PREVALENCE OF DENGUE FEVER (DF) AND DENGUE HEMORRHAGIC FEVER (DHF):
A DESCRIPTION AND FORECASTING

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Junge B. Guillena¹, Edward Laurence Opena and Mirasol L. Baguio²

ABSTRACT

This paper presents the prevalence of dengue fever (DF) and dengue hemorrhagic fever (DHF) cases admitted at Mindanao Sanitarium and Hospital (MSH), Iligan City from the year 2000-2008.

A total of 606 cases were reported to have DHF and 993 for DF. For DHF, 51.81% were males and ages 4-12 contributed 60.73% of the reported cases. In the 993 cases of DF, it has been noted that 55.09% were males; ages 7-34 showed higher DF susceptibility (72.21%). Majority of the dengue cases reported as of 2000-2004 are coming from Iligan City. Also, a possible alternating increase-decrease-increase pattern in the number of cases in each year has been noted to be consistent throughout the study period.

Furthermore, this study tries to develop a univariate time series model forecasting the monthly occurrence of dengue cases at MSH. The results showed that the autoregressive integrated moving average forecast curves were consistent with the pattern of the observed values.

Identification of the predominant dengue serotypes that are most common in Iligan city and nearby localities is one of the strongest recommendations of this study. Further recommendations include: (1) analyses of other patients’ profile like blood type, stress factors, and diet, (2) dissemination of this study’s result to the public via forums and (3) expansion of the research locale.

KEYWORDS AND PHRASES: Dengue Fever, Dengue Hemorrhagic Fever, Prevalence, ARIMA

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Introduction

Due to its recent serious emerging health threats, together with possible dire consequences including death, dengue fever, as caused by dengue virus (Figure 1) infection (though not a new disease), has aroused considerable medical and public health concerns worldwide and is considered one of the most important arthropod-borne viral diseases in humans in terms of morbidity and mortality. Dengue cases were formally included within the disease portfolio of the United Nations Development Programme/World Bank/World Health Organization Special Programme for Research and Training in Tropical Diseases by the Joint Coordination Board in June 1999. Dengue's global prevalence has grown dramatically in recent decades. This disease is now endemic in more than a hundred countries in Africa, the Americas, eastern Mediterranean, SE Asia and the Western Pacific, threatening more than 2.5 billion people. An approximated estimate of 50 to 100 million cases worldwide occur every year which includes 200,000 to 500,000 cases of potential life-threatening dengue hemorrhagic fever (DHF)/dengue shock syndrome (DSS), characterized by thrombocytopenia and increased vascular permeability (Noisakran and Perng, 2007; Pei-Yun and Jyh-Hsiung, 2004).

![The dengue virus](http://www.sciencedaily.com/images/2008/03/080327172348-large.jpg)

Dengue fever and dengue hemorrhagic fevers are classified as classic viral hemorrhagic fevers brought about by *Aedes* spp (Figure 2). The former is milder and is most common in the Caribbean and South America while the later can induce shock in the victim (usually a child) and kill in a few hours and is a leading cause of death among Southeast Asian children (Tortora *et al.*, 2001).

Where the human population occurs in rural villages or islands, an epidemic transmission cycle may occur. Viruses that are introduced quickly infect the majority of susceptible persons in these areas, and increasing herd immunity causes the virus to disappear from the population. Depending on the geographical area, *Aedes* spp. may act as vectors. By the bite of an infected mosquito, humans will be infected with dengue viruses. *A. aegypti*, the principal vector, and a highly domesticated tropical mosquito that prefers laying its eggs in artificial containers commonly found in and around homes (flower vases, automobile tires, etc). Adult mosquitoes tend to rest indoors, unobtrusive, where feeding on humans during daylight hours is their preference. Two biting activity peaks had been identified: early morning for 2 to 3 hours after daybreak and in the afternoon for several hours before dark, though they feed all day indoors and on overcast days. Female mosquitoes are sensitive feeders since their feeding will be disrupted at the slightest movement, and later return to the same or different person to continue feeding. This behavior then leads to multiple infections, if the mosquito is
infective, in a short time even if they only prove without taking blood. Thus, it is not surprising to see several family members of the same household to be infected with dengue virus within 24- to 36-hour time frame, where infection from a single mosquito is not impossible. During infection, the virus undergoes an incubation period of 3 to 14 days, after which the person may experience acute onset of fever with various nonspecific signs and symptoms. During this acute febrile period that would lasts from 2 to 10 days, dengue viruses may circulate in the peripheral blood. If other A. aegypti mosquitoes bite the ill person during this febrile viremic stage, the mosquito may be infected and subsequently transmit the virus to other uninfected persons (Gubler, 1998).

