MI Flu Focus

Influenza Surveillance Updates
Bureaus of Epidemiology and Laboratories

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Current Influenza Activity Levels:

- **National:** During May 11-17, influenza activity continued to decrease in the United States

Updates of Interest:

- **International:** Additional cases of MERS-CoV and avian influenza H7N9 are reported
- **International:** Research indicates that a high proportion of poultry workers in southern China have evidence of H7N9 infection

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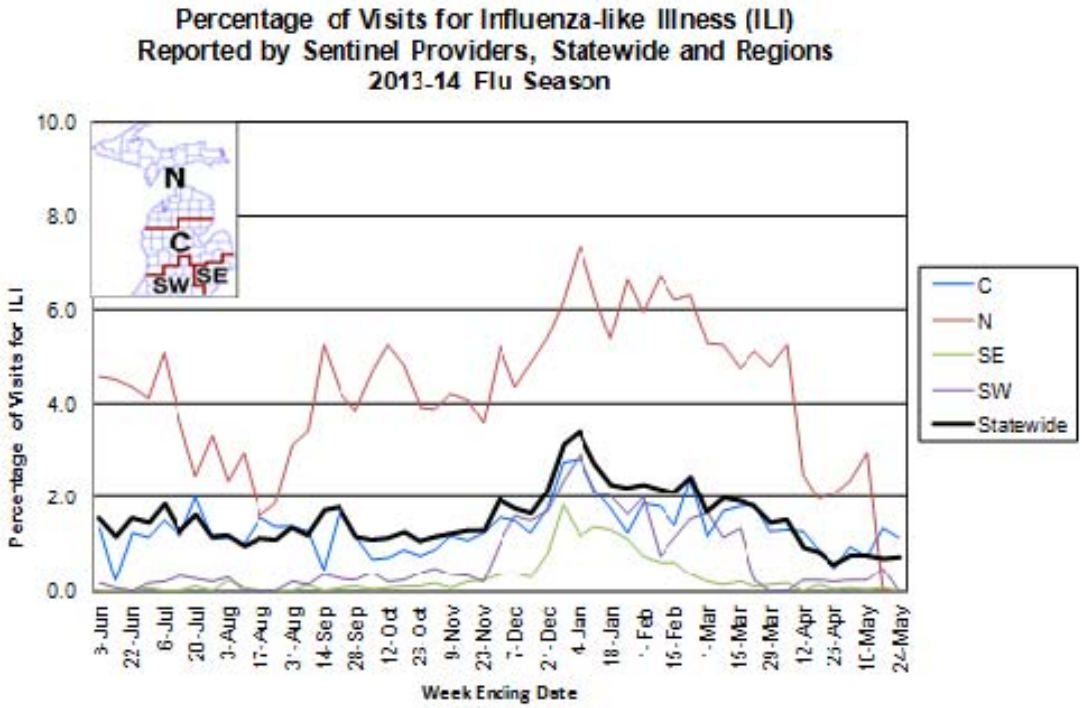
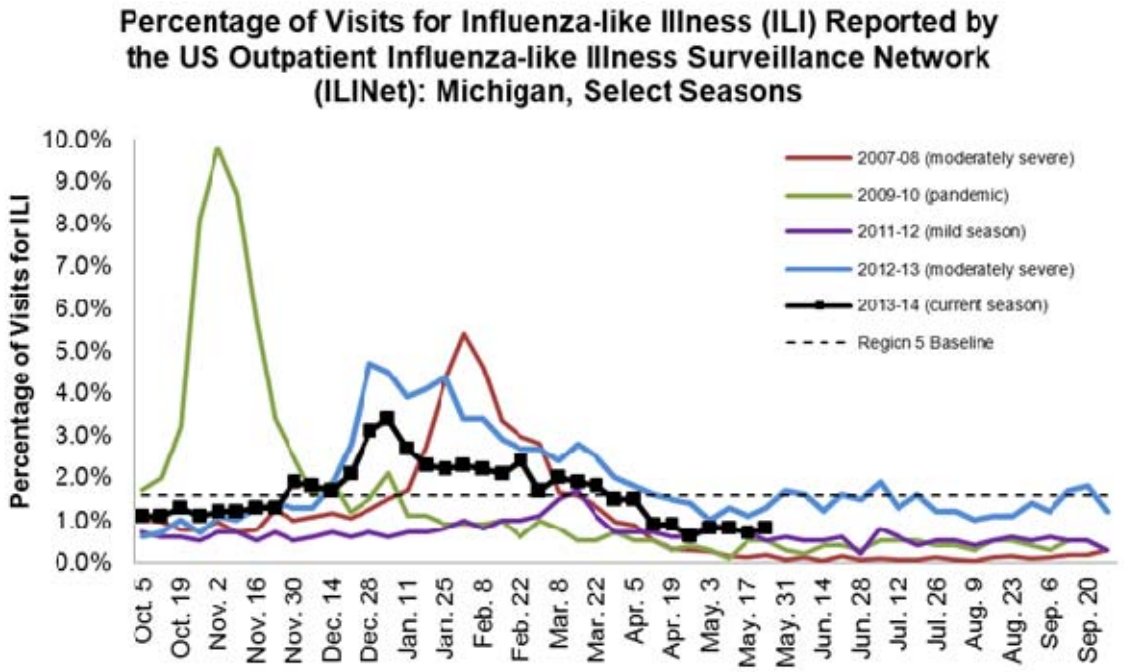
Influenza Surveillance Reports

