WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Disability

Disability is part of being human. Almost everyone will temporarily or permanently experience disability at some point in their life. An estimated 1.3 billion people – about 16% of the global population – currently experience significant disability. This number is increasing due in part to population ageing and an increase in the prevalence of noncommunicable diseases. Disability results from the interaction between individuals with a health condition, such as cerebral palsy, Down syndrome and depression, with personal and environmental factors including negative attitudes, inaccessible transportation and public buildings, and limited social support.

A person's environment has a huge effect on the experience and extent of disability. Inaccessible environments create barriers that often hinder the full and effective participation of persons with disabilities in society on an equal basis with others. Progress on improving social participation can be made by addressing these barriers and facilitating persons with disabilities in their day to day lives

Persons with disabilities die earlier, have poorer health, and experience more limitations in everyday functioning than the rest of the population due to health inequities. These health inequities arise from unfair conditions that affect persons with disabilities disproportionally, including stigma, discrimination, poverty, exclusion from education and employment, and barriers faced in the health system itself. Compared to persons without disabilities, some persons with disabilities:

- die up to 20 years earlier;
- have more than a double risk of developing comorbid conditions such as depression, asthma, diabetes, stroke, obesity or poor oral health;
- find inaccessible health facilities up to 6 times more hindering; and,
- are up to 15 times more limited by inaccessible and unaffordable transportation.

It is a state obligation, through the health sector in coordination with other sectors, to address existing health inequities so that persons with disabilities can enjoy their inherent right to the highest attainable standard of health. Disability inclusion is critical to achieving the Sustainable Development Goals and global health priorities of universal health coverage, protection in health emergencies and healthier populations. Acting to achieve health equity for persons with disabilities is acting to achieve Health for All.

https://www.who.int/health-topics/disability#tab=tab_1

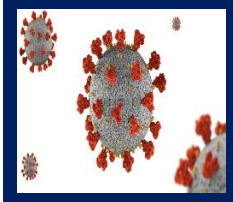
EPI WEEK 47

- Syndromic Surveillance
- Accidents
- Violence

Pages 2-4

Class 1 Notifiable Events

Page 5



COVID-19

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Influenza

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Dengue Fever

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Research Paper

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Sentinel Surveillance in Jamaica

A syndromic surveillance system is good for early detection of and response to public health events.

Sentinel surveillance occurs when selected health facilities (sentinel sites) form a network that reports on certain health conditions on a regular basis, for example, weekly. Reporting is mandatory whether or not there are cases to report.

Jamaica's sentinel surveillance system concentrates on visits to sentinel sites for health events and syndromes of national importance which are reported weekly (see pages 2 -4). There are seventy-eight (78) reporting sentinel sites (hospitals and health centres) across Jamaica.

Table showcasing the Timeliness of Weekly Sentinel Surveillance Parish Reports for the Four Most Recent Epidemiological Weeks – 44 to 47 of 2022

Parish health departments submit reports weekly by 3 p.m. on Tuesdays. Reports submitted after 3 p.m. are considered late.

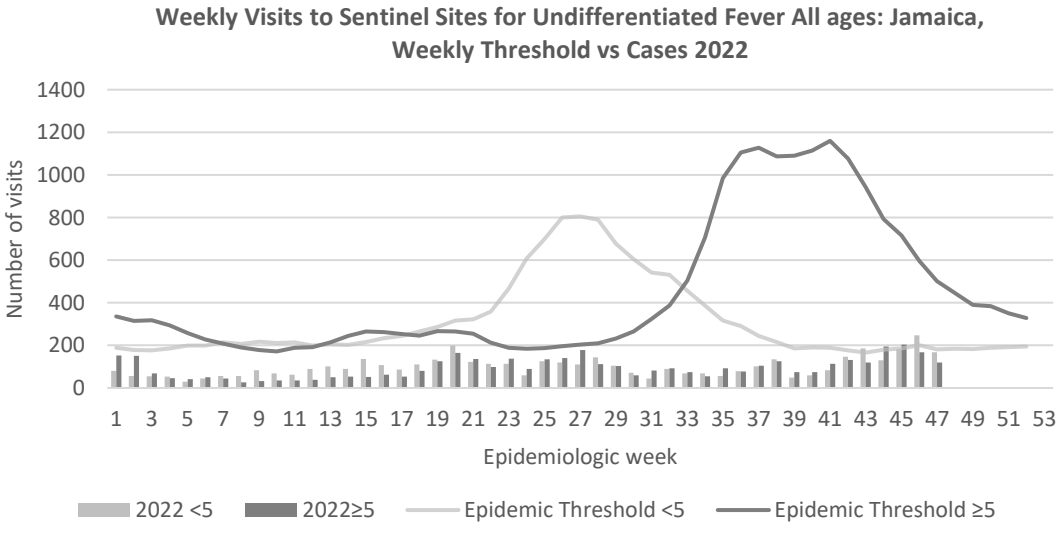
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday

Epi week	Kingston and Saint Andrew	Saint Thomas	Saint Catherine	Portland	Saint Mary	Saint Ann	Trelawny	Saint James	Hanover	Westmoreland	Saint Elizabeth	Manchester	Clarendon
2022													
44	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time
45	On Time	On Time	Late (T)	Late (T)	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time
46	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time
47	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time

REPORTS FOR SYNDROMIC SURVEILLANCE

UNDIFFERENTIATED FEVER

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



2 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

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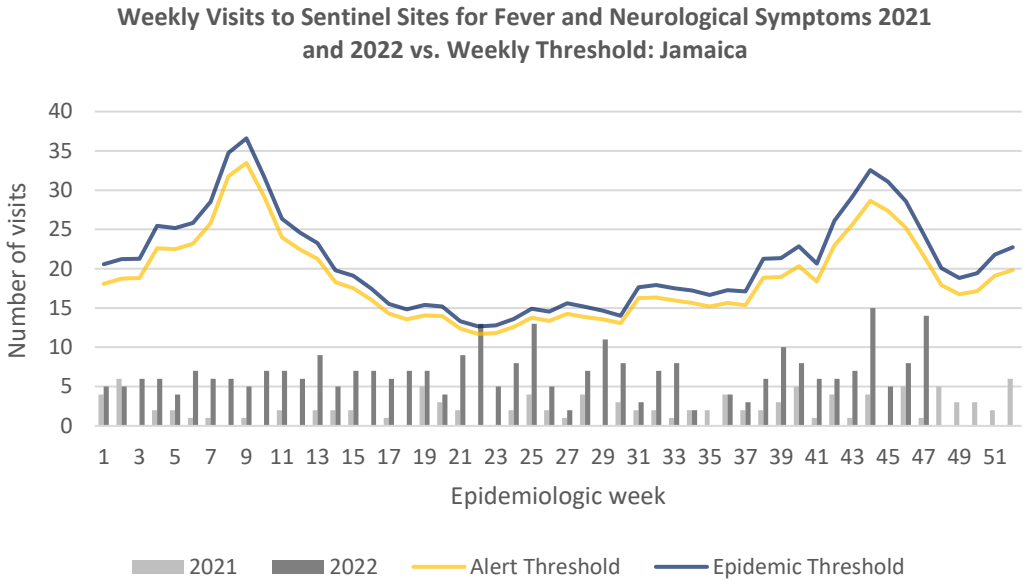
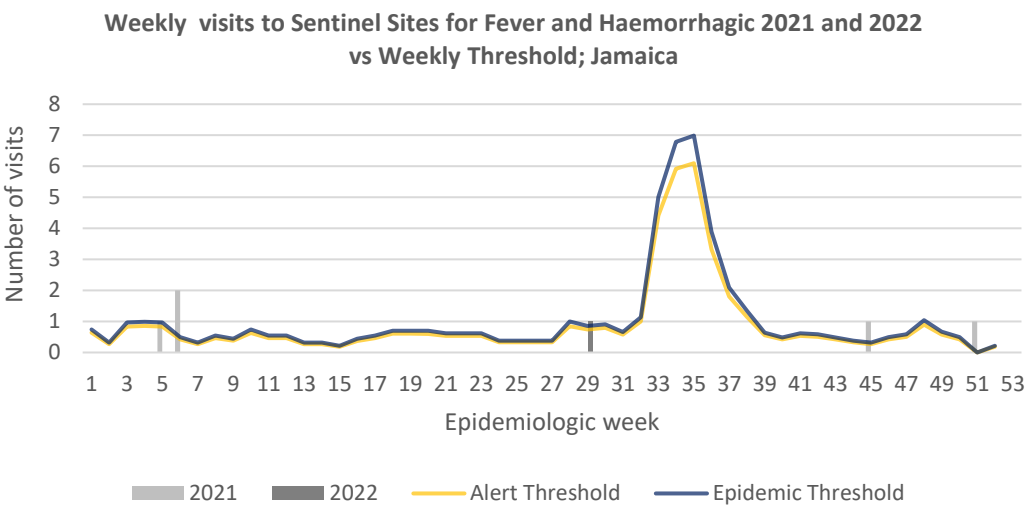
FEVER AND NEUROLOGICAL

Temperature of >38^{0}C /100.4^{0}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

