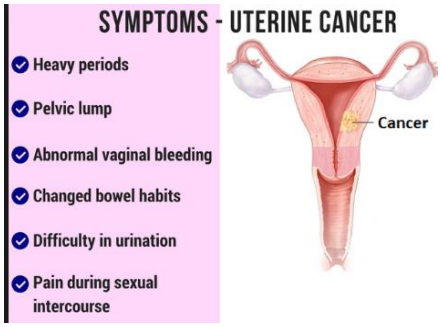
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Cervical Cancer



Each year, more than 300 000 women die of **cervical cancer**. More than half a million women are diagnosed. Every minute, one woman is diagnosed. Cervical cancer is one of the greatest threats to women's health. Each death is a tragedy, and can be prevented. Most of these women are not diagnosed early enough, and lack access to life-saving treatment. Studies have shown that prevention and early treatment of cervical cancer are also highly cost-effective.

Nine in 10 women who die from cervical cancer are in poor countries. This means some of the most vulnerable women in our world are dying unnecessarily. This is not fair or just. Rising cervical cancer deaths is undermining health gains for women made in maternal health and HIV care. Current disparity in survival from cervical cancer, which varies between 33-77%, is unacceptable and can be minimized. Cervical cancer is one of the most preventable and curable forms of cancer, as long as it is detected early and managed effectively. New diagnoses can be reduced in two ways, HPV vaccination and screening of the cervix with follow on treatment of early changes before cancer appears.

Currently, most women diagnosed with cervical cancer are diagnosed with advanced cancers, where opportunity for cure is small. This compounded by lack of access to life-saving treatment in settings where the burden and need is highest.

In May 2018, WHO Director-General, Dr Tedros Adhanom Ghebreyesus made a global call for action towards the elimination of cervical cancer.

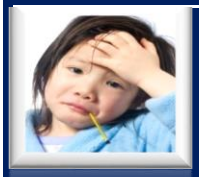
This is in line with the targets of WHO's General Programme of Work: 1 billion more people benefiting from universal health coverage; 1 billion more people better protected from health emergencies; and 1 billion more people enjoying better health and well-being.

We have the tools to achieve global elimination of cervical cancer. We also have the political commitment. Several countries and UN agencies have already joined forces under the UN Joint Global Programme on Cervical Cancer Prevention and Control.

The world is doing something, but to succeed, we need everyone on board. From governments and UN agencies to researchers, healthcare professionals and individuals, we all have a role to play. As the manufacturers of life-saving vaccines, diagnostics and treatments, the private sector is also a key partner in this mission.

