WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Series: 5 Keys to a Healthy Diet (4-5)

4) Eat moderate amounts of fats and oils

- Use unsaturated vegetable oils (e.g. olive, soy, sunflower or corn oil) rather than animals fats or oils high in saturated fats (e.g. butter, ghee, lard, coconut and palm oil)
- Choose white meat (e.g. poultry) and fish, which are generally low in fats, in preference to red meat
- Eat only limited amounts of processed meats because these are high in fat and salt

Where possible, opt for low-fat or reduced'fat versions of milk and dairy products

Avoid processed, baked and fried foods that contain industrially produced trans-fat

Why?

Fats and oils are concentrated sources of energy, and eating too much fat, particularly the wrong kinds of fat, can be harmful to health. For example, people who eat too much saturated fat and trans-fat are at higher risk of heart disease and stroke. Trans-fat may occur naturally in certain meat and milk products, but the industrially produced trans-fat (e.g. partially hydrogenated oils) present in various processed foods is the main source.

5) Eat less salt and sugars

- When cooking and preparing foods, limit the amount of salt and high-sodium condiments (e.g. soy sauce and fish sauce)
- Avoid foods (e.g. snacks), that are high in salt and sugars
- Limit intake of soft drinks or soda and other drinks that are high in sugars (e.g. fruit juices, cordials and syrups, flavoured milks and yogurt drinks)

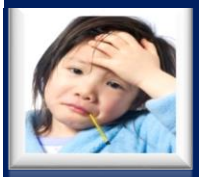
Choose fresh fruits instead of sweet snacks such as cookies, cakes and chocolate

Why?

People whose diets are high in sodium (including salt) have a greater risk of high blood pressure, which can increase their risk of heart disease and stroke. Similarly, those whose diets are high in sugars have a greater risk of becoming overweight or obese, and an increased risk of tooth decay. People who reduce the amount of sugars in their diet may also reduce their risk of noncommunicable diseases such as heart disease and stroke.

Source: https://www.who.int/nutrition/topics/5keys_healthydiet/en/

EPI WEEK 38



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SENTINEL SYNDROMIC SURVEILLANCE

Sentinel Surveillance in Jamaica

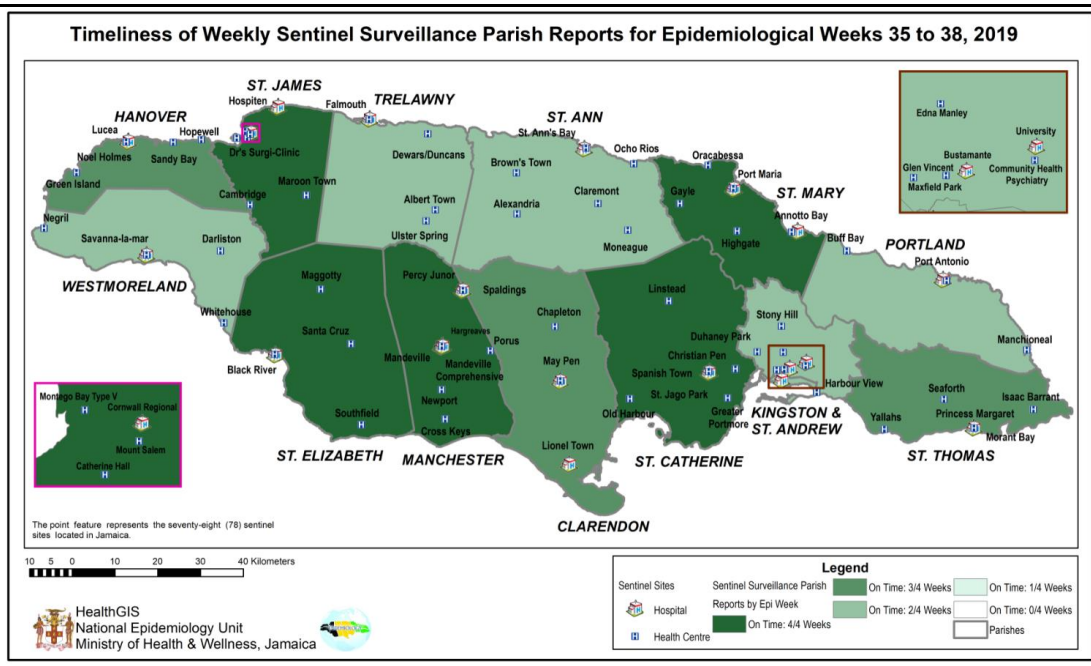
A syndromic surveillance system is good for early detection of and response to public health events.

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.

Map representing the Timeliness of Weekly Sentinel Surveillance Parish Reports for the Four Most Recent Epidemiological Weeks - Weeks 35 to 38

Parish health departments submit reports weekly by 3 p.m. on Tuesdays. Reports submitted after 3 p.m. are considered late.

