

WEEKLY EPIDEMIOLOGY BULLETIN

EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

Flood Waters or Standing Waters



Source: livejamaicauupdates.com/flash-flood-watch-in-effect-for-eastern-central-parishes

Health Risks

Flood waters and standing waters pose various risks, including infectious diseases, chemical hazards, and injuries.

Diarrheal Diseases

Eating or drinking anything contaminated by flood water can cause diarrheal disease.

Chemical Hazards

Be aware of potential chemical hazards during floods. Flood waters may have moved hazardous chemical containers of solvents or other industrial chemicals from their normal storage places.

Drowning

Flood water poses drowning risks for everyone, regardless of their ability to swim. Swiftly moving shallow water can be deadly, and even shallow standing water can be dangerous for small children.

Vehicles do not provide adequate protection from flood waters. They can be swept away or may stall in moving water.

Electrical Hazards

Avoid downed power lines.

Wounds

Flood waters may contain sharp objects, such as glass or metal fragments, that can cause injury and lead to infection.

Cleanup of Flood Water

When returning to your home after a flooding emergency, be aware that flood water may contain sewage.

Adapted from:

www.cdc.gov/healthywater/emergency/flood/standing.htm



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

EPI WEEK 33

SYNDROMES



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CLASS 1 DISEASES

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INFLUENZA

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DENGUE FEVER

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GASTROENTERITIS

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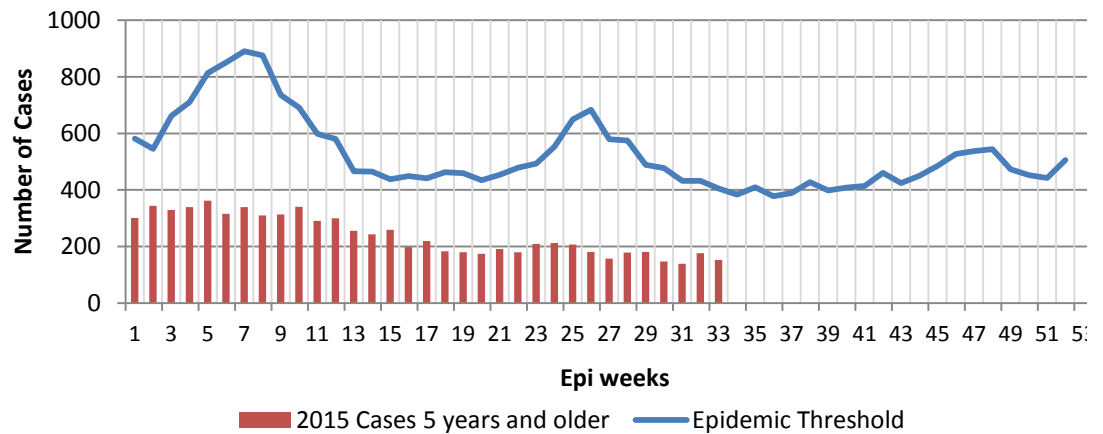
REPORTS FOR SYNDROMIC SURVEILLANCE

GASTROENTERITIS

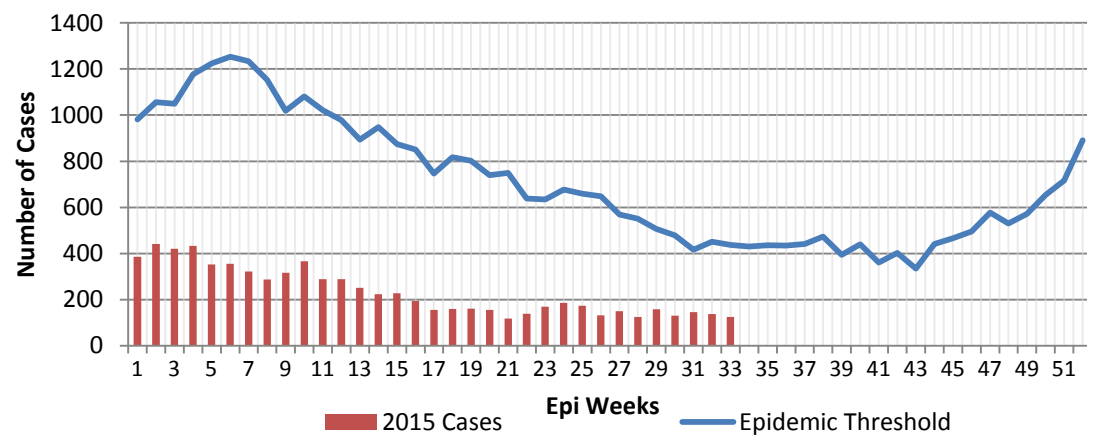
Three or more loose stools within 24 hours.



