

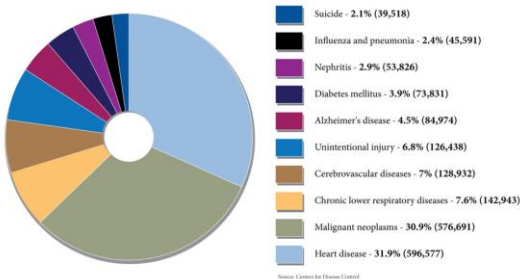
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

More than 1.2 million adolescents die every year, nearly all preventable

LEADING CAUSES OF DEATH



More than 3000 adolescents die every day, totaling 1.2 million deaths a year, from largely preventable causes, according to a new report from WHO and partners. In 2015, more than two-thirds of these

deaths occurred in low- and middle-income countries in Africa and South-East Asia. Road traffic injuries, lower respiratory infections, and suicide are the biggest causes of death among adolescents.

Most of these deaths can be prevented with good health services, education and social support. But in many cases, adolescents who suffer from mental health disorders, substance use, or poor nutrition cannot obtain critical prevention and care services – either because the services do not exist, or because they do not know about them. In addition, many behaviors that impact health later in life, such as physical inactivity, poor diet, and risky sexual health behaviors, begin in adolescence.

In 2015, road injuries were the leading cause of adolescent death among 10–19-year-olds, resulting in approximately 115 000 adolescent deaths. Older adolescent boys aged 15–19 years experienced the greatest burden. Most young people killed in road crashes are vulnerable road users such as pedestrians, cyclists and motorcyclists. The picture for girls differs greatly. The leading cause of death for younger adolescent girls aged 10–14 years are lower respiratory infections, such as pneumonia – often a result of indoor air pollution from cooking with dirty fuels. Pregnancy complications, such as hemorrhage, sepsis, obstructed labor, and complications from unsafe abortions, are the top cause of death among 15–19-year-old girls.

Adolescent health needs intensify in humanitarian and fragile settings. Young people often take on adult responsibilities, including caring for siblings or working, and may be compelled to drop out of school, marry early, or engage in transactional sex to meet their basic survival needs. As a result, they suffer malnutrition, unintentional injuries, pregnancies, diarrheal diseases, sexual violence, sexually-transmitted diseases, and mental health issues.

Downloaded from: http://www.paho.org/hq/index.php?option=com_content&view=article&id=13313%3A%20more%20than%2012%20million%20adolescents%20die%20every%20year%20nearly%20all%20preventable&catid=1443%3A%20web%20bulletins&Itemid=135&lang=en

EPI WEEK 18



SYNDROMES

PAGE 2



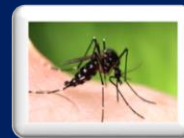
CLASS 1 DISEASES

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INFLUENZA

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DENGUE FEVER

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GASTROENTERITIS

PAGE 7



RESEARCH PAPER

PAGE 8



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

FEVER

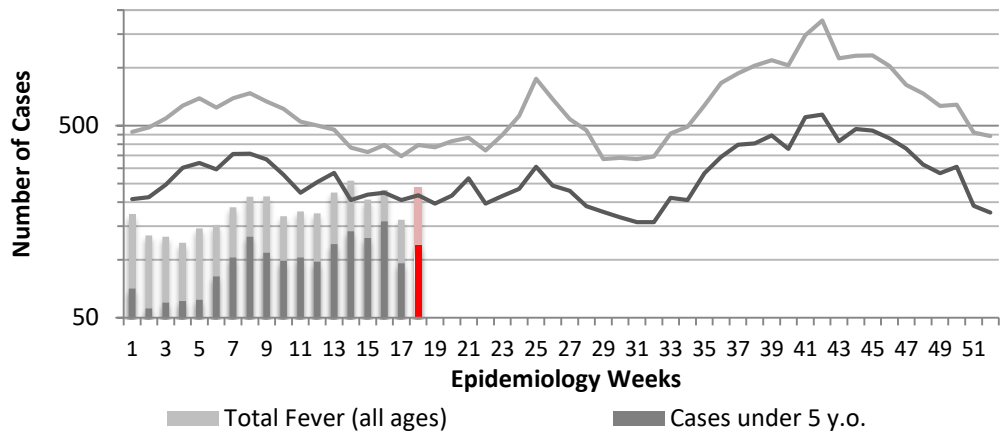
Temperature of $>38^{\circ}\text{C}$ / 100.4°F (or recent history of fever) with or without an obvious diagnosis or focus of infection.



