Influenza Pandemic and Syndromic Surveillance Weekly Report for the Solomon Islands for the period of Epi Weeks 1 to 16, dates including *Monday 4th-January-2010* to *Sunday 25-April-2010.*

Introduction

Syndromic and event based surveillance was intended to continues to be conducted at seven sentinel sites including 4 urban sites established within Honiara including the National Referral Hospital, Kukum Outpatient Clinic, Rove Outpatient Clinic and Mataniko Outpatient Clinic and three provincial sites being Lata Hospital Outpatient Department in Temotu, Kilu'ufi Outpatient Department in Auki and Gizo Outpatient Department in Gizo. However, only the urban sites excluding national referral Hospital provided their data for this report.

Focal diseases for weekly sentinel surveillance include but are not limited to the following: Botulism, Poliomyelitis, Influenza A (H5N1) (Avian Influenza), Influenza A (H1N1) (Pandemic H1N1), Dengue Fever, Malaria, Tetanus, Typhoid, Pertusis, Pneumococcal Disease, Measles, Mumps, Rubella, Meningitis, Cholera, Shigellosis, Varicella and Hepatitis.

Case Definitions

Influenza like Illness (ILI): Sudden onset of a fever over 38 degrees Celsius and a cough or sore throat, myalgia with an absence of other diagnoses.
(This is recorded as Acute Respiratory Infection (Mild) in clinic reports and used as a proxy for ILI)

Severe Acute Respiratory Infection: Fever over 38 degrees Celsius or difficulty breathing AND

- Fast breath (>50 breaths/min) for infant 2 months to ,1 year +/-chest in drawing
- Fast breath (>40 breaths/min) for child aged 1to 5 years +/- chest in drawing

(This is recorded as Acute Respiratory Infection (Moderate/Severe) in clinic reports and is used as a proxy for SARI)

Watery Diarrhoea: Passage of 3 or more loose stools in the past 24 hours

Clinical Malaria: all patients with symptoms of malaria (confirmed and presumptive) who are treated with antimalarial drugs

Results

The result of from the Sendromic surveillance Activities present 2010 data for the urban sentinel sites only, excluding the National referral Hospital. The 16 weeks reports for the site are summarized in the table below.

Consultations for selected syndromes at Urban Clinics, Epiweeks 1-16, 2010

Syndrome	Number	% of total
ILI	4318	32
Clinical Malaria	1584	12
Diarrhoea	400	3
SARI	34	0.3
Total Consultations	**13508**	**100**

Figure 1

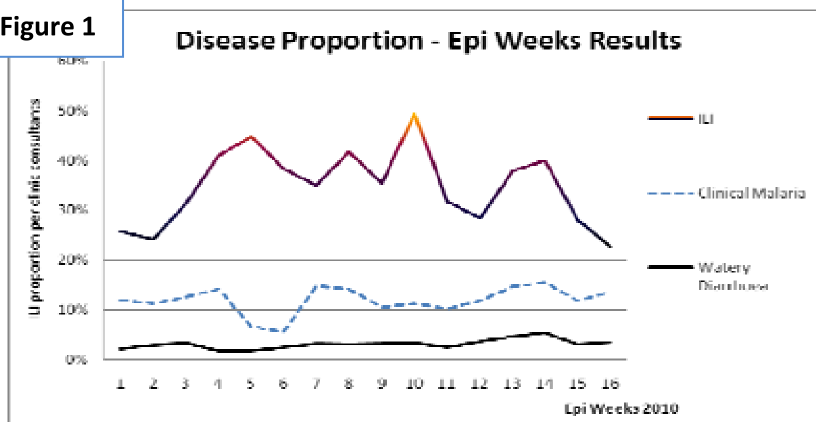
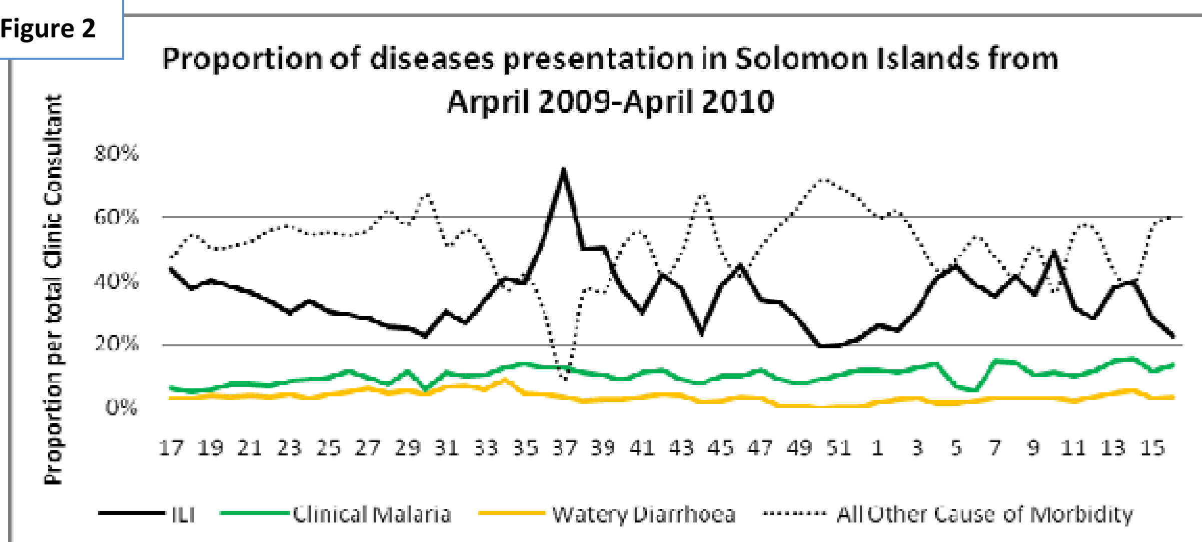


