

# WEEKLY EPIDEMIOLOGY BULLETIN

## NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

### Health is a Human Right

#### Take a stand for the right to health

More people can access essential health services today than ever before, but at least half of the world’s population still go without. Those living in the poorest countries, in the most marginalized communities, face the greatest challenges in access, the highest burden of disease, and the worst health outcomes. This year is an opportunity to stand up for their rights. It is the 70th anniversary of the Universal Declaration for Human Rights, and the 70th anniversary of WHO. Both the Declaration and WHO’s Constitution, the organization’s founding document, assert that health is a fundamental right for all people. These are the **ABCs** of what it will take to deliver the right to health

**A** is for access

The right to health is about ensuring that everyone, everywhere can access affordable, quality healthcare.

This is the defining principle of universal health coverage: no one should get sick and die just because they are poor, because of who they are or where they were born, or because they cannot access the health services they need.

Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality

A rights-based approach to health requires that health policy and programmes must prioritize the needs of those furthest behind first towards greater equity, a principle that has been echoed in the recently adopted 2030 Agenda for Sustainable Development and Universal Health Coverage

**C** is for civil society

Ensuring the participation of communities in health policies and programmes is a fundamental principle of human rights, but also, good for health outcomes. It means engaging and empowering people in the decisions that affect their health, designing health systems around the needs of people instead of diseases and health institutions, so that everyone gets the right care, at the right time, in the right place.

**B** is for breaking down barriers

Achieving universal health coverage requires bold and sustained efforts to reach those most at risk of being left behind.

Whether social, cultural, structural or financial, a rights-based approach means identifying bottlenecks, and breaking down barriers related to access, affordability, the quality or availability of healthcare services.

**D** is for determinants of health

Health is about more than health care. It refers also to the underlying determinants that impact our current and future health: factors like the food we eat, the water we drink, the air we breathe, the houses we live in, or the education we receive.

SDGs work on social determinants of health.

These factors are shaped by legal and economic policies and systems, development agendas, social norms, policies and political systems, and require coordinated responses to ensure that people are able to achieve their highest attainable standard of health.

This is why the year’s groundbreaking Declaration of Action, agreed by all WHO member states, talks not only about the need to provide affordable, quality health care, but also about making the healthy choices and environments that will protect the health of the world’s people.

**E** is for equality and non-discrimination

Inequalities can always impact on health – linked to where someone lives or where they were born, their gender, ethnicity, age, race, sexuality, culture or religion, health or any other status.

Inequality can also be reflected in discrimination, and abuse that occurs in healthcare itself, affecting both health workers and service users. This undermines universal health coverage in multiple ways: by jeopardising investment in health, deterring people from seeking healthcare, and discriminating or demeaning people of their dignity.

Source: <https://www.who.int/news-room/feature-stories/detail/take-a-stand-for-the-right-to-health>

### EPI WEEK 47



SYNDROMES

PAGE 2



CLASS 1 DISEASES

PAGE 4



INFLUENZA

PAGE 5



DENGUE FEVER

PAGE 6



GASTROENTERITIS

PAGE 7



RESEARCH PAPER

PAGE 8

# REPORTS FOR SYNDROMIC SURVEILLANCE

## FEVER

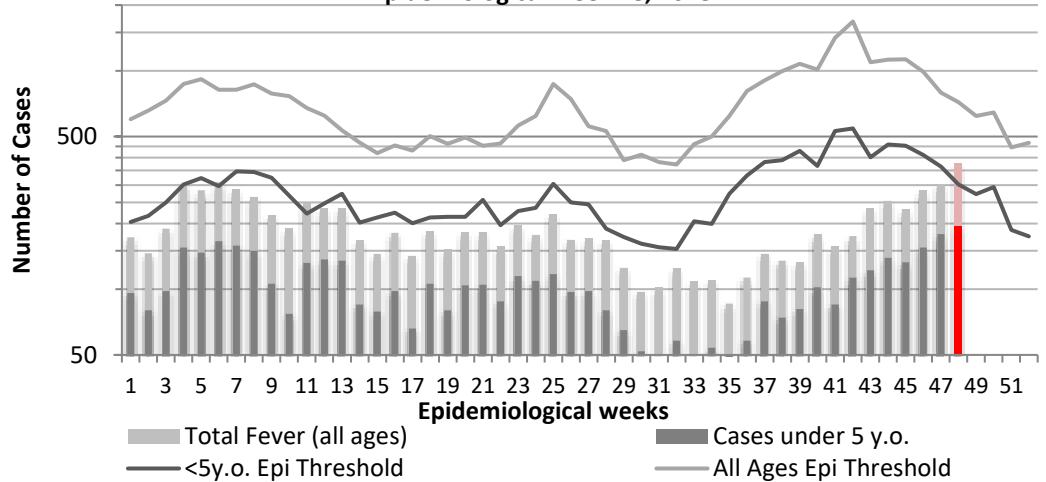
Temperature of  $>38^{\circ}\text{C}$  /  $100.4^{\circ}\text{F}$  (or recent history of fever) with or without an obvious diagnosis or focus of infection.



