lack the informal supports and networks that help connect families.

For example, the community in a new housing development might want a parent support group and information about parenting. These services can be planned and provided jointly by the departments of Health, Community Services and Housing. The successful Schools as Community Centres program is another approach that has helped many families, and this will be extended.

IMPLEMENTING FAMILIES FIRST

Families First will require health services—maternal and child health, mental health, drug and alcohol, health promotion—to rethink how information and support is provided to families. In particular, health services will need to:

- work within a network of government and non-government services to link families to support that best meets their needs
- acknowledge that a range of activities affect health outcomes
- find new ways to reach those families that don't traditionally access services
- deliver services to families in various settings, for example, in homes, centres and community settings
- clarify the roles of health professionals in the four fields of activity, for example, mental health's role in the multidisciplinary teams.

It is believed that the integrated approach of Families First to develop self-efficacy within families and communities is an effective strategy for improving the health and well being of children.

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For more information, please contact Dianne Hudson, Office of Children and Young People on (02) 9228 5598; or email **familiesfirst@mail.cabinet.nsw.gov.au**. A paper outlining the framework of Families First is available.

INFECTIOUS DISEASES, NSW: JULY 1999

TRENDS

Winter's arrival brought marked declines in the incidence of several notifiable diseases, including **arboviral infections** (perhaps due to fewer exposures to infected mosquitos) and **salmonellosis** (Figure 5 and Table 4). Declines were also seen in the incidence of **gonorrhoea** and **pertussis**, although some of this change may be due to delayed notification of cases.

Winter typically leads to an upswing in cases of **meningococcal disease**, prompting calls for increased vigilance among health care workers and the community for signs of this disease. Of course, doctors should treat suspected cases empirically **immediately,** even before transport to hospital, with parenteral (preferably **intravenous**) **benzylpenicillin** in a single dose of 100,000 units/kg or 60 mg/kg, to a maximum dose of 6 million units (4g). If available, **ceftriaxone** (50mg/kg for adults, or 100mg/kg for children to a maximum of 4g) intravenously or **cefotaxime** (100 mg/kg to a maximum of 2g) intravenously are preferred; however, neither are typically included in the doctors' bag. Blood cultures should be collected, prior to administration of antibiotics if possible, but their collection should not delay treatment. Your local Public Health Unit should be **notified** of all suspected cases by telephone, and PHU staff will help arrange for chemoprophylaxis for the close contacts of cases (who are at increased risk of illness).

RABIES DEATH FROM DOG BITE IN CHINA

Malcolm Rea

A resident of the Hunter Area Health Service, who had been living in China for more than a year, died in May from rabies following a dog bite that they received in China in September 1998. The patient did not receive pre-exposure or post-exposure vaccination. Because the patient died overseas, documentation on the clinical course of the disease is not yet available. Rabies infection was confirmed by the Centers for Disease Control and Prevention (CDC), Atlanta, with a positive immunofluorescence test on slides made from formalin-fixed blocked brain tissue. Further testing confirmed that the rabies virus was 100 per cent homologous with a rabies sample in the CDC virus repository from a case from China.

International travellers to countries where rabies is enzootic should be aware of the risk of rabies from bites or scratches from potentially-rabid animals (for example, monkeys, bats, dogs and cats in most countries), and information about the management of bites or scratches (that is, immediate thorough cleaning with soap and water, and urgent medical evaluation). If they are likely to come

FIGURE 3

REPORTS OF SELECTED INFECTIOUS DISEASES, NSW, JANUARY 1994 TO JUNE 1999, BY MONTH OF ONSET

These are preliminary data: case counts in recent months may increase because of reporting delays

