Released July 14, 2017, 2017 ISSN 0799-3927

Week ending July 1,2017 Epidemiology Week 26

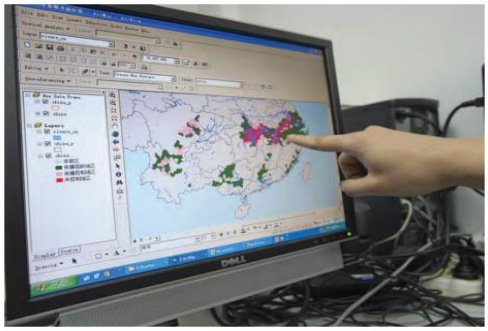
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

WHO Guidelines on Ethical Issues in Public Health Surveillance (PART 3)

13. Results of surveillance must be effectively communicated to relevant target audiences.



14. With appropriate safeguards and justification, those responsible for public health surveillance have an obligation to share data with other national and international public health agencies.

15. During a public health emergency, it is imperative that all parties involved in surveillance share data in a timely fashion.

Medical student and district surveillance officer investigating suspected Ebola cases in Western Region of Sierra Leone.

16. With appropriate justification and safeguards, public health agencies may use or share surveillance data for research purposes.

17. Personally identifiable surveillance data should not be shared with agencies that are likely to use them to take action against individuals or for uses unrelated to public health.

Downloaded from:
http://apps.who.int/iris/bitstream/10665/255721/1/9789241512657-eng.pdf?ua=1

EPI WEEK 26

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

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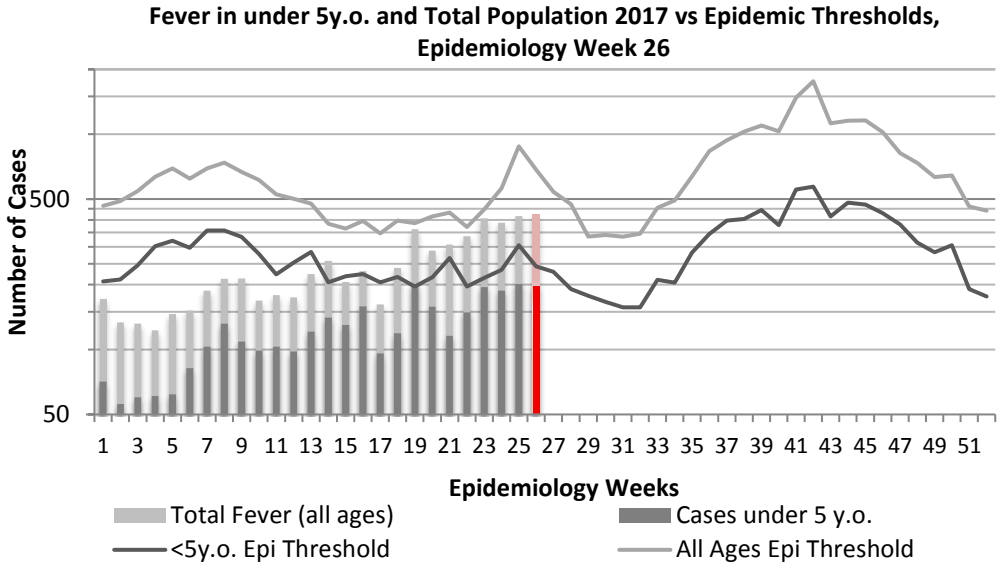
REPORTS FOR SYNDROMIC SURVEILLANCE

FEVER

Temperature of >38^0C /100.4^0F (or recent history of fever) with or without an obvious diagnosis or focus of infection.