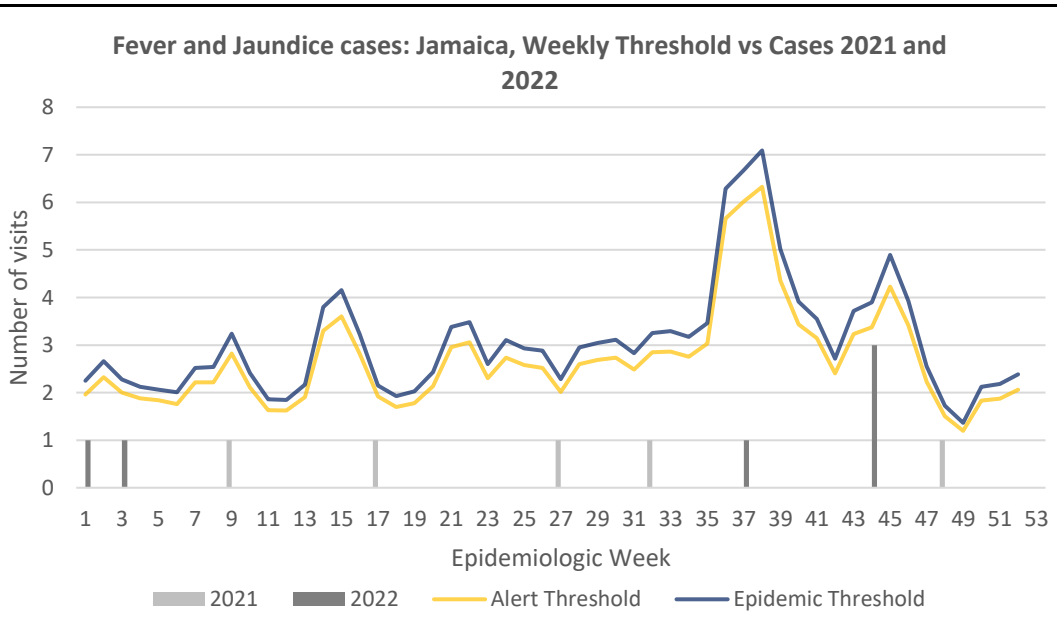
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



FEVER AND JAUNDICE

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

The epidemic threshold is used to confirm the emergence of an epidemic in order to implement control measures. It is calculated using the mean reported cases per week plus 2 standard deviations.



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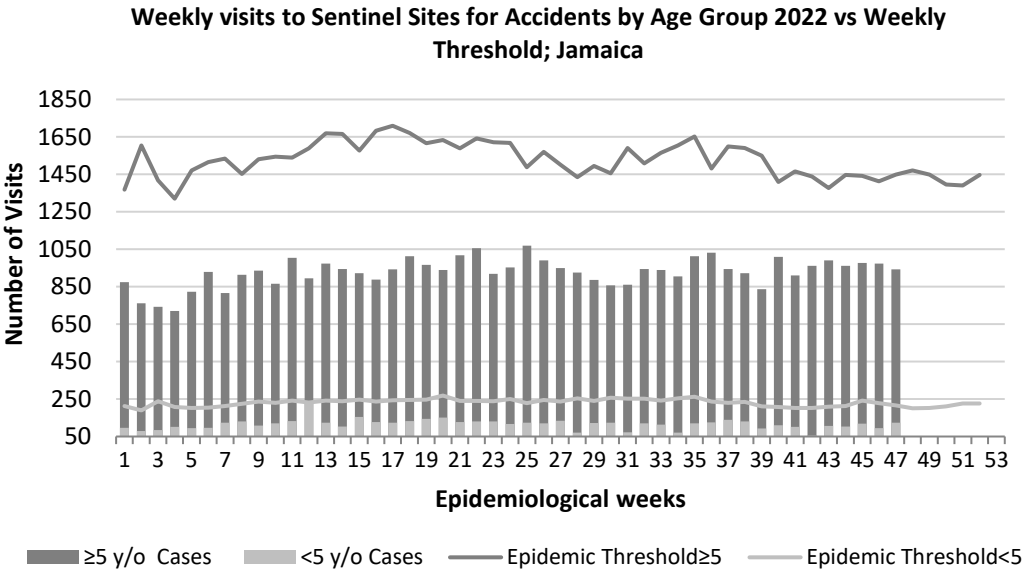
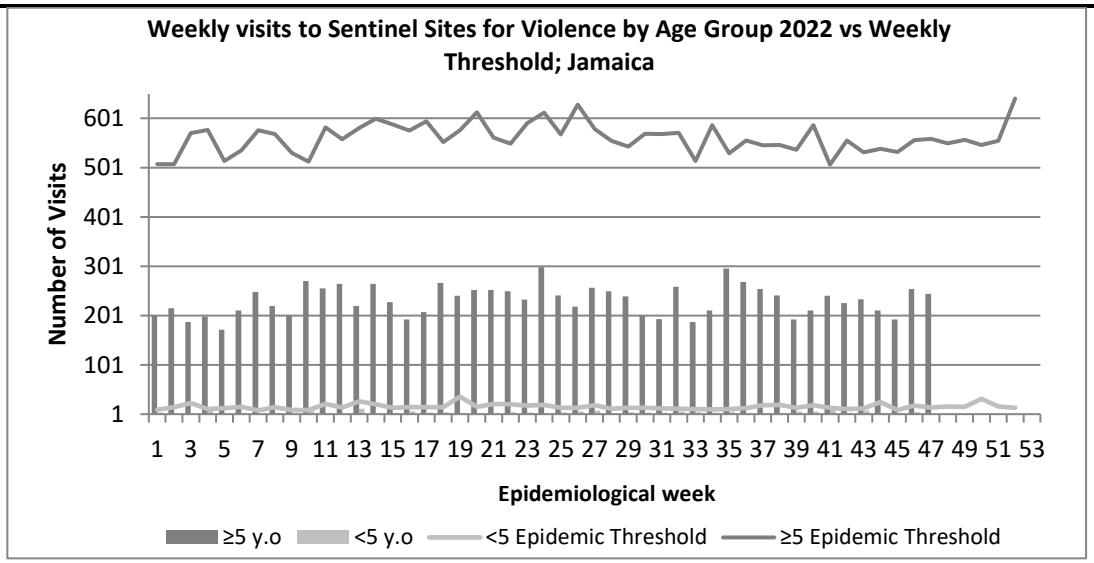
ACCIDENTS

