





CDR WEEKLY




Current Issue: Volume 14 Number 44

Published on: 28 October 2004


NEWS STORIES:

-  [Modernisation of the International Health Regulations – round two inter-governmental working group, Geneva, 1-12 November 2004](#)
 -  [Control of Communicable Diseases Manual, 18th Edition](#)
-

Immunisation

-  [Laboratory reports of invasive meningococcal infections, England and Wales: weeks 21-24/2004](#)
 -  [Laboratory reports of *Haemophilus influenzae* by age group and serotype, England and Wales: July to September 2004](#)
 -  [Surveillance of viral infections in donated blood, England and Wales: 2003](#)
-

CDR SUBSCRIPTION:

-  To subscribe to *CDR Weekly*, please visit: <<http://www.hpa.org.uk/cdr/contact.htm>>

Current Issue: Volume 14 Number 44
Published on: 28 October 2004**News**
 Last updated: **28 October 2004**
 Next update due: **4 November 2004**

-  [Modernisation of the International Health Regulations – round two inter-governmental working group, Geneva, 1-12 November 2004](#)
 -  [Control of Communicable Diseases Manual, 18th Edition](#)
-


Modernisation of the International Health Regulations – round two inter-governmental working group, Geneva, 1-12 November 2004

The *International Health Regulations (IHR)* (1) are a legally binding code of practices and procedures designed to prevent the international spread of infectious diseases, while at the same time not interfering unnecessarily with the international movements of people and goods. The current regulations include; procedures for notification of certain diseases, health related rules for international trade and travel, health organisation (including procedures and practices at airports, seaports, and borders), and documentation requirements. For some time these have, however, been recognised to be inadequate for the global village of the 21st Century and to contribute little when faced with new and emerging infections such as SARS. For example, they set out roles and responsibilities for the World Health Organization and its member states, but only in relation to three diseases. It is universally accepted that they need modernisation (2,3). The case for this was summarised in the *CDR Weekly* of 20 May 2004 <<http://www.hpa.org.uk/cdr/PDFfiles/2004/cdr2004.pdf>> (4)

In June 2004, *CDR Weekly* reported the European Region of the World Health Organization consultation on the proposed redrafting of the IHR in Copenhagen (5). The European Commission (EC) and Presidency have been negotiating overall statements representative of member countries' positions on the proposed new IHR, the last of these was recently sent to WHO. Further detailed comments from the European Union (EU) states' public health experts were agreed at Technical Workshops held by the Commission on 6 July and 18-19 October 2004.

The Health Protection Agency (HPA) has been advising the Department of Health and others in preparing a position for the United Kingdom (UK). Following consultation with counterparts in the devolved administrations and other interested parties, the HPA's Interim Advice was published on 12 May at <http://www.hpa.org.uk/hpa/international/IHR_statement.htm>.

Subsequent to this interim advice, the proposed new regulations have been redrafted over the summer in the light of regional consultations and other views. An improved draft was published by WHO in late September, <http://www.who.int/gb/ghs/pdf/A_IHR_IGWG_3-en.pdf> along with a guide to the changes <http://www.who.int/gb/ghs/pdf/A_IHR_IGWG_4-en.pdf> and a review of how the new regulations would interface with other international agreements <http://www.who.int/gb/ghs/pdf/A_IHR_IGWG_ID1-en.pdf>.

Despite improvements there are a number of areas of international disagreement. The proposed new IHR includes an algorithm decision instrument to be applied to incidents and outbreaks. This determines whether they might constitute an international public health emergency and therefore need to be reported to WHO. The HPA and some other European countries have tested the algorithm for WHO and find it to be robust, though perhaps overly sensitive. For example, applying the algorithm to the 29 significant outbreaks and incidents involving infectious diseases in the UK in 2003 would have resulted in 11 being notified to WHO. No incident or outbreak with international significance would have been missed by the use of this instrument. Some national authorities, however, such as the United States, Russia, and Japan, have a strong preference to keep an additional list of notifiable diseases. Most of the European states feel that this will undermine the principle of the new algorithm.