KEY

RED CURRENT WEEK

Fever in under 5y.o. and Total Population 2017 vs Epidemic Thresholds, Epidemiology Week 18

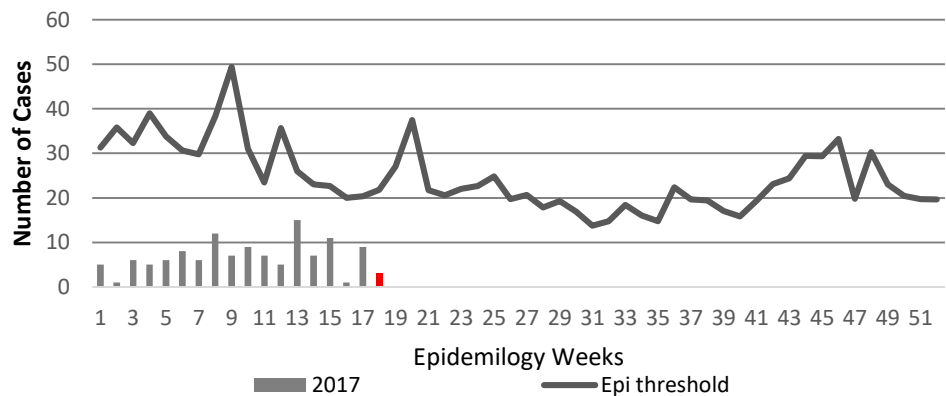


FEVER AND NEUROLOGICAL

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 2017, Epidemiology Week 18

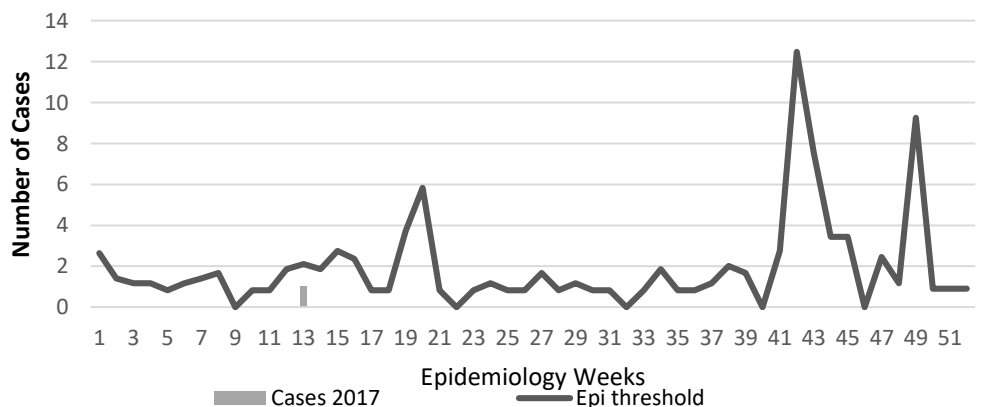


FEVER AND HAEMORRHAGIC

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 Haem Weekly Threshold vs Cases 2017, Epidemiology Week 18