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



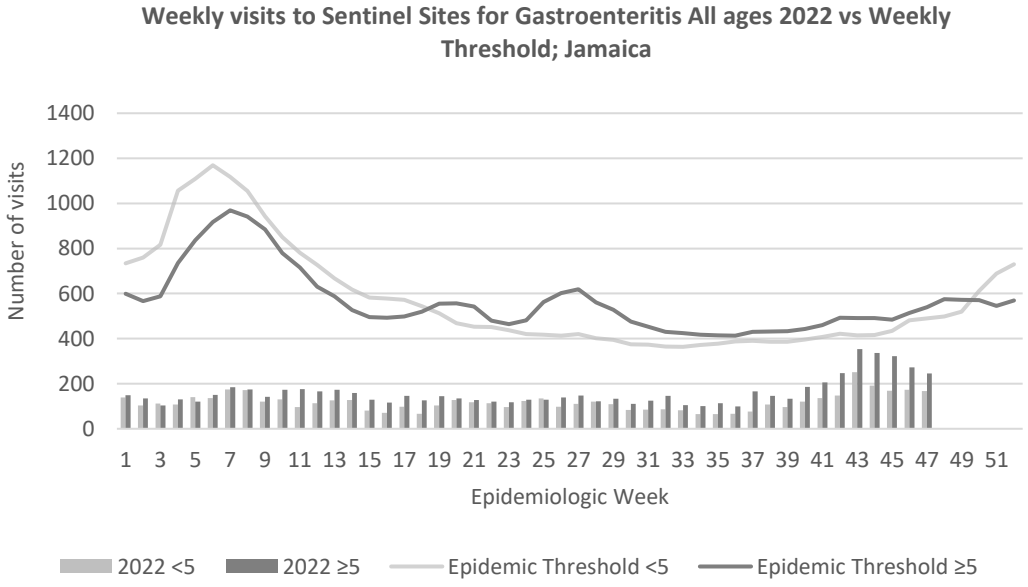
VIOLENCE

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



GASTROENTERITIS

Inflammation of the stomach and intestines, typically resulting from bacterial toxins or viral infection and causing vomiting and diarrhoea.



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CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS	Confirmed YTD[α] CURRENT YEAR 2022	Confirmed YTD[α] PREVIOUS YEAR 2021
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	196[β]	167[β]
	Cholera	0	0
	Dengue Hemorrhagic Fever[γ]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	55462	77946
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	8	6
	Hepatitis C	2	4
	HIV/AIDS	NA	NA
	Malaria (Imported)	0	0
	Meningitis (Clinically confirmed)	18	34
	Monkeypox	18	NA
EXOTIC/ UNUSUAL	Plague	0	0
H IGH 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
	Congenital Rubella Syndrome	0	0
	Congenital Syphilis	0	0
	Fever and Rash – Measles	0	0
	Fever and Rash – Rubella	0	0
	Maternal Deaths[δ]	54	79
	Ophthalmia Neonatorum	48	40
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	0
	Tetanus	2	0
	Tuberculosis	34	38
	Yellow Fever	0	0
	Chikungunya[ε]	0	0
	Zika Virus[θ]	0	0

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.

[γ] Dengue Hemorrhagic Fever data include Dengue related deaths;

[δ] Figures include all deaths associated with pregnancy reported for the period.

