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Department of Health launches an implementation action plan for the national sexual health and HIV strategy

The Department of Health (DH) has published an *Implementation action plan for the national sexual health and HIV strategy* (1). The original strategy document (2) was published for consultation on 27 July 2001. The strategy aims are to reduce the transmission of HIV and sexually transmitted infections (STIs); reduce the prevalence of undiagnosed HIV and STIs; reduce unintended pregnancy rates; improve health and social care for people living with HIV; and to reduce the stigma associated with HIV and STIs. Over 400 submissions were received during an extensive six month consultation period.

Feedback on the strategy

Most people involved in the consultation welcomed publication of the strategy and felt that it was long overdue. Strong consensus was found around sexual ill health in England and its links with poverty, social exclusion, and varying standards of service provision. There was strong support for the main interventions proposed, in particular the development of service standards to ensure consistent quality of care regardless of the point of access. Many respondents were concerned about exactly how the strategy would be implemented, particularly following the mainstreaming of HIV funding. There were also strong views that improving clinical services – while important – would not of itself be sufficient to achieve the strategy's goals. It will require partnership working with other government departments and local government in order to succeed. Some of specific points arising from the consultation are summarised in table 1.

Table 1 Summary of feedback received on the Sexual Health Strategy

Area of concern	Specific comments
Nature of strategy	Many felt that the strategy is overly descriptive and somewhat vague and non-committal about action to achieve change. Many felt that the strategy focuses too narrowly on the work of the Department of Health and the NHS. Some commented on a 'medical model' that is problem-oriented and centres on disease diagnosis and treatment. The successful mainstreaming of sexual health will depend substantially on success in reducing the prevalence and impact of stigma and prejudice, among the general population and among professional groups.

Prioritisation given to the strategy	There was concern that the strategy would not have the status of, for example, a national service framework (NSF), and may be regarded as optional at local level.
Funding the strategy and its interventions	Many argued that removal of ring-fencing for HIV prevention funding is premature, and should be deferred for a minimum of one further financial year so as not to coincide with devolution of commissioning responsibility to primary care trusts (PCTs).
Capacity of existing services to meet needs	Sexual health services, in particular GUM and services provided in general practice, are already perceived to be over-stretched. Implementation of the action plan, in particular the national campaign, needs to ensure that capacity is increased before uptake. There was a need for a greater contribution from other government departments and from local government in order to deliver the strategy's aims. There were concerns about the devolution of overall commissioning responsibility to (PCTs) and that there is unlikely to be sufficient expertise within any one PCT to ensure effective commissioning of HIV prevention services for all local target groups and communities.

The implementation plan

In response to the consultation, the Department of Health has now developed a 27-point action plan which provides a framework for delivery, and sets out detailed milestones towards the goals of better prevention, better services and better support for people with HIV and STIs. The implementation action plan details how the interventions will be delivered and reflects the changes underway through *Shifting the balance of power* (3) in which primary care trusts (PCTs) have greater freedoms and empowerment in managing their services.

Implementation is already underway with the commissioning of a mapping exercise and research into the effectiveness of HIV and STI prevention. The DH aims to establish an independent advisory group to advise government on implementation of the strategy, and to monitor progress. During 2002/3, the DH plans to invest a further £14million in order to: pump-prime change in genitourinary medicine (GUM) clinics and abortion services; start to roll out the chlamydia screening programme; launch a national information campaign; undertake additional campaign work, including a targeted HIV testing campaign, and extend availability of public information leaflets; campaign to reduce drug misuser injecting; extend the availability of hepatitis B vaccine; develop and evaluate pilot projects, including one stop shops; develop service standards, the training strategy, mechanisms for user involvement, and disseminate good practice; and improve surveillance and progress the chlamydia re-infection study

Other planned interventions relevant to HIV/STI surveillance and prevention include:

- National roll-out of patient-based data collection from GUM clinics to improve STI surveillance, following successful testing in London and the South East.
- The national chlamydia screening programme will be introduced in ten sites, selected from those areas which have expressed an interest, building on the learning from the successful pilots in Portsmouth and the Wirral.
- Relevant performance indicators will be included within the PCT performance indicator set, in particular to monitor progress in reducing undiagnosed HIV, newly acquired HIV and gonorrhoea infections and increasing the offer and uptake of hepatitis B vaccine.
- The reporting requirements of the AIDS Control Act will be amended to ensure that they support implementation of the strategy. A national report of the data collected will be published annually, and will assess progress towards the national targets.
- The Health Development Agency is undertaking a review of the evidence base for local HIV and STI prevention.
- All PCTs have been asked to identify a sexual health and HIV lead, with an appropriate level of seniority and public health expertise, to lead implementation of the strategy at local level.
- A sexual health and HIV Commissioning Toolkit will be published to support implementation and development of PCT and local authority plans from April 2003.
- Launch a new national information campaign about the risks of unprotected sex, targeting young adults in particular. The design of the campaign will be informed by a review of the evidence on what works.
- Groups at special risk will be targeted through partnership with the voluntary sector at national and

local level. *eg* publication of a new framework and action plan for work with African communities.