***Figure 1**:* Aggregated data for Epi weeks 1 to Epi week 16 inclusive from Honiara sentinel sites excluding National Referral Hospital.
ILI is still the leading cause of Morbidity

As shown below *Figure 2,* this report presents the establishment of an Annual Surveillance Activities which began in April 2009.

Figure 2



The epidemic curves should serve as benchmark or reference in drawing threshold in monitoring any progress in the efforts and the promise to offer better health service to this nation.

Total clinic consults remain high in all centres. This places pressure on human resources at the clinic level with many clinics working overtime. Lata, Kilu'ufi and Gizo and the National Referral Hospital weekly data were not received for this reporting period. Therefore, situations for these sites are not reflected in this report.

It would be worthwhile for decision makers to have evidence based decision regarding the incidence of diseases mornitored in this suveillance. The graphs below demonstarte the trend of disease reported to indicated sentinel sites performance in this reporting period.

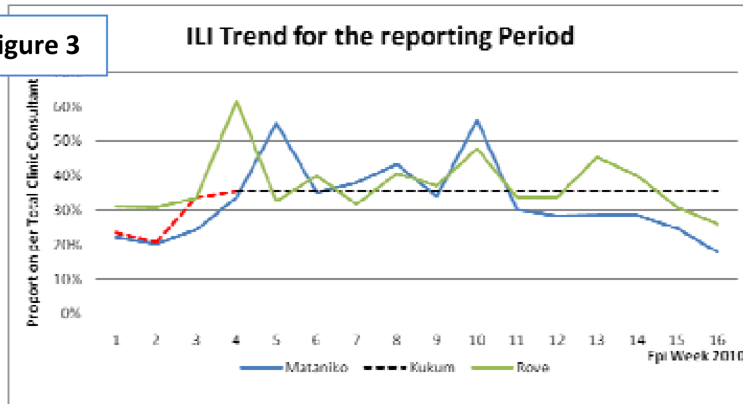


Figure 3 shows the health event of ILI in Honiara as indicated by Data from Urban Health Clinics. Kukum has been temporally closed so the status was carried forward from the last reporting week. There was no data submitted from the National Referral Hospital.

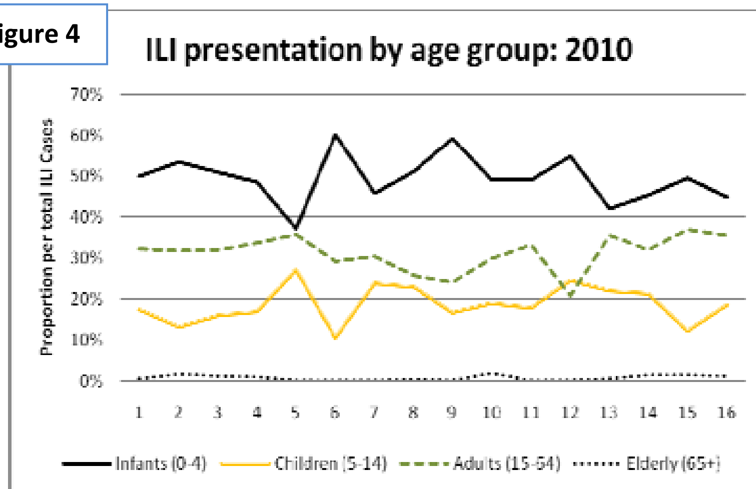


Figure 4 illustrate the high presentation of ILI cases among infants aged 0 to 4 which account for almost half of reported cases of ILI. Children (5-14yr) account for approximately 20% of reported cases of ILI and as shown in the graph elderly people rarely presented to clinic with ILI disease.