[ε] CHIKV IgM positive cases

[θ] Zika PCR positive cases

[β] Updates made to prior weeks in 2020.

[α] Figures are cumulative totals for all epidemiological weeks year to date.

NA- Not Available

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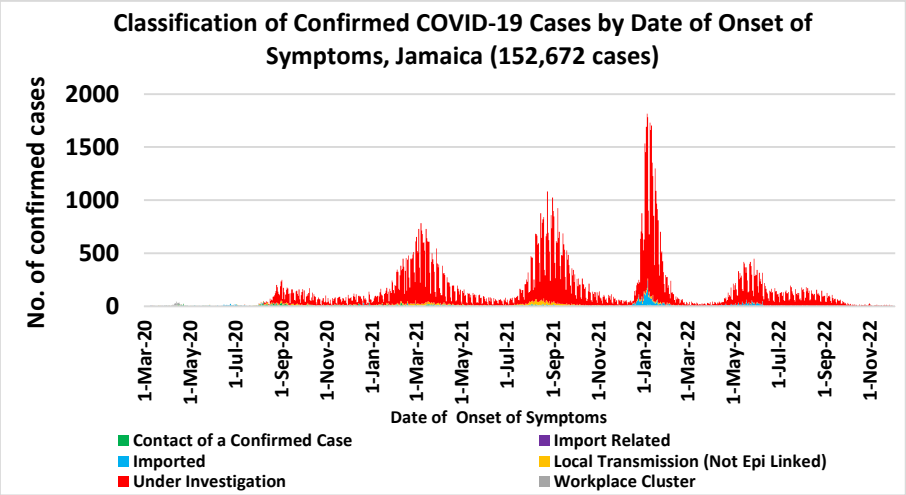
COVID-19 Surveillance Update

March 10, 2020 – EW 47 , 2022

CASES	EW 47	Total
Confirmed	55	152672
Females	29	88082
Males	26	64587
Age Range	21 days old–85 years	1 day to 108 years

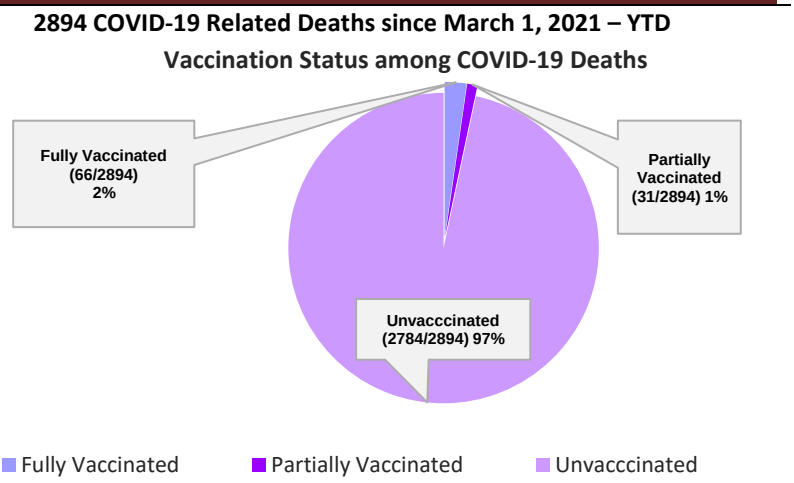
* 3 positive cases had no gender specification
* PCR or Antigen tests are used to confirm cases



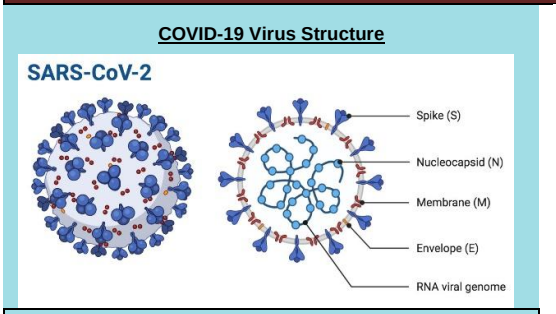
COVID-19 Outcomes

Outcomes	EW 47	Total
ACTIVE *past 2 weeks*		110
DIED – COVID Related	0	3447
Died - NON COVID	0	295
Died - Under Investigation	0	332
Recovered and discharged	9	101947
Repatriated	0	93
Total		152672

