Released June 21, 2016 ISSN 0799-3927

Week ending June 4, 2016 Epidemiology Week 22

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

Yellow fever global vaccine stockpile in emergencies

When a major outbreak of yellow fever hits, countries urgently need vaccine supplies to control the spread of the disease. By mid-June 2016, almost 18 million doses of yellow fever vaccine have been distributed in emergency vaccination campaigns in Angola, Democratic Republic of the Congo, and Uganda. If countries do not have sufficient yellow fever vaccine supplies, they can access the global stockpile of emergency vaccines.

WHO

When a major outbreak of yellow fever hits, countries need to access vaccine supplies urgently for rapid vaccination campaigns to control spread of the disease.

Urban yellow fever can spread rapidly in densely populated cities, causing thousands of deaths and very serious humanitarian consequences. Vaccination is the most important measure for preventing the disease.

If countries do not have sufficient yellow fever vaccine supplies, they can access the global stockpile of emergency vaccines.

The yellow fever vaccine takes a long time to produce – around 12 months – and it is difficult to forecast in advance the quantities that will be needed each year to respond to outbreaks.

The ICG originally planned to stock 2 million doses per year, but, with increasing demands the emergency stockpile was increased to 6 million doses per year in 2003.

In the face of increasing demands this year, the 4 major manufacturers who supply the global stockpile of the yellow fever vaccine have been working around the clock to replenish the stockpile. In early June 2016, it was at 6.2 million doses but this may not be enough if there are simultaneous outbreaks in other densely populated areas.

Source: http://who.int/features/2016/yellow-fever-vaccine-stockpile/en/

EPI WEEK 22

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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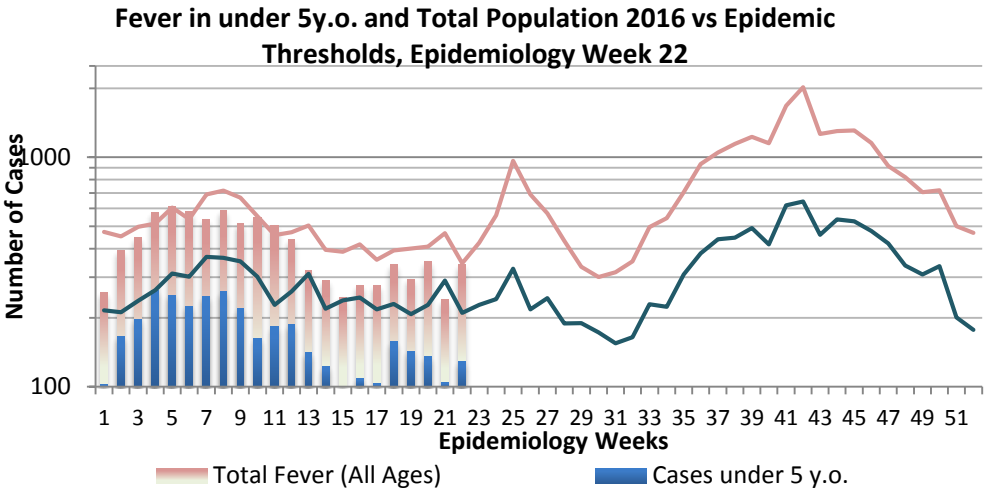
REPORTS FOR SYNDROMIC SURVEILLANCE

