 1999-2000 - Department of Health - *The management and control of hospital acquired infection in acute NHS trusts in England*. 1 February 2001. ISBN: 0101502125. CM 5021.

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Invasive meningococcal infections, England and Wales: laboratory reports, weeks 01-04/01

	Method of diagnosis			Total reports 01-04/01	Cumulative total* 2001	Annual total 2000
	CSF and blood		Other sites			
	culture	non-culture**				
Group A	1	–	–	1	1	2
Group B	103	99	19	221	221	1645
Group C	33	19	1	53	53	712
Group W135	7	4	3	14	14	109
Group X	1	–	–	1	1	4
Group Y	3	1	1	4	4	29
Group Z	–	–	–	–	–	–
Group 29E	–	–	–	–	–	–
Ungroupable	–	–	5	5	5	22
Ungrouped	–	25	–	25	25	137
Total	148	148	28	324	324	2660

* combined CDSC and Meningococcal Reference Unit data. ** latex antigen, microscopy, polymerase chain reaction.

Virus infections, England and Wales: laboratory reports, weeks 08-11/01

Laboratory reports	Number of reports received				Total reports 08-11/01	Cumulative total 2001
	08/01	09/01	10/01	11/01		
Coxsackie A	–	–	1	2	3	9
Coxsackie B	3	1	1	1	6	29
Cytomegalovirus	13	7	12	17	49	176
Echovirus	3	2	2	7	14	53
Parvovirus B19	3	7	3	3	16	66
Varicella zoster virus	3	7	5	3	18	92

Laboratory confirmed cases of measles, mumps and rubella, England and Wales: October to December 2000 quarter

The four weekly reporting of laboratory confirmed cases of measles, mumps, and rubella previously published in *CDR Weekly* are being replaced by quarterly reporting (table 1). Cases include those confirmed by salivary IgM antibody tests as well as routine laboratory reports. Analyses are by specimen date rather than by week of report as was used previously, and therefore totals may differ from those formerly published in this section.

Figure 1 Salivary IgM antibody tests in cases notified to ONS: weeks 40-52/00

	Cases		Salivary IgM antibody results		
	Notified	Tested (%)	Total positive	Recently vaccinated	Confirmed
Measles	466	334 (72)	7	1	6
Mumps	547	401 (73)	199	–	199
Rubella	307	220 (72)	–	–	–

Measles

There were 11 cases of confirmed measles with onset dates in the October to December 2000 quarter. Two were aged 1 year (vaccination status unknown) and two were unvaccinated 2 year olds. Two linked cases in school children were reported, an unvaccinated 16 year old male became infected at a football match after sitting next to a 17 year old female who had measles. Five adult cases were reported including an unvaccinated paediatric SHO who had a history of contact with a child with a rash on a ward, two immunocompromised males aged 26 and 33 years, an unvaccinated 26 year old male, and a 27 year old female traveller from Australia.

Mumps

Two hundred and forty-one cases of mumps with onset dates in October to December 2000 were confirmed. Nearly 90% of the cases have been reported from three regions (Northern and Yorkshire 100; North West 80; West Midlands 31) and are associated with outbreaks in schools (table 2). Seventy-seven percent of the cases were born between 1981 and 1990 (10 to 19 years old). The number of confirmed cases of mumps has been increasing throughout 2000 and there were 177, 179, and 91 respectively in the previous three quarters. The decrease in the third quarter and subsequent increase in the fourth represent decreased transmission during the school holidays following by increased transmission when schools resumed in September. Those born before 1983 are too old to have been offered MMR vaccine. Children born between 1983 and 1986 may have been offered a single dose as part of a school entry catch-up programme from 1988, when MMR was introduced. Children born from 1987 will have been offered one routinely scheduled dose of MMR vaccine. Many of will have had a second dose of measles-rubella vaccine in the school campaign in 1994. About 10% of children who have had only a single dose of a mumps-containing vaccine fail to respond, emphasising the need to include a second dose of MMR in the schedule, which was introduced in 1996.