### KEY

**RED** CURRENT WEEK

Fever in under 5y.o. and Total Fever vs epidemic Thresholds, Jamaica  
Epidemiological week 48, 2018

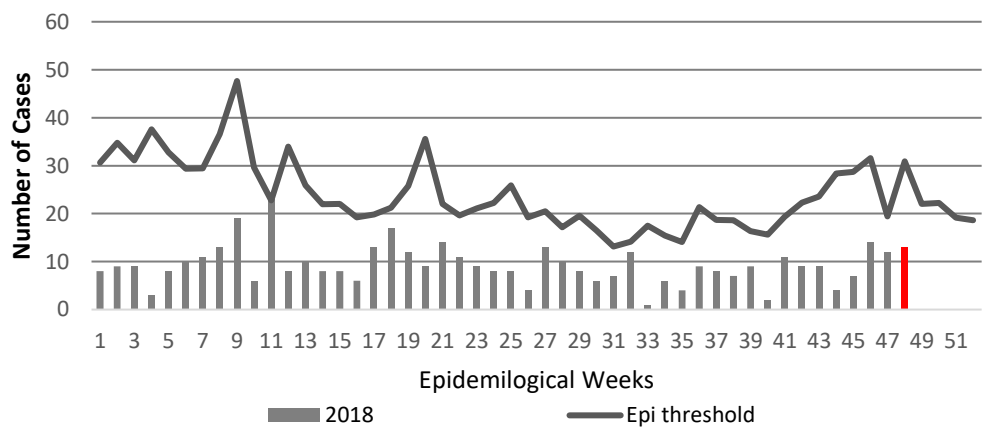


## FEVER AND NEUROLOGICAL

Temperature of  $>38^{\circ}\text{C}$  /  $100.4^{\circ}\text{F}$  (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).



Total Fever and Neurological Symptoms vs epidemic threshold Jamaica: Week 48, 2018

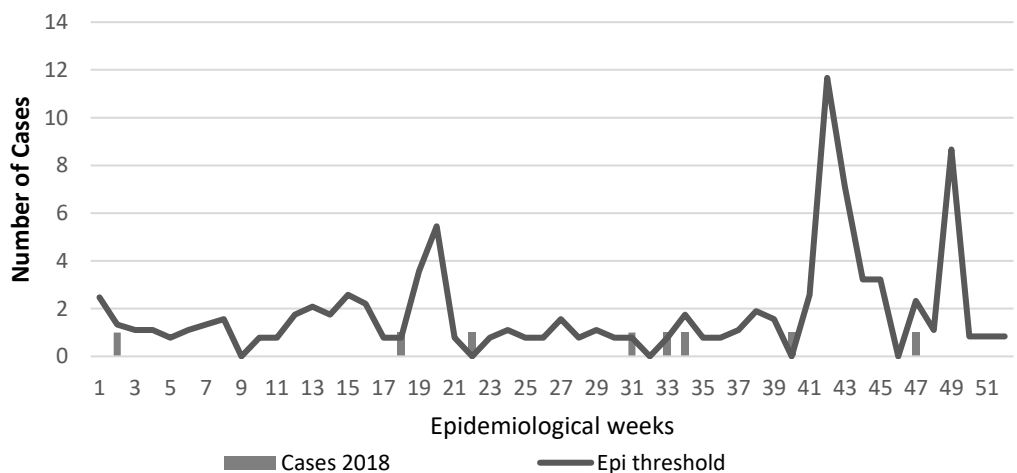


## FEVER AND HAEMORRHAGIC

Temperature of  $>38^{\circ}\text{C}$  /  $100.4^{\circ}\text{F}$  (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