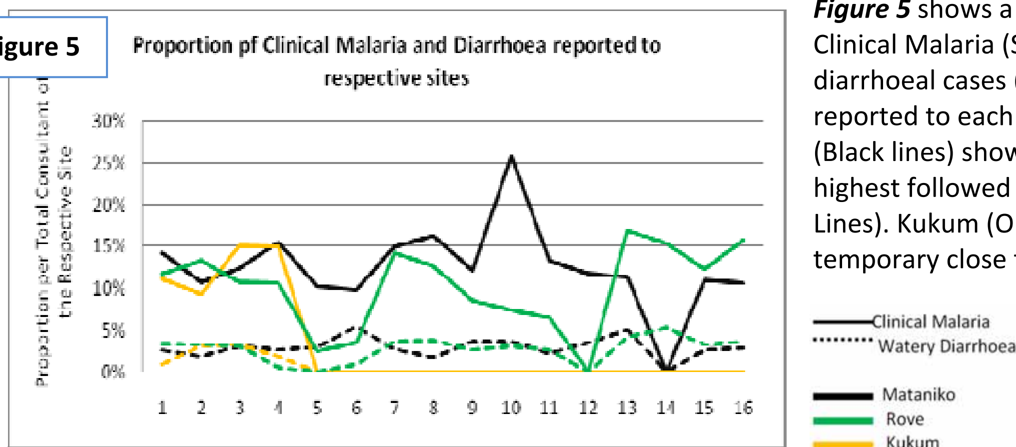


Figure 5 shows a comparison of the Clinical Malaria (Solid Lines) and diarrhoeal cases (Doted Lines) reported to each sites. Mataniko (Black lines) shown to have the highest followed by Rove (Geen Lines). Kukum (Orrange)has been temporary close for renovation.

Epi- notes:

The Solomon Islands continued to experience an outbreak of influenza like illness ever since this reporting period. NPS indicating Influenza A and Influenza B, Influenza A swabs were used to send to the WHO reference laboratory in Melbourne, Australia for testing for H1N1. The dropping fame of H1N1 in the country reduces and put to rest related activities including swab collection. However, Panvax donation from the World Health organisation to cater for 10% of Nation's population was received and safely stored on the 3rd of March 2010.

H1N1 2009 and 2010 Confirmed cases in the Solomon Islands

Solomon Islands Status on H1N1 still remains as of the last report in October 2009.

Date tested and later confirmed for H1N1	Age	Gender	Ethnicity	Country of Origin	Occupation	Comment
3/7/09	15 years	Male	Caucasian	Australia	Student	Individual one of a group of students from Australia visiting local teaching facility. Isolated on facility. Mild respiratory symptoms only. No contact with Solomon Islanders. Contract tracing conducted.
4/7/09	20 years	Female	Caucasian	Australia	Student	Individual one of a group of students visiting local teaching facility. Individual within same group as male above. Isolated on facility. Mild respiratory symptoms only. No contact with Solomon Islanders. Contract tracing conducted.
29/7/09	41 years	Male	uncertain	Australia	AFP	Arrived unwell with mild respiratory symptoms from Australia. Admitted to Private Medical Facility. Contact tracing of travellers conducted.
1/10/09	1 year and 10/12 months	Male	Micronesian (Kilu'ufi)	Solomon Islands	Infant	No history of travel. Mild respiratory symptoms only.

Method of control for Respiratory/Influenza Infections including control of the patient, contacts and the immediate environment.

1. Give/consider prescribing Tamiflu to those in high risk categories. These include children under the age of 5 years, those with underlying chronic medical condition(s), adults over the age of 55 years and pregnant women.

2. Educate the public and health care personnel in basic personal hygiene, especially the danger of unprotected coughs and sneezes, and hand to mucous membrane transmission.

3. Instructions on good respiratory etiquette should be provided including: Covering nose and mouth with a tissue when you cough or sneeze. Coughing into a sleeve. Throw the tissue in the rubbish bin after you use it. Do not spit.

4. Avoid crowding in the living and sleeping quarters, especially in Institutions and barracks. Provide adequate ventilation. Isolate the sick if possible, by staying/nursing in a separate room or area. Do not mix with other people who are not symptomatic.

5. Stay at home until completely recovered. Social distancing and social isolation practices. Keep windows open and allow ventilation of the room.

6. Washing of hands regularly least with soap and running water, especially after cough or sneeze.

7. Avoid touching eyes, nose or mouth with unwashed hands.

8. Household surfaces including door knobs, taps and light switches should be cleaned regularly with soap and water or disinfectant.

9. Bed rest, medication for fever, antibiotics if appropriate, good nutrition. General support and advice should be given to caregivers on the use of antipyretics (acetylsalicylic acid should be avoided in children), oral fluids, and nutrition.

10. Instructions must be provided on the use of antibiotics (if necessary) for bacterial complications of influenza when prescribed.

11. Don’t share tooth brushes, towels, pillows or anything else like that.