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Consultation on draft guidance on testing healthcare workers joining or re-joining the NHS for tuberculosis, HBV, HCV, and HIV

The Department of Health has published for consultation draft guidance on health clearance for four serious communicable diseases (tuberculosis [TB], hepatitis B [HBV], hepatitis C [HCV] and human immunodeficiency virus [HIV]) for healthcare workers joining or re-joining the NHS (1). This is part of the implementation of the Chief Medical Officer's communicable disease strategy, Getting ahead of the curve and is based on a report from an expert group (2,3). The expert group was asked to undertake a risk assessment of the likelihood of patients becoming infected from healthcare workers carrying these infections, and to make recommendations on policy options (3).

The proposal is for all healthcare workers joining or re-joining the NHS, or commencing training, will have specified health checks for TB and HBV, and the offer of testing for HCV and HIV. These are referred to as 'standard health checks'. All health care workers who will perform exposure prone procedures will also need to have 'additional health checks' and be shown to be free from infection with HBV, HCV, and HIV.

At the same time registered healthcare workers who believe that they may have been exposed to infection are under a professional obligation to promptly seek and follow confidential advice on the need to be tested. Existing guidelines specify the circumstances when testing is indicated for NHS staff (4-6).

Box 1

Standard Health Checks

A check for active tuberculosis and tuberculosis immunity (tuberculin testing)

- including personal history of tuberculosis
- presence of symptoms compatible with tuberculosis
- check for BCG history and scar

If no or inconclusive evidence of a scar a tuberculin test should be performed and this should be given to all persons who have spent time in areas where Tb prevalence is high especially where HIV prevalence is also high

An offer of hepatitis B immunisation with post-immunisation testing of the response

An offer of hepatitis C (HCV) and HIV testing including a reminder of professional responsibilities and personal risk factors for these infections. These are:

HCV:

Receipt of unscreened blood or plasma products in the UK prior to September 1991 and 1985 respectively.

Sharing of injecting equipment while misusing drugs.

Occupational exposure to the blood of patients known to be HCV infected or at high risk of infection.

Involvement as a health worker or patient in invasive procedures in parts of the world where infection control precautions may have been inadequate or with high HCV prevalence populations.

HIV:

Unprotected sexual intercourse between men.

Sharing of injecting equipment while misusing drugs.

Had unprotected heterosexual 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 .

Involvement as a health worker or patient in invasive procedures in parts of the world where infection control precautions may have been inadequate or with high HIV prevalence populations.

Significant occupational exposure to HIV infected material.

Engaged in unprotected sexual intercourse with someone in any of the above categories .

Reference 1

Box 2

Additional Health Clearance

Healthcare workers or those entering training who will perform exposure prone procedures (see Box 1) should be tested for

- Hepatitis B infection ie testing for hepatitis B surface antigen. Those who test negative should be immunised and have their response checked. Those positive should be tested for hepatitis B e-markers and if negative for these for HBV viral load.
- Hepatitis C infection ie testing for hepatitis C antibody. Those who test positive should be tested for hepatitis C RNA.
- Human immunodeficiency virus infection ie testing for HIV antibody

Reference 1

Implementation of the guidance will have a number of advantages. These will include:

- further reducing the already low risk to patients of being infected by healthcare workers with any of these four infections;
- protecting healthcare workers with impaired immunity (for example those who are HIV infected) from infection with TB and HBV;
- reminding health care workers of their professional responsibilities in relation to serious communicable diseases and reinforcing the current guidance for them on tuberculosis, HBV, HCV, and HIV;
- enabling people entering the healthcare professions to make informed choices on their choice of specialty; and
- reducing the burden on the NHS of conducting extensive 'look-back' exercises whenever an exposure seems to have occurred.

Much of the guidance is already in place. It is current policy to screen all new entrants to the health services for evidence of tuberculosis and to be checked for hepatitis B immunity. HCV testing is recommended for healthcare workers who are about to start careers or training involving exposure prone procedures. Healthcare workers who believe that they may have been exposed to HCV or HIV infection should seek medical advice about the need for testing (4-6). What is new is the requirement for people who will perform exposure prone procedures to be tested for HCV and HIV before appointment or commencing training and that only those shown to be non-infectious for HBV, HCV, and HIV be allowed to perform their procedures. It is also proposed that for those people coming from abroad, the required standard and additional tests should be carried out in their own country before they apply for training or employment in the UK. Confirmatory testing will be completed in the UK before the start of training or employment.

