

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

What is microcephaly?

Microcephaly is condition where a baby's head is much smaller than expected. During pregnancy, a baby's head grows because the baby's brain grows. Microcephaly can occur because a baby's brain has not developed properly during pregnancy or has stopped growing after birth, which results in a smaller head size.



Baby with Microcephaly

Baby with Typical Head Size



Microcephaly can be an isolated condition, meaning that it can occur with no other major birth defects, or it can occur in combination with other major birth defects.

Babies with microcephaly can have a range of other problems, depending on how severe their microcephaly is.

Microcephaly has been linked with the following problems:

- Seizures
- Developmental delay, such as problems with speech or other developmental milestones (like sitting, standing, and walking)
- Intellectual disability (decreased ability to learn and function in daily life)
- Problems with movement and balance
- Feeding problems, such as difficulty swallowing
- Hearing loss
- Vision problems

These problems can range from mild to severe and are often lifelong. In some cases, these problems can be life-threatening. Because it is difficult to predict at birth what problems a baby will have from microcephaly, babies with microcephaly often need close follow-up through regular check-ups with a healthcare provider to monitor their growth and development.

Source: <http://www.cdc.gov/ncbddd/birthdefects/microcephaly.html>

EPI WEEK 1



SYNDROMES

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CLASS 1 DISEASES

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INFLUENZA

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GASTROENTERITIS

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NOTIFICATIONS-
All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE-30 sites*. Actively pursued



SENTINEL REPORT- 79 sites*. Automatic reporting

*Incidence/Prevalence cannot be calculated

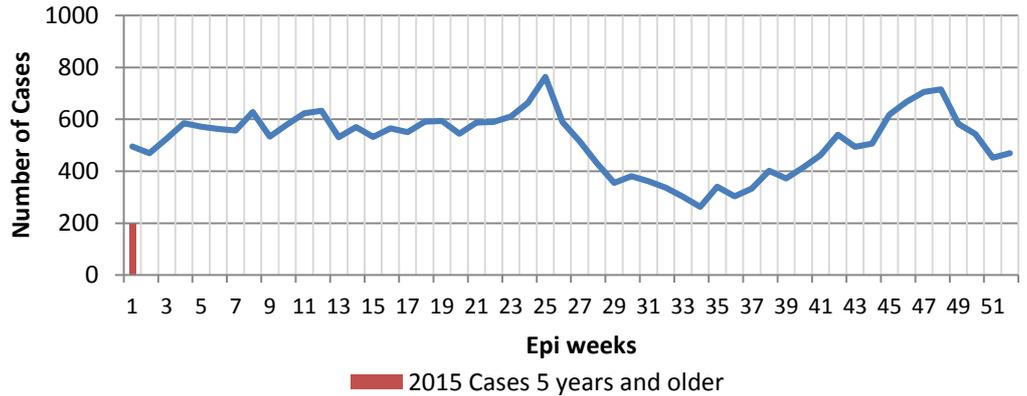
REPORTS FOR SYNDROMIC SURVEILLANCE

GASTROENTERITIS

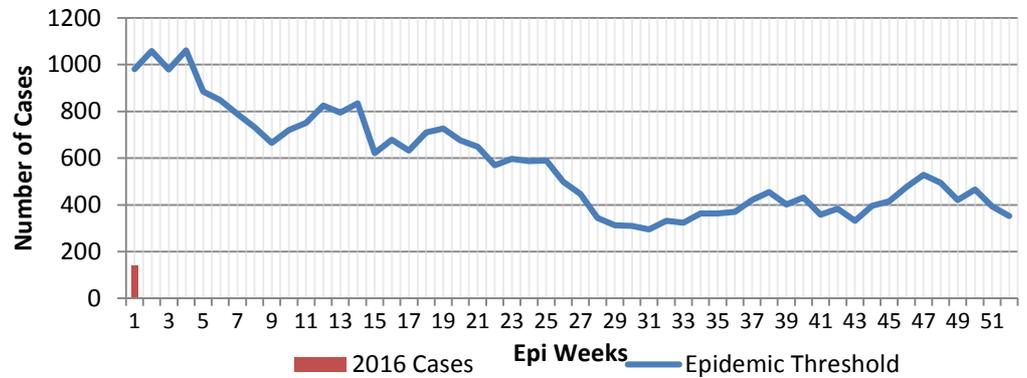
Three or more loose stools within 24 hours.