*Vaccination programme March 2021 – YTD

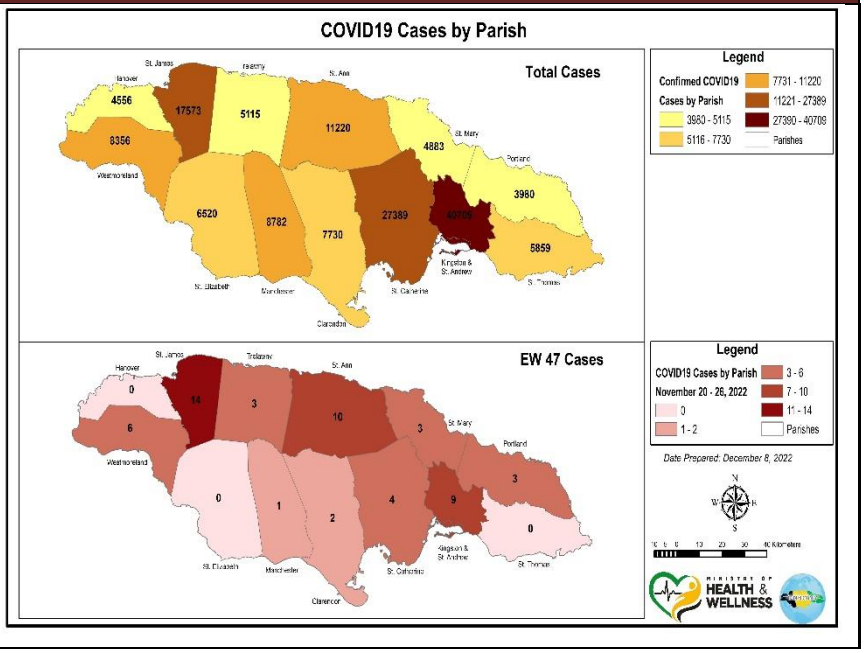


COVID-19 Parish Distribution and Global Statistics



COVID-19 WHO Global Statistics EW44-EW47

Epi Week	Confirmed Cases	Deaths
44	2,412,513	7,998
45	2,533,370	8,071
46	2,746,939	8533
47	3,010,501	7981
Total (4weeks)	**10,703,323**	**32,583**



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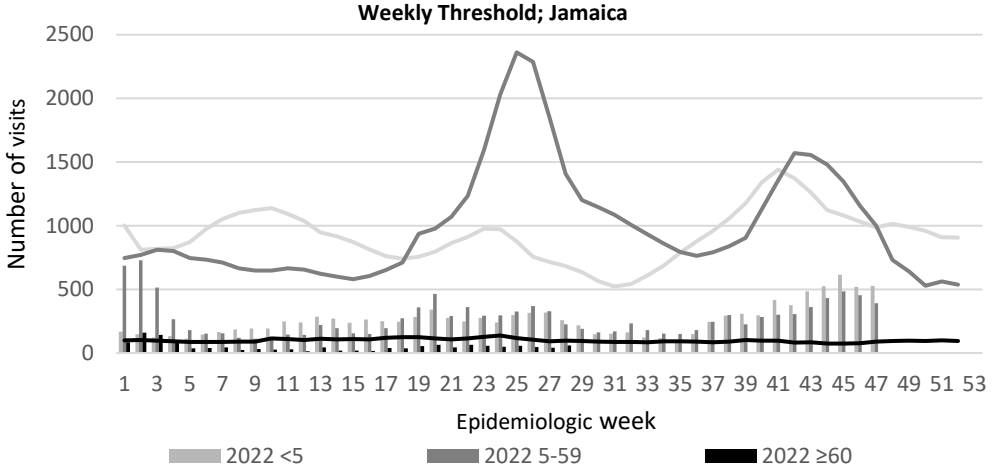
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 47

November 20– Nov 26, 2022 Epidemiological Week 47

	EW 47	*YTD*
SARI cases	*14*	*471*
Total Influenza positive Samples	*0*	*47*
Influenza A	*0*	*47*
H3N2	*1*	*41*
H1N1pdm09	*0*	*6*
Not subtyped	*0*	*0*
Influenza B	*0*	*0*
Parainfluenza	*0*	*0*

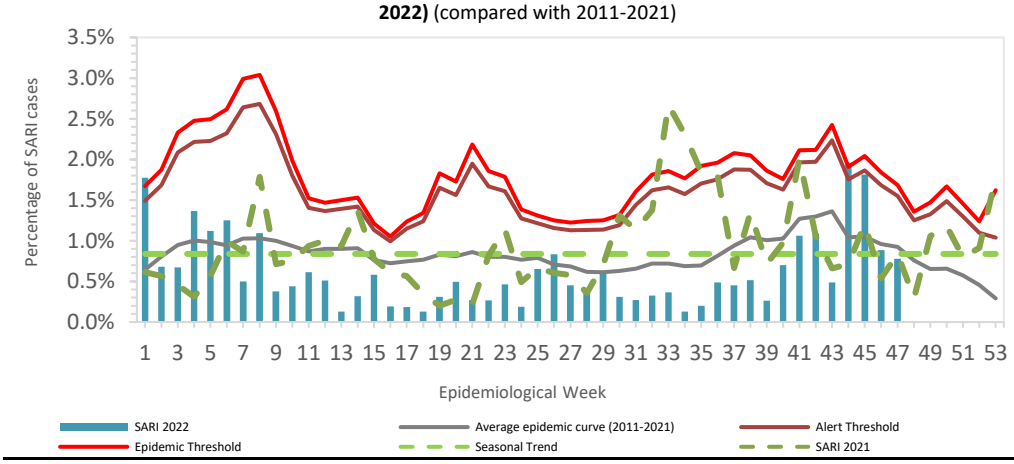
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2022 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 47 fourteen (14) SARI admissions were reported.