Box

Exposure Prone Procedures

Procedures where there is a risk that injury to the healthcare worker could result in exposure of the patient's open tissues to the blood of the healthcare worker. Such procedures occur mainly in surgery (including some procedures in minor surgery undertaken by general practitioners), obstetrics and gynaecology, dentistry and midwifery. See *Expert Group Report (Annex 2) (3)*

Comments on the draft guidance should be sent to Linda Lazarus, Department of Health, Room 631B Skipton House, 80 London Road, London SE1 6LH or by email to healthclear@doh.gsi.gov.uk by 30 April 2003.

1. Department of Health. *Consultation on draft guidance on health clearance for serious communicable diseases: new health care workers*. London: DoH, 2003. Available at <<http://www.doh.gov.uk/healthclear/guidance.htm>>

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The public health impact of flooding

Floods have been estimated to account for 40 % of natural disasters worldwide and are projected to increase in frequency and severity in future, because of global warming (1-4). Although public and media interest in flooding is raised during periods of heavy rainfall, as has been seen recently in the United Kingdom, protection against flooding requires constant long term vigilance, planning, political commitment and public support. The immediate health impacts of being flooded are easily recognized and well documented, including drowning, injuries, electrocution, exposure to toxic fumes, and respiratory, enteric, skin and middle ear infections (3,5,6).

Population vulnerability to flooding varies widely according to the severity of flooding, geography, and political and economic development. Established market economies like the UK are relatively well protected by multiple societal activities including flood defenses, planning controls to limit building in flood planes, sound public water supplies and sanitation, emergency rescue services and access to medical care with robust food supplies (3,5,7,8).

There have only been two published population based studies of the longer term impacts of being

flooded in established market economies, following floods in Bristol in 1967 and Brisbane in 1974 (9,10). Both studies suggested that individuals were psychologically distressed many months after suffering flooding, but the absence of well validated measures of psychological distress and of multivariable statistical methods available to these researchers precluded detailed study of the relationship between mental and physical health.

A community based survey of flooded and non-flooded householders conducted in Lewes, Sussex, nine months after severe flooding in October 2000 explored psychological and physical measures of illness in multivariable models. Publication of the results of this study are awaited with interest and may further inform policy for flood impact amelioration, including the operation of the insurance market (11).

The Public Health Laboratory Service has developed guidelines on coping with the immediate impacts of floods (12). Comments on these guidelines are welcomed, and should be addressed to Mark Reacher, CDSC, 61 Colindale Avenue, London NW9 5EQ: email MReacher@phls.org.uk.

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5. Howard MJ, Brillman JC, Burkle FM. Infectious disease emergencies in disasters. *Emerg Med Clin North Am* 1996; 14: 413-28.
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First outbreak of infections caused by *Klebsiella pneumoniae* producing a CTX-M extended-spectrum β -lactamase in the United Kingdom

An outbreak caused by *Klebsiella pneumoniae* carrying a CTX-M type β -lactamase was detected in a Birmingham hospital. This affected 33 patients between June 2001 and February 2002 on 15 different wards and departments. Most isolates were from urinary tract infections, but some were from assorted specimens, including blood and sputa. This is the first report of an outbreak involving a CTX-M β -lactamase-producing bacterium in the United Kingdom (UK), although sporadic isolates with CTX-M enzymes have been encountered elsewhere in the same period (1). This is a worrying development as CTX-M β -lactamases confer resistance to all cephalosporins, but are not readily detectable by the ceftazidime-based tests commonly used in the UK to detect extended-spectrum β -lactamases (ESBLs).

ESBLs are β -lactamases that have acquired, usually by point mutation, alterations in their sequence that allow them to degrade extended-spectrum ("third generation") cephalosporins such as cefotaxime and ceftazidime. ESBLs were first recognized in the early 1980s and originally thought to be a scientific curiosity. In the last five years, however, their frequency has increased sharply worldwide and they are now a major treatment problem in many clinical settings. An outbreak of ESBL producers at a hospital in Lanarkshire was described in *CDR Weekly* earlier this year (2).

