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Week ending Feb. 26- March 4, 2017 Epidemiology Week 9

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Weekly Spotlight

World Water Day 2017

Why waste water?

World Water Day, on 22 March every year, is about taking action to tackle the water crisis. Today, there are over 663 million people living without a safe water supply close to home, spending countless hours queuing or trekking to distant sources, and coping with the health impacts of using contaminated water.

Globally, the vast majority of all the wastewater from our homes, cities, industry and agriculture flows back to nature without being treated or reused – polluting drinking, bathing, irrigation and losing valuable nutrients and other recoverable materials.

Reducing and safely treating and reusing wastewater, for example in agriculture and aquaculture, protects worker, farmers and consumers promotes food security, health and wellbeing.

Water safety and quality

Water safety and quality are fundamental to human development and well-being. Providing access to safe water is one of the most effective instruments in promoting health and reducing poverty.

As the international authority on public health and water quality, WHO leads global efforts to prevent transmission of waterborne disease. This is achieved by promoting health-based regulations to governments and working with partners to promote effective risk management practices to water suppliers, communities and households.

Sanitation and wastewater

Safely managed sanitation and safe wastewater treatment and reuse are fundamental to protect public health. WHO is leading efforts to monitor the global burden of sanitation related disease and access to safely managed sanitation and safely treated wastewater under the Sustainable Development agenda.

WHO support implementation by promoting risk assessment and management in normative guidelines and tools and collaborates with partners in other health initiatives such as; neglected tropical diseases, nutrition, infection prevention and control and antimicrobial resistance to maximize health benefits of sanitation interventions.

Downloaded from: http://www.who.int/water_sanitation_health/sanitation-waste/en/
http://www.who.int/water_sanitation_health/water-quality/en/
http://www.who.int/water_sanitation_health/news-events/world-water-day-2017/en/

EPI WEEK 9

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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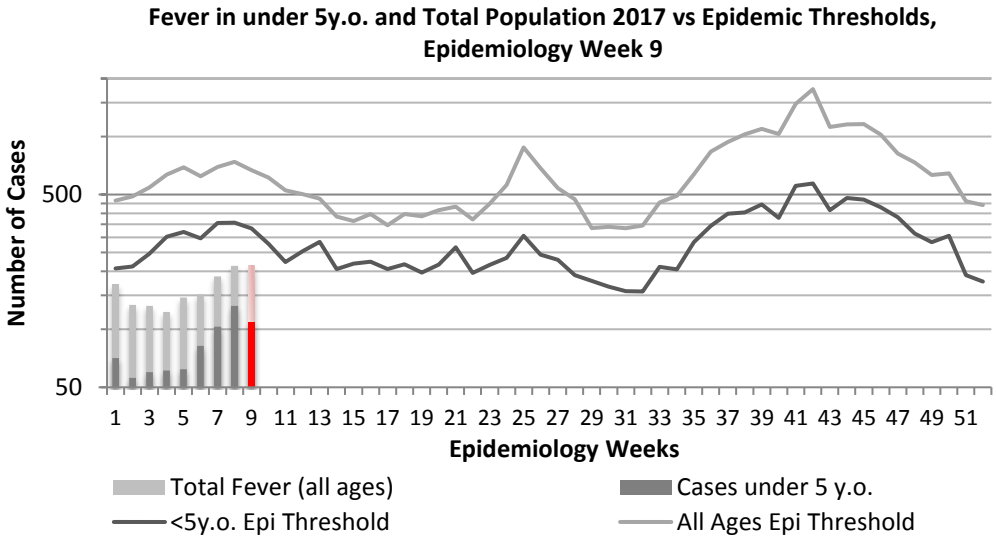
REPORTS FOR SYNDROMIC SURVEILLANCE