GE ≥5 Weekly Threshold vs Cases 2015, EW 1-33



GE <5 Weekly Threshold vs Cases 2015, EW 1-33

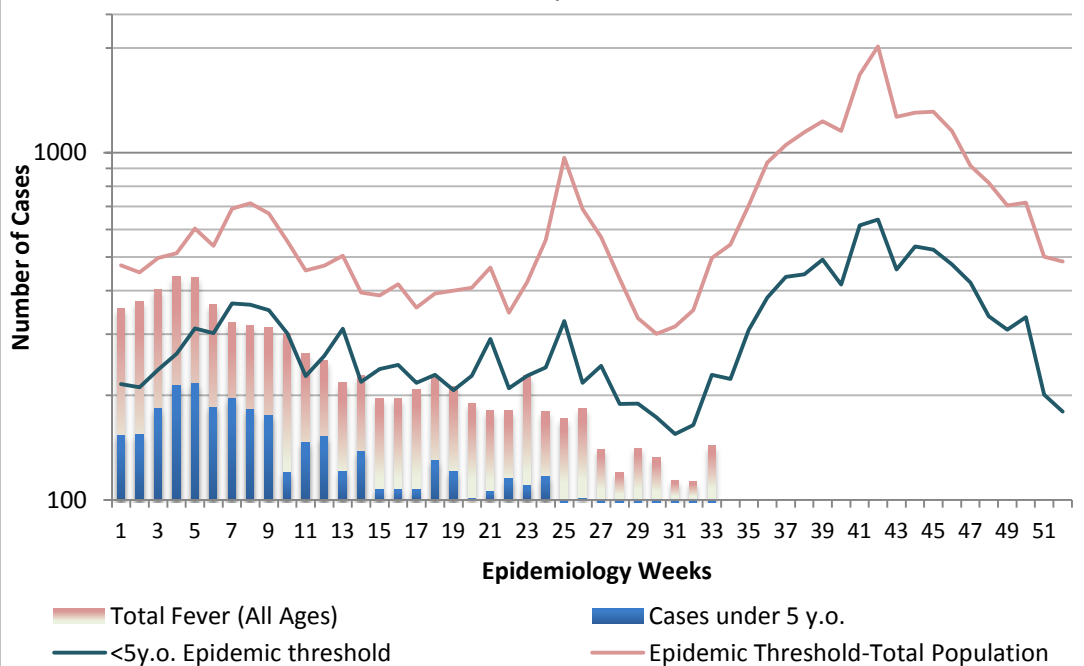


FEVER

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 2015 vs Epidemic Thresholds, EW 1-33



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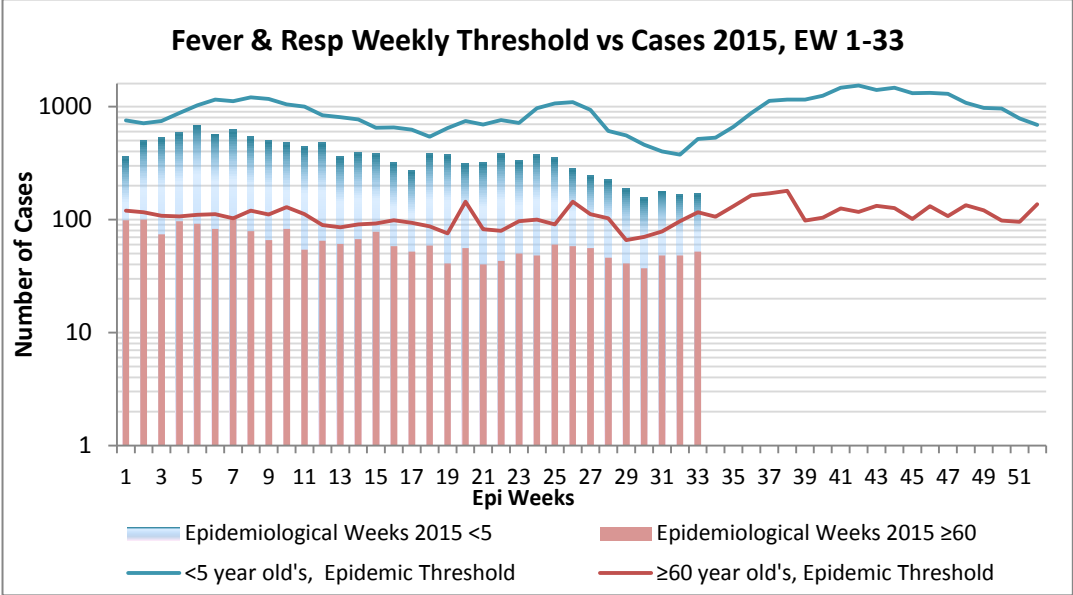
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REPORTS FOR SYNDROMIC SURVEILLANCE