GE ≥5 Weekly Threshold vs Cases 2016, EW 1



GE <5 Weekly Threshold vs Cases 2016, EW 1

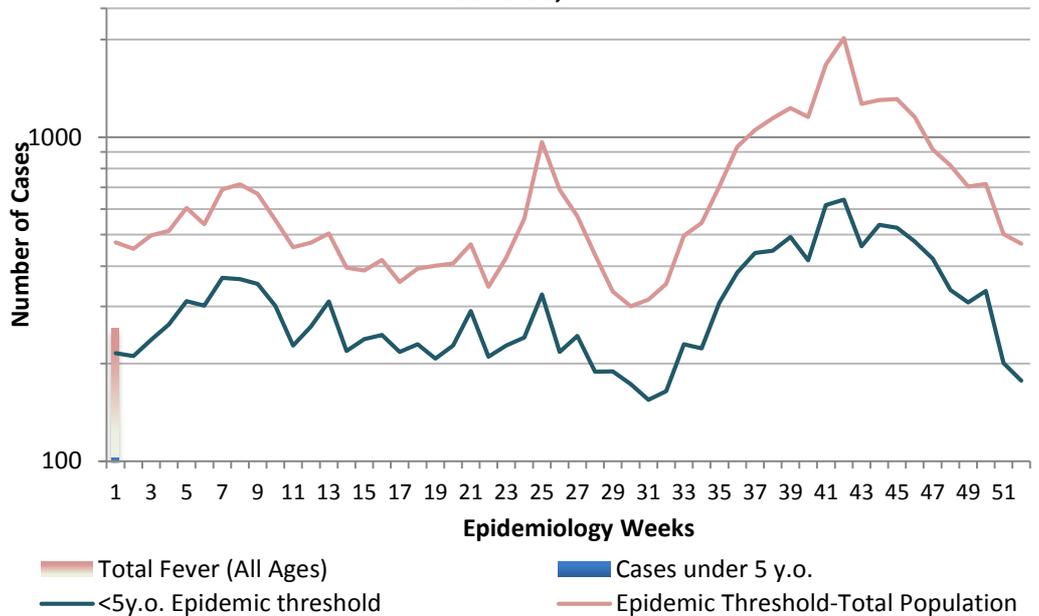


FEVER

Temperature of $>38^{\circ}C$ / $100.4^{\circ}F$ (or recent history of fever) with or without an obvious diagnosis or focus of infection.



Fever in under 5y.o. and Total Population 2016 vs Epidemic Thresholds, EW 1



NOTIFICATIONS- All clinical sites

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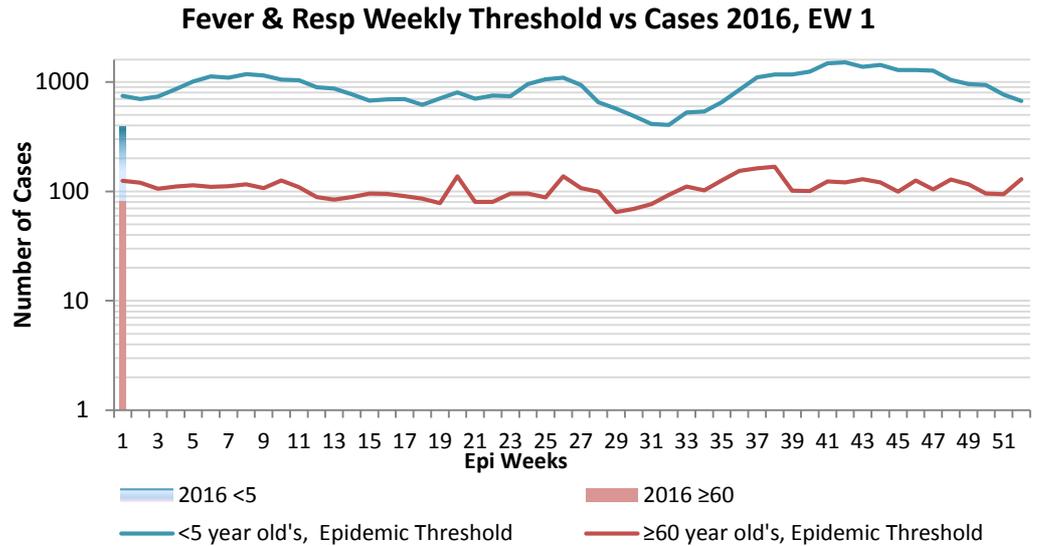
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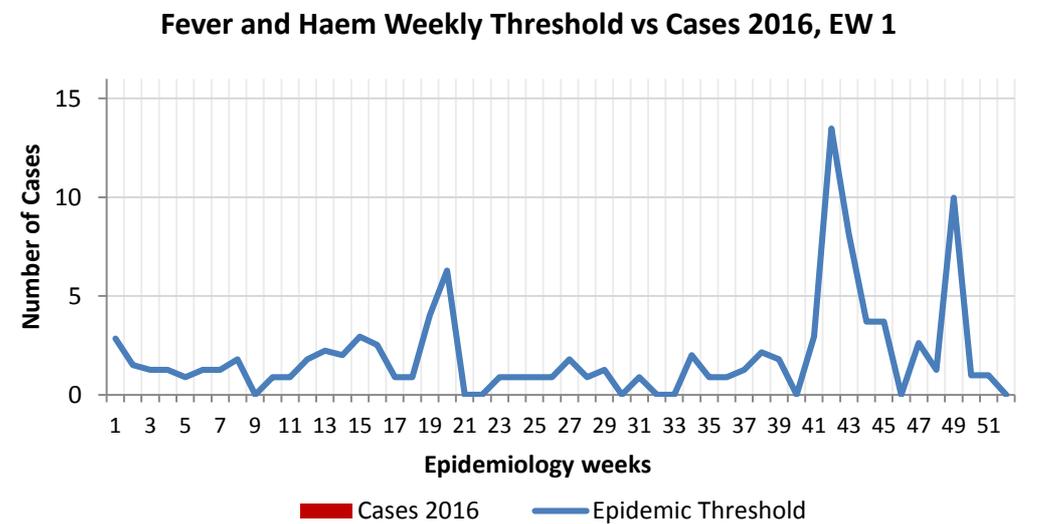
FEVER AND RESPIRATORY

