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Week ending May 21, 2016 Epidemiology Week 20

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

Zika and the Olympics

Based on current assessment, cancelling or changing the location of the 2016 Olympics will not significantly alter the international spread of Zika virus. Brazil is 1 of almost 60 countries and territories which to date report continuing transmission of Zika by mosquitoes. People continue to travel between these countries and territories for a variety of reasons. The best way to reduce risk of disease is to follow public health travel advice.

WHO advises pregnant women not to travel to areas with ongoing Zika virus transmission. This includes Rio de Janeiro. Pregnant women's sex partners returning from areas with circulating virus should be counselled to practice safer sex or abstain throughout the pregnancy.

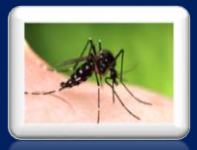
Anyone considering travel to the Olympics should:

- Follow the travel advice provided by their countries' health authorities, and consult a health worker before travelling.
- Whenever possible, during the day, protect themselves from mosquito bites by using insect repellents and by wearing clothing – preferably light-coloured – that covers as much of the body as possible.
- Practice safer sex (for example, use condoms correctly and consistently) or abstain from sex during their stay and for at least 8 weeks after their return, particularly if they have had or are experiencing symptoms of Zika virus.
- Choose air-conditioned accommodation (where windows and doors are usually kept closed to prevent mosquitoes from entering the rooms).
- Avoid visiting areas in cities and towns with no piped water or poor sanitation (ideal breeding grounds of mosquitoes), where the risk of being bitten by mosquitoes is higher.

Based on the current assessment of Zika virus circulating in almost 60 countries globally and 39 countries in the Americas, there is no public health justification for postponing or cancelling the games. WHO will continue to monitor the situation and update our advice as necessary.

Source: http://who.int/mediacentre/news/releases/2016/zika-health-advice-olympics/en/

EPI WEEK 20



NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE-30 sites*. Actively pursued

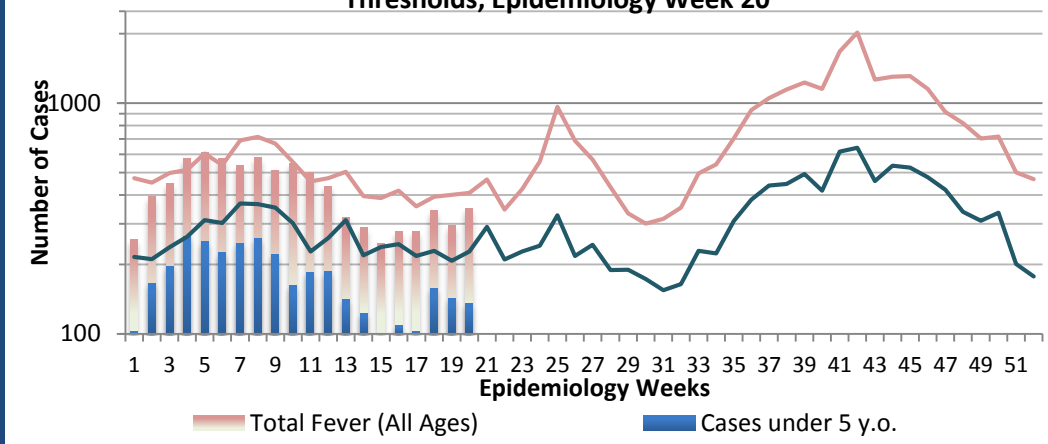
SENTINEL REPORT- 79 sites*. Automatic reporting

