

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

World Blood Donor Day 2016: Blood connects us all

Every year, on **14 June**, countries around the world celebrate World Blood Donor Day. The event serves to thank voluntary, unpaid blood donors for their life-saving gifts of blood and to raise awareness of the need for regular blood donations to ensure the quality, safety and availability of blood and blood products for patients in need.

Transfusion of blood and blood products helps save millions of lives every year. It can help patients suffering from life-threatening conditions live longer and with higher quality of life, and supports complex medical and surgical procedures. It also has an essential, life-saving role in maternal and child care and during man-made and natural disasters.



The objectives of 2016 World Blood Donor Day

- thank blood donors for their life-saving gift of blood and highlight the theme of blood connecting us all
- create wider public awareness of the need for regular, unpaid blood donation, and inspire those who have not yet donated blood to start donating, particularly young people in good health
- promote and highlight the need to share life by donating blood
- focus attention on blood services as a community service, and the importance of community participation for a sufficient, safe and sustainable blood supply
- persuade ministries of health to show their appreciation to regular voluntary unpaid donors and commit to self-sufficiency in safe blood and blood products based on 100% voluntary, unpaid donations.

Join the Ministry of Health, Jamaica at Emancipation Park 8:00 am to 7:00pm for the **DONORFEST Blood Drive & Wellness Fair: Share Life, Give Blood**

Source: <http://www.who.int/campaigns/world-blood-donor-day/2016/event/en/>

EPI WEEK 21



SYNDROMES

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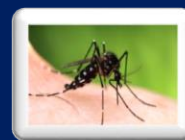
CLASS 1 DISEASES

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INFLUENZA

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DENGUE FEVER

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GASTROENTERITIS

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NOTIFICATIONS-
All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE-30 sites*. Actively pursued



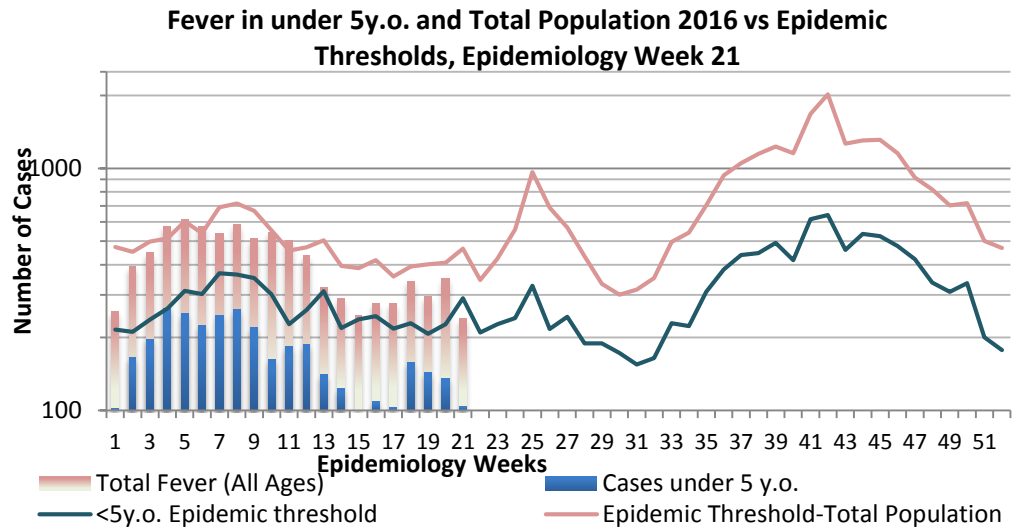
SENTINEL REPORT- 79 sites*. Automatic reporting