Other outstanding issues include whether:

- requirements on states to produce data and specimens (Article 5) would be robust enough for the appearance of a new emerging infection or pandemic influenza
- under article 58, the IHR would have pre-eminence where there are pre-existing arrangements such as those under Decision 2119 of the European Union <<http://europa.eu.int/scadplus/leg/en/cha/c11548b.htm>>.

To resolve these and many other detailed issues a fortnight-long meeting of an Intergovernmental Working Group will be held in Geneva from 1-12 November. <<http://www.who.int/gb/ghs/e/index.html>>.

References:

1. WHO. *International Health Regulations (IHR) (1969). Third annotated edition*. Geneva: World Health Organization, 1983. Available at <<http://www.who.int/csr/ihr/current/en/>>.
2. Gostin LO. International Infectious Disease Law – Revision of the WHO's International Health Regulations. *JAMA* 2004; **291**: 2623-7.
3. Anon. The International Health Regulations and Beyond. *Lancet Infect Dis* 2004; **4**: 606-7..
4. HPA. Modernisation of the *International Health Regulations* – WHO European Region consultation. *Commun Dis Rep CDR Wkly* [serial online] 2004 [cited 28 October 2004]; **14** (20): News. Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2004/cdr2004.pdf>>.
5. HPA. Modernisation of the International Health Regulations – WHO Consultation. *Commun Dis Rep CDR Wkly* [serial online] 2004 [cited 28 October 2004]; **14** (25): News. Available at <<http://www.hpa.org.uk/cdr/PDFfiles/2004/cdr2504.pdf>>.

Control of Communicable Diseases Manual, 18th Edition



The new 18th edition of *Control of Communicable Diseases Manual* (CCDM), an official publication from the American Public Health Association, is now available. The manual addresses concerns about the impact of communicable diseases around the globe as emerging and unknown communicable diseases continue to thrive, kill, maim, and surprise the masses.




The 18th edition of CCDM is full of detailed information for public health workers in official and voluntary health agencies, including those serving in the armed forces and other governmental agencies, and for all students of medicine. Each listing in the manual includes identification, infectious agents, disease occurrence, mode of transmission, incubation period, susceptibility and resistance, and methods of infection control that are not limited to, but include prevention and epidemic control measures.

The latest editor to take on the task of overseeing the 18th edition is Dr David Heymann who, along with his team from the World Health Organization (WHO), compiled a group of experts from around the world to serve as reviewers, authors, and editors. Thanks to their contributions, this book is a valuable resource that is responsive to the needs of the global health community.

Copies can be obtained directly from the American Public Health Association, 800 I Street, NW Washington, DC 20001-3710 Fax: +00 1 (202) 777 2531, ISBN 0-87553-034-6 soft cover ISBN 0-87553-035-4 hardcover. Copies can also be purchased online at <<http://www.apha.org/media/science.htm#ccdm>>.

Immunisation

Last updated: 28 October 2004
Next update due: 25 November 2004

-  [Laboratory reports of invasive meningococcal infections, England and Wales: weeks 21-24/2004](#)
-  [Laboratory reports of *Haemophilus influenzae* by age group and serotype, England and Wales: July to September 2004](#)
-  [Surveillance of viral infections in donated blood, England and Wales: 2003](#)

Laboratory reports of invasive meningococcal infections, England and Wales: weeks 21-24/2004

	Method of diagnosis			Total reports	Cumulative*
	CSF and blood Culture	Non-culture	Other sites	21-23/04	Total to week 24/2004
Group A	–	–	–	–	1
B	40	31	3	74	601
C	1	2	–	3	34
W135	2	–	–	2	23
X	–	–	–	–	–
Y	–	–	1	1	15
Z	–	–	–	–	–
29E	–	–	–	–	–
Ungroupable	–	–	–	–	1
Ungrouped	–	4	–	4	28
Total	43	37	4	84	703

