WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Why the HIV epidemic is not over

Fear, stigma and ignorance. That is what defined the HIV epidemic that raged through the world in the 1980s, killing thousands of people who may only have had a few weeks or months from diagnosis to death - if they even managed to be diagnosed before they died.

December 1, 2018 marks the 30th anniversary of World AIDS Day – a day created to raise awareness about HIV and the resulting AIDS epidemics. Since the beginning of the epidemic, more than 70 million people have acquired the infection, and about 35 million people have died. Today, around 37 million worldwide live with HIV, of whom 22 million are on treatment.

When World AIDS Day was first established in 1988, the world looked very different to how it is today. Now, we have easily accessible testing, treatment, a range of prevention options, including pre-exposure prophylaxis of PrEP, and services that can reach vulnerable communities.

In the late 1980s, however, “the outlook for people with HIV was pretty grim,” says Dr Rachel Baggaley, coordinator of HIV testing and prevention at WHO.

At the beginning of the 1980s, before HIV had been identified as the cause of AIDS, the infection was thought to only affect specific groups, such as gay men in developed countries and people who inject drugs. The HIV virus was first isolated by Dr Françoise Barré-Sinoussi and Dr Luc Montagnier in 1983 at the Institut Pasteur. In November that year, WHO held the first meeting to assess the global AIDS situation and initiated international surveillance. It was then that the global health community understood that HIV could also spread between heterosexual people, through blood transfusions, and that infected mothers could transmit HIV to their babies

Source: http://www.who.int/news-room/feature-stories/detail/violence-against-women

EPI WEEK 46

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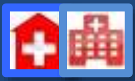
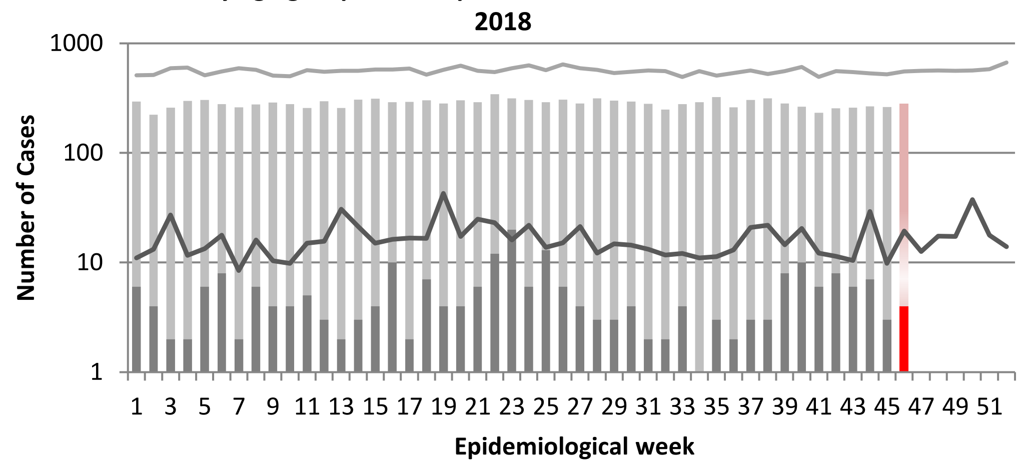
REPORTS FOR SYNDROMIC SURVEILLANCE