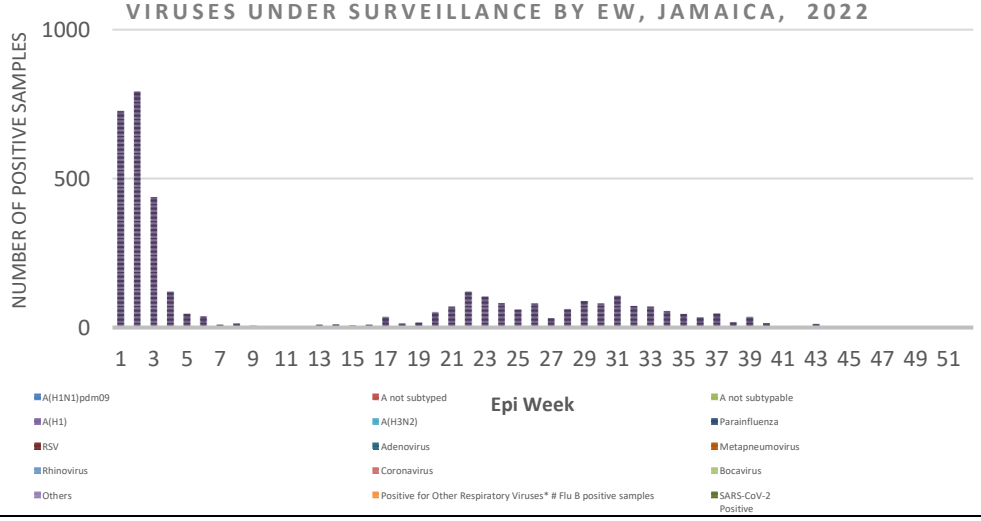
Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2022) (compared with 2011-2021)



Caribbean Update EW 47

Caribbean: Influenza activity continues moderate across the subregion with A(H3N2) virus predominance. In contrast, SARS-CoV-2 activity remained low. In addition, the Dominican Republic and Puerto Rico have shown increased influenza activity but continue at low-intensity levels, while Guadeloupe and Martinique recorded increased RSV activity.

DISTRIBUTION OF INFLUENZA AND OTHER RESPIRATORY VIRUSES UNDER SURVEILLANCE BY EW, JAMAICA, 2022



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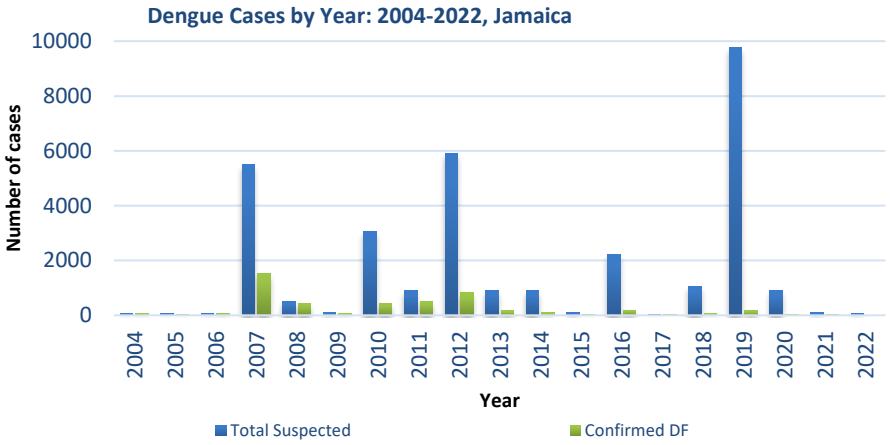
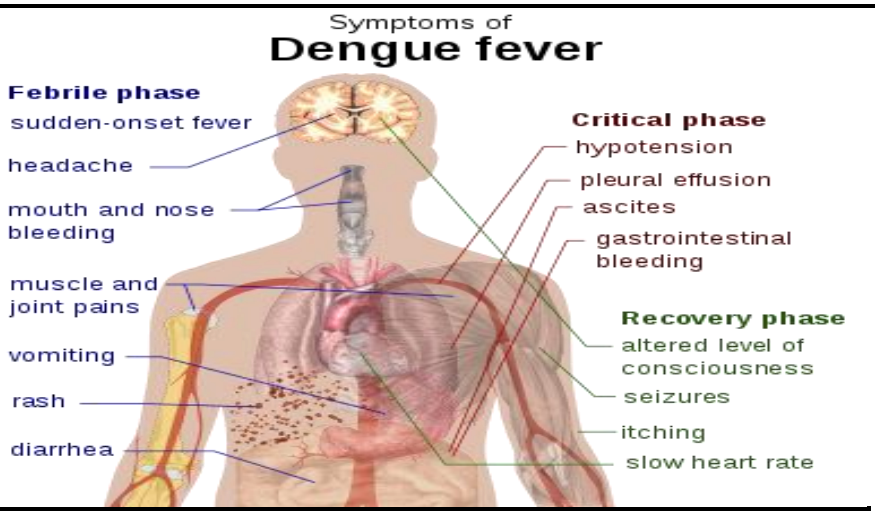
Dengue Bulletin