Michigan Disease Surveillance System (as of May 29): MDSS influenza data for the week ending May 24, 2014 indicated that compared to levels from the previous week, individual reports remained steady and aggregate reports slightly decreased. Aggregate reports are moderately lower than levels seen during the same time period last year, while individual reports are similar.

Emergency Department Surveillance (as of May 29): Emergency department visits due to both constitutional and respiratory complaints remained steady during the week ending May 24, 2014. Emergency department visits from both constitutional and respiratory complaints are similar to levels during the same time period last year. In the past week, there were 9 constitutional alerts in the SW(1), C(6) and N(2) Influenza Surveillance Regions and 2 respiratory alerts in the SW(1) and C(1) Regions.

Sentinel Provider Surveillance (as of May 29): During the week ending May 24, 2014, the proportion of visits due to influenza-like illness (ILI) increased to 0.8% overall; this is below the regional baseline (1.6%). A total of 36 patient visits due to ILI were reported out of 4,767 office visits. Data were provided by 17 sentinel sites from the following regions: Central (8), North (1), Southeast (6), and Southwest (2). ILI decreased in three regions: C (1.1%), SE (0.0%), and SW (0.0%) and remained the same in one region: N (0.0%). Please note: These rates may change as additional reports are received.





As part of pandemic influenza surveillance, CDC and MDCH highly encourage year-round participation from all sentinel providers. New practices are encouraged to join the sentinel surveillance program today! Contact Stefanie DeVita at 517-335-3385 or DeVitaS1@michigan.gov for more information.

Hospital Surveillance (as of May 29): The CDC Influenza Hospitalization Surveillance Project provides population-based rates of severe influenza illness through active surveillance and chart review of lab-confirmed cases, starting on October 1, 2013 and ending April 30, 2014, for Clinton, Eaton, Genesee, and Ingham counties. As of May 29th, there have been 232 influenza hospitalizations (69 pediatric, 163 adult) within the catchment area. Based on these counts, within the catchment area there are 33.0 pediatric influenza hospitalizations/100,000 population and 23.9 adult influenza hospitalizations/100,000.

The MDCH Influenza Sentinel Hospital Network monitors influenza hospitalizations reported voluntarily by hospitals statewide. Reporting for the 2013-14 season has concluded. 458 hospitalizations were reported during September 29, 2013-April 26, 2014.

Laboratory Surveillance (as of May 24): During May 18-24, 4 A/H3 (1SE,1SW,2C) and 4 influenza B (3SE,1N) results were reported by MDCH Bureau of Laboratories. For the 2013-14 season (starting Sept. 29, 2013), MDCH has identified 403 positive influenza results:

- Influenza 2009 A/H1N1pdm: 340 (77SE,132SW,94C,38N)
- Influenza A/H3: 29 (13SE,11SW,5C)
- Influenza A unsubtypable: 1 (1SE)
- Influenza A and B (LAIV recovery): 1 (1SE)
- Influenza B: 37 (11SE,15SW,5C,6N)
- RSV: 2 (2SW)
- Adenovirus: 2 (1SE,1SW)
- Parainfluenza: 3 (1SE,2SW)
- Human metapneumovirus: 4 (4SW)

10 sentinel labs (SE,SW,C) reported for the week ending May 24, 2014. 3 labs (SE,C) reported sporadic influenza A activity. 1 lab (N) reported only sporadic influenza B activity. No labs reported RSV activity. 1 lab (SW) reported sporadic parainfluenza activity. 1 lab (SW) reported low hMPV activity. 1 lab (SW) had sporadic adenovirus activity. Testing volumes are at low levels.