Total Fever and Haemorrhagic Symptoms vs epidemic threshold Jamaica: Week 48, 2018



**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

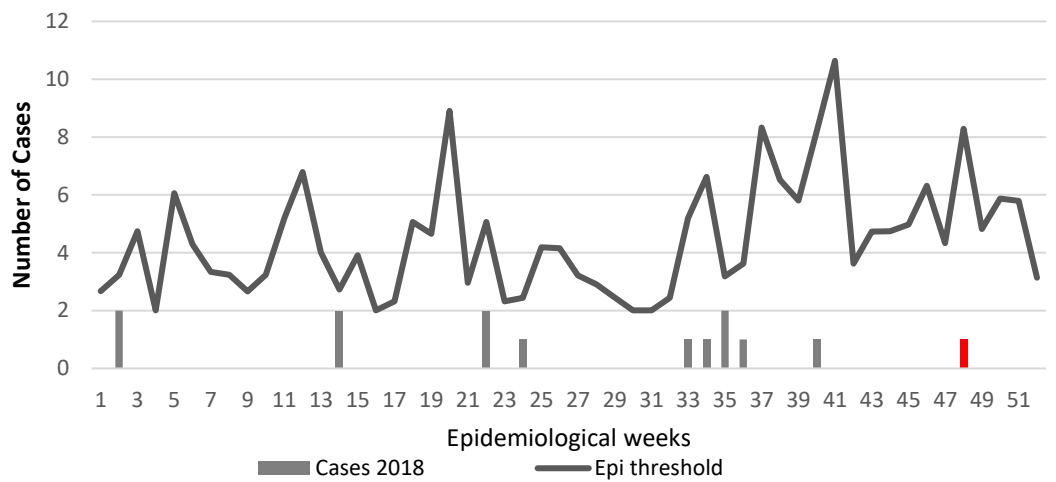
### FEVER AND JAUNDICE

Temperature of  $>38^{\circ}C$  /  $100.4^{\circ}F$  (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.



Total Fever and Jaundice vs epidemic threshold, Jamaica: Week 48, 2018



### ACCIDENTS

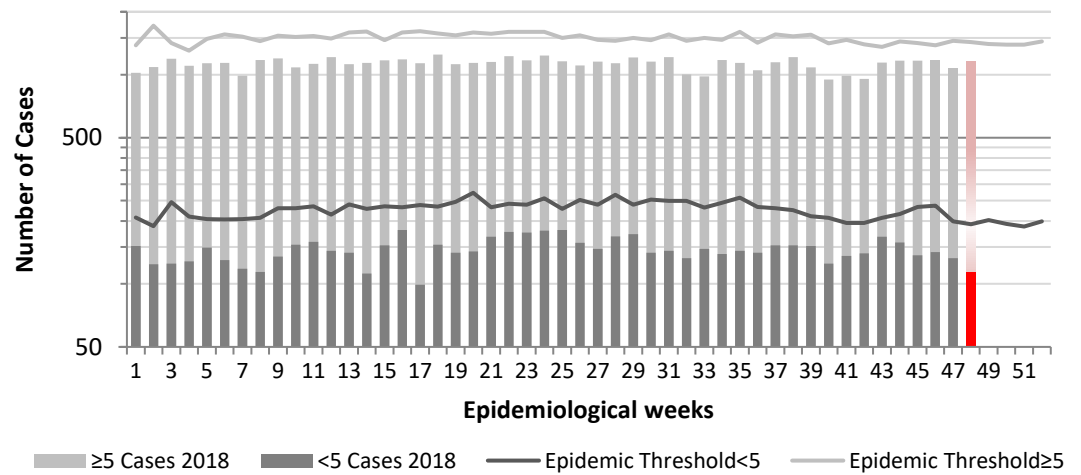
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.