FEVER

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

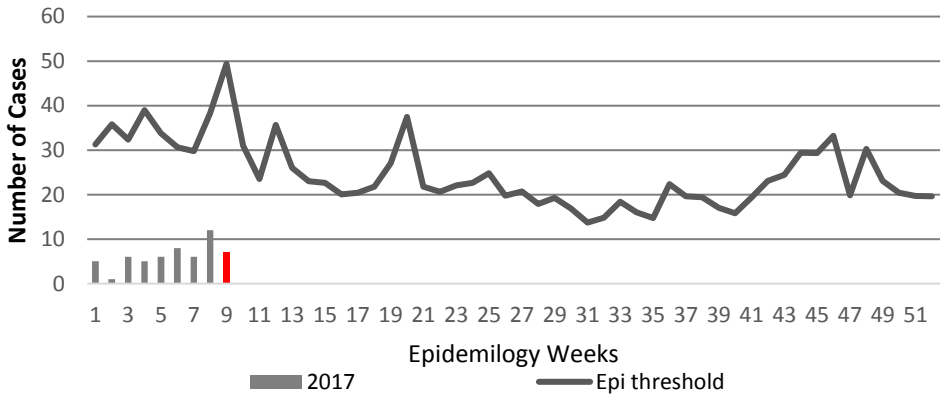
KEY

RED CURRENT WEEK



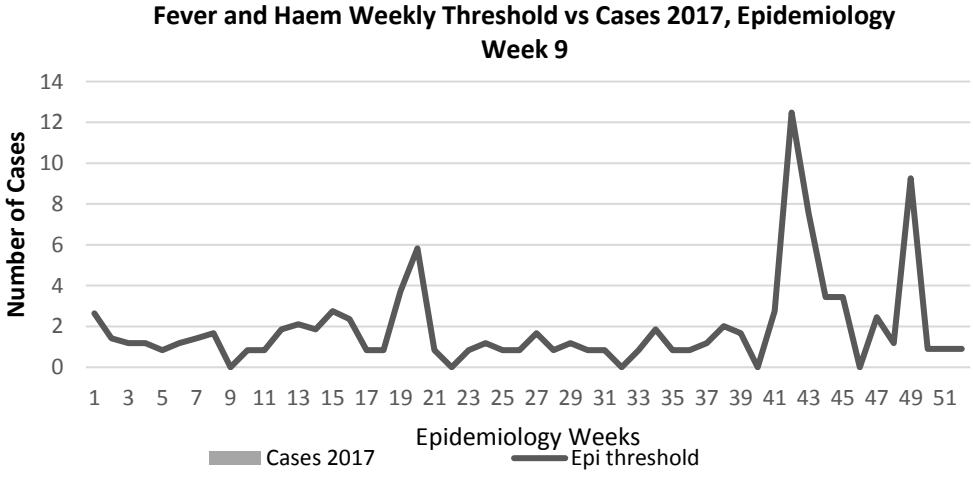
FEVER AND NEUROLOGICAL

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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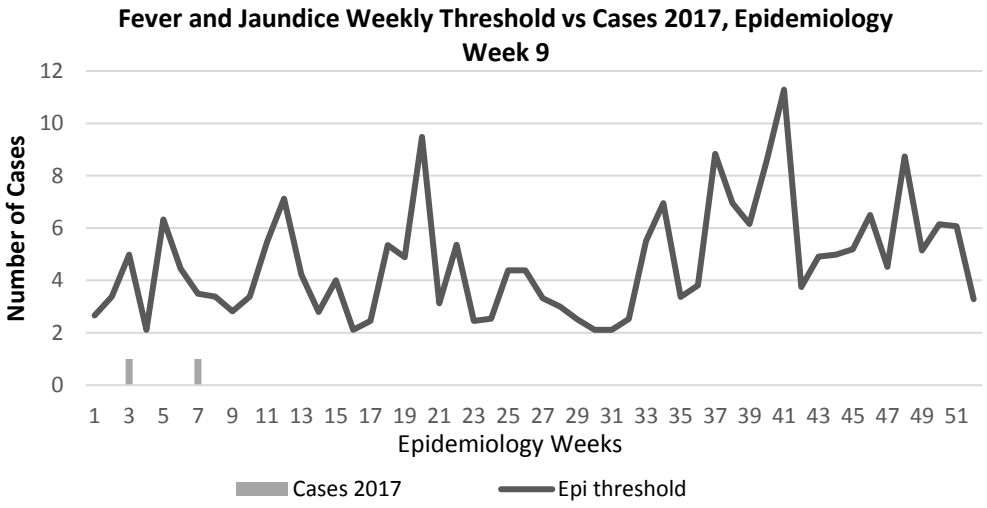
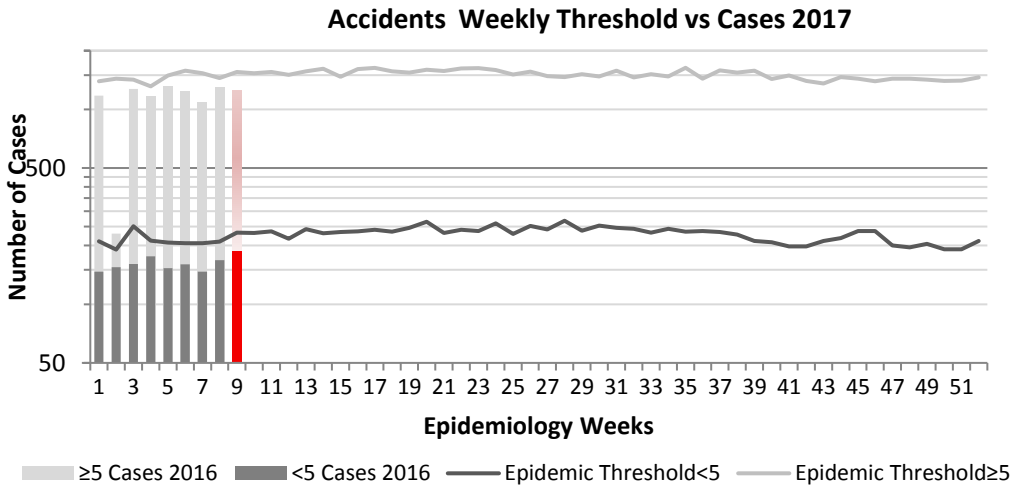
FEVER AND JAUNDICE