*Incidence/Prevalence cannot be calculated

REPORTS FOR SYNDROMIC SURVEILLANCE

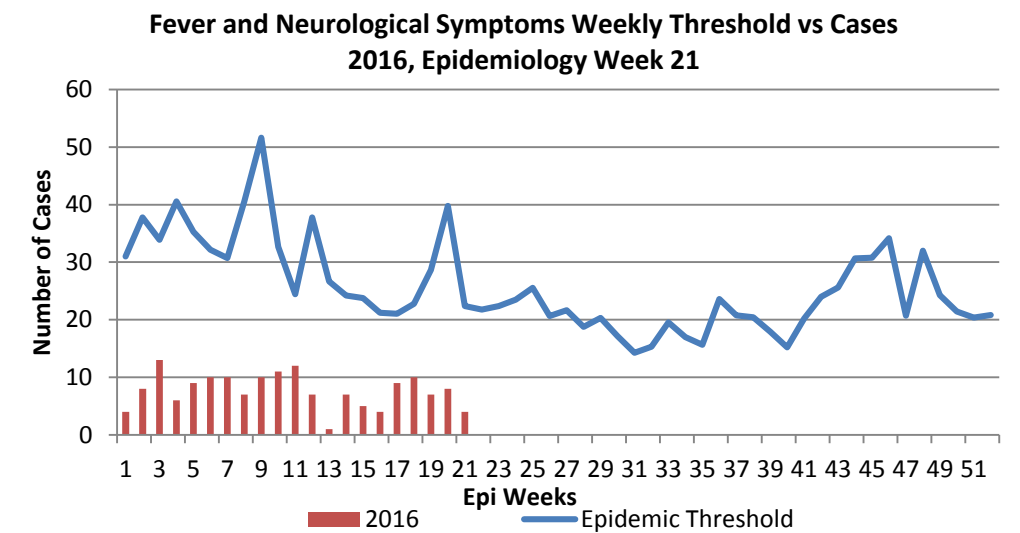
FEVER

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



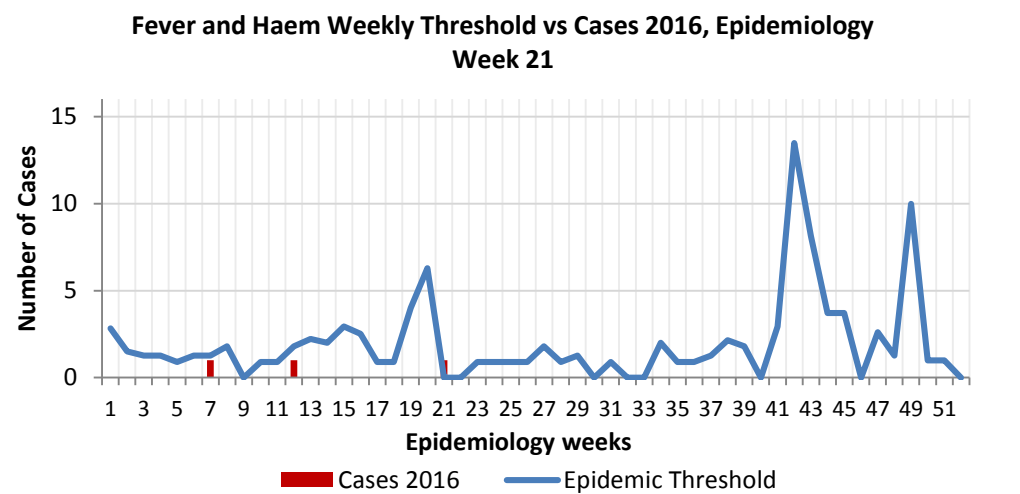
FEVER AND NEUROLOGICAL

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 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.



