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National increases in salmonellosis

The Health Protection Agency's (HPA) Laboratory of Enteric Pathogens (LEP) is continuing to confirm human isolates of *Salmonella* Enteritidis phage type 14b and *S.* Typhimurium PT U277 (1). Both strains are fully sensitive to the panel of antimicrobial agents used by LEP for epidemiological typing. After excluding cases which were reported to be associated with foreign travel, 58 human isolates of the outbreak strain of *S.* Enteritidis PT 14b and 50 human isolates of *S.* Typhimurium PT U277 have been confirmed by LEP since 1 June 2003. Both strains are distributed across all of the regions of England and Wales, although there is a predominance of cases in the southern parts of England. All age groups are affected, but there is an excess of cases of *Salmonella* Enteritidis phage type 14b among males aged between 20 and 40 years.
The Health Protection Agency has completed the first phase of epidemiological investigations. A national case-control study has been designed in an attempt to identify how infection is being transmitted. This investigation will be a joint exercise involving the Local and Regional Services, the Communicable Disease Surveillance Centre, and the Specialist and Reference Microbiology Divisions of the HPA. This will be the first time since the inception of the Agency that a a national outbreak investigation has been attempted, which coordinates local epidemiological investigation of infection through the national network of public health specialists based in local Health Protection Units using a standardised epidemiological protocol.

For further information please contact: Mark Reacher or Bob Adak, Gastrointestinal Diseases Division, Health Protection Agency, Communicable Disease Surveillance Centre (tel: 020 8200 1295, ext: 4551 or 3431, email: bob.adak@hpa.org.uk).

1. Health Protection Agency. National increases in salmonellosis. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 24 July 2003]; **13** (27): news. Available at <http://www.phls.org.uk/publications/cdr/archive03/News/news2703.htm#salm>.

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National Travel Health Network and Centre launched

The National Travel Health Network and Centre (NaTHNaC) was officially launched on 22 July 2003 by

HRH the Princess Royal. The Centre will provide a comprehensive public health and specialist travel health service, setting the best possible national standard for advice and guidance on travel health for healthcare professionals - protecting the health of travellers and decreasing the amount of travel related illnesses.

The Chief Medical Officer's report *Getting Ahead of the Curve* points out that infectious diseases account for 41% of global disease and a significant contributory risk factor is global travel (1). One identified action to tackle the increase of infectious diseases is to strengthen and modernise surveillance. The Department of Health (DoH) has therefore committed itself to funding NaTHNaC to meet the health needs of British residents, whose visits abroad have increased by 8% annually to over 59 million visits in 2002.

There are a number of organisations which provide travel health advice and disease surveillance, but until now these organisations have had no firm link with each other. NaTHNaC is a 'joining up' of these organisations so there is one central, co-ordinated provider of information and advice. It brings together the main experts in travel related medicine to ensure:

- Consistent, authoritative, and evidence-based national guidance to advise current policy and practice in the commercial and non-commercial sectors and other existing sources of information
- Surveillance of infectious and non-infectious hazards abroad and producing regular and accessible outputs
- Written, accessible evidence-based guidelines for specialist conditions
- Individual specialist advice for those advising patients with complex medical problems
- Training materials and workshops for professionals delivering travel health advice
- Short-term and long-term research priorities
- Administration of Yellow Fever Vaccination Centres
- Quality standards and accreditation for training and travel clinics

The Centre is funded by the DoH with oversight management by the HPA. The administrative centre is based at The Hospital for Tropical Diseases, part of University College London Hospitals NHS Trust, with other staff based at the Liverpool School of Tropical Medicine. The travel health surveillance staff are located at the HPA's Communicable Disease Surveillance Centre (CDSC) in Colindale. One of the first priorities has been to set up the telephone advice line for healthcare professionals and to develop guidelines for travellers with specific needs. The travel surveillance section will monitor global disease occurrences, develop innovative approaches to the surveillance of travel-related illness in England, and produce regular outputs of surveillance data. NaTHNaC is the first national institution, in the world, created solely for protecting traveller's health.The telephone advice line for health professionals **(020 7380 9234)** has been operating since the end of March 2003 (having already taken over 1000 calls) and is operational every weekday from 9am until 12 noon. Queries are answered by specialist nurses who have medical cover on hand The official NaTHNaC website <http://www.nathnac.org> has also been launched and will contain up-to-date information on travel vaccines and diseases, news on outbreaks related to travel, and information about yellow fever vaccination centres.

