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- [A cluster of lymphogranuloma venereum in The Netherlands with connections to the UK](#)
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## News

Last updated: **22 January 2004**  
Next update due: **29 January 2004**

-  [Update on avian influenza A \(H5N1\) in humans in Vietnam](#)
-  [A cluster of lymphogranuloma venereum in The Netherlands with connections to the UK](#)
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### Update on avian influenza A (H5N1) in humans in Vietnam

On 19 January 2004, the World Health Organization (WHO) confirmed a fifth case of H5N1 avian influenza in humans in Vietnam. All five confirmed cases have been fatal. Further information is available at [http://www.who.int/csr/don/2004\\_01\\_19/en/](http://www.who.int/csr/don/2004_01_19/en/). Several other patients with severe respiratory illness remain under investigation in Hanoi, Vietnam.

Epidemics of highly pathogenic avian influenza recently reported in some south east Asian countries are being monitored closely because of their potential significance for human health [http://www.who.int/csr/don/2004\\_01\\_15/en/](http://www.who.int/csr/don/2004_01_15/en/). The epidemics of avian influenza in poultry in the Republic of Korea, Vietnam, and Japan, are now known to have been caused by an H5N1 strain of avian influenza.

A qualitative risk assessment by the Department for Environment Food and Rural Affairs (DEFRA) has concluded that there is negligible risk of transmission of highly pathogenic avian influenza from east Asia to the United Kingdom through trade routes. There remains, however, a very small background risk of introduction of this disease due to the presence of low pathogenic strains of influenza virus in migratory birds, which may mutate to highly pathogenic strains <http://www.defra.gov.uk/animalh/diseases/monitoring/riskassess.htm>.

Sequence data from the H5N1 variant isolated from fatal human cases in Vietnam indicates that the virus had not yet acquired genes from the human influenza virus, and no human-to-human transmission has been detected [http://www.who.int/csr/don/2004\\_01\\_16/en/](http://www.who.int/csr/don/2004_01_16/en/).

WHO remains concerned, however, that the simultaneous occurrence of large and fatal outbreaks in birds in south east Asia may indicate that influenza A H5N1 is becoming established in birds in this part of the world. Widespread epidemics in birds increase opportunities for human exposure, which in turn increases the opportunities for the avian and human strains of influenza virus to exchange genetic material. If a new virus subtype emerges as a result, and if that virus proves capable of spreading easily and sustainably from person-to-person, the conditions for the start of an influenza pandemic would have been met.

Despite the seriousness of the current outbreak in humans, WHO believes that it can be controlled, provided decisive measures are taken to eliminate the animal reservoir for human infections. Surveillance for human respiratory disease in this part of the world has been intensified [http://www.who.int/csr/don/2004\\_01\\_16/en/](http://www.who.int/csr/don/2004_01_16/en/). The Health Protection Agency is staying in close contact with the Department of Health, DEFRA, and WHO to monitor the situation.



A cluster of lymphogranuloma venereum (LGV) among men who have sex with men (MSM) has been reported from Rotterdam in the Netherlands. Between April and December 2003, ten confirmed, two probable, and one possible, cases were reported as infected with *C. trachomatis* serovar L2 (LGV2), as well as one confirmed LGV1 case. Cases presented with proctitis or constipation. Rectal swabs from all cases tested positive for chlamydia by PCR, although urethral swabs were negative. All cases were white males aged from 26 to 48 years. Thirteen were HIV positive (and already aware of their HIV status), and eight had a concomitant sexually transmitted infection (STI). One is hepatitis C (HCV) positive, and sexual transmission was the likely route of infection. All men reported unprotected insertive and receptive anal sexual contact. Fisting (insertive and receptive) was reported commonly. Many sexual contacts were anonymous, hampering individual contact tracing. Sexual contacts were reported in Germany, Belgium, United Kingdom, and France. Three further suspect cases of LGV have been identified in the past week following intensified contact tracing in The Netherlands.

LGV is an STI caused by *Chlamydia trachomatis* serovars L1, L2, and L3. The incidence of LGV in the developed world is low, and incidental cases are normally considered to be imports from areas where LGV is endemic, such as west and east Africa, India, southeast Asia, south and central America, and some Caribbean islands (1,2). The ulcerous character of LGV favours transmission and acquisition of HIV and other STIs as well as other bloodborne diseases (3). Recommended treatment is 100 mg doxycycline twice daily for 21 days (4).

Notification of the outbreak has been cascaded to genitourinary medicine physicians in the UK via the British Association of Sexual Health and HIV (BASHH) Newsletter. European Union STI surveillance and microbiological collaborators in the European Surveillance of STI (ESSTI) Network have also been informed through the ESSTI\_ALERT early warning system, as well as the official European Early Warning System.