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



ACCIDENTS

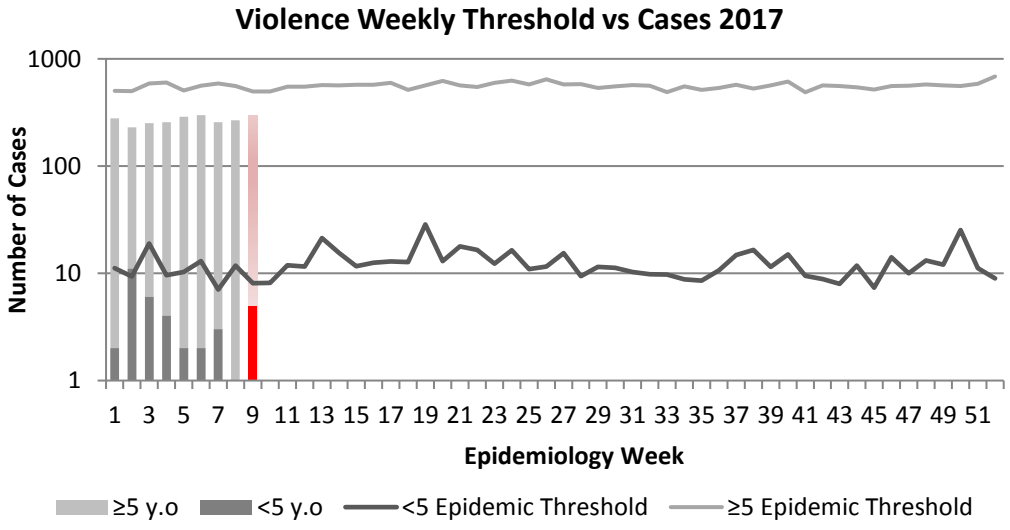
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



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	14	31
	Cholera	0	0
	Dengue Hemorrhagic Fever[1]	0	0
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	2	1
	Hepatitis C	0	0
	HIV/AIDS - See HIV/AIDS National Programme Report		
	Malaria (Imported)	0	0
	Meningitis (Clinically confirmed)	2	10
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
	Fever and Rash – Rubella	0	0
	Maternal Deaths[2]	6	5
	Ophthalmia Neonatorum	39	68
	Pertussis-like syndrome	0	0
	Rheumatic Fever	1	1
	Tetanus	0	0
	Tuberculosis	0	0
	Yellow Fever	0	0
	Chikungunya	0	0
	Zika Virus	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.