*Incidence/Prevalence cannot be calculated

REPORTS FOR SYNDROMIC SURVEILLANCE

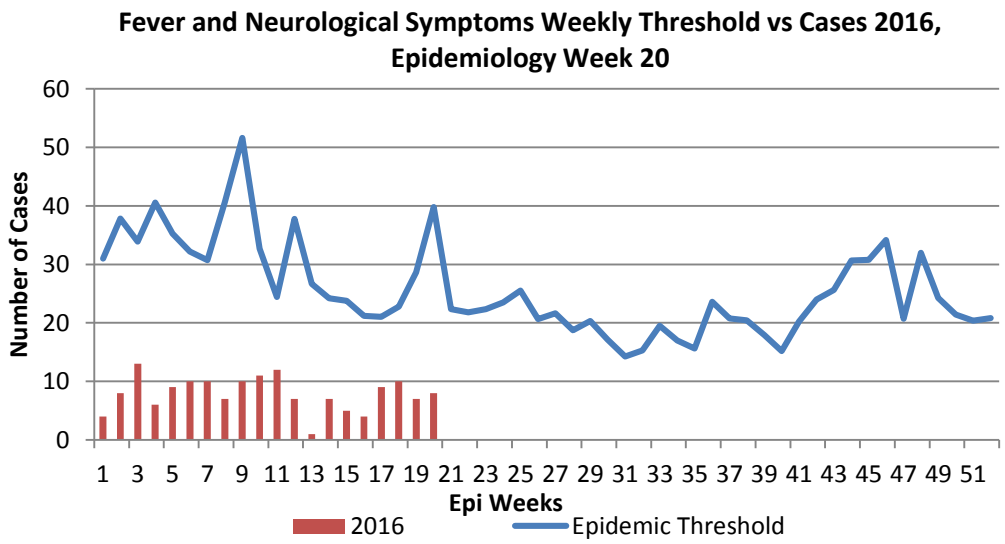
FEVER

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



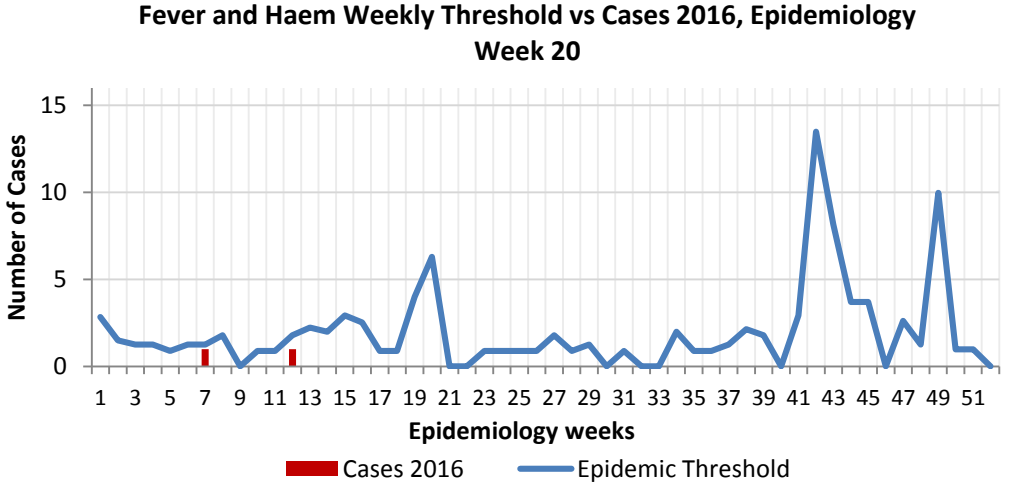
FEVER AND NEUROLOGICAL

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