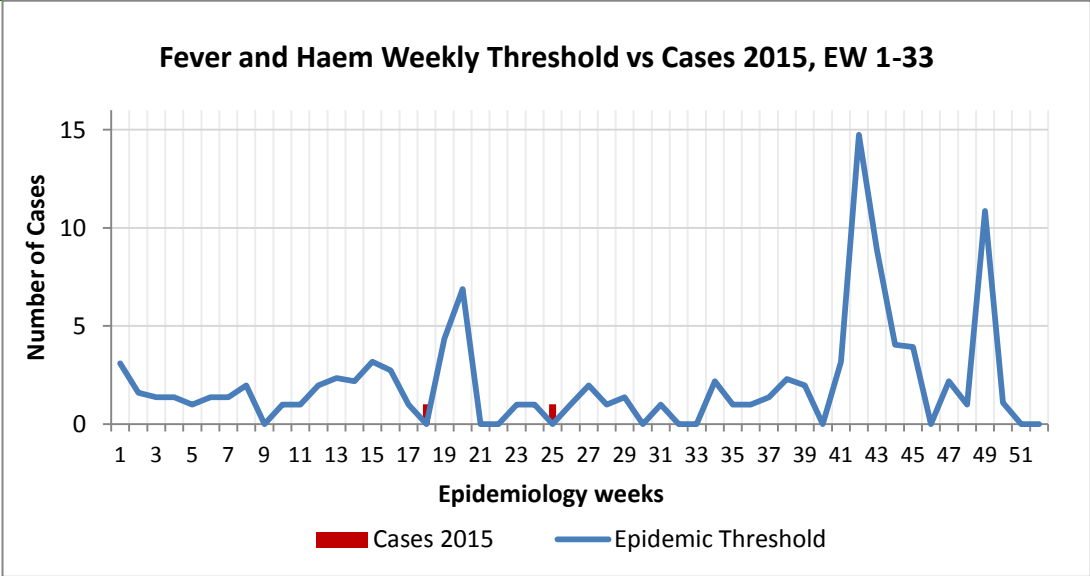
FEVER AND RESPIRATORY

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



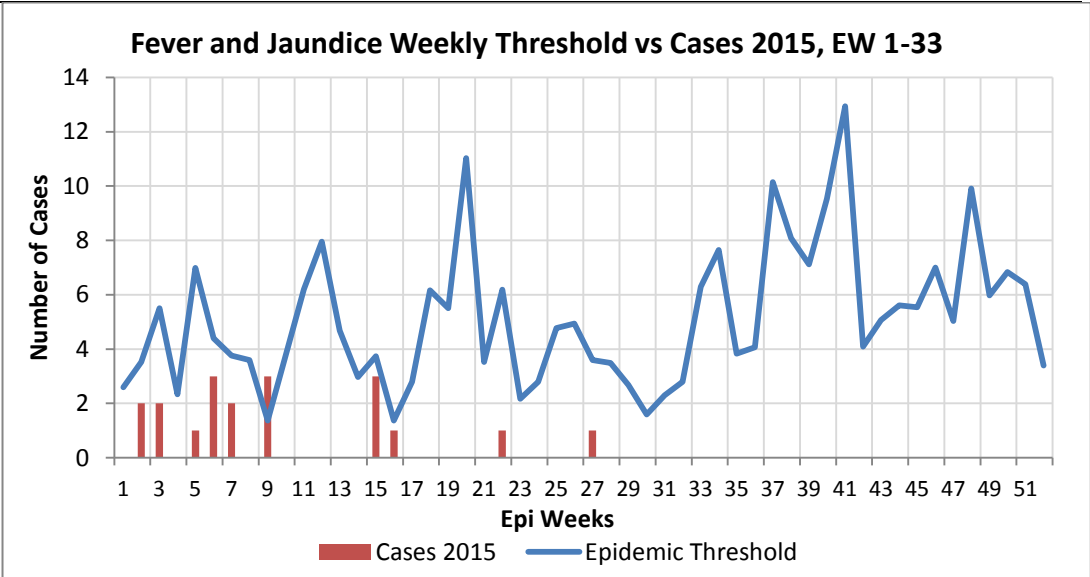
FEVER AND HAEMORRHAGIC

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