Michigan Influenza Antigenic Characterization (as of May 29): For the 2013-14 season, 3 Michigan influenza specimens (1SE,2C) have been characterized at CDC as A/California/07/2009-like/H1N1/pdm09, matching the influenza A/H1N1pdm09 strain in the 2013-14 Northern Hemisphere vaccine. 2 specimens (2C) have been characterized at CDC and MDCH as B/Brisbane/60/2008-like, which is a B/Victoria lineage virus; it is not in the 2013-14 Northern Hemisphere trivalent vaccine but is in the quadrivalent vaccine. 13 specimens (8SE,4SW,1C) have been characterized at CDC and MDCH as B/Massachusetts/02/2012-like, which is a B/Yamagata lineage virus that is included in the 2013-14 trivalent and quadrivalent vaccines.

Michigan Influenza Antiviral Resistance Data (as of May 29): For the 2013-14 season, 123 2009 A/H1N1pdm (33SE,37SW,41C,12N) and 15 A/H3 (6SE,7SW,2C) influenza specimens have been tested at the MDCH BOL for antiviral resistance. None of the influenza specimens tested have been resistant. CDC has made recommendations regarding the use of antivirals for treatment and prophylaxis of influenza, which are available at http://www.cdc.gov/flu/professionals/antivirals/index.htm.

Influenza-associated Pediatric Mortality (as of May 29): 3 pediatric influenza-associated influenza mortalities (1SE,2C) have been reported to MDCH for the 2013-14 season.

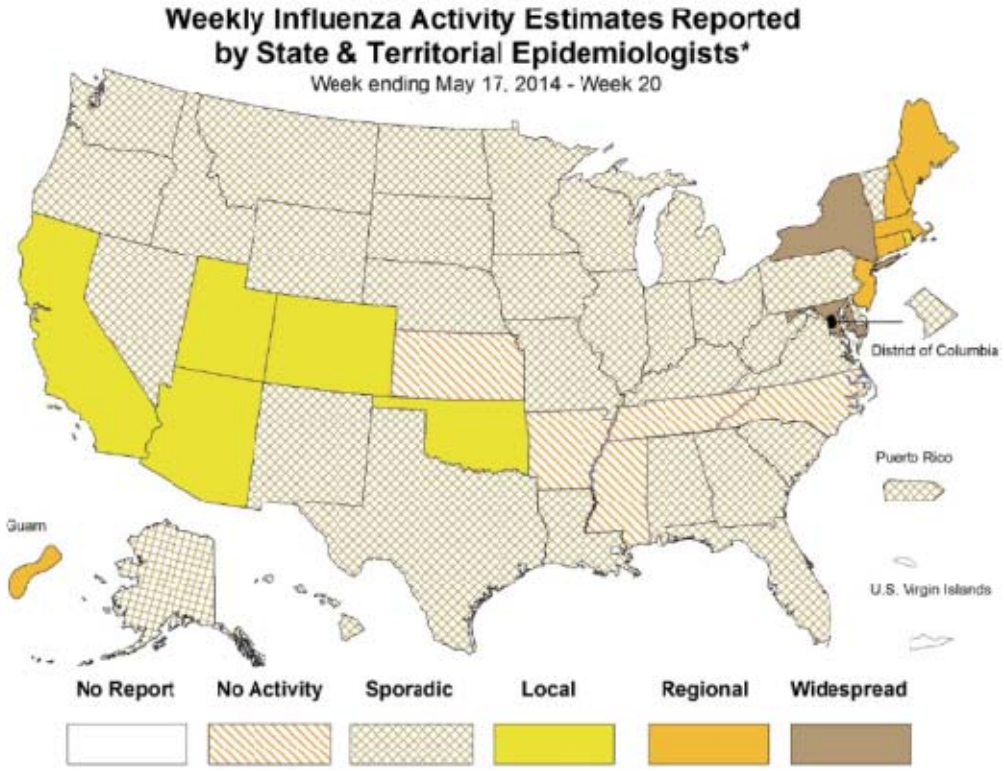
CDC requires reporting of flu-associated pediatric deaths (<18 yrs), including pediatric deaths due to an influenza-like illness with lab confirmation of influenza or any unexplained pediatric death with evidence of an infectious process. Contact MDCH immediately for proper specimen collection. The MDCH protocol is at www.michigan.gov/documents/mdch/ME_pediatric_influenza_guidance_v2_214270_7.pdf.