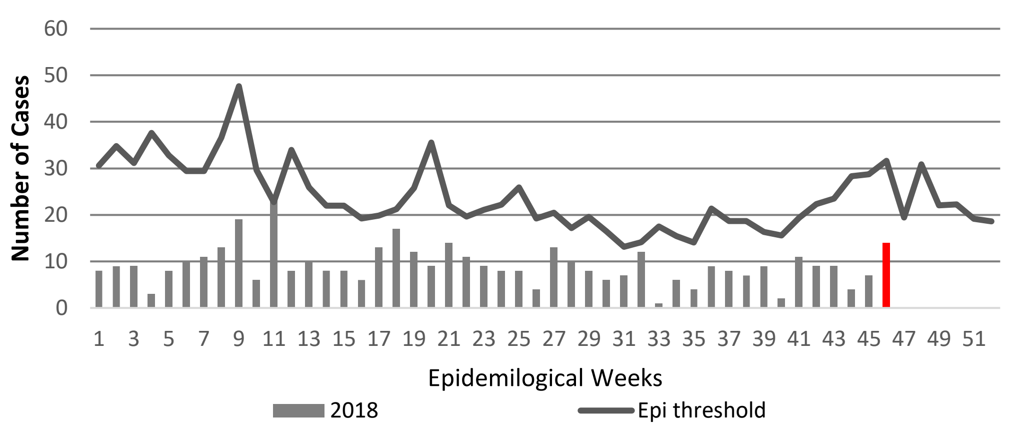
FEVER
Temperature of >38⁰C /100.4⁰F (or recent history of fever) with or without an obvious diagnosis or focus of infection.



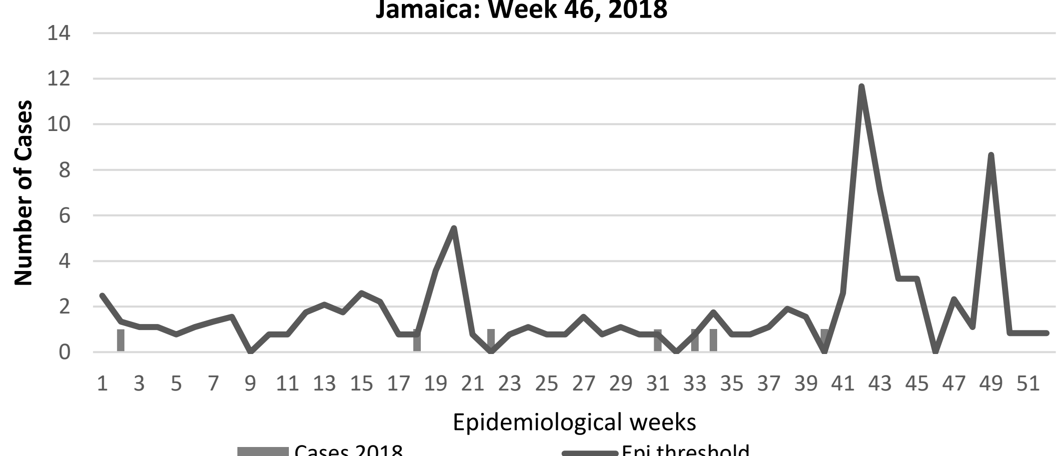
KEY
RED CURRENT WEEK



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).

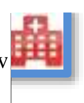


FEVER AND HAEMORRHAGIC
Temperature of >38⁰C /100.4⁰F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



2 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

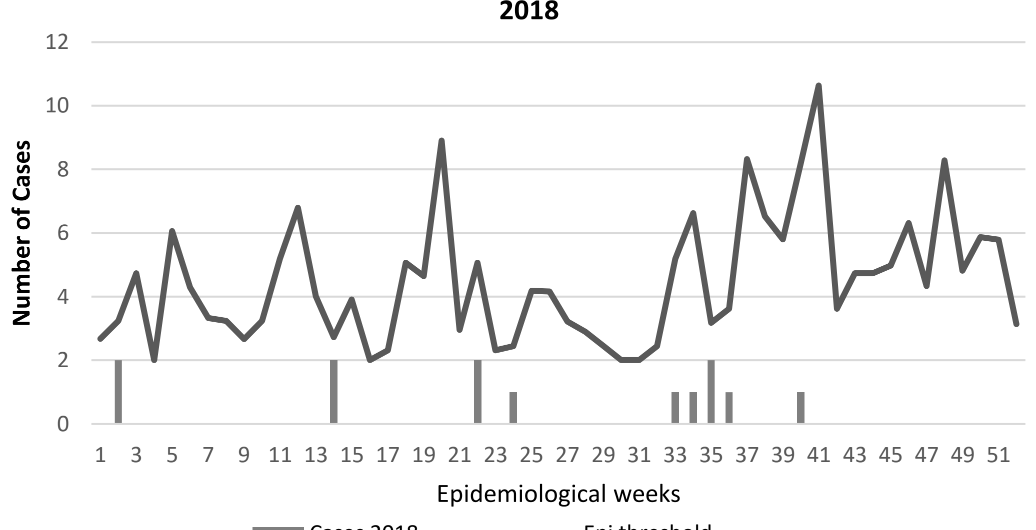
SENTINEL REPORT- 79 sites. Automatic reporting