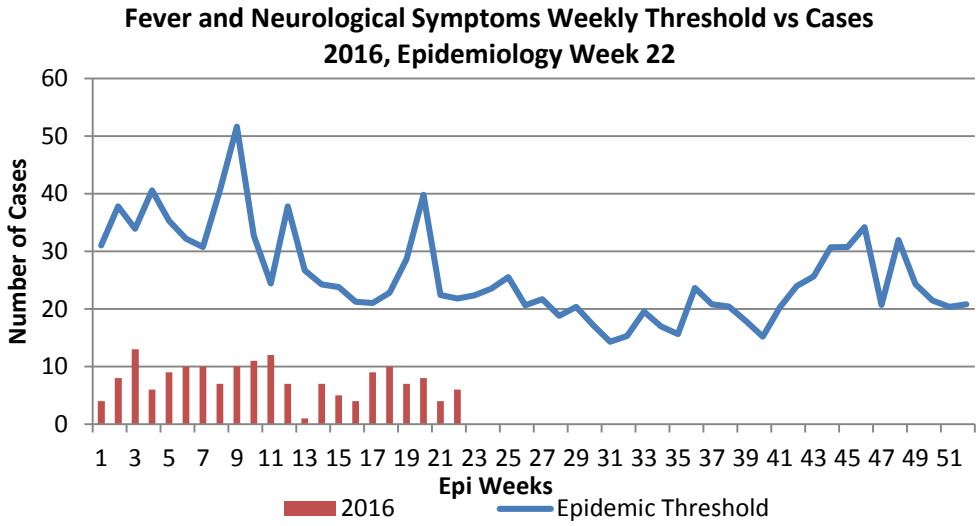
FEVER

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



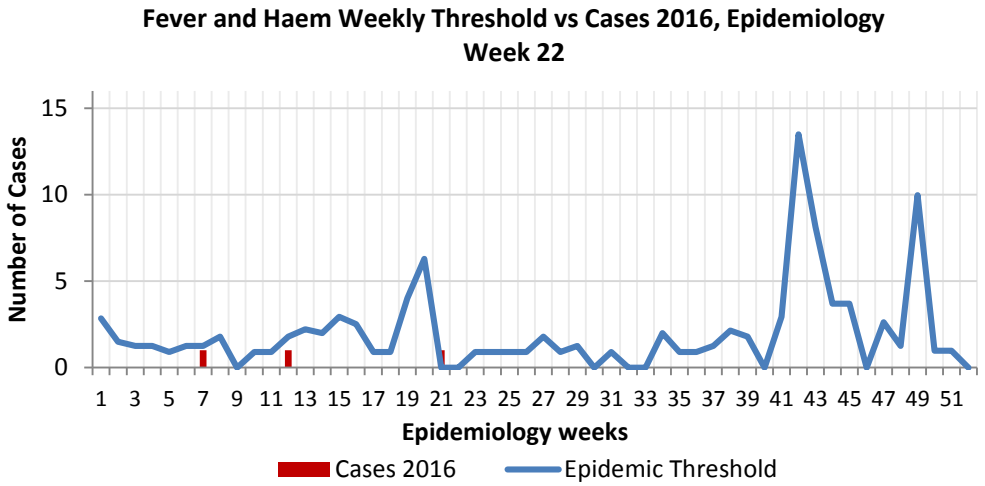
FEVER AND NEUROLOGICAL

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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