The risk for influenza A(H5N1) virus infection is unclear among poultry workers in countries where the virus is endemic. To assess H5N1 seroprevalence and seroconversion among workers at live bird markets (LBMs) in Bangladesh, we followed a cohort of workers from 12 LBMs with existing avian influenza surveillance. Serum samples from workers were tested for H5N1 antibodies at the end of the study or when LBM samples first had H5N1 virus–positive test results. Of 404 workers, 9 (2%) were seropositive at baseline. Of 284 workers who completed the study and were seronegative at baseline, 6 (2%) seroconverted (7 cases/100 poultry worker–years). Workers who frequently fed poultry, cleaned feces from pens, cleaned food/water containers, and did not wash hands after touching sick poultry had a 7.6 times higher risk for infection compared with workers who infrequently performed these behaviors. Despite frequent exposure to H5N1 virus, LBM workers showed evidence of only sporadic infection.

Human infections and deaths caused by highly pathogenic avian influenza A (H5N1) viruses in several countries (1); by A(H9N2) virus in Bangladesh (2); and by A(H7N2), A(H7N9), A(H9N2), and A(H10N8) viruses in China (3–5) reflect the persistent public health threat posed by different avian influenza A virus subtypes. Subtype H5N1 virus remains endemic among poultry in Bangladesh, China, Egypt, Indonesia, and Vietnam (6). Among these countries the first human cases of H5N1 virus were identified in China and Vietnam during 2003 (1). The seroprevalence of antibodies against H5N1 virus among poultry workers was 0%–4% in Bangladesh, China, Indonesia, and Vietnam during 2001–2009 (7–13); published data on seroprevalence among poultry workers in Egypt are not available. Beyond the countries where H5N1 is endemic, 0%–10% seroprevalence has been reported among poultry workers in Nigeria; South Korea; Thailand; and Hong Kong, China (14–17). The incidence of H5N1 virus infection among occupationally exposed populations has not been determined in countries where the virus is endemic or nonendemic.

In Bangladesh, a country with a population density of 964/km² and 257 million poultry (18,19), H5N1 virus infection was first detected among poultry in 2007. By the end of 2013, the country had reported 549 outbreaks among poultry to the World Organisation for Animal Health (20). The first human case of H5N1 virus infection in Bangladesh was identified during 2008 (21). Live bird markets (LBMs) are often associated with poultry-to-human transmission of H5N1 virus (22). For example, butchering and exposure to sick poultry were associated with detection of H5 antibody among LBM workers in Hong Kong (17). In one study, workers from 16 LBMs in Bangladesh were rarely observed using personal protective equipment (PPE) or washing their hands during the handling of poultry, suggesting a high likelihood of exposures to H5N1 virus (23). Data are limited on the risk for avian influenza A virus infections among poultry workers in Bangladesh (7).

Seroprevalence studies among humans yield information about how many persons have serologic evidence of infection at a certain point and time, but they do not provide information about when people became infected or the risk for infection with prolonged exposures to contaminated animals or environments. Studies designed to estimate the rate of seroconversion of antibodies to H5N1 virus among poultry workers may also help elucidate the...
risks of poultry-to-human transmission of H5N1 virus in countries, such as Bangladesh, where H5N1 virus is endemic among poultry. Such information may help public health officials develop, prioritize, and reinforce prevention and control strategies. During 2009–2010, a total of 61 H5N1 outbreaks, resulting in the culling of 220,432 birds, were reported among poultry in Bangladesh (24); no human cases were identified during this period. We followed a cohort of LBM workers in Bangladesh to determine the seroprevalence of antibodies to H5N1 virus, the incidence of seroconversion, and risk factors for poultry-to-human transmission of H5N1 virus.

Methods

Study Sites
We conducted this study among workers in 12 LBMs in 4 districts of Bangladesh: 8 in Dhaka, 2 in Chittagong, and 1 each in Netrokona and Rajshahi. We selected these LBMs because they served as sentinel sites for existing avian influenza surveillance throughout the study period; surveillance included the monthly collection of poultry and environmental samples (25,26). The samples were tested for influenza A and subtype H5 by using real-time reverse transcription PCR (27). By April 2009, H5N1 virus was detected from farms in 47 of 64 districts in Bangladesh, including the 4 districts where the LBMs in our study were located (20).

The LBMs in Dhaka, which were open daily from 6:00 AM to midnight, sold chickens, ducks, geese, and quail. The workers slaughtered, defeathered, eviscerated, and sold the poultry. LBMs outside Dhaka were in rural subdistricts and were open once or twice a week. Backyard poultry farmers and, occasionally, commercial poultry farmers sold poultry at these LBMs.

Poultry Worker Enrollment and Baseline Data Collection
We aimed to recruit ≈400 workers. All workers 18–59 years of age were eligible for enrollment. This age limit maximized the specificity of detection of H5N1 virus antibodies by microneutralization assay with confirmatory Western blot because the specificity of these assays is lower among older adults (28). The field team prepared a list of 721 eligible poultry workers present at the LBMs from 8:00 AM to 5:00 PM.

In 2009, we enrolled a convenience sample of consenting workers from rural subdistrict LBMs during May–June and from urban Dhaka LBMs during October–November, when poultry surveillance became operational (Figure). The poultry workers were enrolled as a closed cohort. The field team used a structured questionnaire (online Technical Appendix 1 Figure 1, http://wwwnc.cdc.gov/EID/article/21/4/14-1281-Techapp1.pdf) to collect demographic data and information about any history of chronic medical conditions; habits involving frequent hand-to-mouth contact (i.e., smoking, smokeless tobacco use, and betel leaf/nut use); the location of poultry handling; and practices that may have placed the workers at risk for H5N1 virus infection (i.e., not wearing PPE, eating while working with poultry, holding or carrying poultry, and eating raw or undercooked poultry or eggs). Medical technologists collected a 10-mL blood specimen from each study participant.

