HSC Public Health Agency

Transmit

Health protection service bulletin

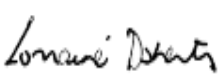
September 2015: Issue 8

Foreword

In this edition of Transmit, we have focused on sexually transmitted infections (STIs). Surveillance data is presented for Chlamydia, Gonorrhoea, Genital Herpes and Genital warts.

Chlamydia and Genital warts are the most common STIs but there is an increasing trend in both gonorrhoea and genital herpes. Sixty five new diagnoses of infectious syphilis were made in 2014. The incidence of STIs in N. Ireland highlights the need for clear public health messages -

- Always using a condom when having sex with casual and new partners;
- Getting tested if at risk, as these infections are frequently asymptomatic;
- MSM having unprotected sex with casual or new partners should have an HIV/STI screen at least annually, and every three months if changing partners regularly;
- Reducing the number of sexual partners and avoiding overlapping sexual relationships.



Assistant Director of Public Health
(Health Protection)

Contents

Duty Room Updates

This section of Transmit aims to bring current Public Health issues and events to the attention of our professional colleagues.

The Duty Room provides specialist health protection advice, guidance and operational support on all health protection matters.

The Duty Team will respond to all enquiries from health professionals and others, including nursing and residential homes, local councils, community health services (including schools and social services). The new contact details for the Duty Room are:

Health Protection Duty Room

Tel: 0300 555 0119
Fax: 02895 363947
Email: pha.dutyroom@hscni.net

Immunisations September 2015
Frequently Asked Questions

The Health Protection Duty Room receives a great variety of calls about immunisation issues. Since September the majority of enquires have been associated with the recent changes to the childhood immunisation programme. The following are examples of some of the most frequently asked questions.

1. **Should Men B vaccine (Bexsero®) be given to babies returning for their 12 month vaccines this autumn?**
   No. Babies coming into the practice now for their 12 month booster vaccines are not eligible for the routine Men B vaccine programme. The routine Men B vaccination programme is for infants born from 1st July 2015 and those in the catch up cohort born from 1st May to 30th June 2015; hence the first babies to receive the booster (i.e. dose at 12 months old) of Men B vaccine are those who will be 12 months old from May next year (i.e. May 2016)

2. **Can parents who are concerned about fever post Men B vaccine defer vaccination of their infant?**
   The aim of the Men B vaccination programme is to protect infants before they become most at risk of Group B invasive meningococcal disease. In the UK the peak for disease is around 6 months of age, therefore the routine schedule for vaccination against Men B disease is set at 2 and 4 months old. Parents should be informed about this and advised about administering prophylactic infant strength paracetamol to protect their child against potential post vaccination fevers.

3. **Can Men B vaccine be given to an infant who has recently been given BCG vaccine?**
   Yes, Men B vaccine can be given at any time before or after BCG. Men B is not a live vaccine although BCG is live. There is no difficulty in giving these vaccines at any interval before or after each other. Men B vaccine should ideally be given on its own into the anterolateral aspect of the infant's LEFT thigh. BCG is conventionally given in the area of the insertion of the LEFT DELTOID muscle of the upper arm. NO immunisations should be given into the same arm as the BCG for a minimum of 3 months because of

the risk of regional lymphadenitis. As all infant vaccines (except the BCG) up to the age of 12 months are given into the anterolateral thigh, this should not be an issue for babies receiving primary immunisations. It is also recommended that the 12 month dose of Men B vaccine is given into the LEFT anterolateral thigh also.

4. Can a parent request the Men B vaccine for a child born before 1st May 2015?

Parents can seek advice from a GP about the possibility of obtaining the vaccine privately from the manufacturer/community pharmacist via a GP or a Private Clinic. A GP cannot charge his/her own registered patient for a private prescription. Parents who request the vaccine privately will be liable for the costs of the vaccine and any additional administration charges. GPs or Private clinic staff must not use Men B vaccine stock procured for the national programme to facilitate any patients whom they undertake to give the vaccine to on a private basis.

5. What if a child is late coming in for their 2 or 4 month primary vaccine appointments, should they still receive Men B vaccine?