In view of the international distribution of the sexual contacts healthcare providers should be aware of this ongoing incident and have a high index of suspicion for associated cases among MSM.

### References

1. Engelkens HJH, Stolz E. Genital ulcer disease. *Int J Dermatol* 1993; **32**: 169-81.
2. Perine P L, Stamm W E. Lymphogranuloma venereum. In: Holmes KK, Mårdh PA, Sparling PF, *et al*, eds. *Sexually Transmitted Diseases*. New York: McGraw-Hill, 1999:423-32.
3. Fleming DT, Wasserheit JN. From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sex Transm Inf* 1999; **75**: 3-17.
4. Roest RW, van der Meijden WI. European guideline for the management of tropical genito-ulcerative diseases. *Int J STD AIDS* 2001; **12** (Suppl 3): S78-83.

### Links

Further information on this outbreak is available in *Eurosurveillance Weekly*, at <http://www.eurosurveillance.org/ew/2004/040122.asp>



## Erratum: COVER programme: April to June 2003

(*Commun Dis Rep CDR Wkly* 25 September 2003; **13**(39): immunisation. Available at <http://www.hpa.org.uk/cdr/PDFfiles/2003/cdr3903.pdf>).

On 25 September 2003, table 3 was published with incorrect data. These data have now been corrected.

**Table 3 Completed primary immunisations (all antigens) by 5 years: April to June 2003**






Region/Country	PCT/HB/AR* (total)	DTPol3 %	P3 %	Hib3 %	MenC %	MMR1 %	MMR2 %	DTPol4 %
<b>Regions of England</b>								
North East	16 (16)	95.7	95	95.3	91.6	93.9	82.5	82.4
North West	42 (42)	95.6	94.3	94.7	90.8	92.2	77.2	82.8
Yorkshire & Humber	33 (34)	95.3	94.5	94.6	86.7	92.9	78.6	82.2
East Midlands	28 (28)	97.1	96.4	96.5	92.7	94.6	79.6	86.1
West Midlands	30 (30)	96.0	95.1	95	91.2	93.8	79.1	83.9
East of England	41(41)	95.5	94.7	95	90	91.6	79.9	85.6
London	32 (32)	87	86.3	86.4	72.7	78.9	56.2	61.7
South East	49(49)	94.4	93.5	93.7	88.5	91.2	75.6	83.4
South West	32 (32)	96.8	95.8	96.1	91.2	92.8	79.6	86.9
<b>England (Total)</b>	<b>303 (304)</b>	<b>94.2</b>	<b>93.4</b>	<b>93.6</b>	<b>87.3</b>	<b>90.4</b>	<b>75.0</b>	<b>80.6</b>
<b>Wales</b>	<b>3 (3)</b>	<b>94.7</b>	<b>92.5</b>	<b>94.2</b>	<b>90.5</b>	<b>90.2</b>	<b>74</b>	<b>81.8</b>
<b>Northern Ireland</b>	<b>4 (4)</b>	<b>98</b>	<b>97.9</b>	<b>97.3</b>	<b>95.6</b>	<b>97</b>	<b>87.9</b>	<b>90.6</b>
<b>Scotland 6 years†</b>	<b>15 (15)</b>	<b>–</b>	<b>–</b>	<b>–</b>	<b>–</b>	<b>–</b>	<b>90.4</b>	<b>94.9</b>
<b>England, Wales &amp; Northern Ireland</b>	<b>325 (326)</b>	<b>94.4</b>	<b>93.5</b>	<b>93.7</b>	<b>87.8</b>	<b>90.6</b>	<b>75.4</b>	<b>81.0</b>

\* PCTs/health boards/administrative regions

† No data available at 5 years

**Immunisation**

Last updated: **22 January 2004**  
 Next update due: **26 February 2004**

-  [Laboratory reports of invasive meningococcal infections, England and Wales laboratory reports: weeks 33-38/03](#)
-  [Laboratory reports of hepatitis A in England and Wales: July to September 2003](#)
-  [Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: July to September 2003](#)
-  [Laboratory reports of hepatitis C infection by age group and sex, England and Wales: July to September 2003](#)
-  [COVER programme: July to September 2003](#)