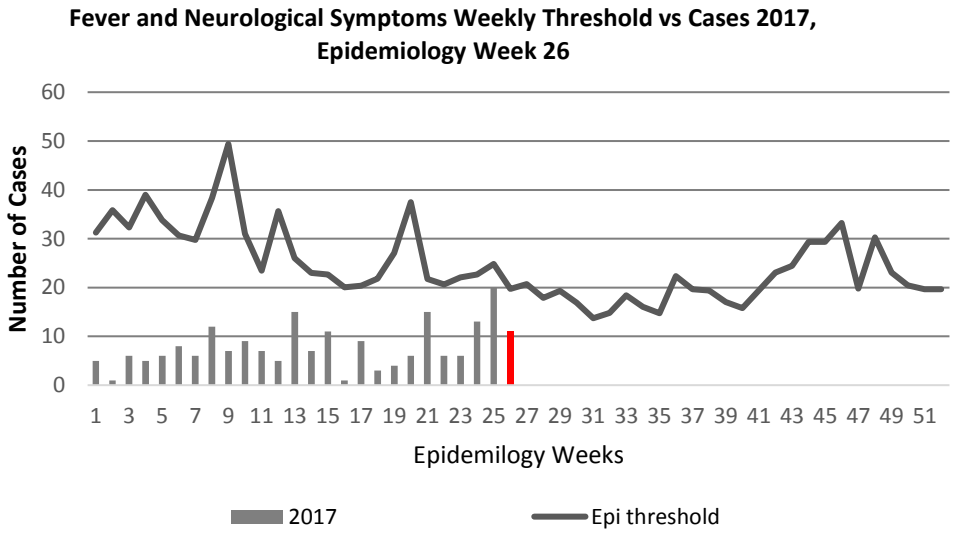
KEY

RED CURRENT WEEK



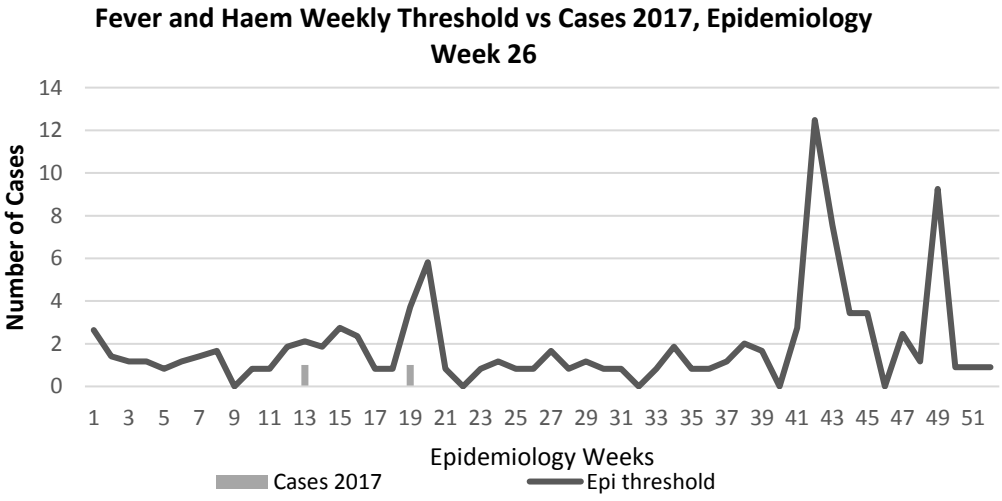
FEVER AND NEUROLOGICAL

Temperature of >380C /100.40F (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 >38^0C /100.4^0F (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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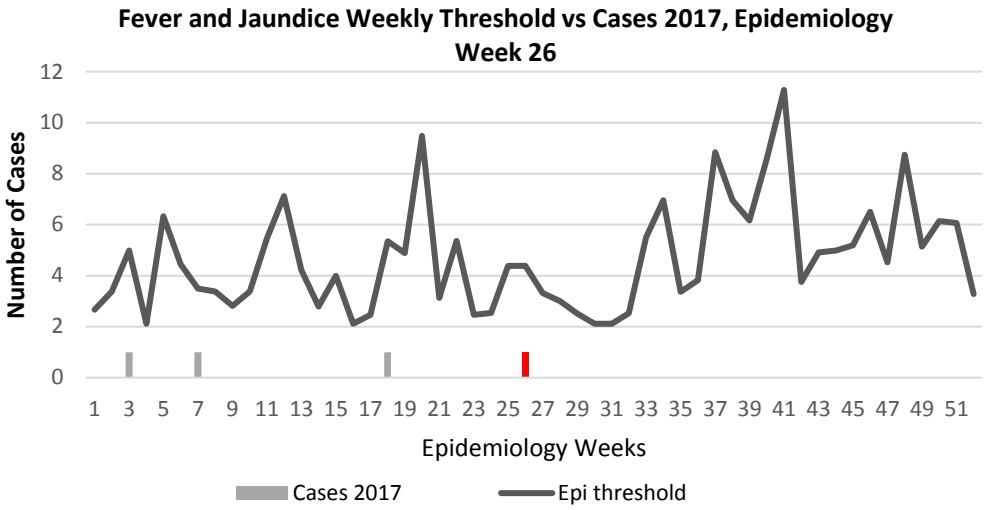