 ISSN 0799-3927

FEVER AND JAUNDICE

Temperature of >38⁰C /100.4⁰F (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.

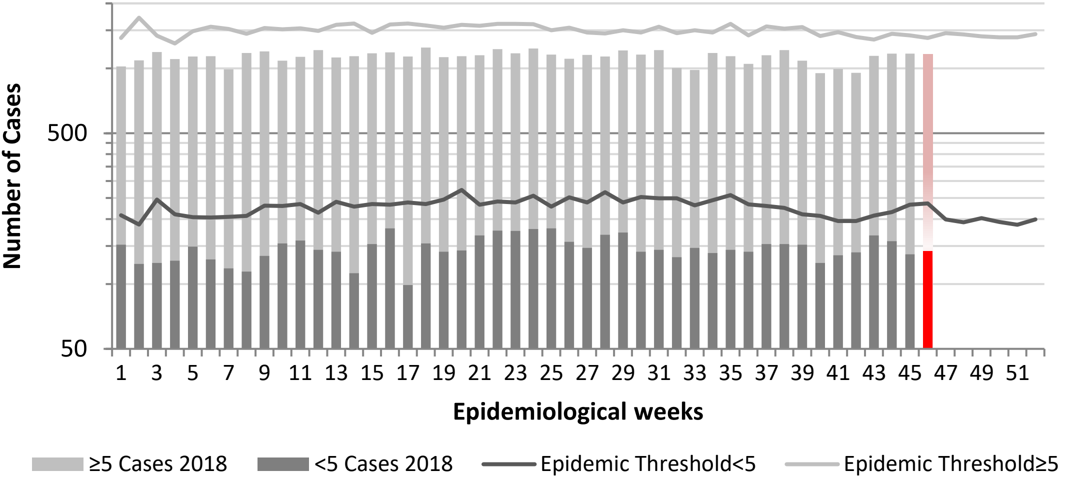


ACCIDENTS

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

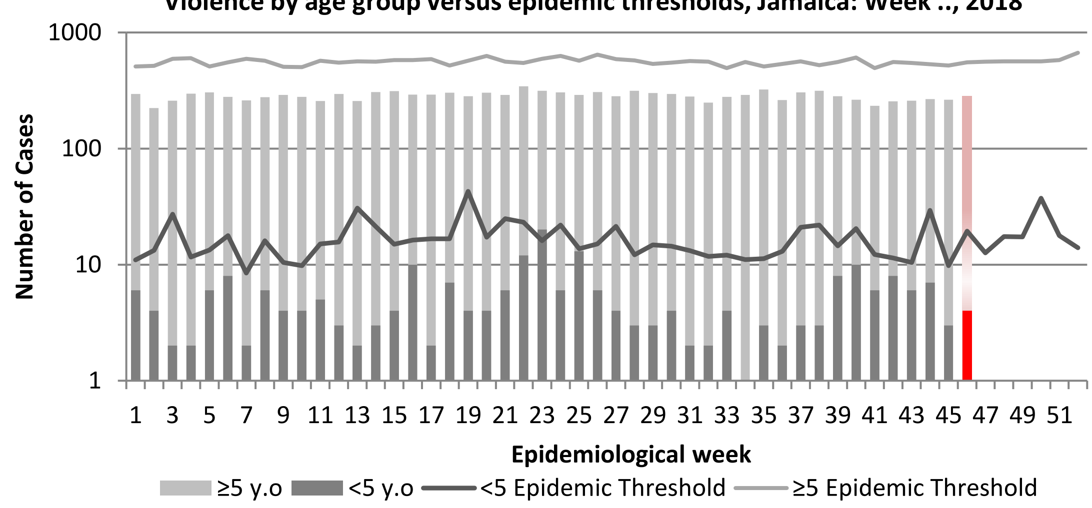
KEY

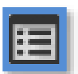
RED CURRENT WEEK



VIOLENCE

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





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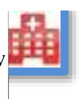