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

Laboratory reports of *Haemophilus influenzae* by age group and serotype, England and Wales: July to September 2004* (2003)

Serotype	Age					Total
	<1 year	1-4 years	5-14 years	>15 years	Not known	
b	2(3)	5(15)	3(7)	24(21)	2(1)	36(47)
nc	6(2)	1(3)	2(4)	28(28)	3(1)	40(38)
a,e,f	1(–)	–(–)	–(–)	2(4)	1(–)	4(4)
not typed†	3(1)	2(1)	2(2)	22(20)	–(–)	29(24)
Total	12(6)	8(19)	7(13)	76(73)	6(2)	109(113)

* All data are provisional.

†Awaiting further typing data from the Oxford *Haemophilus* reference unit.

Surveillance of viral infections in donated blood, England and Wales: 2003



Donated blood is collected from volunteer (unpaid) adult donors who do not acknowledge any medical conditions, travel history, or behaviours, that are known to be associated with an increased risk of blood-borne infections. In 2003, all donations were tested for hepatitis B virus surface antigen (HBsAg), hepatitis C virus antibodies (anti-HCV), HIV antibodies (anti-HIV), anti-human T-lymphotrophic virus antibodies (anti-HTLV), and treponemal antibodies, along with nucleic acid testing (NAT) for HCV RNA (on pools of 48 donations followed by resolution of positive pools to identify individual positive donations). Donations are released to the blood supply only if none of these markers of infection are detected and if found negative for HCV RNA by NAT.

Donors who have any markers of infection detected by any method are informed of their infection, are told to stop donating blood, and are referred to appropriate services for further care. Blood donors are classified by blood centres as repeat donors if they have attended to donate blood previously. Previous donations, however, from repeat donors may not have been tested for some of these markers.

A total of 275 (11.16 per 100,000 donations) of 2,463,527 donations collected by the English and Welsh blood services during 2003 had markers of viral infections (including three HCV NAT positives) (table). Of these 275 infected donations, 117 (43%) were positive for anti-HCV and/or HCV RNA, 85 (31%) were positive for HBsAg, 39 (14%) were positive for anti-HIV, and 34 (12%) were positive for anti-HTLV. The three anti-HCV negative, HCV RNA positive donations detected during 2002 were collected from donors with recent infection who subsequently seroconverted for anti-HCV; one was a new donor and two were repeat.

In 2003, new donors contributed 11% of all blood donations, and 77% of infected donations. For HTLV, however, 47% of infections were among new donors and 53% among repeat donors – although none of the repeat donors had been previously tested for HTLV since national routine testing began in August 2002.

Blood donations have been tested for anti-HIV since 1985 and for anti-HCV since 1991. The annual rates of these two markers in donations of blood from new and repeat blood donors are shown in figures 1 and 2.

Table 1 Infections detected in blood donations collected in England and Wales during 2003

Donations with confirmed marker of infection	Infections in blood donors				
	HBV (HBsAg)	HCV (anti-HCV/HCV RNA)*	HIV (anti-HIV)	HTLV (anti-HTLV)	Any of these three markers†
All donations	85	117	39	34	275
per 100,000 donations tested	3.45	4.75	1.58	1.38	11.16
1 in x donations‡	28,983	21,056	63,167	72,457	89,588
Donations from new donors	74	101	20	16	211
per 100,000 donations tested	30.46	41.57	8.23	6.59	86.85
1 in x donations‡	3,283	2,405	12,147	15,184	11,511
Donations from repeat donors§	11	16	19	18	64
per 100,000 donations tested	0.50	0.72	0.86	0.81	2.88
1 in x donations‡	201,871	138,786	116,873	123,366	34,697