1. Department of Health. *Getting ahead of the curve - a strategy for combating infectious diseases (including other aspects of health protection)*. London: Department of Health; 2002. Available at <http://www.doh.gov.uk/cmo/publications.htm>.

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European Commission proposes European Centre for Disease Prevention and Control

The European Commission has adopted a proposal to create a European Centre for Disease Prevention and Control (ECDC) to reinforce the means to control communicable diseases effectively in Europe (1). The structure of the existing European Union (EU) network on communicable diseases, managed by the Commission and based on ad hoc cooperation between member states since 1991, is not thought to have the ability to protect the EU's citizens sufficiently against threats to their health posed by communicable diseases, including the possibility of the deliberate release of infectious agents ("bio-terrorism").

In May 2003, Health Ministers recognised the need to strengthen the EU's preparedness to deal with disease outbreaks. The proposed new Centre will mobilise and significantly reinforce the synergies between the existing national centres for disease control. The ECDC will also improve planning. It will have a small core staff and an extended network of contacts in Member States' public health institutes and academia. By pooling expertise around Europe it is hoped to provide authoritative scientific advice on serious health threats, recommend control measures, allow quick mobilisation of intervention teams and thus enable a rapid and effective EU-wide response. The Regulation establishing the Centre will have to be agreed by the European Parliament and Council under the codecision procedure. Only when the Regulation is finally adopted can work start on creating a management board, appointing the director and recruiting staff. The Commission is aiming to have the ECDC start work in 2005.

1. *Strengthening Europe's defences against health threats: Commission proposes European Centre for Disease Prevention and Contro l(Press release) IP/03/1091*. Brussels: European Commission, 23 July 2003. Available at <http://europa.eu.int/rapid/start/cgi/guesten.ksh?p_action.gettxt=gt&doc=IP/03/1091|0|RAPID&lg=EN&display=>

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Fighting infection – House of Lords report on infectious disease in England

The House of Lords Science and Technology Committee has published a report on the diagnosis, treatment, prevention, and control of infectious disease. The report, *Fighting infection*, is available at <http://www.hpa.org.uk/news/house_lords_180703.htm>. The Health Protection Agency's response can be found at
<http://www.publications.parliament.uk/pa/ld/ldsctech.htm>.

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Invasive meningococcal infections, England and Wales: laboratory reports, weeks 13-16/03

	Method of diagnosis				
	CSF and blood	Other sites			
	culture	non-culture	culture	Total reports	Cumulative* total to week 162003
Group A	–	–	–	–	–
B	50	51	2	103	**511**
C	6	4	–	10	**53**
W135	–	2	–	–	**14**
X	–	–	–	–	**1**
Y	1	–	–	1	**8**
Z	–	–	–	–	–
29E	–	–	–	–	–
Ungroupable	–	–	–	–	–
Ungrouped	–	5	–	5	**31**
Total	**57**	**62**	**2**	**121**	**618**

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

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Laboratory reports of hepatitis A in England and Wales: first quarter 2003

During the first quarter of 2003, 281 laboratory reports of hepatitis A were made to the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC), 27% (76) more than in the equivalent quarter of 2002. Forty-six per cent (130) were men aged between 15 and 44 years (table 1) and the majority of cases occurred in the Yorkshire and Humberside region. Three people acquired their infection abroad (Pakistan 1; Spain 1; Switzerland 1) and six infections were reported to be in injecting drug users (IDUs). The overall number of cases of hepatitis A in the first quarter of 2003

decreased by 6% (19) compared to that of the fourth quarter of 2002. Most of this decrease was seen in males and females aged between 15 and 44 years.