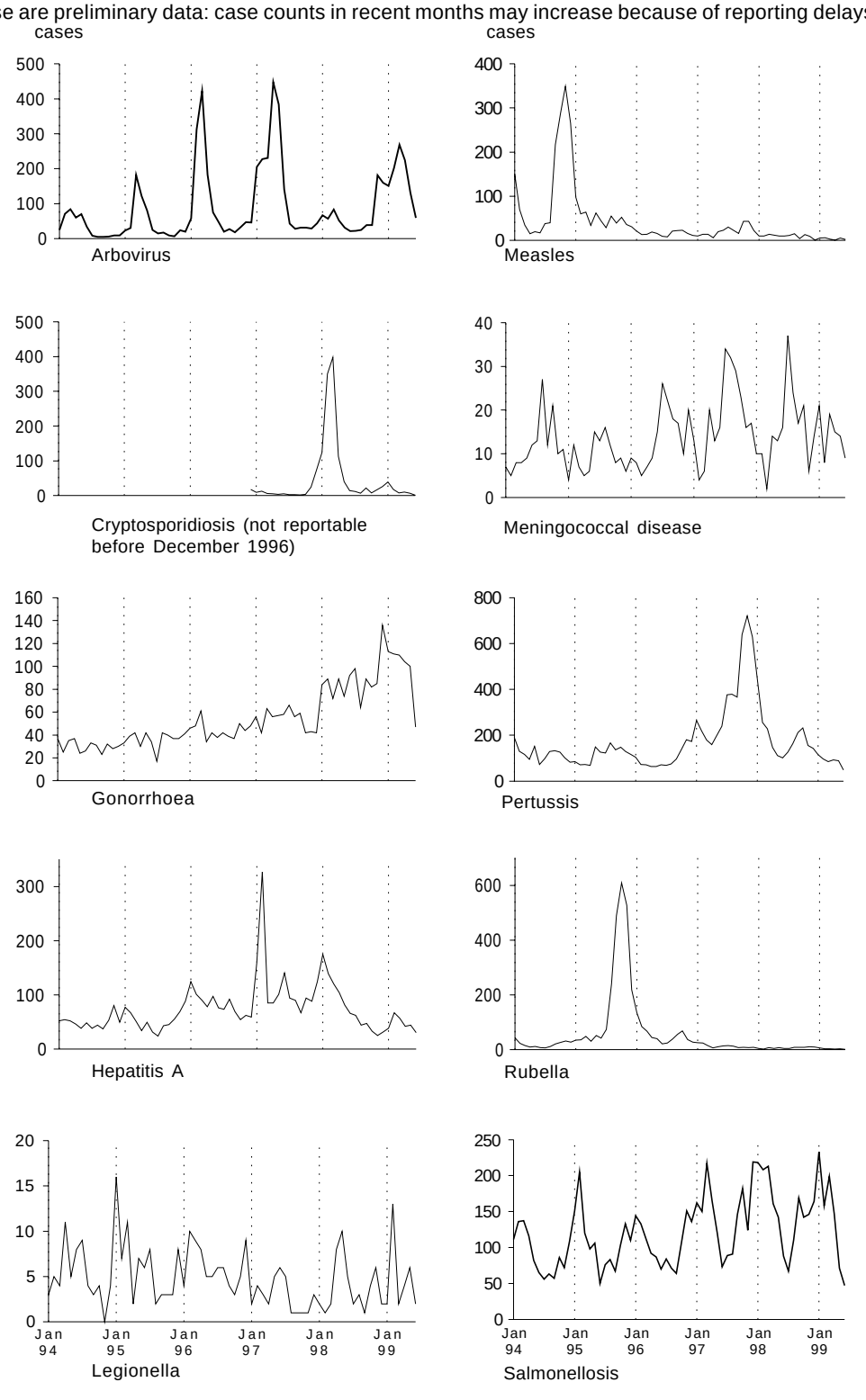


TABLE 4

REPORTS OF NOTIFIABLE CONDITIONS RECEIVED IN JUNE 1999 BY AREA HEALTH SERVICES

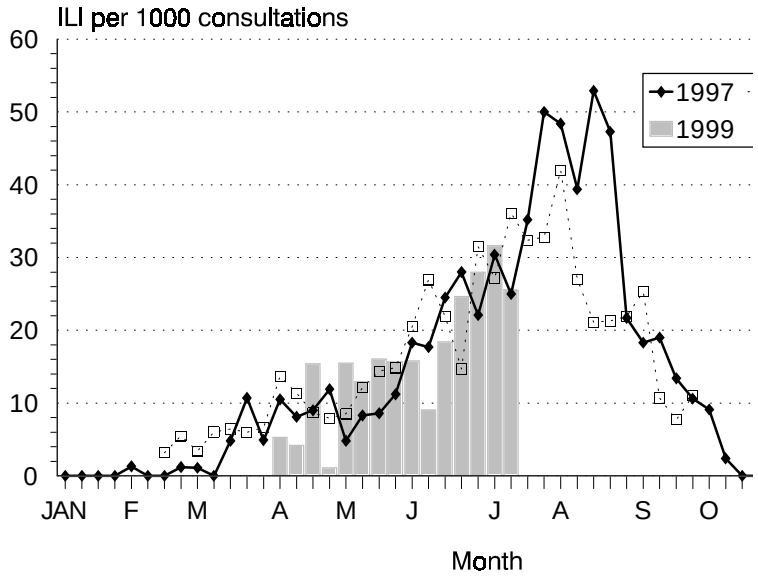
Condition	Area Health Service (1999) CSA	NSA	WSA	WEN	SWS	CCA	HUN	ILL	SES	NRA	MNC	NEA	MAC	MWA	FWA	GMA	SA	Total for Jun†	To date†
Blood-borne and sexually transmitted																			
AIDS	–	–	–	–	–	1	–	–	–	1	–	–	–	–	–	–	–	2	81
HIV infection*	–	–	–	–	–	–	–Reported second monthly–				–	–	–	–	–	–	–	–	148
Hepatitis B: acute viral*	–	–	2	–	–	–	–	–	–	–	–	–	–	1	–	–	–	3	29
Hepatitis B: other*	50	31	31	4	4	7	10	5	30	1	5	1	–	1	–	4	2	189	1592
Hepatitis C: acute viral*	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	1	28
Hepatitis C: other*	65	34	–	45	–	51	54	12	46	39	27	13	4	43	3	22	7	470	3549
Hepatitis D: unspecified*	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	1	5
Hepatitis, acute viral (not otherwise specified)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Chancroid*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Chlamydia (genital)*	19	6	3	2	–	9	18	7	16	21	6	6	3	6	9	5	1	141	1106
Gonorrhoea*	21	10	1	1	1	1	2	2	31	2	1	1	1	3	2	–	–	81	643
Syphilis	7	2	2	1	–	–	–	–	5	2	4	–	1	5	3	1	–	34	296
Vector-borne																			
Arboviral infection*	–	3	–	–	–	4	4	4	2	16	15	1	2	3	5	2	12	73	1140
Malaria*	5	3	–	1	–	–	–	3	3	–	–	–	–	–	–	–	–	15	101
Zoonoses																			
Brucellosis*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	3
Leptospirosis*	–	–	–	–	–	–	–	–	–	2	2	–	–	–	–	–	–	4	24
Q fever*	–	–	–	–	–	1	2	–	–	3	2	–	4	1	1	–	–	14	76
Respiratory and other																			
Blood lead level*	4	2	–	2	1	2	6	–	4	–	–	–	–	–	21	–	–	44	323
Legionnaires' disease*	1	–	–	1	–	1	–	3	–	–	–	–	–	–	–	–	–	6	30