Most ESBLs are derived from the widespread TEM and SHV type β -lactamases, which are the commonest plasmid-mediated β -lactamases of Gram-negative bacteria, and many different TEM and SHV variants are now recognized. In the early 1990s an ESBL group unrelated to TEM and SHV was documented – the CTX-M family. CTX-M enzymes are derived, by horizontal gene transfer and subsequent mutation, from the chromosomal β -lactamases of *Kluyvera* spp. They have spread into different species of clinical Enterobacteriaceae, especially in southern South America and, increasingly, elsewhere. In Argentina they rapidly became the most prevalent ESBL type, more frequent than the TEM and SHV variants. Recently, CTX-M enzymes have been found also to be the most prevalent ESBLs in parts of China, Poland, and Spain as well as in South America(3). Very recently they were also recognized in a number of different locations in the United States (US), suggesting that they are becoming widely dispersed (4).

Problems in detection

CTX-M β -Lactamase producers were first noted in Birmingham in June 2001, when isolates of *Klebsiella pneumoniae* were found that had borderline resistance to ceftazidime by British Society for Antimicrobial Chemotherapy (BSAC) disc diffusion methodology. The minimum inhibitory concentrations (MICs) of ceftazidime for these isolates were between 0.5 and 2 mg/L – values at or below the BSAC susceptible breakpoint of 2 mg/L for ceftazidime, but above the modal MIC for fully-susceptible *Klebsiella pneumoniae* (c. 0.12 mg/L). Double disc synergy tests between co-amoxiclav and ceftazidime nevertheless indicated the presence of an ESBL. Further testing showed the isolates to be clearly resistant to cefotaxime (MICs: 2-16, MIC90: 8 mg/L) and showed synergy between clavulanic acid and cefotaxime. Molecular typing demonstrated that most of the 33 *Klebsiella pneumoniae* isolates with this susceptibility pattern were clonal, and PCR-based DNA sequencing revealed that they all carried the same CTX-M type β -lactamase, which has a novel DNA sequence and has been designated CTX-M-26.

CTX-M enzymes present a particular problem since, on laboratory testing, their producers often appear sensitive to ceftazidime. Consequently, those laboratories that test only ceftazidime – which is the best indicator cephalosporin for TEM and SHV-derived ESBLs – are at risk of missing CTX-M producers (5). Current BSAC and NCCLS guidelines suggest that any ESBL-producing isolate should be reported as resistant to all extended-spectrum cephalosporins, irrespective of laboratory results for individual compounds. Although the clinical evidence for this course of action is not extensive it seems prudent, since clinical failures can occur even when resistance is not obvious in vitro (6). Laboratories that use ceftazidime as the screening cephalosporin for ESBLs (as many do) will not reliably detect strains with CTX-M ESBLs and therefore both ceftazidime and cefotaxime should be used. Alternatively, one of the proprietary cefpodoxime-based ESBL screening systems can be used (7,8). It is important to detect strains carrying these enzymes early, to enable appropriate control measures and prevent further spread. Research on the evolution and properties of this group of ESBLs is currently ongoing at the University of Birmingham. Those interested in working on them should contact Professor Peter Hawkey, email: peter.hawkey@heartsol.wmids.nhs.uk. The Antimicrobial Resistance Monitoring and Reference Laboratory in the Central Public Health Laboratory would welcome information on new isolations of CTX-M enzymes, but outbreaks should be reported to the relevant regional epidemiologist.

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Communicable Disease and Public Health – December 2002 issue published

Communicable Disease and Public Health volume 5 number 4 has recently been published. Contents list, editorials and summaries are available at

<http://www.phls.co.uk/publications/cdph/issues/CDPHvol5/No4/CDPHv5n4.html>

Articles in this issue include an editorial on heterosexual clusters of HIV infection and papers on the public health response to a local cluster of heterosexually acquired HIV infection in Doncaster, and on HIV patient notification involving dental healthcare. Three articles on hepatitis B vaccine include the fast-tracked article Universal hepatitis B vaccination of UK adolescents: a feasibility and acceptability study, forming key evidence for the ongoing debate on hepatitis B vaccination.