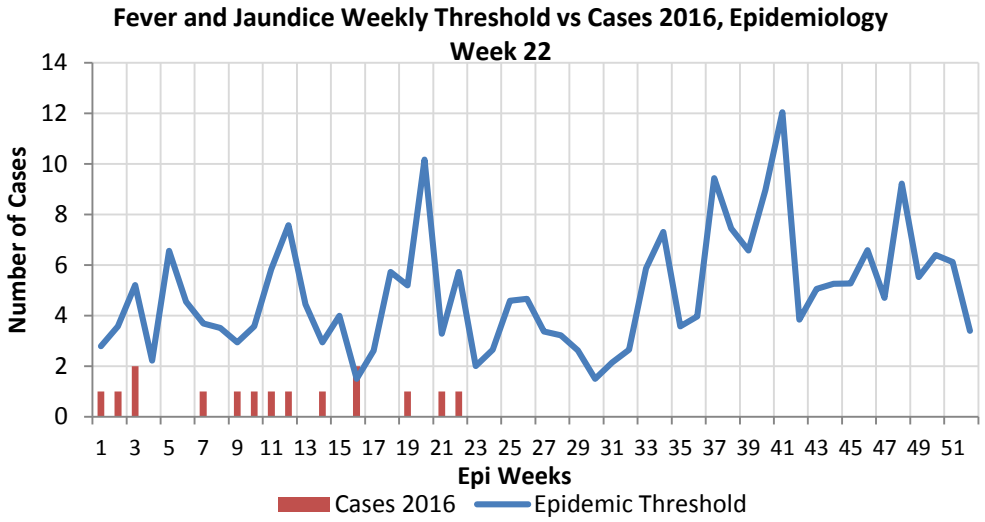
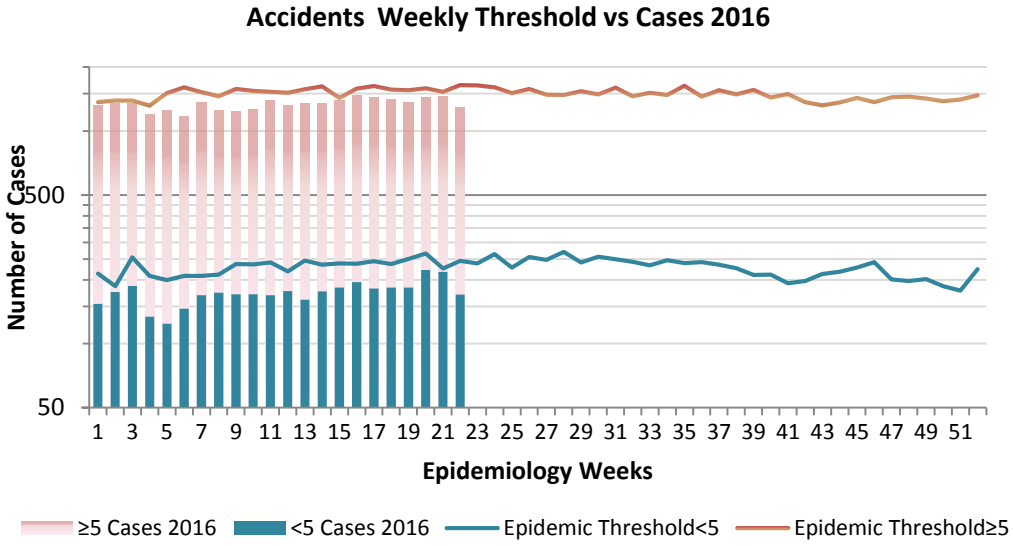
FEVER AND JAUNDICE

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



ACCIDENTS

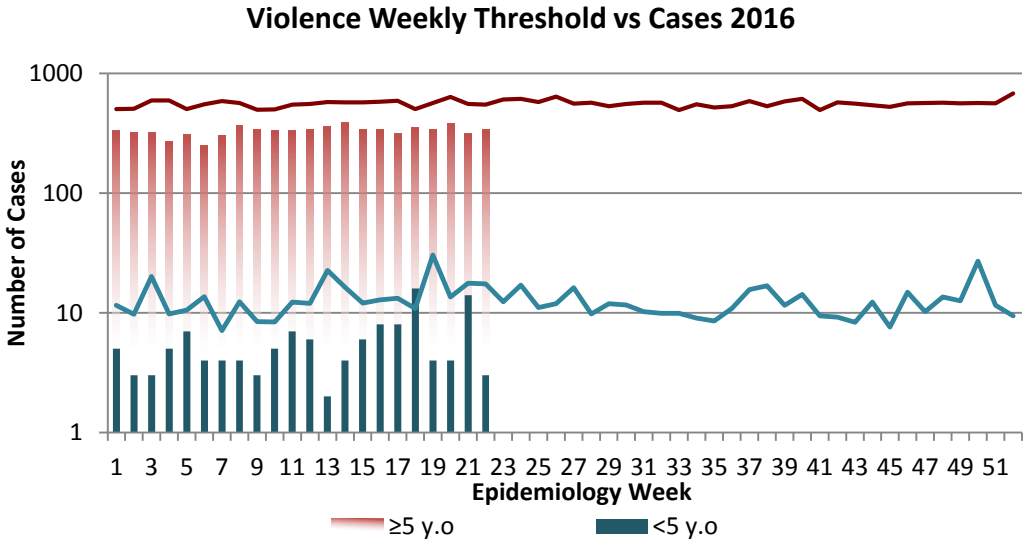
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



