WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH, JAMAICA

Measles and the Vaccine (Shot) to Prevent It

Measles is about.

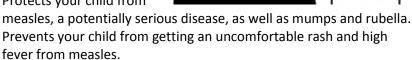
Get vaccinated!

Click here for more details

Fact Sheet for Parents

The best way to protect against measles is to get the measles-mumps-rubella shot (MMR). Doctors recommend that all children get the MMR shot.

Why should my child get the MMR shot? Protects your child from



Keeps your child from missing school or child care (and keeps you from missing work to care for your sick child).

The MMR shot is very safe, and it is effective at preventing measles (as well as mumps and rubella). Vaccines, like any medicine, can have side effects. But most children who get the MMR shot have no side effects. The side effects that do occur are usually very mild, such as a fever, rash, soreness or swelling where the shot was given, or temporary pain and stiffness in the joints (mostly in teens and adults). More serious side effects are rare. These may include high fever that could cause a seizure.

What are the symptoms of measles?

Measles starts with a fever that can get very high. Some of the other symptoms that may occur are:

Cough, runny nose, and red eyes

- Rash of tiny, red spots that start at the head and spread to the rest of the body
- Diarrhea
- Ear infection

Measles spreads when a person infected with the measles virus breathes, coughs, or sneezes. It is very contagious. You can catch measles just by being in a room where a person with measles has been, up to 2 hours after that person is gone. And you can catch measles from an infected person even before they have a measles rash. Almost everyone who has not had the MMR shot will get measles if they are exposed to the measles virus.

To learn more about the MMR shot, talk to your child's doctor, call 1-800-CDC-INFO, or visit www.cdc.gov/vaccines/parents.

Downloaded from: https://www.cdc.gov/vaccines/parents/diseases/child/measles.html

EPI WEEK 17



SYNDROMES

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CLASS 1 DISEASES

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INFLUENZA

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DENGUE FEVER

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GASTROENTERITIS

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RESEARCH PAPER

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REPORTS FOR SYNDROMIC SURVEILLANCE

FEVER

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



<u>KEY</u>

RED CURRENT WEEK

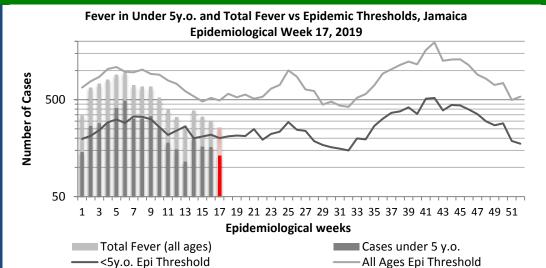
FEVER AND NEUROLOGICAL

Temperature of >38°C /100.4°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).

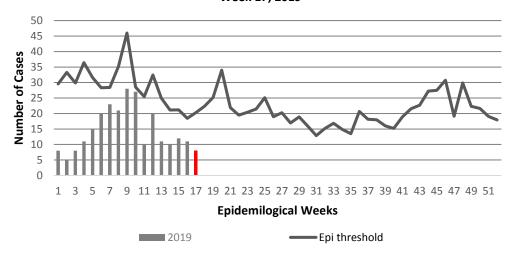
FEVER AND HAEMORRHAGIC

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

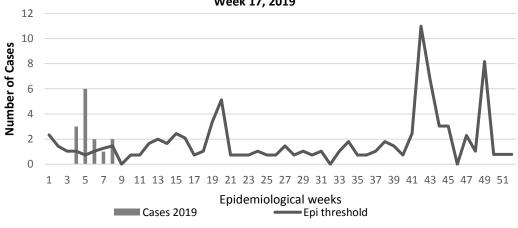




Total Fever and Neurological Symptoms vs Epidemic Threshold Jamaica: Week 17, 2019



Total Fever and Haemorrhagic Symptoms vs Epidemic Threshold Jamaica: Week 17, 2019





2 NOTIFICATIONS-All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



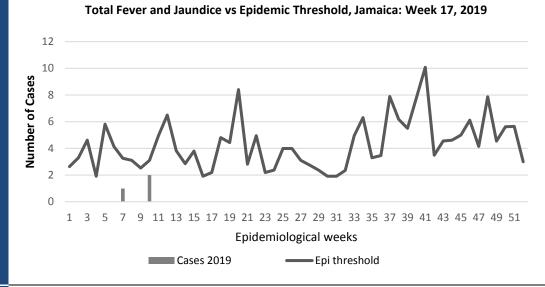
HOSPITAL ACTIVE SURVEILLANCE-30 sites. Actively pursued



FEVER AND JAUNDICE

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





ACCIDENTS

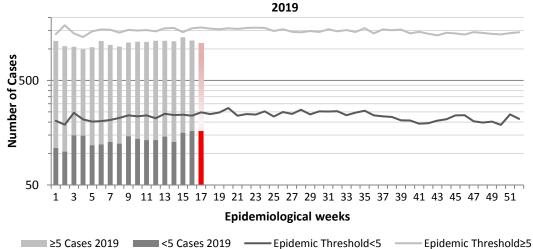
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.