**KEY**

**RED CURRENT WEEK**



Accidents by age group versus epidemic thresholds, Jamaica: Week 48, 2018

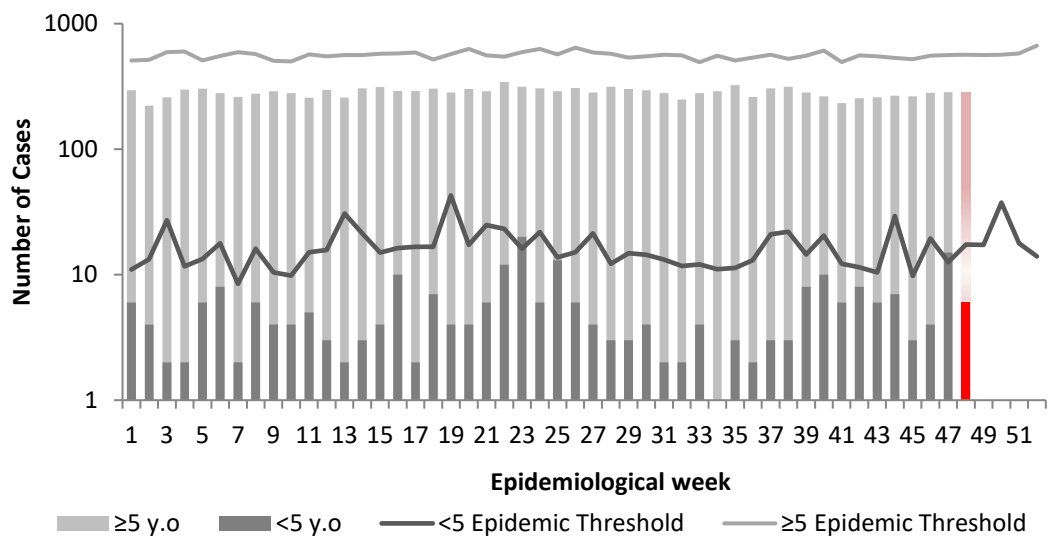


### VIOLENCE

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



Violence by age group versus epidemic thresholds, Jamaica: Week 48, 2018



**3 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

CLASS ONE NOTIFIABLE EVENTS				Comments	
			CONFIRMED YTD		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.
	CLASS 1 EVENTS		CURRENT YEAR	PREVIOUS YEAR	
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning <sup>1</sup>		(439) 135	(466) 192	Pertussis-like syndrome and Tetanus are clinically confirmed classifications.
	Cholera		0	0	
	Dengue Hemorrhagic Fever <sup>2</sup>		2	3	
	Hansen's Disease (Leprosy)		0	2	
	Hepatitis B		47	53	
	Hepatitis C		9	10	
	HIV/AIDS		NA	NA	
	Malaria (Imported)		5	0	
	Meningitis (Clinically confirmed)		35	115	
EXOTIC/ UNUSUAL	Plague		0	0	
HIGH MORBIDITY/ MORTALITY	Meningococcal Meningitis		0	0	<sup>1</sup> Numbers in brackets indicate combined suspected and confirmed Accidental Poisoning cases
	Neonatal Tetanus		0	0	
	Typhoid Fever		0	0	
	Meningitis H/Flu		0	0	
SPECIAL PROGRAMMES	AFP/Polio		0	0	<sup>2</sup> Dengue Hemorrhagic Fever data include Dengue related deaths; <sup>3</sup> Figures include all deaths associated with pregnancy reported for the period. <sup>4</sup> CHIKV IgM positive cases <sup>5</sup> Zika IgM positive cases 
	Congenital Rubella Syndrome		0	0	
	Congenital Syphilis		0	0	
	Fever and Rash	Measles	0	0	
		Rubella	0	0	
	Maternal Deaths <sup>3</sup>		57	49	
	Ophthalmia Neonatorum		288	342	
	Pertussis-like syndrome		0	0	
	Rheumatic Fever		0	0	
	Tetanus		0	0	
	Tuberculosis		41	117	
Yellow Fever		0	0		
Chikungunya <sup>4</sup>		10	0		
Zika Virus <sup>5</sup>		1	0	NA- Not Available	

