

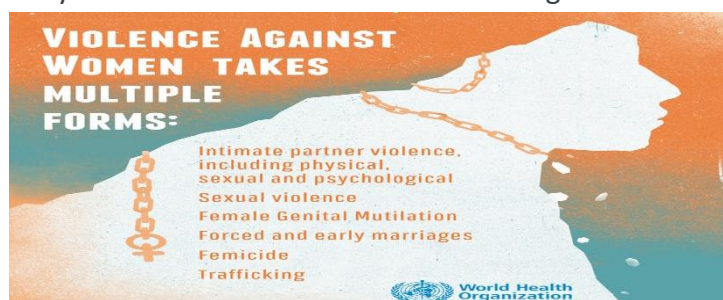
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Violence against women

Key facts

- Violence against women – particularly intimate partner violence and sexual violence – is a major public health problem and a violation of women's human rights.
- Global estimates published by WHO indicate that about 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.
- Most of this violence is intimate partner violence. Worldwide, almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime.
- Globally, as many as 38% of murders of women are committed by a male intimate partner.
- Violence can negatively affect women's physical, mental, sexual, and reproductive health, and may increase the risk of acquiring HIV in some settings.
- Men are more likely to perpetrate violence if they have low education, a history of child maltreatment, exposure to domestic violence against their mothers, harmful use of alcohol, unequal gender norms including attitudes accepting of violence, and a sense of entitlement over women.
- Women are more likely to experience intimate partner violence if they have low education, exposure to mothers being abused by a partner, abuse during childhood, and attitudes accepting violence, male privilege, and women's subordinate status.
- There is evidence that advocacy and empowerment counselling interventions, as well as home visitation are promising in preventing or reducing intimate partner violence against women.
- Situations of conflict, post conflict and displacement may exacerbate existing violence, such as by intimate partners, as well as and non-partner sexual violence, and may also lead to new forms of violence against women.



Source: <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>

EPI WEEK 9

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

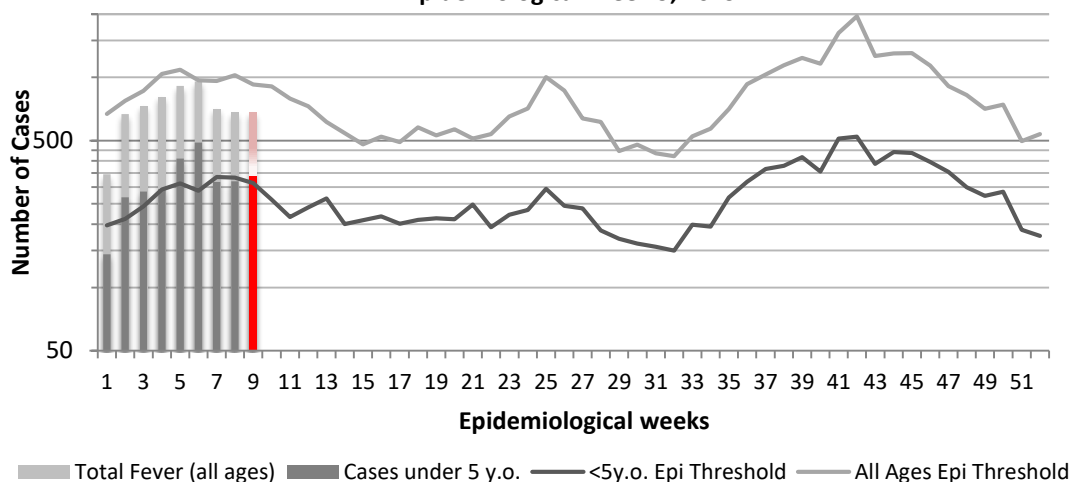
Temperature of $>38^{\circ}\text{C}$ / 100.4°F (or recent history of fever) with or without an obvious diagnosis or focus of infection.



