

SURVEILLANCE SYSTEMS REPORTED IN *CDI*, 2008

This article describes the surveillance schemes that are routinely reported on in *Communicable Diseases Intelligence (CDI)*.

In Australia, communicable diseases surveillance systems exist at national, state and local levels. State and local surveillance systems are crucial to the timely and effective detection and management of outbreaks and in assisting in the effective implementation of national policies. The national surveillance system combines some of the data collected from state and territory-based systems to provide an overview at a national level. Specific functions of the national surveillance system include: detection and management of outbreaks affecting more than one jurisdiction; monitoring of the need for and impact of national control programs; guidance of national policy development and resource allocation; and description of the epidemiology of rare diseases for which there are only a few notifications in each jurisdiction. National surveillance also assists in quarantine activities and facilitates international collaborations such as reporting to the World Health Organization.

Surveillance has been defined by the World Health Organization as the 'continuing scrutiny of all aspects of the occurrence and spread of disease that are pertinent to effective control.' It is characterised by 'methods distinguished by their practicability, uniformity, and frequently by their rapidity, rather than complete accuracy.'¹ Although some surveillance schemes aim for complete case ascertainment, others include only a proportion of all cases of the conditions under surveillance, and these samples are subject to systematic and other biases. Results generated from surveillance schemes must be interpreted with caution, particularly when comparing results between schemes, between different geographical areas or jurisdictions and over time. Surveillance data may also differ from data on communicable diseases gathered in other settings.

The major features of the surveillance schemes for which *CDI* publishes regular reports are described below.

Other surveillance schemes for which *CDI* publishes annual reports include tuberculosis notifications (*Commun Dis Intell* 2008;32:1–11), the Australian Mycobacterium Reference Laboratory Network (*Commun Dis Intell* 2008;32:12–17), invasive pneumococcal disease surveillance (*Commun Dis Intell* 2008;32:18–30), the National Arbovirus and Malaria Advisory Committee (*Commun Dis*

Intell 2008;32:31–46), and the Australian Rotavirus Surveillance Program (*Commun Dis Intell* 2007;31:375–379).

Australian Childhood Immunisation Register

Accurate information on the immunisation status of children is needed at the community level for program management and targeted immunisation efforts. A population-based immunisation register can provide this need. The Australian Childhood Immunisation Register (ACIR) commenced operation on 1 January 1996 and is now an important component of the *Immunise Australia Program*. It is administered and operated by Medicare Australia (formerly the Health Insurance Commission). The Register was established by transferring data on all children under the age of seven years enrolled with Medicare to the ACIR. This constitutes a nearly complete population register, as approximately 99% of children are registered with Medicare by 12 months of age. Children who are not enrolled in Medicare are added to the Register when a recognised immunisation provider supplies details of an eligible immunisation. Immunisations are generally notified to Medicare Australia either by electronic means, the Internet or by paper ACIR notification forms. Immunisations recorded on the Register must have been given in accordance with the guidelines for immunisation determined by the National Health and Medical Research Council.

From the data finally entered onto the ACIR, Medicare Australia provides regular quarterly coverage reports at the national and state level. Coverage for these reports is calculated using the cohort method described in *Commun Dis Intell* 1998;22:36–37. With this method, a cohort of children is defined by date of birth in three-month groups. This birth cohort has the immunisation status of its members assessed at the three key milestones of 12 months, 24 months and 6 years of age. Analysis of coverage is undertaken three months after the due date for completion of each milestone, so that time is available for processing notifications and the impact on coverage estimates of delayed notification to the ACIR is minimised. Only children enrolled with Medicare are included in order to minimise inaccuracies in coverage estimates due to duplicate records.

Medicare Australia coverage reports for the three milestones are published in *CDI* each quarter. Coverage estimates are provided for each state and

territory and Australia as a whole and for each individual vaccine assessed at each milestone. Changes in 'fully immunised' coverage from the previous quarter are also included in the tables.