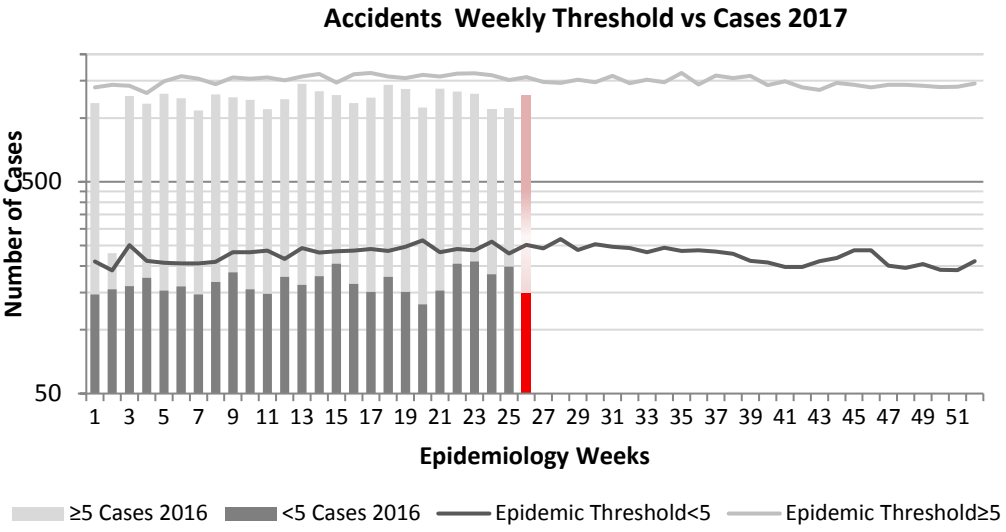
FEVER AND JAUNDICE

Temperature of $>38^0C$ /100.4^0F (or recent history of fever) in a previously healthy person presenting with jaundice.



ACCIDENTS

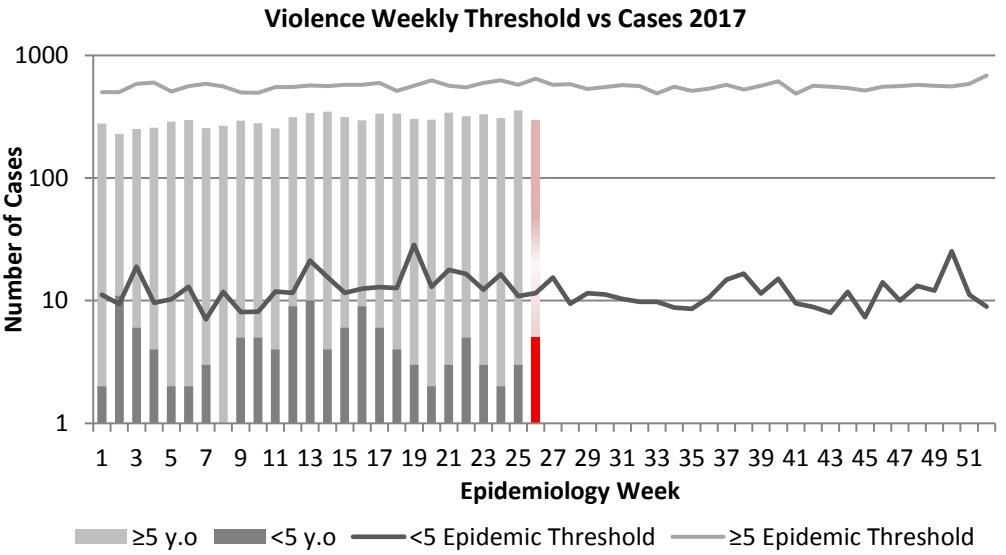
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