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CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS	CONFIRMED YTD CURRENT YEAR	CONFIRMED YTD PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning[1]	(439) 135	(456) 189
	Cholera	0	0
	Dengue Hemorrhagic Fever[2]	2	3
	Hansen's Disease (Leprosy)	0	2
	Hepatitis B	42	53
	Hepatitis C	7	10
	HIV/AIDS	NA	NA
	Malaria (Imported)	5	0
	Meningitis (Clinically confirmed)	35	102
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[3]	55	46
	Ophthalmia Neonatorum	272	323
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	0
	Tetanus	0	0
	Tuberculosis	34	113
	Yellow Fever	0	0
	Chikungunya[4]	10	0
	Zika Virus[5]	1	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.

[1] **Numbers in brackets indicate combined suspected and confirmed Accidental Poisoning cases**

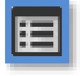
[2] **Dengue Hemorrhagic Fever data include Dengue related deaths;**

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

[4] **CHIKV IgM positive cases**

[5] **Zika IgM positive cases**

NA- Not Available



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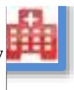

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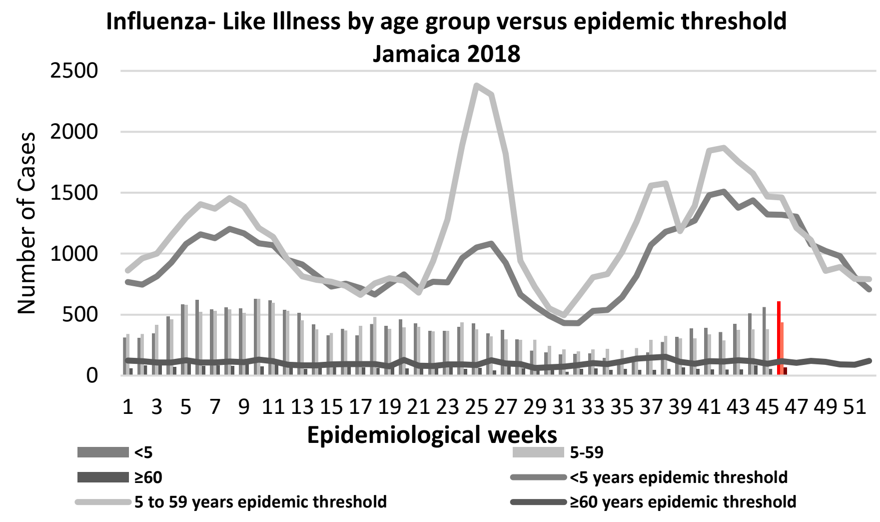
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