KEY

RED CURRENT



Accidents by Age Group Versus Epidemic Thresholds, Jamaica: Week 17,

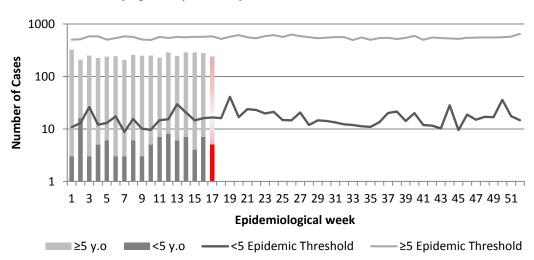


VIOLENCE

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



Violence by Age Group Versus Epidemic Thresholds, Jamaica: Week 17, 2019





3 NOTIFICATIONS-All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE-30 sites. Actively pursued



— CLAS	LASS ONE NOTIFIABLE EVENTS Commer									
			Confirm	ned YTD	AFP Field Guides					
	CLASS 1 EV	VENTS	CURRENT YEAR	PREVIOUS YEAR	from WHO indicate that for an effective					
AL.	Accidental P	oisoning	6	54	surveillance					
Ž	Cholera		0	0	system, detection rates for AFP					
ATI	Dengue Hen	norrhagic Fever ¹	0	0	should be					
ERN	Hansen's Di	sease (Leprosy)	0	0	1/100,000					
SPECIAL PROGRAMMES MORTALIY PORTALIY PROGRAMMES MORTALIY PROGRAMME	Hepatitis B		3	8	population under 15 years old (6 to					
	Hepatitis C		1	1	7) cases annually.					
	HIV/AIDS		NA	NA						
ATI	Malaria (Im	ported)	0	0	Pertussis-like syndrome and					
Z	Meningitis (Clinically confirmed)	5	22	Tetanus are					
	Plague		0	0	clinically confirmed					
)LI	Meningococ	cal Meningitis	0	0	classifications.					
IGH BID TAI	Neonatal Te	tanus	0	0	1 Dengue					
H 10R 10R	Typhoid Fev	ver	0	0	Hemorrhagic Fever data include					
22	≥ ≥ Meningitis H/Flu		0	0	Dengue related					
	AFP/Polio		0	0	deaths;					
	Congenital F	Rubella Syndrome	0	0	2 Figures include					
∞	Congenital S	Syphilis	0	0	all deaths					
	Fever and Rash	Measles	0	0	associated with pregnancy reported					
RAN		Rubella	0	0	for the period.					
SOG	Maternal De	aths ²	15	33	- 3 CHIKV IgM					
L PR	Ophthalmia	Neonatorum	61	104	positive					
CIA	Pertussis-like syndrome		0	0	cases					
SPEC	Rheumatic Fever		0	0	4 Zika - PCR positive cases					
\sim	Tetanus		0	0						
	Tuberculosis	3	5	24						
	Yellow Feve		0	0						
	Chikunguny	a ³	0	0						
	Zika Virus ⁴		0	0	NA- Not Available					







INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE-30 sites. Actively pursued

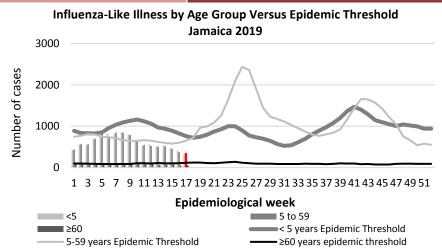


NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 17

April 21-27, 2019 Epidemiological Week 17

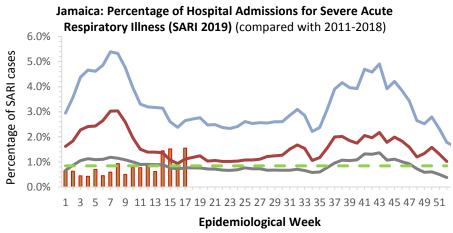
April 2019								
	EW 17	YTD						
SARI cases	24	238						
Total Influenza positive Samples	5	305						
Influenza A	4	258						
H3N2	0	58						
H1N1pdm09	4	218						
Not subtyped	0	6						
Influenza B	1	20						
Parainfluenza	0	2						



Comments:

Swine flu is a respiratory disease caused by the influenza virus (Influenza A H1N1 and H3N2) that infect the respiratory tract of pigs and result in a barking cough, decreased appetite, nasal secretions and listless behaviour. Occasionally, it may be transmitted to humans in very close contact. In 2009, the new Influenza A (H1N1) virus that emerged and led to a pandemic was designated as Influenza A (H1N1) pdm09 virus to distinguish it from the seasonal Influenza A (H1N1).