November 20- November 26, 2022 Epidemiological Week 47 | Epidemiological Week 47



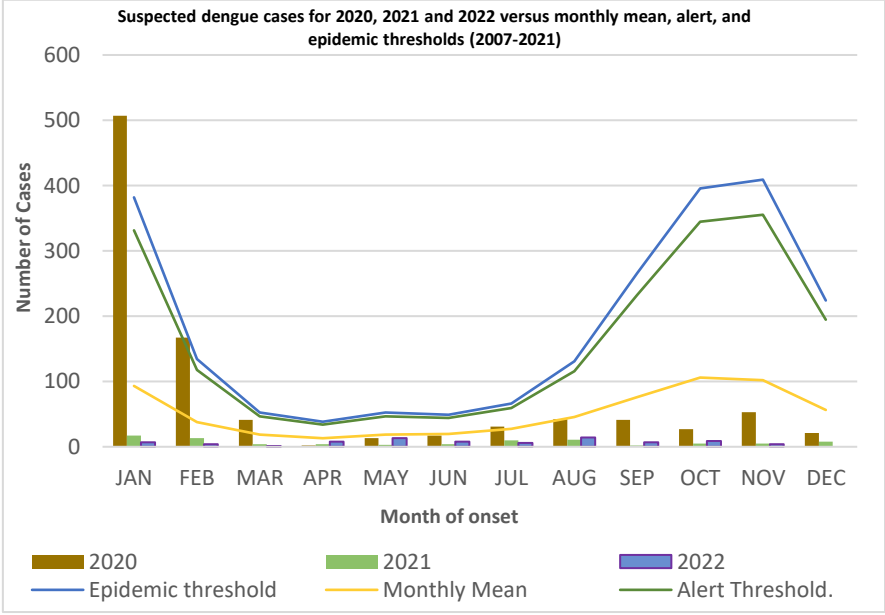
Reported suspected and confirmed dengue with symptom onset in week 47 of 2022

	2022*	
	EW 47	YTD
Total Suspected Dengue Cases	0	81
Lab Confirmed Dengue cases	0	0
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- *Figure as at Nov 26, 2022
- Only PCR positive dengue cases are reported as confirmed.
- IgM positive cases are classified as presumed dengue.



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RESEARCH PAPER

Abstract

Depression and the Impact on Productivity in the Workplace: Findings from a Jamaican Survey on Depression in the Workplace

Margarett Barnett

Objectives: The World Health Organization predicts the rise of the global burden of depression to become the leading cause of disability by 2030. The study aims to 1) address a gap in the literature in terms of baseline data for assessing the burden and impact of depression in the Jamaican workplace, and 2) quantify the links between depression, cognitive dysfunction, absenteeism and presenteeism by means of the The Work Limitation Questionnaire (WLQ) was developed by Lerner et al., to measure the degree to which health problems interfere with specific aspects of job performance and the productivity impact of these work limitations.-

Methods: 300 employed adults in a Jamaican Quasi-government institution have been recruited for the survey. Self-reported answers will be recorded for various demographic variables, diagnosis of depression, number of days taken off for depression (absenteeism), and work performance ratings and behaviours while working with depression (presenteeism). The responses pertaining to absenteeism and presenteeism will be analysed according to the presence or absence of cognitive dysfunction.

Conclusion: Absenteeism causes increased workload for other employees, reduced output, and lost income from hiring temporary workers. In addition, reduced productivity at work, or 'presenteeism', is a major but less acknowledged concern for employers, and may be even more costly than absenteeism. It is hoped that this research will bring to the fore that there is a vital need to improve employees' access to quality treatment preferably through programs based on integrated care models.

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