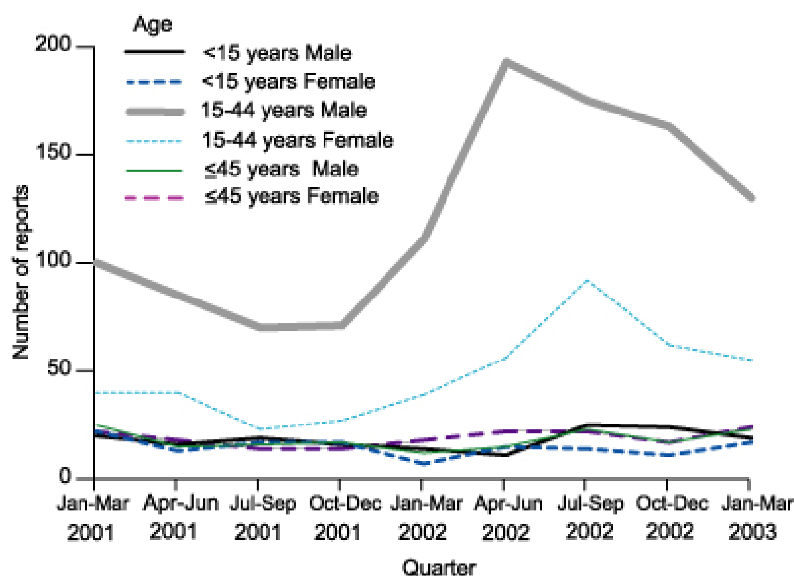
Laboratory reports of hepatitis A in England and Wales: first quarter 2003*

Age Group (years)	Janl-Mar 2003			
	Male	Female	Not known	Total
<1	–	–	–	–
1-4	1	6	1	8
5-9	10	4	2	16
10-14	12	7	–	19
15-24	53	31	2	86
25-34	60	19	1	80
35-44	17	5	1	23
45-54	4	12	–	16
55-64	5	3	–	8
≥65	10	9	1	20
NK	3	1	1	5
Total	**175**	**97**	**9**	**281**

NK = Not known

Risk factor information is incomplete so the trends are difficult to interpret. It was previously mentioned that the increase seen in females for the third quarter of 2002 could be secondary cases acquired from men, and may be linked to the outbreaks in IDUs (1, 2). This suggestion was reinforced by the observation last quarter (3) that the peak in female cases occurred subsequent to the peak observed in male cases before starting a similar declining trend. The decline continued this quarter (figure 1).

Figure 1 Number of cases of hepatitis A by age group and sex, January 2001 - March 2003



Under-reporting and variations in regional reporting continue to present a challenge. There were 341 cases of hepatitis A were formally notified in the first quarter of 2003, 18% more than were laboratory confirmed. The largest discrepancy was seen in the East Midlands, where 52 cases were formally notified while only 16 laboratory reports were made. Discrepancy between notifications and laboratory reports was also high in London, where 23 notifications and 8 laboratory reports were made. If the low numbers are a true reflection of current incidence in London it is difficult to explain, as populations at high-risk are concentrated in the city. Since the IDU population is so mobile, the ongoing outbreaks would be expected to have spread into London as well. Under-reporting by London laboratories continues as reported previously. The number of notifications exceeded the number of laboratory reports for all regions except in the North West and West Midlands, where the number of laboratory confirmations remained higher. This is similar to last quarter and is probably due to under-notification by general practitioners in the area.

The total number of laboratory reports, as well as the number of notifications, has decreased this quarter compared to last. This may reflect a real reduction in the number of cases of hepatitis A, and attributes the containment of the numerous outbreaks that have been occurring, around the country, to control measures such as vaccination of IDUs, including

prisons (2, 4, 5).

Priorities for the development of hepatitis A virus surveillance include improving risk factor reporting by clinicians to laboratories and from laboratories to CDSC, increasing the speed and rates of notification of cases by clinicians to Health Protection Units, obtaining greater participation in laboratory reporting of cases (especially in London,) and providing better detection and definition of outbreaks through application of hepatitis A virus genotyping.

1. Health Protection Agency. Laboratory Reports of hepatitis A in England and Wales; third quarter 2002. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 22 July 2003]: immunisation. Available at <http//www.phls.org.uk/publications/cdr/PDFfiles/2003/cdr0403.pdf>

2. Perrett K, Granerød J, Crowcrof N, Carlisle R. Changing epidemiology of hepatitis A: should we be doing more to vaccinate injecting drug users? *Commun Dis Public Health* 2003; **6**(2): 97-100.

