Released Oct. 10, 2016 ISSN 0799-3927

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight
World Mental health Day
October 10, 2016

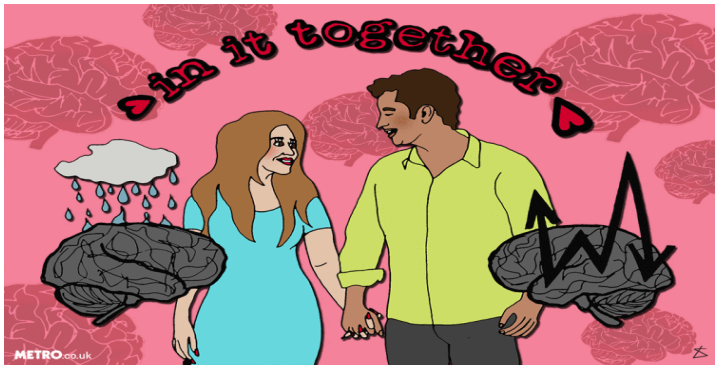
Theme: Psychological first aid (PFA)

What is PFA? Humane, supportive & practical assistance to fellow human beings who recently suffered a serious stressor.

The theme of this year's World Mental Health Day, observed on 10 October, covers "psychological first aid". Efforts in support of the day will focus on basic pragmatic psychological support by people who find themselves in a helping role whether they be health staff, teachers, firemen, community workers, or police officers.

Despite its name, psychological first aid covers both psychological and social support. Just like general health care never consists of physical first aid alone, similarly no mental health care system should consist of psychological first aid alone. Indeed, the investment in psychological first aid is part of a longer-term effort to ensure that anyone in acute distress due to a crisis is able to receive basic support, and that those who need more than psychological first aid will receive additional advanced support from health, mental health and social services.

Learning the basic principles of psychological first aid will help you to provide support to people who are very distressed, and, importantly, to know what not to say.



Sounce:http://www.who.int/mental_health/world-mental-health-day/2016/en/

EPI WEEK 38

NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE-30 sites*. Actively pursued

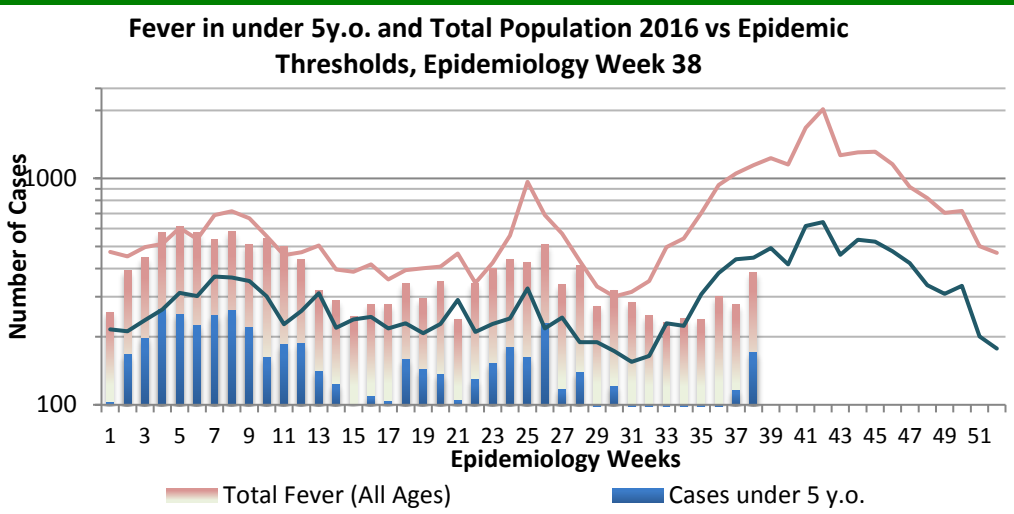
SENTINEL REPORT- 79 sites*. Automatic reporting