Temperature of $>38^{\circ}\text{C}$ / 100.4°F (or recent history of fever) in a previously healthy person with or without respiratory distress presenting with either cough or sore throat.



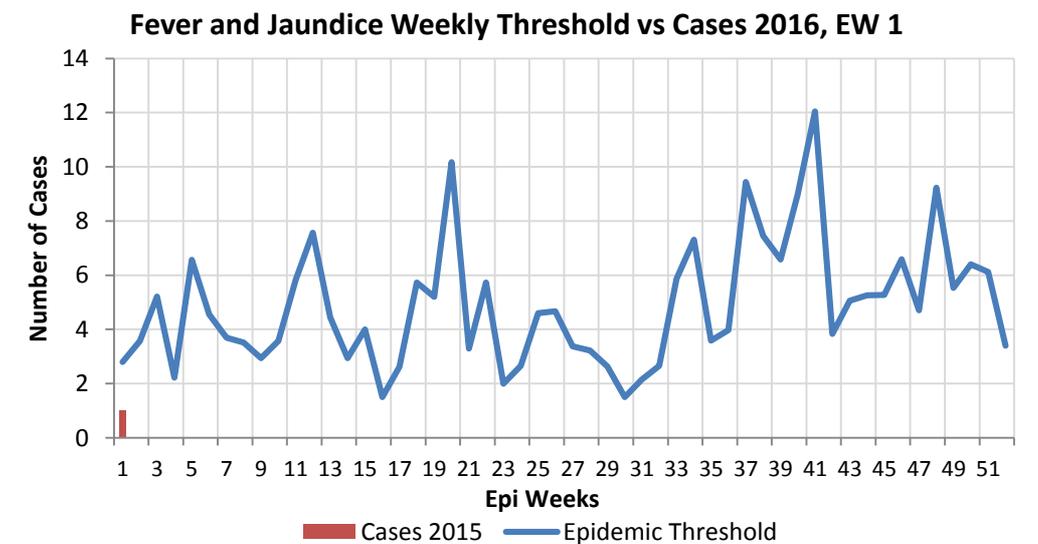
FEVER AND HAEMORRHAGIC

Temperature of $>38^{\circ}\text{C}$ / 100.4°F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



FEVER AND JAUNDICE

Temperature of $>38^{\circ}\text{C}$ / 100.4°F (or recent history of fever) in a previously healthy person presenting with jaundice.



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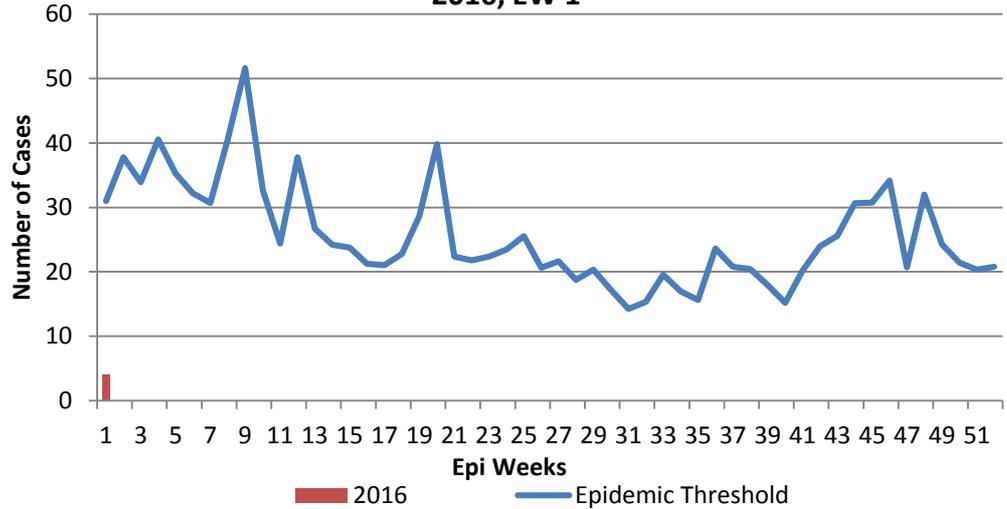
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FEVER AND NEUROLOGICAL