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 9

Feb 26- March 4, 2017 Epidemiology Week 9

January 2017		
	EW 9	*YTD*
SARI cases	*12*	*102*
Total Influenza positive Samples	***0***	***1***
Influenza A	***0***	***0***
H3N2	*0*	*0*
H1N1pdm09	*0*	*0*
Not subtyped	*0*	*0*
Influenza B	*0*	***1***
Other	*0*	***0***

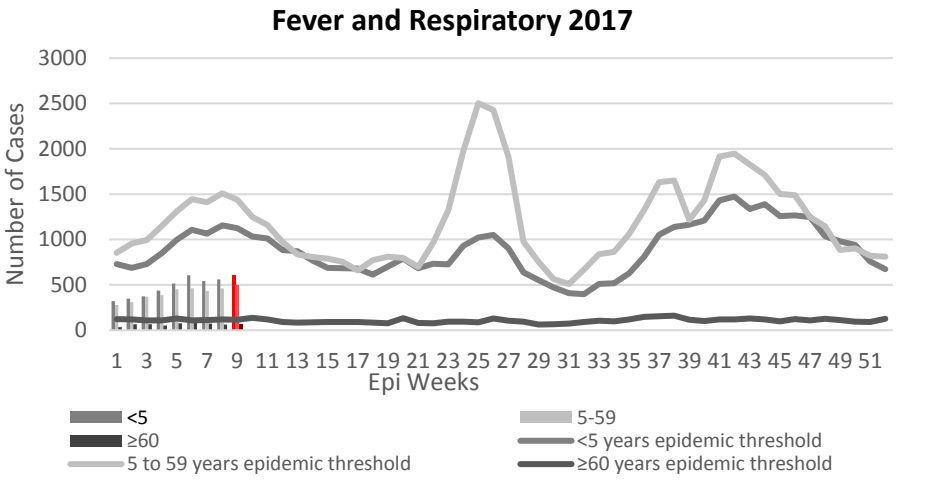
Comments:

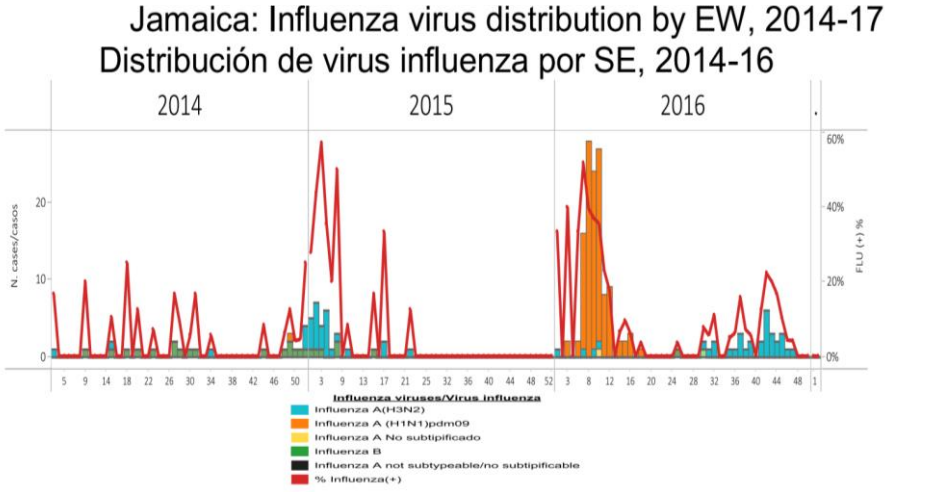
During EW 9, SARI activity decreased, but remained below the alert threshold and slightly above the average epidemic curve.

During EW 9, SARI cases were most frequently reported among children aged from 12 to 23 months of age.

During EW 9, pneumonia case-counts increased and were at same levels observed in 2016 and 2015, with the highest proportion in Kingston and Saint Andrew.

During EW 9, no influenza activity was reported.