### Laboratory reports of invasive meningococcal infections, England and Wales laboratory reports: weeks 33-38/03

	Method of diagnosis			Total reports 33-38/03	Cumulative* total to week 38/2003
	CSF and blood culture	Non-culture	Other sites culture		
Group A	–	–	–	–	1
B	39	41	7	87	904
C	8	–	–	8	83
W135	2	–	–	2	24
X	–	–	–	–	2
Y	1	–	–	1	11
Z	–	–	–	–	–
29E	1	–	–	–	1
Ungroupable	–	–	–	–	2
Ungrouped	–	3	–	3	56
<b>Total</b>	<b>51</b>	<b>44</b>	<b>7</b>	<b>102</b>	<b>1084</b>

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

## Laboratory reports of hepatitis A in England and Wales: July to September 2003

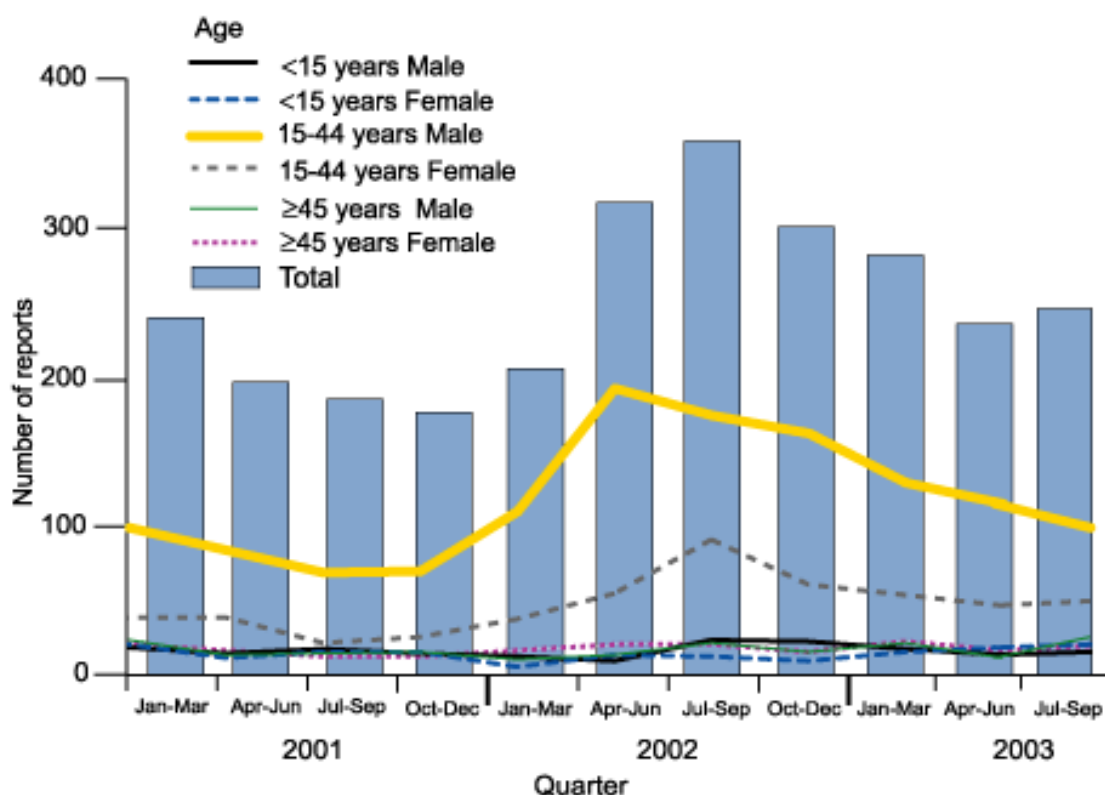
During the third quarter of 2003, 245 laboratory reports of hepatitis A were made to the Health Protection Agency's Communicable Disease Surveillance Centre (CDSC), 31% (112) less than in the equivalent quarter of 2002. The last two quarters have seen a decrease in the number of cases compared to the equivalent quarters in the previous year. Forty-one per cent (100) were men aged between 15 and 44 years (table) and the majority of cases occurred in the East Midlands and Yorkshire and Humberside regions. Six people acquired their infection abroad (Pakistan 3; India 1; Nigeria 1; United States 1) and five infections were reported to be in injecting drug users (IDUs). The overall number of cases of hepatitis A in the third quarter of 2003 increased by 4% (10), compared to that of the second quarter of 2003. Most of this increase occurred in the younger age groups, particularly males aged between 5 and 14 years and females aged between 1 and 4 years, although the small numbers make it hard to draw any definite conclusions based on this observation. The number of cases in males aged between 15 and 44 years, the age group where most increase was seen previously, continued to decline this quarter (figure).