Leprosy	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Meningococcal infection (invasive)	1	–	1	1	1	–	–	1	1	–	–	–	–	1	–	1	–	8	85
Mycobacterial tuberculosis	4	4	7	1	–	–	1	1	9	–	–	–	–	1	–	1	–	29	195
Mycobacteria other than TB	13	17	–	1	–	2	5	–	4	4	–	–	–	2	–	–	1	50	217
Vaccine-preventable																			
Adverse event after immunisation	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	1	20
H. influenzae b infection (invasive)*	–	–	–	–	–	–	1	1	–	–	–	–	–	–	–	–	–	2	6
Measles	–	1	1	–	–	–	–	–	–	–	–	–	–	–	1	–	–	3	21
Mumps*	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	1	10
Pertussis	7	16	3	5	7	3	33	4	8	1	2	1	–	–	–	2	1	93	630
Rubella*	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	20
Tetanus	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Faecal-oral																			
Botulism	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Cholera*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2
Cryptosporidiosis*	–	1	–	–	–	–	–	–	–	–	1	–	1	–	–	–	–	3	95
Giardiasis*	5	18	–	4	1	4	8	5	7	13	2	4	–	1	–	1	–	73	617
Food-borne illness (not otherwise specified)	–	–	–	–	–	–	–	–	–	7	–	–	1	–	–	–	–	8	16
Gastroenteritis (in an institution)	–	–	–	74	–	1	–	–	–	–	–	–	–	–	–	–	–	75	164
Haemolytic uraemic syndrome	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	8
Hepatitis A*	1	3	12	3	3	2	1	5	6	1	–	–	–	1	–	1	1	40	283
Hepatitis E*	–	–	3	–	–	–	–	–	–	–	–	–	–	–	–	–	–	3	5
Listeriosis*	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	11
Salmonellosis (not otherwise specified)*	3	10	1	4	1	4	4	1	5	8	4	2	2	1	–	1	2	54	930
Typhoid and paratyphoid*	–	–	1	–	1	1	–	–	–	1	–	–	–	–	–	–	–	4	14
Verotoxin producing *E. coli**	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