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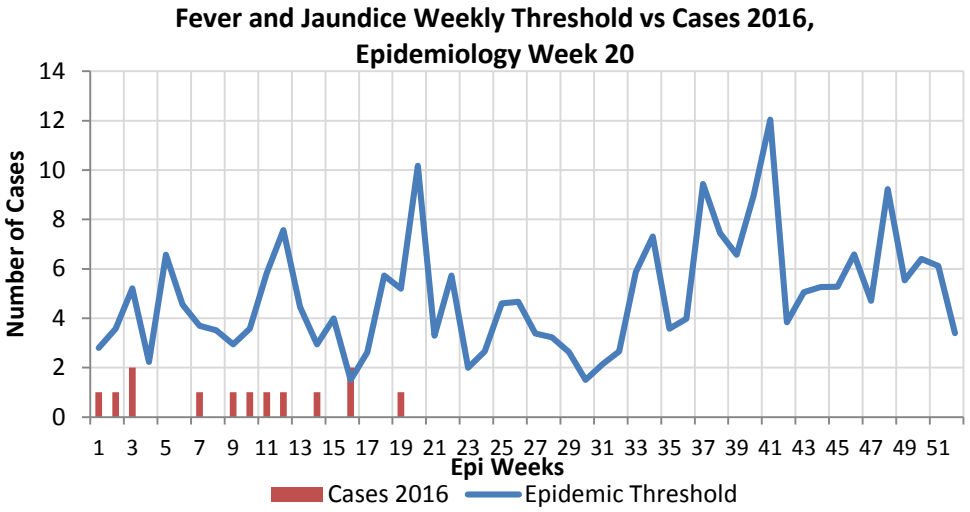
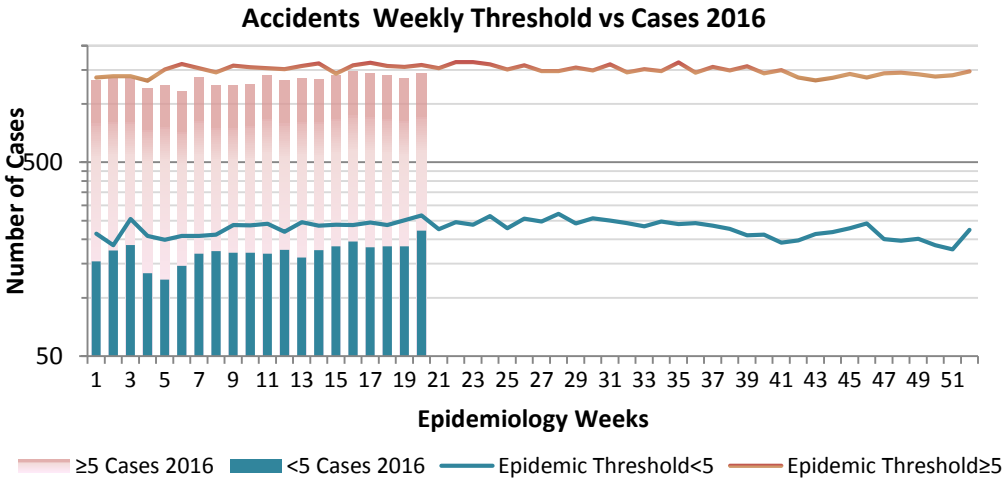
FEVER AND JAUNDICE

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



ACCIDENTS

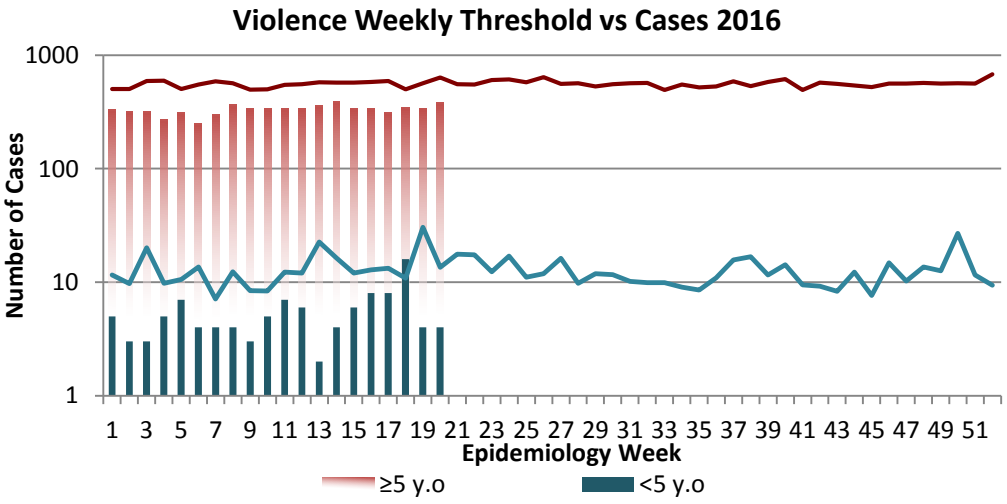
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