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	85
	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 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	17	2
		Rubella	0	0
	Maternal Deaths[2]		22	23
	Ophthalmia Neonatorum		192	140
	Pertussis-like syndrome		0	0
	Rheumatic Fever		1	8
	Tetanus		0	1
	Tuberculosis		0	0
	Yellow Fever		0	0
	Chikungunya		0	1
	Zika Virus		24	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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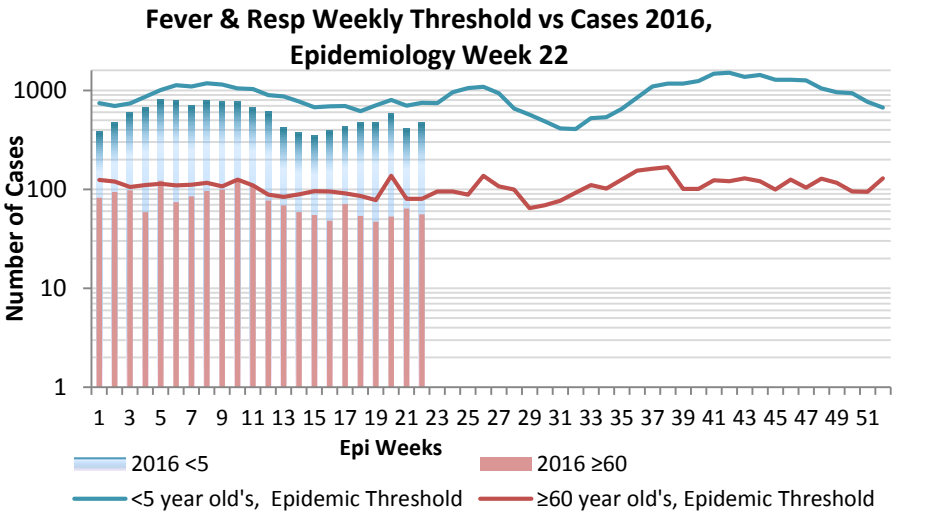
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 22

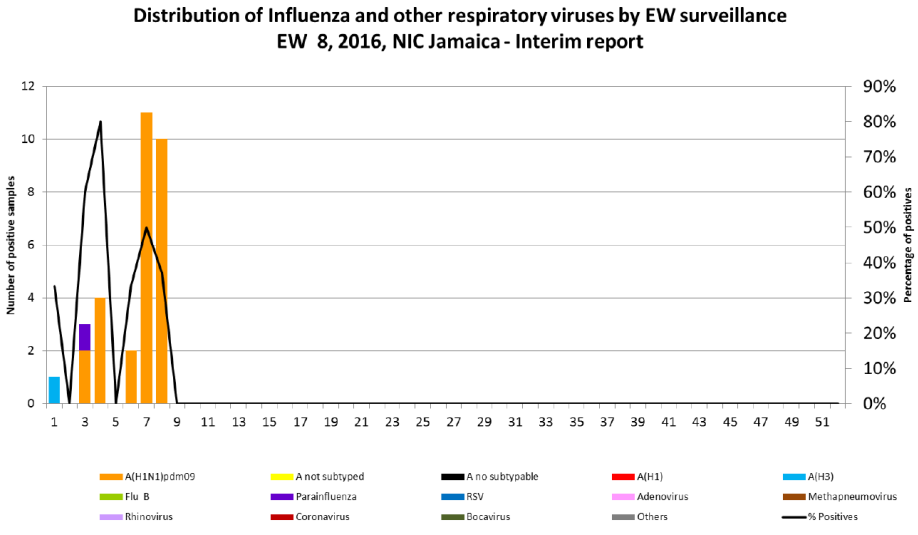
May 29 – June 4, 2016 Epidemiology Week 22

May, 2016	EW 22	YTD
SARI cases	11	666
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