KEY

RED CURRENT
WEEK

Fever in Under 5y.o. and Total Fever Versus Epidemic Thresholds, Jamaica
Epidemiological Week 9, 2019

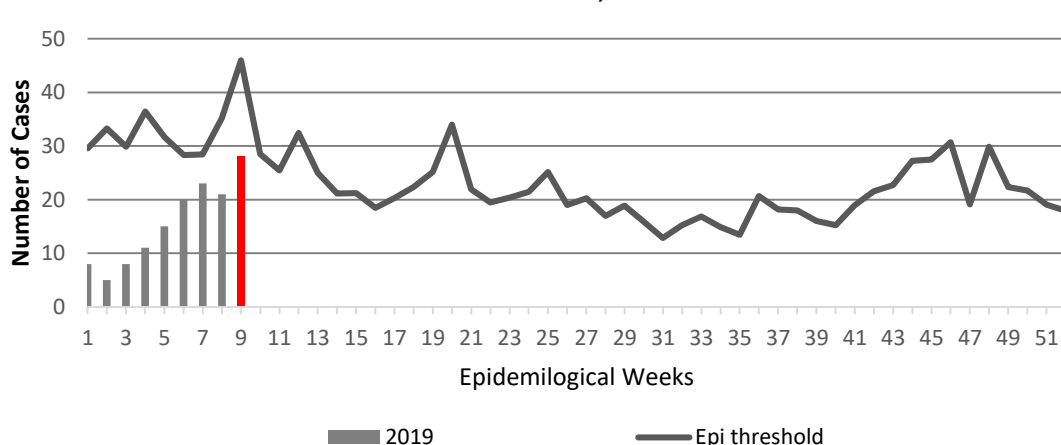


FEVER AND NEUROLOGICAL

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



Total Fever and Neurological Symptoms Versus Epidemic Threshold Jamaica:
Week 9, 2019

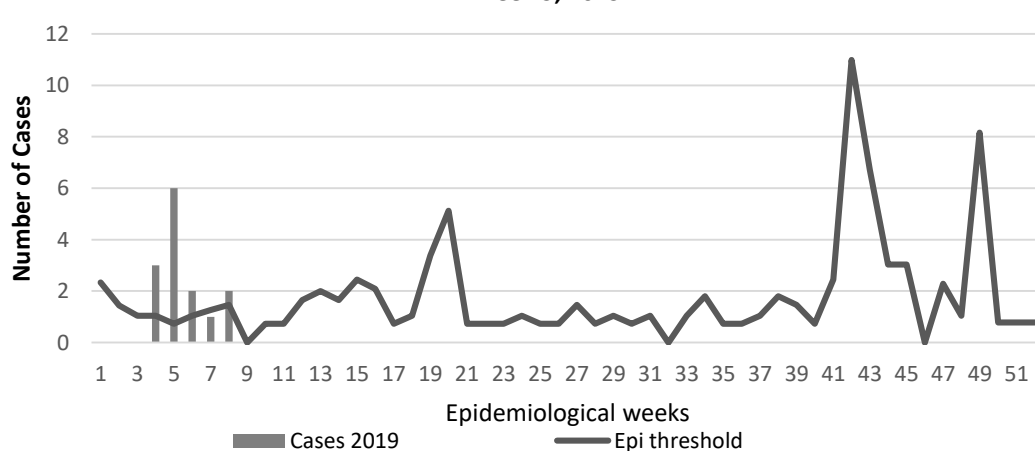


FEVER AND HAEMORRHAGIC

Temperature of $>38^{\circ}\text{C}$ / 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 Haemorrhagic Symptoms Versus Epidemic Threshold Jamaica:
Week 9, 2019