Follow-up Data Collection
During January–April 2010, which included the peak period of H5N1 virus circulation among poultry (26), we followed up with study participants one time. Follow-up occurred ≥21 days after virus was first detected through poultry surveillance (25) or 1 year after enrollment if H5N1 virus was not detected in an LBM where a study participant worked (Figure). At follow-up, the field team collected information about any history of influenza-like illness (i.e., subjective or measured fever and cough or sore throat) and shortness of breath or difficulty breathing within the 21 days before the follow-up visit and about exposure to sick poultry and precautions taken in the 3 days before respiratory symptom onset (if applicable) or 7 days before collection of the H5N1 virus–positive poultry or environmental surveillance sample (online Technical Appendix 1 Figure 2). In LBMs where H5N1 virus was not detected through poultry surveillance within 1 year after baseline data collection, the field team obtained follow-up data during June 2010, using a questionnaire similar to the one used at baseline. Medical technologists collected a 10-mL blood specimen from all participants during follow-up.

Data Collection from Nonpoultry Workers
In 2010, to get a sense of the baseline seroprevalence rate in a seemingly lower-risk population and to optimize the interpretation of the microneutralization assay results, we obtained samples from a group of nonpoultry workers. We enrolled a convenience sample of nonpoultry workers (18–59 years of age) from 3 accommodating nongovernmental organizations; these persons worked in Dhaka, did not own poultry, and had not participated in studies associated with influenza or other animals since the first detection of H5N1 virus among poultry in Bangladesh during 2007. During July and August 2010, using a structured questionnaire (online Technical Appendix 1 Figure 3), the field team collected demographic data and information about any history of chronic medical conditions; habits involving frequent hand-to-mouth contact (e.g., smoking, smokeless tobacco use, and betel leaf/nut use); and lifetime history of ever handling poultry. Medical technologists collected a 10-mL blood specimen from each nonpoultry worker.
Processing of Blood Specimens and Laboratory Analysis

All blood specimens were transported to the icddr,b laboratory in Dhaka on frozen cold packs at 2°C–8°C. Specimens collected outside Dhaka were centrifuged at the end of each day to separate serum and then transported. Specimens collected in Dhaka were transported to and centrifuged at icddr,b the same day. All serum samples were split into 3 aliquots and stored at icddr,b at −70°C. One aliquot was shipped on dry ice to the Influenza Division at the Centers for Disease Control and Prevention (CDC; Atlanta, GA, USA) for H5N1 serologic testing.

We performed the microneutralization assay as previously described (28,29), using H5N1 clade 2.2 (A/Bangladesh/3233/2011) virus, the most common strain identified through surveillance in Bangladesh during the study period. Serial 2-fold dilutions of serum (1:10–1:1,280) were tested. Samples that tested positive by microneutralization assay were also tested by a confirmatory Western blot assay against influenza strain recombinant hemagglutinin A/bar-headed goose/Qinghai/1A/2005 (clade 2.2). Samples with positive assay results or that demonstrated evidence of seroconversion against H5N1 virus were also tested by microneutralization and hemagglutination inhibition assays against pandemic influenza A(H1N1)pdm09 virus strain A/Mexico/4108/2009 (H1N1) to exclude potential serum antibody cross-reactivity. Serum samples that had high titers to A(H1N1)pdm09 virus were adsorbed with A(H1N1)pdm09 virus and then retested by microneutralization for reactivity to H5N1 virus. A seropositive result was defined as an H5N1 virus microneutralization titer ≥40 (equivalent to World Health Organization criteria >80) and confirmation by an H5-specific Western blot (28–30). Seroconversion against H5N1 virus was defined as detection of a ≥4-fold rise in microneutralization antibody titer between the initial serum sample and a paired second serum sample, with the second sample achieving a titer ≥40. Serum samples were tested ≥2 times by using the microneutralization assay. Microneutralization titers were expressed as the geometric mean of replicate titers.

Estimating Seroprevalence and Seroconversion

We calculated the proportion of poultry workers and non-poultry workers that were seropositive at baseline, the proportion of poultry workers that seroconverted against H5N1 virus, and 95% CIs of the proportions, assuming binomial distribution. We calculated the incidence of seroconversion against H5N1 virus among workers with
paired serum samples who were from LBMs where H5N1 virus was detected through poultry surveillance; workers who were seropositive at baseline were excluded. We calculated the incidence by dividing the number of seroconversions by the person-time each participant contributed to the study between baseline and follow-up data collection and calculated 95% CIs, assuming a Poisson distribution. To be conservative, we assumed that workers were at risk of acquiring H5N1 virus between baseline and follow-up serum collection even though the LBM may have been free of H5N1 virus during some of that period. We extrapolated our calculated incidence of seroconversion among the participating poultry workers to estimate the annual number of poultry workers infected with H5N1 virus among the 721 eligible workers. To compare characteristics between poultry workers and nonpoultry workers, exposure to poultry, and use of PPE between workers who were followed versus those who were lost to follow-up, we performed the 2-sample Wilcoxon rank-sum test and 2-sample test of proportions.

**Statistical Analysis of Potential Risk Factors for H5N1 Virus Infection**

We assessed risk factors for H5N1 virus infection (seropositivity or seroconversion) only among poultry workers with paired serum samples. Candidate risk factors were collinear, precluding the use of a regression model. Therefore, we performed the Kaiser-Meyer-Olkin test to assess the applicability of factor analysis for this dataset (31) and selected sets of common behaviors that explained >90% of variance among the candidate variables. Using the contribution of individual behavior (factor loading) as the basis, we grouped the behaviors into 3 sets and estimated the factor score for each set. Poultry workers with scores above median and those with scores below median were classified, respectively, as frequently and infrequently engaging median and those with scores below median were classified, respectively, as frequently and infrequently engaging.

**H5N1 Serologic Testing Results**

Of 404 poultry workers, 9 (2%) were seropositive for H5N1 virus antibodies at baseline (95% CI 1%–4%). During November 2009–March 2010, routine icddr,b poultry surveillance identified H5N1 virus at 11 (92%) of the 12 LBMs and in 25 (93%) of 27 monthly samples. We obtained a second blood specimen from 278 (72%) of 387 participating poultry workers from the 11 LBMs (online Technical Appendix 2 Table 1, http://wwwnc.cdc.gov/EID/article/21/4/14-1281-Techapp2.pdf). Because of a delay in the availability of laboratory results for poultry and environmental surveillance samples, the median interval between detection of H5N1 virus at LBMs and collection of a second blood sample from poultry workers at the corresponding LBM was 56 days (IQR 49–61 days).