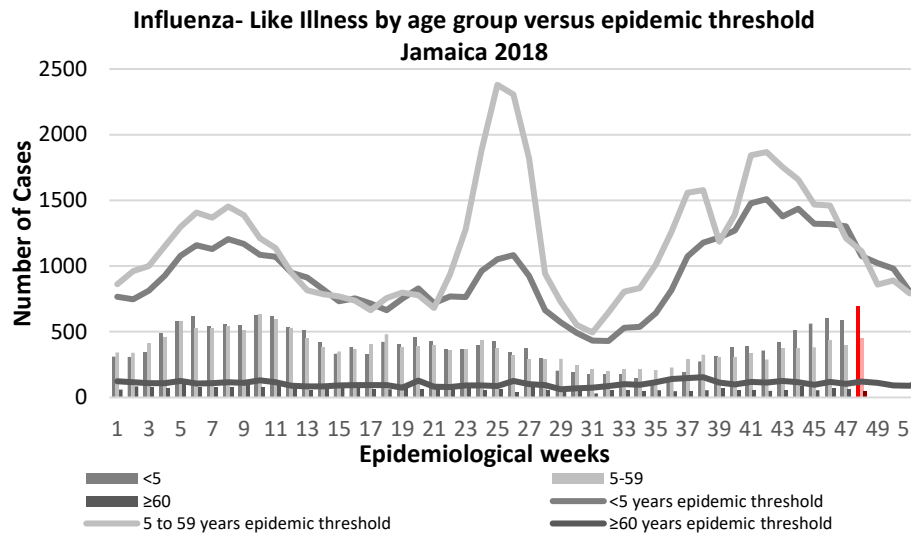
	<b>4 NOTIFICATIONS-</b> All clinical sites		<b>INVESTIGATION REPORTS-</b> Detailed Follow up for all Class One Events		<b>HOSPITAL ACTIVE SURVEILLANCE-</b> 30 sites. Actively pursued		<b>SENTINEL REPORT-</b> 79 sites. Automatic reporting
--	---	---	---	---	---	---	---

# NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

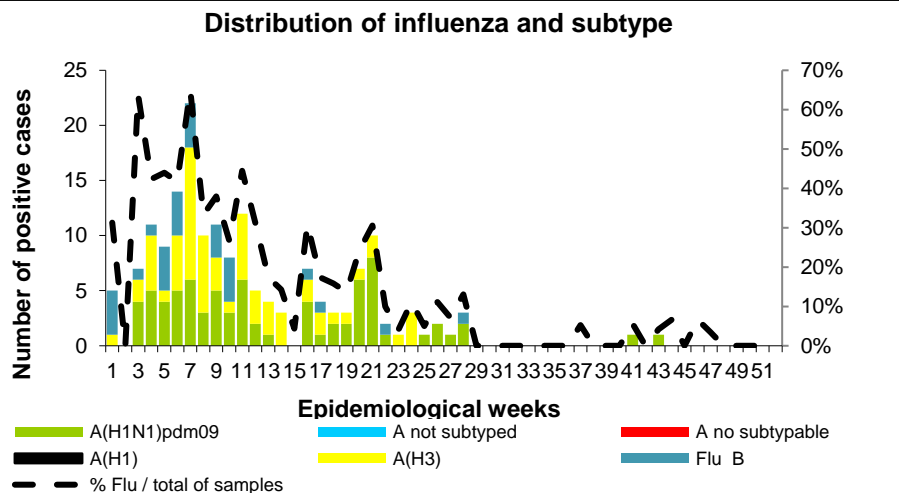
## EW 48

November 25- December 1, 2018 Epidemiological Week 48

November 2018		
	EW 48	YTD
SARI cases	8	337
<b>Total Influenza positive Samples</b>	<b>0</b>	<b>170</b>
<b>Influenza A</b>	<b>0</b>	<b>141</b>
H3N2	0	65
H1N1pdm09	0	76
Not subtyped	0	1
<b>Influenza B</b>	<b>0</b>	<b>29</b>
<b>Parainfluenza</b>	<b>0</b>	<b>7</b>