Source: https://www.who.int/cancer/cervical-cancer

EPI WEEK 3



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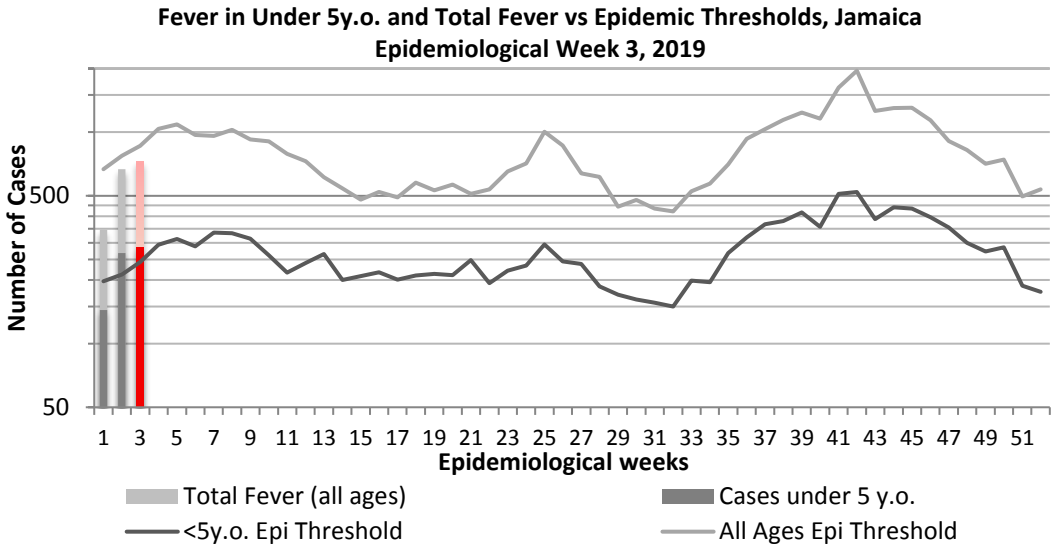
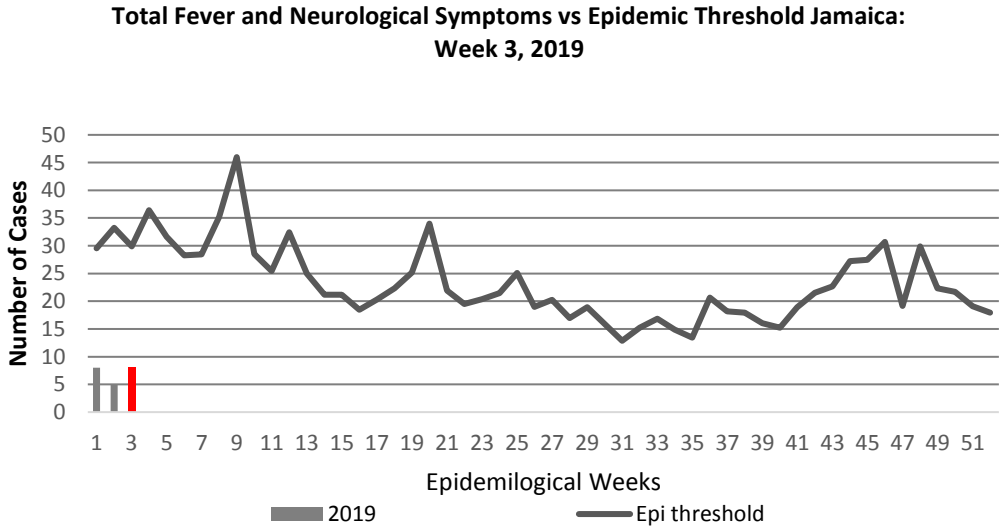
REPORTS FOR SYNDROMIC SURVEILLANCE

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

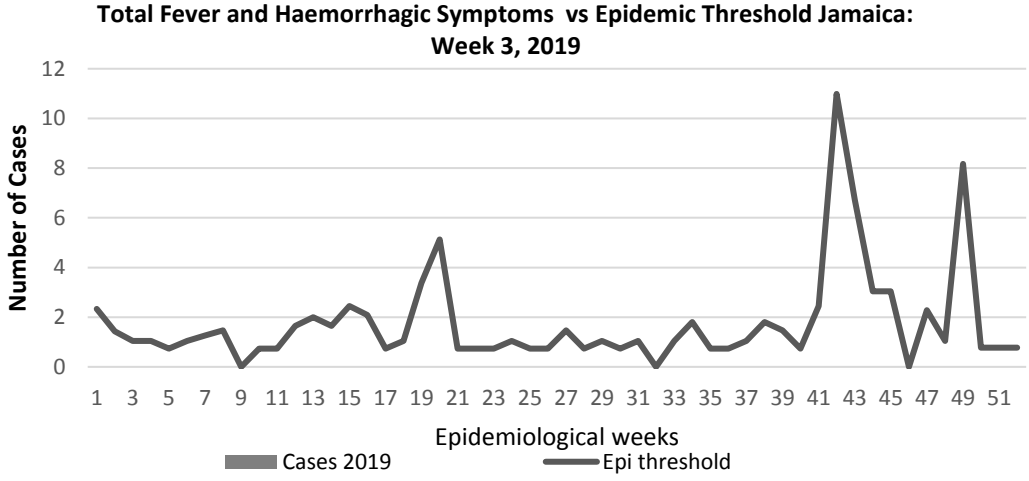
KEY
RED CURRENT WEEK



FEVER AND NEUROLOGICAL
Temperature of >38^{0}C /100.4^{0}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).



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.