*Incidence/Prevalence cannot be calculated

REPORTS FOR SYNDROMIC SURVEILLANCE

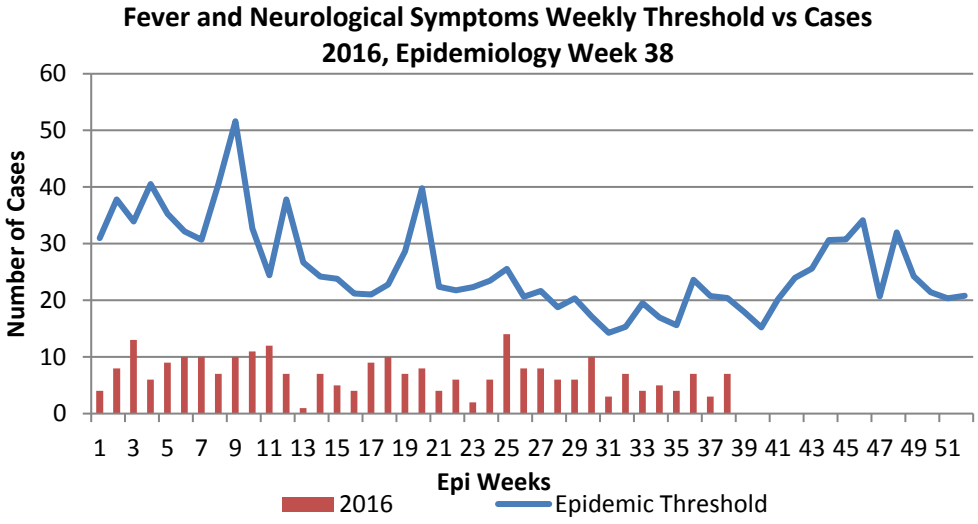
FEVER

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



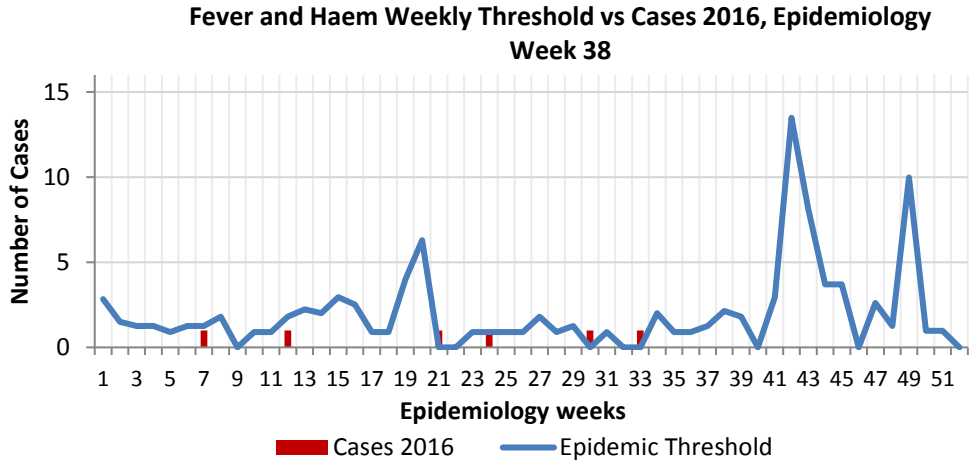
FEVER AND NEUROLOGICAL

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.



NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

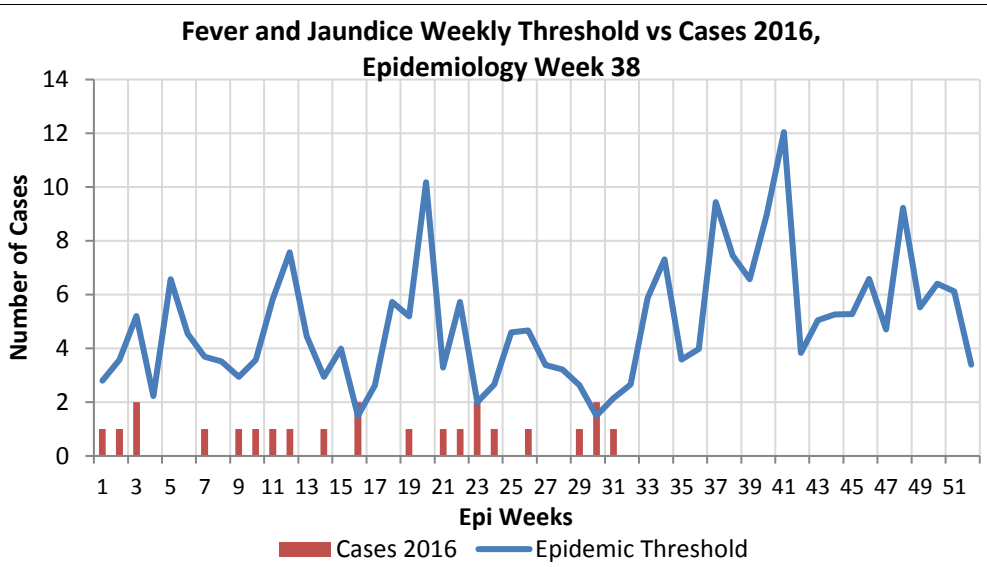
HOSPITAL ACTIVE SURVEILLANCE-30 sites*. Actively pursued

SENTINEL REPORT- 79 sites*. Automatic reporting

*Incidence/Prevalence cannot be calculated

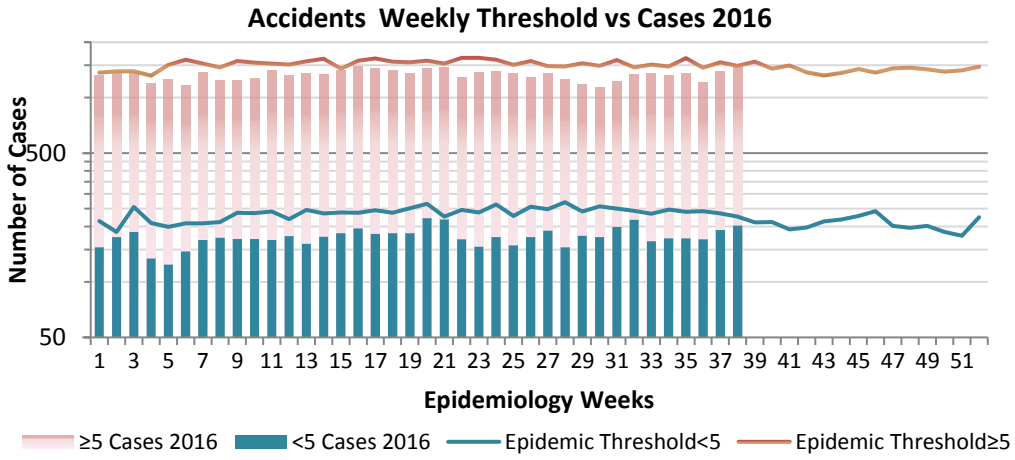
FEVER AND JAUNDICE

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



ACCIDENTS

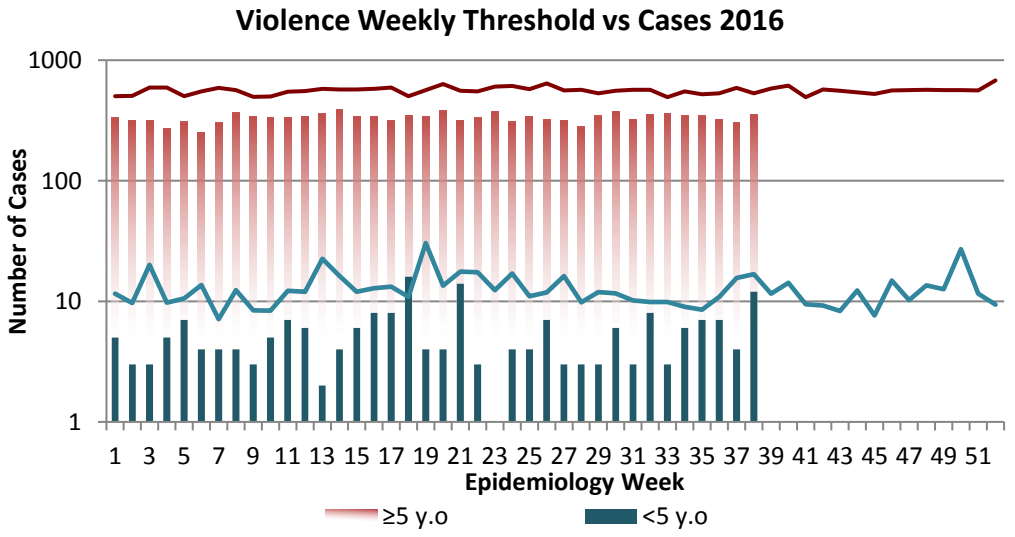
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



