Compulsory notification of HIV infection within a new system for anonymous reporting of notifiable diseases in France

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The implementation of compulsory notification of HIV in France has been the subject of debate for many years, mainly due to concern for the human rights of patients with HIV, with only AIDS cases being notified. An anonymous reporting system for HIV infection was scheduled to begin in 1999, but this was delayed due to opposition from organisations demanding measures to strengthen patient anonymity and data protection. The new system is the product of extensive collaboration between the Institut de Veille Sanitaire (InVS), patient associations, civil rights groups, health care professionals (microbiologists, clinicians, epidemiologists), the ministry of health, and expert committees (on safety, ethics), all of whom are represented on a steering committee. The new arrangements, which reinforce patient anonymity and data protection, meets the requirements of the parties involved, and has been authorised by the National Commission for data processing and liberty (CNIL), the national authority for the protection of personal data collected on individuals.

The system rests on three main principles:

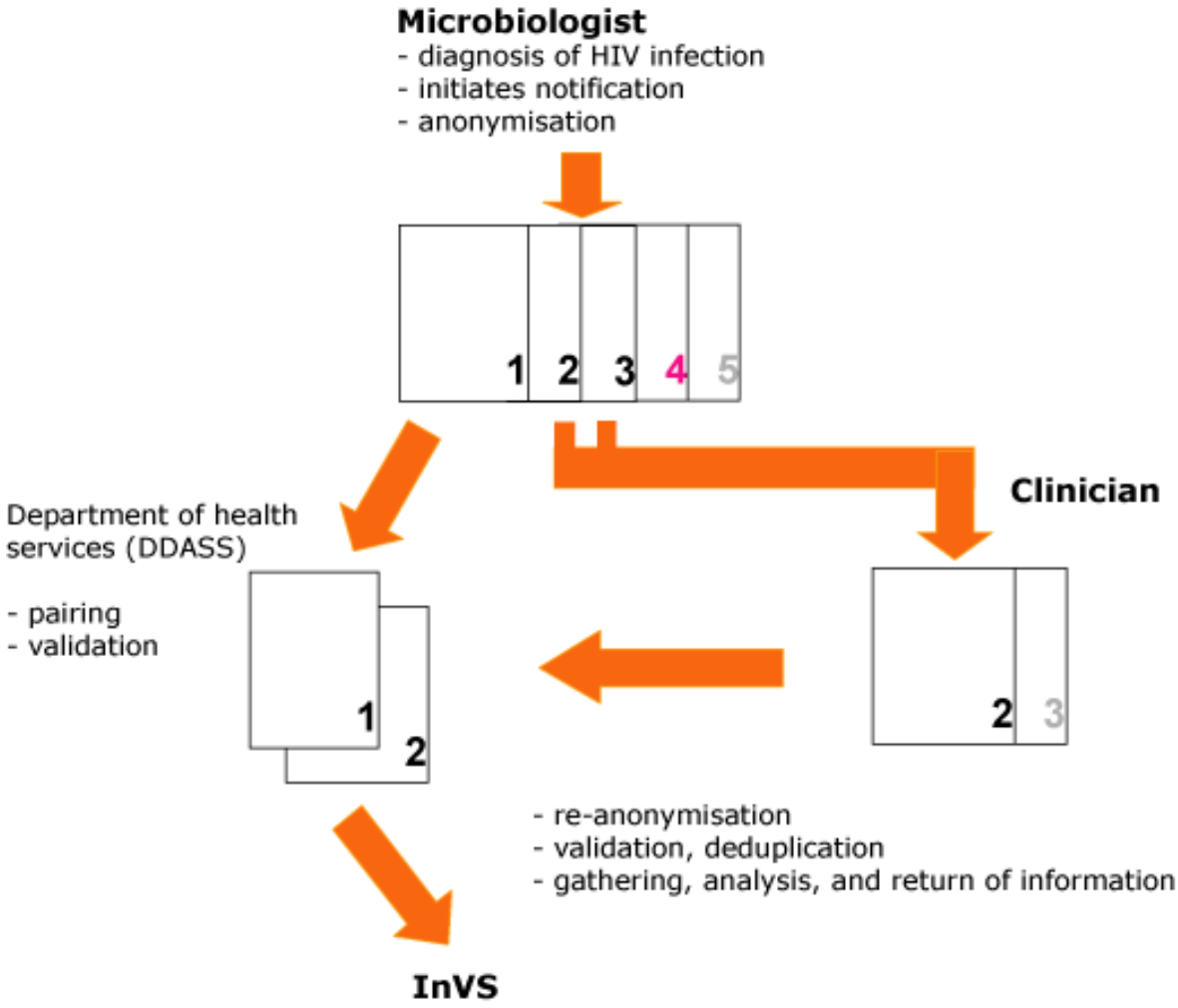
- Cases are notified by the microbiologist and the clinician (in the case of children under 13 years, the paediatrician is the only person to notify) (figure). The microbiologist, who performs the diagnostic test for HIV infection, "initiates" the notification, and sends the notification form to the doctor who completes it;
- Double anonymisation: (i) creation of an initial anonymous code by the microbiologist, using software provided by InVS, (ii) automatic transformation of this code to a second code upon entry into the InVS database;
- Patients are given information on the compulsory nature of the notification by their doctor.