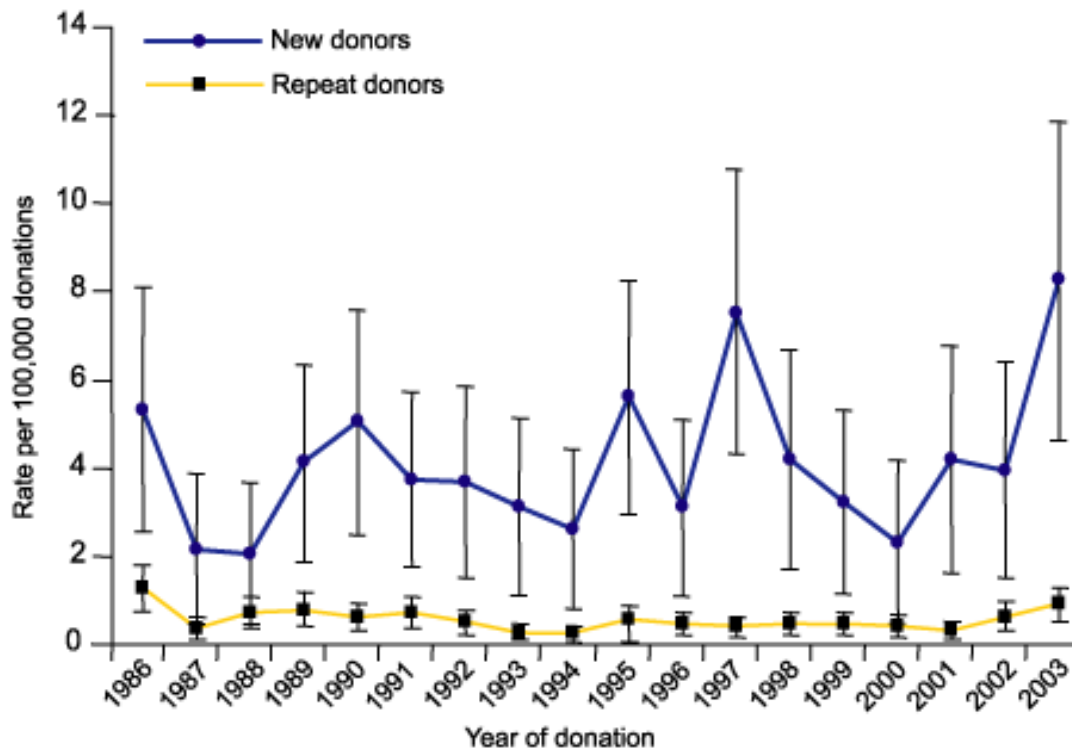
* Including three anti-HCV negative donors positive for HCV RNA by nucleic acid testing.

† One donor had markers of two infections: HBsAg and anti-HCV, anti-HIV and anti-HCV.

‡ Frequency is expressed here as one out of x donations, eg, the frequency of HBsAg among donations in 2003 in England and Wales was one out of 28,983 donations.