Figure 2 Laboratory confirmed cases of mumps by agegroup and region, England and Wales: weeks 40-52/00

Region	Age group					Total
	1-4	5-9	10-14	15-19	20+	
Northern and Yorkshire	1	7	70	18	4	100
Trent	–	1	2	1	1	5
Eastern	–	2	7	1	4	14
London	–	–	2	1	1	4
South East	–	–	–	–	1	1
South West	–	–	2	–	3	5
West Midlands	–	19	9	3	–	31
North West	–	2	58	10	10	80
Wales	–	–	1	–	–	1
Total	1	31	151	34	24	241

Rubella

Only seven cases of rubella with onset dates in October to December were confirmed this quarter. There were two cases of congenital rubella syndrome where maternal infection was acquired in Zambia and Pakistan respectively. The other cases included three adult males aged 28 years, 46 years and 75 years, a male whose age was not stated, and a female aged 43 years.

COVER programme: October to December 2000

Vaccination coverage statistics for children up to five years of age in the United Kingdom

This report of the COVER programme presents coverage data for children in the United Kingdom (UK) who reached their first, second, or fifth birthday during the evaluation quarter, October to December 2000. This is the second quarter to also include coverage data on Meningococcal conjugate Group C vaccine (MenC) following its introduction in the UK vaccination programme in November 1999 (1). Children who reached their first birthdays in the quarter would have been scheduled for their third dose primary vaccinations (third dose diphtheria, tetanus, pertussis (DTP vaccine), *Haemophilus influenzae* type b (Hib vaccine), polio vaccine, and menC vaccine) from February to April 2000. Children who reached their second birthdays would have been scheduled for their third dose primary vaccinations from February to April 1999 and first measles, mumps, and rubella (MMR) vaccination from October 1999 to April 2000. These children would have been scheduled for one catch-up dose of MenC from December 1999. Children who reached their fifth birthdays would have been scheduled for their third dose primary vaccinations from February to April 1996, their first MMR from October 1996 to April 1997, their pre-school booster DT, polio, and second dose MMR from February 1999 onwards. One catch-up dose of MenC would have been scheduled from April 2000 onwards.

Methods

Data from computerised child health information systems were submitted in February and March 2001 for children resident in UK health authorities and health boards on 31 December 2000 and reaching their first, second or fifth birthdays during the evaluation quarter (October to December 2000). Details of the data requested have been published (2). These routine request parameters now include MenC.

Results

Coverage at 12 and 24 months

Data were received from all health authorities and health boards in Wales, Northern Ireland and Scotland and all but two health authorities in England (tables 1 and 2). Five English trusts, each serving part/s of a health authority, were unable to provide data this quarter. Thirty-one of the participating health authority/boards (26%) achieved the 95% target for three doses of diphtheria, tetanus and polio vaccine (D3), 18 (15%) for three doses of pertussis vaccine (P3), and 26 (22%) for Hib3 at 12 months of age. Eighty-two health authority/boards (68%) achieved 95% coverage for D3, 59 (49%) for P3, and 77 (64%) for Hib3 at 24 months of age. Two health boards had achieved 95% coverage for MMR at 24 months. Coverage of all antigens at 12 and 24 months (including MMR) was similar to that reported in the previous quarter (3).

Table 1 Completed primary immunisations (all antigens) by 12 months: October to December 2000

Region/country	Number of participating districts (total)	D3	P3	Hib3	MenC
England					
Northern and Yorkshire	13 (13)	91.5	90.8	91.3	88.1
Trent	9 (11)	93.3	92.6	93.1	91.5
Eastern	8 (8)	93.9	93.4	93.6	91.4
London	15 (16)	83.4	82.8	82.8	77.2
South East	14 (14)	91.7	91.1	91.5	88.1
South West	8 (8)	93.2	92.5	93.0	89.7
West Midlands	13 (13)	91.8	90.9	91.7	85.3
North West	16 (16)	91.2	90.5	90.8	89.3
England (total)	96 (99)	90.8	90.1	90.5	87.0
Wales	5 (5)	94.7	93.5	94.4	92.9
Northern Ireland	4 (4)	94.0	93.3	94.2	
Scotland	15 (15)	95.3	94.6	95.1	93.9
United Kingdom	120 (123)	91.5	90.8	91.2	
District/health board range		(77.2-98.4)	(75.7-97.3)	(76.8-98.0)	