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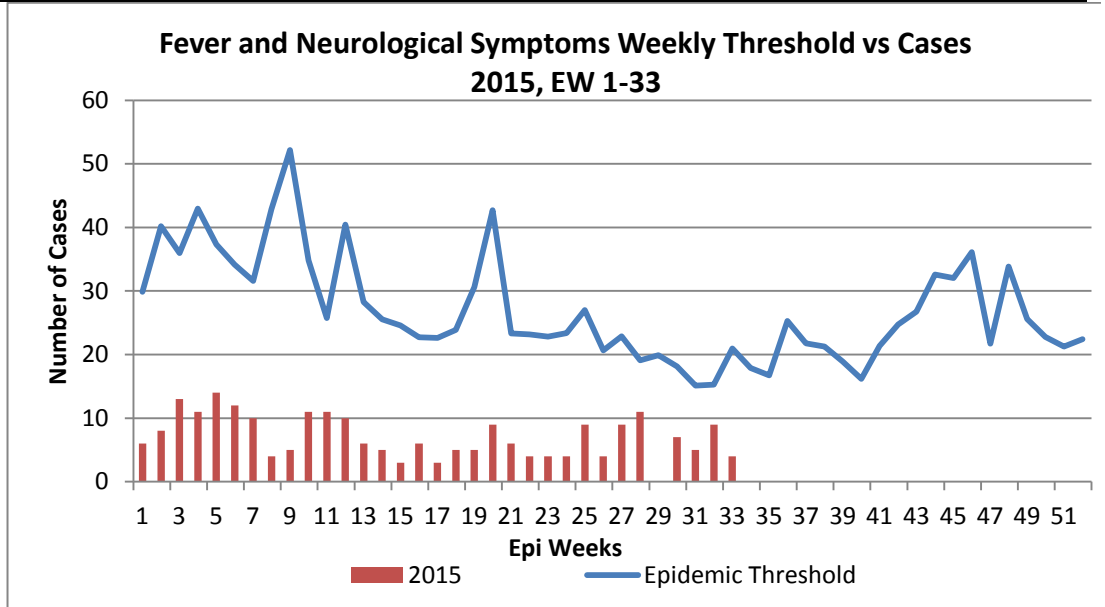
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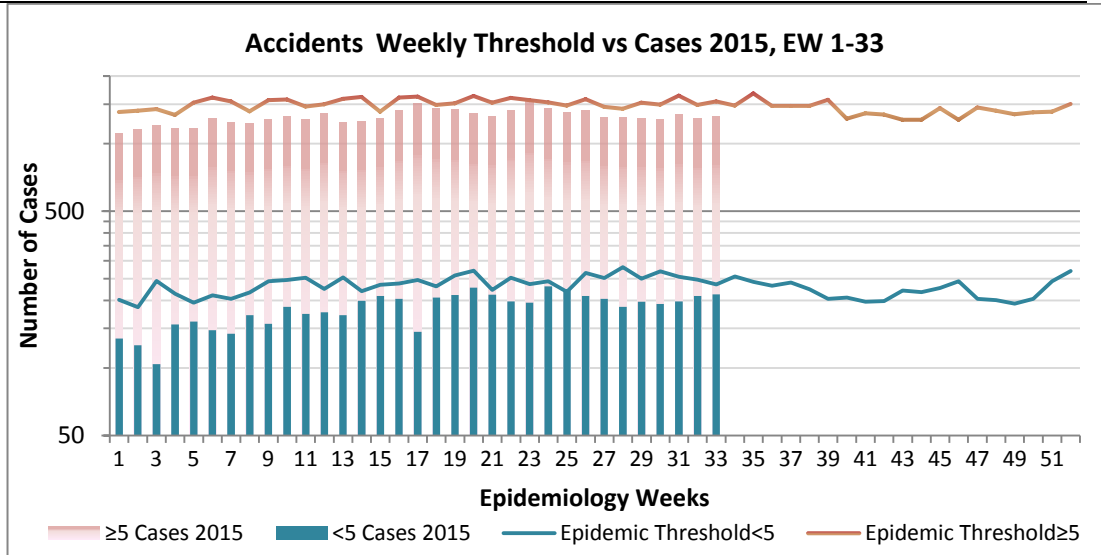
FEVER AND NEUROLOGICAL

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).