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		18	76
	Cholera		0	0
	Dengue Hemorrhagic Fever[1]		2	0
	Hansen's Disease (Leprosy)		1	0
	Hepatitis B		13	19
	Hepatitis C		2	2
	HIV/AIDS - See HIV/AIDS National Programme Report			
	Malaria (Imported)		1	0
	Meningitis		11	42
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]		20	22
	Ophthalmia Neonatorum		190	134
	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

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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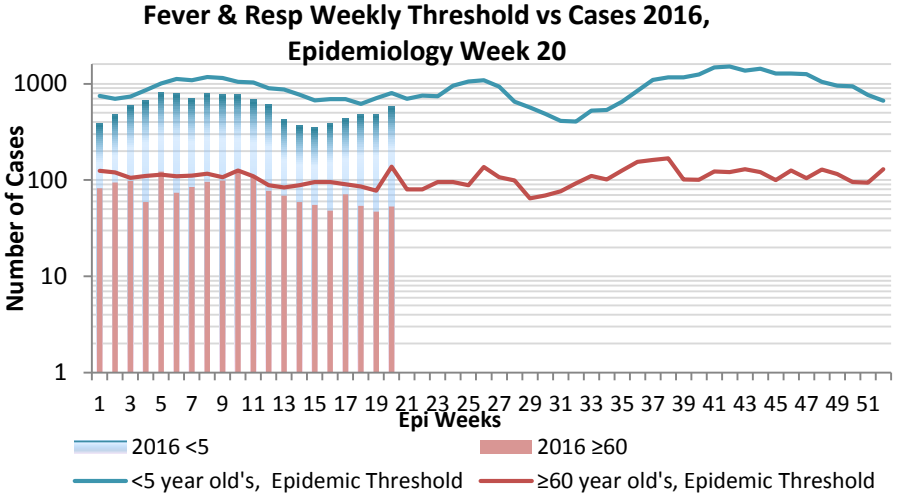
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 20

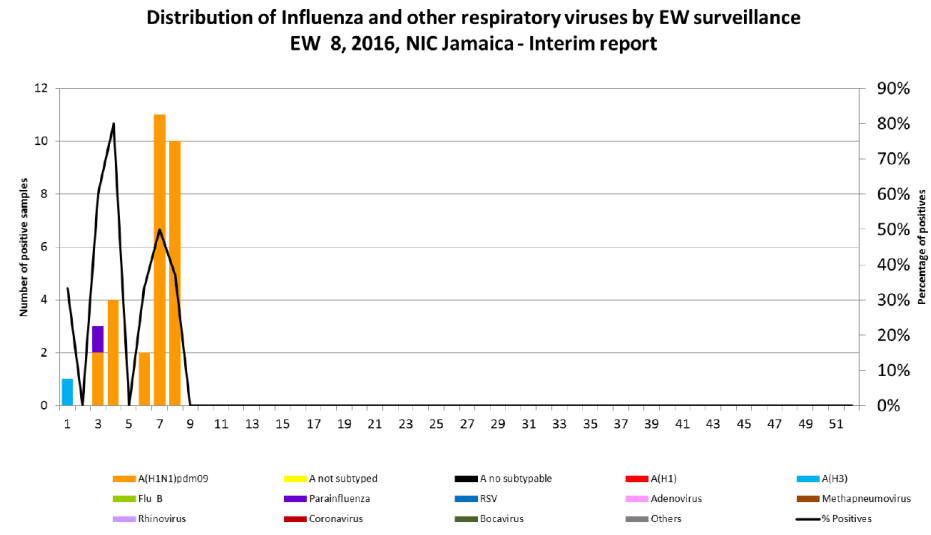
May 15 – May 21, 2016 Epidemiology Week 20

May, 2016	EW 20	YTD
SARI cases	10	645
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.