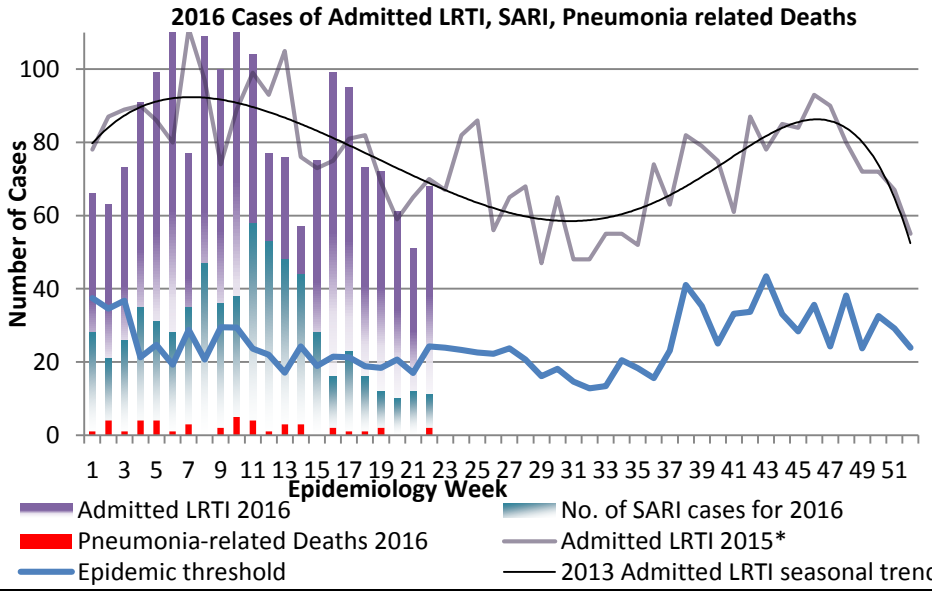
Year to date, respiratory syndromes account for 4.2% of visits to health facilities.

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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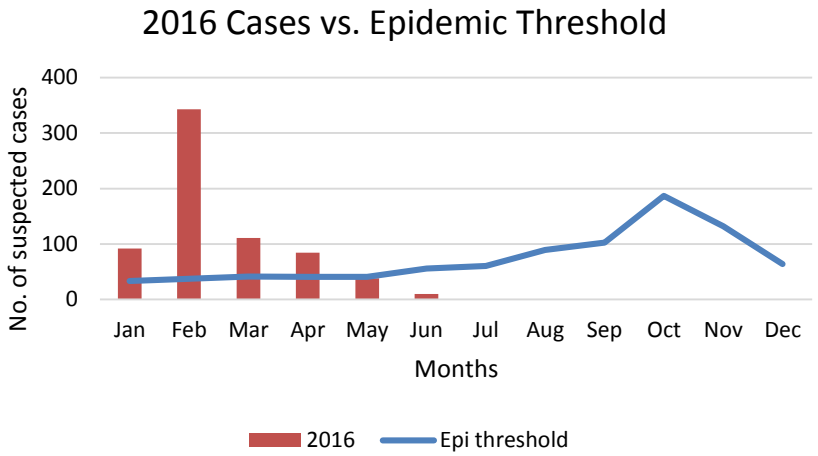
Dengue Bulletin

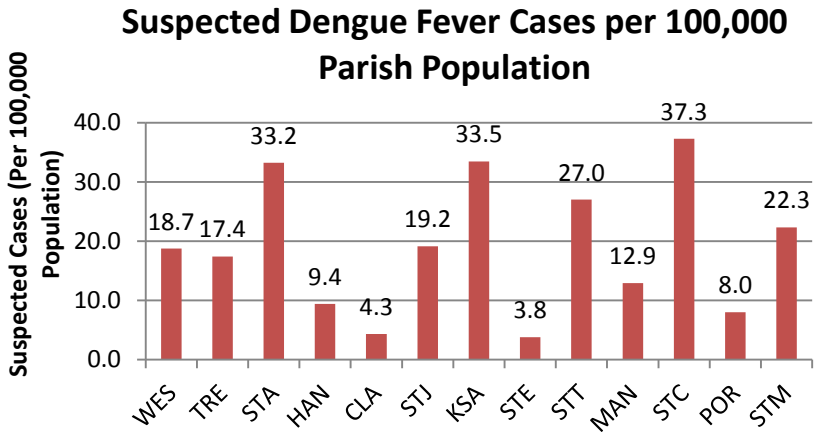
May 29 – June 4, 2016 Epidemiology Week 22