2 NOTIFICATIONS-
All clinical
sites



**INVESTIGATION
REPORTS-** Detailed Follow
up for all Class One Events



**HOSPITAL
ACTIVE
SURVEILLANCE-**
30 sites. Actively
pursued



**SENTINEL
REPORT-** 78 sites.
Automatic reporting

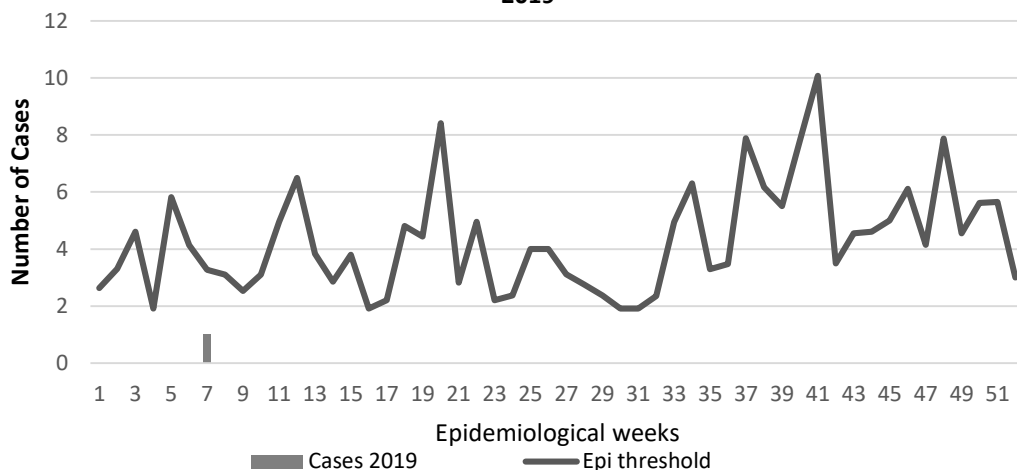
FEVER AND JAUNDICE

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



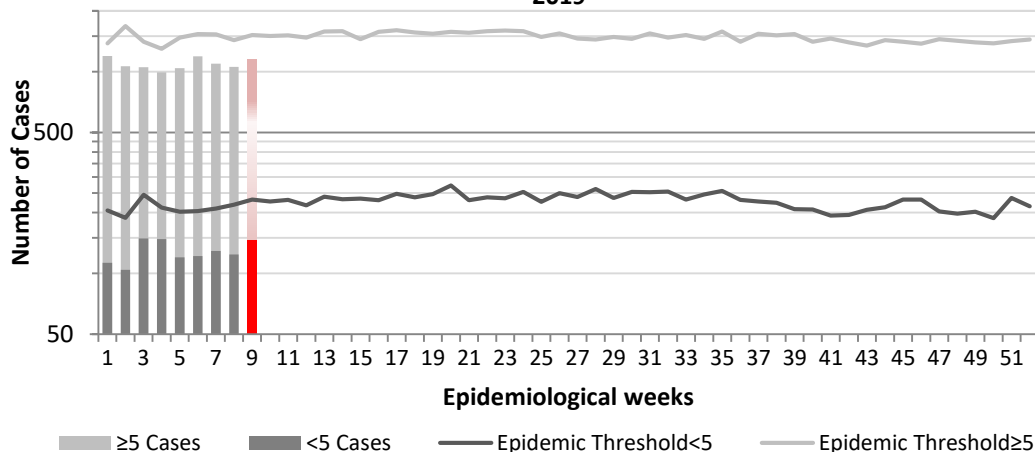
Total Fever and Jaundice Versus Epidemic Threshold, Jamaica: Week 9, 2019

**ACCIDENTS**

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

KEY**RED CURRENT WEEK**

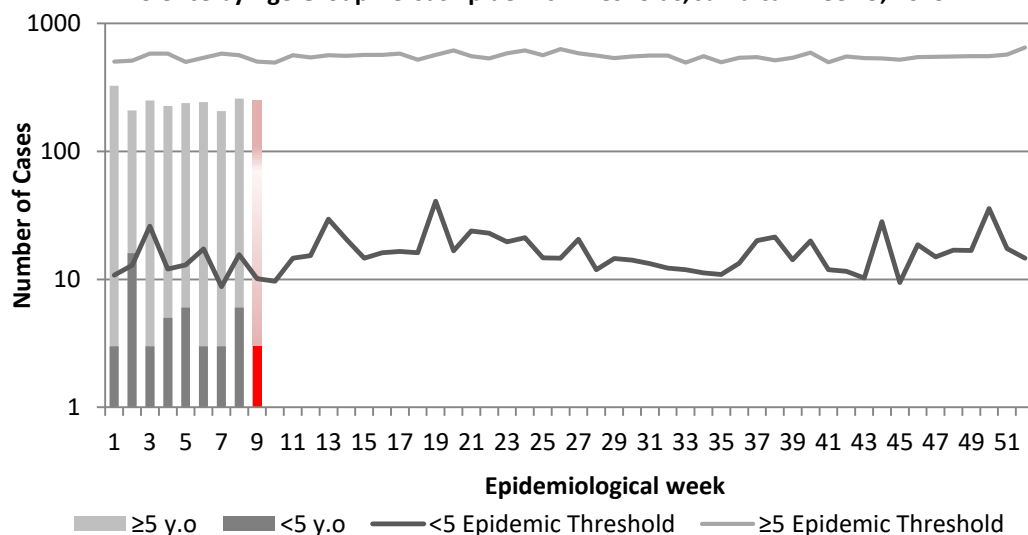
Accidents by Age Group Versus Epidemic Thresholds, Jamaica: Week 9, 2019