3. Health Protection Agency. Laboratory Reports of hepatitis A in England and Wales; fourth quarter 2002. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 22 July 2003]: immunisation. Available at <http://www.phls.org.uk/publications/cdr/PDFfiles/2003/cdr1703.pdf >

4. Crowcroft NS. Hepatitis A virus infections in injecting drug users. *Commun Dis Public Health* 2003; **6**(2): 82-84.

5. Sundkvist T, Smith A, Mahgoub H, Kirkby A, Kent R, Wreghitt T, *et al*. Outbreak of hepatitis A infection among intravenous drug users in Suffolk and suspected risk factors. *Commun Dis Public Health* 2003; **6**(2): 101-5.

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Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: first quarter 2003

There were 138 reports of acute hepatitis B infection in the first quarter of 2003. The majority of cases (75%) occurred in those aged 15 to 44 years (table 1). During the first quarter of 2003 injecting drug use was the main risk factor associated with hepatitis B infection, accounting for 39% (20/51) of individuals with known risk factors (table 2). Hepatitis B infection associated with heterosexual exposure accounted for 29% (15/51), 16%in men who had sex with men, and 16% in individuals with other risk exposures.

Table 1 Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: first quarter 2003*

Age Group (years)	Jan-Mar 2003		
	Female	Male	Total
<1	–	–	–
1-4	–	1	1
5-9	–	1	1
15-24	9	11	20
25-34	22	27	49
35-44	7	27	34
45-54	3	11	14
55-64	4	6	10
≥65	2	6	8
NK	–	1	1
Total	**47**	**91**	**138**

*All data are provisional
NK = Not known

Table 2 Laboratory reports of acute hepatitis B infection by exposure category in England and Wales: first quarter 2003*

Risk Exposure	Jan-Mar
IDU*	20
Sex between men	15
Sex between men & women	8
Other identified risk	8
No identified risk	87
Total	**138**

*All data are provisional

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Laboratory reports of acute hepatitis C infection by age group and sex, England and Wales: first quarter 2003

A total of 1670 reports of hepatitis C infection were reported in the first quarter of 2003 (table 3). Sixty-five per cent (1080/1670) of the cases occurred in those aged 25 to 44 years. Cases in males exceeded those in females.

Age Group (years)	Jan-Mar 2002			
	Male	Female	NK	Total
<1	–	–	–	**–**
1-4	5	12	1	**18**
5-9	–	1	–	**1**
10-14	1	1	–	**2**
15-24	78	96	3	**177**
25-34	174	377	16	**567**
35-44	137	368	8	**513**
45-54	66	151	4	**221**
55-64	21	42	1	**64**
≥65	24	26	3	**53**
NK	17	30	7	**54**
Total	**523**	**1104**	**43**	**1670**

NK = Not known

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Laboratory Reports of *Haemophilus influenzae* by age group and serotype, England and Wales

Laboratory Reports of *Haemophilus influenzae* by age group and serotype, England and Wales 2nd quarter 2003 (2002)

Serotype	Age					Total
	<1 year	1-4 years	5-14 years	>=15 years	Not known	
b	8(4)	18(25)	6(6)	21(17)	–(–)	53(52)
nc	6(20)	2(2)	2(3)	29(60)	–(–)	39(85)
a,e,f	–(1)	–(3)	–(–)	14(5)	–(–)	14(9)
not typed	1(3)	2(–)	–(1)	38(38)	1(–)	42(42)
Total	15(28)	22(30)	8(10)	102(120)	1(–)	148(188)

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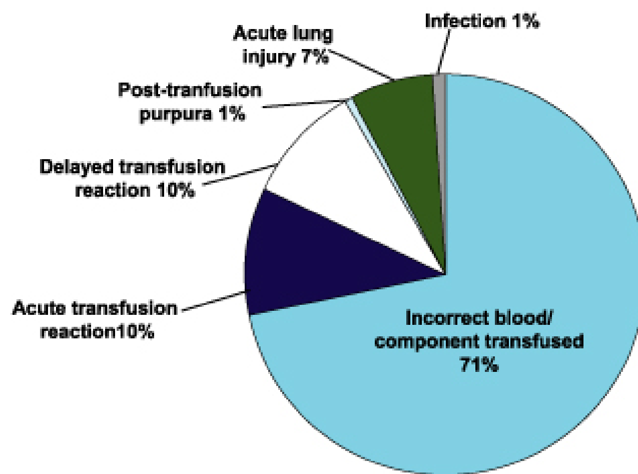
Serious hazards of transfusion (SHOT): annual report 2001-02

The surveillance system for serious transfusion complications (serious hazards of transfusion, [SHOT]) (1) issued its sixth annual report on 17 July 2003 (2).