DISTRIBUTION

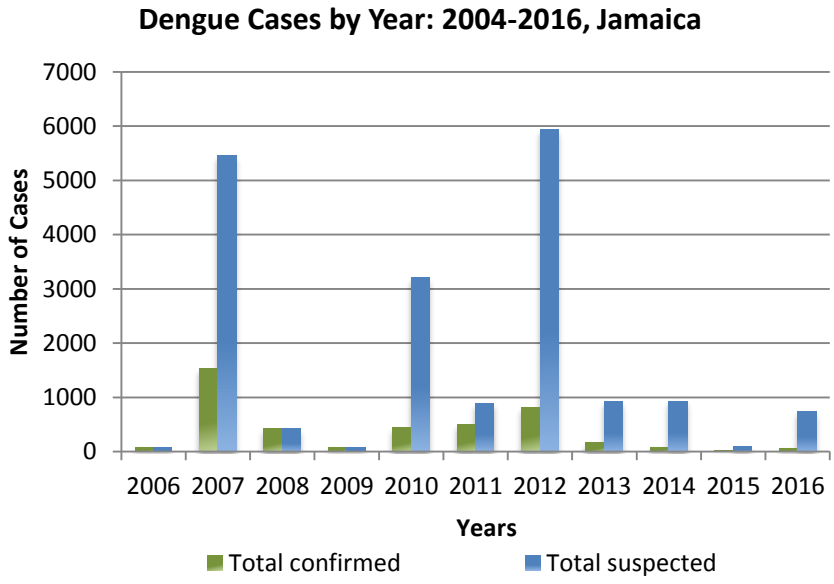
Year-to-Date Suspected Dengue Fever

	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	128	204	14
TOTAL	258	427	132	817	**100**



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

		2016		2015 YTD
		EW 22	YTD	
Total Suspected Dengue Cases		10	817	30
Lab Confirmed Dengue cases		1	68	2
CONFIRMED	DHF/DSS	0	2	0
	Dengue Related Deaths	0	0	0



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Gastroenteritis Bulletin

EW 22

May 29 – June 4, 2016 Epidemiology Week 22

Weekly Breakdown of Gastroenteritis cases

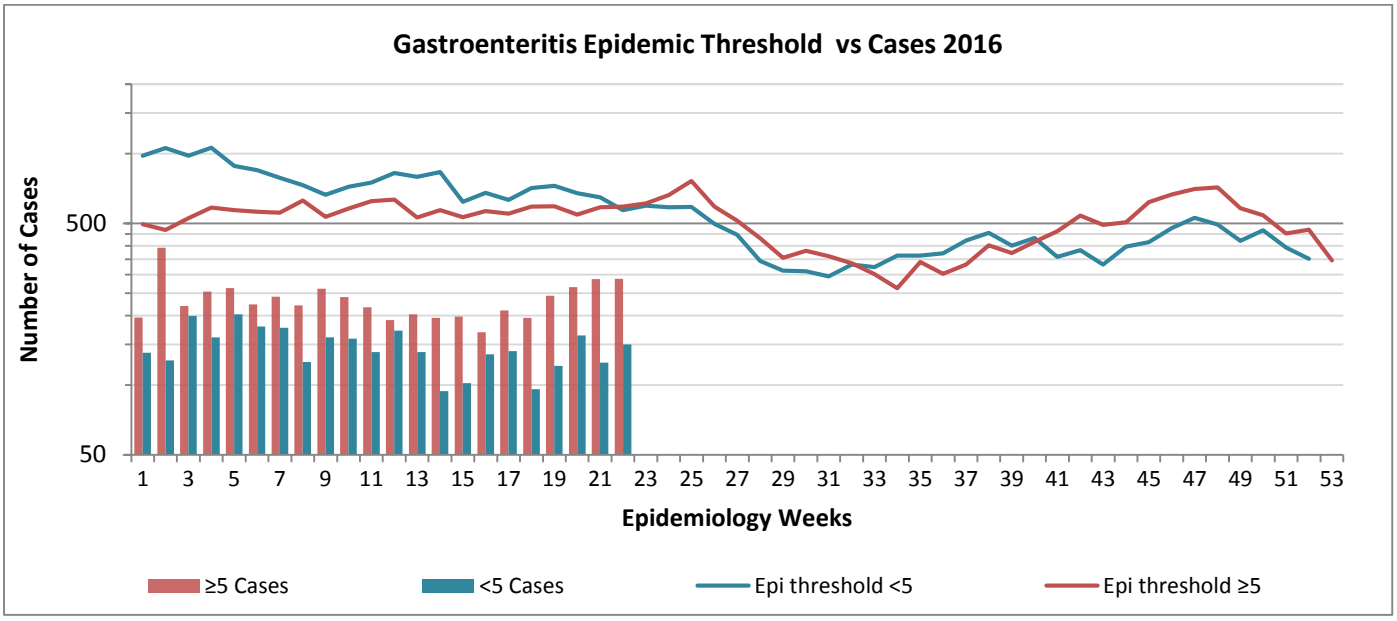
Year	EW 22			YTD		
	<5	≥5	Total	<5	≥5	Total
2016	150	288	438	3208	4976	8184
2015	139	180	319	6046	5967	12013