* lab-confirmed cases only † includes cases with unknown postcode

CSA = Central Sydney Area
NSA = Northern Sydney Area
WSA = Western Sydney Area
WEN = Wentworth Area
SWS = South Western Sydney Area
CCA = Central Coast Area
HUN = Hunter Area
ILL = Illawarra Area
SES = South Eastern Sydney Area
NRA = Northern Rivers Area
MNC = North Coast Area
NEA = New England Area
MAC = Macquarie Area
MWA = Mid Western Area
FWA = Far West Area
GMA = Greater Murray Area
SA = Southern Area

FIGURE 4

NSW GP SENTINEL SURVEILLANCE—INFLUENZA-LIKE-ILLNESS, BY WEEK OF CONSULTATION, WITH HISTORICAL COMPARISONS



into special contact with animals because of the nature of their work (for example, veterinarians or wild life workers), or where immediate access to appropriate medical care (including post-exposure therapy) may be difficult, they should also be offered pre-exposure vaccination.

NSW INFLUENZA SURVEILLANCE ACTIVITY UPDATE

Summary

During the end of June and first two weeks of July influenza activity continued at a moderately high level in both laboratory diagnoses and clinical activity. The influenza season appeared to arrive earlier this year than in the previous few years, at the same time of year that respiratory syncitial virus (RSV) activity usually peaks. However, by mid-July influenza activity had not exceeded the peaks achieved in recent years.

Clinical activity

Rates of reported influenza-like illness increased during late June and the first two weeks of July (Figure 6). Reports were received each week from 30 general practitioners through four Public Health Units from more than 3100 consultations per week. Because of the often non-specific nature of influenza-like illness, these reports may include illness due to causes other than influenza viruses.

Virological activity

The laboratory reporting rate for influenza A continued at a level higher than for the same period last year, but not as high as last year's peak (Figure 7). In the second week of July, 90 cases of influenza A were reported (75 virological, 15 serological), seven cases of influenza B (six virological, one serological) and 154 cases of RSV. In the same week last year, 53 cases of influenza A, two of influenza B and 159 cases of RSV were reported. The rate of RSV isolation has been included in Figure 7 to show how the rates of these two viruses have increased at the same time of year this season, whereas in previous years influenza A had peaked later in July–August. This source of data tends to include a high proportion of hospitalised patients, particularly children, and may not accurately reflect the impact of the disease on other sections of the community.