INDICATORS

Burden

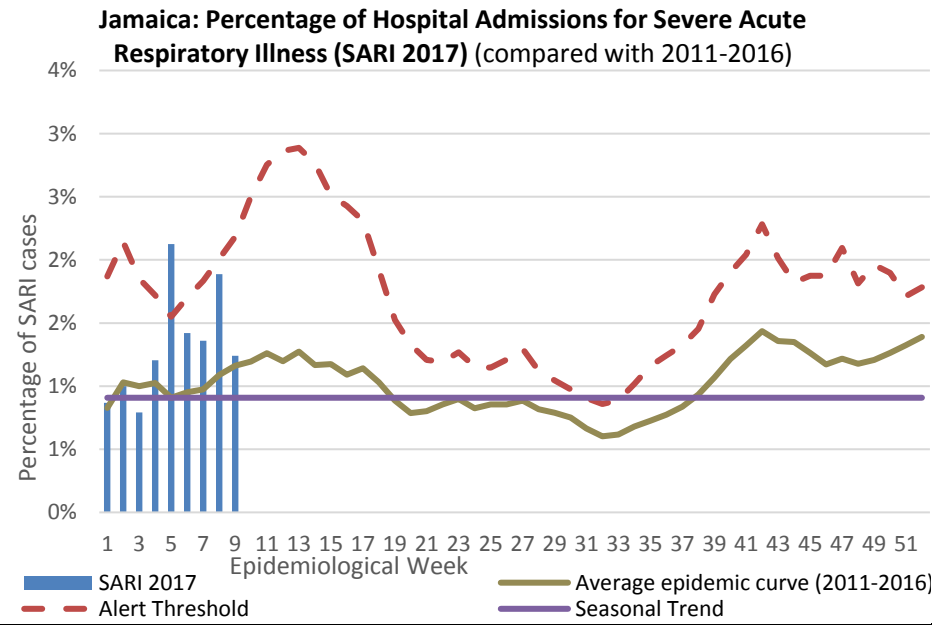
Year to date, respiratory syndromes account for 3.3% of visits to health facilities.

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

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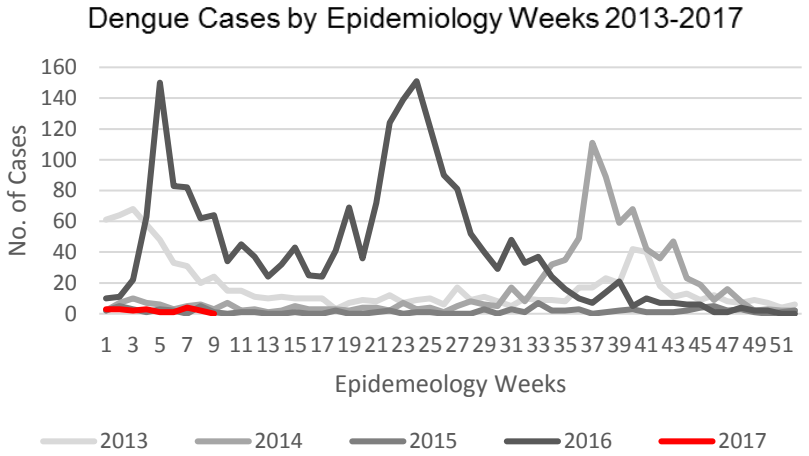
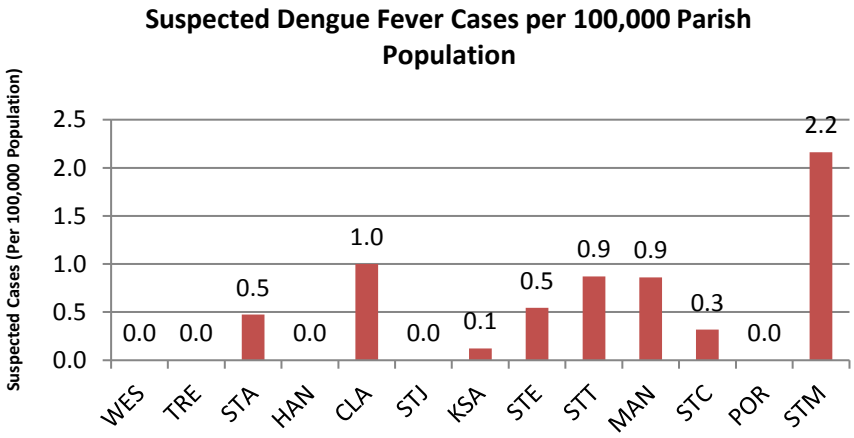