Only newly diagnosed cases have to be notified. The data to be collected on the notification forms include age, sex, nationality, country of residence, country of birth, occupation, reason for attending screening, previous HIV serology, route of transmission, and clinical stage.

Facilities for eliminating duplicate reports and for following the progression of disease (HIV, AIDS, and death) in an individual, were requirements of the new system. The anonymising software generates a unique sixteen-letter code from the initials of the first name and surname, sex, and date of birth. The second coding stage, at the InVS database level, produces a second, unique code, made up of over 100 characters.

In addition to the compulsory notification system, InVS and the laboratory of the National Reference Centre (CNR) coordinate virological surveillance of HIV. This applies to individuals over the age of 13 who, according to information from their doctor, are not opposed to participating in the surveillance system. The aim of the study is to evaluate whether or not the HIV infection is recent (less than six months old), using a detuned assay, and to identify whether the case is infected with group B virus or not, by serotyping. The notifying microbiologist takes a sample on blotting paper from the bottom of the tube that was used for the diagnostic test, and sends this to the National Reference Centre. The sample is analysed and the results sent to InVS, where it is linked to the epidemiological information provided by the compulsory notification form. This process enables those recently infected to be described, and provides an estimate of HIV incidence.

Figure: Notification of HIV infection (adults and adolescents 13 yrs and over)



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Dengue fever in Cairns, Australia: update

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There are now 85 confirmed cases of dengue fever in Cairns as of 19 March 2003. No cases have been reported outside of Cairns in this outbreak. [Rosalie Spencer, Queensland Health - personal communication, 19 March 2003] The areas currently affected are Parramatta Park, Manunda, Cairns North, Yorkeys Knob, and Trinity Beach (1).

Since the outbreak began in February 2003 (2), the Dengue Action Response Team (DART) has been conducting house to house checks in most inner city, and some northern beaches suburbs, encouraging residents to eliminate mosquito breeding sites around their yards and homes. The DART has also been spraying household insecticide sprays inside homes and is advising people in all affected and potentially affected areas to use mosquito coils and repellents to avoid bites.

No cases of dengue haemorrhagic fever (DHF) have been reported, but people who acquired dengue in the last large outbreak in Cairns in 1997-99 would be at risk of developing haemorrhagic fever if they caught dengue fever again in this outbreak. DHF can occur when a person previously infected with dengue, becomes infected with a different dengue serotype, and is potentially fatal.

Travellers to Australia are strongly reminded to take measures to prevent mosquito bites, to protect themselves against dengue fever and other mosquito borne diseases. (See reference 2 for specific advice).

References :

1. Queensland Health, Queensland Government, Australia. Dengue update (press release). 17 March 2003.
2. Lawrence J. Dengue fever in Cairns, Australia. *Eurosurveillance Weekly* 2003; **7**: 030306 (http://www.eurosurveillance.org/ew/2003/030306.asp).

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Institute of medicine publishes new report on microbial threats to health

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"Microbial Threats to health: emergence, detection, and response", published this week by the Institute of Medicine focuses on the need for renewed commitment faced with the increased impact of infectious diseases in the United States since publication of the landmark report, "Emerging Infections: Microbial Threats to Health in the United States" in 1992. The report's authors, the Committee on Emerging Microbial Threats to Health in the 21st century, recommend enhanced global capacity for response to infectious diseases and stresses the importance of a robust public health system in responding to any disease outbreak.

The report recommends that the US should seek to enhance the global capacity for response to infectious disease threats, focusing in particular on threats in the developing world (1). It also calls for the US to take a leadership role in promoting the implementation of a comprehensive system of surveillance for global infectious diseases that builds on the current global capacity of infectious disease monitoring, and recommends that there should be responsibility for the national vaccine strategy at the highest level of government.

Thirteen principal factors in the emergence of microbial threats are listed in the report, along with details of the existing measures for dealing with them. The report's recommendations also include enhancing infectious disease reporting by medical healthcare and veterinary healthcare providers, and automatic electronic laboratory reporting of notifiable infectious diseases from all relevant major clinical laboratories to their respective state health departments as part of a national electronic infectious disease reporting system.

To avert an imminent crisis resulting from microbial agents' increasing resistance to available antimicrobial drugs, the committee recommends procedures to alert infectious disease control stakeholders to the problem, and more finely targeted use of antimicrobials. The new report is available at: http://www.iom.edu/iom/iomhome.nsf/Pages/Recently+Released+Reports.

Reference:

1. Institute of Medicine. Microbial threats to health: emergence, detection, and response - summary March 2003. (http://www.iom.edu/iom/iomhome.nsf/WFiles/MicrobialThreat8pgFINAL/$file/MicrobialThreat8pgFINAL.pdf)

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