Children who come in late for their routine primary immunisations should be vaccinated according to the national schedule. Use the document "Vaccination of individuals with uncertain or incomplete immunisation status" PHE September 2015, to help you, it can be accessed at: https://www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status
Only children born on or after 1st May 2015 should be offered Men B vaccination; these children are eligible to catch up on the Men B vaccine up to the age of 2 years.

6. Should those returning to University i.e. going into 2nd, 3rd, 4th etc. year be given the Men ACWY vaccine?

No, the Men ACWY vaccination programme is for those in the designated age cohorts, which include new 1st year university entrants this autumn up to the age of 25, as the risk of invasive meningococcal disease is greatest in the first few weeks of first year at university.

7. Is there a minimum interval between Pertussis vaccinations for pregnant women?

Pregnant women require the pertussis vaccine in each pregnancy under the current circumstances. The Pertussis vaccination should ideally be given between 28 – 32 weeks gestation so that pertussis antibodies may be transferred to the baby via the placenta from 34 weeks gestation. Pertussis antibodies whether acquired by vaccination or natural infection decline over time and so pregnant women should be offered the Pertussis vaccine (Boostrix IPV®) at each and every pregnancy via Primary Care as advised by CMO (see link) http://www.dhsspsni.gov.uk/hss-md-9-2014.pdf. The pertussis vaccine may be given beyond 32 weeks gestation up to delivery, to women who missed the vaccine at the optimal time.

Links to further sources of information are listed below:
http://www.publichealth.hscni.net/publications/advice-giving-infant-paracetamol-after-menb-vaccination

http://www.publichealth.hscni.net/publications/immunisation-against-meningococcal-b-disease-infants-aged-two-months

http://www.publichealth.hscni.net/publications/introduction-meningococcal-acwy-programme-adolescents

HSC Public Health Agency

Respiratory outbreak and seasonal influenza awareness for Independent Sector Nursing & Residential Homes

AGENDA

1. **Welcome & meeting aims**
2. **Update on influenza and respiratory-related outbreaks in Care Homes**
3. **PHA role in investigation and management of respiratory outbreaks**
4. **Identification and notification of respiratory-related outbreaks**
5. **Infection prevention & control advice and public health interventions**
6. **How to swab**
7. **Care home monitoring during respiratory-related outbreaks**
8. **Importance of flu vaccine for residents and staff**

Dates, Times and Venues of meetings

LCG Area	Date & Time	Venue
Belfast Area	30/10/2015 @ 2-4pm	Large Conference Room, Everton Complex
Belfast Area	22/09/2015 @ 2-4 pm	Dining Room 1, Knockbracken H/C Park
Northern Area	16/10/2015 @ 2-4 pm	MDEC Lecture Theatre, Causeway Hospital
Northern Area	21/10/2015 @ 2-4 pm	Lecture Theatre, Fern House, Antrim
South Eastern Area	06/10/2015 @ 2-4 pm	Laganview Conference centre, Lagan Valley Hospital
South Eastern Area	29/09/2015 @ 2-4 pm	Lecture Theatre, UHD Main Block
Southern Area	01/10/2015 @ 2.30-4.30pm	Boardroom, Tower Hill, Armagh
Southern Area	23/10/2015 @ 2-4 pm	Boardroom, Tower Hill, Armagh
Western Area	05/10/2015 @ 2-4 pm	Boardroom, Gransha Park House
Western Area	12/10/2015 @ 2-3.30pm	Bawnacre, Irvinestown

LCG Area	Date & Time	PHA staff
Belfast Area	30/10/2015 @ 2-4pm	Eamon Nancarrow/Dr Bennett
Belfast Area	22/09/2015 @ 2-4 pm	Eamon Nancarrow /Dr Bradley/Dr McKee
Northern Area	16/10/2015 @ 2-4 pm	Hilda Crookshanks /Dr Armstrong/Dr Ewing
Northern Area	21/10/2015 @ 2-4 pm	Hilda Crookshanks /Dr Dallat/Dr Ewing
South Eastern Area	06/10/2015 @ 2-4 pm	Geraldine Reid/Dr Gallagher
South Eastern Area	29/09/2015 @ 2-4 pm	Geraldine Reid/Chris Nugent
Southern Area	01/10/2015 @ 2.30-4.30pm	Caroline McGeary/Dr Doherty
Southern Area	23/10/2015 @ 2-4 pm	Caroline McGeary/Dr Johnston
Western Area	05/10/2015 @ 2-4 pm	Alison Quinn
Western Area	12/10/2015 @ 2-3.30pm	Alison Quinn

STI surveillance in Northern Ireland, 2014

This section of Transmit aims to present a brief overview of STI surveillance in Northern Ireland. The data are also available as tables and a slide set at www.publichealth.hscni.net/directorate-public-health/health-protection/sexually-transmitted-infections.