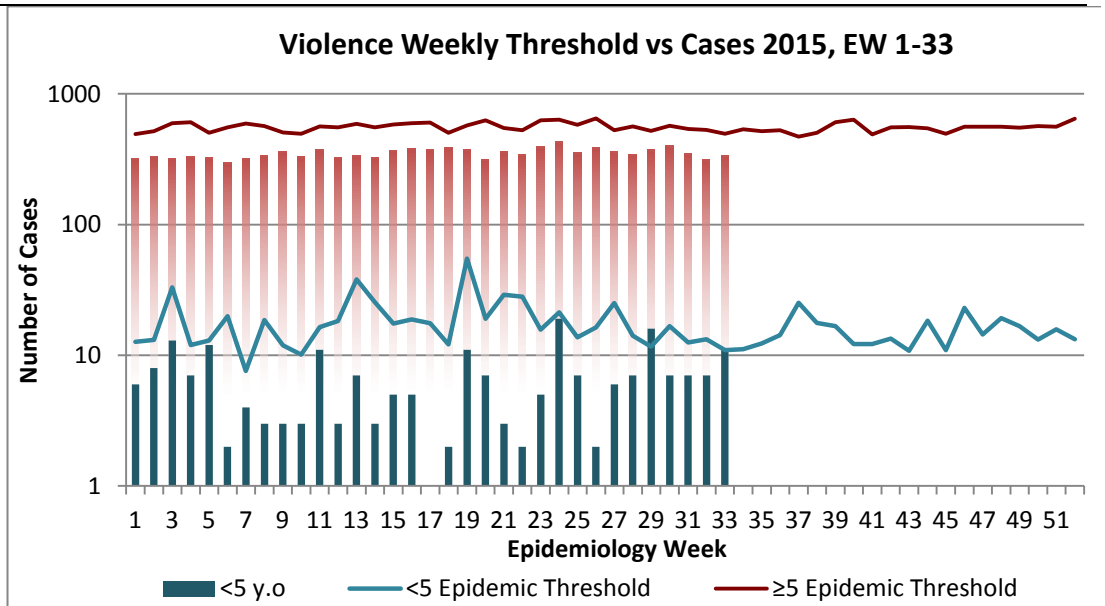
ACCIDENTS

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



VIOLENCE

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



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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	392	408	
	Cholera	0	0	
	Dengue Hemorrhagic Fever ¹	0	0	
	Hansen's Disease (Leprosy)	1	1	
	Hepatitis B	13	48	
	Hepatitis C	2	9	
	HIV/AIDS - See HIV/AIDS National Programme Report			
	Malaria (Imported)	2	1	
	Meningitis	231	473	
EXOTIC/ UNUSUAL	Plague	0	0	
HIGH MORBIDITY/ MORTALITY	Meningococcal Meningitis	0	0	
	Neonatal Tetanus	0	0	
	Typhoid Fever	3	0	
	Meningitis H/Flu	0	0	
	AFP/Polio	0	0	
SPECIAL PROGRAMMES	Congenital Rubella Syndrome	0	0	
	Congenital Syphilis	0	0	
	Fever and Rash	Measles	0	0
		Rubella	0	0
	Maternal Deaths ²	26	35	
	Ophthalmia Neonatorum	161	192	
	Pertussis-like syndrome	0	0	
	Rheumatic Fever	5	14	
	Tetanus	1	0	
	Tuberculosis	45	39	
Yellow Fever	0	0		
UNCLASSIFIED**	Leptospirosis	16	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.

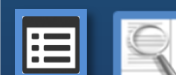
The TB case detection rate established by PAHO for Jamaica is at least 90% of their calculated estimate of cases in the island, this is 180 (of 200) cases per year.


*Data not available

**Leptospirosis is awaiting classification as class 1, 2 or 3

¹ Dengue Hemorrhagic Fever data include Dengue related deaths;

² Maternal Deaths include early and late deaths.



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NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

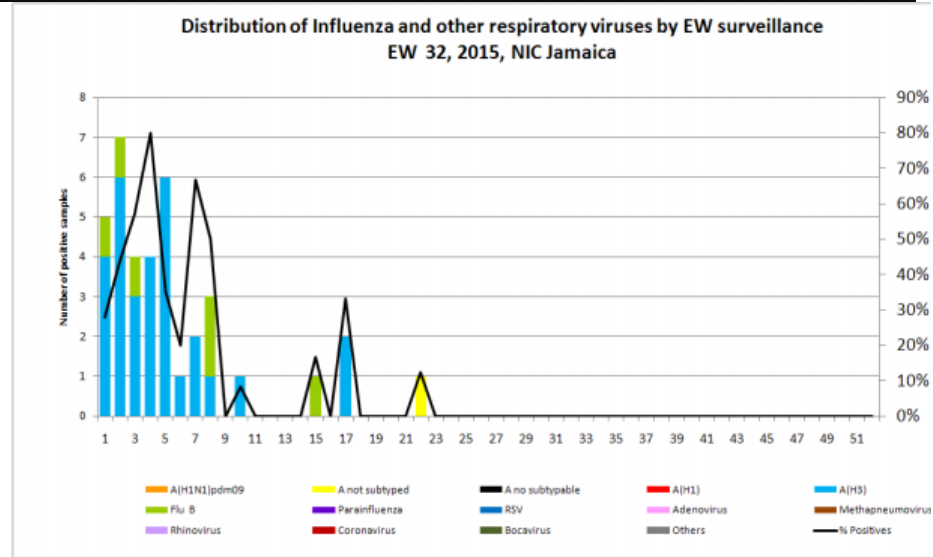
EW 33

August 16 – August 22, 2015

Epidemiology Week 33

August, 2015			Admitted Lower Respiratory Tract Infection and LRTI-related Deaths				
	EW 33	YTD	Current year		Previous year		
			Week 33 2015	YTD 2015	Week 33 2014	YTD 2014	
SARI cases	8	575					
Total Influenza positive	0	37					
Samples			Admitted Lower Respiratory Tract Infections	55	2562	54	2218
Influenza A	0	31	Pneumonia-related Deaths	0	41	5	51
H3N2	0	30					
H1N1pdm09	0	0					
Influenza B		6					

Comments:
 Influenza A/H3N2 is the predominant circulating virus (81%), while Influenza B Yamagata continues to circulate at low levels of 16%. Both viruses are components of the 2014 -2015 Influenza Vaccines for the Northern Hemisphere. There has been no detection of the influenza variant A/H3 virus (A/H3N2v), influenza Avian H5 or H7 viruses among samples tested.