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

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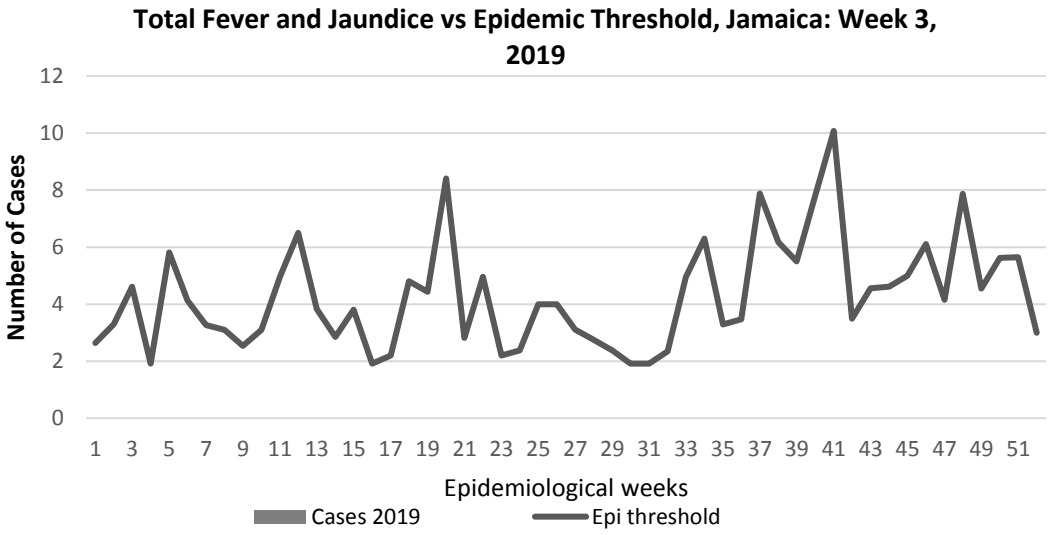
FEVER AND JAUNDICE

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

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.