Influenza Congregate Settings Outbreaks (as of May 29): One new respiratory outbreak at a long-term care facility in the Central Region was reported during the previous week; an investigation is ongoing. 20 respiratory outbreaks (2SE,9SW,7C,2N) have been reported to MDCH during the 2013-14 season:

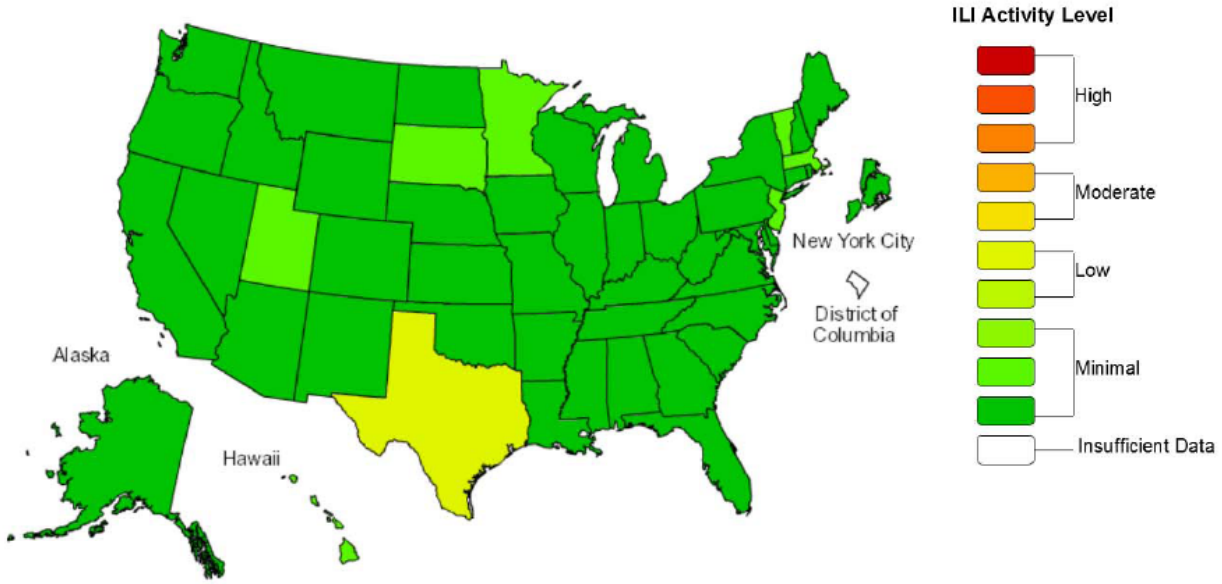
- Influenza 2009 A/H1N1pdm: 4 (1SE,2SW,1C)
- Influenza A/H3: 1 (1SW)
- Influenza A: 4 (3SW,1C)
- Influenza B: 2 (1SW,1N)
- Influenza positive: 1 (1SW)
- Human metapneumovirus: 2 (1SE,1N)
- RSV: 1 (1SW)
- Negative/no testing: 5 (5C)

National (CDC [edited], May 23): During week 20 (May 11-17, 2014), influenza activity continued to decrease in the United States. Of 3,885 specimens tested and reported during week 20 by U.S. World Health Organization and National Respiratory and Enteric Virus Surveillance System collaborating laboratories, 339 (8.7%) were positive for influenza. The proportion of deaths attributed to pneumonia and influenza was below the epidemic threshold. One influenza-associated pediatric death was reported. A season-cumulative rate of 35.6 laboratory confirmed influenza-associated hospitalizations per 100,000 population was reported. The proportion of outpatient visits for influenza-like illness (ILI) was 1.1%, which is below the national baseline of 2.0%. One of 10 regions reported ILI at or above region-specific baseline levels. One state experienced low ILI activity; 49 states and New York City experienced minimal ILI activity, and the District of Columbia had insufficient data. The geographic spread of influenza in two states was reported as widespread; Guam and five states reported regional influenza activity; six states reported local influenza activity; the District of Columbia, Puerto Rico, and 32 states reported sporadic influenza activity; five states reported no influenza activity, and the U.S. Virgin Islands did not report.

Complete weekly FluView reports are available online at: http://www.cdc.gov/flu/weekly/.