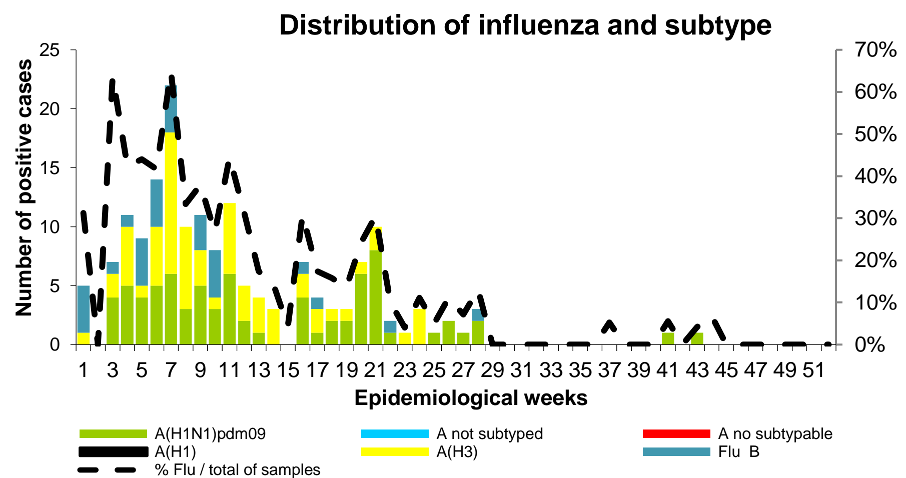
EW 46

November 11-17, 2018 Epidemiological Week 46

November 2018		
	EW 46	*YTD*
SARI cases	*13*	*308*
Total Influenza positive Samples	*0*	*170*
Influenza A	*0*	*141*
H3N2	*0*	*65*
H1N1pdm09	*0*	*76*
Not subtyped	*0*	*1*
Influenza B	*0*	*29*
Parainfluenza	*0*	*7*



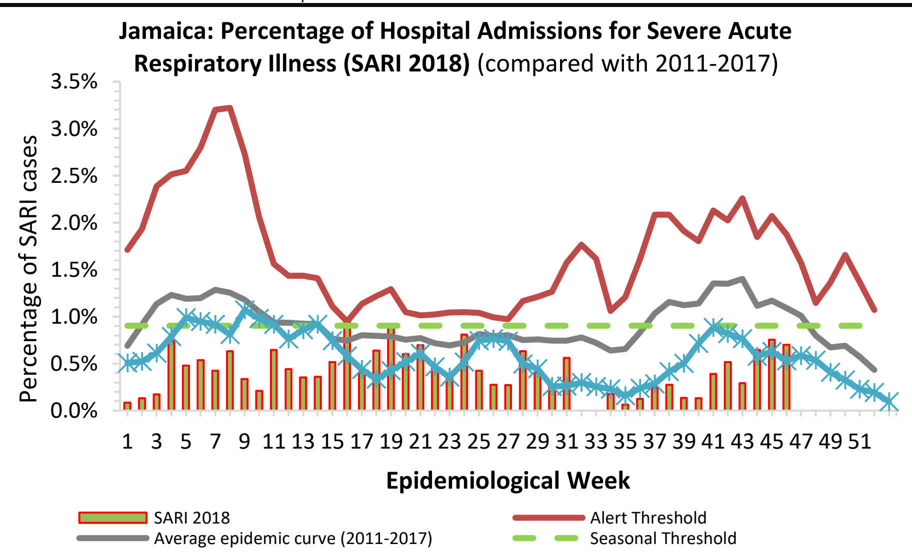
Comments:
During EW 46 SARI activity remained below the seasonal threshold, similar to the previous seasons for the same period. Decreased influenza activity was reported; with influenza A(H1N1)pdm09 predominating in previous weeks

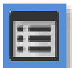


GLOBAL AND REGIONAL UPDATES

Worldwide: Seasonal influenza subtype A accounted for the majority of influenza detections.

Caribbean: Influenza virus activity slightly increased, and low RSV activity was reported throughout most of the sub-region. In Jamaica, influenza activity decreased, with influenza A(H1N1)pdm09 and A(H3N2) co-circulating.