- A new HIV testing campaign will start by end 2002. The DH will fund targeted campaigns to encourage uptake of HIV testing and access to services.
- The Expert Advisory Group on AIDS will continue to provide expert scientific and medical advice on HIV to the Chief Medical Officers of the UK Health Departments, pending the planned review of advisory groups as part of the infectious disease strategy Getting Ahead of the Curve.
- Medical Research Council is to commission new research projects from 2003. The content of the joint Medical Research Council and DH research programme is being reviewed to ensure that it effectively supports implementation of the Sexual health and HIV strategy.

The national strategy for sexual health and HIV – implementation action plan is available from Department of Health Publications, PO Box 777, London SE1 6XU; tel: 08701 555 455; fax: 01623 724 524. A pdf file can be downloaded from <wwww.doh.gov.uk/sexualhealthandhiv>.

1. Department of Health. *The national strategy for sexual health and HIV – implementation action plan.* London: Department of Health, 2002. Available at <http://wwww.doh.gov.uk/sexualhealthandhiv>.

2. Department of Health. *The national strategy for sexual health and HIV.* London: Department of Health, 2001. Available at <http://www.doh.gov.uk/nshs/bettersexualhealth.pdf>.

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

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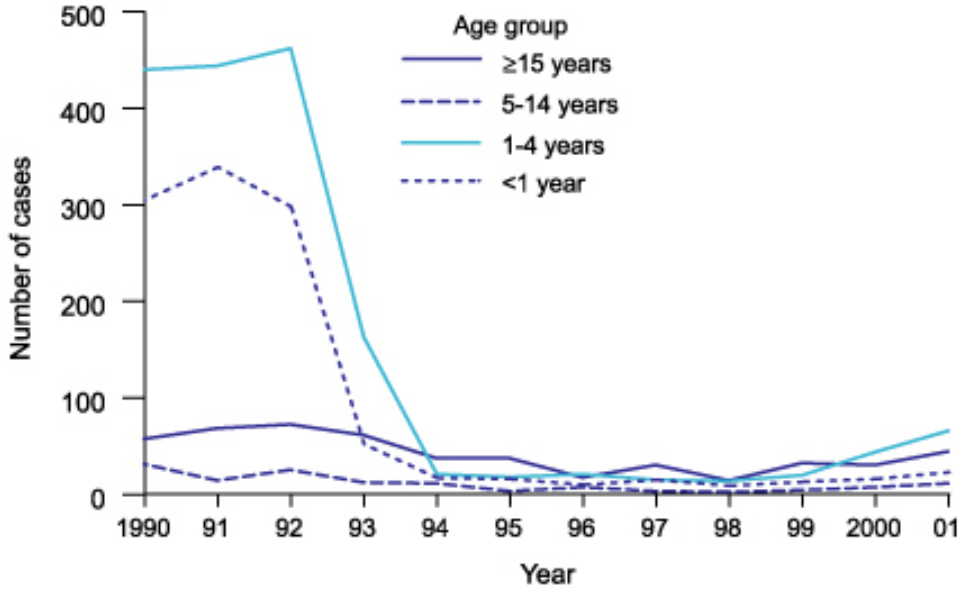
Continuing surveillance of invasive *Haemophilus influenzae* disease

Routine infant immunisation with conjugate *Haemophilus influenzae* type b (Hib) vaccine in the United Kingdom began in October 1992. Prior to this, Hib was the most common cause of bacterial meningitis in young children. Surveillance of invasive Hib infection is conducted by reconciliation of reports to PHLS Communicable Disease Surveillance Centre (CDSC) from laboratories in England and Wales with isolates referred to the PHLS Haemophilus Reference Unit. The number of cases of invasive Hib disease fell dramatically after the introduction of the vaccine, and has remained at relatively low levels. An increase in the number of cases has been observed since 1998; this increase has affected all age groups but is most marked in those aged 1 to 4 years (figure). In 1990, prior to the implementation of the vaccination programme, the incidence of Hib infection in the those under 5 years of age was 22 per 100,000 in 1990. By 1998, the incidence had decreased to 0.68 per 100,000, but increased to 2.81 per 100,000 in 2001. The reason for this increase is unclear. Possibilities include waning population immunity, which could be linked to a reduction in natural boosting as a consequence of the low levels of carriage observed in pre-school children following the introduction of Hib vaccine. Further evaluation of trends in Hib carriage and population immunity is required.