Influenza-Like Illness (ILI) Activity Level Indicator Determined by Data Reported to ILINet
2013-14 Influenza Season Week 20 ending May 17, 2014



This map uses the proportion of outpatient visits to healthcare providers for influenza-like illness to measure the ILI activity level within a state. Therefore, outbreaks occurring in a single city could cause the state to display high activity levels. Data collected in ILINet may disproportionately represent certain populations within a state, and therefore, may not accurately depict the full picture of influenza activity for the whole state. Data displayed on this map are based on data collected in ILINet, whereas the State and Territorial flu activity map are based on reports from state and territorial epidemiologists.

International (WHO [edited], May 19): Globally the northern hemisphere influenza season was at inter-seasonal levels in most countries. Influenza B virus continued to be the majority of late season detections in most regions. In North America, levels were at inter-seasonal levels with some influenza B circulation still detected. In Europe, activity was at inter-seasonal levels in most countries. In eastern Asia, activity approached inter-seasonal levels in most countries with influenza B predominating. In tropical Asia, activity continued to decline in most countries. In northern Africa and western Asia, activity remained low in most countries, with influenza B the predominant virus detected. In the southern hemisphere, activity is still low, although in some countries influenza-like illness activity is slowly increasing. Influenza detections were still low. Based on FluNet reporting (as of 15 May 2014), during weeks 17-18 (20 April - 3 May 2014), National Influenza Centres and other labs from 81 countries, areas or territories reported. The WHO labs tested more than 40300 specimens. 3739 were positive, of which 1696 (45.4%) were typed as A and 2043 (54.6%) as B. Of the sub-typed A viruses, 278 (31.2%) were A(H1N1)pdm09 and 613 (68.8%) were A(H3N2). Of the B viruses, 49 (89.1%) belong to the B-Yamagata lineage and 6 (10.9%) to the B-Victoria lineage.

The full report is online at
www.who.int/influenza/surveillance_monitoring/updates/latest_update_GIP_surveillance/en/index.html.

Weekly reporting of influenza activity to the CDC has ended for the 2013-2014 influenza season.

For additional flu vaccination and education information, the MDCH *FluBytes* newsletter is available at http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_22779_40563-125027--,00.html.

Novel Influenza Activity and Other News

WHO Pandemic Phase: Post-pandemic – Influenza disease activity has returned to levels normally seen for seasonal influenza.

International, MERS-CoV (WHO [edited], May 23): On 21 May 2014, the National IHR Focal Point of the United Arab Emirates (UAE) reported 3 additional cases of Middle East respiratory syndrome coronavirus (MERS-CoV) in Abu Dhabi, UAE.

Details of the patients are as follows:

- A 71 year-old male in Abu Dhabi. He was admitted to hospital on 11 February 2014 and is known to have several comorbidities. On 4 May, he developed fever and on 7 May tested positive for MERS-CoV by PCR. Currently, he is in a stable condition. He had contact with a previously confirmed case in the hospital: a health-care worker (a 39 year-old female) reported to WHO on the 11 May 2014. He has no history of contact with animals and no history of consumption of raw camel products.
- A 26 year-old male in Abu Dhabi. He was detected through general screening at his workplace on 7 May without any history of contact to a laboratory confirmed MERS-CoV case. He tested positive for MERS-CoV by PCR on 8 May 2014. While asymptomatic at the time of screening, the investigation revealed that he had mild cough on 1 May 2014. He has no comorbidities and no travel history. He had contact with animals (cows and sheep but not camels), but has no history of consumption of raw camel products. He was admitted to hospital for isolation on 8 May and discharged on 14 May.
- A 36 year-old male from Abu Dhabi. He developed symptoms, including fever and mild breathing difficulty, on 2 May and was seen in an outpatient service on 4 May. His condition deteriorated and he was admitted to hospital on 7 May with high grade fever and developed breathing difficulty. On 9 May, he tested positive for MERS-CoV by PCR. He recovered and was discharged on 12 May. He is known to have comorbidities, but reported no contact with a laboratory confirmed MERS-CoV case and has no travel history. He also has no contact with animals and no history of consumption of raw camel products.

Contact investigations are ongoing and further information will be communicated when available.

Globally, 635 laboratory-confirmed cases of infection with MERS-CoV have officially been reported to WHO, including 193 deaths. This global total includes all of the cases reported in this update, plus 17 laboratory confirmed cases officially reported to WHO by Saudi Arabia between 16 and 18 May. WHO is working closely with Saudi Arabia for additional information on these cases and will provide further updates as soon as possible.

The full report is available online at http://www.who.int/csr/don/2014_05_23_mers/en/.