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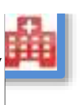

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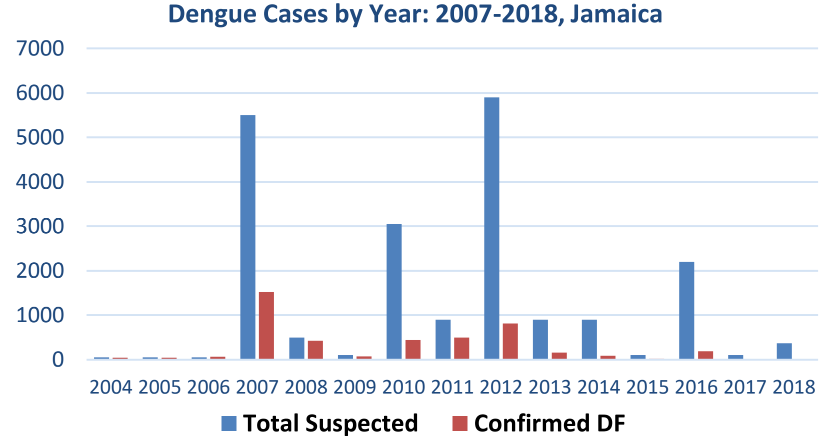
Dengue Bulletin

November 11-17, 2018 | Epidemiological Week 46



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

		2018		2017
		EW 46	YTD	YTD
Total Suspected Dengue Cases		4	377	132
Lab Confirmed Dengue cases		0	8	3
CONFIRMED	*DHF/DSS	0	2	1
	Dengue Related Deaths	0	0	0

DENGUE FEVER

Symtomps
- High Fever
- Headache
- Nausea
- Stomach Ache
- Vomiting
- Muscle Pain
- Rashes
- Diarrhea
- Mild Bleeding gums

Diagnoses
- Antibody detection
- Antigen detection
- RNA detection
- Viral isolation

Prevention
- Cover containers
- Use mosquito nets, sprays.
- Wear full sleeves
- Fumigation

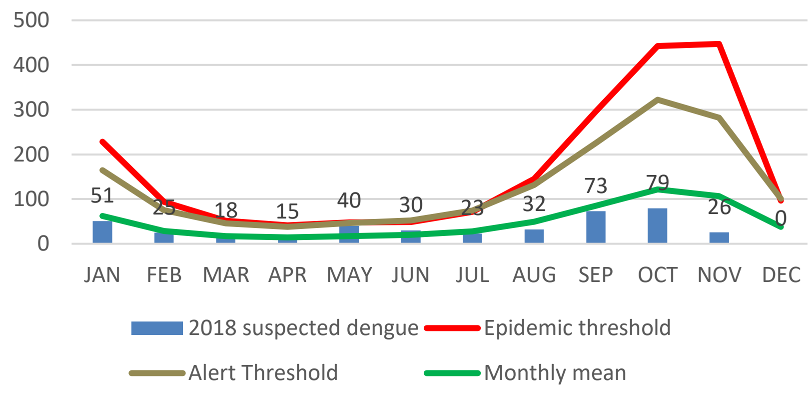
Treatment
- There is no specific treatment for dengue or dengue hemorragic fever. Only symtomatic treatment is given.

MAYOM HOSPITAL

***DHF/DSS: Dengue Haemorrhagic Fever/ Dengue Shock Syndrome**

Points to note:

- **Only PCR positive dengue cases are reported as confirmed.**
- **IgM positive cases are classified as presumed dengue.**