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.



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

Released Oct. 10, 2016 ISSN 0799-3927

CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS		CONFIRMED YTD CURRENT YEAR	CONFIRMED YTD PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		59	126
	Cholera		0	0
	Dengue Hemorrhagic Fever[1]		2	0
	Hansen's Disease (Leprosy)		1	0
	Hepatitis B		24	30
	Hepatitis C		4	4
	HIV/AIDS - See HIV/AIDS National Programme Report			
	Malaria (Imported)		1	0
	Meningitis		29	65
EXOTIC/ UNUSUAL	Plague		0	0
H IGH MORBIDIT/ MORTALIY	Meningococcal Meningitis		0	0
	Neonatal Tetanus		0	0
	Typhoid Fever		1	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]		23	24
	Ophthalmia Neonatorum		338	224
	Pertussis-like syndrome		0	0
	Rheumatic Fever		1	9
	Tetanus		0	1
	Tuberculosis		0	0
	Yellow Fever		0	0
	Chikungunya		0	1
	Zika Virus		91	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.

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

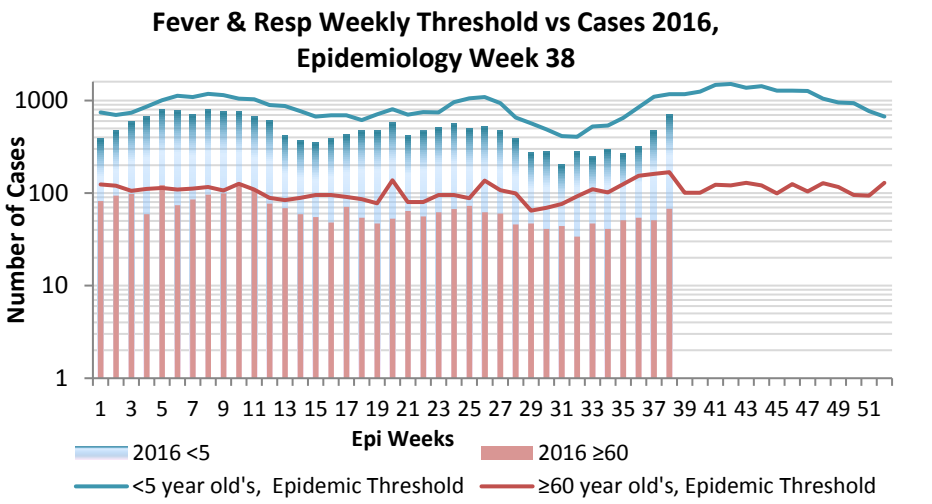
Released Oct. 10, 2016 ISSN 0799-3927

NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 38

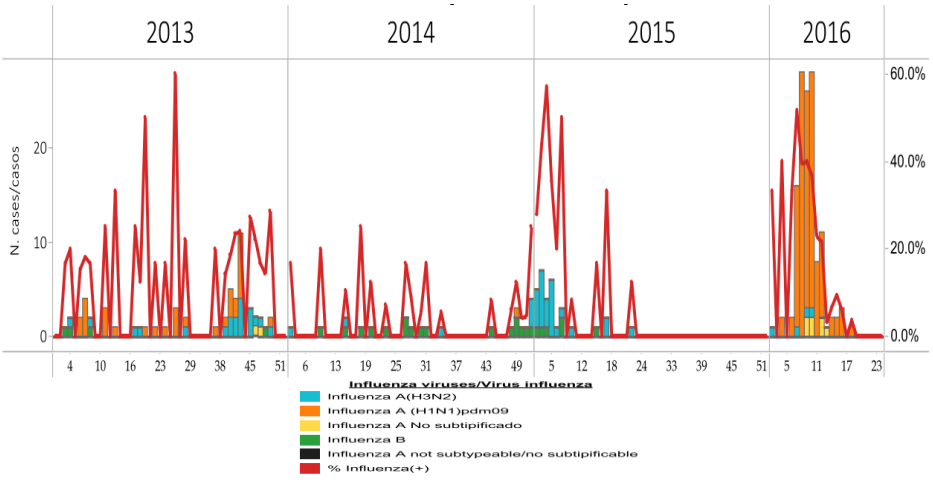
Sept. 18 to Sept. 24, 2016 Epidemiology Week 38

September 2016	EW 38	YTD
SARI cases	10	846
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

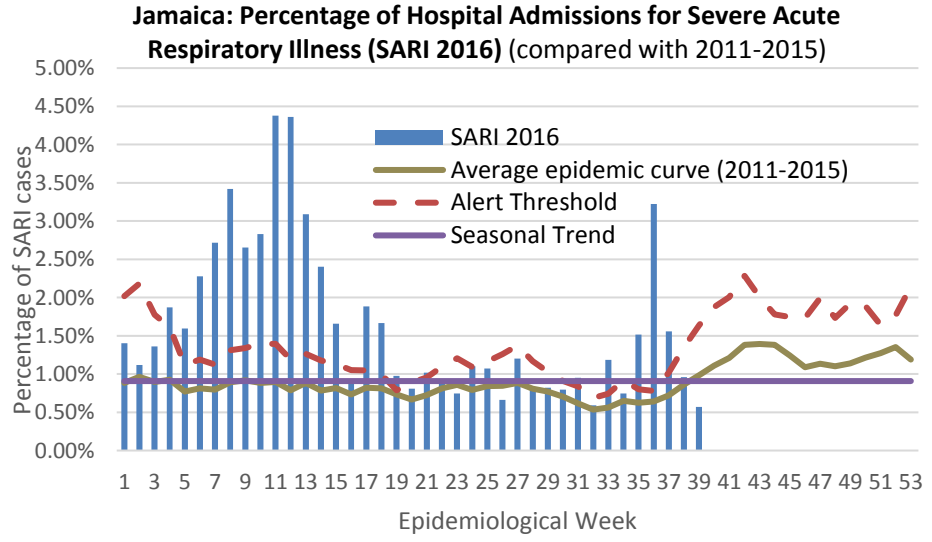
Year to date, respiratory syndromes account for 4.2% of visits to health facilities.

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**

NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE-30 sites*. Actively pursued

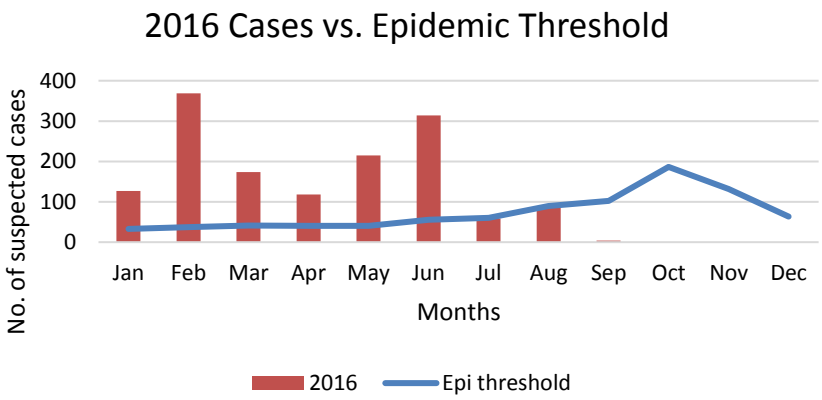
SENTINEL REPORT- 79 sites*. Automatic reporting