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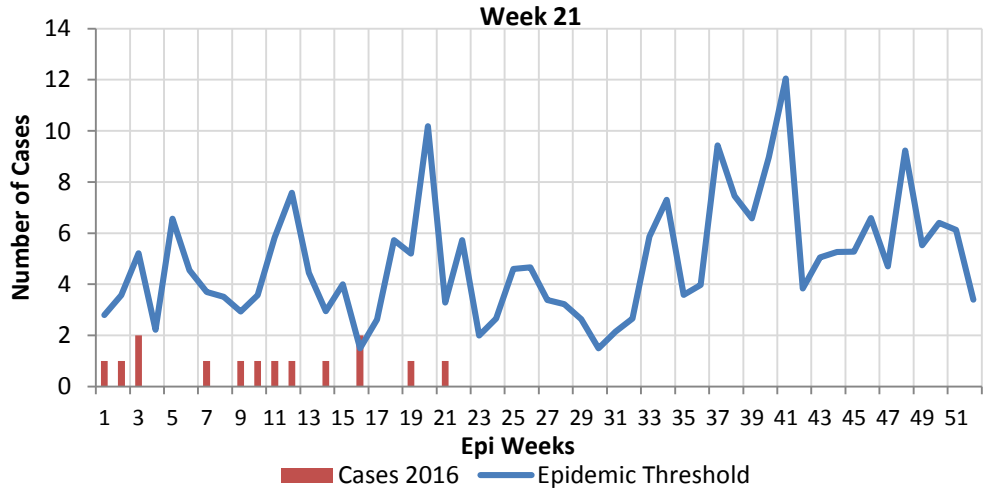
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FEVER AND JAUNDICE