INDICATORS

Burden

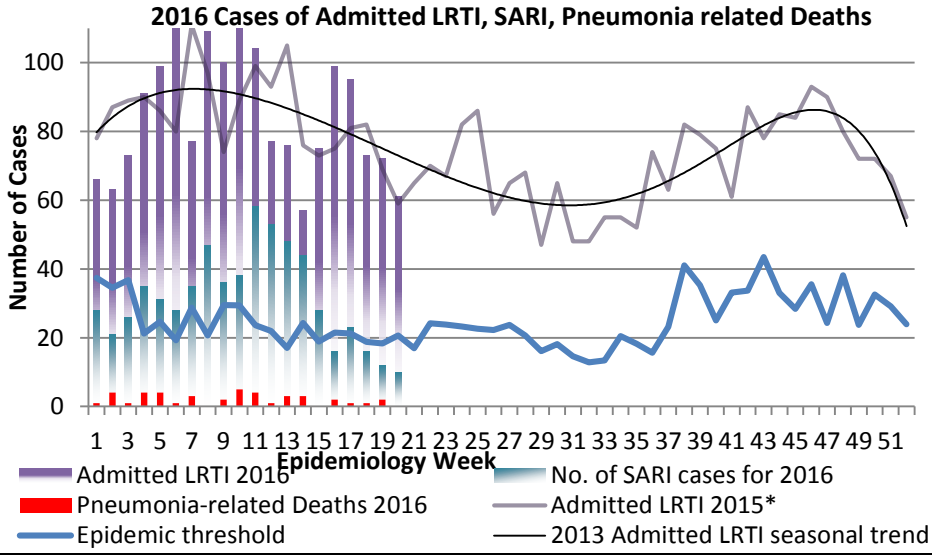
Year to date, respiratory syndromes account for 4.5% of visits to health facilities.

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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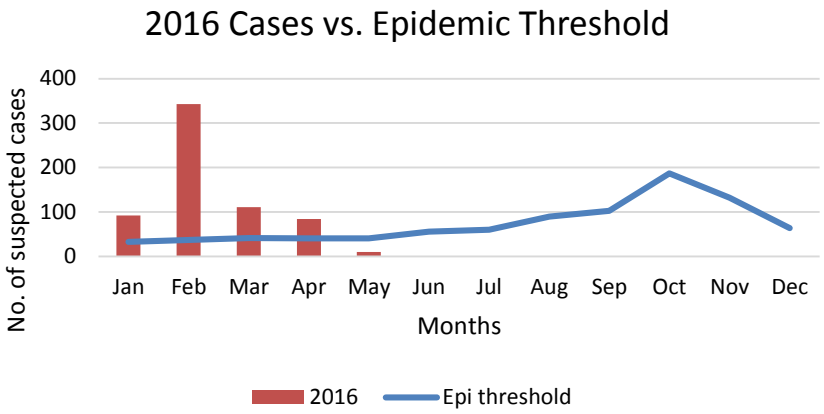
Dengue Bulletin

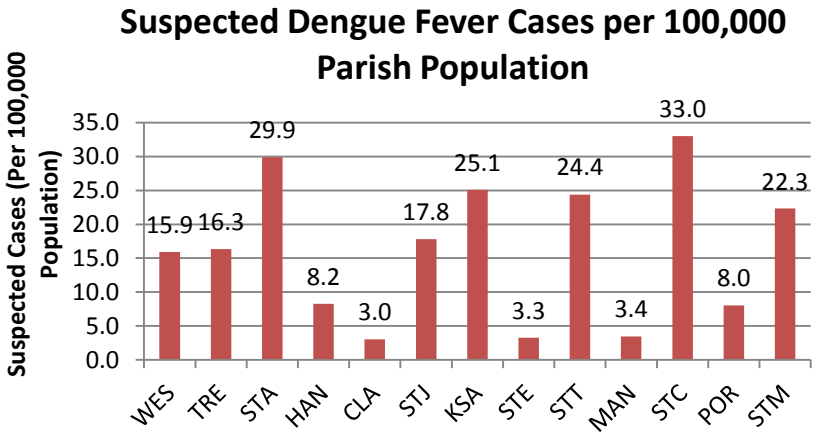
May 15 – May 21, 2016 Epidemiology Week 20