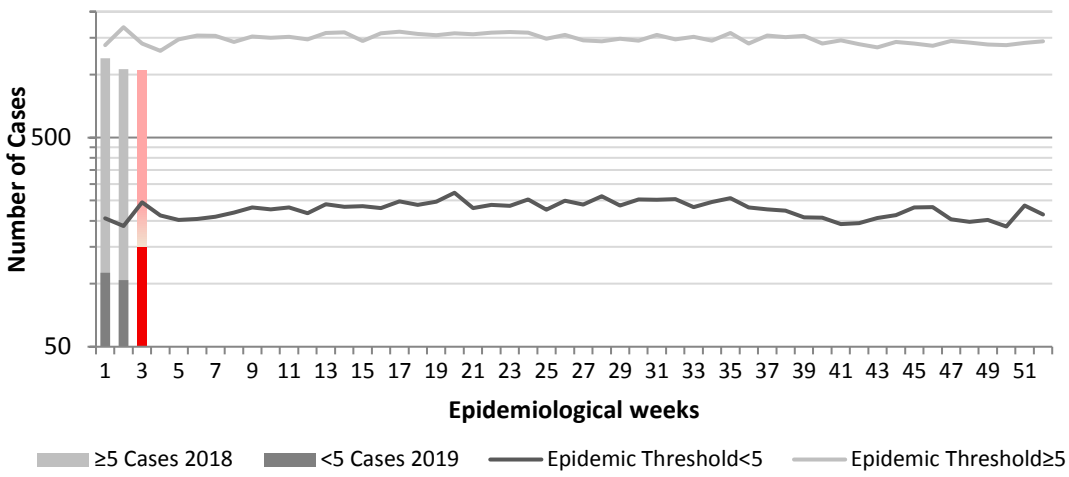


ACCIDENTS

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

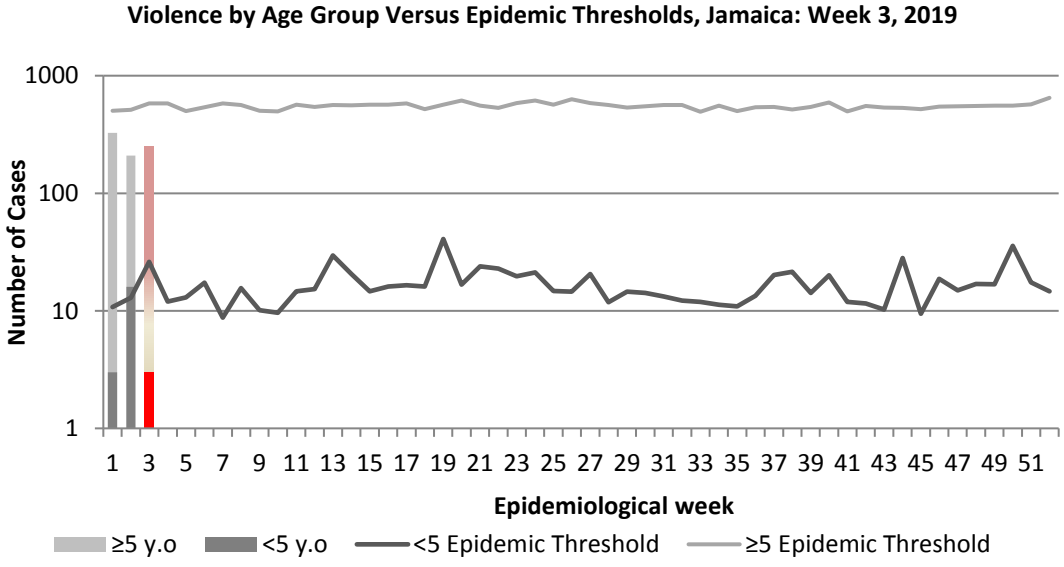
KEY

RED CURRENT WEEK



VIOLENCE

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



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CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS		CONFIRMED YTD CURRENT YEAR	CONFIRMED YTD PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning[1]		6	9
	Cholera		0	0
	Dengue Hemorrhagic Fever[2]		0	0
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		0	0
	Hepatitis C		0	0
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis (Clinically confirmed)		1	3
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
		Rubella	0	0
	Maternal Deaths[3]		1	4
	Ophthalmia Neonatorum		12	14
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		0	0
	Tuberculosis		0	4
	Yellow Fever		0	0
	Chikungunya[4]		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.

[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 PCR positive cases

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	Zika Virus[5]	0	0	NA- Not Available

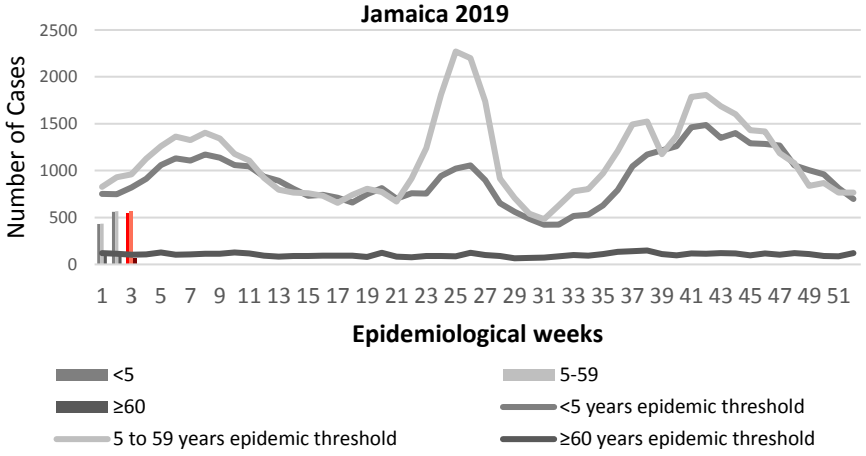
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 3