During EW 17 percentage of hospitalization for SARI exceeded the seasonal and alert thresholds. Increased influenza activity was noted in 2019 with influenza A(H1N1)pdm09 predominating.

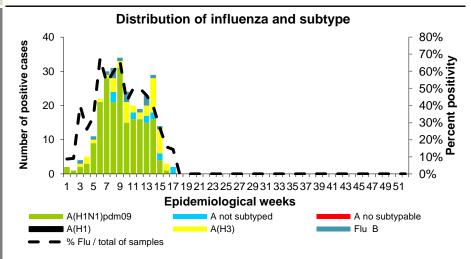




GLOBAL AND REGIONAL UPDATES

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





5 NOTIFICATIONS-All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE-30 sites. Actively pursued



Dengue Bulletin

April 21-27, 2019 Epidemiological Week 17

Epidemiological Week 17







Reported suspected and confirmed dengue with symptom onset in weeks 1-17, 2019

		20	19	2018 YTD	
		EW 17	YTD		
-	cted Dengue ises	0	4537	110	
Lab Confirm	0	16	0		
CONFIRMED	*DHF/DSS	0	0	2	
	Dengue Related Deaths	0	3	0	

Errata:

- There were 3 confirmed dengue related Deaths for epi weeks 11 to 16.
- 2018 YTD total suspected dengue cases by epi week:

 • EW 11 – 50

 • EW 12 – 80

 • EW 13 – 91

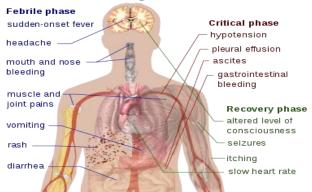
 - EW 14 91
 - EW 15 110
 - EW 16 110

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

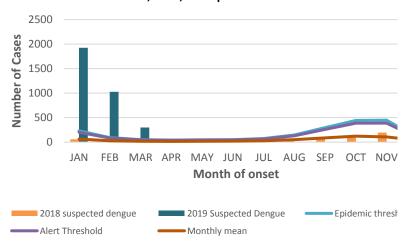
Points to note:

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

Symptoms of Dengue fever



Suspected dengue cases for 2018 and 2019 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



Gastroenteritis Bulletin

E VV

April 21-27, 2019 Epidemiological Week 17

Epidemiological Week 17

17

Weekly Breakdown of Gastroenteritis cases

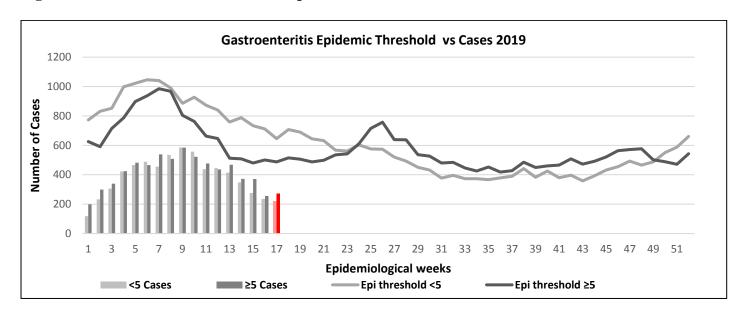
Year		EW 17		YTD				
	<5	≥5	Total	<5	≥5	Total		
2019	221	273	494	6,547	7,016	13,563		
2018	102	168	270	2,808	4,035	6,843		

Gastroenteritis:

In epidemiological week 17, 2019, the total number of reported GE cases showed a 83% increase compared to EW 17 of the previous year.

The year to date figures showed a 98% increase in cases compared to the same period in 2018.

Figure 1: Total Gastroenteritis Cases Reported 2018-2019



Total number of GE cases per parish up to Week 17, 2019

Parishes	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
<5	2440	192	84	355	581	345	500	170	330	222	632	319	377
≥5	1642	333	144	533	798	381	505	220	354	299	775	576	456





RESEARCH PAPER

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

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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.