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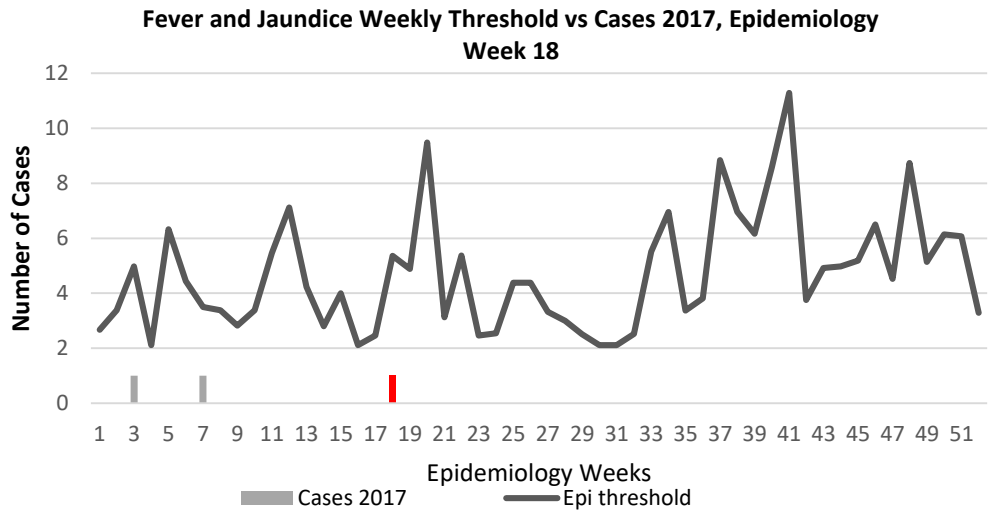


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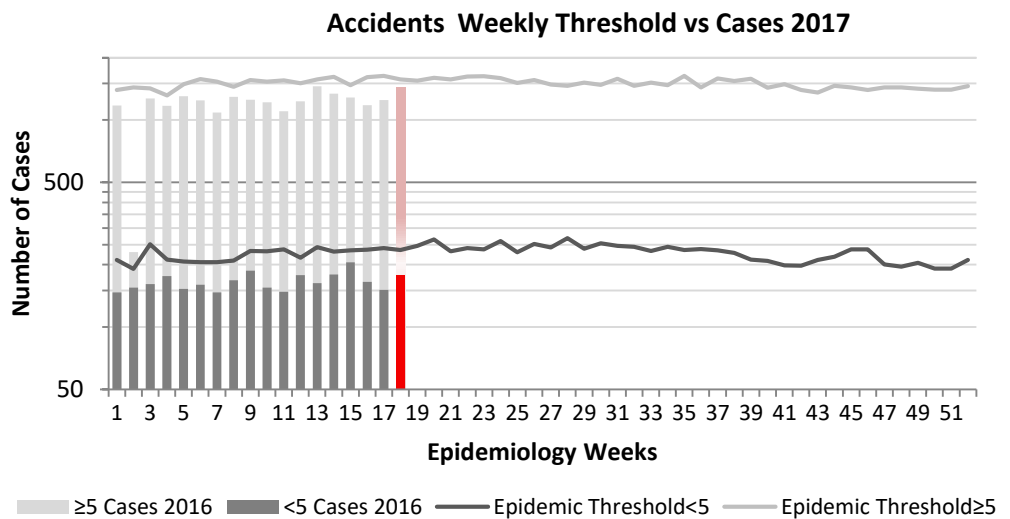
FEVER AND JAUNDICE