Of 9 seropositive poultry workers at baseline, 5 remained seropositive and 1 was seronegative for H5N1 virus antibodies at follow-up (online Technical Appendix 2 Figure); the remaining 3 workers were lost to follow-up. Six (2%) of 284 poultry workers seroconverted during the study period (95% CI 1%–5%) (Table 2). Six other workers

| Table 1. Characteristics of live bird market workers and nonpoultry workers, Bangladesh, 2009–2010* |
|-----------------------------------------------|
| Characteristic                  | Poultry workers, n = 404 | Nonpoultry workers, n = 101 | p value |
|-----------------------------------------------|
| Male sex                              | 404 (100) | 79 (78) | <0.001† |
| Median age, y (IQR)                   | 28 (22–38) | 36 (32–40) | <0.001† |
| Smoke tobacco                         | 236 (58) | 34 (34) | <0.001† |
| Median duration of smoking, y (IQR)    | 8 (4–16) | 15 (9–20) | 0.003‡ |
| Use betel leaf or nut                 | 151 (37) | 22 (22) | 0.003‡ |
| Use smokeless tobacco                 | 15 (4) | 1 (1) | 0.2 |
| Have chronic medical condition§       | 28 (7) | 11 (11) | 0.2 |

*Data are no. (%); exception as indicated. IQR, interquartile range.
†Value for 2-sample test of proportion.
‡Value for 2-sample Wilcoxon rank-sum test.
§Conditions such as asthma; diabetes; chronic heart, lung, kidney, and liver disease; immune disorders; and cancer.
Using this incidence, we estimate that the annual incidence of H5N1 virus infection after exposure to H5N1 virus at the study LBMs was 50 cases per 721 enlisted poultry workers.

### Risk Factors for H5N1 Virus Infection

Seventeen (94%) of the 18 workers who were seropositive or seroconverted against H5N1 virus and 180 (66%) of the 272 seronegative workers reported exposure to poultry through >1 activity. None of the workers who were seropositive or who seroconverted reported exposure to poultry at home, at their farm, or at another place.

Three sets of behaviors explained 95% of the variability among risk behaviors at baseline and follow-up. However, the risk for H5N1 virus infection (risk ratio) was not equal for each set of behaviors (online Technical Appendix 2 Table 2). The set of behaviors with the highest risk ratio consisted of feeding poultry, cleaning feeding trays and water containers, not washing hands after working with sick poultry, and cleaning feces from pens; this set of behaviors was classified as high exposure. The set of behaviors with the second highest risk ratio consisted of feeding poultry, cleaning feeding trays and water containers, not washing hands after working with sick poultry, and cleaning feces from pens; this set of behaviors was classified as high exposure. The set of behaviors with the third highest risk ratio consisted of feeding poultry, cleaning feeding trays and water containers, not washing hands after working with sick poultry, and cleaning feces from pens; this set of behaviors was classified as high exposure.

### Incidence of Seroconversion

In LBMs where H5N1 virus was detected through routine poultry surveillance, we followed 278 poultry workers, of whom 266 were H5N1 virus–seronegative at baseline. These 266 workers contributed 30,043 days (≈82 years) of observation between the collection of paired blood samples, resulting in an incidence of 7 cases/100 poultry worker–years (95% CI 3–16). Using this incidence, we
of behaviors was classified as medium exposure. The set of behaviors with the lowest risk ratio included smoking, medicating poultry, isolating sick poultry, and eating raw or undercooked poultry or eggs; this set of behaviors was classified as low exposure.

Poultry workers who frequently performed high-exposure behaviors had a 7.6 times higher risk for H5N1 virus infection compared with poultry workers who infrequently performed high-exposure behaviors when they also infrequently performed medium-exposure behaviors (p = 0.002) (Table 3). Poultry workers who frequently performed medium-exposure behaviors had a 5.1 times higher risk of H5N1 virus infection compared with poultry workers who infrequently performed medium-exposure behaviors when they also infrequently performed high-exposure behaviors (p = 0.002).

### Discussion

Our study demonstrates that, despite frequent exposure to infected poultry and low PPE use, LBM workers in Bangladesh had low serologic evidence of H5N1 virus infection. These results also suggest that cross-sectional seroprevalence studies may underestimate the risk for H5N1 virus infection if conducted outside the peak time for H5N1 virus circulation or if samples are obtained from infected workers long after exposure to the virus (i.e., when antibody titers have declined below the seropositive threshold).

Two percent of poultry workers were H5N1 virus–seropositive at baseline. This finding suggests that previous infection with H5N1 virus was uncommon despite the frequent exposure of workers to poultry. One of the workers who was seropositive at baseline became seronegative at follow-up, possibly because neutralizing antibodies decreased below the threshold for laboratory detection (34).

The overall 5% seroprevalence of H5N1 virus antibody among poultry workers in our study is similar to the 4% seroprevalence among LBM workers in Vietnam in 2001 (13) but higher than the <1% seroprevalence reported among LBM workers from Bangladesh, Nigeria, Indonesia, and China during 2005–2009 (7,9,11,14). This finding suggests that human infection with H5N1 virus among heavily exposed workers at LBMs occurs infrequently but may be more common than previously reported. Routine poultry surveillance that included subdistrict LBMs in our study detected H5N1 virus from a higher proportion of poultry and environmental samples collected in 2011 than in 2009 and 2010 (3.8% vs. 0.4% and 0.5%, respectively) (26). Indeed, we would expect an increase in seroprevalence of