January 13-19, 2019 Epidemiological Week 3

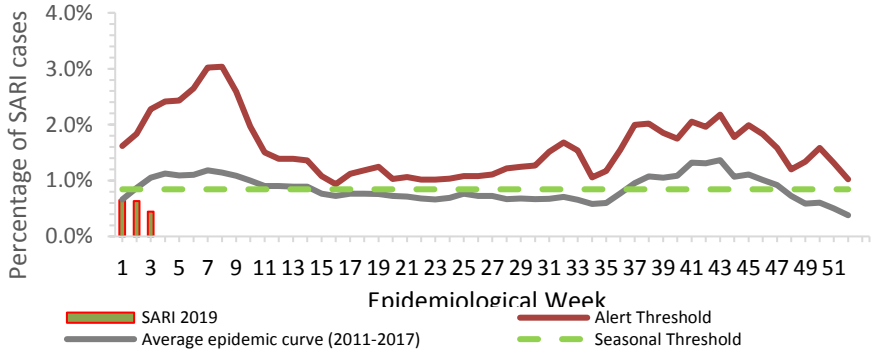
December 2019		
	EW 3	*YTD*
SARI cases	*12*	*22*
Total Influenza positive Samples	***2***	***5***
Influenza A	***2***	***5***
H3N2	***0***	***0***
H1N1pdm09	***1***	***4***
Not subtyped	***1***	***1***
Influenza B	***0***	***0***
Parainfluenza	***0***	***0***

Influenza- Like Illness by Age Group Versus Epidemic Threshold Jamaica 2019



Comments:
During EW 3 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

Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2019) (compared with 2011-2018)



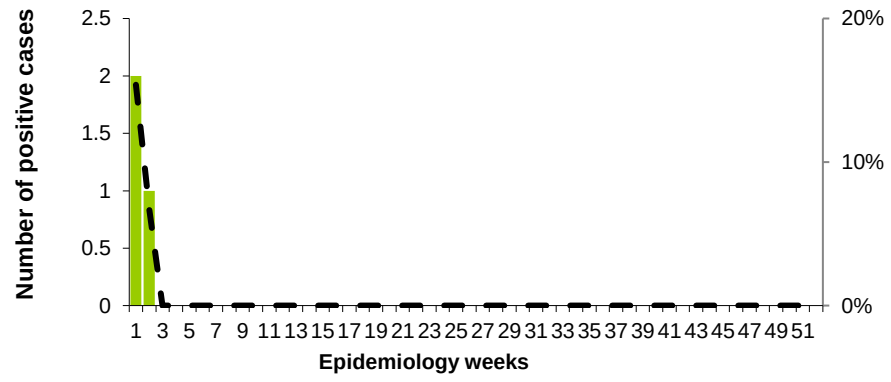
GLOBAL AND REGIONAL UPDATES

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

Caribbean: Influenza activity decreased and RSV activity was reported in most of the subregion. In Cuba and Haiti, the greatest activity of SARI was associated with influenza A (H1N1) pdm09.

”

Distribution of influenza and subtype



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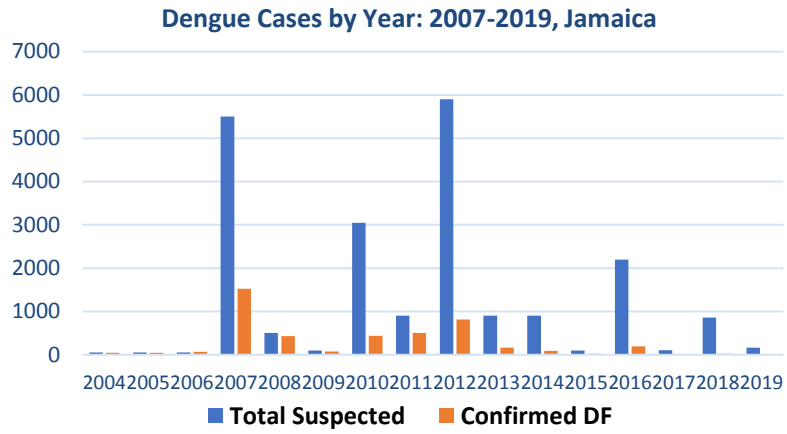
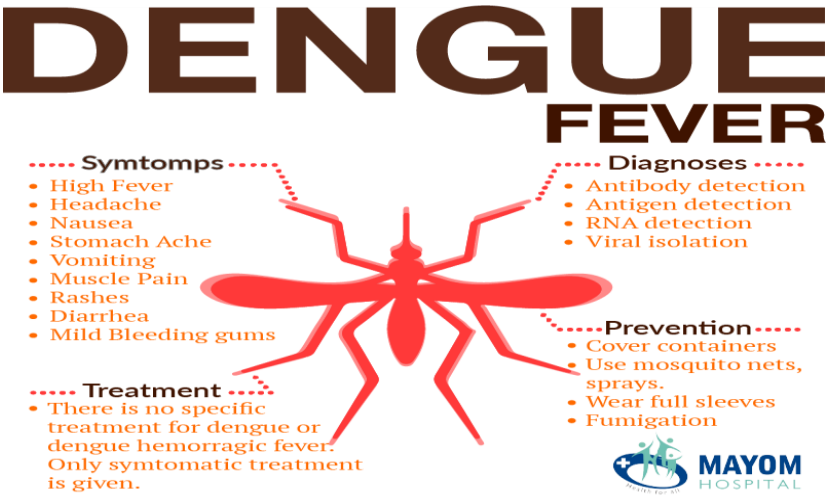
Dengue Bulletin