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



ACCIDENTS

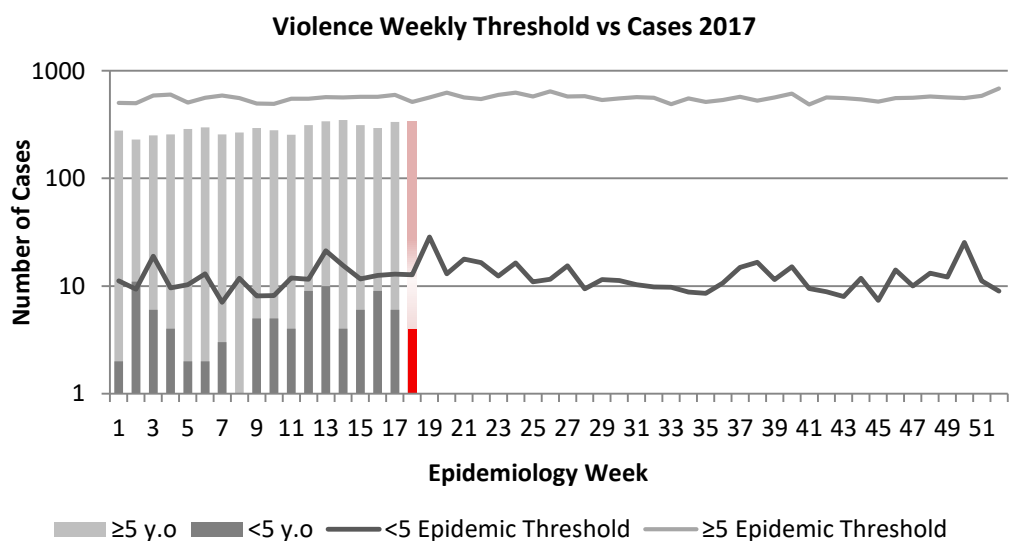
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



VIOLENCE

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

The epidemic threshold is used to confirm the emergence of an epidemic so as to step-up appropriate control measures.



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CLASS ONE NOTIFIABLE EVENTS

Comments

	CLASS 1 EVENTS	CONFIRMED YTD			
		CURRENT YEAR	PREVIOUS YEAR		
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	30	61	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.	
	Cholera	0	0		
	Dengue Hemorrhagic Fever ¹	0	0		
	Hansen’s Disease (Leprosy)	0	0		
	Hepatitis B	5	11		
	Hepatitis C	1	2		
	HIV/AIDS - See HIV/AIDS National Programme Report				
	Malaria (Imported)	2	1		Pertussis-like syndrome and Tetanus are clinically confirmed classifications.
	Meningitis (Clinically confirmed)	8	22		
EXOTIC/ UNUSUAL	Plague	0	0		
HIGH MORBIDITY/ MORTALITY	Meningococcal Meningitis	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.	
	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		
	Fever and Rash	Measles	0		0
		Rubella	0		0
	Maternal Deaths ²	13	23		
	Ophthalmia Neonatorum	78	177		
	Pertussis-like syndrome	0	0		
	Rheumatic Fever	1	3		
	Tetanus	1	0		
	Tuberculosis	0	11		
Yellow Fever	0	0			
Chikungunya		0	0	 	
	Zika Virus	0	17		



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NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

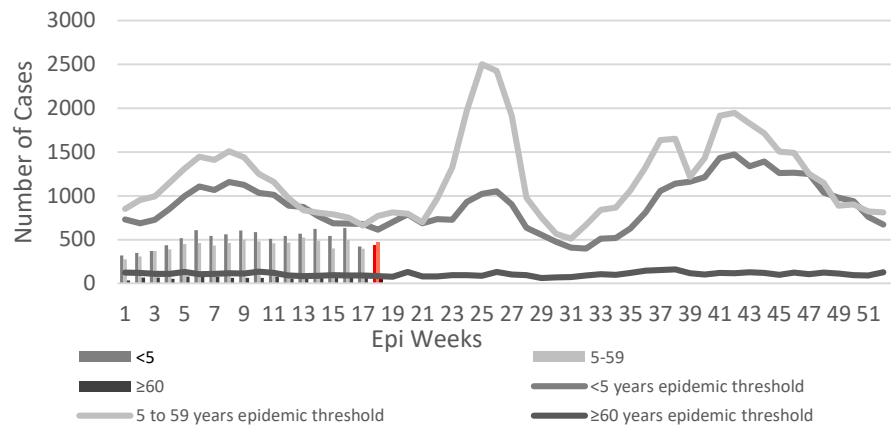
EW 18

April 30- May 6, 2017

Epidemiology Week 18

April 2017		
	EW 18	YTD
SARI cases	5	210
Total Influenza positive Samples	0	7
Influenza A	0	0
H3N2	0	0
H1N1pdm09	0	0
Not subtyped	0	0
Influenza B	0	7
Other	0	0