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Gastroenteritis Bulletin

November 11-17, 2018 | Epidemiological Week 46

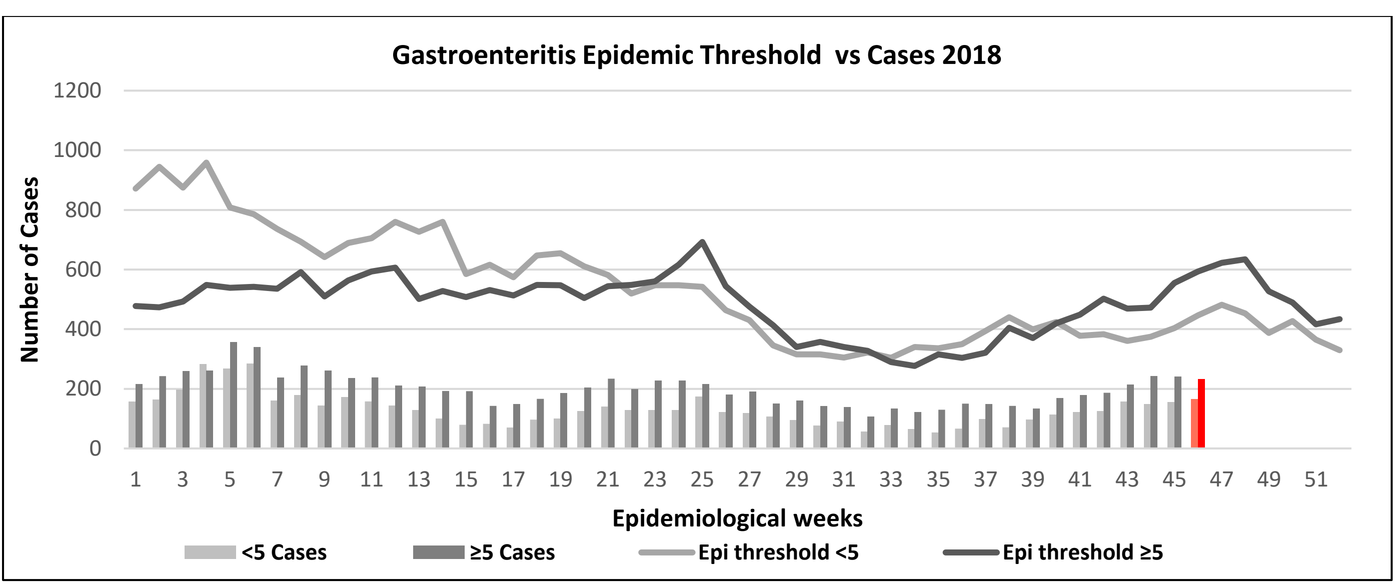
EW 46

Weekly Breakdown of Gastroenteritis cases

Year	EW 46			YTD		
	<5	≥5	Total	<5	≥5	Total
2018	165	223	388	6,012	9,211	15,233
2017	126	184	310	7,152	9,162	16,314

Gastroenteritis:
In epidemiological week 45, 2018, the total number of reported GE cases showed a 25% increase compared to EW 45 of the previous year.
The year to date figures showed a 7% decrease in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2017-2018



Total number of GE cases per parish for Week 46, 2018

Parishes	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
<5	2024	153	103	409	626	347	352	224	256	205	536	417	360
≥5	1602	307	167	717	1193	606	796	344	502	365	940	829	843

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RESEARCH PAPER

Knowledge, Attitudes, and Practices regarding screening for Cervical Cancer of Female Health Care Workers age 20-60 years employed to Manchester Health Services.

By: **Thompson-Nelson K**

Southern Regional Health Authority

Recent statistics highlighted that there is a problem of low compliance in cervical cancer screening among women of reproductive age in Manchester.

Objectives : To assess the knowledge, attitudes and practices of female health care workers regarding screening for cervical cancer, to assess level of compliance to the screening guidelines and to identify barriers to screening.

Methods: This study was a cross-sectional descriptive one, utilizing both quantitative and qualitative designs. Quantitative design was done using a researcher to administer the questionnaires. These study participants were selected using random sampling (N=150) and the staff lists were coded using numbers to ensure anonymity of subjects. The qualitative design included in-depth interviews of four participants who were not included in the quantitative phase of the study.

Results: There was a high awareness of cervical cancer and Pap smear among the group in that 99% and 100% respectively heard about cervical cancer and Pap smear. More than 50% scored, "poor to very poor." regarding knowledge of risk factors for the disease. Of the sample 55% were in compliance with the cervical cancer screening guidelines and 91% displayed a positive attitude to screening while 89% had ever done a Pap smear. Fear, comfort and privacy were the most outstanding barriers to screening mentioned, and the majority of the smears were done at private facilities.

Conclusion : This study has revealed information that will help Coordinators at the National and Local level to devise strategies necessary to strengthen the existing screening programme, educate re risk factors of the disease as well as to empower health care workers to improve compliance to the screening guidelines and uptake of screening in the public health care facilities.