Salmonella in salad vegetables is featured in Collaborative investigation of an outbreak of *Salmonella enterica* serotype *Newport* in England and Wales in 2001 associated with ready-to-eat salad vegetables, highlighting the benefits of an integrated approach to outbreak investigations.

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Respiratory

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Laboratory reports of respiratory infections made to CDSC from PHLS and NHS laboratories in England and Wales

Data are recorded by week of report, but include only specimens taken since 1 October 2002 (ie, recent specimens)

Table 1 Reports of influenza infection made to CDSC, by week of report, weeks 49-52/02

Week	49/02	50/02	51/02	52/02	Total
Week ending	08/12/02	15/12/02	22/12/02	29/12/02	
Influenza A	1	1	-	-	2
Isolation	-	-	-	-	-
DIF	-	-	-	-	-
Four-fold rise in paired sera	-	-	-	-	-
PCR	-	-	-	-	-
Other	-	-	-	-	-
Influenza B	1	1	-	-	2
Isolation	-	-	-	-	-
DIF	-	-	-	-	-
Four-fold rise in paired sera	-	-	-	-	-
PCR	-	-	-	-	-
Other	1	1	-	-	2
Influenza (untyped)	-	-	-	-	-
Isolation	-	-	-	-	-

DIF	-	-	-	-	-
Four-fold rise in paired sera	-	-	-	-	-
PCR	-	-	-	-	-
Other	-	-	-	-	-

DIF = Direct Immunofluorescence.

'Other' = 'Antibody detection - Single high titre' or 'method not specified'

Table 2 Respiratory viral detections by any method (culture, direct immunofluorescence, PCR, four-fold rise in paired sera, single high serology titre), by week of report, weeks 49-52/02

Week	49	50	51	52	Total
Week ending	08/12/02	15/12/02	22/12/02	29/12/02	
Adenovirus*	9	9	11	1	30
Coronavirus	-	-	-	-	-
Parainfluenza **	5	6	9	3	23
Rhinovirus	1	2	3	4	10
Respiratory syncytial virus (RSV)	365	538	644	244	1791

*Respiratory samples only. Excludes diagnoses made by electron microscopy (EM)

**includes parainfluenza types 1, 2, 3, 4 and untyped

Table 3 Respiratory viral detections by age group, weeks 49-52/02

Age group (years)	<1 year	1-4 years	5-14 years	15-44 years	45-64 years	65+ years	Unknown	Total
Adenovirus*	7	6	1	14	-	1	1	30
Coronavirus	-	-	-	-	-	-	-	-
Influenza A	-	-	-	-	1	-	1	2
Influenza B	-	-	-	1	-	1	-	2
Parainfluenza**	5	12	3	-	2	-	1	23
Rhinovirus	5	4	1	-	-	-	-	10
Respiratory syncytial virus (RSV)	1445	226	5	10	5	12	88	1791

*Respiratory samples only. Excludes diagnoses made by electron microscopy (EM)

**includes parainfluenza types 1, 2, 3, 4 and untype

Table 4 Laboratory reports of infections associated with atypical pneumonia by week of report, weeks 49-52/02

Week	49/02	50/02	51/02	52/02	Total
Week ending	08/12/02	15/12/02	22/12/02	29/12/02	
<i>Coxiella burnettii</i>	1	2	–	–	3
Rrespiratory <i>Chlamydia</i> sp.*	1	1	2	–	4
Rrespiratory <i>Chlamydia</i> sp.*	1	1	2	–	4
<i>Mycoplasma pneumoniae</i>	12	15	22	14	63
<i>Legionella</i> sp.	8	3	5	4	20

*includes *Chlamydia psittaci*, *Chlamydia pneumoniae* and *Chlamydia* sp detected from blood, serum and respiratory specimens

Table 5 Reports of legionnaires' disease (pneumonic and non-pneumonic*) cases in England and Wales, by week of report, weeks 49-52/02

Week	49/02	50/02	51/02	52/02	Total
Week ending	08/12/02	15/12/02	22/12/02	29/12/02	
Nosocomial		1	–	–	1
Community	3	1	3	2	9
Travel abroad	5	1	1	2	9
Travel UK	–	-1	1	–	1(1)
Total	8	3(1)	5	4	20(1)
Male	7	2(1)	3	2	14(1)
Female	1	1	2	2	6

* non-pneumonic cases in brackets

Twenty cases were reported with pneumonia and one as a non-pneumonic case. Fifteen were male aged between 43 and 79 years and six were female aged between 44 and 82 years. One M 61y and F 57y died. Eleven cases were associated with travel: Spain (5), Canada (1), Egypt (1), Germany (1), Italy (1), and UK (2). One travel case is associated with a community outbreak in Cumbria. Nine cases, seven males aged between 44 and 77 years and two females aged 44 and 54 years had community acquired infection. One F 82y had a hospital-acquired infection.