**Table Laboratory reports of hepatitis A in England and Wales: July to September 2003\***

Group	Male	Female	NK†	Total
<1	–	–	–	–
1-4	6	4	–	10
5-9	10	8	1	19
10-14	11	10	–	21
15-24	50	22	2	74
25-34	38	17	1	56
35-44	12	12	1	25
45-54	5	6	1	12
55-64	7	8	–	15
≥65	5	7	1	13
<b>Total</b>	<b>144</b>	<b>94</b>	<b>6</b>	<b>245</b>

\*Provisional data; †NK = Not known.

**Figure Number of laboratory reports of hepatitis A by age group and sex: January 2001 to September 2003**



Under-reporting and variations in regional reporting continue to present a challenge. Three hundred and twenty-eight cases of hepatitis A were formally notified in the third quarter of 2003, 25% more than laboratory confirmed. The largest discrepancy was seen in the London region, where thirty-eight cases were formally notified and only 11 laboratory reports were made. Under-reporting by London laboratories continues as reported previously. Discrepancy between notifications and laboratory reports was also high in the North West, East Midlands, and South West regions. The number of notifications exceeded the number of laboratory reports for most regions. In the Eastern, North West, and Yorkshire and Humberside regions, however, the number of laboratory confirmations remained higher than the number of notifications. This was particularly evident in the North West, where 23 laboratory confirmations were made and only 15 cases were formally notified. This is probably due to under-notification by clinicians in those areas.

The total number of laboratory reports, as well as the number of notifications, has increased this quarter compared to last. This may reflect a real increase in the number of cases of hepatitis A. There have been reports of additional outbreaks occurring in the IDU community and the increase seen may reflect this.

Priorities for improving control of hepatitis A include enhancing 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 means such as the application of hepatitis A virus genotyping.



## Laboratory reports of acute hepatitis B infection by age group and sex, England and Wales: July to September 2003

A total of 75 reports of acute hepatitis B infection were reported in the third quarter of 2003. The majority of cases (68%) occurred in those aged 15 to 44 years (table 1). The number of acute cases reported in this quarter is less than the number of cases reported in the previous two quarters. (138 and 123 in quarter 1 and 2 respectively). Late reporting has contributed to the low number of reports seen in quarter 3.

**Table 1 Laboratory reports acute of hepatitis B infection by age group and sex, England and Wales: July to September 2003\***

Age group (years)	Male	Female	NK*	Total
<1	–	–	–	–
1-4	1	–	–	1
5-9	–	–	1	1
10-14	–	–	–	–
15-24	5	4	2	11
25-34	15	5	1	21
35-44	14	4	–	18
45-54	12	1	1	14
55-64	4	–	–	4
≥65	3	1	–	4
NK*	1	–	–	1
<b>Total</b>	<b>55</b>	<b>15</b>	<b>5</b>	<b>75</b>

\*NK = Not known

During the third quarter of 2003, injecting drug use was the main risk-factor associated with hepatitis B infection, accounting for 34% (10/29) of individuals with known risk-factors (table 2). Hepatitis B infection associated with heterosexual exposure accounted for 21% (6/29), 21% in men who have sex with men, and 24% in individuals with other risk-exposures.

**Table 2 Laboratory reports acute of hepatitis B infection by exposure category in England and Wales July to September 2003\***

Summary	Total
IDU*	10
Sex between men and women	6
Sex between men	6
other identified risk	7
NRI	46
<b>Total</b>	<b>75</b>

\*IDU = Injecting drug user's

## Laboratory reports of hepatitis C infection by age group and sex, England and Wales: July to September 2003

A total of 1755 reports of hepatitis C infection were reported in the third quarter of 2003 (table). Sixty-five per cent (1122/1731) of the cases occurred in those aged between 25 and 44 years. Cases in males exceeded those in females.

**Table Laboratory reports of hepatitis C infection in England and Wales: July to September 2003\***

Group	Male	Female	NK*	Total
<1	–	–	–	–
1-4	2	7	–	9
5-9	1	1	–	2
10-14	3	1	–	4
15-24	106	89	6	201
25-34	393	186	15	594
35-44	370	149	9	528
45-54	179	71	4	254
55-64	60	18	5	83
≥65	30	22	4	56
NK*	11	9	4	24
<b>Total</b>	<b>1155</b>	<b>553</b>	<b>47</b>	<b>1755</b>

\*NK = Not known



## **Vaccination coverage statistics for children aged up to five years in the United Kingdom**

This report of the COVER programme presents coverage data for children in the United Kingdom (UK) who reached their first, second, or fifth birthday during the evaluation quarter – July to September 2003 (annual COVER begins on 1 April each year, *ie*, 1 April 2003 to 30 June 2003 is the first quarter). This is the thirteenth quarter to include coverage data on meningococcal conjugate group C vaccine (MenC) following its introduction in the UK vaccination programme in November 1999 (1).