Fever and Respiratory 2017



Comments:

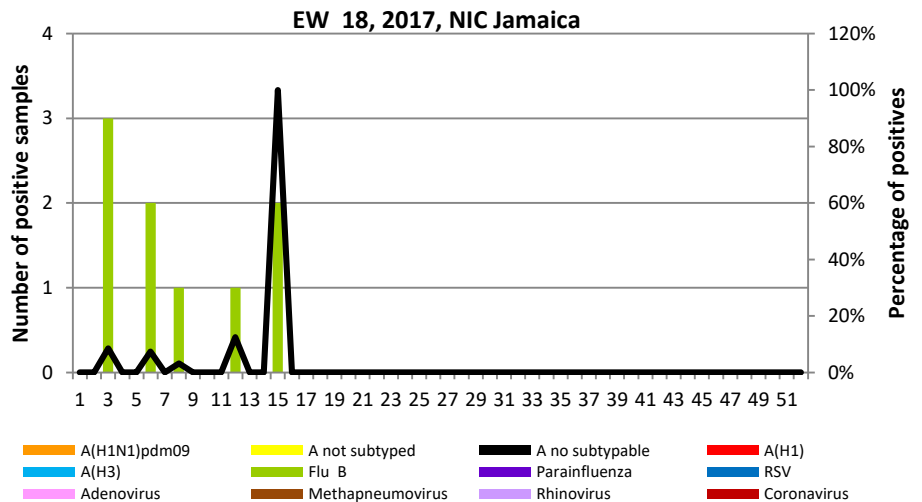
During EW 18, SARI activity slightly decreased and was below the average epidemic curve.

During EW 18, SARI cases were most frequently reported among children between 0-4 years of age.

During EW 18, pneumonia case-counts slightly decreased (150 cases in EW 18), and were similar to the levels observed in 2015 and the prior season.

During EW 18, no influenza detections were reported but only one sample was tested.

Distribution of Influenza and other respiratory viruses among SARI cases by EW surveillance



INDICATORS

Burden

Year to date, respiratory syndromes account for 3.3% of visits to health facilities.

Incidence

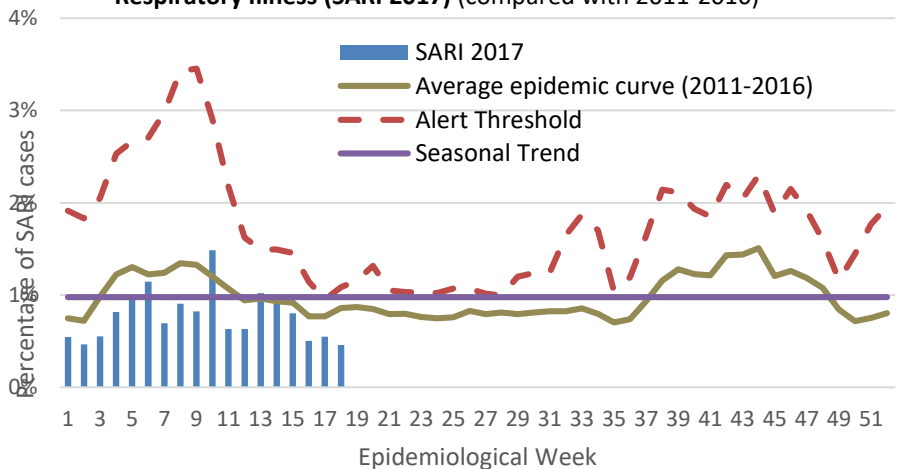
Cannot be calculated, as data sources do not collect all cases of Respiratory illness.



Prevalence

Not applicable to acute respiratory conditions.

Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2017) (compared with 2011-2016)



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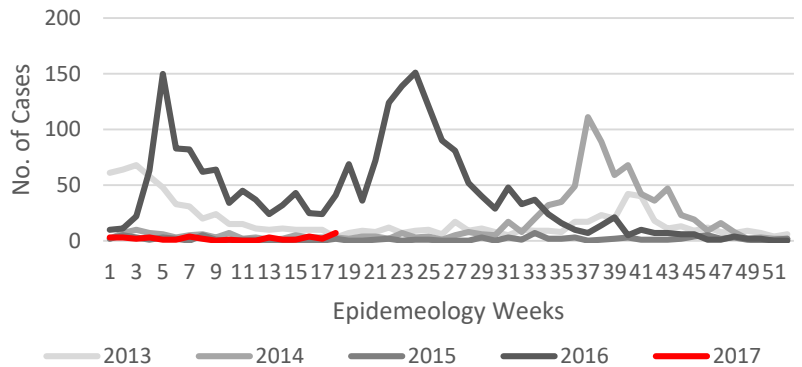
Dengue Bulletin

April 30- May 6, 2017

Epidemiology Week 18



Dengue Cases by Epidemiology Weeks 2013-2017

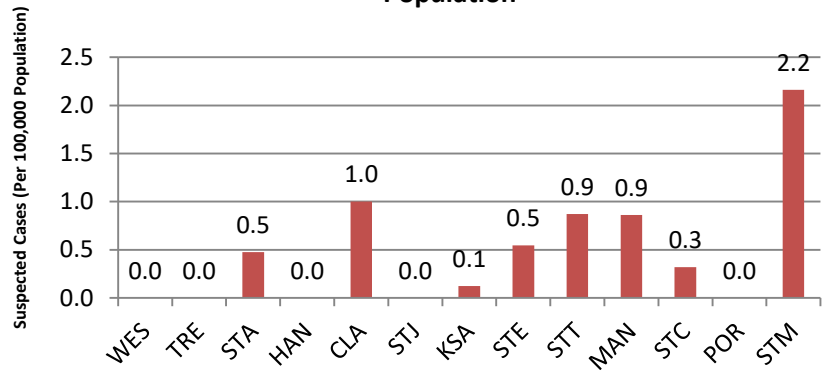


DISTRIBUTION


Year-to-Date Suspected Dengue Fever

	M	F	Un-known	Total	%
<1	1	0	0	1	2.6
1-4	2	1	0	3	7.9
5-14	4	5	0	9	23.7
15-24	4	3	0	7	18.4
25-44	6	5	1	12	31.6
45-64	1	3	0	4	10.5
≥65	0	0	0	0	0
Unknown	1	1	0	2	5.3
TOTAL	19	18	1	38	100

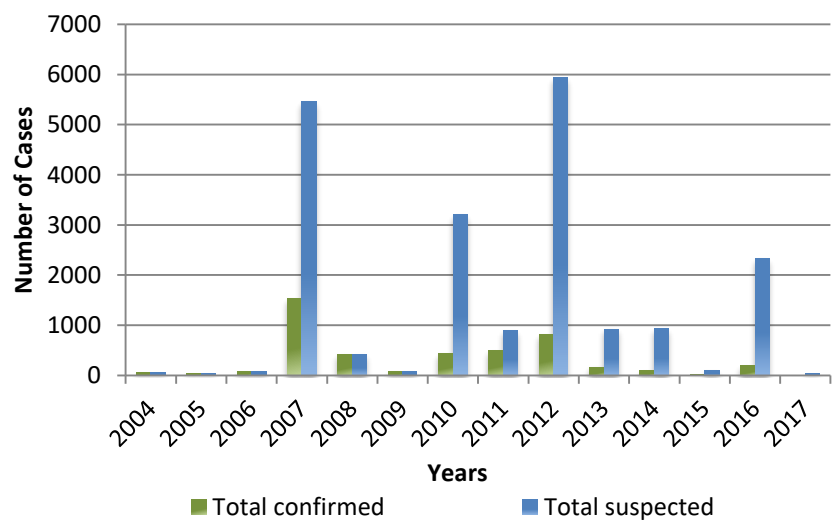
Suspected Dengue Fever Cases per 100,000 Parish Population