Figure *Haemophilus influenzae* type b disease in England and Wales by age group: 1990 to 2001



In 1992, surveillance of invasive *H. influenzae* in vaccinated children was enhanced by reporting via the British Paediatric Surveillance Unit (BPSU). In 1995, paediatric reporting was expanded to include all invasive *H. influenzae* disease in children, but this condition was removed from the BPSU orange card reporting scheme in October 2000. Continued surveillance of cases of invasive *H. influenzae* disease is of great importance in determining whether the current rise in incidence will be sustained or whether it is a transient phenomenon. Ongoing case ascertainment will occur through consultants in communicable disease control and microbiologists in addition to ad-hoc reports from paediatricians. Cases of invasive *H. influenzae* disease should be reported to Mary Slack at the PHLS Haemophilus Reference Unit, (tel: 01865 220859/220852, fax: 01865 220890), to Jodie McVernon of the Oxford Vaccine Group at the John Radcliffe Hospital, Oxford, (tel: 01865 221068, fax: 01865 220479), or Mary Ramsay at CDSC (tel: 020 8200 6868 ext 4085, fax: 020 8200 7868). Isolates of *H. influenzae* from cases of invasive disease should be submitted (on chocolate agar slopes) for confirmatory typing to Mary Slack, PHLS Haemophilus Reference Unit, Level 7, John Radcliffe Hospital, Oxford, OX3 9DU.

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Europe declared free of polio

The European region* of the World Health Organization (WHO) has been certified free of poliomyelitis (1). The decision was made at a meeting of the European Regional Commission for the Certification of Poliomyelitis Eradication in Copenhagen on 21 June 2002.

The European region has been free of indigenous poliomyelitis for over three years. The last case of indigenous wild poliomyelitis in Europe occurred in eastern Turkey in 1998, when an unvaccinated 2 year-old boy was paralysed by the virus. Poliovirus imported from polio-endemic countries, however, remains a threat. In 2001 there were three polio cases among Roma children in Bulgaria and one non-paralytic case in Georgia, all caused by poliovirus originating on the Indian subcontinent. The last indigenous case in the United Kingdom (UK) was in an unvaccinated 2 year-old boy in Belfast in 1982.

Success in Europe was finally achieved through a series of coordinated national immunization campaigns, known as Operation MECACAR (eastern MEditerranean, CAucasus, Central Asian Republics), which involved 18 polio-endemic countries and areas in the European and Eastern Mediterranean regions of WHO. Sixty million children under 5 years of age received two extra doses of polio vaccine every year from 1995 to 1998. Since 1997, MECACAR has included special door-to-door mass vaccination in the high-risk areas of these countries. Supplementary vaccination campaigns have continued in the highest-risk countries through to 2002.

Since the Global Polio Eradication Initiative was launched in 1988, two other WHO regions have been certified polio-free: the Americas in 1994, and the Western Pacific in 2000. Polio cases have dropped from an estimated 350,000 in 125 countries in 1988 to 480 reported cases in ten polio-endemic countries in 2001.

Despite European polio-free status it is essential to maintain a high level of surveillance in the UK while polio still occurs in parts of Asia and Africa. Laboratories should continue to send poliovirus isolates and uncharacterised enteroviruses to the CPHL Enteric, Respiratory and Neurological Virus Laboratory (2). Rapid reporting of suspected paralytic polio to the PHLS Communicable Disease Surveillance Centre is essential to ensure appropriate investigations are carried out

* **Member States of the WHO European Region:** Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Israel, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, the former Yugoslav Republic of Macedonia, Tajikistan, Turkey, Turkmenistan, Ukraine, United Kingdom, Uzbekistan, Yugoslavia.

1. World Health Organization. *Europe achieves historic milestone as region is declared polio-free. (press release).* Geneve: World Health Organization, 21 June 2002. Available online at <http://www.who.int/inf/en/pr-EURO.2002-12.02.html>.

2. PHLS Guidance Note: Surveillance of Polio. Q.SOP 31.

Immunisation

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Virus infections, England and Wales: laboratory reports, weeks 21-25/02

	Number of reports received						
Laboratory reports	**21/02**	**22/02**	**23/02**	**24/02**	**25/02**	**Total reports 21-25/02**	**Cumulative total 2002**
Coxsackie A	–	–	1	–	–	**1**	**8**
Coxsackie B	–	5	2	1	5	**13**	**41**
Cytomegalovirus	22	17	18	15	24	**96**	**493**
Echovirus	6	1	1	11	5	**24**	**169**
Parvovirus B19	31	46	32	75	40	**224**	**645**
Varicella zoster virus	12	11	3	15	17	**58**	**281**

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Invasive meningococcal infections, England and Wales: laboratory reports, weeks 13-16/02

	Method of diagnosis			Total reports 13-16/02	Cumulative total* 2002
	CSF and blood		Other sites		
	culture	non-culture**	culture		
Group A	1	–	–	**1**	**1**
Group B	66	55	3	**124**	**656**
Group C	4	1	–	**5**	**73**
Group W135	2	3	2	**7**	**46**
Group X	–	–	–	–	**2**

Group Y	4	1	–	**5**	**11**
Group Z	–	–	–	**–**	**–**
Group 29E	–	–	–	**–**	**–**
Ungroupable	–	10	–	**15**	**61**
Ungrouped	–	–	–	**–**	**1**
Total	**77**	**70**	**5**	**152**	**851**

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

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Laboratory confirmed cases of measles, mumps and rubella, England and Wales: January to March 2002