January 13-19, 2019 Epidemiological Week 3 | Epidemiological Week 3



Reported suspected and confirmed dengue with symptom onset in weeks 1-52, 2019

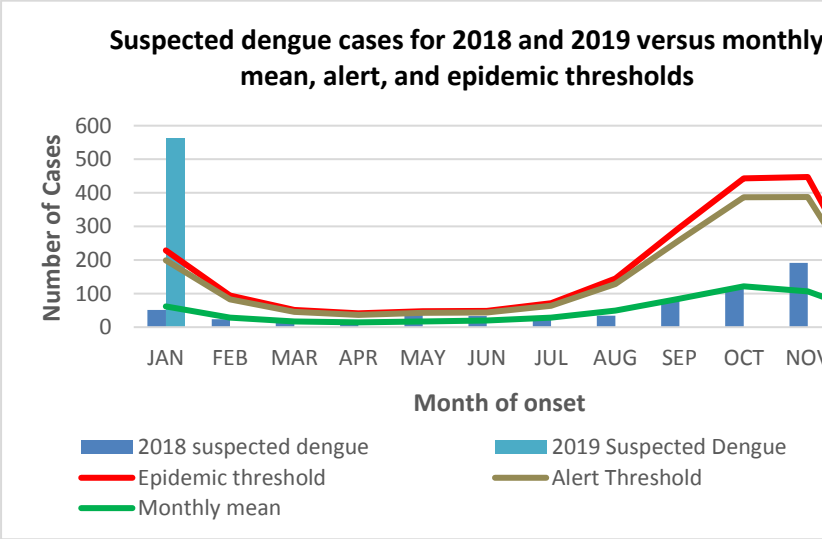
		2019		2018 YTD
		EW 3	YTD	
Total Suspected Dengue Cases		230	772	33
Lab Confirmed Dengue cases		4	13	0
CONFIRMED	*DHF/DSS	0	0	0
CONFIRMED	Dengue Related Deaths	0	0	0