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Common animal associated infections, England and Wales: laboratory reports, weeks 49-52/02

Organism	Total reports for weeks 49-52		Cumulative totals for weeks 01-52	
	2002*	2001	2002*	2001
<i>Borrelia burgdorferi</i> **#	7	8	190	267
<i>Leptospira hardjo</i> **##	–	1	3	4
<i>Leptospira icterohaemorrhagiae</i> **##	–	–	9	12
<i>Leptospira other</i> **##	–	1	18	11
<i>Pasteurella haemolytica</i>	–	–	4	6
<i>Pasteurella multocida</i>	6	33	189	291
<i>Pasteurella pneumotropica</i>	–	–	4	7
<i>Pasteurella</i> spp	3	7	55	74
<i>Toxocara canis</i>	–	–	3	–
<i>Toxocara cati</i>	–	–	–	–
<i>Toxocara</i> spp	–	–	–	1
<i>Toxoplasma gondii</i>	3	10	30	40
<i>Toxoplasma</i> spp	10	13	58	66

* provisional data; ** by specimen date; # Lyme Disease Reference Laboratory and CDSC;

Leptospira Reference Laboratory and CDSC.

Common imported infections, England and Wales: laboratory reports, weeks 49 - 52/02

Organism	Cumulative total reports for weeks 49 - 52		Cumulative totals for weeks 01 - 52	
	2002*	2001	2002*	2001
Arbovirus	–	–	–	–
Dengue virus	1	1	13	2
<i>Ascaris</i> spp	3	24	95	141
Hookworms (unspecified)	3	14	125	68
<i>Leptospira</i> spp	–	8	5	21
<i>Ancylostoma duodenale</i>	–	–	–	–
<i>Necator americanus</i>	–	–	–	–
<i>Hymenolepis diminuta</i>	–	–	–	1
<i>Hymenolepis nana</i>	4	3	25	46
<i>Hymenolepis</i> spp	–	–	–	–
<i>Schistosoma haematobium</i>	4	10	41	60
<i>Schistosoma intercalatum</i>	–	–	–	–
<i>Schistosoma mansoni</i>	–	3	17	21
<i>Schistosoma</i> spp	4	11	24	46
<i>Strongyloides stercoralis</i>	–	5	12	32
<i>Strongyloides</i> spp	–	–	3	2

* Provisional data

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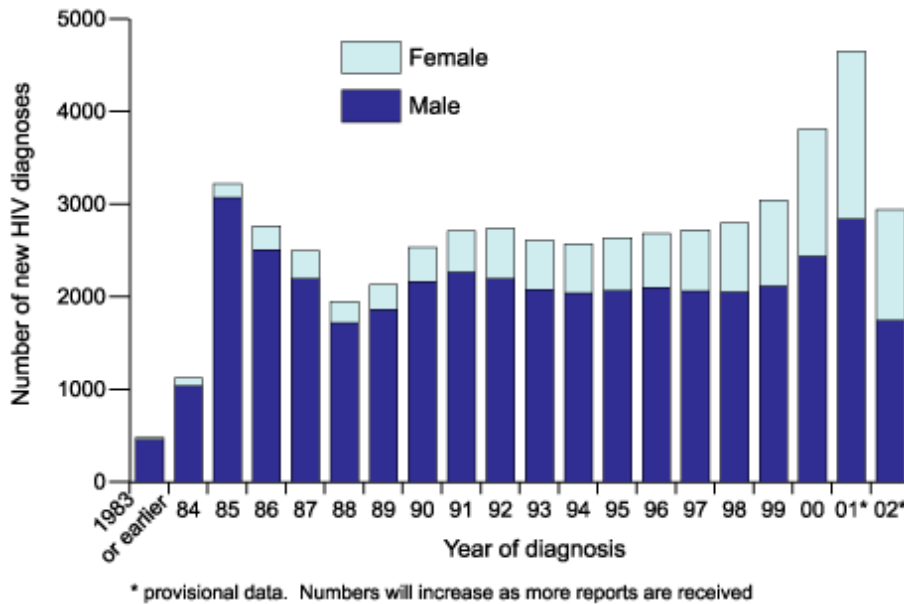
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HIV and women in the UK