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

	CLASS 1 EVENTS		CONFIRMED YTD CURRENT YEAR	CONFIRMED YTD PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		54	84
	Cholera		0	0
	Dengue Hemorrhagic Fever[1]		0	3
	Hansen's Disease (Leprosy)		0	2
	Hepatitis B		15	15
	Hepatitis C		2	4
	HIV/AIDS - See HIV/AIDS National Programme Report			
	Malaria (Imported)		3	1
	Meningitis (Clinically confirmed)		22	32
EXOTIC/ UNUSUAL	Plague		0	0
H IGH MORBIDIT/ MORTALIY	Meningococcal Meningitis		0	0
	Neonatal Tetanus		0	0
	Typhoid Fever		0	0
	Meningitis H/Flu		0	0
SPECIAL PROGRAMMES	AFP/Polio		0	0
	Congenital Rubella Syndrome		0	0
	Congenital Syphilis		0	0
	Fever and Rash	Measles	0	0
		Rubella	0	0
	Maternal Deaths[2]		18	25
	Ophthalmia Neonatorum		117	202
	Pertussis-like syndrome		0	0
	Rheumatic Fever		3	6
	Tetanus		1	0
	Tuberculosis		17	15
	Yellow Fever		0	0
	Chikungunya		0	0
	Zika Virus		0	74

Comments

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 70% of their calculated estimate of cases in the island, this is 180 (of 200) cases per year.

*Data not available

1 Dengue Hemorrhagic Fever data include Dengue related deaths;

2 Maternal Deaths include early and late deaths.

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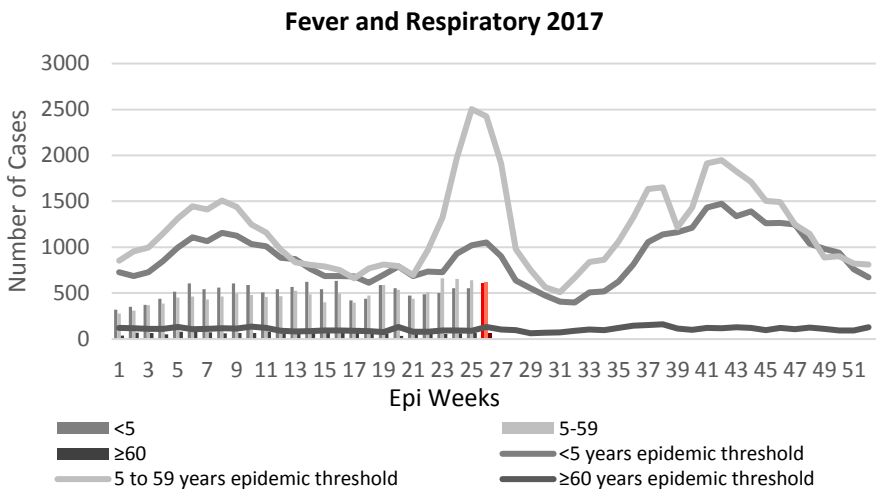
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 26

June 25 – July 1, 2017 Epidemiology Week 26

June 2017		
	EW 26	*YTD*
SARI cases	*13*	*273*
Total Influenza positive Samples	***2***	***26***
Influenza A	***0***	***0***
H3N2	*0*	*0*
H1N1pdm09	*0*	*0*
Not subtyped	*0*	*0*
Influenza B	*4*	***26***
Other	*0*	***0***