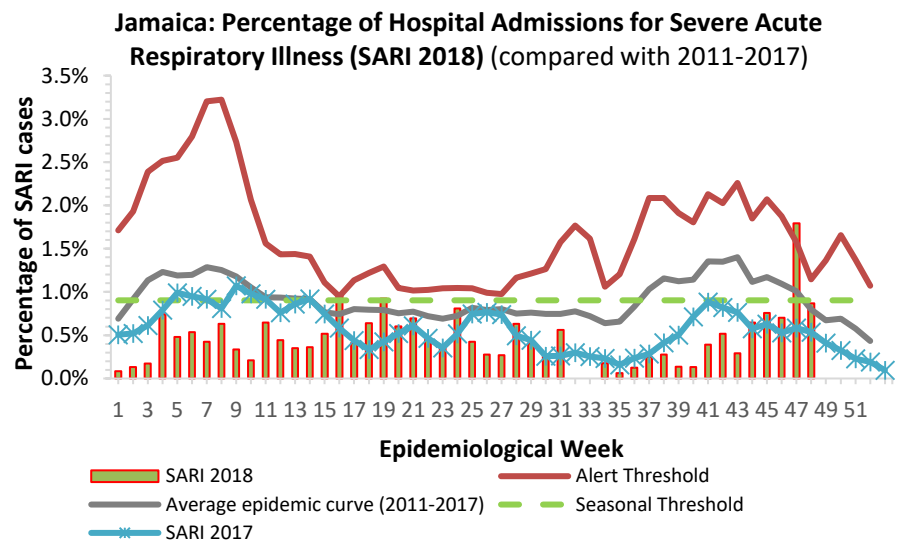
**Comments:**  
During EW 48 SARI activity remained below the seasonal threshold, similar to the previous seasons for the same period. Decreased influenza activity was reported; with influenza A(H1N1)pdm09 predominating in previous weeks



### 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.



**5 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

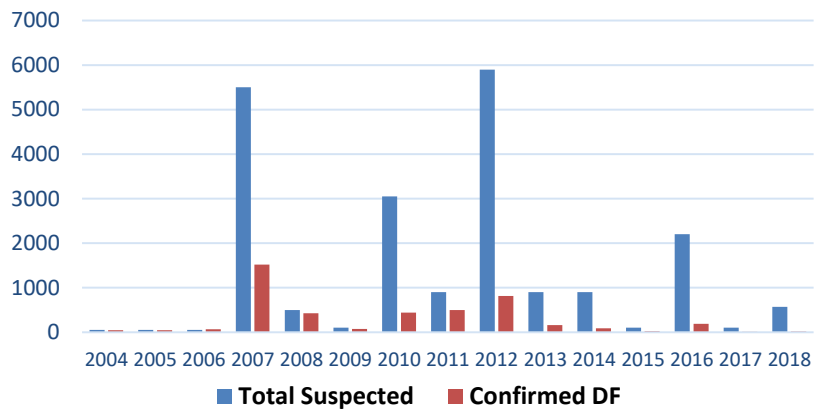
# Dengue Bulletin

November 25- December 1, 2018

Epidemiological Week 48



Dengue Cases by Year: 2007-2018, Jamaica



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

	2018		2017 YTD
	EW 48	YTD	
Total Suspected Dengue Cases	27	597	154
Lab Confirmed Dengue cases	0	11	6
<b>CONFIRMED</b>	*DHF/DSS	0	3
	Dengue Related Deaths	0	0

# DENGUE FEVER

**Symptoms**

- 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 hemorrhagic fever. Only symptomatic treatment is given.

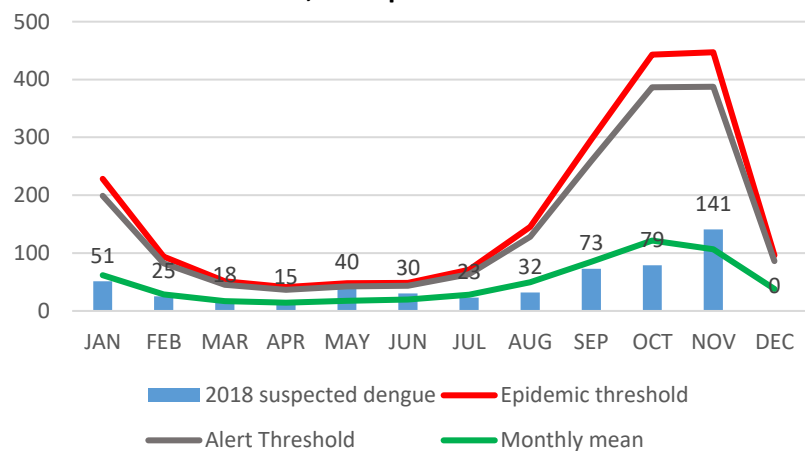
**MAYOM HOSPITAL**

\*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.