The monthly reporting of laboratory confirmed cases of measles, mumps, and rubella previously published in the *CDR Weekly* have been replaced by quarterly reporting since October/December 2000. Cases include those confirmed by oral fluid IgM antibody tests and routine laboratory reports (table 1). Analyses are by date of onset rather than by week of report as was used previously and therefore totals may differ from those previously published. The numbers of cases confirmed by oral fluid antibody detection from 1995 to 2001 are available from the appropriate measles, mumps, and rubella pages of the PHLS website, and total confirmed cases by region and age, again from the appropriate measles, mumps, and rubella pages)

Table 1 Total confirmed cases of measles, mumps and rubella, and oral fluid IgM antibody tests in cases notified to ONS, weeks 01-13/02

	Cases			Oral fluid	IgM antibody			
	Notified	**Tested**	**%**	**Total positive**	**Recently vaccinated**	**Confirmed**	**Other lab confirmed**	**Total confirmed cases**
Measles	1199*	1386	116%	91	9	82	44	**126**
Mumps	723	466	64%	100	0	100	13	**131**
Rubella	460	400	87%	5	1	4	8	**12**

* due to the increase in confirmed measles in this quarter many oral fluid tests were submitted early for detection of IgM antibody for suspected cases, some of which were not subsequently notified, thus more samples were submitted than notified in this period.

Measles

One hundred and twenty-six cases of confirmed measles with onset dates in the first quarter of 2002 were reported, compared to only 32 cases in the fourth quarter of 2001. Ninety-six were aged less than 15 years (17 less than one year, 54 aged 1 to 4 years; 17 aged 5 to 9 years; six aged 10 to14 years, two children, age not stated), 11 were aged 15 to 19 years, and there were 19 adults aged between 20 and 32 years.

The increase was mainly due to the continuation of the outbreak in two health authorities in South London that started in December 2001 (www.phls.co.uk/publications/CDR%20Weekly/archive02/immunisationarchive02.html). Fifty of the 91 cases confirmed in London during this quarter were from these two health authorities and linked to several nurseries and schools in the area. Thirty-five out of 50 of the cases occurred in unvaccinated children aged less than five years, including seven infants who were too young to be vaccinated routinely. Smaller clusters in four other health authorities in London, each with six or seven cases, were also identified. As for all childhood vaccines, MMR vaccine coverage in London has been, and remains, lower than any other region in the United Kingdom (see COVER report, this issue).

An awareness of the increase in confirmed measles in London and intense media coverage of the outbreak during the early part of this quarter lead to many oral fluid samples from suspected cases being submitted for detection of IgM antibody. Some of these suspected cases were not subsequently formally notified, and thus more samples were submitted and tested than notified in this period (table 1).

Small clusters of cases were identified in three other regions of England; seven cases in a religious community in the Northern and Yorkshire region, five cases in pre-school children and one member of staff at a nursery in the South East region, and four cases in the Eastern region linked to an international school following an importation from Ukraine.

The predominant genotype associated with the London outbreak, and most of the other clusters, was D5. This genotype, an endemic strain in Thailand and other countries in Southeast Asia, has previously only rarely been recorded in the United Kingdom (UK). It was documented in a case in August 2001 with a history of recent travel to Thailand and subsequently in several clusters of cases in colleges and universities reported in the fourth quarter of 2001 (1). Other genotypes identified in this quarter were D4, associated with a single case imported from Pakistan, D8 from one case imported from Lithuania, and two cases of B3 where follow-up information to identify the possible source of these infections was not available. Genotype B3 is a strain endemic in west and central Africa. In other cases, where genotyping was not available, there was a history of recent travel to, or possible contact with travellers from, Argentina, Brazil, Ecuador, Kyrgizstan, Libya, Bangladesh, India, Kosovo, Spain, and Portugal. Genotyping demonstrates the ease with which measles can be imported into the UK from all over the world because of the frequency of international travel. This highlights the need for high vaccination coverage and a global approach to the prevention of this highly infectious disease.

An adult with severe lung disease who died was also confirmed as having measles (genotype D5) which may have been a contributory factor in their death, was also reported in this quarter. An infant in the same family also had confirmed measles with a similar onset, however, the source of their infections was not ascertained. One measles death in a child was reported to ONS this quarter. Laboratory investigations, however, conclusively excluded measles infection in this child. Adenovirus infection was confirmed and may have contributed to death.

Mumps

One hundred and thirty-one cases of mumps with onset dates in the first quarter of 2002 were confirmed, compared to 115 in the previous quarter (1).

Two cases of mumps meningitis were reported; a 14 year-old male with a history of receiving one dose of MMR, and an unvaccinated 18 year old male. Eighty per cent of the cases were reported from four regions (Northern and Yorkshire 30, North West 51, West Midlands 12, Wales 12) and were mainly associated with outbreaks in schools. Northern and Yorkshire and North West regions have accounted for 65% of all confirmed cases reported between 1999 and 2001.

Seventy-one per cent of the cases in this quarter (93/131) were born between 1983 and 1990 (aged 12 to 19 years). Those born before 1983 are too old to have been offered MMR vaccine. Those born between 1983 and 1986 may have been offered a single dose of MMR as part of a school entry catch-up programme from 1988, when the vaccine was introduced. Those born from 1987 will have been offered one routinely scheduled dose of MMR vaccine and many of them will have had measles-rubella (MR) vaccine in the school campaign in 1994. About 10% of those vaccinated with only a single dose of a mumps-containing vaccine fail to respond, emphasising the need to include a second dose of MMR in the schedule, which was introduced in 1996.