The 2001-02 SHOT report documents relatively rare incidents of serious complications associated with blood transfusion in the United Kingdom (UK) during 2001-02 (figure), and cumulatively for six years since October 1996. In previous reports, the year-end date for SHOT reporting has been 30 September. From 2003, the reporting year becomes January to December, therefore this report covers a transitional period of 15 months, so from October 2001 to December 2002.

Figure Cases of serious complications associated with blood transfusion reported in the United Kingdom: 2001 to 2002



The sixth annual report describes a similar profile of complications as previous reports. Ninety-three per cent (378/405) of eligible hospitals in the UK participated in SHOT, a similarly high level of participation seen in the previous year (92%). It is of concern, however, that 51% of participating hospitals did so by confirming no incidents had occurred during the reporting year, suggesting incidents are occurring unnoticed or unreported.

Thirty-four initial reports of post-transfusion infections (PTI) in UK were made during 2001-02, 9 fewer than the previous year (43 reported October 2000 to September 2001). Five PTI reports were classified, after appropriate investigations, as transfusion-transmitted infections (TTI). These TTIs contributed only 1% of the total complications of transfusion reported between October 2001 and December 2002.

All five TTIs were due to transfusion of single units of platelets contaminated with bacteria. Four of the five units were five days old, and one was three days old. In three cases, the implicated organism was *Staphylococcus epidermidis*, one Group B *streptococcus,* and one *Morganella morganii*. All recipients had major morbidity, none died.

Full details of all these cases, and of the non-infectious complications are included in the Annual Report (2). Forty cases of transfusion-transmitted infections have been reported in UK since October 1995 (table). Twenty-six of these were bacterial contaminations, including six of the seven deaths. The majority of these cases (22/26) involved transfusion of platelets.

Table Cumulative total transfusion-transmitted infections: reported in UK from 1/10/1995 to 31/12/2002 by year of transfusion (The number of incidents is shown with the total number of identified infected recipients in brackets)

Infection	Year of transfusion										
	pre-1995	1995	1996	1997	1998	1999	2000	2001	2002	Total	Deaths
Hepatitis A virus	–	–	1(1)	–	–	–	–	–	–	1(1)	–
Hepatitis B virus	1(1)b	1(1)	1(1)	1(1)	1(1)	2(3)	1(1)	–	–	8(9)	–
Hepatitis C virus	–	–	1(1)	1(1)	–	–	–	–	–	2(2)	–
HIV †	–	–	1(3)	–	–	–	–	–-	–	1(3)	–
Bacteria	-	1(1)	1(1)	3(3)	4(4)	4(4)	7(7)	5(5)	1(1)	26(26)	-
infection was implicated in the death of a recipient	–	–	–		2	1	3	–	–	–	6
Malaria	–	–	–	1(1)	–	–	–	–	–	1(1)	–-
infection was implicated in the death of a recipient	–	–	–	1	–	–	–	–	–		–
HTLV I	1(1)	–	–	–	–	–	–	–	–	1(1)	–

Total	2(2)*	2(2)	5(7)	6(6)	5(5)	6(6)	8(8)	5(5)	1(1)	40(43)	–
infection was implicated in the death of a recipient	–	–	–	1	2	1	3	–	–	–	7

*One household member who was caring for the recipient was diagnosed with acute HBV.
†One additional investigation, initially reported during 97-98 and concluded during 98-99, failed to confirm or refute transfusion transmission of HIV infection during the early 1990s. As the patient had received multiple transfusions, and had no other risk factors for infection, transfusion with HIV infectious blood was concluded to be the probable, although unproven, source of infection.

Transfusion transmitted infections continue to be rare in the UK. No viral infection for which testing of blood donations is mandatory has been transmitted through transfusion since 2000. Bacterial contaminations are the commonest reported infectious complication of transfusion. The report recommends increased efforts to prevent bacterial contamination of blood components including the diversion of the first few mL of the blood donation collected (most likely to contain skin flora) away from the pack that enters component production and improved arm cleansing techniques. Methods of testing platelets for bacterial contamination should be evaluated and hospitals should consult guidelines (available from blood centres) about the appropriate investigation of post-transfusion reactions that are suspected to be due to bacteria. The residual risk of transfusion transmitted infections is continually being reviewed to assess the need for additional screening methods, for example HBV RNA testing.