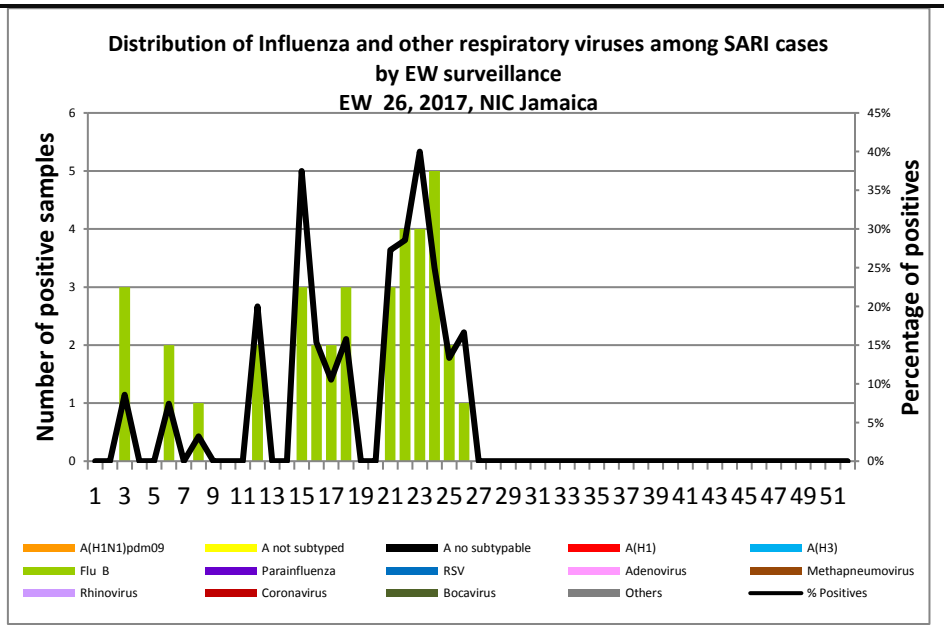


Comments:

During EW 25, SARI activity increased above the average epidemic curve and the alert threshold as compared to previous weeks.

During EW 25, SARI cases were most frequently reported among children between 0-4 years of age.

During EW 25, few influenza detections were reported, with decreased activity (12.5% positivity) and influenza B predominating.



INDICATORS

Burden

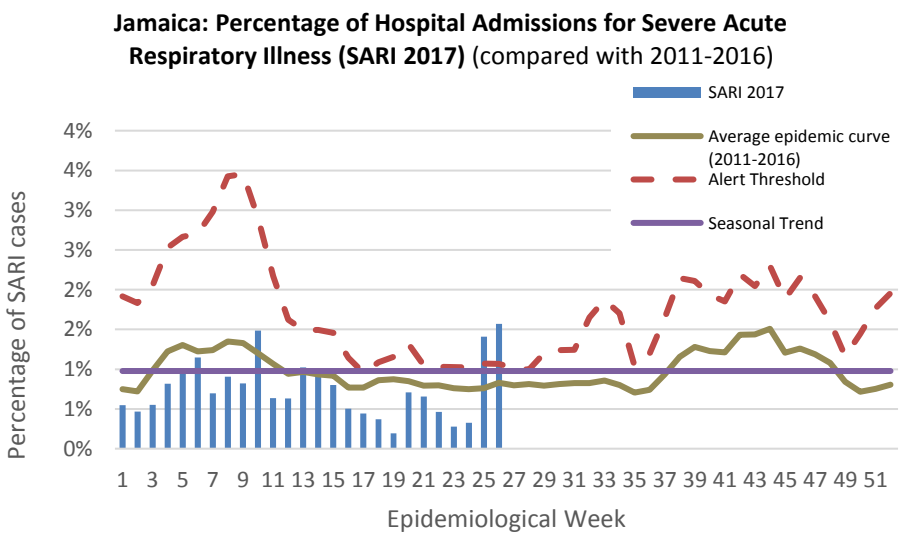
Year to date, respiratory syndromes account for 4.4% of visits to health facilities.

Incidence

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

Prevalence

Not applicable to acute respiratory conditions.



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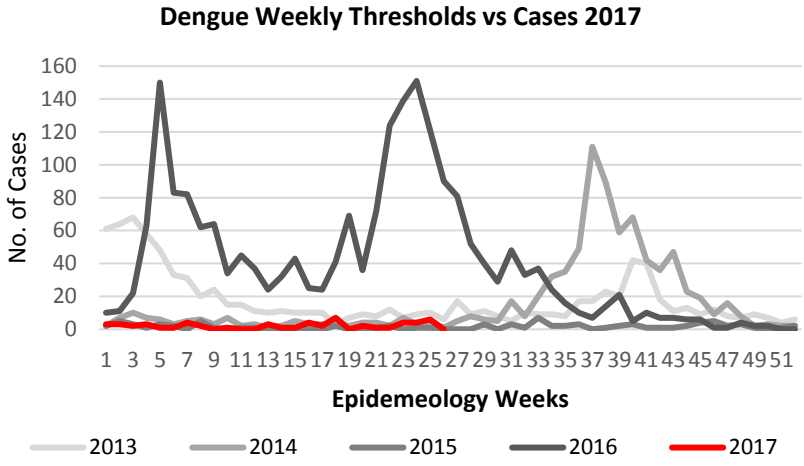
Dengue Bulletin