Surveillance methods

KC60 returns

The most comprehensive source of surveillance data for sexually transmitted infections (STIs) in Northern Ireland is the statutory KC60 return received each quarter from GUM clinics. This return records the numbers of new diagnoses for a range of STIs. Individual patients may contribute more than one diagnosis. For selected conditions, additional age, gender and sexual orientation information are provided. Regularly updated summary statistics are presented at www.publichealth.hscni.net/directorate-public-health/health-protection/sexually-transmitted-infections.

Laboratory reporting

Laboratory data represent an important complementary source to clinician-initiated surveillance arrangements for *Chlamydia trachomatis* and *Neisseria gonorrhoea*. Antibiotic susceptibility information for *Neisseria gonorrhoea* isolates is provided.

Enhanced syphilis surveillance

Enhanced surveillance arrangements for infectious syphilis in Northern Ireland have been in place since the outbreak was first recognised in September 2001. Based on anonymised, confidential reporting by GUM clinicians to the Public Health Agency (PHA), a range of demographic, clinical and risk factor data are collected on cases of primary, secondary and early latent stage syphilis.

Key Summary points from KC60 returns

Diseases

Figure 1 – Trends in new diagnoses of selected STIs in Northern Ireland GUM clinics, 2000-2014

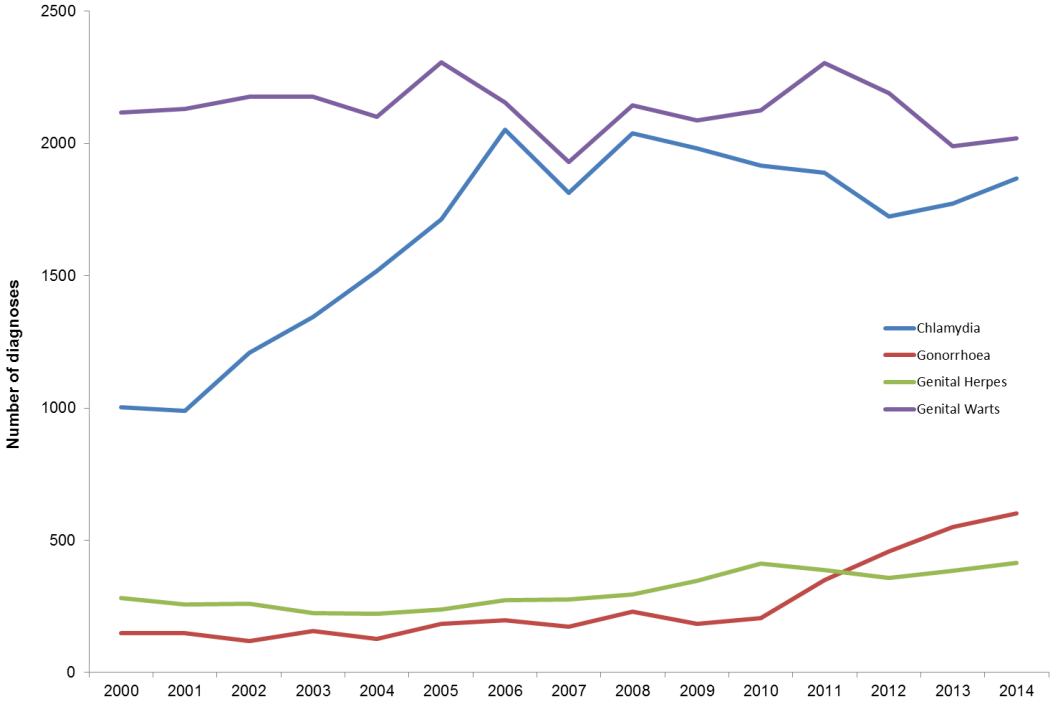


Figure 2 - Number of diagnoses of uncomplicated gonorrhoea by sexual orientation in Northern Ireland GUM clinics, 2000-2014