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

		2017		2016 YTD
		EW 17	YTD	
				
Total Suspected Dengue Cases		2	31	663
Lab Confirmed Dengue cases		0	0	81
CONFIRMED	DHF/DSS	0	0	3
	Dengue Related Deaths	0	0	0

Dengue Cases by Year: 2007-2017, Jamaica



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Gastroenteritis Bulletin

EW
18

April 30- May 6, 2017

Epidemiology Week 18

Weekly Breakdown of Gastroenteritis cases

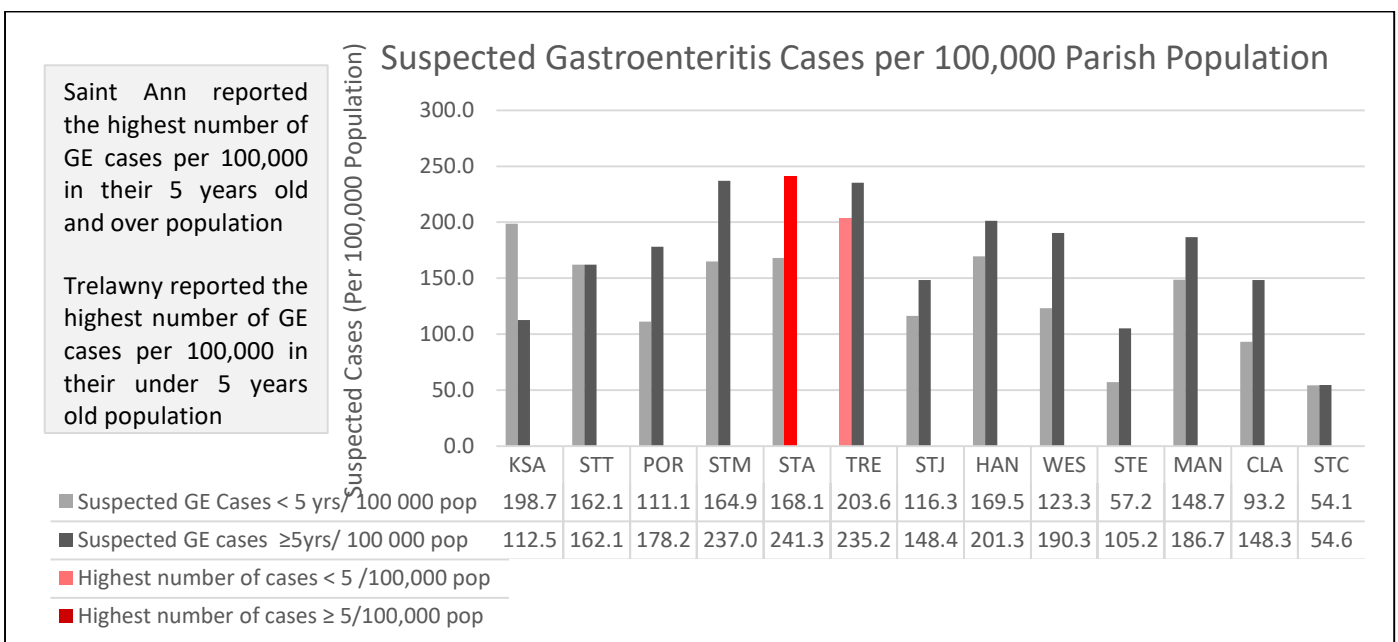
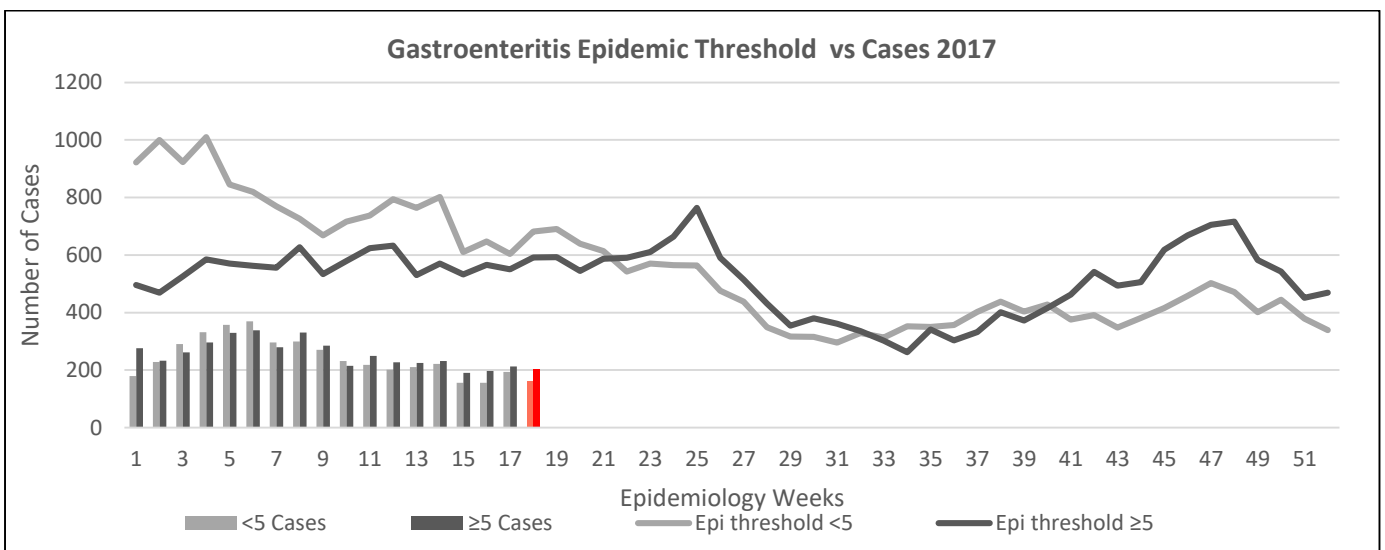
Year	EW 17			YTD		
	<5	≥5	Total	<5	≥5	Total
2017	160	205	365	4,368	4,581	8,949
2016	96	195	291	2,648	3,893	6,541