*Incidence/Prevalence cannot be calculated

Released Oct. 10, 2016 ISSN 0799-3927

Dengue Bulletin

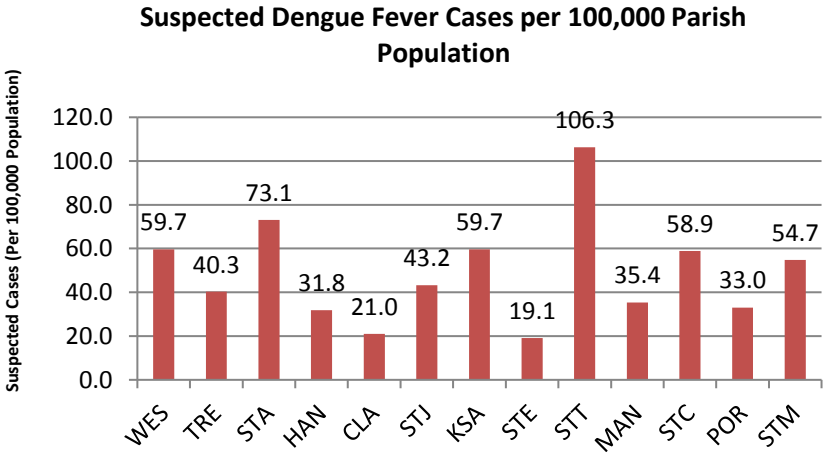
Sept. 18 to Sept. 24, 2016 Epidemiology Week 38



DISTRIBUTION

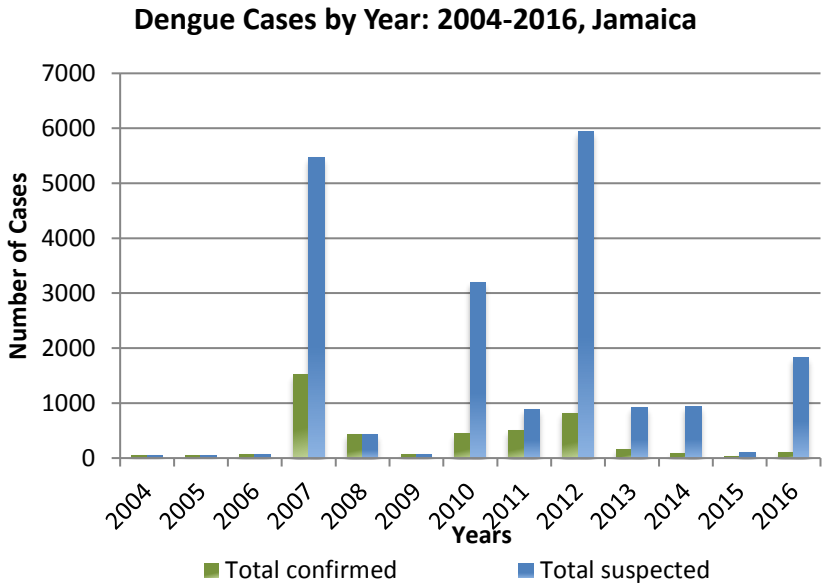
Year-to-Date Suspected Dengue Fever

	M	F	Un-kwn	Total	%
<1	4	10	0	14	1
1-4	24	25	0	45	5
5-14	126	135	3	229	19
15-24	101	180	4	245	20
25-44	151	373	6	451	29
45-64	62	184	2	209	10
≥65	9	18	0	25	2
Unknown	48	89	271	136	14
TOTAL	525	1014	286	1825	**100**



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

		2016		2015
		EW 38	YTD	YTD
Total Suspected Dengue Cases		1	1825	30
Lab Confirmed Dengue cases		0	110	2
CONFIRMED	DHF/DSS	0	2	0
	Dengue Related Deaths	0	0	0



