Chagas disease, also known as American trypanosomiasis, is a potentially life-threatening illness caused by the protozoan parasite Trypanosoma cruzi (T. cruzi). About 6 million to 7 million people worldwide are estimated to be infected with Trypanosoma cruzi, the parasite that causes Chagas disease. Chagas disease is found mainly in endemic areas of 21 continental Latin American countries (1), where it is mostly vector-borne transmitted to humans by contact with faeces or urine of triatomine bugs, known as 'kissing bugs', among many other popular names, depending on the geographical area.

The medical care cost of patients with chronic cardiac, digestive, neurologic or mixed forms of the disease has been calculated to be >80% higher than the cost of spraying residual insecticide to control vectors and prevent infection.

Chagas disease is named after Carlos Ribeiro Justiniano Chagas, a Brazilian physician and researcher who discovered the disease in 1909.

**Distribution**

Chagas disease occurs principally in the continental part of Latin America, and not in the Caribbean islands. In the past decades, however, it has been increasingly detected in the United States of America, Canada, and many European and some Western Pacific countries. This is due mainly to population mobility between Latin America and the rest of the world.

Downloaded from: [https://www.who.int/news-room/fact-sheets/detail/chagas-disease-(american-trypanosomiasis)](https://www.who.int/news-room/fact-sheets/detail/chagas-disease-(american-trypanosomiasis)}
A syndromic surveillance system is good for early detection of and response to public health events.

Sentinel surveillance occurs when selected health facilities (sentinel sites) form a network that reports on certain health conditions on a regular basis, for example, weekly. Reporting is mandatory whether or not there are cases to report.

Jamaica's sentinel surveillance system concentrates on visits to sentinel sites for health events and syndromes of national importance which are reported weekly (see pages 2-4). There are seventy-eight (78) reporting sentinel sites (hospitals and health centres) across Jamaica.
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).

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. Visits for Fever and Haemorrhagic symptoms were reported in weeks 4 to 8 only, year to date.

FEVER AND JAUNDICE
Temperature of $>38^\circ\text{C}$ /$100.4^\circ\text{F}$ (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. Visits to sentinel sites for Fever and Jaundice were reported in weeks 7 and 10 only, year to date.
**ACCIDENTS**
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.

**KEY**
VARIATIONS OF BLUE SHOW CURRENT WEEK

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

**GASTROENTERITIS**
Inflammation of the stomach and intestines, typically resulting from bacterial toxins or viral infection and causing vomiting and diarrhoea.

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**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

### Confirmed YTD

<table>
<thead>
<tr>
<th>CLASS 1 EVENTS</th>
<th>CURRENT YEAR</th>
<th>PREVIOUS YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Poisoning</td>
<td>29</td>
<td>139</td>
</tr>
<tr>
<td>Cholera</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dengue Hemorrhagic Fever*</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Hansen’s Disease (Leprosy)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>11</td>
<td>24</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Malaria (Imported)</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Meningitis (Clinically confirmed)</td>
<td>15</td>
<td>37</td>
</tr>
<tr>
<td>Plague</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Meningococcal Meningitis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neonatal Tetanus</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Typhoid Fever</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Meningitis H/Flu</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>AFP/Polio</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Congenital Rubella Syndrome</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Congenital Syphilis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fever and Rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rubella</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Deaths**</td>
<td>38</td>
<td>44</td>
</tr>
<tr>
<td>Ophthalmia Neonatorum</td>
<td>116</td>
<td>196</td>
</tr>
<tr>
<td>Pertussis-like syndrome</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tetanus</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>30</td>
<td>34</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chikungunya***</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Zika Virus****</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### 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.

- Dengue Hemorrhagic Fever data include Dengue related deaths;

- Figures include all deaths associated with pregnancy reported for the period.

- **CHIKV IgM positive cases

- Zika PCR positive cases

---

### AFP Field Guides

- 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.

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### Not Available

- NA - Not Available

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### Special Programmes

- Congenital Rubella Syndrome
- Congenital Syphilis
- Fever and Rash
- Measles
- Rubella
- Maternal Deaths**
- Ophthalmia Neonatorum
- Pertussis-like syndrome
- Rheumatic Fever
- Tetanus
- Tuberculosis
- Yellow Fever
- Chikungunya***
- Zika Virus****
Epi Week Summary
During EW 32, 1 case of influenza was detected. Percent positivity remained low.

During EW 32, 2 SARI admissions were reported.

Regional Update EW32
Caribbean: Influenza and SARI activity were low and continue to decrease in the sub-region. RSV activity was increased in Cuba and the Dominican Republic.

Global Update EW32
In the temperate zones of the southern hemisphere, influenza activity appeared to have peaked in most countries. In tropical Africa, influenza activity was low across reporting countries, except for a few countries in Eastern Africa. In Southern Asia, influenza activity was low across reporting countries. In South East Asia, influenza activity was decreasing or low across reporting countries except in Myanmar. In the temperate zone of the northern hemisphere, influenza activity remained at inter-seasonal levels. Worldwide, seasonal influenza A viruses accounted for most detections.

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### National Surveillance Unit

**Influenza Report**

August 4 – August 10, 2019  
Epidemiological Week 32

<table>
<thead>
<tr>
<th>SARI cases</th>
<th>EW 32</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Influenza positive Samples</td>
<td>1</td>
<td>366</td>
</tr>
<tr>
<td>Influenza A</td>
<td>1</td>
<td>324</td>
</tr>
<tr>
<td>H3N2</td>
<td>0</td>
<td>86</td>
</tr>
<tr>
<td>H1N1pdm09</td>
<td>0</td>
<td>225</td>
</tr>
<tr>
<td>Not subtyped</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Influenza B</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>Parainfluenza</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

---

**Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2019 vs Weekly Threshold; Jamaica**

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

**Distribution of influenza and subtype**

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**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
Dengue Bulletin
August 4 – August 10, 2019  Epidemiological Week 32  Epidemiological Week 32

Reported suspected and confirmed dengue with symptom onset in weeks 1-32, 2019

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Suspected Dengue Cases</td>
<td>16 (EW 32)</td>
<td>4103 (YTD)</td>
</tr>
<tr>
<td>Lab Confirmed Dengue cases</td>
<td>0</td>
<td>32 (YTD)</td>
</tr>
<tr>
<td>CONFIRMED Dengue Related Deaths</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

Points to note:

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

Working Women and Household Fast-food Consumption

Author: Elroy Galbraith (BSc. Hons, MSc.)
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Abstract

Objectives:
This study examined how the participation of married women in the workforce affected household consumption of food away from home (FAFH) in Jamaica. The main hypothesis was that there was a positive relationship between hours worked by married females and household consumption of FAFH.

Method:
This study employed a backward step logistic regression on data collected during the 2012 Jamaica Survey of Living Conditions. Data came from households in which the female was in a married or common-law relationship with another household member. The predictors included employment data for both the husband and wife; household size, composition, economy and location; as well as the status of the female in the household. The outcome variable was a dummy variable indicating the decision to consume any meal away from home (breakfast, lunch or dinner).

Results:
Participation of the wife in the workforce significantly affected the household consumption of FAFH. The longer the wife worked outside the home the more likely it was for the household to purchase and consume FAFH. The most important predictor was the economy of the household, while the age and status of the female and household size were also significant.

Conclusion:
Participation of married females in the workforce increased household consumption of FAFH, even when controlling for various characteristics of the household. Traditional household divisions of labour along gender lines persist in the developing country, and could possibly pose a threat to nutrition and well-being.

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