Temperature of $>38^{\circ}\text{C}$ / 100.4°F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).



Fever and Neurological Symptoms Weekly Threshold vs Cases 2016, EW 1

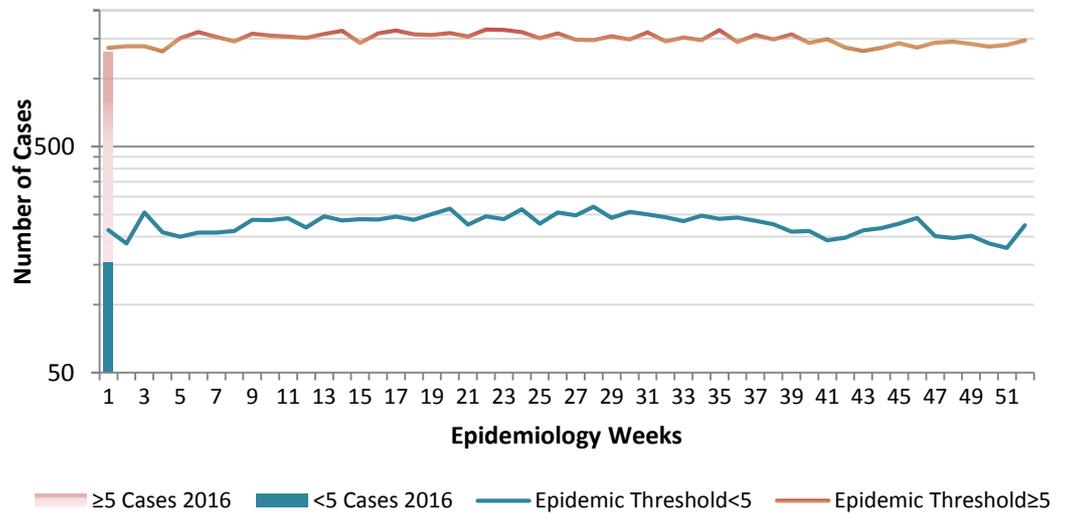


ACCIDENTS

Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



Accidents Weekly Threshold vs Cases 2016

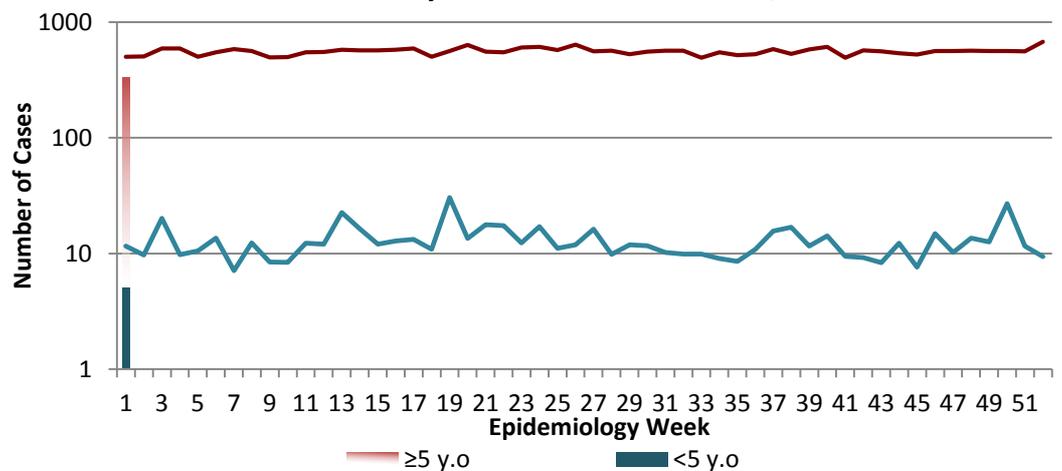


VIOLENCE

Any injury for which the cause is intentional, e.g. gunshot wounds, stab wounds, etc.