DISTRIBUTION

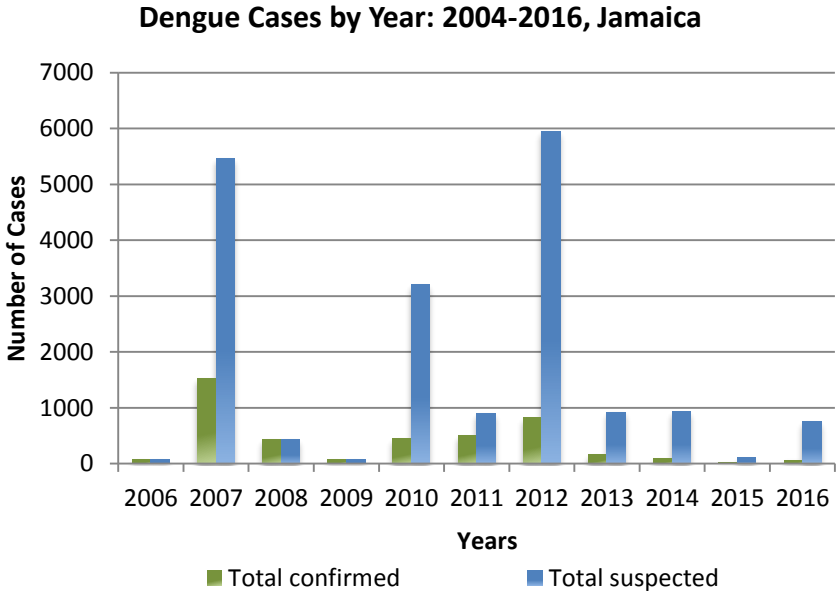
Year-to-Date Suspected Dengue Fever

	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**



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

		2016		2015 YTD
		EW 20	YTD	
Total Suspected Dengue Cases		6	698	27
Lab Confirmed Dengue cases		2	67	1
CONFIRMED	**DHF/DSS**	0	2	0
	Dengue Related Deaths	0	0	0



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Gastroenteritis Bulletin

EW 20

May 15 – May 21, 2016 Epidemiology Week 20

Weekly Breakdown of Gastroenteritis cases

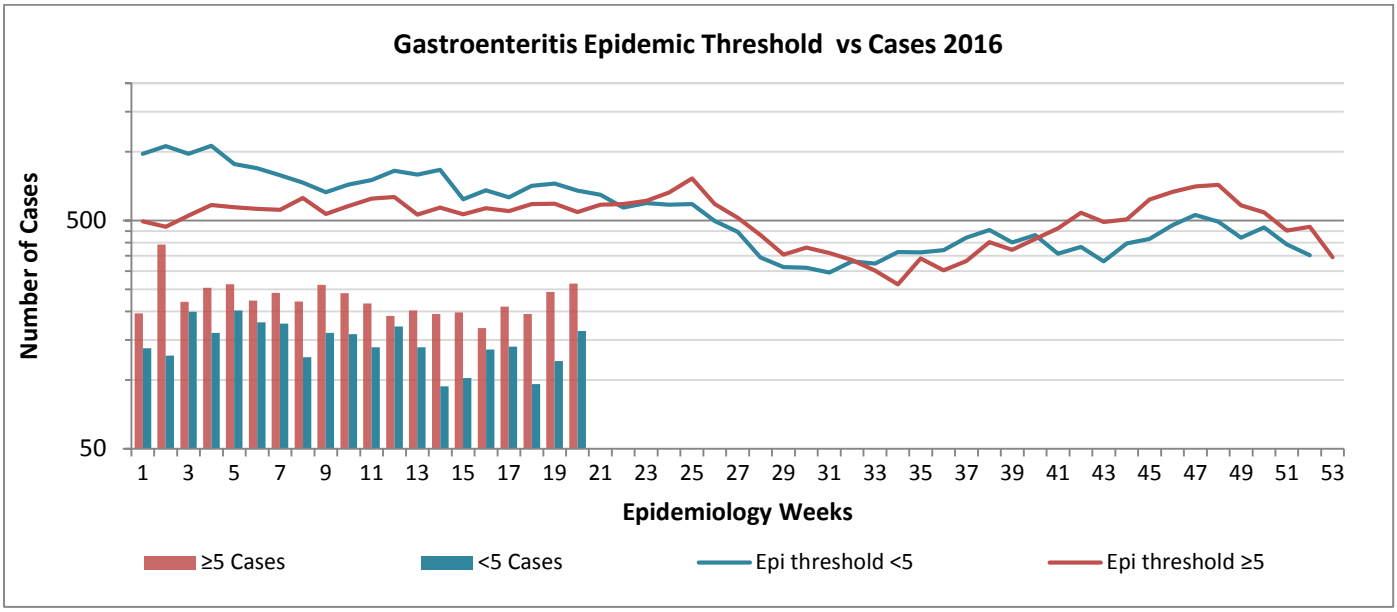
Year	EW 20			YTD		
	<5	≥5	Total	<5	≥5	Total
2016	164	265	429	2933	4401	7334
2015	155	174	329	5789	5596	11385