***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

EW 3

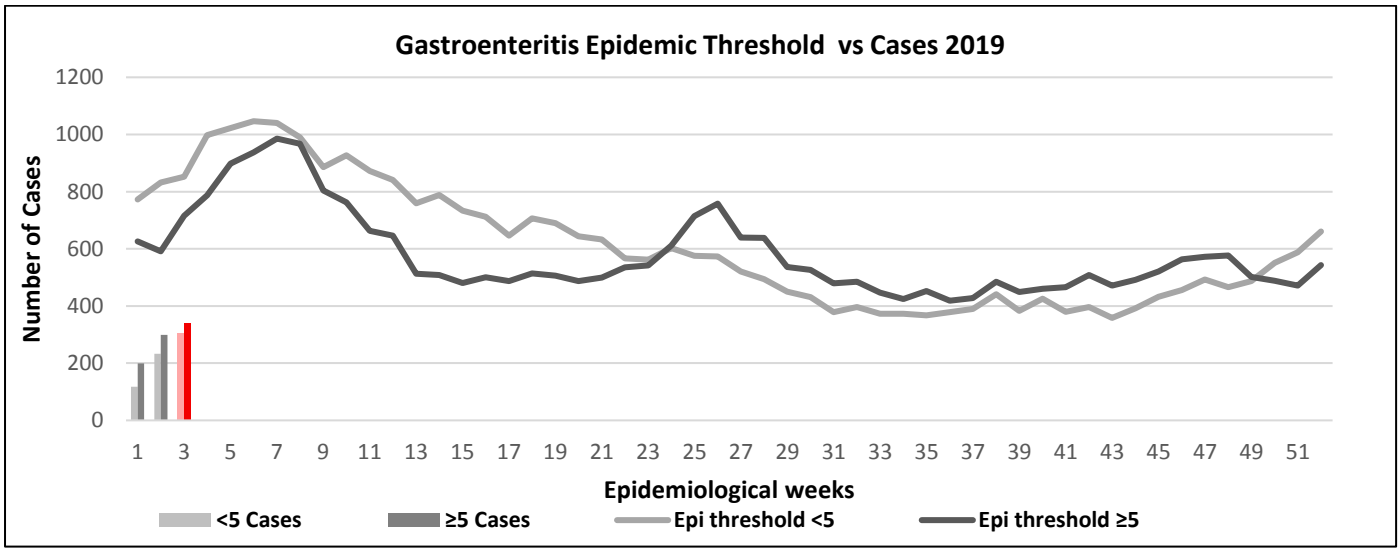
January 13-19, 2019 Epidemiological Week 3 | Epidemiological Week 3

Weekly Breakdown of Gastroenteritis cases

Year	EW 3			YTD		
	<5	≥5	Total	<5	≥5	Total
2019	306	340	646	657	839	1,495
2018	197	259	456	518	718	1,236

Gastroenteritis:
In epidemiological week 3, 2019, the total number of reported GE cases showed a 42% decrease compared to EW 3 of the previous year.
The year to date figures showed a218% increase in cases for the period.

Figure 1: Total Gastroenteritis Cases Reported 2018-2019



Total number of GE cases per parish up to Week 3 , 2019

Parishes	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
<5	159	33	19	63	112	49	65	15	28	29	134	78	54
≥5	0	0	0	0	0	0	0	0	0	0	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

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RESEARCH PAPER

Title: *A Review of the 1918 Influenza Pandemic - The Jamaica Experience*

Authors: *Iyanna Wellington, Ardene Harris, Nicolas Elias, Shara Williams, Kelly-Ann Gordon-Johnson, Nathlee McMorris, Neisha Vanhorne, Lesley-Ann James, Andriene Grant, Karen Webster-Kerr*

Institution: *National Epidemiology Unit, Ministry of Health, Jamaica*

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ABSTRACT

Objective: To describe the 1918 influenza pandemic in Jamaica and explore the socio-political and health-care contexts of the event.

Methods: Reviewed documents to obtain data on demographic parameters, hospital admissions for influenza, social conditions, and health system response.

Results: The Jamaican population in 1918 was 809,005 (384,319 males and 424,686 females). Health care was delivered by a network of: private practices, hospitals, infirmaries, and dispensaries.
The 1918 influenza pandemic started in January; the first recorded case of pandemic influenza in Jamaica occurred around October 1918 and by December the pandemic in Jamaica waned. In 1918/19 the proportion of influenza hospitalizations was 157 times greater than the mean for the preceding 10 years (1,412/10,000 versus 9/10,000). The influenza-specific death rate in 1918/19 was 3,288/10,000 in hospitalized patients while the maximum annual influenza-specific death rate in non-outbreak years was 80/10,000. The crude death rate declined by 32% from 1918/19 to 1919/20.

The First World War, local riots, food shortages, and recent hurricanes may have challenged the local authorities' reaction to the emergence of the pandemic in Jamaica. The response to the outbreak included: school closures, bans on public gatherings, disinfection of public transport, local travel bans, hiring of additional sanitary workers, opening of emergency hospitals and soup kitchens, health education, and policy changes.

Conclusion: The 1918 influenza outbreak in Jamaica was sudden and severe. The response to the 1918 influenza outbreak was affected by the socio-political realities of the day, which should be kept in mind for future pandemic preparedness planning.