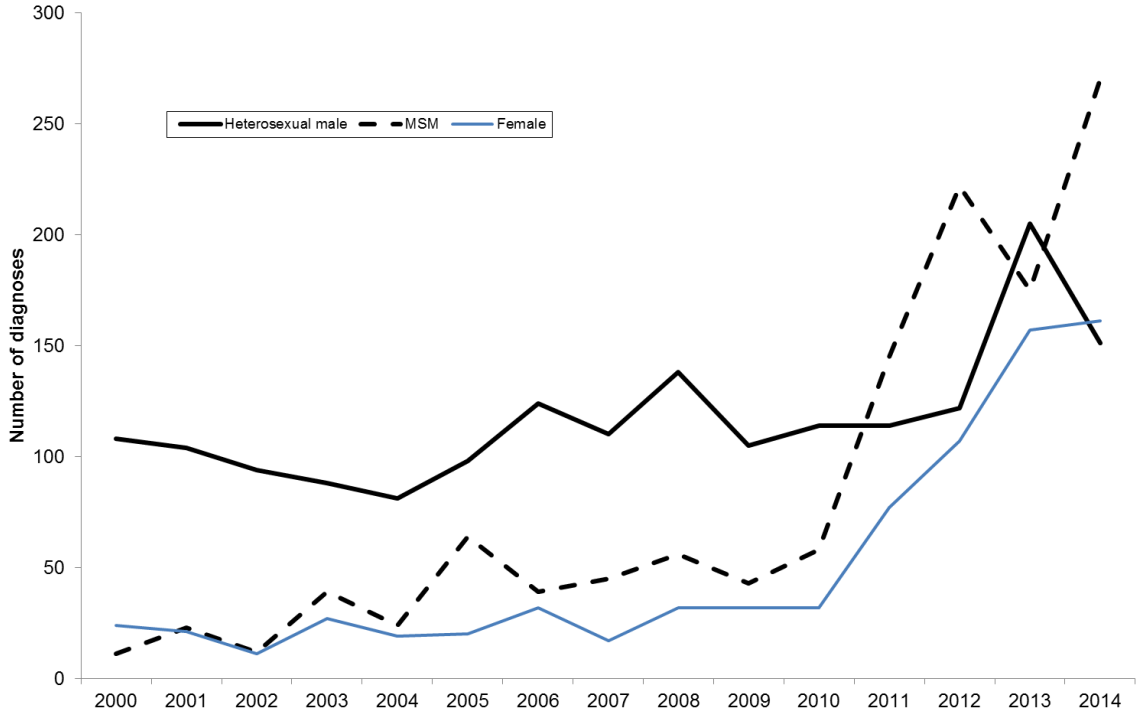
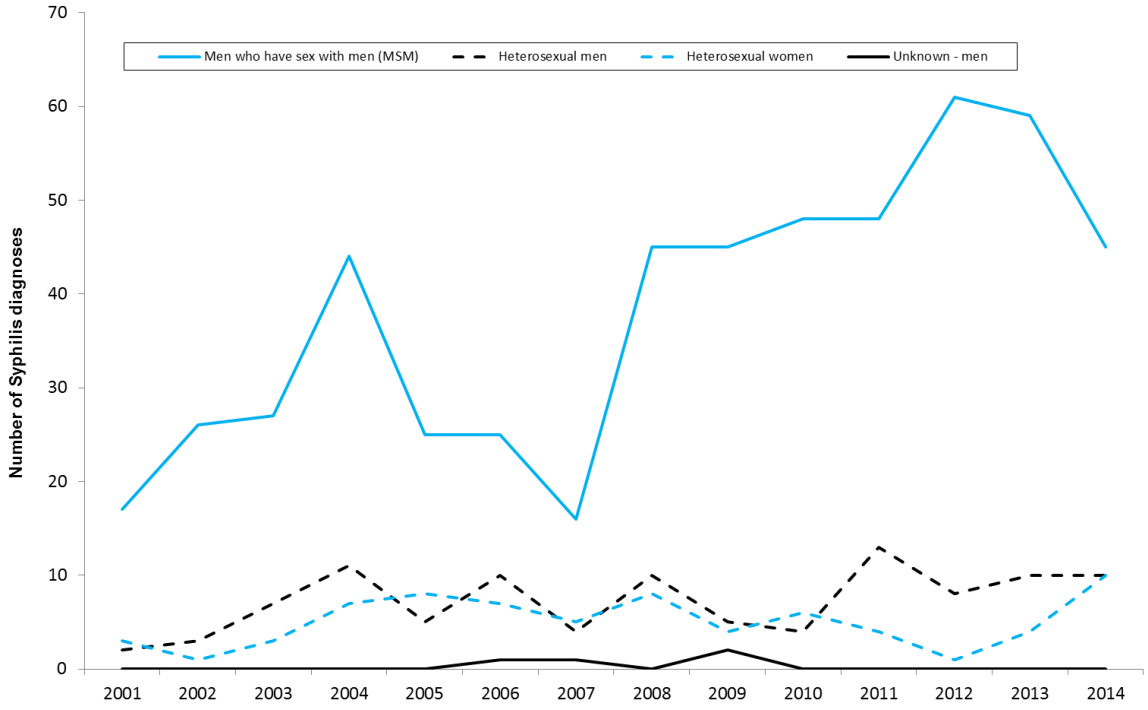