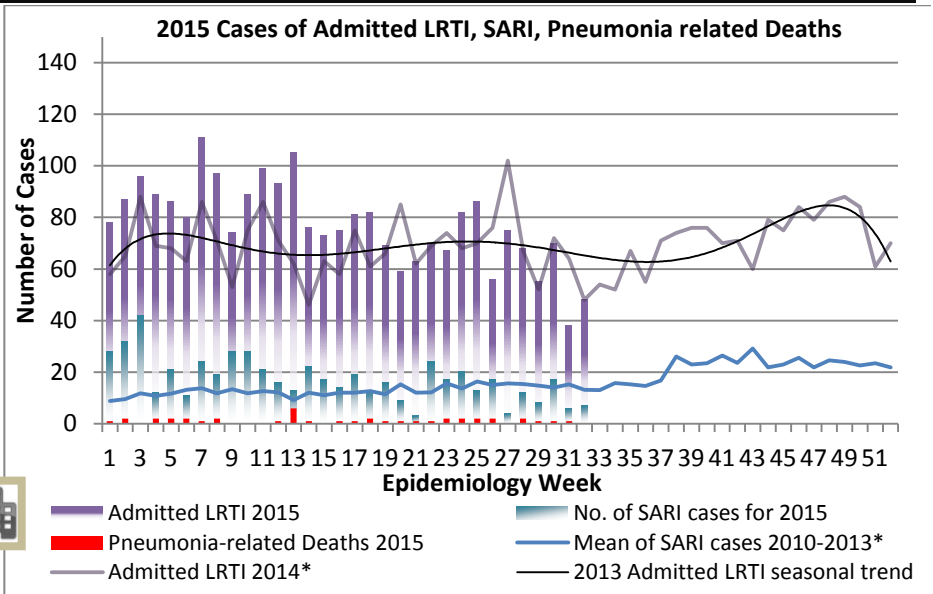


INDICATORS


Burden
 Year to date, respiratory syndromes account for 3.4% 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.



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

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Dengue Bulletin

August 16 – August 22, 2015

Epidemiology Week 33

DENGUE AND SEVERE DENGUE

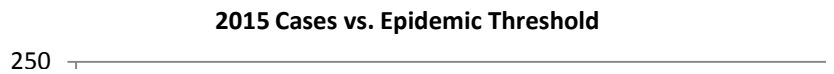
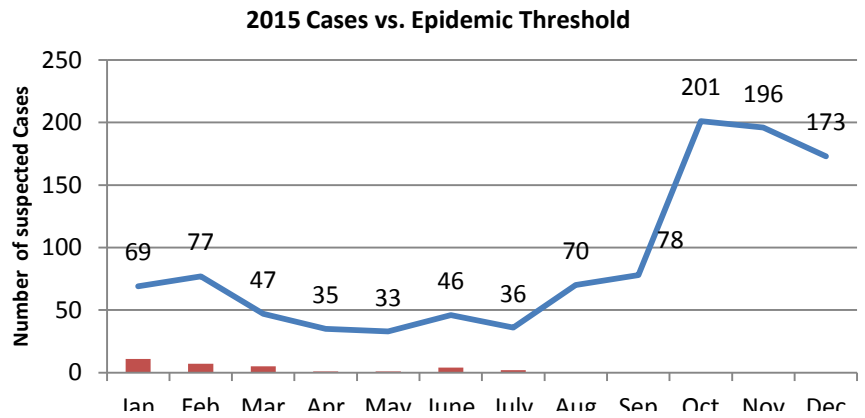
Classic dengue incidence per 100,000 (CI -95%): 14.6 (12.0–17.1)

Hemorrhagic dengue incidence per 100,000 (CI- 95%): 0.14 (0.03–0.24)

Classic dengue lethality % (CI- 95%): 0.12 (0.04–0.26)

Classic dengue mortality per 100,000 (CI -95%): 0.02 (0.00–0.04)