Table 2 Laboratory confirmed cases of mumps by age group and region, England and Wales: weeks 01-13/02

	Age group						
Region	<1y	1-4y	5-9y	10-14y	15-19y	20y+	**Total***
Northern and Yorkshire	0	0	0	7	16	7	**30**
Trent	0	0	1	2	5	1	**8**
Eastern	0	0	0	0	0	5	**5**
London	0	0	0	1	1	0	**2**
South East	0	0	0	0	4	5	**9**

South West	0	0	0	0	2	0	**2**
West Midlands	0	0	0	1	6	5	**12**
North West	0	0	2	23	20	6	**51**
Wales	0	0	0	10	1	1	**12**
Total	**0**	**0**	**2**	**44**	**55**	**30**	**131**

Rubella

Twelve cases of rubella with onset dates in the first quarter of 2002 were confirmed: a one-year old child, ten adults of whom six were aged 21 to 31 years (three males, three females), and four aged 37 to 42 years (two males, two females) including a case imported from Germany. One female, age not stated, was also reported.

1. PHLS. Laboratory confirmed cases of measles, mumps and rubella, England and Wales: October to December 2001. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 27 June 2002]; **12** (13): immunisation. Available online at <www.phls.co.uk/publications/CDR%20Weekly/archive02/immunisationarchive02.html>.

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COVER programme : January to March 2002

Vaccination coverage statistics for children up to five years of age 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, January to March 2002. This is the seventh 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 for their third dose primary vaccinations (third dose diphtheria, tetanus, pertussis (DTP vaccine), Haemophilus influenzae type b (Hib vaccine), polio vaccine and MenC vaccine) from May 2001 to July 2001. Children who reached their second birthdays would have been scheduled for their third dose primary vaccinations from May 2000 to July 2000 and first measles, mumps and rubella (MMR) vaccination from January 2001 to July 2001. Children who reached their fifth birthdays would have been scheduled for their third dose primary vaccinations from May 1997 to July 1997, their first MMR from January 1998 to July 1999, their pre-school booster DT, polio and second dose MMR from May 2000 onwards. One catch-up dose of MenC would have been scheduled from April 2000 onwards.

Methods

Data from computerised child health information systems were submitted in May and June 2002 for children resident in UK health authorities, health boards, and British Forces Germany (BFG) on 31 March 2002 and reaching their first, second, or fifth birthdays during the evaluation quarter (January to March 2002). Details of the data requested have been published (2). These routine request parameters now include MenC.

Results

Coverage at 12 and 24 months

Data were received from all health authorities and health boards in England, Wales, Northern Ireland and Scotland (tables 1 and 2). Four English trusts, serving part of four health authorities, were unable to be included this quarter. Twenty-five of the participating health authorities/boards (21%) achieved the 95% target for three doses of diphtheria, tetanus and polio vaccine (D3), 20 (17%) for three doses of pertussis vaccine (P3), and 28 (24%) for three doses of Hib vaccine (Hib3) at 12 months of age. Sixty health authorities/boards (50%) achieved 95% coverage for D3, 47 (39%) for P3, and 56 (47%) for Hib3 at 24 months of age and all countries/regions, except for London, achieved at least 90% coverage for these antigens. Only one health authority/board achieved 95% coverage for MMR at 24 months. UK coverage was slightly higher for all antigens at 12 months compared to that reported in the previous quarter (3) and slightly lower for all antigens at 24 months, except for MenC which rose from 90.8% in October to

December 2001 to 91.8% this quarter. This is the second 24-month cohort to be entirely routinely scheduled for three doses of MenC vaccine.

Table 1 Completed primary immunisations (all antigens) by 12 months: January to March 2002

Region/country	HA* (total)	D3	P3	Hib3	MenC
England					
Northern & Yorkshire	13 (13)	91.7	91.2	91.3	90.3
Trent	11 (11)	92.5	92.2	92.5	91.6
Eastern	7 (7)	92.9	92.5	92.9	92.3
London	14 (14)	82.8	82.5	82.7	82.7
South East	13 (13)	92.3	92.1	92.4	91.3
South West	8 (8)	93.3	92.7	93.1	92.2
West Midlands	13 (13)	90.4	89.9	90.4	90.1
North West	16 (16)	91.3	90.8	91.1	90.8
England (total)	95 (95)	**90.5**	**90.1**	**90.3**	**89.8**
Wales	5 (5)	**93.8**	**93.0**	**93.6**	**93.0**
Northern Ireland	4 (4)	**94.9**	**94.4**	**94.8**	**94.8**
Scotland	15 (15)	**95.4**	**95.2**	**95.3**	**94.6**
United Kingdom	119 (119)	**91.2**	**90.8**	**91.0**	**90.5**

* Health authority

Table 2 Completed primary immunisations (all antigens) by 24 months: January to March 2002