A commentary on ACIR immunisation coverage estimates is included with the tables in each issue and graphs are used to provide trends in immunisation coverage.

Australian Gonococcal Surveillance Programme

The Australian Gonococcal Surveillance Programme (AGSP) is a continuing program to monitor antimicrobial resistance in *Neisseria gonorrhoeae* and includes the reference laboratories in all states and territories. These laboratories report data on sensitivity to an agreed core group of antimicrobial agents on a quarterly basis and provide an expanded analysis as an annual report in *CDI* (*Commun Dis Intell* 2007;31:180–184). The antibiotics that are currently routinely surveyed are the penicillins, ceftriaxone, ciprofloxacin and spectinomycin, all of which are administered as single dose regimens. One main purpose of the AGSP is to help define standard protocols for antibiotic treatment of gonococcal infection. When *in vitro* resistance to a recommended agent is demonstrated in 5% or more of isolates, it is usual to reconsider the inclusion of that agent in current treatment schedules. Additional data are also provided on other antibiotics from time to time. At present all laboratories also test isolates for the presence of high level resistance to the tetracyclines and intermittent surveys of azithromycin resistance are conducted. Comparability of data is achieved by means of a standardised system of MIC testing and a program-specific quality assurance process.

Australian Meningococcal Surveillance Programme

The reference laboratories of the Australian Meningococcal Surveillance Programme report data of laboratory-confirmed cases confirmed either by culture or by non-culture techniques. Culture-positive cases where a *Neisseria meningitidis* is grown from a normally sterile site or skin, and non-culture based diagnoses, derived from results of nucleic acid amplification assays and serological techniques are defined as invasive meningococcal disease (IMD) according to Public Health Laboratory Network definitions.

Data are reported annually and quarterly in *CDI*. Data in the quarterly reports are restricted to a description of the number of cases per jurisdiction, and serogroup where known. A full analysis of labo-

ratory-confirmed cases of IMD, including phenotyping and antibiotic susceptibility data are published annually (*Commun Dis Intell* 2007;31:185–194).

Australian Paediatric Surveillance Unit

The Australian Paediatric Surveillance Unit (APSU) is a national, active surveillance mechanism with monthly reporting by approximately 1,270 Australian paediatricians and other child health clinicians. APSU conducts surveillance for uncommon conditions of childhood, including genetic disorders, child mental health problems, rare injuries, and rare infections and vaccine preventable diseases. Communicable diseases currently under surveillance include: acute flaccid paralysis (to identify potential cases of poliovirus infection); congenital cytomegalovirus infection; congenital rubella; perinatal exposure to HIV, HIV infection and AIDS; neonatal herpes simplex virus infection; hepatitis C virus infection; group B *Streptococcus* sepsis; and neonatal, congenital and severe complications of varicella virus infection. Surveillance for intussusception and its causes (e.g. rotavirus infection) and for acute rheumatic fever (group A *Streptococcus* infection) commenced in 2007. APSU may occasionally be used for short-term rapid response surveillance e.g. surveillance for the severe complications of influenza in children <5 years of age in 2007.

The primary objectives of the APSU are to document the number of Australian children aged under 15 years, newly diagnosed with specified conditions; their geographic distribution; clinical features; current management; and outcome. Contributors to the APSU are clinicians known to be working in paediatrics and child health in Australia. In 2007, over 1,270 clinicians participated in the surveillance of 16 conditions through the APSU, with an overall monthly response rate of 96%. APSU is a unit of the Royal Australasian College of Physicians, and its activities are supported by the Department of Health and Ageing; the Faculty of Medicine, University of Sydney; and the National Health and Medical Research Council Enabling Grant 402784. For further information please contact the APSU Director, Professor Elizabeth Elliott on telephone: +61 2 9845 3005, facsimile +61 2 9845 3082 or email: apsu@chw.edu.au

Australian Sentinel Practice Research Network

The Royal Australian College of General Practitioners and the Department of General Practice at the University of Adelaide operate the Australian Sentinel Practice Research Network (ASPREN). ASPREN is a national network of

general practitioners who report presentations of defined medical conditions each week. The aim of ASPREN is to provide an indicator of the burden of disease in the primary health care setting and to detect trends in consultation rates.

