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## News

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### World AIDS day 2002

World AIDS day is commemorated around the globe on 1 December. It celebrates progress made in the battle against the epidemic — and brings into focus remaining challenges. This year the theme of the World AIDS Campaign 2002-2003 is "Live and let live". The campaign aims to focus attention on the need to eliminate stigma and discrimination, major obstacles to effective HIV/AIDS prevention and care.

Globally, it is estimated that approximately 40 million people were living with HIV/AIDS at the end of 2001. During 2001 an estimated 5 million people were newly infected with HIV, of whom 800,000 were children. In the same year, 3 million deaths were attributed to HIV/AIDS. Sub-saharan Africa continues to bear the brunt of the pandemic, however rapidly the world's fastest growing HIV/AIDS epidemic is currently located in eastern Europe and the central Asian Republics. In 2002, there were an estimated 250,000 new infections there, bringing the total for the region to 1.2 million people living with HIV/AIDS. Several countries in Asia and the Pacific, including China, Indonesia, and Papua New Guinea, also face huge growth in their epidemics. A comprehensive new report AIDS epidemic update 2000 issued this week by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) in advance of World AIDS Day, provides the most up to date information on the state of the global pandemic (1).

HIV continues to be a major public health issue in Britain. Today, it is estimated that there are over 41,000 people living with HIV in the UK of which 12,900 remain undiagnosed. HIV cuts across British society, affecting individuals irrespective of their age, gender, race, social class and sexual orientation. Stigma and discrimination continue to be relevant issues for people living with HIV/AIDS in the UK. They influence individuals' willingness to access care for HIV; their ability to disclose to relatives, friends and partners; and ultimately their ability to access emotional, social and clinical support for their disease. Although many gains have been made in raising awareness about HIV/AIDS, more work needs to be done to challenge prejudice.

There are two short reports in this issue of *CDR Weekly*, one summarising the status of the global pandemic (2) and the other presenting recent results of the Unlinked Anonymous Prevalence Monitoring programme (3). In addition, a World AIDS Day homepage has been added to the PHLS website (4). This provides ready access to the current information on HIV and STI trends and other key resources.

1. Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO). *AIDS Epidemic Update* 2002. ISBN 92-9173-253-2. Available at <http://www.unaids.org/worldaidsday/2002/press/Epiupdate.html>

2. PHLS. HIV/AIDS. A global overview: an overview of current global HIV/AIDS surveillance figures, with a focus on China, India and the Russian Federation. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 29 November 2002]; **12**(48): HIV/STI. Available at <http://www.phls.org.uk/publications/cdr/archive02/hivarchive02.html>

3. PHLS. Prevalence of HIV and hepatitis infection in the United Kingdom in 2001: findings from the Unlinked Anonymous Prevalence Monitoring Programme. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 29 November 2002]; **12**(48): news. Available at <http://www.phls.org.uk/publications/cdr/archive02/News/news4802.htm>

4. *PHLS world AIDS day 2002 homepage* [online] [cited 29 November 2002]. London: PHLS, 29 November 2002. Available at <[http://www.phls.org.uk/topics\\_az/hiv\\_and\\_sti2/wad2002.htm](http://www.phls.org.uk/topics_az/hiv_and_sti2/wad2002.htm)>

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## High HIV incidence in homosexual men, increase in HIV prevalence in heterosexuals, and increased hepatitis C prevalence in recent injecting drug users

The latest results from large scale unlinked anonymous testing in the United Kingdom (1, 2, 3 ) show both a continuing high rate of HIV transmission among homosexual and bisexual men and the increasing impact of the global HIV epidemic on heterosexuals in the UK. The results also show that transmission of hepatitis C has increased in those who began to inject drugs recently. Almost 630,000 unlinked anonymous tests were conducted on leftover serum and saliva specimens collected in 2001 as part of the national monitoring programme of the prevalences of HIV, hepatitis B, and hepatitis C ([http://www.phls.org.uk/topics\\_az/hiv\\_and\\_sti/hiv/epidemiology/ua.htm](http://www.phls.org.uk/topics_az/hiv_and_sti/hiv/epidemiology/ua.htm)).

In 2001, one in twenty (5%) homosexual and bisexual men in London who had syphilis tests at genitourinary medicine (GUM) clinics were infected with HIV and were unaware of their infection. For those in this exposure group aged under 25, one in 24 (4%) was HIV-infected and unaware of their status, indicating transmission of HIV infection at relatively high levels in recent years. Application of the serological test algorithm for recent HIV seroconversion (4) confirms that throughout England and Wales the incidence of HIV infection in this group of homosexual men has stayed high at around 2.5% per year from 1995 to 2001. This is despite the large increase in the use of highly active anti-retroviral therapy in the many HIV-infected homosexual men who have had their HIV infection diagnosed (5,6). Many HIV-infected homosexual men have been engaging in unsafe sex that could have transmitted their HIV infection to HIV negative partners. Against a background of a doubling in homosexually acquired gonorrhoea over two years (7), 26% of homosexual and bisexual men who were aware of their HIV infection prior to their GUM clinic attendance and 41% of those who were unaware of their HIV infection, were also infected with an acute STI.

In heterosexual men and women attending GUM clinics in London, HIV prevalence rose from 0.86% and 0.91% respectively in 2000 to 1.3% and 1.2% in 2001. HIV prevalence in pregnant women in England also showed a further increase in 2001. In London, one in 286 women giving birth was HIV infected, whilst outside of London, one in 2256 was HIV infected. Among heterosexuals born in sub-Saharan Africa and attending London GUM clinics in 2000/2001, one in 21 men and one in 13 women was HIV-infected, compared to one in 428 men and one in 573 women born in the UK. Of the HIV-infected women giving birth in England in 2001, 70% lived in London and 77% were born in sub-Saharan Africa.