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

Released Oct. 10, 2016 ISSN 0799-3927

Gastroenteritis Bulletin

EW 38

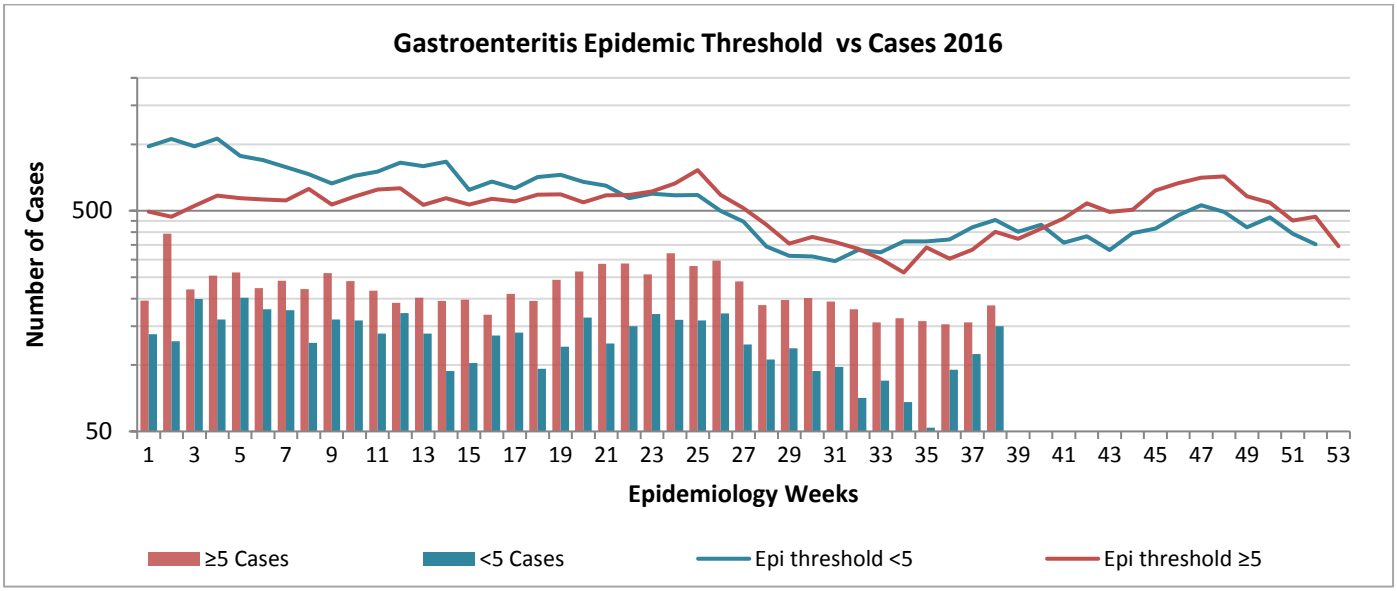
Sept. 18 to Sept. 24, 2016 Epidemiology Week 38