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Table 3. Risks for testing seropositive or seroconverting against avian influenza A(H5N1) virus among live bird market workers, Bangladesh 2009–2010

| Characteristic/behavior | Poultry workers | Regression model |
|-------------------------|-----------------|-----------------|
|                         | Seronegative, n = 272 | Seropositive or seroconverted, n = 18 | Simple RR (95% CI) | Multiple RR (95% CI) | p value† |
| Median age, y (IQR)     | 27 (23–38)      | 27 (20–30)      | 0.9 (0.9–1.0) | 0.9 (0.9–1.1) | 0.8 |
| Risk behavior           |                 |                 |                 |                 |     |
| High exposure           |                 |                 | 4.8 (0.8–28.2) | 7.6 (2.8–20.9) | <0.001 |
| Feed poultry            |                 |                 | 196 (72)        | 17 (94)         |     |
| Clean feeding tray      |                 |                 | 156 (57)        | 15 (83)         |     |
| Clean water container   |                 |                 | 155 (57)        | 16 (89)         |     |
| Clean feces from poultry pen |           |                 | 125 (46)        | 14 (78)         |     |
| Do not wash hands after handling sick poultry | | | 133 (49) | 10 (56) | |
| Medium exposure         |                 |                 | 3.5 (0.8–14.7) | 5.1 (1.8–14.1) | 0.002 |
| Slaughter poultry       |                 |                 | 198 (73)        | 17 (94)         |     |
| Deatheater poultry      |                 |                 | 142 (52)        | 15 (83)         |     |
| Eviscerate poultry      |                 |                 | 143 (53)        | 15 (83)         |     |
| Collect or transport poultry feces | | | 53 (19) | 1 (6) | |
| Stuff poultry into bags  |                 |                 | 113 (42)        | 14 (78)         |     |
| Low exposure            |                 |                 | 1.0 (0.3–3.3)   | –              | –    |
| Smoke                   |                 |                 | 159 (58)        | 7 (39)          |     |
| Medicate poultry        |                 |                 | 15 (6)          | 2 (11)          |     |
| Isolate sick poultry    |                 |                 | 130 (48)        | 10 (56)         |     |
| Eat raw/undercooked poultry or eggs | | | 103 (38) | 6 (33) | |

Risk of infection from

| Risk of infection from | Poultry workers | Regression model |
|------------------------|-----------------|-----------------|
| Medium-exposure behaviors when frequently performing both medium- and high-exposure behaviors‡ | – | – | 1.4 (0.3–6.2) | 0.6 |
| High-exposure behaviors when frequently performing both high- and medium-exposure behaviors‡ | – | – | 2.1 (0.4–12.9) | 0.4 |

Data are no. (%) except as indicated. IQR, interquartile range; RR, risk ratio; –, not applicable.

†Value for multivariate model.

‡The ratio of RR for interaction between medium- and high-exposure behaviors was 0.3 (1.4/5.1 for medium-exposure behaviors and 2.1/7.6 for high-exposure behaviors (95% CI 0.08–0.88; p = 0.031).
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cause the modified horse erythrocyte hemagglutination seroconversions that occurred after follow-up. Third, be up with workers at that LBM. Thus, we may have missed incidence of seroconversion if some of these workers were infected or in an overestimation if none of them were in falsals and losses to follow-up may have led to selection of the poultry workers declined to participate, and 28% of increased transmissibility among humans (23).

The single seropositive LBM worker in China also reported slaughtering birds for 5 years (36). The use of PPE while performing high-exposure behaviors and frequent handwashing may reduce the risk for H5N1 virus infection (37). Nevertheless, because poultry workers handle poultry throughout the workday, it may be challenging for them to use PPE every time they have contact with poultry or their feces (38). Virus exposure and subsequent infection via mucous membranes and the respiratory tract may also be reduced among workers if they avoid touching their eyes, mouth, and nose while at work. Formative research would be helpful to explore if and how environmental controls (e.g., handwashing stands, improved ventilation flow, scalding pots); improved poultry handling techniques (e.g., slaughtering poultry inside plastic bags); and improved PPE (e.g., more accessible, cost-effective, and better tolerated equipment) could help decrease the risk for virus transmission at LBMs.

In Bangladesh, most identified cases of H5N1 virus infection in humans have been asymptomatic or mildly symptomatic (2,21). However, in 2013, the potential for severe and fatal illness from H5N1 virus infection in Bangladesh was highlighted by a fatal case in a child who had been exposed to infected backyard poultry (39). An increase in H5N1 virus infections among occupationally exposed poultry workers could signal the emergence of a virus with increased transmissibility among humans (40).

Our study has several limitations. First, almost 20% of the poultry workers declined to participate, and 28% of those enrolled at baseline were lost to follow-up. The refusals and losses to follow-up may have led to selection bias, resulting in an underestimation of seroprevalence and incidence of seroconversion if some of these workers were infected or in an overestimation if none of them were infected. Second, once H5N1 virus was detected in surveillance samples from an LBM, we conducted a final follow-up with workers at that LBM. Thus, we may have missed seroconversions that occurred after follow-up. Third, because the modified horse erythrocyte hemagglutination assay is insensitive for the detection of antibody to A/Bangladesh/3233/2011 (H5N1, clade 2.2) virus, we could not use it for confirmation of seropositivity and seroconversion in this study. Fourth, poultry workers in Bangladesh were engaged in multiple activities, making it difficult to identify which specific behavior was the predominant risk factor for H5N1 virus infection. Last, we were unlikely to have accurately ascertained clinical illness associated with H5N1 virus infections because of the lag between collection of H5N1 virus–positive poultry and environmental surveillance samples and the collection of follow-up blood samples from workers.

In conclusion, our study suggests that a low but substantive proportion of LBM poultry workers in Bangladesh become infected with H5N1 virus after unprotected, ongoing sporadic exposures to H5N1 virus–infected poultry and virus-contaminated environments of LBMs. The risk behaviors identified in our study may help public health officials explore interventions to interrupt poultry-to-human transmission of H5N1 virus and other avian influenza A viruses among the poultry workers. The cost of any interventions needs to take into account the anticipated potential modest benefit of decreasing an infrequent event with uncertain pandemic potential.