Figure 2 Aedes aegypti.

Four dengue virus serotypes had been identified: DEN-1, DEN-2, DEN-3 and DEN-4 which belongs to the genus Flavivirus, family Flaviviridae and contains approximately 70 viruses. Flaviviruses are relatively small (40-50 mm) and spherical with a lipid envelope. They have common epitopes on the envelope protein that result in extensive cross-reactions in serologic tests. These make unequivocal serologic diagnosis of flavivirus difficult, which is especially true among the four dengue viruses. A dengue serotype infection provides lifelong immunity to that virus but no cross-protective immunity to the other three serotypes. Thus, a person residing in an endemic dengue area can be infected with three, and probably four, dengue serotypes during their lifetime (Gubler, 1998).

Dengue studies had been conducted in different localities like Thailand, the Mexico-Texas border, Puerto Rico, Indonesia and the Philippines, where each locality is differently focusing on the microevolution of the different strains, clinical diagnosis, household-based seroepidemiologic survey, and the epidemiology of the disease in local residents (Carlos et al., 2005; Ramos et al., 2008; Porter et al., 2005; Perez et al., 2001; Jarman et al., 2008).

Dengue is an endemic viral disease affecting tropical and subtropical regions around the world, predominantly in urban and semiurban areas. Dengue fever (DF) and its more serious forms, dengue hemorrhagic fever (DHF) are becoming important public health problems and were formally included within the disease portfolio of the World Health Organization Special Programme for Research and Training in Tropical Diseases by the Joint Coordination Board in June 1999 (WHO, 1999 as cited by Huang, et. al, 2004).

Dengue virus causes a wide spectrum of illnesses, ranging from inapparent, flu-like mild undifferentiated fever, and classical DF to the more severe form, DHF-DSS, from which rates of morbidity and mortality are high (Huang, et. al, 2004). Additionally, DF is characterized by fever of 3 to 5 days’ duration, headache, muscle and joint pain, and a rash, which is self-limited and from which patients usually recover completely. There is no specific treatment for DF, and most forms of therapy are supportive in nature (Huang, et. al, 2004)
This study aimed to describe the demographic characteristics of the admitted patients in terms of age, gender and their place of origin and to develop a univariate time series model for the monthly dengue fever (DF) and dengue hemorrhagic fever (DHF) cases at Mindanao Sanitarium and Hospital located in Iligan City based on study period from 2000-2008 inclusively.

Methodology

This study was primarily conducted at Mindanao Sanitarium and Hospital, one of the tertiary hospital institutions in Iligan city, Lanao del Norte. A secondary data found in the Logbooks available at the Medical Records department of the said hospital. The researchers sought permission from the President of the hospital through the head of the medical records department where the necessary data to be gathered are on file. Upon approval of the letter, the researchers went over records of patients who were diagnosed of either dengue fever or dengue hemorrhagic. Specifically, their demographic characteristics such as: age, gender, place of residence or origin was noted. Lastly, counting the monthly number of DF and DHF from the year 2000-2008 was still considered.

This study utilized descriptive statistical technique as frequency and percentages to describe the important features of the data set in table or graphical forms. On the other hand, the tentative ARIMA models derived were analyzed with the Box-Jenkins method, which was suitable for a long a forecasting time. The Box-Jenkins method for identifying an appropriate ARIMA model for estimating and forecasting a univariate timeseries consisted of tentative identification, estimation, diagnostic checking and forecasting (Promprou, S., et. al, 2006).