Children who reached their first birthdays in the quarter would have been scheduled to receive their third-dose primary vaccinations (third-dose diphtheria, tetanus, pertussis (DTP vaccine), *Haemophilus influenzae* type b (Hib vaccine), polio vaccine, and MenC vaccine) during the period between November 2002 and January 2003. Children who reached their second birthdays would have been scheduled to receive their third-dose primary vaccinations between November 2001 and January 2002 and first measles, mumps, and rubella (MMR) vaccination between July 2002 and January 2003. Children who reached their fifth birthdays would have been scheduled to receive their third-dose primary vaccinations between November 1998 and January 1999, their first MMR during the period July 1999 and January 2001, their pre-school diphtheria, tetanus, acellular pertussis (DTaP) booster, polio, and second-dose MMR from November 2001 onwards. One catch-up dose of MenC would have been scheduled for these children from January 2001 onwards.

### **Methods**

Data from computerised child health information systems were submitted in November and December 2003 for children resident in UK Primary Care Trusts (PCTs) in England, Administrative Regions (AR) in Wales, Health Boards (HB) in Scotland and Northern Ireland, and British Forces Germany (BFG) on 30 September 2003, for those reaching their first, second, or fifth birthdays during the evaluation quarter (July to September 2003). The numbers were requested of children completing a primary course of each antigen: (three-doses of diphtheria (D3), tetanus (T3), pertussis (P3), polio (Pol3), *Haemophilus influenzae* type b (Hib3), Meningococcal conjugate Group C (MenC3) vaccines; and one-dose of measles, mumps, and rubella (MMR1) vaccine given at any time up to their first or second birthdays. Numbers were also requested for resident children who had received a primary course of each antigen (DTPol3, P3, and Hib3), a pre-school booster dose (DTPol4), at least one MMR (MMR1), and two-doses of MMR (MMR2) given at any time up to their fifth birthdays.

For this quarter, COVER data in England were collected by PCT and summarised by Government Office Regions (GORs). The PCTs and GORs have different boundaries and populations to health authorities and regional health authorities used in previous reports. The PCT responsible population for COVER data includes all children registered with a general practitioner (GP) whose practice forms part of the PCT, regardless of where the child is resident. In addition, the PCT responsible population will also include any children not registered with a GP, who are resident within the PCTs statutory geographical boundary. Children resident within the PCT geographical area, but registered with a GP belonging to another PCT, are the responsibility of the latter mentioned PCT <[http://www.hpa.org.uk/infections/topics\\_az/vaccination/eval\\_quarterly-.pdf](http://www.hpa.org.uk/infections/topics_az/vaccination/eval_quarterly-.pdf)>.

These data are evaluated against the World Health Organization (WHO) targets of 95% coverage annually for each antigen (except MenC) by two years of age at the national level, and of at least 90% coverage annually in each strategic health authority (2).

### **Results**

#### **Coverage at 12 and 24 months**

Data were received from 325 PCTs (England), Health-Boards (Scotland and Northern Ireland), and Administrative Regions (Wales) (tables 1 and 2). One hundred and eleven of the participants (36%) achieved the 95% target at 12 months for three doses of diphtheria, tetanus, and polio vaccine (DTPol3). One hundred and twelve (36%) achieved the 95% target at 12 months for three doses of Hib vaccine (Hib3), and 95 (30%) for three doses of pertussis vaccine (P3). One hundred and eighty-one participants (58%) achieved 95% coverage at 24 months for DTPol3, 162 (52%) for P3, and 171 (55%) for Hib3. All countries/regions, except for London, achieved at least 90% coverage for these antigens. No participants achieved 95% coverage for MMR at 24 months. Coverage for the UK at 12 months increased by 0.1% for DTPol3, P3, Hib3 and by 0.6% for MenC, compared to that reported in the previous quarter (3)\*. Coverage for DTPol3, P3, and Hib3 at 24 months decreased slightly by 0.2%, 0.2%, and 0.3% respectively, while MenC at 24 months increased by 0.4%. Coverage for MMR1 at 24 months increased 0.9% from 78.9% to 79.8%.