In injecting drug users (IDUs) attending specialist agencies, the prevalence of hepatitis C in those who had begun injecting in the previous three years rose from 8.4% in 2000 to 17% in 2001, indicating high levels of ongoing transmission. Overall, the prevalence of antibodies to hepatitis B and C remained steady at 21% and 35% respectively, while HIV prevalence remained low, at less than one per cent. Equipment sharing rates in IDUs continue to be high and there was evidence for a small increase in sharing practises among younger drug users.

A significant number of HIV-infected homosexual men still remain undiagnosed after a GUM clinic visit. Of those who could potentially have had their HIV-infection diagnosed, 56% remained undiagnosed after leaving the clinic. The uptake of voluntary confidential testing (VCT) for HIV in homosexual men, however, increased between 1997 and 2001 from 40% to 54% in London and from

60% to 64% elsewhere. There have also been improvements in VCT uptake in heterosexual GUM clinic attendees. These data highlight the need for clinic-based interventions aimed at encouraging the uptake of HIV testing.

In 2001 substantial improvements in VCT for HIV were seen in pregnant women in England and Scotland. Eighty two per cent of maternal HIV infections were diagnosed before delivery in 2001 in London; meeting targets set by the Department of Health in 1999 (8). In England, outside London 64% of HIV-infected pregnant women were diagnosed prior to delivery compared with 55% in 2000. It is estimated that 100 HIV infections in newborn infants were prevented in 2001 by early maternal diagnosis and the use of interventions to reduce the risk of maternal transmission.

The unlinked anonymous surveys continue to provide essential and otherwise unavailable information on HIV and hepatitis prevalences in the UK. These surveys also provide vital data for evaluating antenatal and other voluntary confidential testing programmes (8, 9, 10) and for monitoring standards and targets put forward in national strategies (9, 10). The data for 2001 highlight the need for continued investment in HIV and hepatitis prevention services.

More comprehensive tables and figures of data supplementary to the 2002 report of the Unlinked Anonymous Surveys Steering Group, as well as electronic slides of the figures, are available at [www.phls.org.uk/topics\\_az/hiv\\_and\\_sti/hiv/epidemiology/ua.htm](http://www.phls.org.uk/topics_az/hiv_and_sti/hiv/epidemiology/ua.htm).

1. *Key points from the Unlinked Anonymous Surveys*. [online] [cited 29 November 2002]. Available at [http://www.phls.org.uk/topics\\_az/hiv\\_and\\_sti/hiv/epidemiology/ua#KeyPoints](http://www.phls.org.uk/topics_az/hiv_and_sti/hiv/epidemiology/ua#KeyPoints)
2. Unlinked Anonymous Surveys Steering Group. *Prevalence of HIV and hepatitis infections in the United Kingdom 2001*. Department of Health; London: 2002. Available at <http://www.doh.gov.uk/hiv/hepatitis/report2001.htm>.
3. PHLS. *HIV in the UK. Press Release*. London: PHLS, 29 November 2002. Available at [http://www.phls.org.uk/press\\_media/press\\_releases/index.htm](http://www.phls.org.uk/press_media/press_releases/index.htm)
4. Murphy G, Parry JV, Gupta SB, Graham C, Jordon LT, Nicoll AN, *et al.*. Test of HIV incidence shows continuing HIV transmission in homosexual/bisexual men in England and Wales. *Commun Dis Public Health* 2001; **4** (1): 33-7.
5. Gary G, Parry J, Jordan L, Charlet A, Gill N. *Trend in HIV incidence in homosexual men attending STI Clinics in England and Wales 1995-2000*. PHLS 27th annual scientific conference. September 2002, Warwick. London: PHLS, 2002..
6. *Infectious diseases can only be tackled by addressing social inequalities. PHLS 27th annual scientific conference. Press Release*. London: PHLS, 5 September 2002. Available at [http://www.phls.org.uk/press\\_media/press\\_releases/archive/02pr/020905pr.htm](http://www.phls.org.uk/press_media/press_releases/archive/02pr/020905pr.htm)
7. PHLS, DHSS&PS and the Scottish ISD(D)5 Collaborative Group. *Sexually transmitted infections in the UK: new episodes seen at genitourinary medicine clinics, 1990 to 2001*. London: Public Health Laboratory Service, 2002. Available at [http://www.phls.co.uk/topics\\_az/hiv\\_and\\_sti/epidemiology/sti\\_data.htm](http://www.phls.co.uk/topics_az/hiv_and_sti/epidemiology/sti_data.htm).
8. NHS Executive. *Reducing mother to baby transmission of HIV. Health Service Circular 1999/183*. DoH: London, August 1999.
9. *The national strategy for sexual health and HIV*. London: Department of Health, 2001. Available at <http://www.doh.gov.uk/nshs/index.htm>.
10. Hepatitis C strategy for England. Department of Health, London, 2002. Available at <http://www.doh.gov.uk/cmo/hcv/strategy/77797dhhepcstrat.pdf>.

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## Fatal infection with European bat lyssavirus rabies-related virus in Scotland

The Veterinary Laboratories Agency confirmed on Sunday 24 November that the man in Scotland with a rabies-like illness was infected with a European bat lyssavirus (EBL) (1). Unfortunately he died later that day. The virus strain, EBL 2, was the same as that isolated from a Daubenton's bat in Lancashire earlier this year (2). This is the fourth confirmed human EBL infection (3, 4, 5). Since the case in Lancashire, the advice that all bat handlers be vaccinated has been re-iterated. Preventive vaccine is provided both for licensed and voluntary at handlers free of charge by PHLS (6). The PHLS also provides vaccine for anyone who is bitten, scratched, or comes into some other types of close contact with bats. Only those coming into such close contact are at any risk at all of acquiring infection with EBL. Vaccination is extremely effective, and there are no recorded cases of EBL infection in anyone who has been fully vaccinated before or after exposure. Once symptoms of rabies develop however the disease appears to be inevitably fatal.