Source: Pan American Health Organization

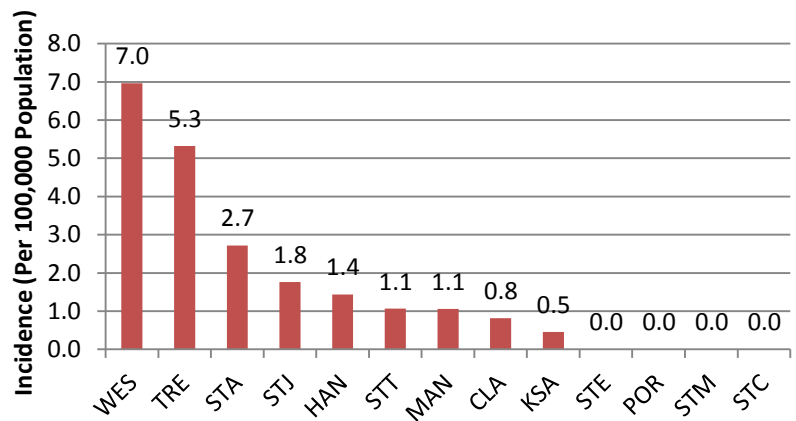


DISTRIBUTION

Year-to-Date Suspected Dengue Fever

	M	F	Total	%
<1	3	2	5	15.2
1-4	1	0	1	3.0
5-14	3	3	6	18.2
15-24	3	3	6	18.2
25-44	6	5	11	33.3
45-64	2	1	3	9.1
≥65	1	0	1	3.0
Unknown	0	0	0	0
TOTAL	19	14	33	100

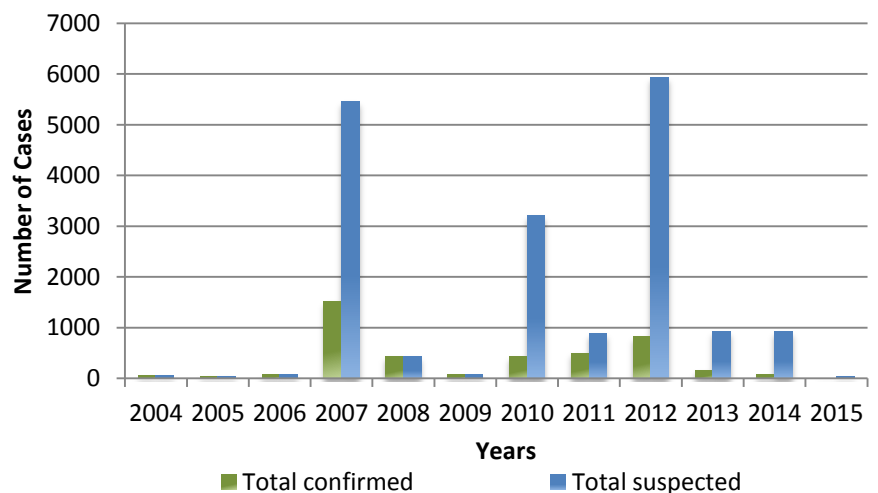
Parish Incidence



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

	2015		2014 YTD
	EW 33	YTD	
Total Suspected Dengue Cases	0	33	154
Lab Confirmed Dengue cases	0	3	4
CONFIRMED	DHF/DSS	0	0
	Dengue Related Deaths	0	0