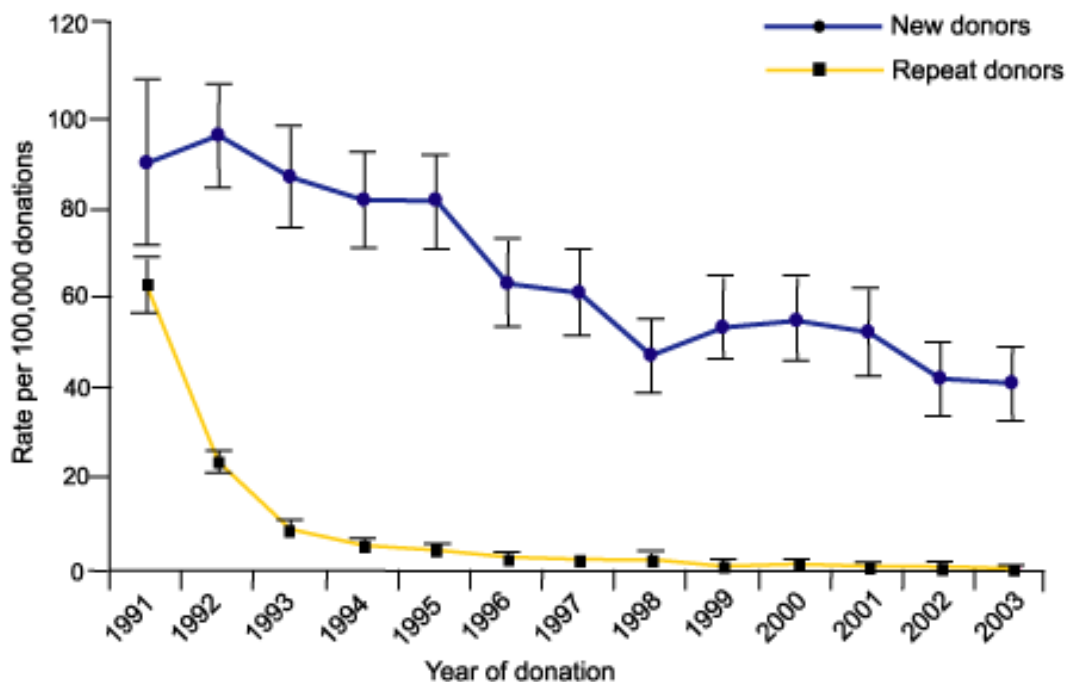
§ Includes donations from repeat donors newly tested for markers of infection.

Figure 1 HIV infected blood donations: England and Wales donations collected from 1/10/85 to 31/12/2003



Error bars show 95% confidence intervals

Figure 2 HCV infected blood donations: England and Wales donations collected from 1/9/91 to 31/12/2003



Error bars show 95% confidence intervals

The annual prevalence of HBsAg, anti-HCV, and anti-HIV among blood donors in England and Wales is low compared to the rest of Europe. In 2003, the prevalence of anti-HIV among all donors (1.58 per 100,000 donations) was higher than seen in all (or any) of the previous 16 years (chi square = 15.3, $p < 0.001$). The prevalence of anti-HCV has decreased significantly since the early 1990s. The prevalence of HBsAg and of anti-HCV by age group and sex of donors is shown in figure 3a and 3b.

Figure 3a Age and sex of infected blood donors of newly tested donors*, donations collected during 2003: HBsAg