International, MERS-CoV (WHO [edited], May 28): On 25 May 2014, the National IHR Focal Point of Jordan reported to WHO an additional Middle East respiratory syndrome coronavirus (MERS-CoV) case in Amman, Jordan.

The case is a 69 year-old male Jordanian citizen and resident of Amman governorate. The patient was admitted to hospital on 29 April 2014 for a surgical procedure. He was discharged on 3 May 2014. On 8 May, the patient presented with fever. His condition deteriorated and he was admitted to the same hospital on 11 May. Two days later, on 13 May, he started to complain of cough. A specimen was collected from the patient and it tested negative for MERS on the same day, but a chest X-Ray showed pneumonia. A second specimen was collected and it tested positive by PCR on 23 May. The patient is currently in the intensive care unit in a critical condition.

The patient is known to have comorbidities, no history of travel, and no history of contact with animals. He also has no history of contact with a laboratory confirmed MERS-CoV case. However, he was admitted to the same hospital where a laboratory confirmed MERS-CoV fatal case was admitted. This case was reported to WHO on 6 May.

Contact tracing and screening of family members, health workers, and patients for MERS-CoV is currently ongoing.

Globally, 636 laboratory-confirmed cases of infection with MERS-CoV have officially been reported to WHO, including 193 deaths. This global total includes all of the cases reported in this update, plus 17 laboratory confirmed cases officially reported to WHO by Saudi Arabia between 16 and 18 May. WHO is working closely with Saudi Arabia for additional information on these cases and will provide further updates as soon as possible.

The full report is available online at http://www.who.int/csr/don/2014_05_28_mers/en/.

National, MERS-CoV (CDC press release, May 28): After completing additional and more definitive laboratory tests, CDC officials have concluded that an Indiana MERS patient did not spread the virus to an Illinois associate during a business meeting they had before the patient became ill and was hospitalized.

CDC and state and local public health officials are conducting voluntary testing of people who had contact with two travelers who went from Saudi Arabia to the U.S. where they were confirmed to have Middle East

Respiratory Syndrome, or MERS. One type of tests conducted by state and CDC labs uses respiratory samples and can quickly indicate if a person has active infection with the virus. These tests are called PCR, or polymerase chain reaction, assays. Another type of testing, conducted on blood samples in CDC labs, is called serology and is designed to look for antibodies to Middle East Respiratory Syndrome Coronavirus (MERS-CoV). Antibodies would indicate that a person had been previously infected with the virus and developed an immune response. To conduct serology for MERS-CoV, CDC performs three separate tests – ELISA or enzyme-linked immunosorbent assay, IFA or immunofluorescent assay, and a third more definitive test called the neutralizing antibody assay which takes longer than the other two tests.

The Illinois resident, a business associate who had extended face-to-face contact with the Indiana MERS patient, tested negative for active MERS-CoV infection by PCR in the days after his interaction with the man. Given the Illinois man's contact with the MERS patient, CDC conducted serology testing to see if the Illinois man had antibodies to MERS-CoV. Preliminary ELISA and IFA results announced by CDC on May 17 indicated that the Illinois resident appeared to be positive for MERS-CoV antibodies.

"The initial ELISA and IFA serology results indicated the possibility that the Illinois resident had been previously infected with MERS-CoV," said David Swerdlow, M.D., who is leading CDC's MERS-CoV response. "This compelled us to notify and test those people with whom he had close contact in the days following his interaction with the Indiana MERS patient."

CDC scientists have since tested additional blood samples and completed the slower, definitive serology test, the neutralizing antibody test, which requires at least five days before a result is available. Based on the result of all of these tests, which require careful interpretation, CDC has concluded that the Illinois resident was not previously infected with MERS-CoV.

"While we never want to cause undue concern among those who have had contact with a MERS patient, it is our job to move quickly when there is a potential public health threat," said Swerdlow. "Because there is still much we don't know about this virus, we will continue to err on the side of caution when responding to and investigating cases of MERS in this country."

To date, active MERS-CoV infection has not been found in any of the contacts of the two people in the U.S. confirmed to have the disease. However, investigations are ongoing, including voluntary serology testing of contacts. This vigilant approach is intended to help CDC reduce any immediate public health threat, as well as help the global scientific community gain a better understanding of how MERS-CoV spreads so we can more effectively control this disease in the future. There is currently no evidence of sustained spread of MERS-CoV in community settings.

As CDC continues to gather additional information, officials will update the agency's MERS recommendations as needed. At this time, CDC's recommendations to the public, travelers, doctors and other healthcare providers have not changed.