Suspected dengue cases for 2018 versus monthly mean, alert, and epidemic thresholds



**6 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

# Gastroenteritis Bulletin

**EW**  
**48**

November 25- December 1, 2018

Epidemiological Week 48

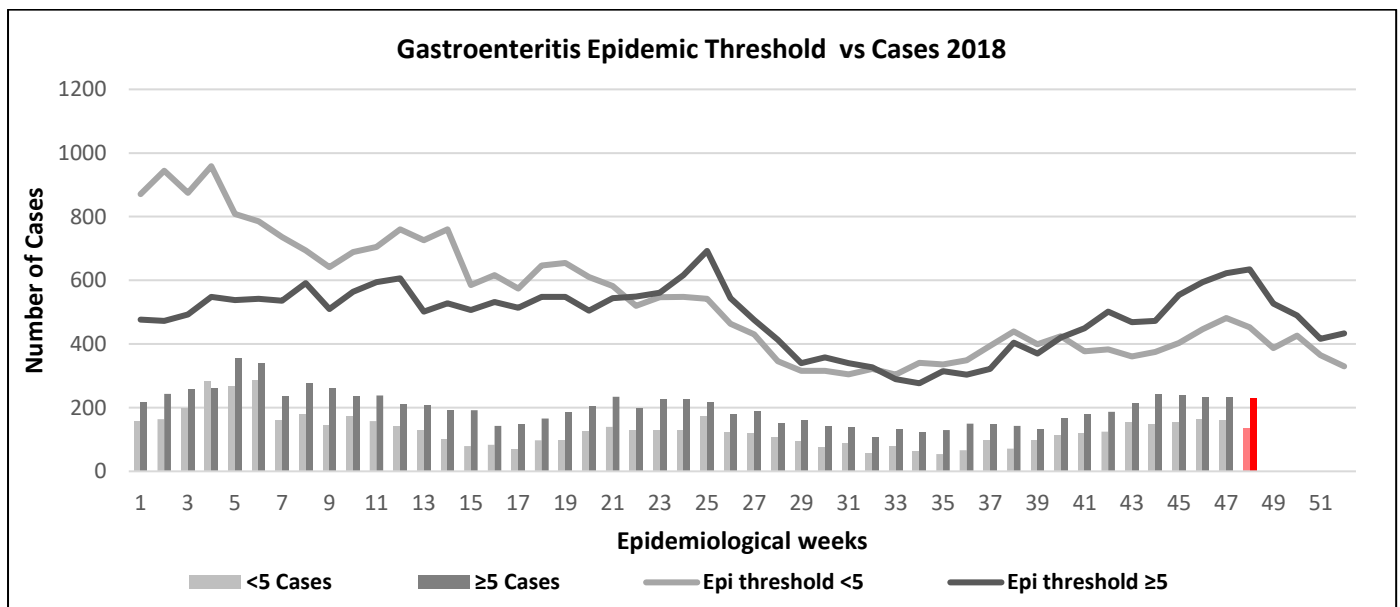
## Weekly Breakdown of Gastroenteritis cases

Year	EW 48			YTD		
	<5	≥5	Total	<5	≥5	Total
2018	136	230	366	6,324	9,710	16,034
2017	199	227	426	7,484	9,596	17,083

### Gastroenteritis:

In epidemiological week 48, 2018, the total number of reported GE cases showed a 14% increase compared to EW 48 of the previous year. The year to date figures showed a 6% decrease in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2017-2018



## Total number of GE cases per parish for Week 48, 2018

Parishes	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
<5	2112	157	106	429	654	363	359	230	266	217	587	456	388
≥5	1713	318	171	757	1243	629	828	357	518	383	1025	891	977



**7 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

---

# 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.



8 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