Gastroenteritis:

In Epidemiology Week 18, 2017, the total number of reported GE cases showed an 8.5% increase compared to EW 18 of the previous year. The year to date figure showed a 7.2% increase in cases for the period.



Figure 1: Total Gastroenteritis Cases Reported 2016-2017



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RESEARCH PAPER

A Description of Registered Nurses' Documentation Practices and their Experiences with Documentation in a Jamaican Hospital

C Blake-Mowatt, JLM Lindo, S Stanley, J Bennett

The UWI School of Nursing, Mona, The University of the West Indies, Mona, Kingston 7, Jamaica

Objective: To determine the level of documentation that exists among registered nurses employed at a Type A Hospital in Western Jamaica.

Method: Using an audit tool developed at the University Hospital of the West Indies, 79 patient docketts from three medical wards were audited to determine the level of registered nurses' documentation at the hospital. Data were analyzed using the SPSS® version 17 for Windows®. Qualitative data regarding the nurses' experience with documentation at the institution were gathered from focus group discussions including 12 nurses assigned to the audited wards.

Results: Almost all the docketts audited (98%) revealed that nurses followed documentation guidelines for admission, recording patients' past complaints, medical history and assessment data. Most of the docketts (96.7%) audited had authorized abbreviations only. Similarly, 98% of the nurses' notes reflected clear documentation for nursing actions taken after identification of a problem and a summary of the patients' condition at the end of the shift. Only 25.6% of the docketts had nursing diagnosis which corresponded to the current medical diagnosis and less than a half (48.3%) had documented evidence of discharge planning. Most of the nurses' notes (86.7%) had no evidence of patient teaching. The main reported factors affecting documentation practices were workload and staff/patient ratios. Participants believed that nursing documentation could be improved with better staffing, improved peer guidance and continuing education.

Conclusion: Generally, nurses followed the guidelines for documentation; however, elements were missing which included patient teaching and discharge planning. This was attributed to high patient load and nurse/patient ratio.



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