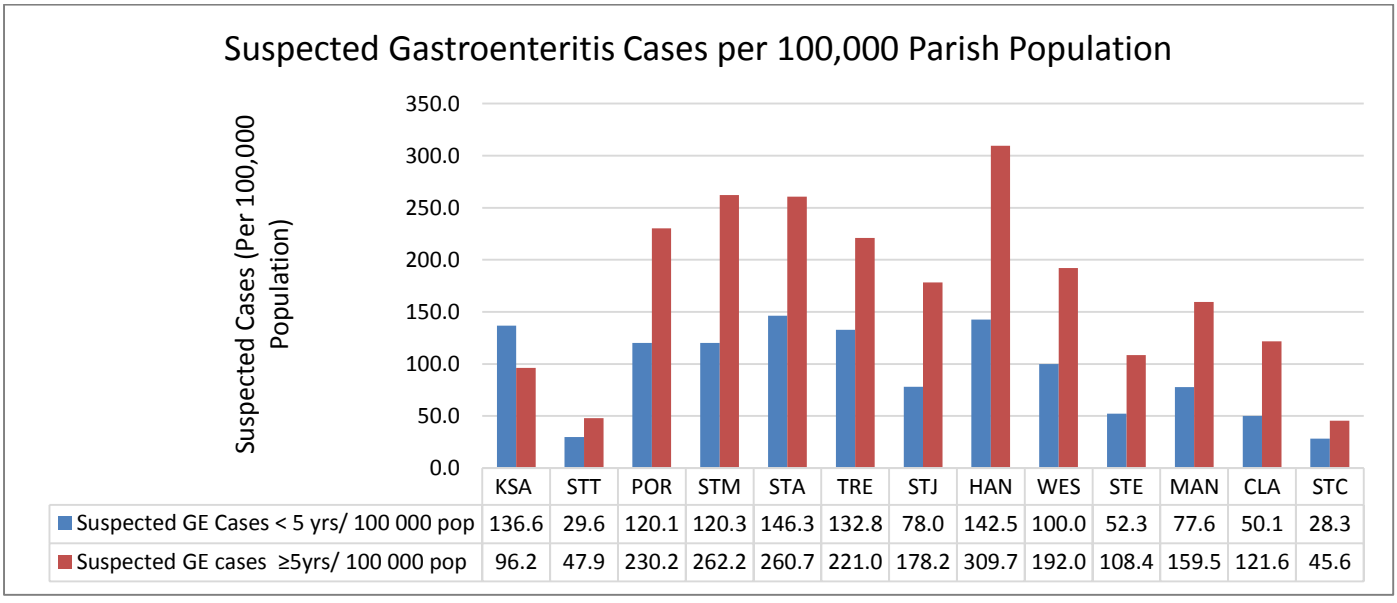
Gastroenteritis: Three or more loose stools within 24 hours.

In Epidemiology Week 22, 2016, the total number of reported GE cases showed a 27% increase compared to EW 22 of the previous year.

The year to date figure showed a 31% 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.

The Ministry of Health
24-26 Grenada Crescent
Kingston 5, Jamaica
Tele: (876) 633-7924
Email: mohsurveillance@gmail.com