Violence Weekly Threshold vs Cases 2016, EW 1



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— CLASS ONE NOTIFIABLE EVENTS and LEPTOSPIROSIS

Comments

	CLASS 1 EVENTS	CONFIRMED YTD			
		CURRENT YEAR	PREVIOUS YEAR		
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	5	9	AFP Field Guides from WHO indicate that for an effective surveillance system, detection rates for AFP should be 1/100,000 population under 15 years old (6 to 7) cases annually. Pertussis-like syndrome and Tetanus are clinically confirmed classifications.	
	Cholera	0	0		
	Dengue Hemorrhagic Fever ¹	0	0		
	Hansen's Disease (Leprosy)	0	0		
	Hepatitis B	0	1		
	Hepatitis C	0	0		
	HIV/AIDS - See HIV/AIDS National Programme Report				
	Malaria (Imported)	1	0		
	Meningitis	3	10		
EXOTIC/ UNUSUAL	Plague	0	0	The TB case detection rate established by PAHO for Jamaica is at least 70% of their calculated estimate of cases in the island, this is 180 (of 200) cases per year.	
HIGH MORBIDITY/ MORTALITY	Meningococcal Meningitis	0	0		
	Neonatal Tetanus	0	0		
	Typhoid Fever	0	0		
	Meningitis H/Flu	0	0		
SPECIAL PROGRAMMES	AFP/Polio	0	0	*Data not available	
	Congenital Rubella Syndrome	0	0		
	Congenital Syphilis	0	0	**Leptospirosis is awaiting classification as class 1, 2 or 3	
	Fever and Rash	Measles	0		0
		Rubella	0		0
	Maternal Deaths ²	0	0		
	Ophthalmia Neonatorum	5	14	1 Dengue Hemorrhagic Fever data include Dengue related deaths;	
	Pertussis-like syndrome	0	0		
	Rheumatic Fever	0	0	2 Maternal Deaths include early and late deaths.	
	Tetanus	0	0		
Tuberculosis	0	0			
Yellow Fever	0	0	 		
UNCLASSIFIED**	Leptospirosis	1	0		



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NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 1

January 3– January 9, 2016

Epidemiology Week 1

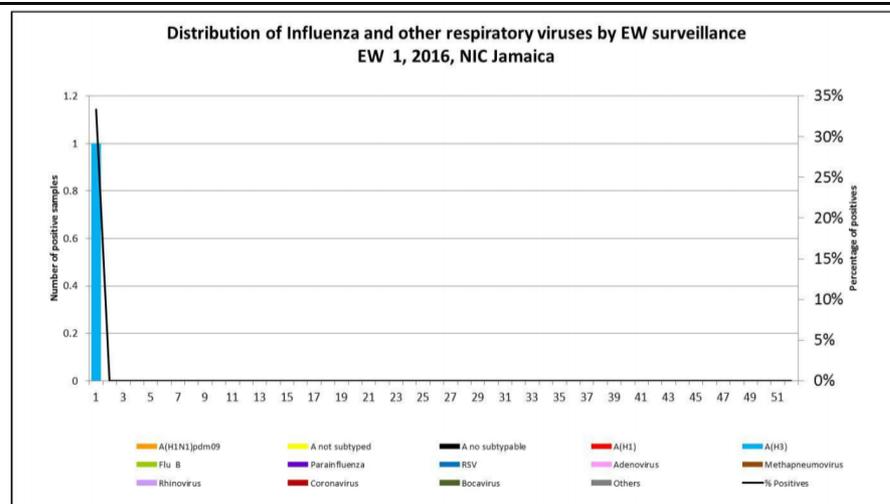
January, 2016		
	<i>EW 1</i>	<i>YTD</i>
SARI cases	28	28
Total Influenza positive	<i>1</i>	<i>1</i>
Samples		
<u>Influenza A</u>	<i>1</i>	<i>1</i>
H3N2	<i>1</i>	<i>1</i>
H1N1pdm09	<i>0</i>	<i>0</i>
Influenza B	<i>0</i>	<i>0</i>

Admitted Lower Respiratory Tract Infection and LRTI-related Deaths

	Current year		Previous year	
	Week 1 2016	YTD 2016	Week 1 2015	YTD 2015
 Admitted Lower Respiratory Tract Infections	72	72	84	84
Pneumonia-related Deaths	2	2	0	0

Comments:

The percent positivity of influenza viruses circulating among respiratory samples tested in EW 1, 2016 was 33%. Influenza A/H3N2 was the only virus detected. This virus sub-type is included in the annual influenza vaccine. There has been no detection of the influenza variant A/H3 virus (A/H3N2v), influenza Avian H5 or H7 viruses among samples tested.