1. CDSC. Surveillance of the complications of blood transfusion. *Commun Dis Rep CDR Wkly* [serial online] 1996 [cited 23 July 2003]; **6** (47): news. Available at <http://www.phls.org.uk/publications/cdr/CDR96/cdr4796.pdf>.
2. Serious Hazards of Transfusion Scheme. *Annual Report 2001-02*. Manchester: SHOT, 2002. ISBN 0 9532 789 5 6.(Copies can be obtained from the SHOT office (tel 0161 251 4208), price £25 to non-NHS, or viewed at< http://www.shotuk.org/>

HIV/STIs

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AIDS and HIV infection in the United Kingdom: monthly report (July 2003)

AIDS and HIV infection in the United Kingdom: monthly report (July 2003)

United Kingdom (UK) data from the Health Protection Agency's HIV and Sexually Transimitted Division, Scottish Centre for Infection and Environmental Health, Institute of Child Health, London, and the UK Haemophilia Centre Doctors' Organisation.

In the second quarter of 2003 the number of individuals reported to the United Kingdom (UK) HIV data set increased by 1655, bringing the cumulative total since the AIDS reporting began in 1982 to 57,763. Thirty-four per cent (19,656) of the total have been reported as having had an AIDS defining condition, of whom 12,666 (64%) have died. A further 2593 (4.5%) of the total have died without having had a report of an AIDS defining condition. Some of the individuals reported may have left the country, and there may also be some multiple reports of individuals due to data transcriptions errors, incomplete reports, and name changes. As a result of these errors, matches between related reports have not been made, despite every effort being made to identify duplicate reporting. The total number of reports received for 2002 now stands at 5542, which is the highest for any year since reporting began (table 1).

Fifty-seven per cent (3152) of those reported for 2002 were probably infected through sex between men and women. Sex between men accounted for 29% (1617) of reports of new diagnoses. Both these totals will rise as further reports are received, and the follow-up process identifies the likely route of infection for the 10% for whom it has not yet been established. The number of diagnoses of HIV infection attributed to injecting drug use have fallen over the last decade from around 200 a year to just over 100 since 1999, with the current total for 2002 at 98. Diagnoses of HIV transmitted perinatally from mother to child have not fallen as much as might have been expected following the implementation of a policy to routinely offer and recommend an HIV test to all pregnant women. One reason for this is the growing number of women moving to the UK when already HIV infected, bringing children born elsewhere who have not benefited from antenatal HIV prophylaxis.

Over most of the past decade the numbers of diagnoses of HIV acquired through sex between men has been running at under 1500 a year (table 1). The total for 2001 is now very close to 1700, and the total for 2002 may well exceed this number by July 2004 with late reports and the resolution of the likely route of infection for those currently in the undetermined category. This may be reflecting better diagnosis rather than a rise in the total homosexually infected pool, but it will contribute to the demand for services and treatment in the same way in either case.

Table 1 HIV infected individuals* by year of first reported UK† diagnosis: data to the end of June 2003

How infection was probably acquired	<1993	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Sex between men‡	14,429	1502	1482	1472	1545	1401	1355	1347	1498	1714	1617	528	**29,890**
Sex between men and women	3037	769	796	851	835	1005	1160	1427	1981	2829	3152	1094	**18,936**
Injecting drug use	2493	204	167	183	173	168	130	112	109	128	98	32	**3997**
Blood factor treatment	1337	4	2	–	2	2	2	1	1	2	3	–	**1356**
Blood/tissue transfer	184	13	15	20	18	27	8	20	22	23	22	5	**377**
Mother to infant	176	66	65	61	62	81	94	82	102	82	99	36	**1006**
Other/undetermined	580	62	47	64	56	51	65	78	107	196	551	344	**2201**
Total	**22,236**	**2620**	**2574**	**2651**	**2691**	**2735**	**2814**	**3067**	**3820**	**4974**	**5542**	**2039**	**57,763**

Totals, particularly for recent years, will rise as further reports are received.
Numbers within acquisition categories will rise as follow-up is completed for those currently in the undetermined category.
*Individuals with a diagnosis of HIV infection or AIDS reported by a microbiologist or clinician.
† includes 71 individuals first reported from the Isle of Man or the Channel Islands.
‡ includes 707 men who also injected drugs

In the early years of the UK HIV epidemic it was assumed that bisexual men and heterosexually active injecting drug users (IDUs) would form a significant bridge for HIV spread to the general population. In the UK these fears have not been fully realised (table 2). Among those diagnosed by the end of 1992 who were classified as having acquired HIV heterosexually, 13% (383 of 3037) had a record of sex with a high-risk partner/individual. In the following decade the proportion fell to 3% (543 of 15899).