**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 9, 2019



3 NOTIFICATIONS-
All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued



SENTINEL REPORT- 78 sites. Automatic reporting

CLASS ONE NOTIFIABLE EVENTS				Comments
			CONFIRMED YTD	
	CLASS 1 EVENTS		CURRENT YEAR	PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning ¹		6	20
	Cholera		0	0
	Dengue Hemorrhagic Fever ²		0	0
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		1	3
	Hepatitis C		1	0
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis (Clinically confirmed)		1	8
EXOTIC/ UNUSUAL	Plague		0	0
HIGH MORBIDITY/ MORTALITY	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		9	13
	Ophthalmia Neonatorum		43	62
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		0	0
	Tuberculosis		5	6
	Yellow Fever		0	0
	Chikungunya ⁴		0	0
	Zika Virus ⁵		0	0

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



4 NOTIFICATIONS- All clinical sites



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NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 9

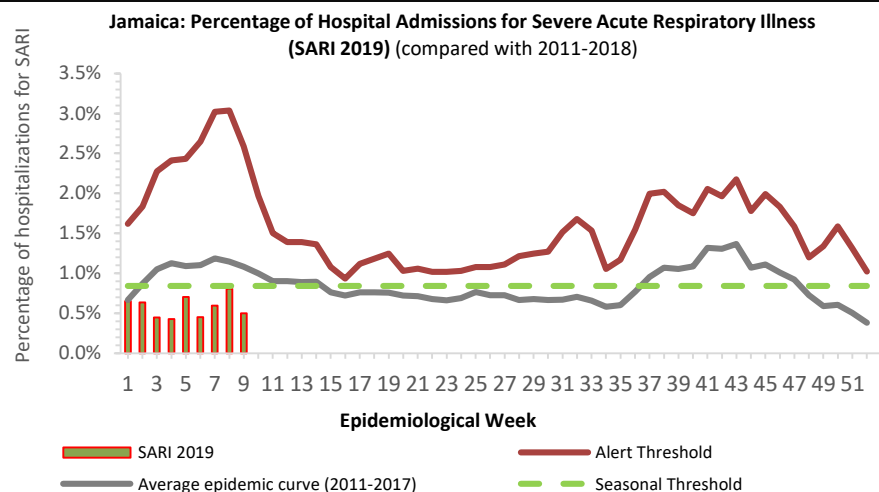
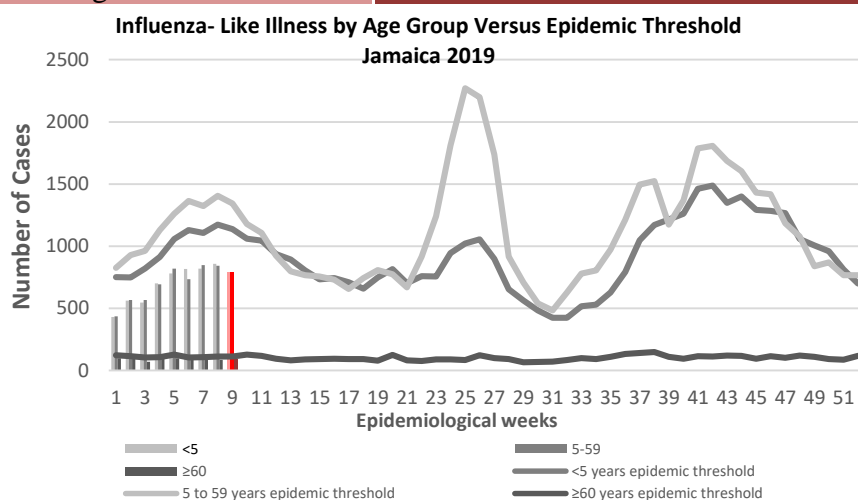
February 24 – March 2, 2019 Epidemiological Week 9

February 2019

	EW 9	YTD
SARI cases	9	99
Total Influenza positive Samples	8	59
Influenza A	7	56
H3N2	0	6
H1N1pdm09	0	34
Not subtyped	7	16
Influenza B	1	3
Parainfluenza	1	1

Comments:

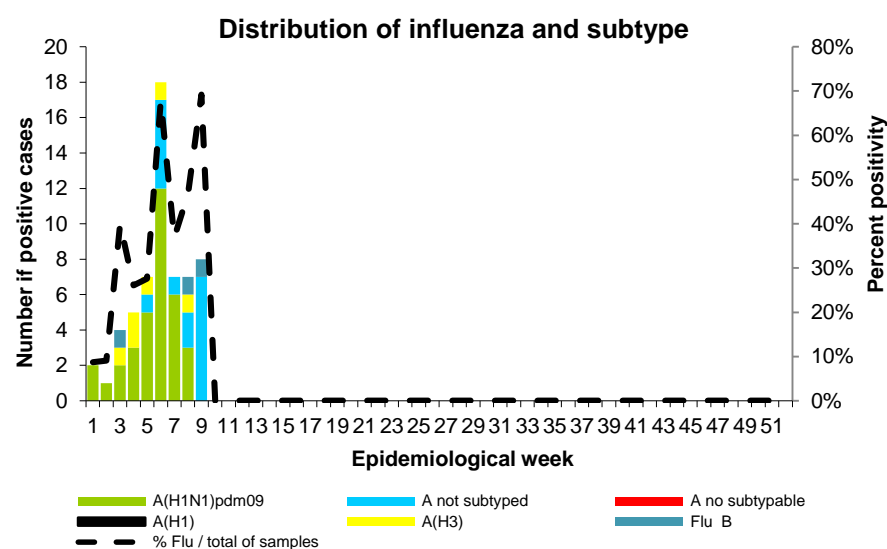
During EW 9 SARI activity remained below the seasonal threshold, similar to the previous seasons for the same period. Influenza A(H1N1)pdm09 predominated in previous weeks.



GLOBAL AND REGIONAL UPDATES

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

Caribbean: In general, influenza virus activity decreased in the sub-region. In Jamaica influenza detections increased with influenza A(H1N1)pdm09 predominating.



5 NOTIFICATIONS-
All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



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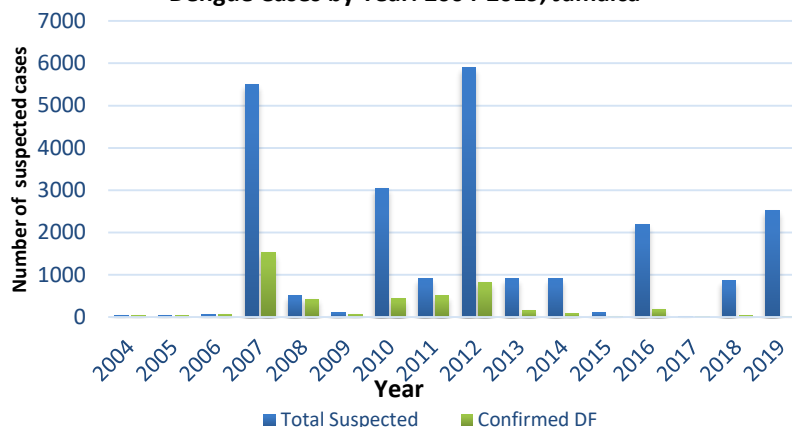
SENTINEL REPORT- 78 sites. Automatic reporting

Dengue Bulletin

February 24 – March 2, 2019 Epidemiological Week 9 Epidemiological Week 9



Dengue Cases by Year: 2004-2019, Jamaica



Reported suspected and confirmed dengue with symptom onset in weeks 1-9, 2019

		2019		2018 YTD
		EW 9	YTD	
Total Suspected Dengue Cases		150	2515	50
Lab Confirmed Dengue cases		0	16	0
CONFIRMED	*DHF/DSS	0	0	0
	Dengue Related Deaths	0	2	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.

Symptoms of Dengue fever

Febrile phase

sudden-onset fever

headache

mouth and nose bleeding

muscle and joint pains

vomiting

rash

diarrhea

Critical phase

hypotension

pleural effusion

ascites

gastrointestinal bleeding

Recovery phase

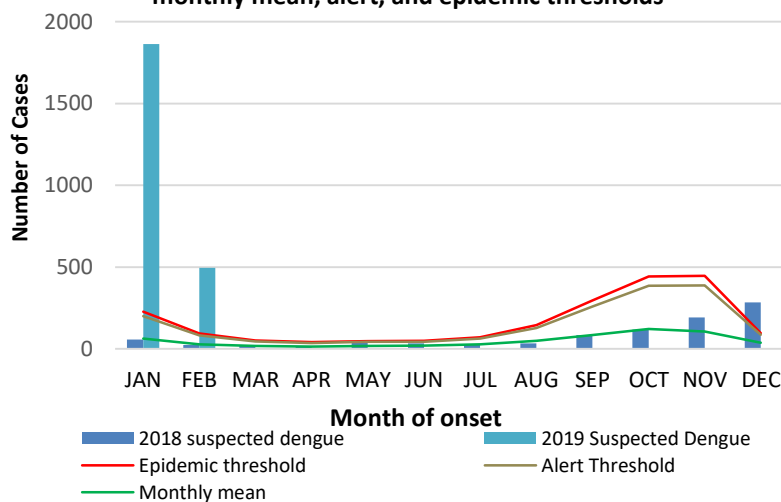
altered level of consciousness

seizures

itching

slow heart rate

Suspected dengue cases for 2018 and 2019 versus monthly mean, alert, and epidemic thresholds