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



Fever and Jaundice Weekly Threshold vs Cases 2016, Epidemiology

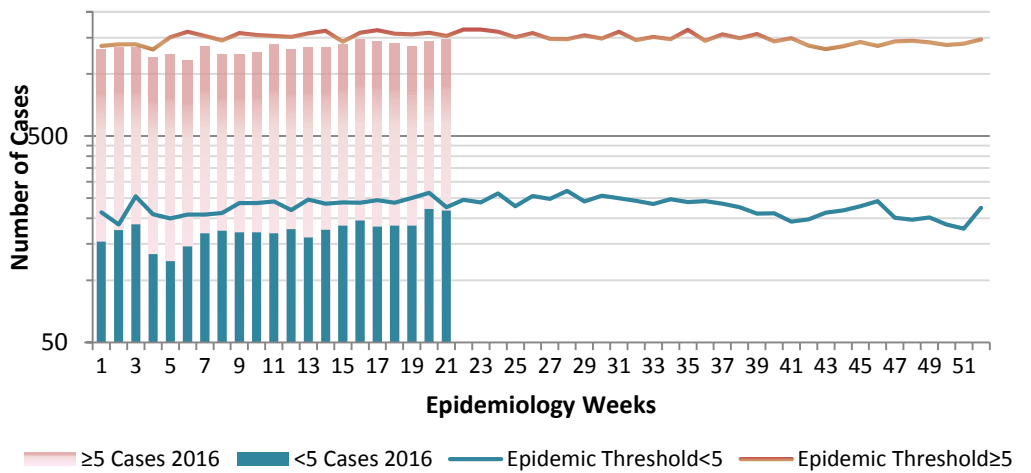


ACCIDENTS

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



Accidents Weekly Threshold vs Cases 2016



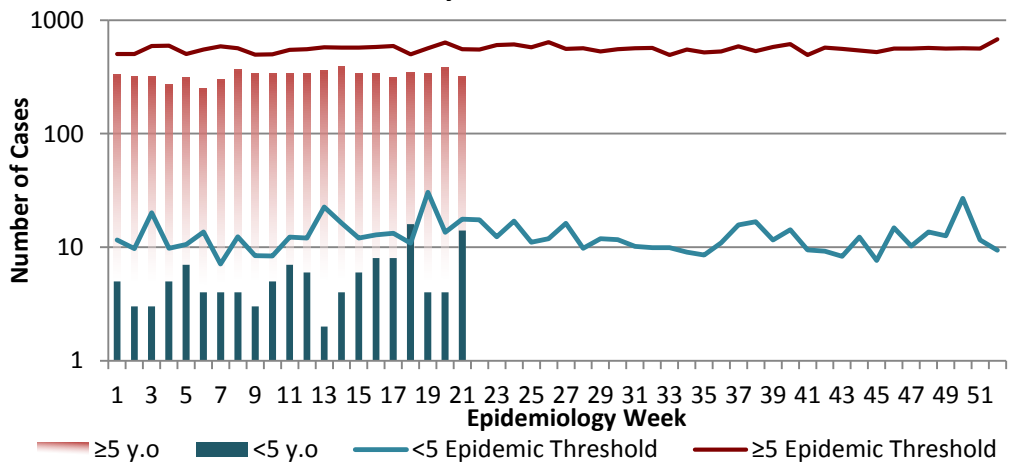
VIOLENCE

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

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



Violence Weekly Threshold vs Cases 2016



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— CLASS ONE NOTIFIABLE EVENTS

Comments

	CLASS 1 EVENTS	CONFIRMED YTD			
		CURRENT YEAR	PREVIOUS YEAR		
NATIONAL/INTERNATIONAL INTEREST	Accidental Poisoning	18	81	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	2	0		
	Hansen's Disease (Leprosy)	1	0		
	Hepatitis B	14	20		
	Hepatitis C	4	2		
	HIV/AIDS - See HIV/AIDS National Programme Report				
	Malaria (Imported)	1	0		
	Meningitis	10	48		
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 ¹ Dengue Hemorrhagic Fever data include Dengue related deaths; ² Maternal Deaths include early and late deaths.	
	Congenital Rubella Syndrome	0	0		
	Congenital Syphilis	0	0		
	Fever and Rash	Measles	17		2
		Rubella	0		0
	Maternal Deaths ²	20	22		
	Ophthalmia Neonatorum	192	138		
	Pertussis-like syndrome	0	0		
	Rheumatic Fever	1	8		
	Tetanus	0	1		
	Tuberculosis	0	0		
	Yellow Fever	0	0		
Chikungunya	0	1			
Zika Virus	16	0			



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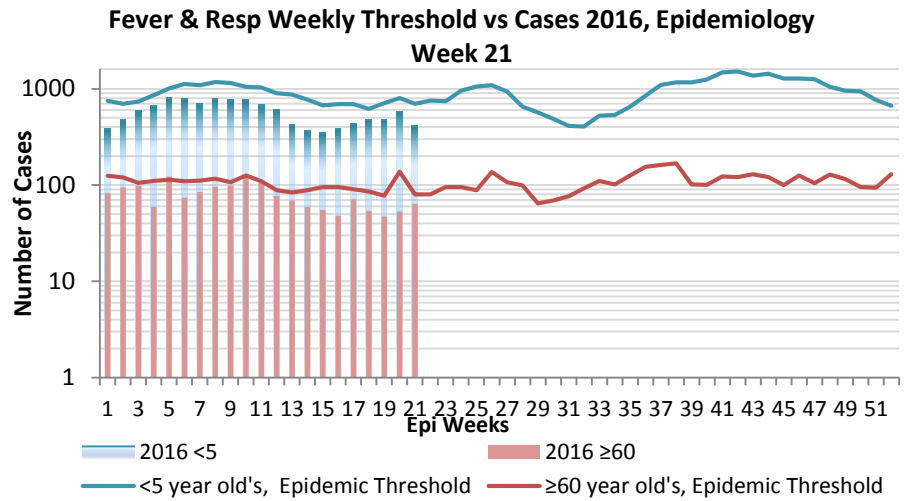
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 21