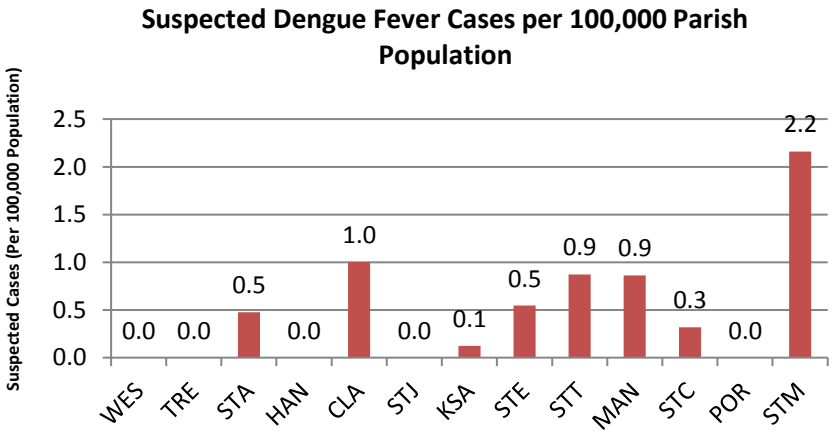
June 25- July 1, 2017 Epidemiology Week 26



DISTRIBUTION

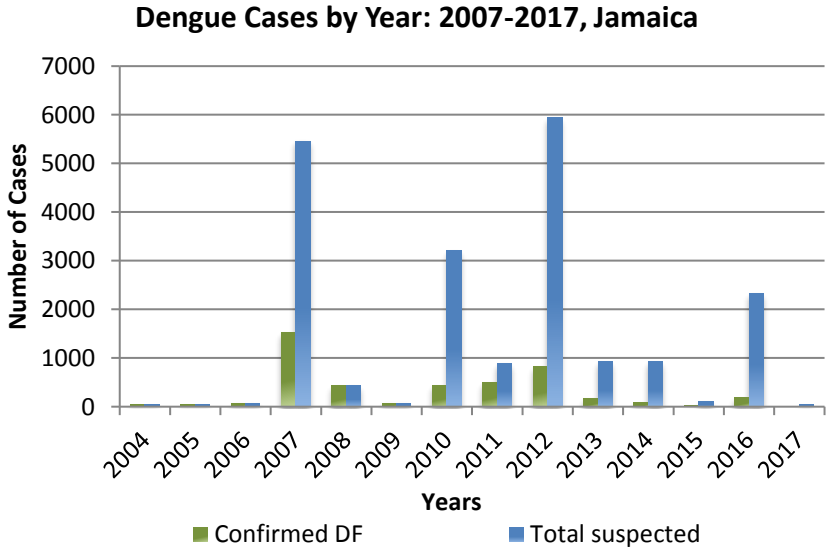
Year-to-Date Suspected Dengue Fever

	M	F	Un-known	Total	%
<1	2	0	0	2	3.7
1-4	2	2	0	4	7.2
5-14	6	9	0	15	26.8
15-24	5	5	0	10	18
25-44	11	5	1	17	30.5
45-64	2	3	0	5	9
≥65	0	0	0	0	0
Unknown	1	1	0	2	3.7
TOTAL	30	25	1	56	**100**



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

		2017		2016 YTD
		EW 26	YTD	
Total Suspected Dengue Cases		0	56	1488
Lab Confirmed Dengue cases		0	2	107
CONFIRMED	DHF/DSS	0	0	3
	Dengue Related Deaths	0	0	0