**Table 1 Completed primary immunisations (all antigens) by 12 months: July to September 2003**

Region/Country	Reports * (total)	DTPol3 %	P3 %	Hib3 %	MenC %
<b>Regions of England</b>					
North East	15 (16)	92.7	92.4	92.7	92.8
North West	42 (42)	91.9	91.5	91.8	91.7
Yorkshire and Humberside	34 (34)	91.3	91.1	91.3	90.4
East Midlands	28 (28)	93.2	92.9	92.7	91.7
West Midlands	30 (30)	92.3	92	92.4	92.5
East of England	41 (41)	93.7	93.1	93.6	93.1
London	32 (32)	82.8	82.6	83.6	82.1
South East	49 (49)	92.2	91.9	92.3	91.7
South West	32 (32)	93.9	93.4	93.7	93.0
<b>England (Total)</b>	<b>303 (304)</b>	<b>90.8</b>	<b>90.5</b>	<b>90.9</b>	<b>90.2</b>
<b>Wales</b>	<b>3 (3)</b>	<b>93.8</b>	<b>92.7</b>	<b>93.6</b>	<b>93.5</b>
<b>Northern Ireland</b>	<b>4 (4)</b>	<b>95.1</b>	<b>94.7</b>	<b>95.4</b>	<b>95.6</b>
<b>Scotland 6 years</b>	<b>15 (15)</b>	<b>95.5</b>	<b>95.2</b>	<b>95.3</b>	<b>94.8</b>
<b>United Kingdom</b>	<b>325 (326)</b>	<b>91.5</b>	<b>91.1</b>	<b>91.5</b>	<b>91.1</b>

\*PCTs/health boards/administrative regions

**Table 2 Completed primary immunisations (all antigens) by 24 months: July to September 2003**

Region/Country	Reports* (total)	DTPol3 %	P3 %	Hib3 %	MenC %	MMR1%
<b>Regions of England</b>						
North East	15 (16)	95.0	94.3	94.9	94.8	82.8
North West	42 (42)	94.7	94.1	94.3	94.5	81.2
Yorkshire and Humberside	34 (34)	94.0	93.6	93.8	92.8	82.7
East Midlands	28 (28)	96.2	95.8	96.2	95.0	83.9
West Midlands	30 (30)	94.7	94.2	94.3	94.7	81.8
East of England	41 (41)	94.3	93.8	94.1	93.6	78.2
London	32 (32)	87.3	87.0	85.8	85.2	67.4
South East	49 (49)	94.3	93.9	94.2	93.4	78.7
South West	32 (32)	95.9	95.3	95.7	94.7	80.4
<b>England (Total)</b>	<b>303 (304)</b>	<b>93.5</b>	<b>93.0</b>	<b>93.0</b>	<b>92.5</b>	<b>78.5</b>
<b>Wales</b>	<b>3 (3)</b>	<b>95.4</b>	<b>93.8</b>	<b>95.1</b>	<b>94.6</b>	<b>78.6</b>
<b>Northern Ireland</b>	<b>4 (4)</b>	<b>96.9</b>	<b>96.3</b>	<b>96.9</b>	<b>96.9</b>	<b>87.2</b>
<b>Scotland 6 years</b>	<b>15 (15)</b>	<b>97.3</b>	<b>96.9</b>	<b>96.9</b>	<b>96.2</b>	<b>86.4</b>
<b>United Kingdom</b>	<b>325 (326)</b>	<b>94</b>	<b>93.5</b>	<b>93.6</b>	<b>93.2</b>	<b>79.8</b>

\* PCTs/health boards/administrative regions

## Coverage at 5 years

Data were received from 325 PCT/HB/AR in England, Wales, Scotland, and Northern Ireland, although nine PCTs were unable to provide data for DTPol4 and eight PCTs were unable to provide data for MMR2. Coverage at five years decreased by 0.2% for DTPol3, P3, and Hib3, increased by 0.1% for DTPol4, and by 0.9% for MenC compared to the previous quarter. Coverage for MMR1 increased by 0.6% to 91.2% and coverage for MMR2 increased by 0.5% to 75.9% (table 3) (3)\*.

Country-specific data for MenC catch-up coverage at five years was 87.9% in England, 91.7% in Wales, and 96.1% in Northern Ireland (table 3). Data for children reaching their sixth birthday in Scottish health boards were also received for DTPol4 and MMR2; coverage was 95.0% and 90.4% respectively.