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References

1. World Health Organization. Cumulative number of confirmed human cases for avian influenza A(H5N1) reported to WHO, 2003–2014 [cited 2014 Dec 7]. http://www.who.int/influenza/human_animal_interface/EN_GIP_20131008CumulativeNumberH5N1cases.pdf
2. icddr,b. Outbreak of mild respiratory disease caused by H5N1 and H9N2 infections among young children in Dhaka, Bangladesh, 2011. Health and Science Bulletin. 2011;9:5–12.
3. World Health Organization. WHO risk assessment. Human infections with avian influenza A (H7N9) virus. 2014 Feb 28 [cited 2014 Mar 1]. http://www.who.int/influenza/human_animal_interface/influenza_h7n9/140225_H7N9RA_for_web_20140306FM.pdf?ua=1
4. World Health Organization. Influenza at the human-animal interface. Summary and assessment as of 24 January 2014 [cited 2014 Feb 20]. http://www.who.int/influenza/human_animal_interface/Influenza_Summary_IRA_HA_interface_24January14.pdf?ua=1

5. World Health Organization. Avian influenza A (H10N8). World Health Organization (WHO), Western Pacific Region [cited 2014 Feb 20]. http://www.wpro.who.int/china/mediacentre/factsheets/h10n8/en/

6. Food and Agriculture Organization of the United Nations, World Organisation for Animal Health, World Health Organization. FAO-OIE-WHO technical update: current evolution of avian influenza H5N1 viruses [cited 2014 Dec 27]. http://www.who.int/influenza/human_animal_interface/tripartite_notes_H5N1.pdf

7. Nasreen S, Uddin Khan S, Aziz-Baumgartner E, Hancock K, Veguilla V, Wang D, et al. Seroprevalence of antibodies against highly pathogenic avian influenza A (H5N1) virus among poultry workers in Bangladesh, 2009. PLoS ONE. 2013;8:e73200. http://dx.doi.org/10.1371/journal.pone.0073200

8. Lu CY, Lu JH, Chen WQ, Jiang LF, Tan BY, Ling WH, et al. Seroprevalence of antibodies to avian influenza A (H5) and A (H9) viruses among poultry workers in China. N Engl J Med. 2009;360:2583–8. http://dx.doi.org/10.1056/NEJMoa0900358

9. Wang M, Fu C-X, Zheng B-J. Antibodies against H5 and H9 avian influenza among poultry workers in China. N Engl J Med. 2009;360:2583–8. http://dx.doi.org/10.1056/NEJMoa0900358

10. Huo X, Zu R, Qi X, Qin Y, Li L, Tang F, et al. Seroprevalence of antibodies against avian influenza A (H5N1) virus among poultry workers in Jiangsu Province, China: an observational study. BMC Infect Dis. 2012;12:93. http://dx.doi.org/10.1186/1471-2334-12-93

11. Santiah K, Ramy A, Jayaningsih P, Samaan G, Putra AAG, Dibia N, et al. Avian influenza A H5N1 infections in Bali Province, Indonesia: a behavioral, virological and seroepidemiological study. Influenza Other Respir Viruses. 2009;3:374–80. http://dx.doi.org/10.1016/j.influenza.2009.07.002

12. Schultz C, Dung NV, Hai LT, Dan BY, Ling WH, et al. Seroprevalence of antibodies against avian influenza A (H5N1) virus among cullers and poultry workers in Ho Chi Minh City, 2005. PLoS ONE. 2009;4:e4994. http://dx.doi.org/10.1371/journal.pone.004994

13. Uyeki TM, Nguyen DC, Rowe T, Lu X, Hu-Primmer J, Huynh LP, et al. Seroprevalence of antibodies to avian influenza A (H5) and A (H9) viruses among market poultry workers, Hanoi, Vietnam, 2001. PLoS ONE. 2012;7:e43948. http://dx.doi.org/10.1371/journal.pone.0043948

14. Ortiz JR, Katz MA, Mahmoud MN, Ahmed S, Bawa SI, Farnon EC, et al. Lack of evidence of avian-to-human transmission of avian influenza A (H5N1) virus among poultry workers, Kano, Nigeria, 2006. J Infect Dis. 2007;196:1685–91. http://dx.doi.org/10.1086/522158

15. Kwon D, Lee J-Y, Choi W, Choi J-H, Chung Y-S, Lee N-J, et al. Risk of influenza A (H5N1) infection among poultry workers, Hong Kong, 1997–1998. J Infect Dis. 2002;185:1005–10. http://dx.doi.org/10.1086/340044

16. Directorate General of Health Services Bangladesh. 2nd National Avian and Pandemic Influenza Preparedness and Response Plan, Bangladesh, 2009–2011 [cited 2010 Feb 12]. http://oldweb.dghs.gov.bd/bn/important-documents-software/category/7-2012-07-09-07-43-26/download=6/2nd-national-avian-and-pandemic-influenza-preparedness-and-response-plan-bangladesh

17. Bangladesh Bureau of Statistics. 2011 Population and housing census: preliminary results 2011 [cited 2011 Dec 20]. http://www.bbs.gov.bd/WebTextApplication/userfiles/Image/BBS/PHC2011Preliminary%20Result.pdf

18. World Organization for Animal Health. Update on highly pathogenic avian influenza in animals (type H5 and H7): Follow-up report no. 43 (final report) [cited 2013 Jun 27]. http://www.oie.int/wahis_2/public/5%5Ctemp%5CReports/en_fup.0000014568_20131223_145541.pdf

19. Brooks WA, Alamgir ASM, Sultana R, Islam MS, Rahman M, Fry A, et al. Avian influenza virus A (H5N1), detected through routine surveillance, in child, Bangladesh. Emerg Infect Dis. 2009;15:1311–3. http://dx.doi.org/10.3201/eid1508.090028

20. Van X-F, Dong L, Lan Y, Long L-P, Xu C, Zou S, et al. Indications that live poultry markets are a major source of human H5N1 influenza virus infection in China. J Virol. 2011;85:13432–8. http://dx.doi.org/10.1128/JVI.05266-11

21. Bangladesh UNICEF, icddr,b. Evaluation of avian influenza communication for development initiative—improving biosecurity in live bird markets. Pre-intervention assessment report. Dhaka (Bangladesh): United Nations Children Fund; 2013.
36. Wang M, Di B, Zhou D-H, Zheng B-J, Jing H, Lin Y-P, et al. Food markets with live birds as source of avian influenza. Emerg Infect Dis. 2006;12:1773–5. http://dx.doi.org/10.3201/eid1211.060675

37. World Health Organization. Protection of individuals with high poultry contact in areas affected by avian influenza H5N1: consolidation of pre-existing guidance [cited 2008 Mar 15]. http://www.who.int/influenza/resources/documents/guidance_protection_h5n1_02_2008/en/

38. Rimi NA, Sultana R, Khan S, Nasreen S, Puri A, Alamgir ASM, et al. Biosecurity conditions and biosafety practices in the live bird markets of Dhaka city, Bangladesh, 2012. In: Abstracts of the Options for the Control of Influenza VIII; Cape Town, South Africa; 2013 Sep 5–10. Abstract P2-475. London: International Society for Influenza and Other Respiratory Virus Diseases; 2013.