In this method, one must determine first whether the time series is stationary or not. After determining if the series is stationary by way of some transformation or differencing, an ARIMA model was developed. A tentative model was made to express the each observation as a linear function of the previous value of the series (autoregressive parameter) and of the past random shock (moving average parameter). The general form of this tentative model was given below:

\[ Y_t = \delta + \phi_1 Y_{t-1} + \phi_2 Y_{t-2} + \cdots + \phi_p Y_{t-p} - \theta_1 a_{t-1} - \theta_2 a_{t-2} - \cdots - \theta_q a_{t-q} + a_t \]

where:
- \( Y_t \) denotes the number of DF/DHF cases at time \( t \).
- \( Y_{t-1} \) denotes the number of DF/DHF cases at time \( t-1 \).
- \( Y_{t-p} \) denotes the number of DF/DHF cases at time \( t-p \).
- \( \phi_1, \phi_2, \ldots, \phi_p \) are autoregressive parameters (of order \( p \)).
- \( \theta_1, \theta_2, \ldots, \theta_q \) are moving average parameters (of order \( q \)).
- \( a_t \) is a time-series of random shocks or white noise process at time \( t \).
- \( a_{t-1}, a_{t-2}, \ldots, a_{t-q} \) are statistically independent.
- \( \delta \) is a constant term.

The random shock \( a_t \) is a value that is assumed to be randomly selected from a normal distribution that has a mean 0 and variance that is constant at every time period. The random shocks \( a_t, a_{t-1}, \ldots, a_{t-q} \) are assumed to be statistically independent.

The parameters of the tentative model from the identification stage were estimated using the ARIMA module in SPSS version 13. The adequacy of the estimated tentative models was examined. Plotting the residuals against the predicted values of the estimated model was a useful diagnostic checking. The Box-Ljung statistic was used
to determine if the ACF between residuals is correlated and/or the ACF of the residuals of the estimated models fell within the 95% confidence limits.

The final stage of testing the estimated ARIMA model was its ability to forecast.

Results and Discussion

Figure 1 through 6 depicted the descriptive measures of the observed data of Dengue Fever (DF) and Dengue Hemorrhagic Fever (DHF) cases from the year 2000-2008 in Mindanao Sanitarium and Hospital, Iligan City, Lanao del Norte. Figure 1 and 2 present the summary of all the gathered data.

![Graph of Dengue Fever (DF) and Dengue Hemorrhagic Fever (DHF) cases by age](image1)

**Figure 1** Distribution of DHF and DF Cases by Age

![Graph of Dengue Fever (DF) and Dengue Hemorrhagic Fever (DHF) cases by gender](image2)

**Figure 2** Distribution of DHF and DF Cases by Gender

A total of 1599 cases of both DF and DHF had been admitted at MSH from 2000-2008. It has been noted that 62.10% (993) of the total cases acquired DF and only 37.90% (606) for DHF where more males were admitted than females (53.85% and 46.15%, respectively).
Figure 3 Distribution of DHF and DF by year

Figure 3 above revealed that the year 2000 has the lowest number of cases (1.75%) while the years 2005 and 2007 showed the highest (26.52% and 18.45%, respectively.

Figure 4 Distribution of DF according to Gender for 2000-2008

Figure 4 revealed that cases of DF are higher in males (55.09%) than females (44.91%). This result is contradictory to the results of the study conducted by Cordeiro et al. (2007) where they presented that females are more susceptible than males in Pernambuco State, Brazil (1995-2006). But this contradiction of results may suggest farther knowledge that dengue cases in different localities may be affected by the serotype predominating a locality. Hence, this will try to suggest deeper studies of the serotype causing dengue diseases in Iligan City and nearby vicinities.
By Year

Figure 5 Distribution of DHF according to Gender for 2000-2008

Also, as reflected in Figure 5, gender relationship to DHF in the years 2008-2009 revealed that 51.82% of the reported hospital cases are males. This result tries to suggest that Iligan City and nearby vicinities have a population where males are more susceptible to diseases than females.

Generally, female mosquitoes feed on animal blood, including humans. One study concluded that unfed virgin female insects are strongly attracted to humans than males and tries to suggest that some people have stronger “attraction” to mosquitoes than others (Hamilton and Ramsoondar, 2008). Some of these “attractions” were identified by Kline et al. (2003) in Aedes aegypti, the dengue mosquito. According to the other researches, female malarial mosquitoes were governed by olfactory cues that may be responsible for various behaviors of female mosquitoes. Recent evidence pointed that there exists a human-specific kairomones that affects the host-seeking mosquitoes (Takken and Knols, 1999).