DISTRIBUTION

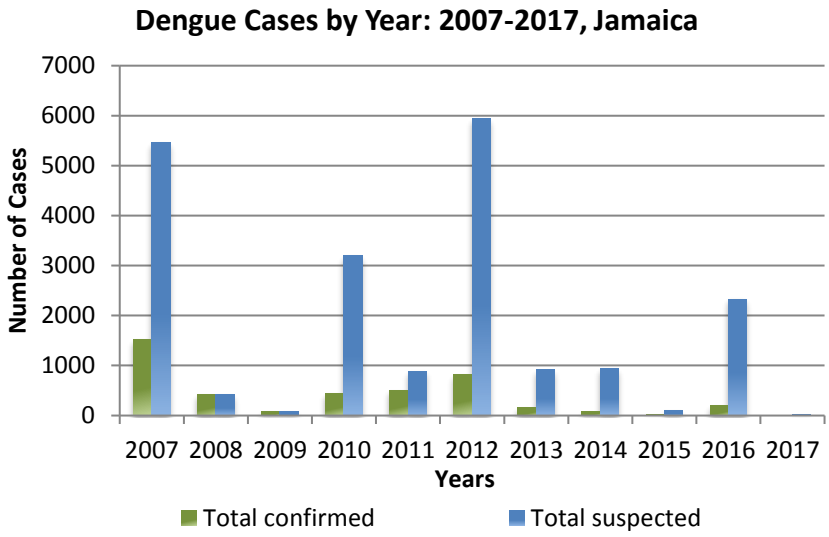
Year-to-Date Suspected Dengue Fever

	M	F	Un-known	Total	%
<1	0	0	0	0	0
1-4	0	0	0	0	0
5-14	4	2	0	6	31.5
15-24	2	2	0	4	21.2
25-44	3	2	1	6	31.5
45-64	2	1	0	3	15.8
≥65	0	0	0	0	0
Unknown	0	0	0	0	0
TOTAL	11	7	1	19	**100**



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

		2017		2016 YTD
		EW 9	YTD	
Total Suspected Dengue Cases		0	19	456
Lab Confirmed Dengue cases		0	0	52
CONFIRMED	DHF/DSS	0	0	1
CONFIRMED	Dengue Related Deaths	0	0	0



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Gastroenteritis Bulletin

EW 9

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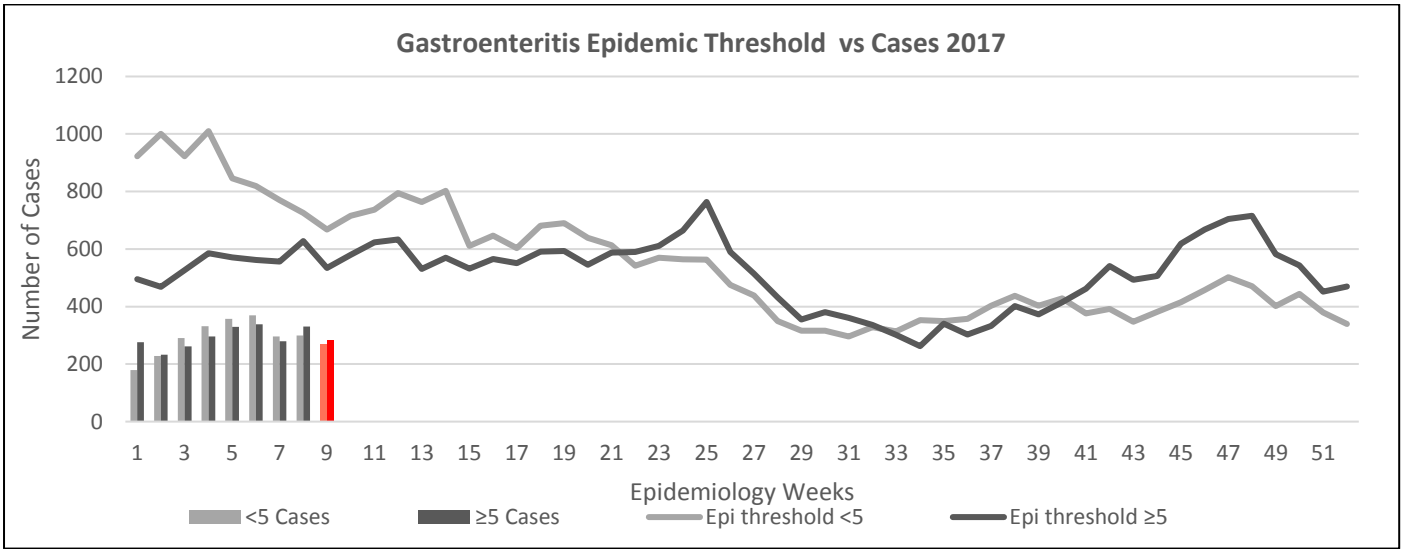
Weekly Breakdown of Gastroenteritis cases