Table 2 Completed primary immunisations (all antigens) by 24 months: October to December 2000

Region/country	Number of participating districts (total)	D3	P3	Hib3*	MenC	MMR1
England						
Northern and Yorkshire	13 (13)	94.9	94.1	94.4	82.2	89.5
Trent	10 (11)	96.6	95.9	96.5	89.9	91.5
Eastern	8 (8)	95.8	94.9	95.5	85.4	89.3
London	15 (16)	89.4	88.7	89.0	70.6	78.8
South East	14 (14)	94.5	93.8	94.3	85.7	87.9
South West	8 (8)	96.3	95.3	96.0	88.0	87.9
West Midlands	13 (13)	95.4	94.6	95.0	87.4	88.7
North West	16 (16)	95.1	94.1	94.8	87.6	88.7
England (total)	97 (99)	94.5	93.7	94.2	84.4	87.4
Wales	5 (5)	96.6	94.8	96.4	89.3	89.0
Northern Ireland	4 (4)	96.3	95.6	96.5		91.6
Scotland	15 (15)	97.3	96.7	97.2	92.9	92.5
United Kingdom	121 (123)	94.9	94.1	94.6		88.0
District/health board range		(85.3-100)	(84.6-100)	(84.8-100)		(69.9-97.8)

* three doses before 13 months or one dose thereafter

The routine coverage for MenC vaccine presented in this report represents about 91% of health authorities in England. All health boards in Scotland and all Welsh health authorities submitted data. Routine coverage at 12 months was 87% in England, 93.9% in Scotland, and 92.9% in Wales. Catch-up coverage for this quarter's 24 month cohort was 84.4% in England, 92.9% in Scotland and 89.3% in Wales.

Coverage at 5 years

Data were received from 96/99 (97%) health authorities in the English regions and for all health authorities/health boards in Wales and Northern Ireland. Data for children reaching their sixth birthday in all Scottish health boards were also received for four doses of diphtheria, tetanus and polio vaccine (D4), and MMR2. Coverage at 5 years in England, Wales and Northern Ireland was 94.5% for D3, 92.8% for P3, and 93.6% for Hib3. Coverage at 5 years in England, Wales and Northern Ireland for D4 was 80.4%, 92.4% for MMR1, and 75.1% for MMR2 (table 3).

Table 3 Completed primary immunisations (all antigens) by 5 years: October to December 2000

Region/country	Number of participating districts (total)	D3	P3	Hib3*	MenC	MMR1	MMR2	D4
England								
Northern and Yorkshire	13 (13)	95.1	93.6	94.5	74.3	93.5	79.9	82.9
Trent	10 (11)	95.1	93.7	94.7	82.9	93.5	79.3	81.2
Eastern	8 (8)	94.8	93.2	94.0	75.3	92.6	77.8	81.7
London	15 (16)	88.8	86.8	86.7	55.6	85.3	60.4	69.1
South East	14 (14)	93.7	92.5	92.7	71.1	91.9	73.4	79.2
South West	8 (8)	97.0	95.5	96.3	77.5	95.3	82.4	86.1
West Midlands	13 (13)	95.9	94.1	94.8	73.5	94.4	77.0	81.2
North West	16 (16)	95.9	93.8	95.2	74.2	93.7	74.3	81.4
England (total)	96 (99)	94.3	92.6	93.3	72.3	92.2	74.7	80.0
Wales	5 (5)	96.4	93.1	95.8	74.4	93.2	74.0	80.5
Northern Ireland	4 (4)	97.7	95.4	97.0		97.2	86.6	89.1
Scotland (6 years)	15 (15)						90.5	94.5
England, Wales, and Northern Ireland	105 (108)	94.5	92.8	93.6		92.4	75.1	80.4

* three doses before 13 months or one dose thereafter

Coverage in Scotland at 6 years for D4 was 94.5%, and 90.5% for MMR2. MenC catch-up coverage at 5 years was 72.3% in England and 74.4% in Wales.