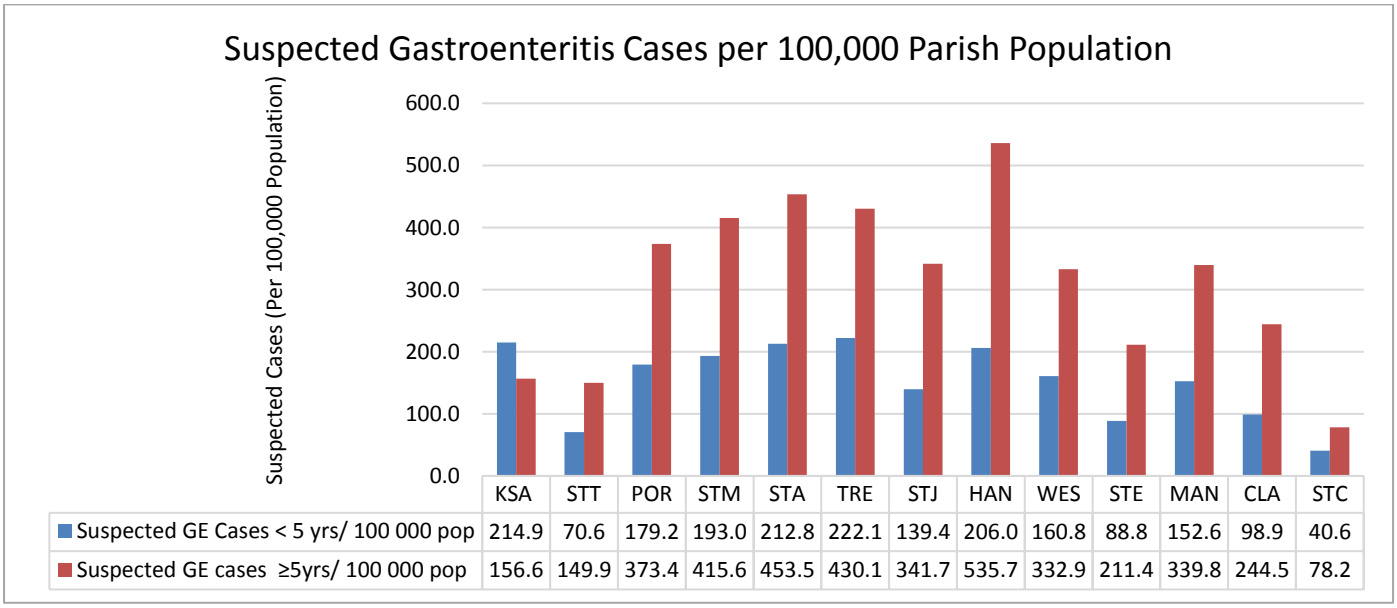
Weekly Breakdown of Gastroenteritis cases

Year	EW 38			YTD		
	<5	≥5	Total	<5	≥5	Total
2016	150	186	336	5,042	8,301	13,343
2015	166	224	390	8,368	8,854	17,222

Gastroenteritis:
In Epidemiology Week 38, 2016, the total number of reported GE cases showed a 12.7% decrease compared to EW 38 of the previous year.
The year to date figure showed a 21.3% 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	214.9	70.6	179.2	193.0	212.8	222.1	139.4	206.0	160.8	88.8	152.6	98.9	40.6
Suspected GE cases ≥5yrs/ 100 000 pop	156.6	149.9	373.4	415.6	453.5	430.1	341.7	535.7	332.9	211.4	339.8	244.5	78.2

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

RESEARCH PAPER

Leadership hubs: Dynamic collaborations to engage nurses in strengthening the health care system for HIV and AIDS care in Jamaica

E Kahwa[1], J. Aiken[1], U Atkinson[1], P Dawkins, [1] C Hepburn -Brown, [1] T Rae[1], S Roelofs[2], N Edwards[2].
[1]The UWI School of Nursing, Mona, University of the West Indies, Kingston7, Jamaica
[2]University of Ottawa, School of Nursing, Ottawa, Canada

Objective: To examine the impact of leadership hubs on quality of nursing care in Jamaica for persons living with HIV/AIDS**.**

Methods: Three leadership hubs consisting of frontline nurses, nurse managers, researchers, decision makers and community representatives were established in purposively selected intervention parishes in Jamaica. Leadership hubs were trained to use research and influence policy. Data were collected before and after the leadership hub intervention in both intervention and control parishes using a survey questionnaire with randomly selected nurses about clinical practice (including stigma), policies and procedures, quality assurance processes, and through an institutional human resource management assessment tool for HIV and AIDS environments. Hubs assessed changes in their own capacity to engage in evaluation research and influence policy.

Results: Hub members reported statistically significant increases in their evaluation of policy capacity ($p<0.01$). While there were statistically significant improvements in pre versus post stigma scores for intervention parishes ($p<0.001$) compared to control parishes, differences were not significant for other clinical practices, policies and procedures of quality assurance processes. Intervention parishes had better post intervention outcomes than control parishes for 50% of quality assurance indicators and 70% of policies and procedures. However, declines were observed in clinical assessment and management outcomes for both intervention and control parishes for 5 of the 12 indicators.

Conclusions: The leadership hub intervention had limited impact on the quality of nursing care for HIV and AIDS. Though leadership hubs are a promising, feasible model, longer intervention periods are required in order to determine their true impact.

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