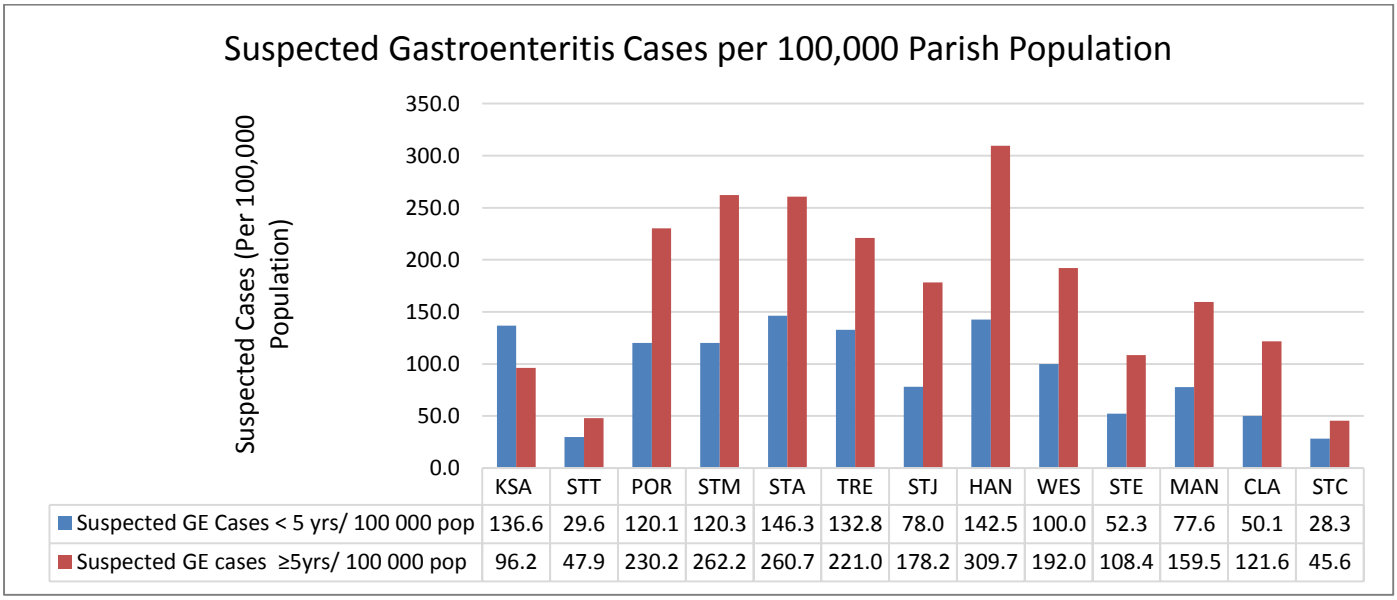
Gastroenteritis: Three or more loose stools within 24 hours.

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.

Figure 1: Total Gastroenteritis Cases Reported 2015-2016





	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
Suspected GE Cases < 5 yrs/ 100 000 pop	136.6	29.6	120.1	120.3	146.3	132.8	78.0	142.5	100.0	52.3	77.6	50.1	28.3
Suspected GE cases ≥5yrs/ 100 000 pop	96.2	47.9	230.2	262.2	260.7	221.0	178.2	309.7	192.0	108.4	159.5	121.6	45.6

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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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