Increasing numbers of people newly diagnosed with HIV have been seen in the United Kingdom (UK) since the late 1990s, with a disproportional increase in the numbers of women in recent years (figure 1).

Figure 1 Number of new HIV diagnoses in the UK by sex and year: data to end of September 2002



By the end of September 2002, 52,729 newly diagnosed HIV infected individuals had been reported, of whom 11,600 (22%) were women. Reports indicate that 2733 (24%) of these women developed AIDS, and 1698 (15%) had died.

Numbers of newly diagnosed HIV infected women began increasing in 1993 at a slow but steady rate, but since 1999 numbers have escalated, with an increase of 48% seen between 2000 and 2001. Similar increases are predicted for 2002.

Women account for 58% of probable heterosexually acquired infections. Seventy-nine per cent of the 11,600 newly diagnosed HIV infected women probably acquired their infection heterosexually (table 1), with 7994 (87%) of these infections probably acquired abroad, 6303 (69%) in Africa. Of those infections acquired in Africa, 1470 have been reported as acquired in Uganda and 1341 in Zimbabwe – numbers infected in Zimbabwe have increased sharply in recent years. Of the 6841 (59%) heterosexually infected women for whom ethnicity was reported, 4804 (70%) were of black African origin – the majority of them (4470) infected in Africa – and 1432 (21%) of white origin, of whom 589 were infected in the UK. The numbers of newly diagnosed heterosexually acquired infections in black Caribbean and Asian women have also increased in recent years, but remain relatively low.

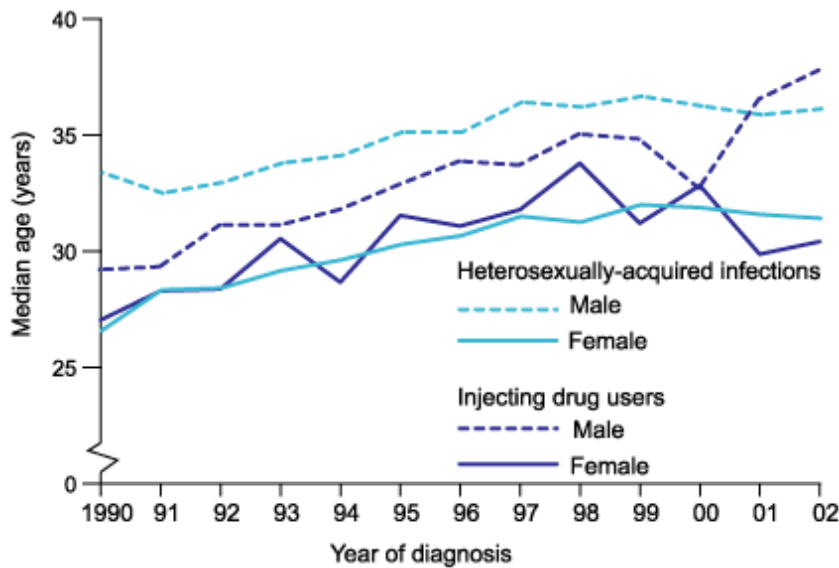
Table 1 Numbers of new diagnoses by sex and trprobable route of transmission in the UK: data to end of September 2002

Infection route	Number of new diagnoses	
	Male	Female
sex between men	28326	–
Sex between men and women	6701	9171
Injecting drug use	2681	1210
Blood factor <i>eg</i> haemophilia	1341	12
Blood transfusion	158	183
Mother to child	438	421
Other/undetermined	1439	603
Total	41084	11600

Injecting drug use accounts for 10% (1210) of newly diagnosed HIV infections in women in the UK. For women who acquired their infections through injecting drug use for whom ethnicity is reported, almost all are of white ethnic origin (697; 96%). Numbers of reported new diagnoses have remained relatively constant over recent years – on average 34 infections per year between 1998 and 2001.