Year	EW 9			YTD		
	<5	≥5	Total	<5	≥5	Total
2017	270	285	555	2,620	2,629	5,249
2016	161	261	422	1,471	2,076	3,547

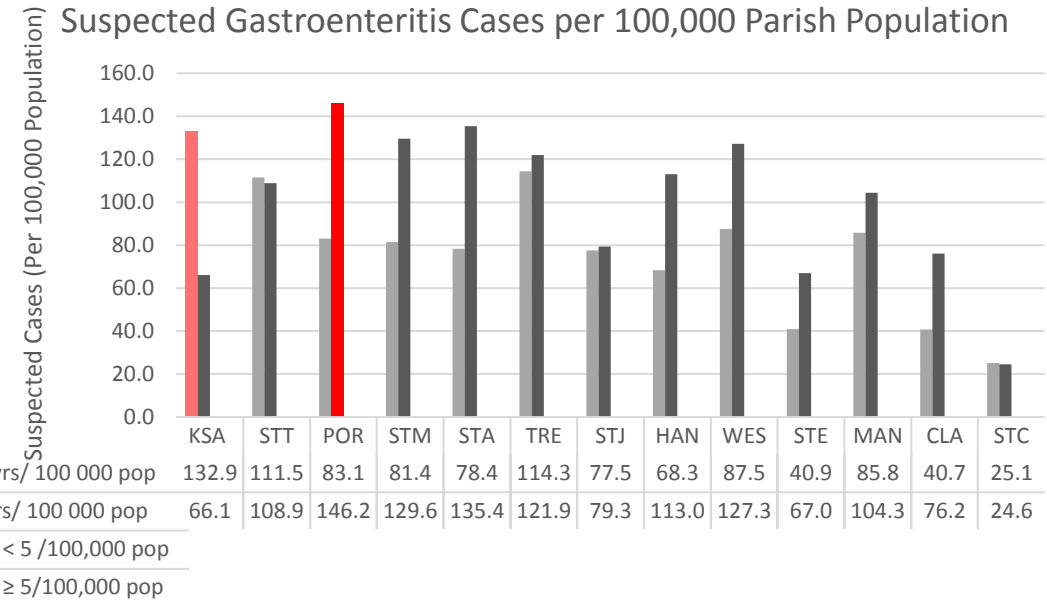
Gastroenteritis:
In Epidemiology Week 9, 2017, the total number of reported GE cases showed a 13% increase compared to EW 9 of the previous year.
The year to date figure showed an 14.7% increase in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2016-2017



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

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



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RESEARCH PAPER

HIV Case-Based Surveillance System Audit

S. Whitbourne, Z. Miller

Objectives: Evaluate the Public Health Surveillance System for HIV reporting, to help ensure that the data collected is accurate and useful for understanding epidemiological trends.

Background: Public health programmes focus on the monitoring, control and reduction in the incidence of target diseases, conditions or health events through various interventions and actions. The surveillance system is the primary mechanism through which specific disease information is collected and needs to be periodically assessed.

Methodology: In 2016, an audit was conducted of the HIV Case-Based Surveillance System in Jamaica. Laboratory records were reviewed from seven major health care facilities representing all four Regional Health Authorities. Cases with a positive HIV test in 2014 were noted and comparisons of positive cases were made with the cases that had been reported to the National Surveillance Unit. Qualitative data was also collected from key personnel in the form of questionnaires related to the processes involved in diagnosis, detection, investigation and reporting of HIV positive cases, but this paper will focus on the quantitative findings.

Findings: Preliminary data analysis reveals a high level of underreporting of HIV cases to the national level.

Conclusions: Audits and other forms of assessment need to be conducted on surveillance systems to ensure that the data supporting a public health programme is reliable and accurate, for effective delivery of services to target populations.

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