INDICATORS

Burden

Year to date, respiratory syndromes account for 3.7% of visits to health facilities.

Incidence

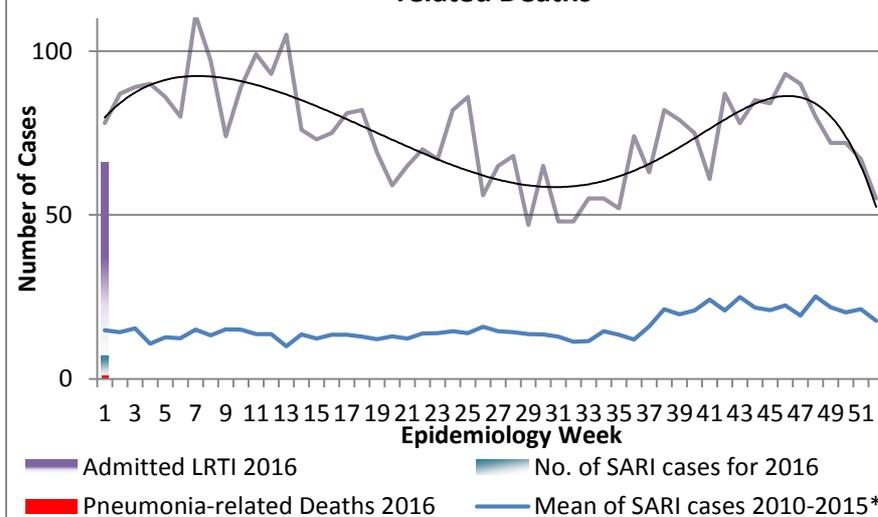
Cannot be calculated, as data sources do not collect all cases of Respiratory illness.



Prevalence

Not applicable to acute respiratory conditions.

2016 Cases of Admitted LRTI, SARI, Pneumonia related Deaths



***Additional data needed to calculate Epidemic Threshold**



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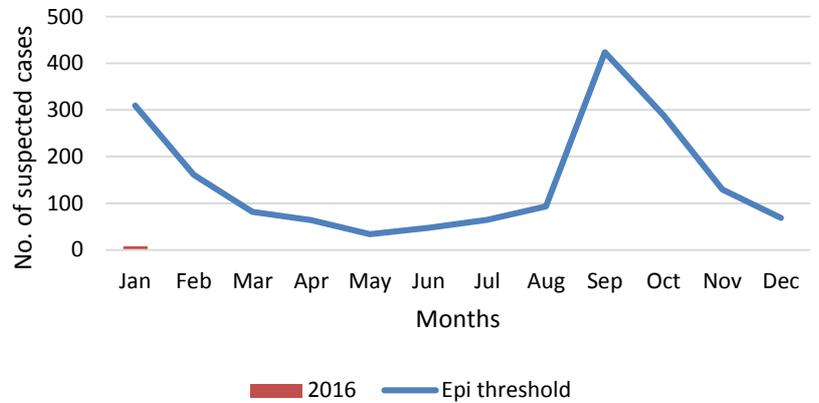
Dengue Bulletin

January 3 –January 9, 2016

Epidemiology Week 1



2016 Cases vs. Epidemic Threshold

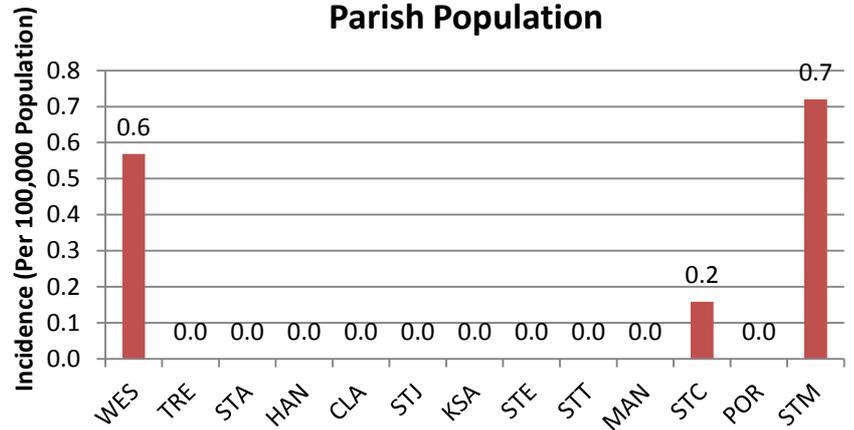


DISTRIBUTION

Year-to-Date Suspected Dengue Fever

	M	F	Total	%
<1	0	0	0	0
1-4	1	0	1	33
5-14	1	0	1	33
15-24	0	1	1	34
25-44	0	0	0	0
45-64	0	0	0	0
≥65	0	0	0	0
Unknown	0	0	0	0
TOTAL	2	1	3	100