Table 2 Individuals* categorised as HIV infected through sex between men and women by year of first reported UK diagnosis and route of infection sub-category: UK data to the end of June 2003

	Year of diagnosis												
	<1993	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total

Exposure to 'high risk' partner(s) ,*ie*, to partner(s) presumed infected through:													
Sexual intercourse between men	109	24	21	12	11	10	11	12	13	23	17	2	**265**
Injecting drug use	199	37	31	41	33	49	48	23	22	36	16	7	**542**
Blood factor treatment (*eg*, for haemophilia)	65	2	2	3	6	1	1	1	1	–	1	–	**83**
Blood/tissue (*eg*, transfusion)	10	3	–	1	3	5	3	4	1	4	2	–	**36**
Exposure to presumed heterosexually infected partner(s):													
Africa	1938	506	534	559	549	642	745	994	1478	2151	2338	725	**13,159**
Latin America/Caribbean	62	24	27	14	25	28	32	62	67	82	108	31	**562**
Asia	66	28	18	39	44	53	78	76	110	97	95	40	**744**
North America	56	16	9	8	8	10	15	7	6	9	4	2	**150**
Europe	127	38	36	42	42	50	42	49	46	46	41	15	**574**
Australasia	6	2	–	2	1	2	4	6	2	5	2	1	**33**
country(ies) not known	24	–	–	2	7	3	17	–	2	1	1	1	**58**
Exposure in the UK to partner(s) presumed infected													
outside Europe	91	17	38	48	42	71	81	90	127	155	153	31	**944**
in Europe	108	42	44	38	29	39	41	48	47	51	35	20	**542**
in country(ies) not known	152	28	30	32	28	31	25	30	27	56	87	34	**560**
Partner's exposure category undetermined‡	24	2	6	10	7	11	17	25	32	113	252	185	**684**
Total	**3037**	**769**	**796**	**851**	**835**	**1005**	**1160**	**1427**	**1981**	**2829**	**3152**	**1094**	**18,936**

Totals, particularly for recent years, will rise as further reports are received.
Numbers within acquisition categories will rise as follow-up is completed for those currently in the undetermined category.
*Individuals with a diagnosis of HIV infection or AIDS reported by a microbiologist or clinician.
‡ numbers will decrease as a result of successful follow-up to clarify currently undetermined partner exposure information

Although the annual numbers of diagnoses of infection attributed to heterosexual contact with a high-risk partner have remained fairly stable over time, diagnoses of heterosexually acquired infections overall have risen four-fold. The most substantial increase has been in those who have probably acquired HIV heterosexually in Africa. In each of the last two years the annual totals (2151 and 2338) have been greater than the cumulative total to the end of 1992 (1938). There have been rises in the numbers acquiring infection heterosexually in Latin America, the Caribbean, and in Asia, but together these regions account for less than 10% of the number attributed to infection in Africa. This disparity is due to two factors, the very high HIV prevalences in many African countries, and the historic links between the UK and Africa. Heterosexual spread within the UK has contributed to relatively few diagnoses to date, but the numbers are rising, particularly for those whose infection has been attributed to heterosexual contact with someone infected outside Europe (from 17 in 1993 to 153 in 2002). For 234 (76%) of the 308 diagnoses in this category in 2001 and 2002 combined, the partner was recorded as having acquired infection in Africa. For those not known to have been heterosexually exposed to someone infected outside Europe the numbers have remained much the same at 40 to 50 a year throughout the 1990s.

The regional distribution of annual numbers of diagnoses shows that all regions have experienced a rise over the last decade (table 3). The largest rise in numbers, from 1627 in 1993 to 2684 in 2002, has been in diagnoses in London. The other English regions, however, have experienced a greater proportional rise, from 2.4 times in the South West and North West regions, to 5.4 times in the Eastern region. For Wales, Scotland, and Northern Ireland, new diagnoses have risen to 1.7, 2.0, and 2.1times their respective numbers for 1993.