39. icddr,b. The first fatal human infection with highly pathogenic avian influenza A (H5N1) virus detected in Bangladesh. Health and Science Bulletin. 2013;11:1–6.

40. Uyeki TM, Bresee JS. Detecting human-to-human transmission of avian influenza A (H5N1). Emerg Infect Dis. 2007;13:1969–71. http://dx.doi.org/10.3201/eid1312.071153

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Highly Pathogenic Avian Influenza A(H5N1) Virus Infection among Workers at Live Bird Markets, Bangladesh, 2009–2010

Technical Appendix 1

International Centre for Diarrhoeal Disease Research, Bangladesh

Sero-prevalence of antibodies to avian influenza A viruses among poultry market workers

| ID # |
|------|

1. Name of Interviewer:

2. Date: ___ ___ (dd /mm /yy)

3. Location: □ Netrokona □ Chittagong □ Rajshahi □ Dhaka

4. Market ID __________

5. Market worker available (For follow-up sample collections)?  □ Yes □ No

6. Initial visit? □ Yes □ No (if no, skip to 9)

7. Consent to participate? □ Yes (if yes, skip to 9) □ No

8. If refused consent provide reason: __________________________ (Stop and thank interviewee)

Generic risk factors:

9. How old are you: ___ (years)

10. Sex: □ Female □ Male (if male, skip to 11)

   a. If female, Are you pregnant, that you are aware? □ Yes □ No

11. What is your ethnicity: __________

12. Height: _____ (meters) (Use tape measure)

13. Weight: _____ (Kg) (Use bathroom scale)

14. Do you smoke? □ Yes □ No (if no, skip to 17)

15. How many sticks a day do you smoke____

16. How many years have you smoked? ____

17. Do you use: (read and select all that apply)

   □ Betel leaf or betel nuts □ gul (remains of tobacco-cake mixed with molasses)
   □ khoi (hand-made tobacco dust) □ None of the above

18. Has a doctor ever told you that you have any of the following conditions?:

   □ Asthma □ Diabetes □ Chronic heart disease □ Chronic lung disease
□ Chronic kidney disease  □ Chronic liver disease  □ Immune problems  □ None of the above

Environmental risk factors:

19. Is there any hand washing station in the market (interviewer to observe and record)? □ Yes  □ No

20. Do you have running water in the market? □ Yes  □ No (skip to Q22)

21. Approximately how far is your water source in the market? _____ (Meters / Feet) (should be blank for the skipped ones)

22. Did you wash your hands with soap and water while in the market yesterday? □ Yes  □ No

23. Daily, do you use ash or mud to wash your hands? □ Yes  □ No

24. If you washed your hands yesterday, when did you do so: (read all the key times)

   Before meals? □ Always □ Often □ Seldom □ Never
   After returning home? □ Always □ Often □ Seldom □ Never
   After defecating? □ Always □ Often □ Seldom □ Never
   Before touching your eyes, nose, or mouth? □ Always □ Often □ Seldom □ Never

25. Daily, how often do wash your hands with ash or mud: (read all the key times)

   Before meals? □ Always □ Often □ Seldom □ Never
   After returning home? □ Always □ Often □ Seldom □ Never
   After defecating? □ Always □ Often □ Seldom □ Never
   Before touching your eyes, nose, or mouth? □ Always □ Often □ Seldom □ Never

Poultry worker risk factors:

26. Do you handle poultry? □ Yes  □ No (if no stop and thank interviewee)

27. Where do you handle poultry (check all that apply)?
 □ Home  □ Market  □ Farm  □ Other _________

28. What kind of tasks do you do when you handle poultry? (read and select all that apply)

   Transport poultry □ Daily □ Weekly □ Monthly □ Never
   Feed poultry □ Daily □ Weekly □ Monthly □ Never
   Clean feeding tray □ Daily □ Weekly □ Monthly □ Never
   Clean water container □ Daily □ Weekly □ Monthly □ Never
   Slaughter poultry □ Daily □ Weekly □ Monthly □ Never
   Defeather poultry □ Daily □ Weekly □ Monthly □ Never
   Eviscerate poultry □ Daily □ Weekly □ Monthly □ Never
   Collect or transport feces □ Daily □ Weekly □ Monthly □ Never
   Cleaning feces from where poultry are kept □ Daily □ Weekly □ Monthly □ Never

29. Do you use any personal protective equipment when handling poultry?
   Protective apron □ Always □ Often □ Seldom □ Never
   Gloves □ Always □ Often □ Seldom □ Never
Dedicated coveralls  □ Always □ Often □ Seldom □ Never
Mask  □ Always □ Often □ Seldom □ Never
Boots  □ Always □ Often □ Seldom □ Never

30. Do you eat lunch or drink tea during or after working with poultry? □ Always □ Often □ Seldom □ Never

31. Do you smoke while working with poultry? □ Always □ Often □ Seldom □ Never

32. Do you carry hand poultry or hold poultry on your lap? □ Always □ Often □ Seldom □ Never

33. Do you carry baskets containing poultry on your head? □ Always □ Often □ Seldom □ Never

34. Do you change your clothes upon returning home after working with poultry? □ Yes □ No

35. Do you eat raw or undercooked poultry or eggs? □ Always □ Often □ Seldom □ Never

Thank you for your cooperation and participation in the survey

Technical Appendix 1 Figure 1. Questionnaire administered to poultry workers at live bird markets, Bangladesh, 2009–2010. The questionnaire was administered to all workers at baseline, and 12 months after baseline to workers at the market where avian influenza A(H5N1) virus was not detected through poultry surveillance during the study.
International Centre for Diarrhoeal Disease Research, Bangladesh