Generally women are younger at HIV diagnosis than men (figure 2). This difference is particularly evident for heterosexually acquired cases, with a median age of 31 years for women since 1990, compared to 35 years for males. This difference in median age at diagnosis between men and women may be partly explained by the fact that women are infected at a younger age than men – younger women sleep with older men. The introduction of antenatal screening and differences in health seeking behaviour may result in women being diagnosed more promptly than their male counterparts. The difference in median age (two years) between male and female injecting drug users is less marked than the difference in HIV-infected heterosexuals.

Figure 2 Median age at diagnosis by sex and route of infection: data to end of September 2002



Most HIV infected women are of childbearing age. The annual report of the Unlinked Anonymous Prevalence Monitoring Programme (1) indicates that the numbers of maternal infections reported as diagnosed during pregnancy in the UK have increased nearly three-fold in recent years, from 90 in 1999 to 261 in 2001. This may reflect improvements in antenatal testing following the introduction of a routine offer of HIV testing to all pregnant women from 2000.. In 2001, 179 (69%) of women newly diagnosed with HIV during pregnancy lived in London. In 2001 there were an estimated 561 births to HIV-infected women in the UK, with an estimated 49 infants infected. This figure would have been substantially higher without improved diagnosis of HIV infection prior to delivery and the subsequent use of appropriate interventions to prevent mother-to-child transmission (1).

The survey of prevalent diagnosed HIV infections (SOPHID) reported that 25,203 individuals as seen for treatment and care in England, Wales, and Northern Ireland in 2001, 6739 (27%) of whom were female (table 2). This represents a 62% increase in the numbers of women being seen for treatment and care since 1999, when 4157 females were reported out of a total of 19179. Over the same period the number of males being seen for care only increased by 23% from 15,022 to 18,464. In 2001, of the 6621 women who were known to reside in England, Wales and Northern Ireland, 4274 (65%) lived in London, of whom 3186 (75%) of known ethnicity were black Africans. Eight hundred and sixty-one (63%) women of white ethnicity seen for treatment and care during 2001 in England, Wales, and Northern Ireland lived outside of London.

Table 2 Diagnosed HIV infected female patients, by ethnicity and region of residence when last seen for care in 2001

NHS Region of Residence	Ethnic group								Total
	White	Black-African	Black-Caribbean	Black-Other/Black Unspecified	Indian/Pakistani/Bangladeshi	Other Asian/Oriental	Other/mixed	Not Known	
North East	42	27	–	–	2	4	1		76
Yorkshire and Humberside	85	87	2	5	5	6	7		197
East Midlands	88	119	5	3	16	7	11		249
Eastern	93	258	7	8	2	8	12	4	392
London	516	3186	180	83	42	27	100	140	4274
South East	194	353	9	3	7	12	11	54	643
South West	89	50	6	–	3	8	13	1	170
West Midlands	75	112	20	6	4	1	8	3	229
North West	135	121	2	2	6	10	11	4	291
England total	1317	4313	231	110	87	83	174	206	6521
Wales	44	14	2	1	1	4	8	5	79
Northern Ireland	16	4	–	–	–	–	1		21
England, Wales, and Northern Ireland total	1377	4331	233	111	88	87	183	211	6621
Other/Abroad	7	6	–	2	–	–	1	–	16
Not known	13	63	1	2	1	1	9	12	102
Total	1397	4400	234	115	89	88	193	223	6739

The 'Direct Method' (2) has been used to estimate the total number of undiagnosed HIV infections in the UK. At the end of 2001 an estimated 41,200 adults were living with HIV in the UK, 12,900 (31%) of whom were unaware of their infection. Of the estimated 10,900 women who had probably acquired their HIV infection heterosexually and were living in the UK in 2001, 4000 (37%) were unaware of their infection (1).

Women made up nearly half of the HIV-infected people globally in 2002 (3). Although this proportion has yet to be observed in the UK, numbers of women being newly diagnosed and living with HIV are increasing rapidly. The HIV epidemic in the UK is no longer largely confined to men. It is important that gender-specific and culturally appropriate treatment, care and support services are available for HIV-infected women and their families.

References

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