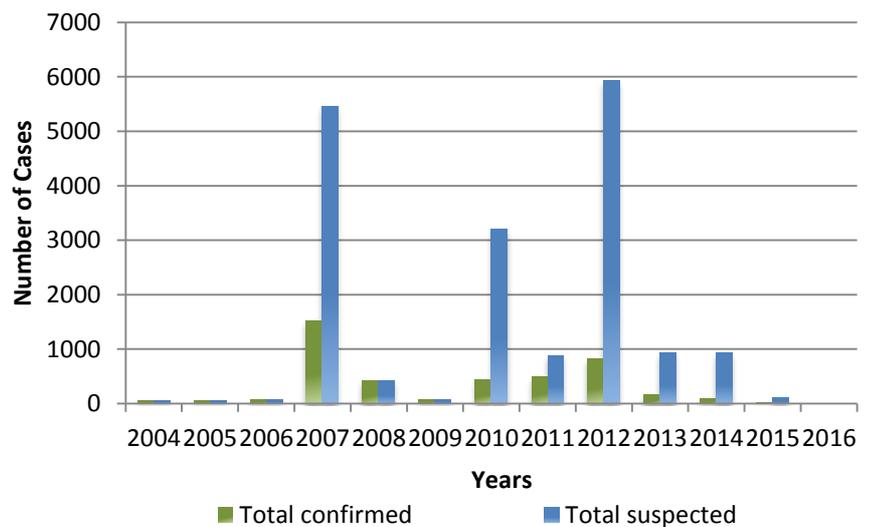
Suspected Dengue Fever Cases per 100,000 Parish Population



Weekly Breakdown of suspected and confirmed cases of DF,DHF,DSS,DRD

		2016		2015 YTD
		EW 1	YTD	
Total Suspected Dengue Cases		3	3	2
Lab Confirmed Dengue cases		0	0	0
CONFIRMED	DHF/DSS	0	0	0
	Dengue Related Deaths	0	0	0