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Gastroenteritis Bulletin

EW 26

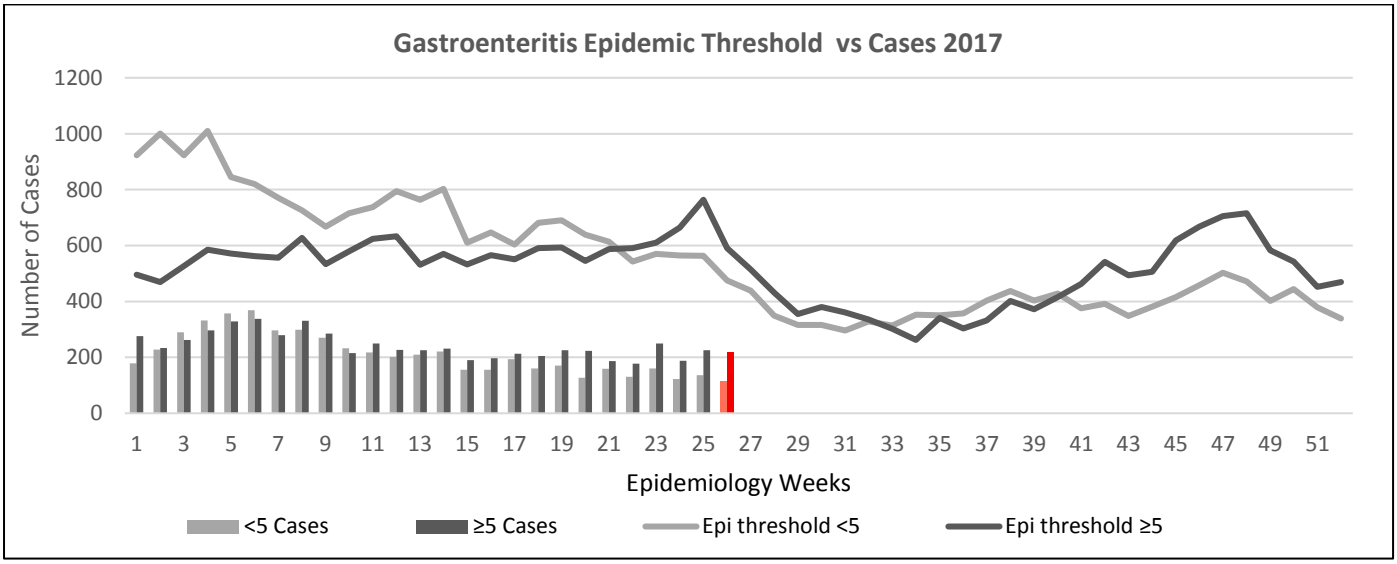
June 25- July 1, 2017 Epidemiology Week 26

Weekly Breakdown of Gastroenteritis cases

Year	EW 26			YTD		
	<5	≥5	Total	<5	≥5	Total
2017	113	220	333	5,485	6,275	11,760
2016	171	297	468	3,868	6,132	10,000

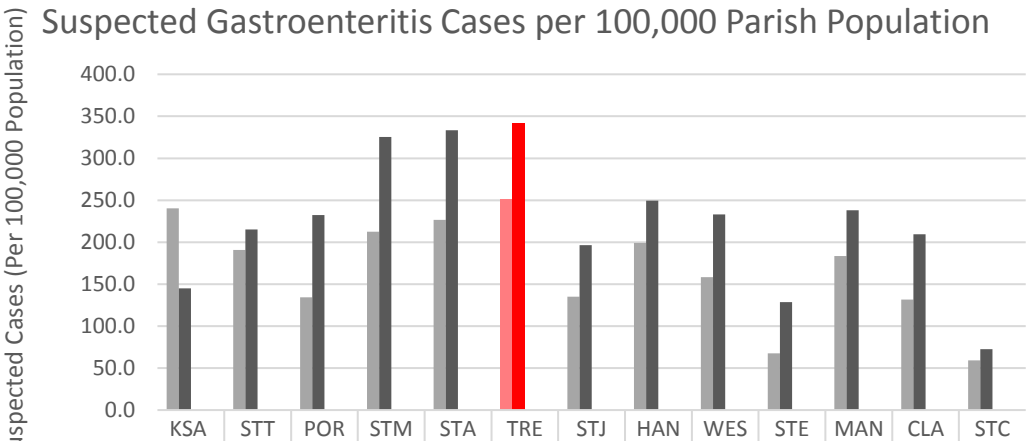
Gastroenteritis:
In Epidemiology Week 26, 2017, the total number of reported GE cases showed an 14% decrease compared to EW 26 of the previous year.
The year to date figure showed a 18% increase in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2016-2017



Trelawny reported the highest number of GE cases per 100,000 in their 5 years old and over population

Trelawny reported the highest number of GE cases per 100,000 in their under 5 years old population



	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
Suspected GE Cases < 5 yrs/ 100 000 pop	240.5	190.8	134.1	212.5	226.5	251.5	135.0	199.0	158.5	67.6	183.7	131.6	59.4
Suspected GE cases ≥5yrs/ 100 000 pop	145.0	215.2	232.2	325.5	333.4	341.9	196.5	249.6	232.9	128.6	238.0	209.4	72.4

Highest number of cases < 5 /100,000 pop

Highest number of cases ≥ 5/100,000 pop

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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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