Figure 6 Distribution of Location* of the Respondents

Figure 6 showed that majority of the respondents with dengue cases are coming from Iligan City which comprises more than 60% of the total cases; followed by Marawi City with 98 dengue cases or 15.83% of the total cases;12 or 2% of dengue cases belongs to other location such as Misamis Occidental, Bukidnon and some areas in Davao Region. This simply implies that since MSH is located in Iligan City, thus majority of the dengue cases reported are from this area.

*Based on reported cases since 2000-2004
**Forecasting**

This section deals on developing a univariate time series model for the monthly DF and DHF cases in MSH, Iligan City using ARIMA Model.

Figure 7 presents the non-stationary trend of monthly dengue cases in MSH from the year 2000 to 2008.

![Graph showing non-stationary trend of monthly dengue cases in MSH from 2000 to 2008.]

**Figure 7** Non-stationary Trend of Monthly Dengue Cases in MSH

The trend of the graphs revealed strong and positive autocorrelation. There does not seem to be a significant trend or any obvious seasonal pattern in the data.

*Dengue Fever (DF)*

![Graph showing autocorrelation plot of the monthly DF cases.]

**Figure 8** Autocorrelation Plot of the Monthly DF Cases
Figure 8 shows that the sample autocorrelations are very strong and dies down extremely slowly. This suggests that the process is non-stationary (not constant in mean and variance) and recommends a first order differencing (considering a difference of previous and present values). Further revealed that the mean fluctuates around zero and showed constancy of variance after first-order differencing. Figure 9 and 10 showed the autocorrelation and partial autocorrelation plot of the differenced data.

![Autocorrelation Plot](image)

**Figure 9** Autocorrelation Plot of the Differenced DF Data

![Partial Autocorrelation Plot](image)

**Figure 10** Partial Autocorrelation Plot of the Differenced DF Data

Figure 9 shows that only the autocorrelation at lag 1 is quite significant. The autocorrelation plot together with run sequence of differenced data suggests that the difference data is stationary. Based on the plot above, an MA (1) model is suggested for the differenced data. To consider some possible inclusion of autoregressive model, an evaluation of partial autocorrelation plot is needed as shown in Figure 10 (above).

Figure 10 revealed that the partial autocorrelation dies down after first lag and consider significant (beyond lower confidence limit). Even though there are some significant lags after lag 1 but not fall at seasonal lag so they are consider not significant. This simply recommends an AR (1) model for the differenced DF data.
As evaluated above, it was shown that the tentative model is first-order autoregressive, first order differencing and first order moving average. To estimate the parameter, Table 1 below presented the concise result.

<table>
<thead>
<tr>
<th>Model</th>
<th>Estimates</th>
<th>Std. Error</th>
<th>t</th>
<th>Approx Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR (1)</td>
<td>0.780</td>
<td>0.086</td>
<td>9.027</td>
<td>0.000***</td>
</tr>
<tr>
<td>MA (1)</td>
<td>0.985</td>
<td>0.085</td>
<td>11.586</td>
<td>0.000***</td>
</tr>
<tr>
<td>Constant</td>
<td>0.054</td>
<td>0.088</td>
<td>0.620</td>
<td>0.537</td>
</tr>
</tbody>
</table>

***-significant at 0.001 level of significance

Table 1 revealed that the estimates of AR (1) and MA (1) are all statistically significant, which could probably be included in the model. This implied that the parameter estimates are significantly different from zero. The forecast model for the differenced DF data, $Y_t$ is an ARIMA (1,1,1) model:

$$Y_t = 1.78Y_{t-1} - 0.78Y_{t-2} - 0.985a_{t-1} + 0.054$$

where:
- $Y_t$ represented the number of DF cases at time $t$
- $Y_{t-1}$ represented the number of DF cases at time $t-1$
- $Y_{t-2}$ represented the number of DF cases at time $t-2$
- $a_{t-1}$ represented white noise process at time $t-1$

To further evaluate the proposed tentative model in terms of its accuracy and predictive ability, a predicted versus residual values plot of the differenced DF data was presented in Figure 11.