The press release is available online at http://www.cdc.gov/media/releases/2014/p0528-mers.html.

International, Human (WHO [edited], May 28): On 26 May 2014, the National Health and Family Planning Commission (NHFPC) of China notified WHO of 3 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus.

Details of the cases are as follows:

- A 40 year-old male from Anqing City, Anhui Province. He had onset of symptoms on 9 May, was admitted to a hospital on 17 May, and is currently in a critical condition.
- A 69 year-old male from Huangshan City, Anhui Province. He had onset of symptoms on 14 May, was admitted to a hospital on 16 May, and is currently in a critical condition.
- A 58 year-old male from Ma'anshan City, Anhui Province. He had onset of symptoms on 8 May, was admitted to a hospital on 19 May, and is currently in a critical condition.

The full report is available online at http://www.who.int/csr/don/2014_05_28_h7n9/en/.

International, Research (Emerging Infectious Diseases [edited], May 23): Lu J, et al. Genetic changes of reemerged influenza (H7N9) viruses, China. Emerg Infect Dis. 2014 Sep.
http://dx.doi.org/10.3201/eid2009.140250

From March 30, 2013, through April 8, 2014, a total of 401 human infections with novel avian influenza A (H7N9) virus were reported in China. In the initial wave from February through May 2013, cases were laboratory confirmed for 133 patients (45 died), mainly in eastern China. From June through early October 2013, only 2 laboratory-confirmed cases were reported in China. One of these, identified on August 10, 2013, was the first case of influenza A(H7N9) virus infection in Guangdong Province (strain A/Guangdong/HZ-01/2013). However, a second wave of influenza A(H7N9) virus infection began on October 14, 2013. As of April 8, 2014, a total of 266 laboratory-confirmed cases had been reported, mainly in Zhejiang Province in eastern China (92 cases, 37 deaths) and Guangdong Province in southern China (99 cases, 30 deaths).

Previous sequencing studies suggested that 6 of the 8 influenza A(H7N9) virus RNA segments were acquired from influenza A(H9N2) virus. This acquisition process involved at least 2 steps of sequential reassortment; the most recent event most likely occurred in the Yangtze River Delta area of eastern China. To date, nearly all analyses have been performed by using sequences obtained from viruses isolated during the first wave of infection; changes associated with viruses isolated during the second wave are largely unknown. We therefore conducted phylogenetic analyses of whole-genome sequence data for 15 influenza A(H7N9) viruses isolated from human patients in Guangdong from November 4, 2013, through January 15, 2014.

We estimated maximum-likelihood trees for all 8 RNA segments by using MEGA version 5.2 and the general time-reversible model (7). RNA segments encoding the hemagglutinin, neuraminidase, and matrix genes of A/Guangdong/H7N9 viruses isolated after November 2013 were genetically similar to those of A/Guangdong/HZ-01/2013 and H7N9 strains from the first wave of influenza. An additional 4 RNA segments (nonstructural protein [NS], nucleocapsid protein [NP], polymerase basic proteins [PB] 1 and 2) of A/Guangdong/H7N9 influenza viruses isolated after November 2013 were clustered with A/Guangdong/HZ-01/2013 virus and were divergent from all currently sequenced subtype H7N9 viruses from the first wave in eastern China. The only exception was the NP segment of A/Guangdong/SZ-026/2014, which was found segregated into a separate cluster with subtype H9N2 viruses from Shandong Province. Moreover, analyses showed that RNA segments encoding NS, NP, PB1, and PB2 of A/Guangdong/H7N9 isolated after November 2013 were most similar to the same segments from influenza A(H9N2) viruses that had recently circulated in Guangdong. That is, NS, NP, PB1, and PB2 showed greater similarity to local subtype H9N2 viruses from Guangdong than to subtype H7N9 viruses from the first wave of influenza.

Notably, 2 separate clusters were observed for the phylogenetic tree of the RNA segment encoding the polymerase acidic gene. A/Guangdong/HZ-01/2013-like viruses clustered with subtype H7N9 viruses from the first wave of influenza. However, A/Guangdong/DG-02/2013-like viruses were clustered with subtype H9N2 influenza viruses circulating in Guangdong, suggesting that recent reassortment with circulating subtype H9N2 viruses occurred after the first case of infection with influenza A(H7N9) virus reported in Guangdong.