Figure 3 – Number of diagnoses of infectious syphilis, by gender and sexual orientation, in Northern Ireland GUM clinics, 2001-2014



In Northern Ireland GUM clinics during 2014 cases of chlamydia, gonorrhoea and genital warts account for 71% of new STI diagnoses. While diagnoses of genital warts and chlamydia are relatively stable, there is an increasing trend in both gonorrhoea and genital herpes (Figure 1).

Diagnoses of chlamydia have increased for the second successive year, by 5%, from 1,772 in 2013 to 1,868 in 2014. The highest diagnostic rates are in the 20-24 year old age group in both men and women.

Diagnoses of uncomplicated gonorrhoea have increased by 10%, from 549 in 2013 to 601 in 2014. This is in the context of an increase of 185% between 2010 and 2013. The rate of increase has been greatest in MSM and in women (Figure 2). The introduction of more sensitive PCR testing as well as increasing transmission are likely to have played a part in this increase.

Diagnoses of genital herpes simplex (first episode) have increased by 8%: 415 in 2014 compared with 385 in 2013. There has been an increased trend since 2004 from 222 in 2004 to 415 in 2014. Women aged 16-24 years and men aged 20-34 years are the most affected.

New diagnoses of genital warts (first episode) increased by 2%: 2,020 in 2014 compared with 1,989 in 2013. The annual number of new diagnoses has remained relatively stable since 2000 (2,117 diagnoses).

Sixty five new diagnoses of infectious syphilis were made in 2014. This represents a decrease of 11% compared with 2013, but remains at a relatively high level. Since the emergence of the outbreak in 2001, diagnoses have been consistently greatest in MSM. During 2014, MSM accounted for 69% of diagnoses (Figure 3).

Risk groups
The 16-34 year old age group are most at risk of being diagnosed with an STI, accounting for 83% of all new STI diagnoses made in 2014.

The burden of STIs has consistently been greatest in 16-24 year old females and 20-34 year old males.

MSM are at disproportionate risk of contracting STIs. While this group makes up an estimated less than 5% of the male population, they accounted for 80% of male syphilis, 64% of male gonorrhoea, 16% of male herpes and 17% of male chlamydia infections diagnosed in GUM clinics in 2014.

Recommendations arising
Safer sex messages should continue to be promoted to the general population, young people and MSM. The risks of unprotected casual sex, both within and outside Northern Ireland, need to be reinforced. Individuals can reduce their risk of acquiring or transmitting an STI by:

- Always using a condom when having sex with casual and new partners;
- Getting tested if at risk, as these infections are frequently asymptomatic;
- MSM having unprotected sex with casual or new partners should have an HIV/STI screen at least annually, and every three months if changing partners regularly;
- Reducing the number of sexual partners and avoiding overlapping sexual relationships.