Region/country	HA* (total)	D3	P3	Hib3	MenC	MMR1
Northern & Yorkshire	13 (13)	94.1	93.6	93.6	92.4	**86.1**
Trent	11 (11)	95.6	95.1	95.5	93.8	**87.8**
Eastern	7 (7)	94.4	93.6	94.0	93.4	**84.4**
London	14 (14)	88.2	87.7	87.6	82.2	**72.6**
South East	13 (13)	94.0	93.3	93.7	91.9	**84.0**
South West	8 (8)	95.5	94.8	95.2	93.5	**85.4**
West Midlands	13 (13)	95.0	94.0	94.4	91.8	**85.4**
North West	16 (16)	93.9	92.9	93.4	93.0	**85.5**
England (total)	95 (95)	**93.5**	**92.8**	**93.1**	**91.1**	**83.3**
Wales	5 (5)	**95.2**	**93.8**	**95.0**	**94.8**	**82.5**
Northern Ireland	4 (4)	**96.3**	**96.2**	**96.7**	**95.9**	**89.7**
Scotland	15 (15)	**97.0**	**96.3**	**96.6**	**96.0**	**87.6**
United Kingdom	119 (119)	**93.9**	**93.2**	**93.6**	**91.8**	**83.8**

* Health authority

Coverage at 5 years

Data were received from all health authorities/health boards in England, Wales, and Northern Ireland. Coverage at 5 years for D3, Hib3 and Men3 was similar to that reported for the previous quarter; P3, MMR1 and MMR2 dropped slightly by 0.2 - 0.3% (table 3) (3). MenC catch up coverage at 5 years was 82.3% in England, 86.3% in Wales, and 91.2% in Northern Ireland (table 3). No data were available for children reaching their sixth birthday in Scottish health boards.

Table 3 Completed primary immunisations (all antigens) by 5 years: January to March 2002

Region/country	HA* (total)	D3	P3	Hib	MenC	MMR1	MMR2	D4
Northern & Yorkshire	13 (13)	94.8	93.6	94.1	85.4	**92.2**	77.1	81.5
Trent	11 (11)	95.5	94.7	95.1	86.7	**93.2**	76.5	79.9
Eastern	7 (7)	94.5	93.3	93.6	87.2	**90.6**	77.2	81.7
London	14(14)	88.9	87.9	87.7	56.7	**83.3**	57.1	63.9
South East	13 (13)	93.2	92.7	92.9	85.2	**90.5**	73.9	81.1
South West	8 (8)	96.8	95.5	96.0	88.1	**93.6**	80.6	86.8
West Midlands	13 (13)	95.3	92.6	94.6	86.9	**93.0**	78.6	87.4
North West	16 (16)	95.6	94.0	94.7	86.5	**92.7**	74.4	80.2
England (total)	95 (95)	**94.0**	**92.8**	**93.3**	**82.3**	**90.8**	**73.8**	**79.9**
Wales	5 (5)	**96.5**	**92.6**	**94.5**	**86.3**	**89.7**	**72.4**	**82.9**
Northern Ireland	4 (4)	**97.9**	**96.1**	**97.2**	**91.2**	**96.6**	**86.6**	**88.9**
England, Wales & Northern Ireland	104 (104)	**94.3**	**92.9**	**93.5**	**82.9**	**91.0**	**73.7**	**79.8**

* Health authority † no data available

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= 179) for all antigens was 98.3%; average coverage at 24 months (n=189) was 98.4% for D3 and P3, 97.94% for Hib3, 95.8% for MMR and 97.4% for MenC. Average coverage at five years (n=172) was 97.7% for Hib3 and 97.1% for MMR1. No data were available for D3 and P3 antigens. Coverage at five years was 90.7% and 93.6% for MMR2 and MenC respectively.

Early coverage of MMR

Data on MMR coverage submitted by 34 participating English health authorities/trusts using the National Child Health System for children aged 16 months in May 2002, (*ie* children born in December 2000) was 69.4%, 1.6% lower than in the previous evaluation (72.0%) for children born in November 2000 (4).

Comments

Up to April 2002, COVER data were collected for each health authority. Health authorities were dissolved in April 2002 and immunisation coverage data will be collected by CDSC for Primary Care Trusts (PCTs). New regional health authorities boundaries also came into effect at the same time. To allow comparisons to be made and for continuity, data will continue to be collected for old health authority boundaries for as long as is practicable and published in this report using the pre-April 2002 regional health authorities definitions until April 2003.

Coverage for all antigens at 12 and 24 months of ages has remained remarkably similar to the two previous quarters except for MMR1 at 24 months which had decreased by 0.2% since last quarter (3, 5). MMR2 and D4 at 5 years in England, Wales, and Northern Ireland, have both decreased only marginally since the last quarter, to 73.7% and 79.8% respectively, although MMR1 at this age remained higher at over 90% . MenC coverage continued to increase at each age evaluated.

Links to PHLS website

http://www.phls.co.uk/facts/Immunisation/Measles/meas.htm

http://www.phls.co.uk/facts/Vaccination/VaccIndex.htm

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. CDSC. COVER/Körner: October to December 1998. *Commun Dis Rep CDR Wkly* 1999; **9**: 115-6.