The risk of infection with EBL to the general public and to domestic animals, including cats, is thought to be minimal. All bats are protected species by law and should not be disturbed. Anyone who finds a bat should avoid handling it and seek help from the Bat Conservation Trust (helpline number: 0845 130 0228).

1. PHLS. Possible rabies-like infection in Scotland. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 28 November 2002]; **12** (47): news. Available at: <http://www.phls.org.uk/publications/cdr/archive02/News/news4702.htm>
  2. PHLS. A case of bat rabies in Lancashire. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 28 November 2002]; **12** (40): news. Available at: <http://www.phls.org.uk/publications/cdr/archive02/News/news4002.html>
  3. Berger R. A human rabies case in Finland possibly of bat origin. *Rabies Bulletin Europe* 1986; **4**:12.
  4. Lumio J, Hillbom M, Roine R, Ketonen L, Haltia M, Valle M, *et al.* Human rabies of bat origin in Europe. *Lancet* 1986; **I** (8477): 378.
  - World Health Organization. Bat rabies in the Union of Soviet Socialist Republics. *Rabies Bulletin Europe* 1987; **4**: 12.
  6. Deputy Chief Medical Officer. *Suspected case of rabies in Tayside, Scotland*. CEM/CMO/2002/16. London: DoH, 25 November 2002. Available at: <http://199.228.212.132/doh/embroadcast.nsf>
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## Supplies of BCG vaccine to resume

The Medicines Control Agency (MCA) has approved the use of BCG Vaccine Statens Serum Institut (SSI) for use in the United Kingdom. Bacillus Calmette-Guerin (BCG) vaccine stocks will again become available over the coming weeks following a four month suspension in supply. The SSI BCG will be used in place of the Evans BCG vaccine that was recalled nationally in August 2002(1,2).

**There are two important changes that health care staff must be aware of before using the SSI vaccine.** The recommended dose of SSI BCG vaccine increases for children above one year of age while the Evans BCG dose increases for children above three months of age. Medical, nursing, and pharmacy staff must be vigilant, as this will represent a change to clinical practice and guidance given in *Immunisation against infectious disease* (the “Green Book”) (3). The SSI BCG is not available as a multiple-puncture percutaneous preparation and must be given intradermally. This may necessitate some training of health staff in areas where the percutaneous multiple puncture method has been used.

BCG vaccination programmes targeting all those at high risk of tuberculosis and school children between the ages of 10 and 14 years are likely to resume over the next two months. Detailed guidance and comparisons between the SSI BCG and the Evans BCG have been published and are available on the Department of Health website ([www.doh.gov.uk/bcg](http://www.doh.gov.uk/bcg)) and further information on the BCG vaccine is also available from ([www.immunisation.org.uk/pdf/bcg.pdf](http://www.immunisation.org.uk/pdf/bcg.pdf)).

There are now 18 different BCG strains in use worldwide derived from the original attenuated live strain of *Mycobacterium bovis* developed by Calmette and Guerin in 1921. The SSI BCG Vaccine contains the BCG Danish strain 1331 as the active substance, while the Evans BCG vaccine contains the Glaxo strain (Copenhagen sub strain)1077. There is no evidence to suggest that the two vaccine strains are appreciably different in immunogenicity.

The BCG is one of the most commonly used vaccines in the world. Although BCG vaccination cannot prevent infection by *M. tuberculosis* there is evidence that vaccination offers good protection against more severe disseminated forms of tuberculosis disease, especially when given to children.

1. Chief Medical Officer. *CEM/CMO/2002/11*. London: Department of Health, 9 August 2002. Available at: <http://www.mca.gov.uk/ourwork/monitorsafeequalmed/defmedsrepcen/bcgtroop.pdf>
  2. Medicines Control Agency. *Drug alert EL(02)A/14*. London: Department of Health, 9 August 2002. Available at: <http://www.mca.gov.uk/ourwork/monitorsafeequalmed/defmedsrepcen/bcg.pdf>
  3. *Immunisation against infectious disease*. London: Department of Health, 1996. Available at: <http://www.doh.gov.uk/greenbook>
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## Inequalities and communicable diseases

The Secretary of State for Health reaffirmed the Government’s commitment to reducing health inequalities and improving public health when delivering the second annual public health lecture of the Faculty of Public Health Medicine on 20 November.

There are marked social and ethnic differentials for a number of communicable diseases, and these were

highlighted in the 1999/2000 *review of communicable diseases* published by the PHLS Communicable Disease Surveillance Centre (CDSC). Three of the priority diseases, tuberculosis, HIV, and sexually transmitted infections, for which action plans were specified in *Getting ahead of the curve* (1), show social inequalities that are greater than those seen for heart disease and cancers. Differentials can also be found for other serious infections such as meningococcal disease, as well as the more common respiratory and gastrointestinal infections.

Particular emphasis was placed on the rising incidence of bacterial sexually transmitted infections among young people, although the success of the meningococcal C immunisation campaign in reducing the incidence of that infection was also noted. This demonstrates how communicable disease interventions, if successful can quickly reduce or eliminate inequalities by reducing incidence in all groups.

The same speech highlighted *Tackling health inequalities – 2002 cross-cutting review*, by the Treasury and the Department of Health, which can be found at (<http://www.doh.gov.uk/healthinequalities/ccsrfinal.pdf>). The creation of an Inequalities Unit within the Department of Health was also announced. The full text of the speech can be found at: <http://www.doh.gov.uk/speeches/faculty-med-milburn.htm>.