Comments

The report for this quarter relates to the first one year old cohort to be offered routinely the MenC vaccine at two, three, and four months with the other primary antigens. Coverage of the new vaccine is very high, within 5% of coverage for other antigens at this age, suggesting that it has been well accepted. The MenC vaccine coverage at 24 months and at five years provides an estimate of coverage for the catch-up programme, when the vaccine was offered to all children up to 17 years of age. These figures also indicate the high acceptability of the vaccine and show the successful efforts of primary care services in identifying and calling up children for the campaign. This high coverage has already had an impact on disease (4), and further reductions in cases and deaths from meningococcal group C infections are expected.

At five years of age, coverage of D4 vaccine has shown a rise of 2% since the previous quarter (5). This increase probably reflects the improvement of supply following shortages of diphtheria-tetanus vaccine in 1999. The small increase in coverage of second dose of MMR vaccine may reflect children being called for both vaccines at this age.

Links to PHLS website:

<http://www.phls.co.uk/facts/Immunisation/Measles/meas.htm>

<http://www.phls.co.uk/facts/Vaccination/VaccIndex.htm>

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AIDS and HIV infection in the United Kingdom: monthly report

United Kingdom data from the PHLS HIV and STI Division, Scottish Centre for Infection and Environmental Health, Institute of Child Health, London, and Oxford Haemophilia Centre (on behalf of UK Haemophilia Centre Directors' Organisation).

AIDS and HIV current totals

By the end of December 2000, 43,834 HIV infected individuals had been reported in the United Kingdom (1). AIDS but not death had been reported in 5,564 (13%), and death with or without AIDS in 13901 (32%). Surveillance of prevalent diagnosed HIV infections recorded a total of 20,408 individuals living with diagnosed HIV infection and seen for care in the UK during 1999 (2).

Ethnicity and HIV/AIDS infection diagnosed in the UK

Information on ethnicity has been requested on the AIDS reporting forms completed by clinicians since the start of surveillance in the early 1980s. At the end of 1997, data on ethnic category were available in 92% of cumulative reported AIDS cases and were discussed previously (3). A table of cumulative AIDS cases by exposure category and ethnicity features in the AIDS/HIV quarterly surveillance tables, available on the PHLS website at <www.phls.co.uk/facts/HIV/hivqnotes.htm>.

The reporting of diagnoses of HIV infection from microbiology laboratories began in the mid-1980s when tests for HIV antibody were developed. Information on ethnicity was first requested on the report form in 1993 when the ethnic categorisation was aligned with that used in the 1991 UK national census (4). The proportion of new HIV diagnoses where ethnicity was reported has increased from 42% (1112/2619) in 1995 to over 70% from 1998 to 2000 (table 1). For diagnoses made in 2000, where ethnicity was reported, 46% were white (967/2081), and 42% were black Africans (874/2081). In 1996 the proportions were 67% and 24% respectively. The figures reflect increasing diagnoses of infections acquired through sex between men and women, the majority of which were acquired in Africa (5).

Table 1 HIV infected individuals* by ethnicity and year of first HIV diagnosis in the United Kingdom: data to end of 2000

Ethnic group	Year of diagnosis**					
	1995	1996	1997	1998	1999	2000
White	748	994	1087	1126	1082	967
Black - Caribbean	30	36	67	76	98	81
Black - African	274	361	537	674	846	874
Black - Other	8	18	20	20	33	20
Indian/Pakistani/Bangladeshi	17	25	38	39	38	50
Other#/mixed	35	43	65	95	93	89
Subtotal	1112	1477	1814	2030	2190	2081
Not known	1507	1188	875	736	753	787
Total	2619	2665	2689	2766	2943	2868

* individuals with laboratory reports of infection plus those with AIDS or death reports for whom no matching laboratory report has been received; ** numbers, particularly for recent years, will increase as further reports are received; # includes Chinese and South East Asian.

Ethnicity of prevalent diagnosed HIV infections

The annual Survey of Prevalent Diagnosed HIV infections records the ethnicity of patients seen for HIV-related care in England, Wales, and Northern Ireland during the preceding year (6). In 1999, the latest year for which data are available, the survey recorded 19,179 individuals seen for HIV-related care (table 2). Information on ethnicity was available for 18,082 (94%) of the individuals, 67% of whom were white, 22% black African, 6% other or mixed, 2% black Caribbean, 2% Indian/Pakistani/Bangladeshi, and 1% black other.