Sexual Health Campaign

A new sexual health campaign “Choose to protect yourself – Always use a condom” was launched by PHA on 17 June 2015. The campaign will run until 31 December 2015 and aims at promoting good sexual health and contributing to reducing STIs in Northern Ireland. The targeted audience is 16-34 year olds as STIs are highest in this age group. To help with the content of the campaign, focus groups were held that were structured by age, gender, socioeconomic group and geographical location.

A new website has been developed to accompany the campaign. This provides information on safer sex and health, STIs, testing, contraception and relationships. Importantly it goes beyond information on diseases and gives practical information on how and when to get tested. A video of a GUM clinic also features to help dispel myths about what happens at a gum clinic.

Have unprotected sex and you could be sleeping with everyone your partner's ever slept with. Testing showed this was a strong message and would encourage behaviour change. Two further messages tested well for use in print and online advertising were *people with STIs don't always have symptoms* and *24% of people with HIV don't know they have it*. The campaign has been promoted through TV, radio, cinema, online, social media and washroom advertising.
For further information go to www.sexualhealthni.info

Dr N Irvine
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Ms M Sloan
Senior Surveillance Officer

PHA Web Links to Surveillance Data

Surveillance data on the main topics of Public Health interest are available through the following web links:

Notifications of Infectious Diseases:
http://www.publichealth.hscni.net/directorate-public-health/health-protection/notifications-infectious-diseases

Group B Streptococcus:
http://www.publichealth.hscni.net/directorate-public-health/health-protection/group-b-streptococcus

Vaccination coverage:
http://www.publichealthagency.org/directorate-public-health/health-protection/vaccination-coverage

Avian Influenza:
http://www.publichealthagency.org/directorate-public-health/health-protection/avian-influenza

Brucellosis:
http://www.publichealthagency.org/directorate-public-health/health-protection/brucellosis-human

Gastrointestinal infections:
http://www.publichealthagency.org/directorate-public-health/health-protection/gastrointestinal-infections

Hepatitis:
http://www.publichealthagency.org/directorate-public-health/hepatitis

Healthcare Associated Infections:
http://www.publichealthagency.org/directorate-public-health/health-protection/healthcare-associated-infections

Meningococcal disease:
http://www.publichealthagency.org/directorate-public-health/health-protection/meningococcal-disease

Respiratory infections:
http://www.publichealthagency.org/directorate-public-health/health-protection/respiratory-infections

Sexually transmitted infections:
http://www.publichealthagency.org/directorate-public-health/health-protection/sexually-transmitted-infections

Tuberculosis:
http://www.publichealthagency.org/directorate-public-health/health-protection/tuberculosis

DHSSPS Web Links

CMO Letters and Urgent Communications relevant to Health Protection, and issued in the three months preceding publication of this edition of Transmit, are accessible through the following web links:

Co-Poisoning
HSS (MD) 36/2014 31 October 2014 (PDF 516KB)

CBRN
HSS (MD) 4/2015 24 March 2015 (PDF 178 KB)

Ebola
HSS (MD) 41/2014 22 December 2014 (PDF 266 KB)

Meningococcal C
HSS (MD) 39/2014 3 December 2014 (PDF 231 KB)

MERS Coronavirus Infection
HSS (MD) 6/2015 5 June 2015 (PDF 187 KB)

Pertussis
HSS (MD) 27/2014 18 August 2014 (PDF 246KB)

Seasonal Flu
HSS (MD) 15/2014 22 September 2015 (PDF 101 KB)

Guidance (PDF 288 KB)

Vaccinations
HSS (MD) 8/2015 26 June 2015 (PDF 314 KB)

HSS (MD) 10/2015 3 July 2015 (PDF 340 KB)

HSS (MD) 9/2015 3 July 2015 (PDF 296 KB)

HSS (MD) 13/2015 8 July 2015 (PDF 282 KB)

HSS (MD) 10a/2015 15 July 2015 (PDF 341 KB)

We welcome your feedback on the content of Transmit.
Please feel free to contact emma.walker@hscni.net with your suggestions or articles that you would like to see included.