May 22 – May 28, 2016

Epidemiology Week 21

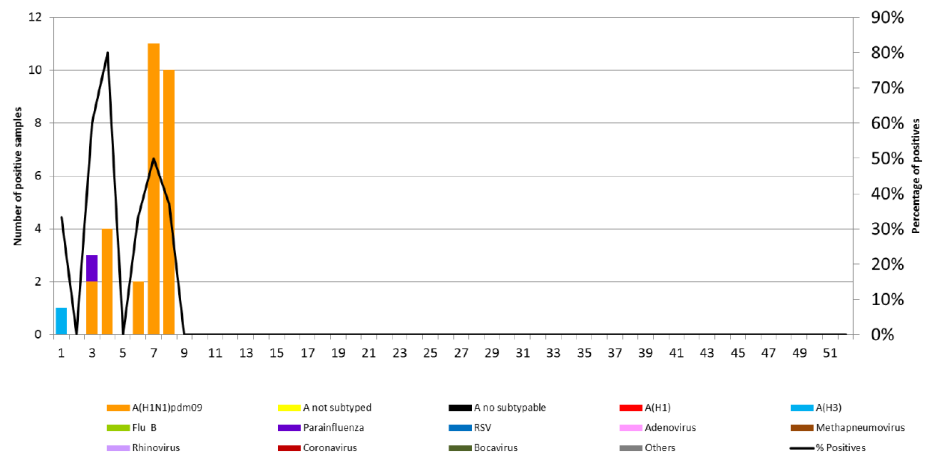
May, 2016		
	EW 21	YTD
SARI cases	12	655
Total Influenza positive Samples	0	114
Influenza A	0	113
H3N2	0	1
H1N1pdm09	0	80
Not subtyped	0	32
Influenza B	0	0
Other	0	1



Comments:

The percent positivity among all samples tested from EW 1 to EW 8, 2016 is 40.3% (N= 77). Influenza A(H1N1)pdm09 continued to circulate in EWs 1 to 8 as the predominant virus at 97%. No Influenza B viruses have been detected since 2016. In addition, there has been no detection of the influenza A/H3v or A/H1v variant viruses, or avian H5 and H7 viruses among human samples tested.

Distribution of Influenza and other respiratory viruses by EW surveillance EW 8, 2016, NIC Jamaica - Interim report