Table 2 HIV infected patients by ethnicity and region of residence when last seen for care in 1999 in England, Wales, and Northern Ireland*

NHS region of residence	Ethnic group							Total
	White	Black Caribbean	Black African	Black other	IPB**	Other#/Mixed	Not known	
England								
Northern and Yorkshire	572	7	52	2	3	24	4	664
Trent	462	5	50	3	33	15	23	591
West Midlands	567	33	55	1	16	18	9	699
North West	1191	11	74	8	18	37	26	1365
Eastern	513	19	91	3	8	27	22	683
London	6506	335	3241	228	163	827	505	11805
South East	1119	15	208	6	19	46	445	1858
South West	619	9	43	2	2	43	5	723
England total##	11553	434	3814	253	262	1037	1039	18392
Wales	278	2	16	–	1	14	3	314
Northern Ireland	92	–	2	–	–	1	–	95
Subtotal	11923	436	3832	253	263	1052	1042	18801
Other/abroad	39	1	11	2	3	10	2	68
Not known	153	13	59	4	6	22	53	310
Total	12115	450	3902	259	272	1084	1097	19179

* patients seen for statutory medical HIV-related care at services in England, Wales, and Northern Ireland in 1999 (includes 204 children born to HIV infected mothers in 1999 whose HIV infection status had not been confirmed: 172 in London, 14 in South East, 4 in Eastern, 4 in North West, 3 in Trent, 3 in West Midlands, 2 resident in Northern and Yorkshire, and 1 in South West; ** Indian, Pakistani, or Bangladeshi; # includes Chinese and South East Asian; ## includes 4 patients where region of residence was not reported.

Ethnicity and region of residence

Sixty-three per cent of patients were reported to live in the London region, and of those where ethnicity was reported, 58% (6506/11300) were white, 29% (3241) black African, 7% (827) other or mixed, 3% (335) black Caribbean, 2% (228) black other and 1% (163) Indian/Pakistani/Bangladeshi. For regions other than London, South East, and Eastern, over 80% of patients were reported to be of white ethnicity and less than 10% were black African.

Ethnicity and route of HIV infection

Ethnicity was reported for 94% of individuals seen for HIV related care in 1999 (table 3). Where ethnicity was known, of the 9932 who probably acquired HIV infection through sex between men, 88% (8723/9932) were of white ethnicity, 7% (663) other or mixed, 2% black Caribbean (169), or black African (164). Among those categorised as infected through sex between men and women, 56% (3024/5392) were of black African ethnicity, 32% (1718) white, 4% (209) other or mixed, 4% (202) black Caribbean and 3% (139) Indian/Pakistani/Bangladeshi. Of those exposed to HIV by routes other than sexual contact, 87% (778/891) were injecting drug users. Eighty-four per cent (380/452) of those infected through blood or blood products were of white ethnicity. Of the children born to HIV infected mothers, 71% (374/524) were of black African ethnicity.

Table 3 Individuals seen for HIV related care in 1999 by ethnicity and exposure category in England, Wales, and Northern Ireland*

NHS region of residence	Ethnic group							
	White	Black Caribbean	Black African	Black other	IPB**	Other#/Mixed	Not known	Total
Sexual intercourse:								
between men	8723	168	164	135	79	663	718	10650
between men and women	1718	202	3024	100	139	209	114	5506
Injecting drug use	778	10	24	–	6	73	45	936
Blood/blood products	380	5	39	1	17	10	43	495
Mother to infant	65	14	374	–	5	66	73	597
Not known	451	51	277	23	26	63	104	995
Total	12115	450	3902	259	272	1084	1097	19179

* patients seen for statutory medical HIV-related care at services in England, Wales, and Northern Ireland in 1999 (includes 204 children born to HIV infected mothers in 1999 whose HIV infection status had not been confirmed: 172 in London, 14 in South East, 4 in Eastern, 4 in North West, 3 in Trent, 3 in West Midlands, 2 resident in Northern and Yorkshire, and 1 in South West;

** Indian, Pakistani, or Bangladeshi; # includes Chinese and South East Asian

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