Table 3 HIV infected individuals* by year of first reported UK diagnosis and region or country of report: data to the end of June 2003

Country/Region of report	<1993	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
North East	369	22	32	21	24	34	22	30	35	50	81	39	**759**
Yorkshire and Humberside	721	79	66	81	90	82	85	92	99	179	291	149	**2014**
East Midlands	420	68	57	51	48	44	60	84	100	195	236	137	**1500**
Eastern	551	84	61	78	55	76	85	95	186	307	457	167	**2202**
London	13,405	1627	1583	1684	1704	1718	1762	1948	2327	2741	2684	922	**34,105**
South East	1803	222	233	168	226	215	204	216	353	491	648	243	**5022**
South West	725	67	108	86	77	91	104	101	103	132	161	69	**1824**
West Midlands	693	82	75	98	62	98	106	101	178	209	321	42	**2065**
North West	1267	145	146	179	187	149	187	205	227	421	355	133	**3601**
England (total)	**19,954**	**2396**	**2361**	**2446**	**2473**	**2507**	**2615**	**2872**	**3608**	**4725**	**5234**	**1901**	**53,092**
Wales	**331**	**41**	**46**	**46**	**36**	**44**	**30**	**34**	**46**	**65**	**70**	**24**	**813**
Northern Ireland	**109**	**12**	**14**	**12**	**16**	**9**	**9**	**14**	**19**	**19**	**24**	**10**	**267**
Scotland	**1813**	**169**	**145**	**146**	**160**	**167**	**154**	**146**	**146**	**158**	**214**	**102**	**3520**
UK Total	**22,207**	**2618**	**2566**	**2650**	**2685**	**2727**	**2808**	**3066**	**3819**	**4967**	**5542**	**2037**	**57,692**

Channel Islands/ Isle of Man	29	**2**	**8**	**1**	**6**	**8**	**6**	**1**	**1**	**7**	–	**2**	**71**

Totals, particularly for recent years, will rise as further reports are received.
Numbers within acquisition categories will rise as follow-up is completed for those currently in the undetermined category.
*Individuals with a diagnosis of HIV infection or AIDS reported by a microbiologist or clinician.

There are differences, too, in the relative regional impact of recent diagnoses of heterosexually and homosexually acquired infections (table 4). Only for the North West and Northern Ireland were there fewer heterosexual than homosexual diagnoses in 2002 (1:0.76 and 1:0.79 respectively). Elsewhere, the ratio varied from 1:1.2 in the South West, to 1:6.0 in Eastern region. Of the 98 infections attributed to IDUs, 49 (50%) were diagnosed in London, as were 53 (53%) of the 99 infections attributed to mother-to-child transmission.

Table 4 First UK diagnoses of HIV in 2002 by country/region of diagnosis and probable route of infection: data to the end of June 2003

Country/region of first UK diagnosis	How infection was probably acquired						
	Sex between men	Sex between men and women	Injecting drug use	Blood product treatment or transfusion	Mother to child transmission	Other/ undetermined	**Total**
North West	148	118	6	1	4	78	**355**
North East	21	57	–	–	–	3	**81**
Yorkshire and Humberside	53	208	9	2	5	14	**291**
West Midlands	56	188	4	3	10	60	**321**
East Midlands	41	168	5	2	12	8	**236**
Eastern	50	300	5	3	5	94	**457**
London	916	1407	49	10	53	249	**2684**
South East	154	456	7	2	5	24	**648**
South West	70	84	3	–	3	1	**161**
Wales	**27**	**37**	**2**	–	–	**4**	**70**
Northern Ireland	**13**	**10**	**1**	–	–	–	**24**
Scotland	**68**	**119**	**7**	**2**	**2**	**16**	**214**
Total	1617	3152	98	25	99	551	**5542**

As reflected by new diagnoses, the UK HIV epidemic remains London focused, but with striking changes affecting most of the areas outside London. Numbers are rising throughout the UK, and the rise has been mainly attributable to diagnoses of heterosexually acquired infection. Although the great majority of these infections were acquired abroad, there is some evidence of an increase in heterosexual transmissions within the UK from those who acquired infection in Africa. Along side prevention initiatives with gay men, sustaining programmes to limit spread within and from these African communities, are of great importance.

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