Dengue Cases by Year: 2004-2016, Jamaica



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Gastroenteritis Bulletin

EW
1

January 3 –January 9, 2016

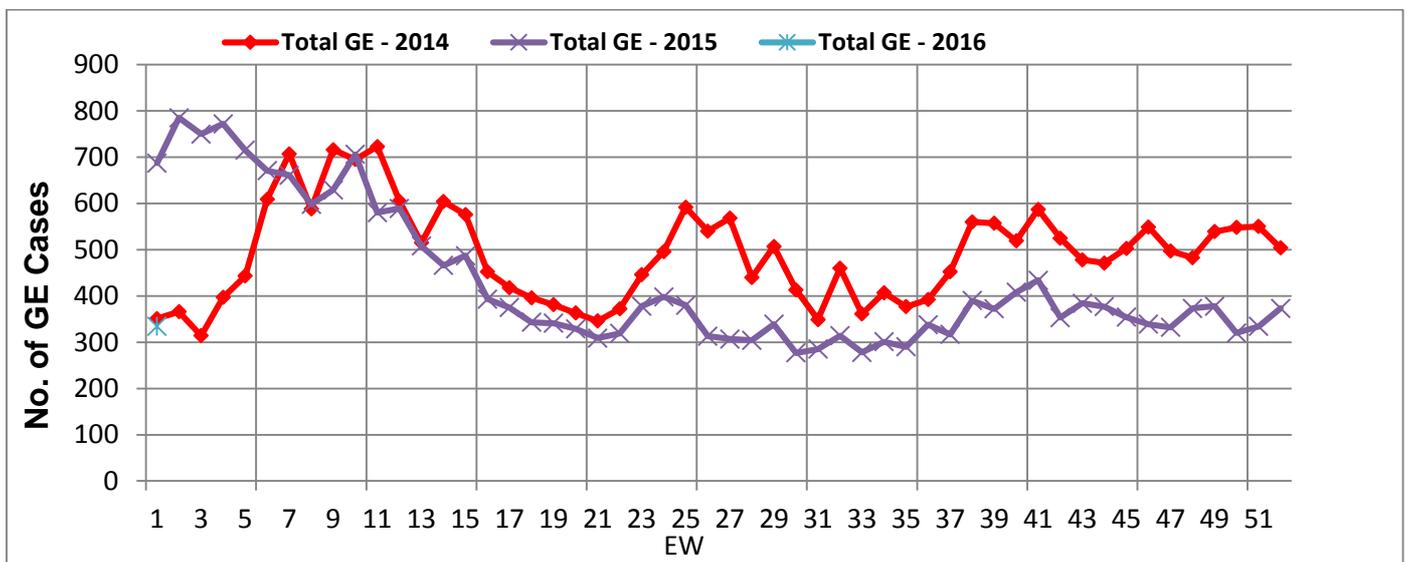
Epidemiology Week 1

Weekly Breakdown of Gastroenteritis cases

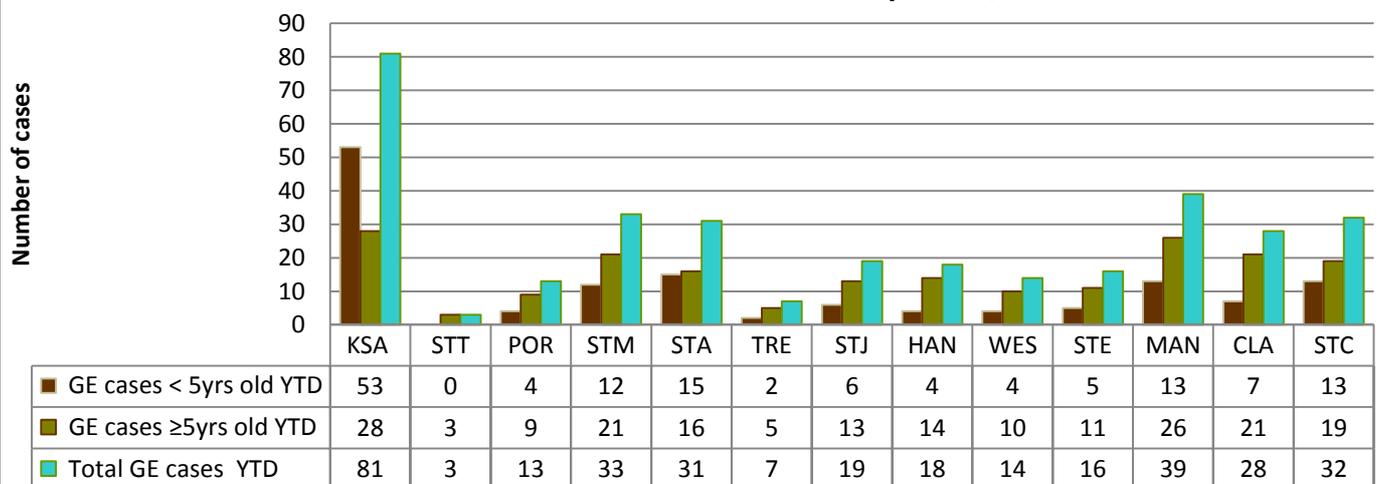
Year	EW 1			YTD		
	<5	≥5	Total	<5	≥5	Total
2016	138	196	334	138	196	334
2015	386	301	687	386	301	687

In Epidemiology Week 1, 2016, the total number of reported GE cases showed a 51% decrease compared to EW 1 of the previous year. The year to date figure showed a 51% decrease in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2014-2016



Total number of GE cases Year To Date by Parish, 2016



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RESEARCH PAPER

Strengthening Health Care Systems for HIV and AIDS in Jamaica: A Programme of Research and Capacity Building 2007-2012

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³Great Lakes University of Kisumu, Kenya,

⁴University of Alberta, Canada

⁵Canadian Nurses' Association, Canada,

⁶Mulago Hospital, Uganda

⁷University of Western Cape, South Africa,

⁸University of Lethbridge, Canada

Objectives: To contribute to health systems strengthening for HIV and AIDS care in Jamaica by fostering dynamic and sustained engagement of nurses in the process of change through capacity building in research and policy.

Methods: This work was done as part of an international program of research which was implemented in Jamaica and three African countries (Kenya, Uganda and South Africa). Using mixed methods and participatory action research, we tested the "leadership hub model" to invigorate nurses' involvement in policy and research and improve nursing care. Data collection included cross sectional surveys of nurses on clinical practice, quality assurance and stigma; an institutional assessment of workplace policies and the impact of the HIV epidemic on the nursing workforce. Capacity building included training in the policy development process, training in research skills including opportunities for collaborating on research projects, research grants for junior investigators, and research internships for nurses.

Results: Three research projects were completed in Jamaica. Sixteen (16) Jamaican nurses participated in the international research internship to build capacity for research. Frontline nurses, nurse researchers, and decision makers improved capacity in using and leading research to influence policy. Three (3) research proposals by junior nurse researchers and three (3) HIV policy evaluation proposals by leadership hubs were funded and successfully completed.

Conclusions: This program of research built research and policy capacity among nurses for leadership roles in improving equity, quality and efficiency of health systems for HIV and AIDS care. Findings from the three interrelated research projects will be presented.



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