1. CDSC. *1999/2000 review of communicable diseases*. London: PHLS, 2001. Chapter 10. Available at: [http://www.phls.co.uk/publications/annual\\_review/Ch10.pdf](http://www.phls.co.uk/publications/annual_review/Ch10.pdf)

2. Department of Health. *Getting ahead of the curve – a strategy for combating infectious disease*. London: Department of Health, 2002. Available at: <http://www.doh.gov.uk/cmo/idstrategy/index.htm>

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## Immunisation

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### Virus infections, England and Wales: laboratory reports, weeks 43-47/02

Laboratory reports	Number of reports received					Total reports 43 -47/02	Cumulative total 2002
	43/02	44/02	45/02	46/02	47/02		
Coxsackie A	–	2	1	1	2	6	24
Coxsackie B	1	1	–	2	4	9	98
Cytomegalovirus	8	27	16	13	22	86	897
Echovirus	–	–	–	1	14	15	259
Parvovirus B19	8	9	18	5	23	63	1375
Varicella zoster virus	1	4	6	4	11	26	456

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### Invasive meningococcal infections, England and Wales: laboratory reports, weeks 33-36/02

	Method of diagnosis			Total reports 33-36/02	Cumulative total* 2002
	CSF and blood		Other sites		
	culture	non-culture**	culture		
Group A	–	–	–	–	1
Group B	27	18	3	48	1020

Group C	3	3	1	7	129
Group W135	4	–	–	4	68
Group X	–	–	–	–	3
Group Y	–	–	–	–	17
Group Z	–	–	–	–	0
Group 29E	–	–	–	–	0
Ungroupable	–	–	–	–	1
Ungrouped	–	2	–	2	95
<b>Total</b>	<b>34</b>	<b>23</b>	<b>4</b>	<b>61</b>	<b>1334</b>

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

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## Enhanced surveillance of meningococcal disease: July to September

Regional enhanced surveillance of meningococcal disease (ESMD) began on 1 January 1998 in five regions of England and was extended to include all English regions, Wales, and Northern Ireland from 1 January 1999. The national enhanced surveillance system relies upon consultants in communicable disease control (CCDC) reporting confirmed and probable cases of meningococcal disease occurring in their district each week. Data are collated at the relevant regional PHLS Communicable Disease Surveillance Centre (CDSC) and sent on to CDSC each month. These data are subsequently published quarterly in *CDR Weekly*. Additionally, CCDCs are asked to report details of any clusters of meningococcal disease occurring in educational establishments.

### Third quarter of 2002: weeks 27-39/2002

In the third quarter of 2002, ESMD identified 457 cases of invasive meningococcal disease in the nine English regions, Wales, and Northern Ireland. This is a decline of 31 and 33 per cent on the totals of 659 and 681 in the previous quarter of 2002 and in the equivalent quarter of 2001, respectively. Yorkshire and Humberside reported the highest number of cases in this quarter (60), although the rate per 100,000 was higher in the North East and Northern Ireland (table 1).

**Table 1 Meningococcal Disease by region and country: weeks 27-39/02**

Region	B	C	Other	Infection not confirmed	Total	Rate per 100,000
North East	20	–	1	13	34	1.32
Yorkshire & Humberside	20	2	2	36	60	1.19
East Midlands	15	4	2	26	47	1.12
Eastern	21	2	–	18	41	0.75
London	11	1	3	34	49	0.66
South East	7	3	–	34	44	0.54
South West	21	1	3	16	41	0.82
West Midlands	14	3	1	26	44	0.82
North West	16	1	–	31	48	0.7
Northern Ireland	13	1	–	8	22	1.3
Wales	14	–	1	12	27	0.92
<b>Total</b>	<b>172</b>	<b>18</b>	<b>13</b>	<b>254</b>	<b>457</b>	

A clinical diagnosis of invasive meningococcal disease was reported for 393 cases identified in England and

Wales compared to 255 cases of meningitis and septicaemia officially notified during the same period to CDSC. This implies about 65% of cases are formally notified. The overall case fatality rate in those with a clinical diagnosis (in England, Wales, and Northern Ireland) was 6.5 per 100 cases, whereas the case fatality rate for cases with septicaemia alone was 8.8 per 100 cases (table 2).

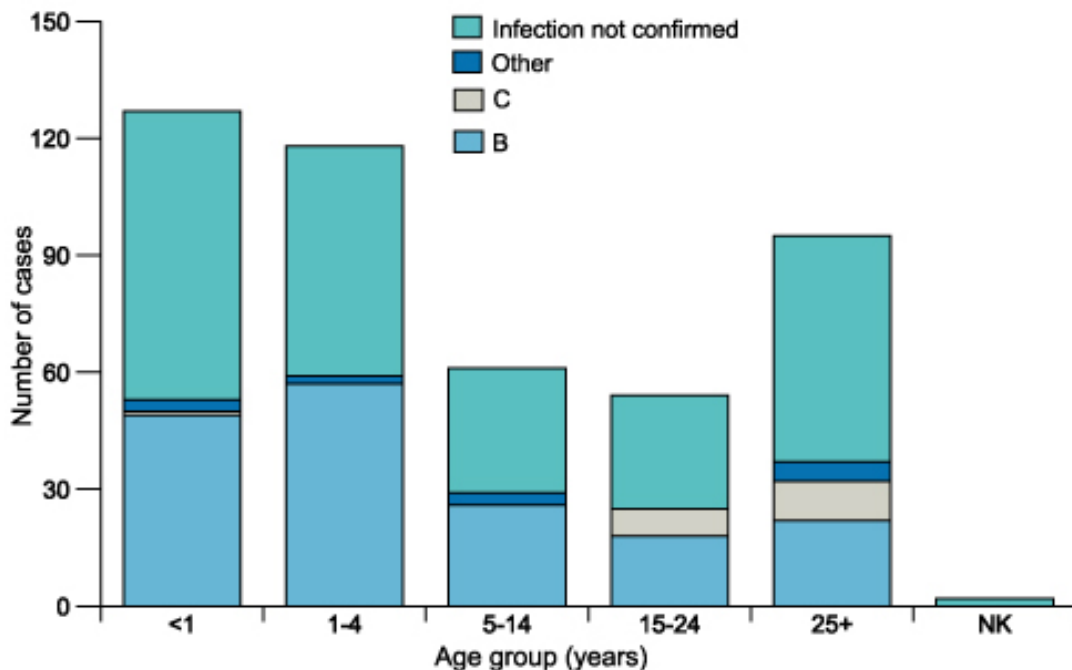
**Table 2 Clinically diagnosed cases (deaths) of meningococcal disease: England, Wales, and Northern Ireland, weeks 27-39/02**