6 NOTIFICATIONS-
All clinical
sites



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Gastroenteritis Bulletin

February 24 – March 2, 2019 Epidemiological Week 9

Epidemiological Week 9

EW
9

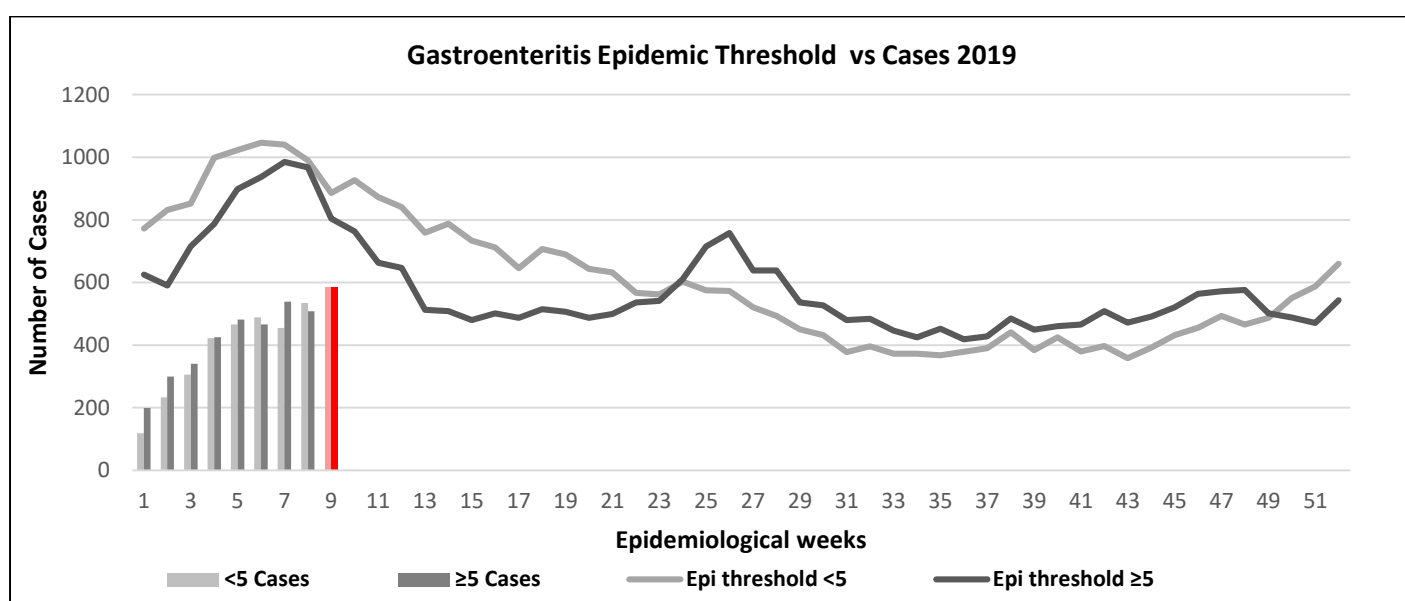
Weekly Breakdown of Gastroenteritis cases

Year	EW 9			YTD		
	<5	≥5	Total	<5	≥5	Total
2019	586	584	1,170	3,610	3,842	7,452
2018	144	261	405	1,840	2,468	4,308

Gastroenteritis:

In epidemiological week 9, 2019, the total number of reported GE cases showed a 189% increase compared to EW 9 of the previous year. The year to date figures showed a 73% increase in cases for the period.

Total Gastroenteritis Cases Reported, 2019



Total number of GE cases per parish up to Week 9, 2019

Parishes	KSA	STT	POR	STM	STA	TRE	STJ	HAN	WES	STE	MAN	CLA	STC
<5	1503	90	39	153	251	214	305	44	125	107	413	156	210
≥5	952	149	75	249	409	217	289	90	154	147	492	327	292



7 NOTIFICATIONS-
All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued



SENTINEL REPORT- 78 sites. Automatic reporting

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*

Corresponding Author / Presenter: *Dr Iyanna Wellington* at wellingtoni@moh.gov.jm

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.



8 NOTIFICATIONS-
All clinical
sites



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