This study provides evidence that influenza A(H7N9) viruses isolated during the second wave of influenza in Guangdong differ genetically (in 5 of the 8 RNA segments) from that of influenza A(H7N9) viruses isolated during the first wave. High similarity of these 5 segments with those of locally circulating subtype H9N2 viruses suggests that rapid and continued reassortment with circulating subtype H9N2 viruses occurred during the second wave of the influenza A(H7N9) virus epidemic. Because reassortment and genetic changes can contribute to host fitness and infection capacity of reemerged influenza A(H7N9) viruses, studies of pathogenicity and transmission, to reveal the exact role of each genetic alteration, are needed.

The full report is available online at http://wwwnc.cdc.gov/eid/article/20/9/14-0250_article.htm.

International, Research (Clinical Infectious Diseases abstract, May 27): Xin Wang, et al. Seroprevalence to avian influenza A(H7N9) virus among poultry workers and the general population in southern China: a longitudinal study. Clin Infect Dis. first published online May 27, 2014. doi:10.1093/cid/ciu399

Background. Confirmed human cases of avian influenza A(H7N9) virus infection continue to occur in mainland China. Few confirmed cases have occurred in poultry workers despite potentially higher rates of exposure.

Methods. A serological survey was conducted in May and December 2013 in poultry market workers, and in March and September 2013 in the general population. Blood samples were collected and tested for antibodies to H7N9 and H5N1 viruses by hemagglutination-inhibition assays. Multivariable analysis was employed to identify risk factors related to H7N9 infection indicated by serology among poultry workers.

Results. In the poultry workers, 36/501 (7.2%) in May and 56/375 (14.9%) in December had HI antibody titer ≥1:160 to H7N9. Of 96 individuals who participated in both surveys, 52 (54.2%) workers had ≥4-fold

rise in H7N9 antibody titers from May to December. In a multivariable analysis, female sex (odds ratio 2.713; 95% CI: 1.098-6.705) and ≥10y of occupational exposure (odds ratio, 3.592; 95% CI: 1.246-10.354) were identified as risk factors for infection. Seroprevalence against H5N1 at ≥1:160 was low in May (4/501; 0.8%) and December (3/375; 0.8%). In the general population, 0/417 individuals in March and 0/408 individuals in September had antibody titer ≥1:160 to H7N9 or to H5N1.

Conclusions. While none of the participants in our study had virologically confirmed H7N9 infection, the high proportion of poultry workers with serologic evidence of H7N9 infection between May and December 2013 suggests a substantial risk of mild H7N9 infections in this group, supporting stricter control measures in live poultry markets.

The abstract is available online at http://cid.oxfordjournals.org/content/early/2014/05/27/cid.ciu399.short.

International Poultry and Wild Bird Surveillance (OIE): Reports of avian influenza activity, including summary graphs of avian influenza H5N1 outbreaks in poultry, can be found at the following website: http://www.oie.int/downld/AVIAN%20INFLUENZA/A_AI-Asia.htm.

For questions or to be added to the distribution list, please contact Susan Peters at peterss1@michigan.gov

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Table. H5N1 Influenza in Humans – As of January 24, 2014. http://www.who.int/influenza/human_animal_interface/EN_GIP_20130124 CumulativeNumberH5N1cases.pdf. Downloaded 02/05/2014. Cumulative lab-confirmed cases reported to WHO. Total cases include deaths.

Country	2003-2010		2011		2012		2013		2014		Total	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Azerbaijan	8	5	0	0	0	0	0	0	0	0	8	5
Bangladesh	1	0	2	0	3	0	1	1	0	0	7	1
Cambodia	10	8	8	8	3	3	26	14	0	0	47	33
Canada	0	0	0	0	0	0	1	1	0	0	1	1
China	40	26	1	1	2	1	2	2	0	0	45	30
Djibouti	1	0	0	0	0	0	0	0	0	0	1	0
Egypt	119	40	39	15	11	5	4	3	0	0	173	63
Indonesia	171	141	12	10	9	9	3	3	0	0	195	163
Iraq	3	2	0	0	0	0	0	0	0	0	3	2
Lao PDR	2	2	0	0	0	0	0	0	0	0	2	2
Myanmar	1	0	0	0	0	0	0	0	0	0	1	0
Nigeria	1	1	0	0	0	0	0	0	0	0	1	1
Pakistan	3	1	0	0	0	0	0	0	0	0	3	1
Thailand	25	17	0	0	0	0	0	0	0	0	25	17
Turkey	12	4	0	0	0	0	0	0	0	0	12	4
Vietnam	119	59	0	0	4	2	2	1	1	1	126	63
Total	516	306	62	34	32	20	39	25	1	1	650	386