Region	Meningitis	Septicaemia	Meningitis & Septicaemia	Not meningitis or septicaemia	Total
North East	9	19 (2)	6	–	34 (3)
Yorkshire and Humberside	18	29 (2)	11	–	58 (4)
East Midlands	16 (1)	21 (4)	7 (1)	3	47 (6)
Eastern	24 (1)	14 (2)	2	–	40 (3)
London	249 (1)	15 (1)	9	1	49 (2)
South East	13	21 (3)	8	2	44 (3)
South West	20	19 (1)	2	–	41 (1)
West Midlands	9	30 (1)	4	–	43 (1)
North West	14	23 (1)	4	–	41 (1)
Notthern Ireland	7	11 (2)	1	1	20 (2)
Wales	3	15	2 (1)	–	20 (1)
<b>Total</b>	<b>133</b>	<b>217 (19)</b>	<b>56</b>	<b>7</b>	<b>413 (27)</b>

Two hundred and three of the 457 cases (44%) identified in ESMD were confirmed as *Neisseria meningitidis* infection, compared to 244 reports of laboratory confirmed meningococcal disease made to PHLS Meningococcal Reference Unit (MRU) in the same period.

Serogroup B *N.meningitidis* was detected in 85% of confirmed cases identified in ESMD, serogroup C in 9% and the remaining 6% included other serogroups and ungrouped cases. Over half (55%) of all confirmed cases were in children under 5 years of age, among whom serogroup B accounted for 95% of infections, and serogroup C accounted for 1%. In children under 14 years of age, only one serogroup C infection occurred in a child under 1 year old. As this child was only one month old upon contracting meningococcal disease, he/she was too young to be vaccinated (figure1).

**Figure Serogroups on *N. meningitidis* identified in cases in England, Wales, and Northern Ireland by age: weeks 27-39/02**



There has continued to be an overall reduction in the observed number of cases of meningococcal disease compared to the equivalent period in the previous year: serogroup B fell by 17% (172 cases compared to 208 in 2001), serogroup C by 62% (18 cases compared to 48 in 2001), other serogroups by 64% (13 compared to 36 in 2001), and unconfirmed by 35% (254 compared to 389 in 2001). This trend may reflect a real reduction in meningococcal disease since a decline is also observed in routine data: clinical notifications fell by 35% (255 compared to 395 in 2001), and laboratory reports by 21% (244 compared to 310 in 2001).

The recent organisational changes in the NHS could have affected the completeness of reporting and may account for some of this decline. It is interesting to note that the majority of the decline in cases of serogroup C occurred in children rather than adults, implying the success of the MenC vaccine. Additionally, it is worth pointing out that the large decline in other serogroups from the third quarter last year to the same quarter this year was not largely due to a decrease in serogroup W135 as previously thought, although infection by this serogroup did decrease slightly.

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## Laboratory confirmed cases of measles, mumps and rubella, England and Wales: July to September 2002

The four weekly reporting of laboratory confirmed cases of measles, mumps, and rubella previously published in the *CDR Weekly* have been replaced by quarterly reporting. Cases include those confirmed by oral fluid IgM antibody tests and routine laboratory reports (table 1). Analyses are by date of onset rather than by week of report as was used previously and therefore totals may differ from those formerly published in this section. Cases confirmed by oral fluid antibody detection from 1995 are available from:

[http://www.phls.org.uk/topics\\_az/measles/data\\_not\\_confirmed.htm](http://www.phls.org.uk/topics_az/measles/data_not_confirmed.htm)

**Table 1 Total confirmed cases of measles, mumps and rubella, and oral fluid IgM antibody tests in cases notified to ONS, weeks 27-39/02**

	Cases			Oral fluid	IgM antibody	Confirmed	Other lab confirmed	Total confirmed cases
	Notified	Tested	%	Total positive	Recently vaccinated			
Measles	646	577	89%	24	4	20	17	37
Mumps	379	263	69%	50	–	50	33	83
Rubella	405	325	80%	6	–	6	10	16

### Measles

Thirty-seven cases of confirmed measles with onset dates in the third quarter of 2002 were reported, compared to 126 and 52 cases in the first and second quarters of 2002 (1). Twenty-five were aged less than 15 years old (1 less than one year, eight aged 1 to 4 years; nine aged 5 to 9 years; seven aged 10 to 14 years); four were aged 15 to 19 years; seven were adults aged between 20 and 36 years, and one case had no age stated.

Twenty-one (57%) of the cases were confirmed in the South East region. Most of these were unvaccinated children and young adults associated with the travelling family cluster previously reported (1). Only nine cases were reported in London this quarter compared to 91 and 34 respectively in the first two quarters of 2002.

## Mumps

Eighty-three cases of mumps with onset dates in the third quarter of 2002 were confirmed, compared to 84 in the previous quarter (1) giving a total of 303 cases for the first nine months of the year. This compares with 644 cases in the same period in 2001 and suggests that the resurgence of mumps in older children and young adults observed over the last four years may be receding. An outbreak of nine clinical cases (four confirmed by oral fluid IgM testing) was identified during July in a platoon of 17-year old military trainees at an Army Foundation College in Yorkshire. MMR vaccine was offered to the 30 unaffected members of the platoon and no further cases were reported.

Sixty-one per cent of the cases reported this quarter were from the Northern and Yorkshire (36) and North West (15) regions. Sixty-five per cent of all the cases were born between 1983 and 1990 (aged 12 to 19 years). Those born before 1983 are too old to have been offered MMR vaccine. Those 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. Those born from 1987 will have been offered one routinely scheduled dose of MMR vaccine and many of them will have had measles-rubella (MR) vaccine in the school campaign in 1994. About 10% of those vaccinated with 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.