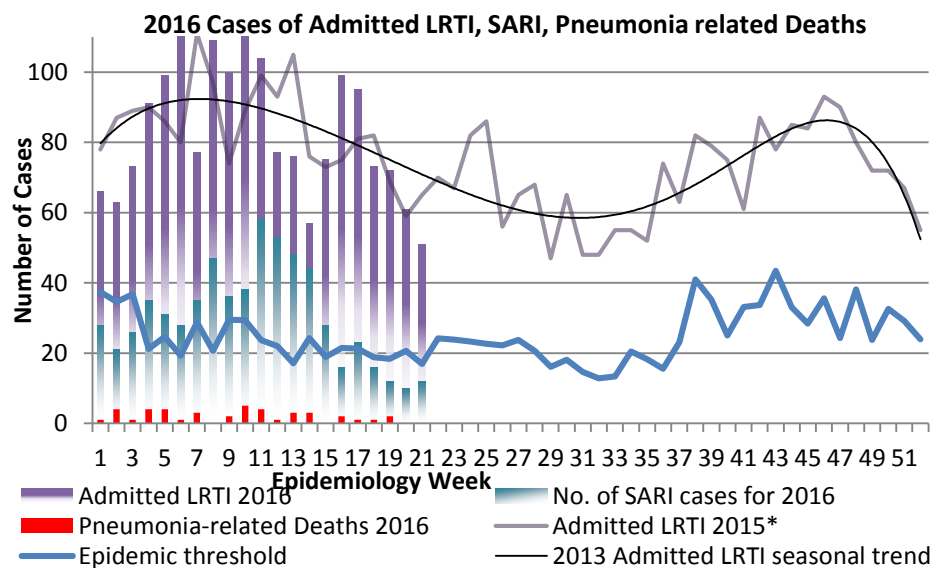


INDICATORS

Burden
Year to date, respiratory syndromes account for 4.2% 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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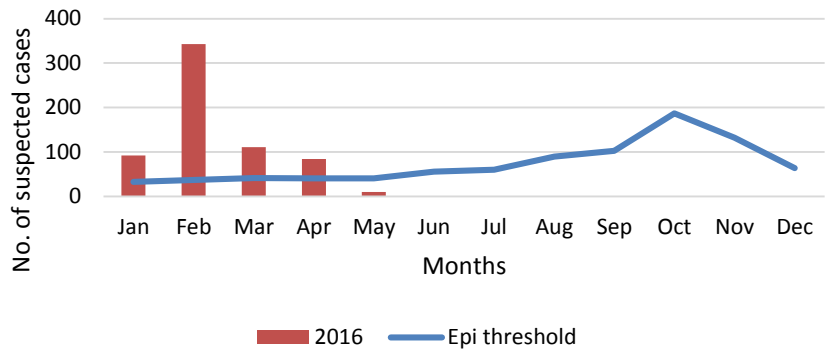
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Dengue Bulletin

May 22 – May 28, 2016

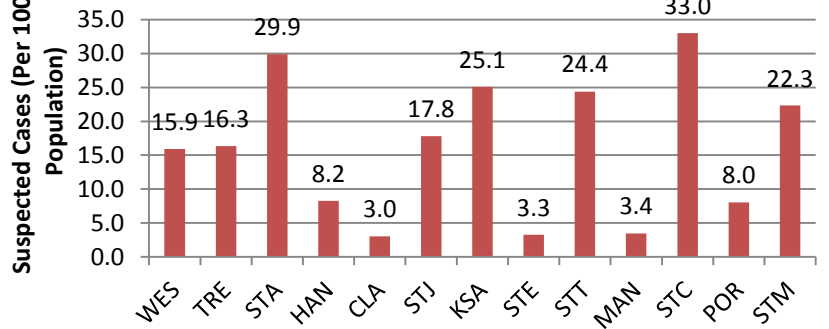
Epidemiology Week 21

2016 Cases vs. Epidemic Threshold



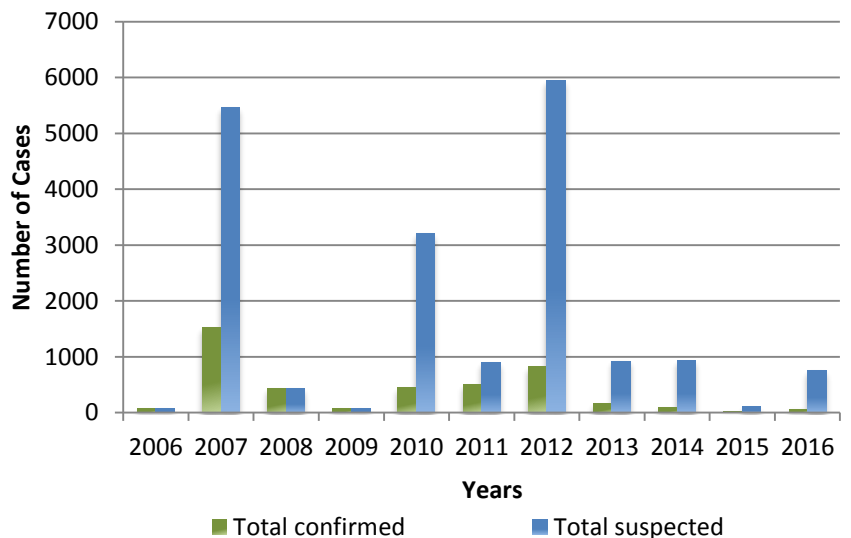
DISTRIBUTION					
Year-to-Date Suspected Dengue Fever					
	M	F	Un-kwn	Total	%
<1	2	10	0	12	1
1-4	8	12	0	20	5
5-14	68	59	1	128	19
15-24	57	85	0	142	20
25-44	69	154	2	225	29
45-64	24	50	1	75	10
≥65	3	8	0	11	2
Unknown	27	49	9	85	14
TOTAL	258	427	13	698	100

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 21	YTD	
CONFIRMED	Total Suspected Dengue Cases	9	731	27
	Lab Confirmed Dengue cases	0	67	1
	DHF/DSS	0	2	0
	Dengue Related Deaths	0	0	0