**Table 3 Completed primary immunisations (all antigens) by 5 years: July to September 2003**

Region/Country	Reports* (total)	DTPol3 %	P3 %	Hib3 %	MenC %	MMR1 %	MMR2 %	DTPol4 %
<b>Regions of England</b>								
<b>North East</b>	15 (16)	95.1	94.4	94.8	91.8	93.7	81.5	83.9
<b>North West</b>	42 (42)	95.6	94.7	94.9	90.8	93.0	77.2	81.3
<b>Yorkshire and Humberside</b>	33 (34)	95.1	94.4	94.2	89.1	92.6	79.1	82.7
<b>East Midlands</b>	28 (28)	96.8	96.1	96.2	92.9	94.1	78.8	84.8
<b>West Midlands</b>	30 (30)	96.1	95.2	95.1	92.7	93.7	79.8	84.9
<b>East of England</b>	41(41)	95.0	94.2	94.4	89.9	91.3	78.6	85.1
<b>London</b>	32 (32)	86.4	85.7	85.8	72.1	81.2	57.5	62.3
<b>South East</b>	49(49)	93.6	92.8	93.0	88.7	90.7	74.7	81.8
<b>South West</b>	32 (32)	97.2	96.5	96.5	92.4	93.5	80.9	87.5
<b>England (Total)</b>	<b>303 (304)</b>	<b>94.0</b>	<b>93.2</b>	<b>93.3</b>	<b>87.9</b>	<b>90.7</b>	<b>75.1</b>	<b>80.4</b>
<b>Wales</b>	<b>3 (3)</b>	<b>95.2</b>	<b>93.0</b>	<b>94.9</b>	<b>91.7</b>	<b>90.5</b>	<b>73.4</b>	<b>82.2</b>
<b>Northern Ireland</b>	<b>4 (4)</b>	<b>97.9</b>	<b>97</b>	<b>97.1</b>	<b>96.1</b>	<b>96.7</b>	<b>86.4</b>	<b>88.7</b>
<b>Scotland 6 years</b>	<b>15 (15)</b>	–	–	–	–	–	<b>90.4</b>	<b>95</b>
<b>England, Wales, and Northern Ireland</b>	<b>325(326)</b>	<b>94.2</b>	<b>93.3</b>	<b>93.5</b>	<b>88.7</b>	<b>91.2</b>	<b>75.9</b>	<b>81.1</b>

PCTs/health boards/administrative regions

† No data available at 5 years

## British Forces Germany Health Service

Comparable COVER data have been received from the regions across British Forces Germany (BFG). The BFG child population is approximately 1500 and is spread over five separate geographical regions throughout Germany. The average coverage at 12 months (n=269) was 100% for all antigens; average coverage at 24 months (n=226) was 98.7% for DTPol3, P3, Hib3 and MenC, and 95.1% for MMR1. Average coverage at five years (n=223) was 97.3% for DTPol3, P3 and Hib3, 96.9% for MMR1, 95.1% for MenC, and 94.6% for MMR2 and DTPol4.

### MMR sentinel surveillance scheme coverage

In order to give a more timely indication of trends in MMR coverage, a sentinel surveillance scheme has monitored MMR coverage in a sample of children becoming 16 and 24 months of age in any month, in England, from April 1999. Initially, this information was requested every four months for all children in the participating trusts/health authorities who were turning 16 months or 24 months old in the defined one-month period. From March 2001, the request was made quarterly so that the information coincided with routine COVER reports. Since March 2002, this information has been routinely collected every month and was extended in June 2002 to include coverage at 20 and 36 months of age to help determine whether there is further improvement in coverage as children get older, because some parents delay MMR vaccination. This sentinel scheme is based on a sample of trusts/PCTs in England and represents approximately 20% of the population, although monthly reporting is not always complete for the whole sample. This means that these data are not geographically representative or sufficiently detailed to allow us to compare different regions, and will be subject to greater variability than the national data due to varying monthly sample size. Data collected from September to November 2003 for children in the four age cohorts is summarised in table 4 (range for the three months was from 69.1% to 70.9% at 16 months, 78.1% to 78.8% at 20 months, 77.9% to 80.1% at 24 months, and 83.8% to 87.1% at 36 months).

**Table 4 Monthly sentinel estimates of measles, mumps, and rubella (MMR) coverage at 16, 20, 24, and 36 months in England: September to November 2003**

Evaluation month	Number of PCTs/trust	Age at vaccination			
		16 months	20 months	24 months	36 months
Sep 03	40	70.3%	78.1%	77.9%	87.1%
Oct 03	40	70.9%	78.8%	79.4%	86.2%
Nov 03	40	69.1%	78.4%	80.1%	83.8%

### Comments

Meningitis C vaccine is now achieving very similar coverage levels to those achieved for the other vaccines offered in the first year of life (ie, diphtheria, tetanus, polio, pertussis, and Hib) for children aged 12 months and 24 months (tables 1 and 2). Coverage of MenC at 5 years is between four and five per cent lower when compared to coverage of these vaccines (table 3). The difference is probably related to the fact that MenC vaccine was offered as part of the routine vaccination schedule for the 12 and 24 month cohorts, whereas it was delivered through the catch-up campaign for the 5 year cohort.