**Table 2 Laboratory confirmed cases of mumps by age group and region, England and Wales: weeks 27-39/02**

Region	Age group						Total*
	<1y	1-4y	5-9y	10-14y	15-19y	20y+	
Northern and Yorkshire	–	1	1	–	28	5	36*
Trent	–	–	–	6	2	2	10
Eastern	–	–	–	–	–	1	1
London	–	–	–	3	–	6	9
South East	–	–	1	–	–	4	5
South West	–	–	–	–	1	–	1
West Midlands	–	–	–	–	–	2	2
North West	–	3	–	5	6	1	15
Wales	–	–	–	1	3	–	4
<b>Total</b>	–	4	2	15	40	21	83*

## Rubella

Sixteen cases of rubella with onset dates in the third quarter of 2002 were confirmed. Six were children; four aged between 4 and 10 years, were associated with a small cluster of cases identified in the South West region (1). Nine were adult cases; four aged 20 to 29 years (1 male, 3 females), and five aged 28 to 56 years (4 males, 1 female). One male, age not stated, was also reported.

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## Laboratory confirmed cases of pertussis by age group, England and Wales January to September 2002

This table shows the number of laboratory confirmed cases of pertussis by age group in England and Wales for the first three quarters of 2002. It is evident from the percentage difference for the equivalent quarter in the previous year (1) that the number of laboratory confirmed cases of pertussis has increased, especially in the older age groups. This could be due to increased diagnosis, increased reporting or an increase in actual disease.

**Table**

Age group	Q1	% difference from Q1/ 01	Q2	% difference from Q2/01	Q3	% difference from Q3/ 01	Total
< 3 months	29	7%	39	-31%	40	-48%	<b>108</b>
3-5 months	12	33%	13	46%	14	-43%	<b>39</b>
6-11 months	1	0%	2	50%	3	-67%	<b>6</b>
1-4 years	7	86%	18	61%	19	11%	<b>44</b>
5-9 years	9	89%	21	76%	12	17%	<b>42</b>
10-14 years	3	33%	10	90%	7	71%	<b>20</b>
15+ years	11	64%	23	91%	30	100%	<b>64</b>
NK	0	–	9	78%	0	–	<b>9</b>
<b>Total</b>	<b>72</b>	<b>38%</b>	<b>135</b>	<b>44%</b>	<b>125</b>	<b>8%</b>	<b>332</b>

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## HIV/STIs

Last updated: 28 November  
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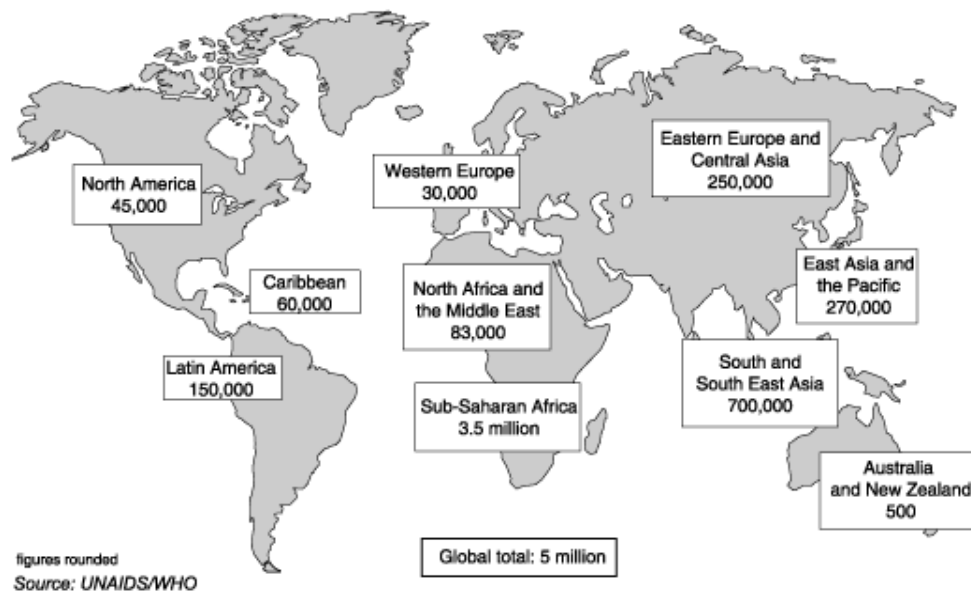
[An overview of current global HIV/AIDS surveillance figures, with a focus on China, India, and the Russian Federation](#)

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### An overview of current global HIV/AIDS surveillance figures, with a focus on China, India and the Russian Federation

It is estimated that worldwide 42 million people will be living with HIV/AIDS at the end of 2002. During 2002 an estimated 5 million people will have been infected with HIV, of whom 800,000 will be children. In the same year, 3.1 million deaths will be attributed to HIV/AIDS. The devastation caused by HIV/AIDS has outstripped any worst-case scenario envisaged at the beginning of the pandemic (1), and there is little reason to believe that the situation is going to improve in the medium term.