Dengue Cases by Year: 2004-2016, Jamaica



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Gastroenteritis Bulletin

EW
21

May 22 – May 28, 2016

Epidemiology Week 21

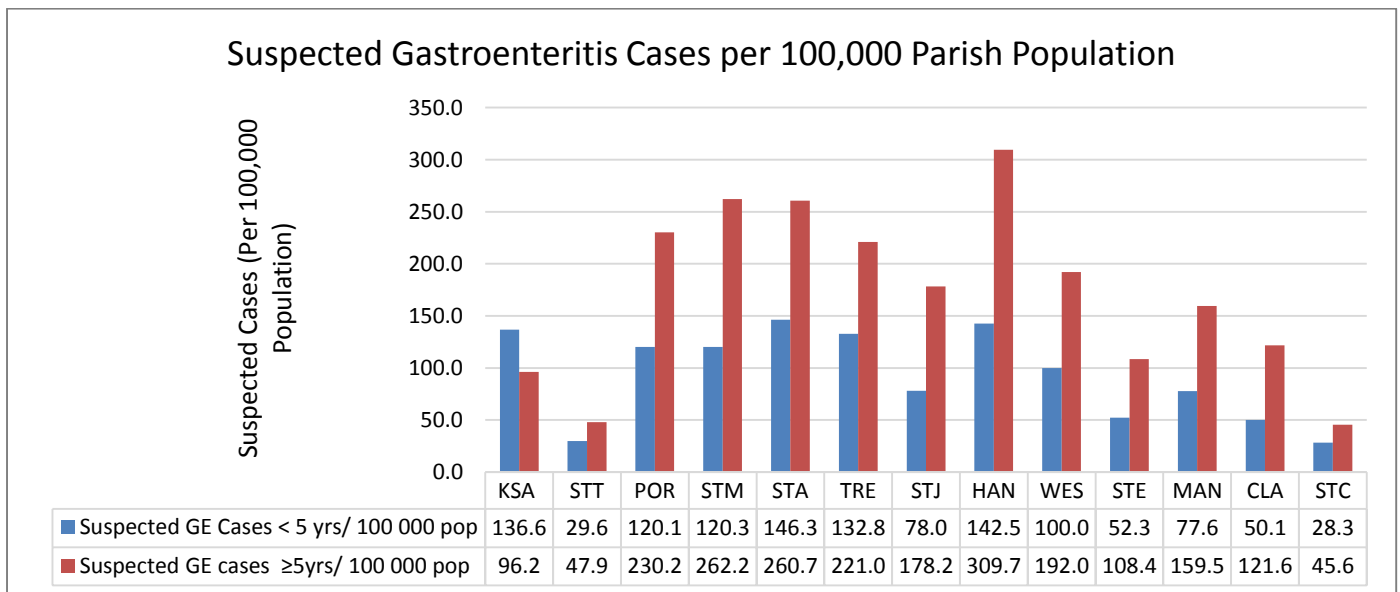
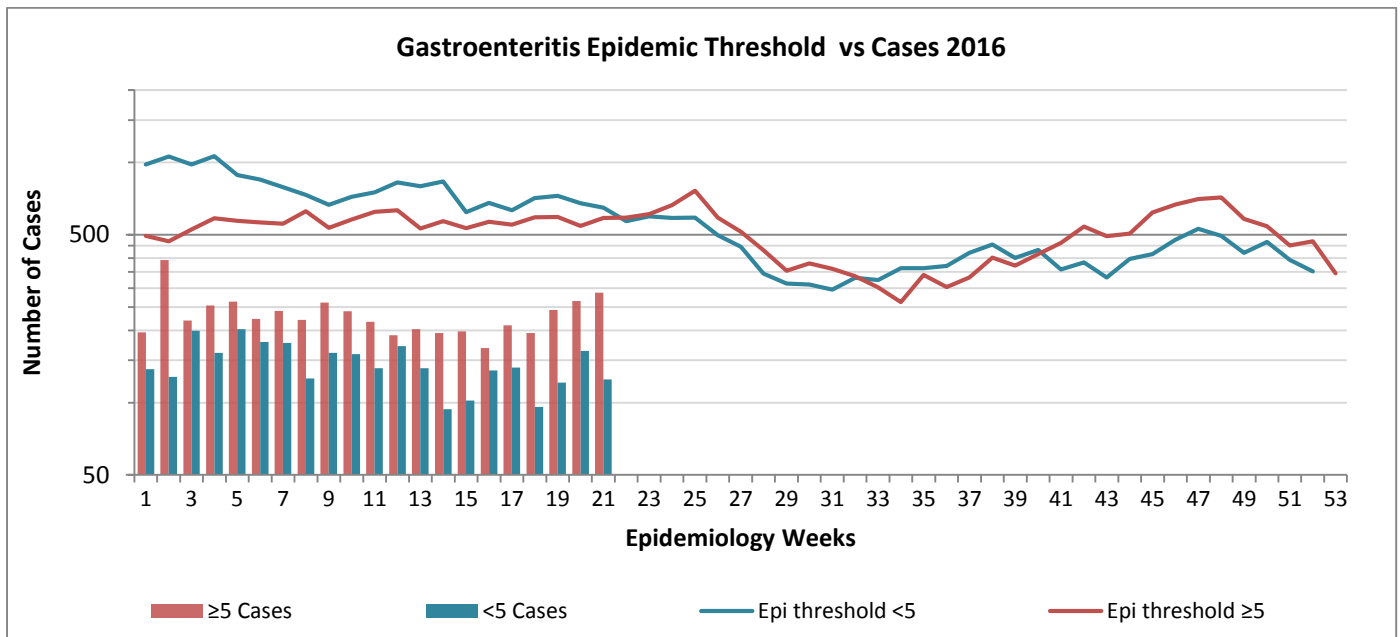
Weekly Breakdown of Gastroenteritis cases