Sero-prevalence of antibodies to avian influenza A viruses among poultry market workers

Market worker questionnaire 21 days after animal surveillance recovers influenza

| ID # | 1 |

1. Name of interviewer:

2. Date: ___ ___ ___ (dd mm yy)

3. Location: □ Netrokona □ Chittagong □ Rajshahi □ Dhaka

4. Market ID __________

5. Market worker available? □ Yes □ No

Influenza like illness:

6. Have you been sick in the past 21 days? □ Yes □ No (if no, skip to 22)

7. When did you first feel sick? Date ___ ___ ___ (dd mm yy)

8. Did you develop a sudden fever? □ Yes □ No

9. Did someone take your temperature? □ Yes □ No (if no, skip to 11)

10. What was your highest temperature? ___ F°

11. Did you develop:
   a. Cough? □ Yes □ No
   b. Sore throat? □ Yes □ No
   c. Shortness of breath or difficulty breathing? □ Yes □ No

12. Did you seek medical attention? □ Yes □ No (if no, skip to 19)

13. Where did you seek medical attention? □ Local clinic □ Local hospital □ Other__________

14. What were you diagnosed with?
   d. □ Cold □ Pharyngitis □ Bronchitis □ Pneumonia □ Dengue □ Other__________

15. Were you told you needed hospitalization? □ Yes □ No

16. Have you taken oseltamivir (show case-patient sample blister pack) for this illness as twice a day for 5 days (or up to the time of the interview)? □ Yes □ No

17. Did a doctor obtain a clinical sample?
   e. From nose or throat □ Yes □ No (if no, skip to 19)
   f. Blood □ Yes □ No

18. Where was this sample obtained? ________________

19. In the 3 days before symptom onset, had anyone at home had similar symptoms? □ Yes □ No
   g. If yes, who__________________
20. In the 3 days before symptom onset, did you know of anyone with similar symptoms?  
☐ Yes  ☐ No (if no Skip to 22)  

21. In the 3 days before symptom onset, had you been close (< 3 feet/2 hands) to anyone you know with similar symptoms outside the home?  
☐ Yes  ☐ No (if no Skip to 22)  

h. If yes, where (check all that apply):  
☐ Market  ☐ School  ☐ Mosque/church/temple  ☐ Street  ☐ Other  
☐ Other ____________________________

Potential risk factors for present illness

22. In the 3 days before symptom onset/7 days before collecting the animal sample (mention the date), had you been around sick poultry?  ☐ Yes  ☐ No  

23. Did you handle the sick poultry?  ☐ Yes  ☐ No (if no skip to 34)  

24. Where did you handle sick poultry (check all that apply)?  
☐ Home (H)  ☐ Market (M)  ☐ Farm (F)  ☐ Other _________  

25. What kind of tasks did you do when you handle the sick poultry and where (check all that apply and add location code [i.e., H,M,F])?  

Transport poultry  ☐ Yes  ☐ No  Location:________  
Feed poultry  ☐ Yes  ☐ No  Location:________  
Clean feeding tray  ☐ Yes  ☐ No  Location:________  
Clean water container  ☐ Yes  ☐ No  Location:________  
Give medicine to the sick poultry  ☐ Yes  ☐ No  Location:________  
Separate sick poultry  ☐ Yes  ☐ No  Location:________  
Slaughter poultry  ☐ Yes  ☐ No  Location:________  
Defeather poultry  ☐ Yes  ☐ No  Location:________  
Eviscerate poultry  ☐ Yes  ☐ No  Location:________  
Collect or transport feces  ☐ Yes  ☐ No  Location:________  
Cull poultry  ☐ Yes  ☐ No  Location:________  
Stuff poultry in bags  ☐ Yes  ☐ No  Location:________  
Bury poultry carcasses  ☐ Yes  ☐ No  Location:________  
Burn poultry products  ☐ Yes  ☐ No  Location:________  
Cleaning feces from place where poultry are kept ☐ Yes  ☐ No  Location:________  

26. Did you take precautions when handling ill poultry (check all that apply)?  

Protective apron  ☐ Always  ☐ Often  ☐ Seldom  ☐ Never  
Gloves  ☐ Always  ☐ Often  ☐ Seldom  ☐ Never  
Dedicated coveralls  ☐ Always  ☐ Often  ☐ Seldom  ☐ Never  
Mask  ☐ Always  ☐ Often  ☐ Seldom  ☐ Never  
Boots  ☐ Always  ☐ Often  ☐ Seldom  ☐ Never  

27. Did you eat during or after working with ill poultry?  ☐ Yes  ☐ No  

28. Did you smoke while working with ill poultry?  ☐ Yes  ☐ No
29. Did you use: (read and select all that apply)

- Betel leaf or betel nuts
- gul (remains of tobacco-cake mixed with molasses)
- khoini (hand-made tobacco dust)
- None of the above

30. Did you hand carry sick poultry or hold poultry on your lap?  □ Yes  □ No

31. Did you carry baskets containing sick poultry on your head?  □ Yes  □ No

32. Did you wash your hands at the market after working with ill poultry?  □ Yes  □ No

33. Did you change your clothes upon returning home after working with ill poultry?  □ Yes  □ No

34. Did you eat raw or undercooked poultry or eggs?  □ Yes  □ No

Thank you

Technical Appendix 1 Figure 2. Questionnaire administered to poultry workers at follow-up during a study of avian influenza A(H5N1) virus infection among workers at live bird markets, Bangladesh, 2009–2010.
International Centre for Diarrhoeal Disease Research, Bangladesh

Sero-prevalence of antibodies to avian influenza A viruses among poultry market workers

Non-poultry workers questionnaire

| ID # |
|------|

1. Name of Interviewer:

2. Date: __/__/____ (dd/mm/yy)

3. Name of the Organization of control:

4. Consent to participate? □ Yes (if yes, skip to 7) □ No

5. If refused consent provide reason:__________________________ *(Stop and thank interviewee)*

Generic risk factors:

6. How old are you: ___ ___ (years)

7. Have you owned or handled poultry during the past 2 years? □ Yes (if yes thank and stop) □ No

8. Have you worked in influenza field studies during past 2 years? □ Yes (if yes thank and stop) □ No

9. Sex: □ Female □ Male (if male, skip to 11)
   a. *If female, Are you pregnant, that you are aware?* □ Yes □ No

10. What is your ethnicity:_____

11. Height:_____ (meters) *(Use tape measure)*

12. Weight:_____ (Kg) *(Use bathroom scale)*

13. Do you smoke? □ Yes □ No (if no, skip to 18)

14. How many sticks a day do you smoke___

15. How many years have you smoked? ____

16. Do you use: *(read and select all that apply)*
   □ Betel leaf or betel nuts □ Gul (remains of tobacco-cake mixed with molasses)
   □ Khoni (hand-made tobacco dust) □ None of the above

17. Do you have any of the following conditions?:
   □ Asthma □ Diabetes □ Chronic heart disease □ Chronic lung disease
Technical Appendix 1 Figure 3. Questionnaire administered to nonpoultry workers during a study of avian influenza A(H5N1) virus infection among workers at live bird markets, Bangladesh, 2009–2010.
Highly Pathogenic Avian Influenza A(H5N1) Virus Infection among Workers at Live Bird Markets, Bangladesh, 2009–2010

Technical Appendix 2

Technical Appendix 2, Table 1. Baseline characteristics among poultry workers, by follow-up status, in a study of avian influenza A(H5N1) virus infection among workers at live bird markets, Bangladesh, 2009–2010*

| Baseline characteristic                  | No. (%) poultry workers | p value |
|-----------------------------------------|-------------------------|---------|
| Median age, y (IQR)                     | 27 (22–38)              | 28 (23–35) | 0.9† |
| Smoker                                  | 166 (57)                | 70 (61) | 0.4‡ |
| Have chronic medical condition§         | 18 (6)                  | 10 (9) | 0.4‡ |
| Exposure to poultry                     |                         |         |
| Transport poultry                       | 204 (70)                | 86 (75) | 0.3‡ |
| Feed poultry                            | 226 (78)                | 72 (63) | 0.002‡ |
| Clean feeding tray                      | 177 (61)                | 66 (58) | 0.6‡ |
| Clean water container                   | 168 (58)                | 63 (55) | 0.6‡ |
| Slaughter poultry                       | 229 (79)                | 75 (66) | 0.006‡ |
| Defeather poultry                       | 180 (62)                | 66 (58) | 0.4‡ |
| Eviscerate poultry                      | 178 (61)                | 65 (57) | 0.4‡ |
| Collect or transport feces              | 61 (21)                 | 21 (18) | 0.6‡ |
| Clean feces from pens                   | 137 (47)                | 51 (45) | 0.7‡ |
| Hand-carry poultry or hold poultry on lap during travel | 265 (91) | 111 (97) | 0.03‡ |
| Carry baskets containing poultry on head | 4 (1)                   | 8 (7) | 0.003‡ |
| Eat raw or undercooked poultry or eggs  | 84 (29)                 | 47 (41) | 0.02‡ |
| Use of personal protective equipment¶  |                         |         |
| Protective apron                        | 0 (0)                   | 0 (0) | – |
| Gloves                                  | 0 (0)                   | 0 (0) | – |
| Dedicated overalls                      | 0 (0)                   | 0 (0) | – |
| Cloth mask                              | 5 (2)                   | 1 (1) | 0.5 |
| Boots                                   | 1 (0.37)                | 0 (0) | 0.5 |

*IRQ, interquartile range; –, not applicable.
†p value for 2-sample Wilcoxon rank-sum test.
‡p value for 2-sample test of proportion.
§Conditions such as asthma; diabetes; chronic heart, lung, kidney, liver, and kidney disease; immune disorder; and cancer.
¶During reported handling of poultry at baseline or handling of sick poultry at follow-up for the followed up workers; and handling of poultry at baseline for the lost to follow-up workers.

Technical Appendix 2, Table 2. Contribution of individual behaviors of poultry workers for each set of exposure behaviors (factor loadings) associated with avian influenza A(H5N1) virus infection among live bird market workers, Bangladesh 2009–2010*

| Behavior                                          | Medium exposure | High exposure | Low exposure |
|---------------------------------------------------|-----------------|---------------|--------------|
| Smoked                                            | −0.0097         | −0.0018       | 0.1193       |
| Fed poultry                                       | 0.3628          | 0.5927        | 0.0646       |
| Cleaned feeding tray                              | 0.3670          | 0.8982        | 0.0150       |
| Cleaned water container                           | 0.3659          | 0.8958        | 0.0628       |
| Medicated poultry                                 | 0.0693          | 0.1218        | 0.2189       |
| Isolated sick poultry                             | 0.1925          | 0.2104        | 0.4459       |
| Slaughtered poultry                               | 0.5669          | 0.3162        | 0.1107       |
| Defeathered poultry                               | 0.9270          | 0.3308        | 0.0413       |
| Eviscerated poultry                               | 0.9179          | 0.3550        | 0.0380       |
| Collected or transported feces                    | 0.2626          | 0.2538        | 0.1016       |
| Stuffed poultry into bags                         | 0.6055          | 0.2928        | 0.0581       |
| Cleaned feces from pens                           | 0.4939          | 0.4968        | −0.0036      |
| Did not wash hands after handling sick poultry    | −0.1326         | −0.0432       | −0.4368      |
| Ate raw or undercooked poultry or eggs            | 0.0280          | 0.0766        | 0.1892       |

*H5N1 virus infection denotes being seropositive at baseline/follow-up and having evidence of seroconversion to H5N1 virus antibodies at follow-up.

Gray shading shows that exposure behaviors with the highest factor loading were grouped together into each set of exposure behaviors that were later classified into high-, medium- and low-exposure on the basis of calculated risk ratios.
Technical Appendix 2, Figure. Timeline for the collection of serum samples for 21 poultry workers (PWs) who were positive for influenza A(H5N1) virus at baseline or who seroconverted at follow-up. The samples were obtained for A(H5N1) virus serologic testing.