The list of conditions is reviewed annually by the ASPREN management committee and an annual report is published. In 2008, four conditions are being monitored; all of which are related to communicable diseases. These include influenza like illness, gastroenteritis, chickenpox and shingles.

There are currently 96 general practitioners participating in the network from all jurisdictions other than the Northern Territory. Sixty-eight per cent of these are in metropolitan areas, 24% in rural and 7% in remote areas of Australia. Approximately 6,000 consultations are recorded each week..

Data for communicable diseases are published in *CDI* every quarter. Data are presented in graphic format as the rate of reporting per 1,000 consultations per week. The conditions are defined as follows.

Influenza-like illness – record once only per patient

Must have the following: fever, cough and fatigue.

Gastroenteritis – record once only per patient

Three or more loose stools, and/or two vomits in a 24 hour period excluding cases who have a known cause, for example bowel disease, alcohol, pregnancy.

Chickenpox – record once only per patient

An acute, generalised viral disease with a sudden onset of slight fever, mild constitutional symptoms and a skin eruption which is maculopapular for a few hours, vesicular for three to four days and leaves a granular scab.

Shingles – record once only per patient

Recurrence, recrudescence or re-activation of chickenpox infection. Vesicles with any erythematous base restricted to skin areas supplied by sensory nerves of a single or associated group of dorsal root ganglia. Lesions may appear in crops in irregular fashion along nerve pathways, are usually unilateral, deeper seated and more closely aggregated than those of chickenpox.

Note: Those conditions which show 'record once only per patient' are to have each occurrence of the condition only recorded on one occasion no matter how many patient contacts are made for this condition. If the condition occurs a second or subsequent

time, it is to be recorded again. Conversely, for other conditions each attendance at which they are addressed in some way is to be recorded.

HIV and AIDS surveillance

National surveillance for HIV and AIDS is coordinated by the National Centre in HIV Epidemiology and Clinical Research (NCHECR), in collaboration with state and territory health authorities, the Australian Government Department of Health and Ageing, the Australian Institute of Health and Welfare and other collaborating networks in surveillance for HIV/AIDS.

Cases of HIV infection are notified to the National HIV Database on the first occasion of diagnosis in Australia, either by the diagnosing laboratory (Australian Capital Territory and Tasmania), by doctor notification (Western Australia) or by a combination of laboratory and doctor sources (New South Wales, Northern Territory, Queensland, South Australia and Victoria). Cases of AIDS are notified through the state and territory health authorities to the National AIDS Registry. Diagnoses of both HIV infection and AIDS are notified with the person's date of birth and name code, to minimise duplicate notifications while maintaining confidentiality.

Currently, two tables presenting the number of new diagnoses of HIV infection, AIDS and deaths following AIDS are published in each issue of *CDI*. The tabulations are based on data available three months after the end of the reporting period, to allow for reporting delay and to incorporate newly available information.

Each year from 1997, the NCHECR has published the *HIV/AIDS, Viral Hepatitis and Sexually Transmissible Infections in Australia Annual Surveillance Report*. The annual surveillance report, available through www.med.unsw.edu.au/nchechr/, provides a comprehensive analysis and interpretation of surveillance data on HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia.