Gastroenteritis: Three or more loose stools within 24 hours.
In Epidemiology Week 20, 2016, the total number of reported GE cases showed a 23% increase compared to EW 20 of the previous year.
The year to date figure showed a 35% decrease in cases for the period.



Year	EW 20			YTD		
	<5	≥5	Total	<5	≥5	Total
2016	125	287	412	3058	4688	7746
2015	118	191	309	5907	5787	11694

Figure 1: Total Gastroenteritis Cases Reported 2015-2016



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RESEARCH PAPER

A Comparison of the Nutritional Status of HIV- positive Children living in Family Homes and an 'Institutionalized' Children's Home

S Dawson, S Robinson, J DeSouza

Epidemiology Research and Training Unit, Ministry of Health, Kingston, Jamaica

Objective: To assess the nutritional status of HIV-infected children living in family homes and in an institution.

Design and Method: A cross-sectional descriptive study was conducted involving 31 HIV- positive children with anthropometric measurements used as outcome indicators. The children who met the inclusion criteria were enrolled, and nutritional statuses for both sets of children were assessed and compared.

Results: Fifteen of the children (48.4%) lived in family homes and sixteen (51.6%) in the institution, with a mean age of 7.2 ± 3.2 years. Significant differences between the two settings were found for the means, Weight-For-Height, WFH ($p=0.020$) and Body Mass Index, BMI ($p=0.005$); children in family homes having significantly better WFH and BMI. Four of the children (13.3%) were underweight; 3 from the institution (18.8%) and 1 (6.7%) from a family home. Two children (6.9%) were found to be 'at risk' of being overweight.

Conclusion: Although anthropometric indices for most of these children are within the acceptable range, there seems to be significant differences in nutritional status between infected children resident in family homes, and those in the institution. The factors responsible for such differences are not immediately obvious, and require further investigation. The influence of ARV therapy on nutritional outcomes in these settings require prospective studies which include dietary, immunologic and biochemical markers, in order to provide data that may help to improve the medical nutritional management of these children.



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