3. PHLS. COVER programme: October to December 2001. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 27 June 2002]; **12** (13): immunisation. Available online at http://www.phls.co.uk/publications/CDR%20Weekly/PDF%20files/2002/cdr1302.pdf

4. PHLS. Coverage of MMR at 16 months shows slight improvement. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 27 June 2002]; **12** (9): news. Available online at http://www.phls.co.uk/publications/CDR%20Weekly/archive02/News/news0202.html

5. PHLS. COVER programme: July to September 2001. *Commun Dis Rep CDR Wkly* [serial online] 2002 [cited 27 June 2002]; **12** (4): immunisation. Available online at http://www.phls.co.uk/publications/CDR%20Weekly/PDF%20files/2002/CDR0402.pdf

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HIV/STIs

Last updated: 27 June 2002
Next update due: 25 July 2002

AIDS and HIV infection in the UK: monthly report - June 2002

United Kingdom data from the PHLS AIDS and STD centre, Scottish Centre for Infection and Environmental Health, Institute of Child Health, London, and Oxford Haemophilia Centre (on behalf of the UK Haemophilia Centres' Doctors Organisation)

Ethnicity and HIV/AIDS infection diagnosed in the United Kingdom

Information on ethnicity has been collected since the early 1980s when surveillance of AIDS began. By the end of March 2002, data on ethnicity were available for almost 94% of cumulative reported AIDS cases. This has risen from 92% completeness at the end of 1997. A table of cumulative AIDS cases by exposure category and ethnic group can be viewed in the HIV/AIDS quarterly surveillance tables, available on the PHLS web site at: http://www.phls.org.uk/facts/HIV/hivqnotes.htm

Reports from microbiology laboratories of diagnoses of newly acquired HIV infection started in the mid-1980s, but information on ethnicity was only requested from 1993. The AIDS report form was replaced in 2000. Clinicians are now asked to report new diagnoses of HIV/AIDS, and death in a person known to be HIV positive without having had an AIDS defining condition, using a new clinician HIV report form (buff forms). The reports from clinicians often link to cases notified from laboratories and assist in completing the ethnicity data. The ethnic categories conform to those used for the United Kingdom national census in 1991 (1).

Recording of ethnicity has been consistently above 70% since 1998 and by 2000 the completeness of information on ethnicity reached almost 85%, although this had fallen back to 76% in 2001 (table 1). The figure for 2001 is, however, likely to rise, as ethnicity is determined through linking new clinician reports to laboratory reports already received. Where ethnicity was recorded for those diagnosed in 2001 39% (1235/3184) were white, and 52% (1647/3184) were black African. This is a continuation of the trend reported earlier (2) and reflects the increasing proportion of diagnoses of infections acquired through sex between men and women, the majority of which are acquired in Africa (3).

Table 1 HIV infected individuals* by ethnicity and year of HIV diagnosis in the United Kingdom: data to end of March 2002

	Year of diagnosis†						
Ethnic group	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Black-African	284	369	542	687	887	1352	1647
Black-Caribbean	31	41	68	78	101	114	136
Black-other	8	20	21	20	35	36	21
Indian\Pakistani\Bangladeshi	18	25	39	41	41	68	39
White	780	1028	1129	1166	1147	1452	1235
Other‡/mixed	36	49	69	102	98	133	106
Subtotal	1157	1532	1868	2094	2309	3155	3184
Not known	1482	1153	855	705	721	568	980
Total	**2639**	**2685**	**2723**	**2799**	**3030**	**3723**	**4164**

*individuals with HIV infection reported from laboratories, or by clinicians, or death reports for whom no matching HIV diagnosis has been received;
†numbers, particularly for recent years, will increase as further reports are received;
includes Chinese and South East Asian.

Ethnicity in prevalent diagnosed HIV infections

The Survey of Prevalent HIV Infections Diagnosed (SOPHID) collects data, including information on ethnicity, on those individuals receiving treatment or care in a calendar year. The ethnic distribution was different from that of newly diagnosed infections: 65% were white, 25% black African, 5% other/mixed, 3% black Caribbean, 1.6% black other, and 1.5% Indian/Pakistani/Bangladeshi. In 2000 21,717 patients were seen for care and ethnicity is recorded for 93% (table 2). The difference in distribution by ethnicity in SOPHID, compared to reports of new diagnoses for the year 2000 (table 1), reflects the increasing proportion of new diagnoses in individuals who probably acquired infection in sub-Saharan Africa. Of the patients seen for care in 2000 where likely route of infection was recorded, nearly two thirds were infected through sex between men. Many of these will have been diagnosed some years ago. They are predominately white, and form a major component of the 65% of individuals seen for HIV related care who were in the white ethnic group.

