Table 8. Cumulative diagnoses of HIV infection, AIDS and deaths following AIDS since the introduction of HIV antibody testing to 31 October 1998, by sex and State or Territory

		State or Territory								
		ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Australia
HIV diagnoses	Female	21	571	8	131	55	4	198	99	1,087
	Male	183	10,456	101	1,856	642	77	3,720	868	17,903
	Sex not reported	0	260	0	0	0	0	24	0	284
	Total[1]	204	11,306	109	1,994	697	81	3,955	970	19,316
AIDS diagnoses	Female	8	166	0	45	20	2	65	23	329
	Male	83	4,476	32	775	325	43	1,562	337	7,633
	Total[1]	91	4,653	32	822	345	45	1,634	362	7,984
AIDS deaths	Female	2	113	0	30	15	2	47	16	225
	Male	62	3,078	24	538	222	28	1,226	241	5,419
	Total[1]	64	3,198	24	570	237	30	1,279	258	5,660

1. Persons whose sex was reported as transgender are included in the totals.

Overseas briefs

Source: World Health Organization (WHO)
This material has been condensed from information on the WHO Internet site. A link to this site can be found under 'Related sites' on the CDI homepage.

Cholera, Somalia

Cholera has occurred seasonally in the country for a number of years and usually starts in late November/ early December ending around May. In the first week of December 1998 cholera was reported in Mogadishu (Banadir Region) and since then several regions have reported cases. The other regions currently affected are Bay, Gedo, Lower Juba and Lower Shabelle. A total of 4,457 cases with 166 deaths have been reported since December, up to 19 February.

The epidemic is occurring in communities already weakened by severe shortage of food and in areas where only polluted water is available as wells have dried up. Supplies for treatment have been made available by WHO to UNICEF. The UN agencies, NGOs and the local health authorities are all collaborating in dealing with the epidemic. As well as clinical case management, efforts have also been directed at preventive measures such as chlorination of public water sources and health education on personal hygiene. At present, tests for cholera can be conducted in four laboratories.

Meningococcal disease

Sudan - update

The outbreak that started in Northern Darfur State in December 1998 has now spread to 15 States, some of them reaching epidemic level. From the beginning of the epidemic up to 9 March, 2,293 cases and 262 deaths have been reported by the Federal Ministry of Health. An appeal has been launched by the Ministry of Health in Khartoum, with support from the executive members of the International Coordinating Group, WHO, UNICEF, IFRC and MSF, for the provision of meningococcal vaccine. There is an urgent need for more vaccines, drugs and technical support to strengthen the surveillance systems and laboratory capacity.

Guinea-Bissau

An outbreak of meningococcal meningitis has been reported in Guinea-Bissau. The outbreak started early January and has mainly affected the regions Oio, Bafata and Gabu. The causative organism has been identified as *Neisseria meningitidis* serogroup A.

Since the beginning of 1999 up to 21 February, 139 cases have been notified, of which 36 were fatal. During 1998 Guinea-Bissau reported 112 cases of meningococcal disease, of which 12 died.

The national health authorities and the local representatives of the Executive Group of the International Coordinating Group for the Provision of Meningococcal Meningitis (ICG) are implementing measures to control the outbreak.

Acute respiratory infection, Afghanistan

On 13 February, an outbreak of an unidentified disease was reported to have occurred in Darwaz, Badakhshan,

Afghanistan. On 26 February, a specialised WHO team arrived on site at one of the affected villages, Jamarche Bala, with the logistic support of the United Nations system. Other villages were visited by *Médecins sans frontières* and Focus (Aga Khan Foundation).

The outbreak began around mid-January after two young men returned from the village of Waram, both suffering from an acute respiratory infection. Over the next two days, approximately 40 persons living in the same household became ill. The disease then spread through the whole village, affecting 70 to 80 per cent of households. The village has a population of 5,400. Preliminary results available on 26 February indicated that in five of the 18 villages affected there had been 6,300 cases and 135 deaths. The deaths occurred among both males and females and involved primarily infants and the elderly. Cases were treated by the team with chloramphenicol, which resulted in a significant improvement, suggesting that severely ill patients were suffering from secondary bacterial infections. There were no deaths among those treated.

The disease is flu-like and is characterised by abrupt onset of fever, headaches and myalgia, followed by chest pain and cough. Living and sanitary conditions are crowded, and the water supply is unprotected. Nutrition is of poor quality. There are no health services in this very remote area, which has not been accessed by routine immunisation teams.

Preliminary conclusions of the WHO team in the field is that the outbreak now declining was an influenza-like illness which has affected a large proportion of the population. The rate of secondary complications (mainly pneumonia) was high. Mortality is 1%-2% of the total population primarily due to lack of antibiotic availability and overall poor living and nutritional conditions.

WHO and its local partners are now helping local authorities to organise follow-up treatment and arranging for additional medical supplies to the area. Clinical specimens collected by the field team will be analysed shortly.

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Contributions

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