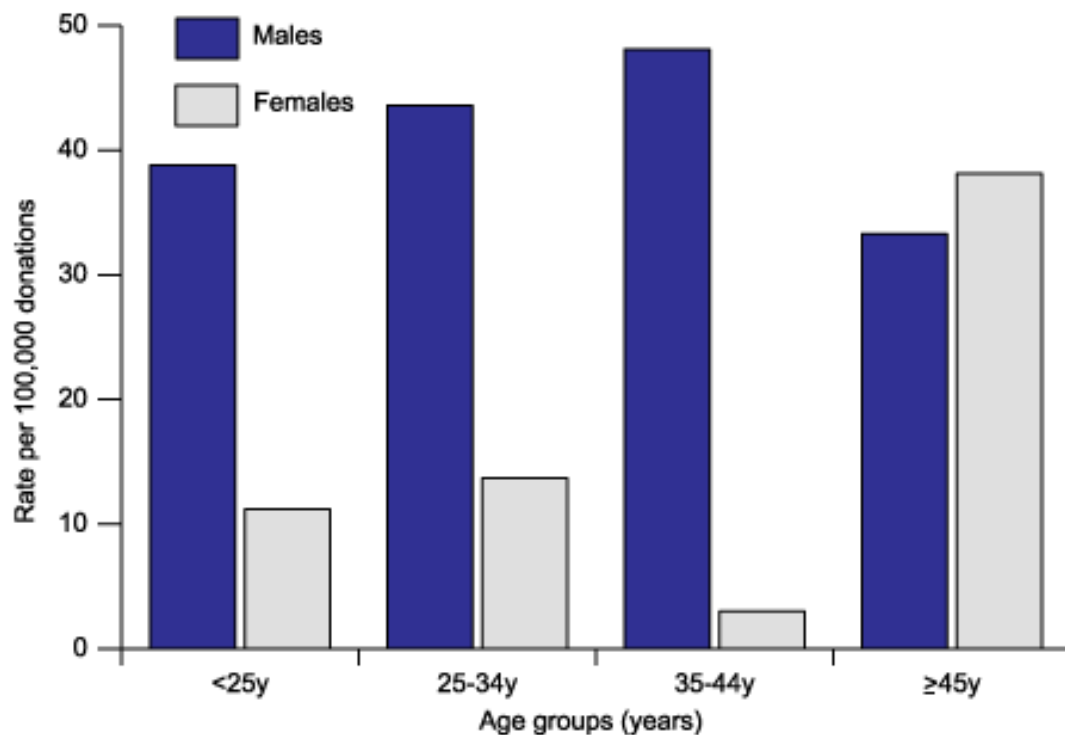
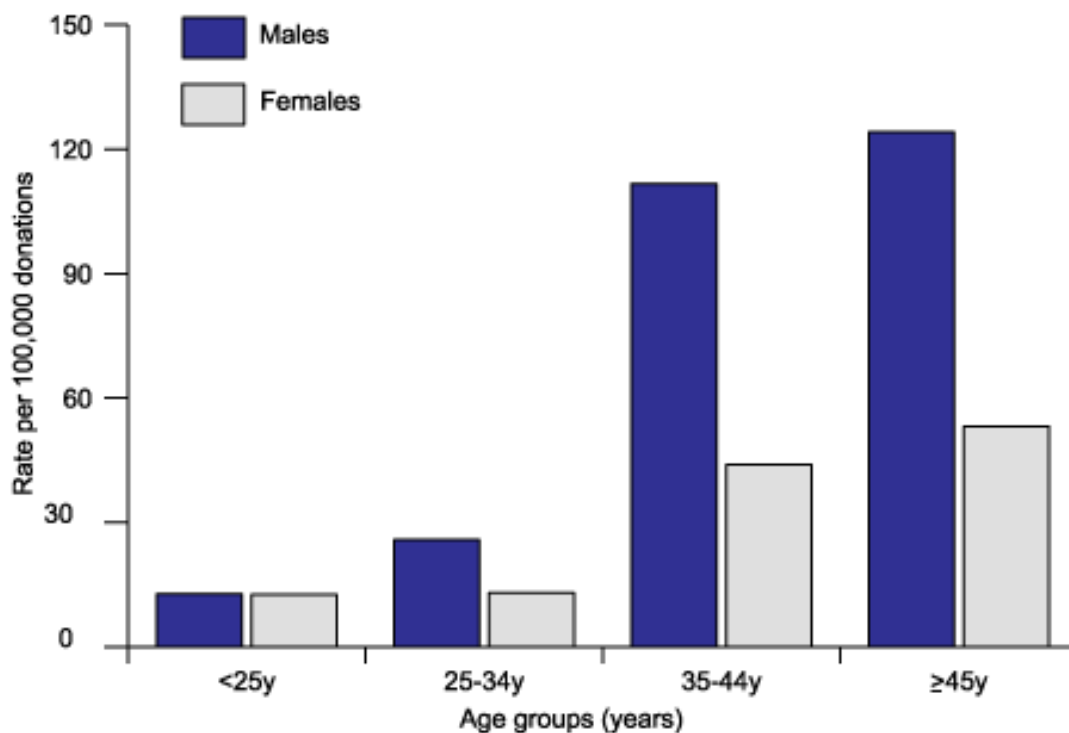


Figure 3b Age and sex of infected blood donors of newly tested donors*, donations collected during 2003: anti-HCV



* Rates adjusted for underreporting by multiplying the denominator estimate for each age and sex group by the proportion of all detected infections for which age and sex information has been reported.