Table 2 HIV infected patients last seen for care in 2000 in England, Wales and Northern Ireland by ethnicity and region of residence *

	Ethnic group							
NHS region of residence	**White**	**Black African**	**Black Caribbean**	**Black Other**	**IPB†**	**Other / Mixed ‡**	**Not Known**	**Total**
England								
Northern & Yorkshire	606	68	4	8	9	18	14	727
Trent	527	81	6	6	39	23	10	692
West Midlands	605	119	37	8	16	16	10	811
North West	1350	99	11	7	31	36	30	1564
Eastern	559	174	19	9	7	22	24	814
London	6888	3931	414	261	166	757	884	13301
South East	1200	328	21	12	22	55	502	2140
South West	675	63	9	1	2	38	15	803
England total #	**12410**	**4863**	**521**	**312**	**292**	**965**	**1489**	**20852**
Wales	296	13	3		2	16	2	332
Northern Ireland	97	5				2		104
Sub total	**12803**	**4881**	**524**	**312**	**294**	**983**	**1491**	**21288**
Outside England, Wales & Northern Ireland	38	12	1	2	3	6	5	67
Not known	144	76	7	6	3	16	110	362
Total	**12985**	**4969**	**532**	**320**	**300**	**1005**	**1606**	**21717**

*patients seen for statutory medical HIV related care at services in England, Wales and Northern Ireland in 2000 (includes 288 children born to HIV infected mothers in 2000 whose HIV infection status had not been confirmed: 8 resident in Northern & Yorkshire, 7 in Trent, 9 in West Midlands, 4 in North West, 5 in Eastern, 223 in London, 24 in South East 6 in South West and 2 where region was not reported);
† includes 3 patients whose region of residence was not known.;
‡ Indian/Pakistani/Bangladeshi;
# Includes Chinese and South East Asian.

Ethnicity and Region of Residence

Sixty-two per cent of prevalent diagnosed HIV infected patients seen for care in 2000, lived in the London region. Of those London residents for whom ethnicity was reported, 56% (6888/12,417) were white, 32% (3931) black African, 6% (757) other/mixed, 3% (414) black Caribbean, 2% (261) black other, and 1% (166) Indian/Pakistani/Bangladeshi. For regions outside of London, the South East and Eastern, and where residence status was known, the picture was very different with 84% of patients reported to be of white ethnicity and only 9% Black African.

Ethnicity and route of HIV infection

Sexual acquisition

Of those who were seen for HIV related care in 2000 where the ethnicity of the patient was known, 10,411 probably acquired their HIV infection through sex between men (table 3). In this group 90% (9325) were of white ethnicity, 5% (541) other/mixed, 2% (202) Black Caribbean, and 1% for Black African (137), Black Other (137), and Indian/Pakistani/Bangladeshi (69).

In those who probably acquired their infection through sex between men and women, 60% (3881/6552) were black African, 29%(1867) white, 4%(241) black Caribbean, 4% (241) other/mixed, 3% (175) Indian/Pakistani/Bangladeshi, and 2% (147) black Other.

Non-sexual acquisition

Four per cent (872) of patients overall acquired their infections through injecting drug use. In this group, where ethnicity was known, 90% (749/836) were of white ethnicity. Eighty-four per cent of those infected through blood or blood products were of white ethnicity (365/436). In mother to child transmissions black

Table 3 Individuals seen for HIV related care in 2000 in England, Wale,s and Northern Ireland by ethnicity and probable route of infection category *

	Ethnicity							
Infection Route	**White**	**Black-African**	**Black Caribbean**	**Black Other**	**IPB†**	**Other / mixed ‡**	**Not Known**	**Total**
Sexual exposure								
Sex between men	9325	137	202	137	69	541	969	11380
Sex between men & Women	1867	3881	241	147	175	241	210	6762
Injecting drug use	749	16	4		6	61	36	872
Blood/blood products recipient	365	34	7	2	14	14	27	463
Mother-to-child transmission	87	493	13	3	8	86	133	823
Other/Not known	592	408	65	31	28	62	231	1417
Total	**12985**	**4969**	**532**	**320**	**300**	**1005**	**1606**	**21717**

*patients seen for statutory medical HIV related care at services in England, Wales and Northern Ireland in 2000 (includes 288 children born to HIV infected mothers in 2000 whose HIV infection status had not been confirmed: 8 resident in Northern & Yorkshire, 7 in Trent, 9 in West Midlands, 4 in North West, 5 in Eastern, 223 in London, 24 in South East 6 in South West and 2 where region was not reported;
† Indian/Pakistani/Bangladeshi;
‡ Includes Chinese and South East Asian.

1. Office of Populations Censuses and Surveys and General Register Office for Scotland. *1991 census, ethnic group and country of birth*. London: HMSO, 1993

2. CDSC. AIDS and HIV infection in the United Kingdom: Monthly report. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited 25 June 2002]; **11** (12): HIV/STIs. Available from <www.phls.org.uk/publications/CDR%20Weekly/archive/hivarchive.html>.

3. CDSC. AIDS and HIV infection in the United Kingdom: Monthly report. *Commun Dis Rep CDR Wkly* [serial online] 2001 [cited 25 June 2002]; **11** (4): HIV/STIs. Available from <www.phls.org.uk/publications/CDR%20Weekly/archive/hivarchive.html>.