**Figure 1 Estimated number of adults and children newly infected with HIV during 2002**



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**Table 1 Regional HIV/AIDS: statistics and features, end of 2002**

Region	Epidemic started	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence rate(*)	%of HIV positive adults who are women	Main mode(s) of transmission (#) for adults living with HIV/AIDS
<b>Sub-Saharan Africa</b>	late '70s early '80s	29.4 million	3.5 million	8.8%	58%	Hetero
<b>North-Africa and Middle East</b>	late '80s	550,000	83,000	0.3%	55%	Hetero, IDU
<b>South and South-East Asia</b>	late '80s	6.0 million	700,000	0.6%	36%	Hetero, IDU
<b>East Asia and Pacific</b>	late '80s	1.5 million	270,000	0.1%	24%	IDU, hetero, MSM
<b>Latin America</b>	late '70s early '80s	1.2 million	150,000	0.6%	30%	MSM, IDU, hetero
<b>Caribbean</b>	late '70s early '80s	440,000	60,000	2.4%	50%	Hetero, MSM
<b>Eastern Europe and Central Asia</b>	early '90s	1.2 million	250,000	0.6%	27%	IDU
<b>Western Europe</b>	late '70s early '80s	570,000	30,000	0.3%	25%	MSM, IDU
<b>North America</b>	late '70s early '80s	980,000	45,000	0.6%	20%	MSM, IDU, hetero
<b>Australia and New Zealand</b>	late '70s early '80s	15,000	500	0.1%	7%	MSM
<b>Total</b>		<b>42 million</b>	<b>5 million</b>	<b>1.2%</b>	<b>50%</b>	

The 2002 World AIDS Day on 1 December highlights “Live and let live” – the theme of the World AIDS Campaign 2002-2003 (2). The campaign focuses on eliminating stigma and discrimination, the major obstacles to effective HIV/AIDS prevention and care. World AIDS Day is commemorated around the globe, celebrating the progress that has been made in the battle against HIV/AIDS, and bringing into focus the remaining challenges.

In this report we summarise the latest epidemiological data on the global HIV pandemic, focussing on China, India, and the Russian Federation. Data, unless specified, is from the UNAIDS AIDS epidemic update of December 2002 (3) or the UNAIDS Barcelona report 2002 (1).

### **Sub-Saharan Africa: by far the worst affected region in the world**

UNAIDS estimates that approximately 3.5 million new infections will have occurred in sub-Saharan Africa in 2002, bringing the total number of people living with HIV/AIDS in this region to 29.4 million. HIV/AIDS will again be the leading cause of mortality, with an estimated 2.4 million deaths attributed to HIV/AIDS during 2002. Most HIV transmission occurs through sexual intercourse, with unsafe blood transfusions and injections, and transmissions from mother to child accounting for a small fraction.

### **Asia and the Pacific: no region is immune**

With an estimated 7.2 million people living with HIV/AIDS in this region by the end of 2002, in terms of absolute numbers Asia and the Pacific is surpassed only by sub-Saharan Africa. Almost 1 million adults and children will have been newly infected with HIV in 2002. Despite well-documented and successful HIV prevention programmes in a few countries, such as Thailand, the HIV/AIDS epidemic continues to spread, and it is anticipated that this region will be severely affected in the coming years.

## China

HIV/AIDS was first reported in China in 1985. Reports of HIV infections rose by more than 67% in the first months of 2001, and by September of the same year the cumulative reported number of people with HIV/AIDS reached 28,133, with 1208 AIDS cases and 641 AIDS-related deaths. It is estimated, however, that only 5% of all HIV/AIDS cases were reported, and so the UNAIDS estimate is one million for the number of adults and children living with HIV/AIDS in China mid-2002. Estimated prevalence among people aged 15 to 49 years was 0.11% in 2001. UNAIDS warns that without immediate and effective measures, HIV/AIDS could afflict as many as 10 million Chinese by the end of 2010. China will be among the world's most heavily infected HIV-infected nations within the next five to ten years. 'High risk' populations in China include injecting drug users (IDUs), commercial sex workers and buyers and sellers of blood. HIV infection is disproportionately high among the rural poor.

The majority of HIV/AIDS infections in China today are due to injecting drug use. Widespread injecting drug use was an early source of HIV infection in China especially in the southern provinces that border the opium-growing regions of Myanmar, Thailand, and Laos. The sharing of needles is a highly effective mode of HIV transmission, and HIV prevalence among IDUs was found to range between 44% and 85% in selected communities of drug users in Yunnan and Xinjiang provinces. There have been reports of an increase in the sharing of equipment by drug users, increasing from 32% in 1999, to 34% in 2000, and to 45% in 2001. Nine provinces are now on the brink of IDU-related HIV epidemics due to very high rates of needle sharing.

IDUs may constitute the largest proportion of HIV cases in China today, but the fastest growing HIV transmission route in China is currently unprotected heterosexual sex. Reports of sexually transmitted infections (STIs) increased from 430,000 cases in 1997 to 860,000 cases in 2000. Trichomoniasis and chlamydia infections are the most prevalent STIs. This significant increase in STIs suggests that non-monogamous unprotected sex is rising, and with a 15 to 49 year old population of 700 million, a generalised HIV epidemic is imminent.

There has also been an explosive increase in commercial sex since the end of the Maoist era (4). The percentage of female prostitutes who do not use condoms decreased from 67% in 1999 to 37% in 2001, and demand for commercial sex is predicted to increase over the next decade as the impact of the excess of young males is felt. The law of only allowing one child per family combined with the deeply ingrained cultural preference for male children, means that over the next decade there will be an excess of 15 million Chinese men. China's HIV epidemic will also be driven by increased population mobility.

Sale of unsafe blood may have infected more than 150,000 rural villagers. The spread of HIV in China through the collection and sale of infected blood has been widely reported in the West. During the early 1990s impoverished farmers were encouraged to sell their blood to collecting centres. Basic blood-donation safety procedures were not followed. Henan province in central China was the focus of this practice and there are reportedly "HIV/AIDS villages" in this province with prevalences reaching 80% (4). A conservative estimate is that 150,000 rural villagers have been infected in this way. The practice was outlawed in 1998 by the *Blood Donation Law*, but there are reports that it still continues.

## India

With a population of over one billion, it is anticipated that HIV spread in India will have a major impact not only on the country itself, but also on the overall spread of HIV in Asia and the Pacific, and beyond.

At the end of 2001, there were an estimated 3.97 million adults and children living with HIV/AIDS in India – more than in any country other than South Africa. Of these 3.8 million were adults, 39% of them women. Official figures of reported cases do not reveal such a large scale problem. This is due to under diagnosis and underreporting, resulting from a lack of testing services and an inadequate surveillance system. Given India's huge population, even a 0.1% increase in the country's prevalence rate would increase the number of Indians living with HIV/AIDS by over half a million.