Figure 11 showed that the residuals in the model did not exhibit significant trend in variation as predicted values increased. This further implied that the residuals fluctuate randomly around zero mean. The autocorrelation function of residuals showed no significant spikes ($Q$ Box-Ljung Statistics = 3.13, $X^2_{0.05,32} = 18.5$).

The figure below presented the observed and predicted values of DF cases from 2000-2008.
**Dengue Hemorrhagic Fever (DHF)**

As evidently seen in Figure 7, the graphical trend of DHF data is not stationary and needs some transformation or differencing. Figure 13 below sufficed the proof of its non-stationary series since the autocorrelation function dies down extremely slowly as lag number increased.

**Figure 13 Autocorrelation Plot of the Monthly DHF Cases**

Figure 13 revealed that the autocorrelation function geometrically decayed at several lags which constitute non-stationary series. Further implication showed that most of the lags fall outside the 95% confidence limit. This showed that the series is not stationary and needs a transformation by taking a natural log (not constant in variance). The autocorrelation and partial autocorrelation plot of the transformed series is presented in Figure 14 and 15.
Figure 14 depicted that the autocorrelation function of the natural log DHF data dies down extremely slowly. This implied that no significant tentative model available for moving average operator of order $p$. Figure 15 showed that the partial autocorrelation function dies down after lag 1. This suggested that lag 1 is a significant spike. A proposed first-order autoregressive AR (1) is recommended.

To determine if the parameter estimates of the tentative forecast model are not significantly different from zero, a model estimates is performed.

<table>
<thead>
<tr>
<th>Model</th>
<th>Estimates</th>
<th>Std. Error</th>
<th>t</th>
<th>Approx Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR (1)</td>
<td>0.822</td>
<td>0.056</td>
<td>14.698</td>
<td>&lt;.001***</td>
</tr>
<tr>
<td>Constant</td>
<td>1.435</td>
<td>0.304</td>
<td>4.722</td>
<td>&lt;.001***</td>
</tr>
</tbody>
</table>

Table 2 revealed that only the parameter estimates of AR (1) model is significantly different from zero ($p < .001$). The forecast model for the natural log transformed DHF data is given by:

$$Y_t = 0.822Y_{t-1} + 1.435$$

Where:
represented the natural log number of DHF cases at time $t$

$Y_t$ represented the natural log number of DHF cases at time $t$

$Y_{t-1}$ represented the natural log number of DHF cases at time $t-1$

$a_{t-1}$ represented white noise process at time $t-1$

**Figure 16** Predicted versus Residuals of the Differenced DHF Data

Figure 16 showed that the residuals of the second differenced DHF data did not exhibit significant trend in variation (either linear or not) as predicted values increased. This further suggested that the residuals fluctuate randomly around zero mean. The autocorrelation function of residuals showed no significant spikes (Q Box-Ljung Statistics = 5.08, $X_{0.05,32}^2 = 18.5$).

The figure below presented the observed and predicted values of DHF cases from 2000-2008.

**Figure 17** Plot of the Observed and Predicted Values of DHF Data

Figure 17 displayed that the observed and predicted values of the natural log transformed data fitted well.
Conclusions

The study concluded that both sexes tend to be more susceptible in acquiring both DF and DHF ($p > .05$). In terms of age, younger patients contact DHF more than DF. Also, it has been noted that alternating increase-decrease pattern of the number of cases of these diseases is consistent throughout the study period.

The forecast curve models developed by the researchers showed consistent trend with the pattern of observed values. The autocorrelation functions of residuals among the three forecast models were not significantly different from zero or the residuals are uncorrelated. Therefore, the three forecast curve models developed are accurate and useful for prediction of possible occurrences of dengue cases as the data per se.

Recommendations of the study includes: (1) the identification of the dengue serotypes causing these diseases in Iligan and nearby vicinities; (2) extension of the research locale which will include private and public hospitals; (3) correlation of other personal data from patients which includes stress factors, diet, home environment and blood type; (4) the forecast models developed offers the potential for improve contingency planning of public health intervention in Iligan City; and (5) the introduction of the derived result to the public via forums.

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http://www.ajtmh.org/cgi/reprint/71/4_suppl/1.pdf?ck=nck (for 12 months old study in Thailand)