Laboratory Virology and Serology Reporting Scheme

The Laboratory Virology and Serology Reporting Scheme (LabVISE) began operating in 1977. The scheme currently comprises 17 laboratories from all states and the Australian Capital Territory. Contributors submit data fortnightly on the laboratory identification of viruses and other organisms. Each record includes mandatory data fields (laboratory, specimen collection date, a patient identifier code and organism), and optional fields (patient's

sex, date of birth or age, postcode of residence, specimen source, clinical diagnosis and the method of diagnosis). Reports are collated, analysed and published quarterly in *CDI*. Each report includes summary tables of total numbers of organisms identified by state or territory and numbers of reports by month and participating laboratory. Monthly updates of LabWISE data are also published on the *Communicable Diseases Australia* website.

LabWISE data should be interpreted with caution. The number and type of reports received is subject to a number of biases. These include the number of participating laboratories, which has varied over time. The locations of participating laboratories also create bias, as some jurisdictions are better represented than others. Also changes in diagnostic practices, particularly the introduction of new testing methodologies, may affect laboratory reports. The ability of laboratory tests to distinguish acute from chronic or past infection must also be considered in interpretation of the data. Although changes in incidence cannot be determined with precision from this data, general trends can be observed, for example with respect to seasonality and the age-sex distribution of patients. See review in *Commun Dis Intell* 2002;26:323–374).

National Enteric Pathogens Surveillance System

Since 1980, the National Enteric Pathogens Surveillance Scheme (NEPSS) has collected, analysed and disseminated data on human enteric bacterial infections diagnosed in Australia. These pathogens include *Salmonella*, *Escherichia coli*, *Vibrio*, *Yersinia*, *Plesiomonas*, *Aeromonas* and *Campylobacter*.

Communicable Diseases Intelligence NEPSS quarterly reports include only *Salmonella*. NEPSS receives reports of *Salmonella* isolates submitted from primary diagnostic laboratories throughout Australia to any of the five serotyping laboratories, two of which (MDU and IMVS) also perform phage typing.

A case is defined as the isolation of a *Salmonella* from an Australian resident, either acquired locally or as a result of overseas travel, including isolates detected during immigrant and refugee screening. Second and subsequent identical isolates from an individual within six months are excluded, as are isolates from overseas visitors to Australia. The date of the case is the date the primary diagnostic laboratory isolated a *Salmonella* from the clinical sample.

NEPSS is operated by the Microbiological Diagnostic Unit — Public Health Laboratory, Department of Microbiology and Immunology,

The University of Melbourne; and is overseen by a Steering Committee of state, territory and Commonwealth stakeholders. NEPSS may be contacted at the Microbiological Diagnostic Unit, by telephone +61 3 8344 5701, facsimile +61 3 8344 7833 or email joanp@unimelb.edu.au

Scientists, diagnostic and reference laboratories, clinicians and public health professionals generate and contribute data to NEPSS, which is supported by state and territory health departments and the Australian Government Department of Health and Ageing.

OzFoodNet: enhanced foodborne disease surveillance

The Australian Government Department of Health and Ageing established the OzFoodNet network in 2000 to collaborate nationally in the investigation of foodborne disease. OzFoodNet conducts studies on the burden of illness and coordinates national investigations into outbreaks of foodborne disease.

OzFoodNet reports quarterly on investigations of gastroenteritis outbreaks and clusters of disease potentially related to food. Annual reports have been produced and published in *CDI* (*Commun Dis Intell* 2007;31:345–365) since 2002. Data are reported from all Australian jurisdictions.

National Influenza Surveillance Scheme

Influenza surveillance in Australia is based on several schemes collecting a range of data that can be used to measure influenza activity.

- Since 2001, laboratory-confirmed influenza has been a notifiable disease in all Australian states and territories (except South Australia) and reported in the National Notifiable Diseases Surveillance System (see above).
- In 2007, six sentinel general practitioner schemes contribute reports of influenza-like illness: the Australian Sentinel Practice Research Network, the Tropical Influenza Surveillance from the Northern Territory, the New South Wales Sentinel General Practice Scheme, the Victorian Sentinel General Practice Scheme, Queensland and Western Australian sentinel general practices.
- The Laboratory Virology and Serology Reporting Scheme laboratory reports of influenza diagnoses including virus type.