The spread of HIV within India is very diverse. At the moment there are several distinct epidemics within India, currently concentrated among high-risk, marginalised groups, with signs of rapid spread into the general population. Median HIV prevalence among women attending antenatal clinics was higher than 2% in Andhra Pradesh, and exceeded 1% in four other states in 2001.

Overall the predominant HIV transmission route is heterosexual sex, focussed in the southern states, particularly Maharashtra and Tamil Nadu, and fuelled by the commercial sex industry and long-distance truckers. Between 1994 and 1997, HIV prevalence among STI clinic attendees in Maharashtra state, increased from 6% to 36%. In the north-western states bordering Myanmar, injecting drug use is widespread and infections are generally concentrated among IDUs and their partners. HIV prevalence among IDUs in Manipur increased from 25% to 61% between 1994 and 1997. Sex between men is also a significant HIV transmission route.

Tuberculosis cases are likely to escalate. With an estimated prevalence of 184 cases per 100,000 population, India has the highest number of tuberculosis cases in the world (5). HIV fuels tuberculosis epidemics in several ways, including promoting progression to active tuberculosis both in those with recently acquired and in those with latent *Mycobacterium tuberculosis* infections.

People are still reluctant to discuss the behaviour that contributes to the spread of HIV, and discrimination and stigma within India is in many respects a gender-related phenomenon. A study by UNAIDS (6) found that women are often blamed by their parents and in-laws for infecting their husbands, or for not controlling their husbands urges to have sex with other women. Children of known HIV positive parents are often denied the right to go to school, or are separated from other children. As in many other countries, HIV positive people in marginalised groups, such as commercial sex workers and IDUs, are often stigmatised for both being infected and being members of these socially excluded groups.

## **Eastern Europe and central Asia: the fastest growing epidemic in the world**

HIV/AIDS is spreading rapidly throughout the countries of this region. In 2002, there will be an estimated 250,000 new infections, bringing the total number of people living with HIV/AIDS to an estimated 1.2 million. The Russian Federation remains at the forefront of the epidemic, but many of the other countries, such as the Ukraine and Estonia, are also experiencing rapidly emerging epidemics. The major route of transmission is injecting drug use.

### **The Russian Federation**

Russia's HIV/AIDS epidemic has exploded in recent years, with a cumulative total of over 200,000 cases of HIV infections reported by mid-2002. Again, these reported figures are believed to grossly underestimate the severity of the HIV/AIDS epidemic in this country, and UNAIDS estimates that at the end of 2001 there were 700,000 adults living with HIV/AIDS in the Russian Federation, of whom 180,000 (26%) were women. The average adult HIV prevalence rate is 0.9%.

The social and economic disruptions following the collapse of the former Soviet Union have contributed to the rapid spread of HIV. Although sex between men has played a part in the transmission of HIV, injecting drug use has been the major route of infection. In 1998, 42% of cases reported were among IDUs; the remaining 48% were reported with an undetermined transmission mode.

The impact of HIV/AIDS on the general population, spreading from core groups, such as IDUs, depends on the presence of 'bridging populations', such as commercial sex workers, as well as risk behaviour among the general population. There has been a recent increase in the number of commercial sex workers in the Russian Federation, and significant increases in the incidence of other STIs imply that 'unsafe' sex is on the increase. The incidence of syphilis increased dramatically from less than 30 cases per 100,000 between 1978 and 1992 to 172 per 100,000 in 1995.

The Russian penitentiary system has been branded an 'epidemiological pump' a reference to the high numbers of individuals who are exposed to and contract tuberculosis while in prison, and are then released back into the civilian sector. These prisons, in which public health care is often absent, are also emerging as 'pumps' for HIV, with a significant proportion of convicts being released with HIV and returning to all parts of the Russian Federation. Of further concern is the high prevalence of multidrug-resistant tuberculosis (MDR-TB) found in some prisons. HIV positive prisoners are more likely to be susceptible to MDR-TB, and so the HIV epidemic may result in escalation of this very serious form of tuberculosis in this region.

There are powerful incentives in the Russian legal system, particularly with regard to infection through IDU (which is illegal) for individuals to hide their HIV status and avoid testing, which in turn facilitates the spread of the infection.

## **Latin America and the Caribbean: driven by unequal socioeconomic development**

An estimated 1.9 million people are living with HIV/AIDS in this region where HIV is well established, and in the absence of effective responses HIV is threatening to spread both more quickly and widely. Two hundred and ten thousand people are estimated to have been newly infected in 2001. In many countries the epidemic is firmly rooted in the wider population and driven mainly by heterosexual intercourse

## **.The Middle East and North Africa: late in arriving but now increasing**

HIV infection rates are still very low in most countries within this region, however there have been recent significant increases in some population groups, such as IDUs. It is currently estimated that 83,000 people will have acquired HIV by the end of 2002, increasing the number of people living with HIV/AIDS to 550,000 in total.

## **High income countries: a continuing threat**

Higher rates of STIs are signalling a rise in unsafe sex, and heterosexual transmission is accounting for a larger proportion of new HIV infections. Approximately 76,000 people will be newly infected with HIV/AIDS in 2002, bringing the total number of people living with HIV/AIDS to 1.6 million in the same year. Until widespread public complacency is addressed the epidemic threatens to grow.

The developing global HIV pandemic has already had a considerable impact within the United Kingdom (UK). Since surveillance began, 20% of the infections diagnosed here have been heterosexually acquired in Africa, mainly in individuals of black African ethnicity (7). Other regions have had a much smaller impact so far. The numbers of infections diagnosed in the UK and acquired in Asia and the Caribbean are rising, though they remain low. With three of the world's largest and most populous countries on the brink of generalised HIV epidemics, and increasing numbers of infections across the globe, the need for vigilance remains, as does the need for culturally appropriate prevention, care, and support services.

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