Dengue Cases by Year, 2004-2015, Jamaica



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Gastroenteritis Bulletin

EW
33

August 16 – August 22, 2015

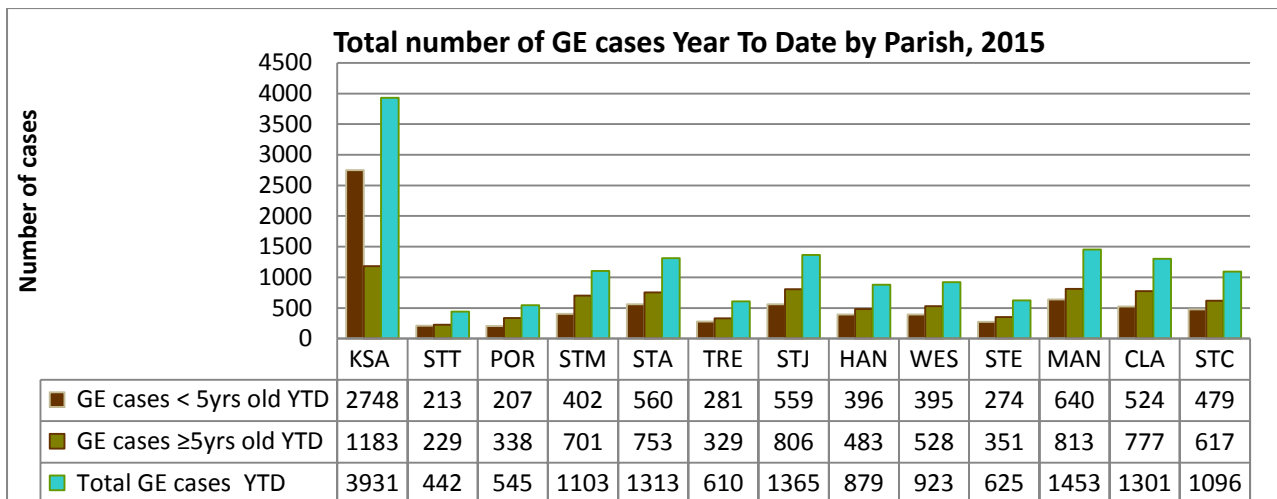
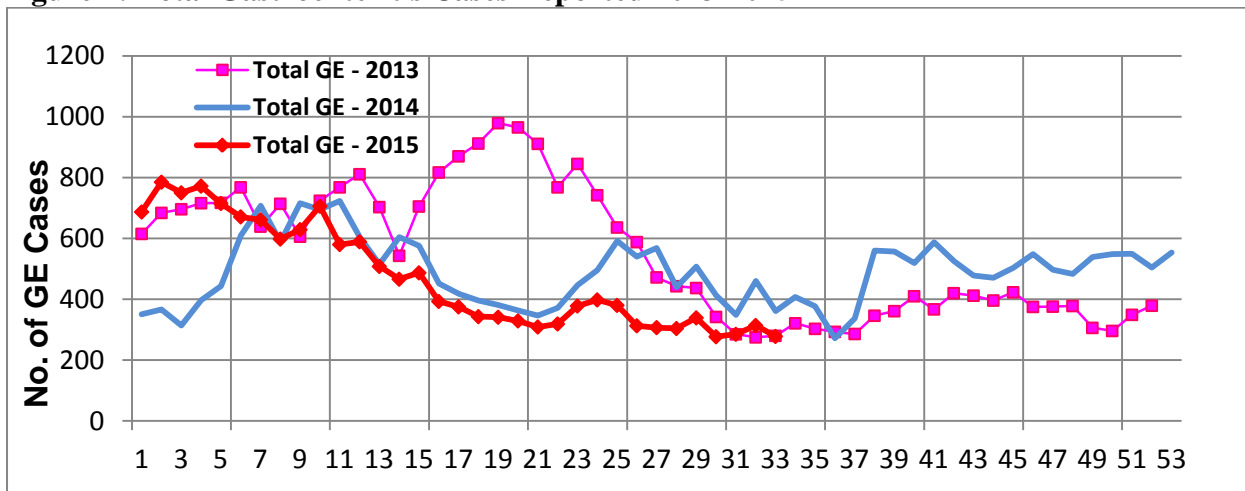
Epidemiology Week 33

Weekly Breakdown of Gastroenteritis cases

Year	EW 33			YTD		
	<5	≥5	Total	<5	≥5	Total
2015	125	153	278	7678	7908	15586
2014	189	172	361	8205	7884	16089

In Epidemiology Week 33, 2015, the total number of reported GE cases showed a 23% decrease compared to EW 33 of the previous year. The year to date figure showed a 3% decrease in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2013-2015



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RESEARCH PAPER

Perspectives of Jamaican Nurses and Decision-makers on the Impact of the HIV/AIDS Epidemic on the Nursing Workforce

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¹The UWI School of Nursing, Mona, University of the West Indies, Kingston7, Jamaica

²University of Ottawa, School of Nursing, Ottawa, Canada

Objective: To understand how the HIV and AIDS epidemic has affected the nursing workforce and the provision of HIV/AIDS nursing services in Jamaica.

Methods: A purposive sample of 20 frontline nurses, nurse managers and 9 decision makers was drawn from participating health institutions. Qualitative semi-structured interviews were audio taped and transcribed verbatim. A coding framework was developed which guided both descriptive and conceptual analysis.

Results: Seventy five percent (75%) of respondents reported that the HIV/AIDS epidemic created increased challenges to the provision of quality nursing care due to higher patient: nurse ratios, increased workload, emotional and physical burnout, greater risk of occupational injury and HIV infection. All (100%) respondents revealed that strict implementation of universal precautions was constrained by inadequate supplies of protective gears and equipment. Thirty five percent (35%) of respondents described stigma perpetrated by nurses towards individuals living with the disease. Conversely, 55% reported a reduction in bias towards patients living with HIV/AIDS. Institutional responses to the epidemic included increased training in HIV /AIDS care and more rigorous application of standards and procedures for infection control; created new opportunities for nurse leadership in implementing programs and new job opportunities for nurses in Non Governmental Organizations involved in HIV and AIDS care.

Conclusions: The epidemic largely has negative effects on the nursing workforce as well as indirect positive outcomes. The negative impact on quality of care exists on individual and institutional levels. Policies and organizational supports are required to reduce the impact of the epidemic on the nursing workforce.



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