The results of each of the schemes are published together fortnightly throughout the influenza season (May to October) on the *Communicable Diseases Australia* Website as the Australian Influenza Report.

Annual reports on influenza in Australia are published in *CDI* each year (*Commun Dis Intell* 2007;31:167–179). These reports include the above data as well as absenteeism data from a major national employer, hospitalisation and mortality data and influenza typing data from the WHO Collaborating Centre for Influenza Reference and Research.

National Notifiable Diseases Surveillance System

National compilations of notifiable diseases have been published intermittently in a number of publications since 1917.² The National Notifiable Diseases Surveillance System (NNDSS) was established in 1990 under the auspices of the Communicable Diseases Network Australia (CDNA).

The system coordinates the national surveillance of more than 60 communicable diseases or disease groups endorsed by the CDNA. Under this scheme, notifications are made from doctors and laboratories to state or territory health authorities under the provisions of the public health legislation in their jurisdiction. Electronic, de-identified unit records of notifications are supplied to the Australian Government Department of Health and Ageing for collation, analysis and reporting in *CDI*.

Data provided for each notification include a unique record reference number, state or territory, disease code, date of onset, date of notification to the relevant health authority, sex, age, indigenous status and postcode of residence. Additional data include: infecting organism and subtype; the diagnosis method; full details of vaccination where appropriate; resident location; dates of onset, specimen collection, notification and date when notification was received by health authorities; outbreak reference number; how the case was found; whether the case was confirmed; and whether the case was imported from overseas.

Aggregated data are presented on the *Communicable Diseases Australia* Internet site and updated three times a week (www.health.gov.au/cda). Data are published in *CDI* every quarter and in an annual report. The reports include numbers of notifications for each disease by state or territory, and totals for Australia for the current period, the year to date, and for the corresponding period of the previous year. The national total for each disease is compared with the average number of notifications over the previ-

ous five years in the same period. A commentary on the notification data is included with the tables in each issue of *CDI* and graphs are used to illustrate important aspects of the data.

HIV infection and AIDS surveillance is conducted by the National Centre for HIV Epidemiology and Clinical Research and is reported in the HIV and AIDS surveillance reports (see below).

Sentinel Chicken Surveillance Programme

The Sentinel Chicken Surveillance Programme is used to provide an early warning of increased flavivirus activity in Australia. The main viruses of concern are Murray Valley encephalitis (MVEV) and Kunjin viruses. MVEV causes the disease Murray Valley encephalitis (formerly known as Australian encephalitis), a potentially fatal disease in humans. Encephalitis is less frequent in cases of Kunjin virus infection and these encephalitis cases have a lower rate of severe sequelae.

These viruses are enzootic in parts of the north-east Kimberley region of Western Australia and the Top End of the Northern Territory but are epizootic in other areas of the Kimberley, Pilbara, Gascoyne Murchison and Mid-west regions of Western Australia, in north Queensland and in Central Australia. MVEV is also responsible for occasional epidemics of encephalitis in eastern Australia. Since 1974, a number of sentinel chicken flocks have been established in Australia to provide an early warning of increased MVEV activity. These programs are supported by individual state health departments. Each state has a contingency plan that will be implemented if one or more chickens in a flock seroconverts to MVEV.

Currently, flocks are maintained in the north of Western Australia, the Northern Territory, New South Wales and in Victoria. The flocks in Western Australia and the Northern Territory are tested all year round but those in New South Wales and Victoria are tested only in the summer months, during the main MVEV risk season. Results are posted on the National Arbovirus Surveillance Website by state representatives. A yearly summary is presented in *CDI* (*Commun Dis Intell* 2008;32:31–46).

References

1. Last JM. A dictionary of epidemiology. New York: Oxford University Press, 1988.
2. Hall R. Notifiable diseases surveillance, 1917 to 1991. *Commun Dis Intell* 1993;226–236.