Directed virological surveillance

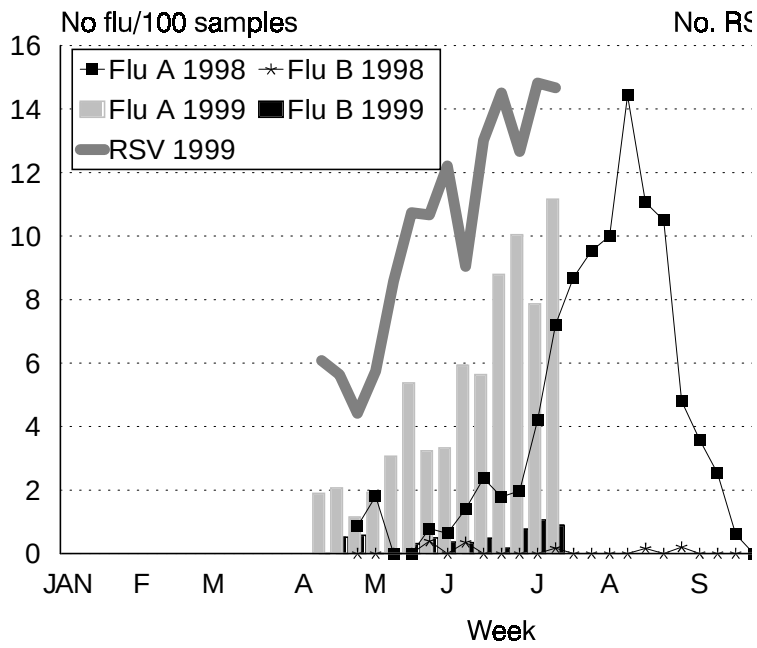
Approximately 30 nasopharyngeal swabs were received by South East Area Laboratory Service (SEALS) and the Institute of Clinical Pathology and Medical Research Westmead (ICPMR) each week from 15 to 20 general practitioners. During the second week of July, the influenza isolation rate increased to a high of 41 per cent, compared to approximately 10 per cent during May and June. Almost all swabs, and all positive swabs, have been from adults. This is in contrast to the routine diagnostic reports (see previous paragraph) which identify illness predominantly in children. Influenza A continues to be the predominant strain of influenza circulating in the community. Approximately 30 general practitioners are participating in the scheme this year from Central Sydney, South Eastern Sydney, Western Sydney, Wentworth, Central Coast, Hunter, Illawarra, Greater Murray and Southern areas.

International surveillance

No country is consistently reporting a high level of

FIGURE 5

RESPIRATORY VIRUS ISOLATION RATES, NSW, 1998–99



influenza activity. The following countries reported influenza activity to the World Health Organization in late June or early July: South Africa, New Zealand, Paraguay, Mauritius and Uruguay. South Africa reported influenza activity at the level of 'local outbreak' for the second week of July (both influenza A and B). Uruguay reported 'widespread outbreak' for the first week of July (both influenza A & B), and New Zealand, Paraguay and Mauritius reported sporadic activity for that week.

VACCINES DELIVERED DIRECTLY TO YOUR DOOR

The NSW Department of Health is committed to improving immunisation coverage rates and reducing the morbidity and mortality associated with vaccine-preventable diseases. Towards this aim, the Department has implemented the recommendation of the *Performance Audit Report on Immunisation in NSW,* conducted by the Audit Office of NSW, to improve the system of vaccine distribution.

From 26 July 1999, all vaccines will be delivered directly to all immunisation service providers each month from the newly established NSW Vaccine Centre.

All providers are reminded of the importance of reporting each immunisation encounter to the Australian Childhood Immunisation Register to facilitate the collection of accurate data on immunisation coverage in NSW and to initiate the Register's reminder system for parents.

For more information, please contact your local Public Health Unit.

THE 1998 MEASLES CONTROL CAMPAIGN IN NSW

Margaret Ashwell
Immunisation Epidemiologist
AIDS/Infectious Diseases Branch

INTRODUCTION

Measles is a highly infectious and often serious viral illness. Complications of measles include direct effects of the virus, such as croup, bronchiolitis, pneumonia, acute encephalitis and subacute sclerosing panencephalitis, or as a result of bacterial superinfection, such as otitis media, pneumonia, etc.[1] However, the mortality and morbidity of measles and its complications can be prevented by vaccination.

The indigenous transmission of measles has been interrupted in both North and South America and in the United Kingdom through tailored vaccination programs. At a 1996 meeting of the World Health Organization, the Pan American Health Organization, and the Centers for Disease Control and Prevention in the United States, it was concluded that it was technically feasible to eradicate measles globally with the available measles vaccines if