Coverage of MMR1 in the UK at 24 months has increased by 0.9% since the last quarter (ie, April to June 2003) to 79.8%, due to increases in several countries/regions including Wales (1.5%), West Midlands (1.3%), South East and South West (0.8%), Scotland (0.6%), and Yorkshire and Humberside (0.3%) (3)\* and is the first increase since the April to June 2002 quarterly evaluation (4). Increased coverage was also observed for MMR1 and MMR2 measured at 5 years, rising by 0.6% and 0.5% respectively, with the North West, London, South West, and Wales showing improvement in MMR1 coverage, and Yorkshire and the Humberside, West Midlands, London, and South West improvement for MMR2. These increases in MMR were predicted through the sentinel surveillance programme (3)\*. Local initiatives to improve MMR coverage and data quality may partly explain why coverage has increased in both the 24 month and 5 year cohorts. Trends should be interpreted with some caution given that this is only the second COVER report summarising data by PCTs and GORs in England.

The monthly sentinel estimates of MMR coverage at 16 months for September to November 2003 (representing children born between April to June 2002, and scheduled for their MMR between April 2003 and October 2003) remain very similar to those recorded in the previous three months (3)\*. The improvement in coverage seen between 24 and 36 months may indicate that some parents are still choosing MMR, but delaying it until their

children are older than the age that it is usually given.

### Relevant links for country specific coverage data

- Wales:

<<http://www.wales.nhs.uk/sites/page.cfm?OrgID=368&PID=2278>>.

- Scotland:

<<http://www.show.scot.nhs.uk/scieh/>>.

- Northern Ireland:

<<http://www.cdscni.org.uk/surveillance/Coveragestats/default.asp>>.

- England



<<http://www.doh.gov.uk/public/sb0316.htm>>.

### Other relevant links

- <[http://www.hpa.org.uk/infections/topics\\_az/vaccination/vac\\_cover.htm](http://www.hpa.org.uk/infections/topics_az/vaccination/vac_cover.htm)>.
- <<http://www.mmrthefacts.nhs.uk/>>.

\*Please note that for reference (3), table 3: *Table 3 Completed primary immunisations (all antigens) by 5 years: April to June 2003*, some data values were re-published on 21 January 2004. The appropriate *erratum* is published in this edition of *CDR Weekly*, Volume 14 number 4.

### References

1. Chief Medical Officer, Chief Nursing Officer, Chief Pharmaceutical Officer. *Introduction of immunisation against group C meningococcal infection* (PL/CMO/99/2, PL/CNO/99/4, PL/CPHO/99/1). London: Department of Health, 1999.
2. WHO Regional Office for Europe. Operational targets for EPI diseases. EUR/ICP/CMD5 01 01 12 Rev. 1
3. HPA. COVER programme: April to June 2003. *Commun Dis Rep CDR Wkly* [serial online] 2003 [cited 15 Jan 2004]; 13(39): immunisation. Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2003/cdr3903.pdf>>. 
4. PHLS. COVER programme: April to June 2002. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 15 Jan 2004]; 12 (39): immunisation. Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2002/cdr3902.pdf>>. 

## Diary

Last updated: 22 January 2004

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### **Diploma in Hospital Infection Control residential course on steam sterilisation, washer-disinfectors, specialist ventilation, and other aspects of hospital hygiene**

There will be two courses in 2004: one from 17th to 21st May (reserves only) and another on 4th to 8th October. Both will be held at Eastwood Park Training Centre in Falfield (near Bristol). The course is a module for the Diploma in Hospital Infection Control offered by HIS, HPA, and London School of Hygiene and Tropical Medicine, but can also be taken by those not registered for the DipHIC. The fee for this course is £1150 (residential) or £900 (non-residential). For details regarding registration and further information about the courses please write to Greta Howell, Laboratory of HealthCare Associated Infection, SRMD, Health Protection Agency, 61 Colindale Avenue, London NW9 5HT, or email <[greta.howell@hpa.org.uk](mailto:greta.howell@hpa.org.uk)>.

Hygiene and Tropical Medicine, Keppel Street, London WC1. Registration including lunch: £70 (students/nurses £20). Application form and programme can be obtained from RSTMH, 26 Portland Place, London W1B 1EY. Tel: 020 7580 2127 Fax: 020 7436 1389, email: <[mail@rstmh.org](mailto:mail@rstmh.org)>.