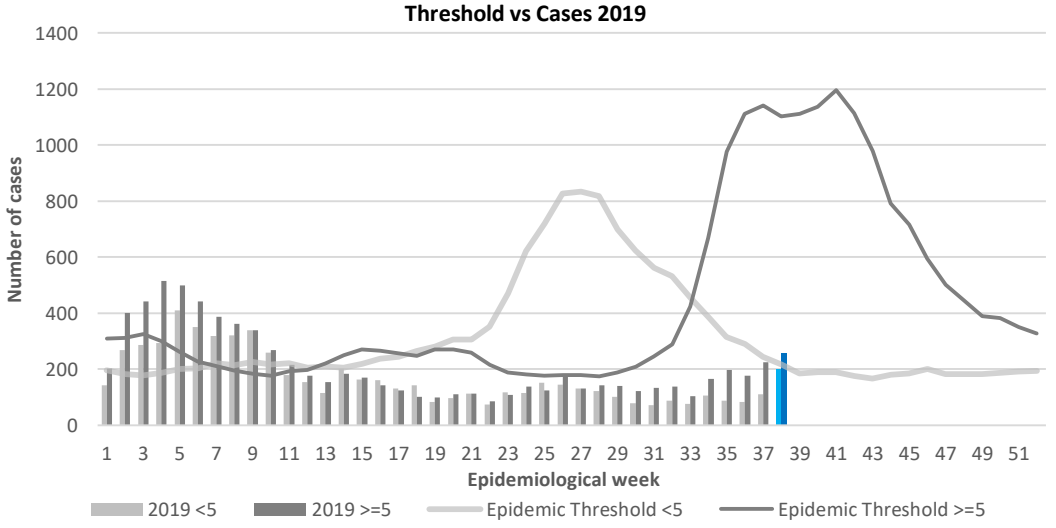


REPORTS FOR SYNDROMIC SURVEILLANCE

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

KEY
VARIATIONS OF BLUE SHOW CURRENT WEEK

Weekly Visits to Sentinel Sites for Undefrentiated Fever All ages: Jamaica, Weekly Threshold vs Cases 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

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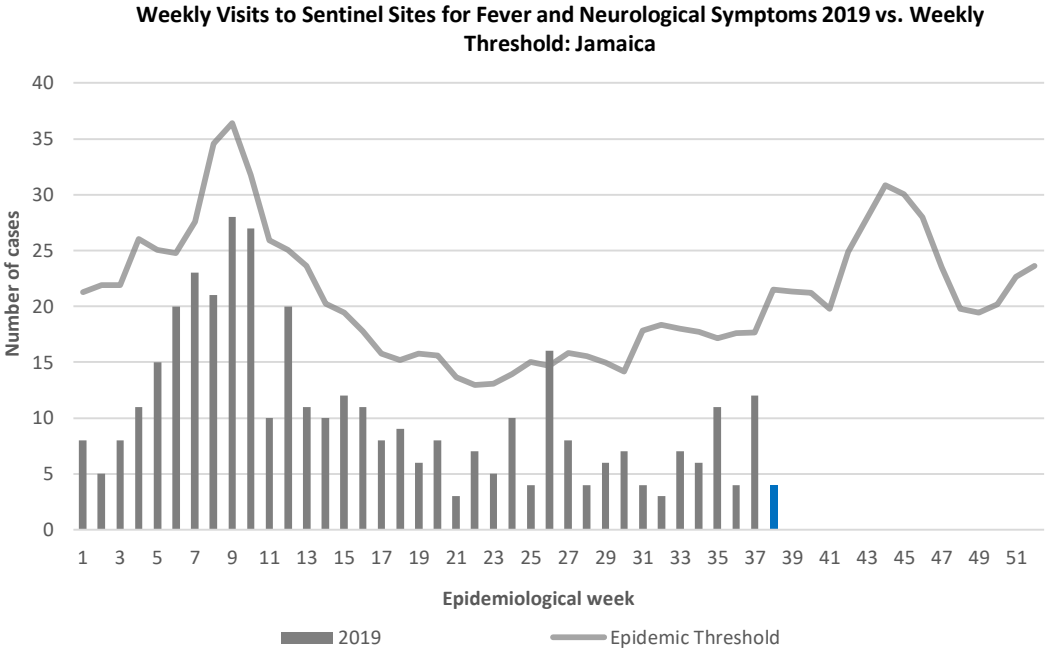
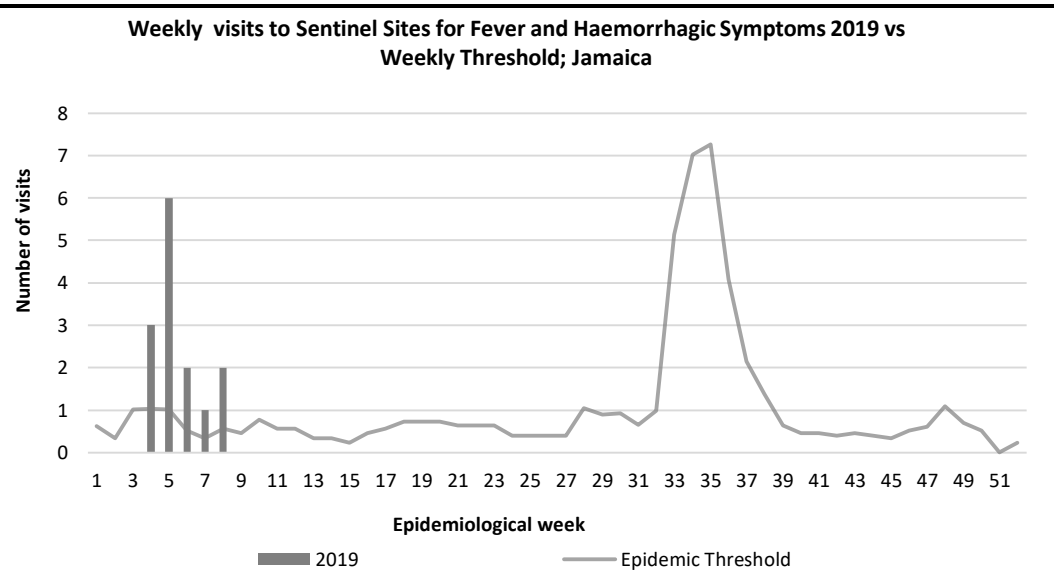
FEVER AND NEUROLOGICAL
Temperature of >38^{0}C /100.4^{0}F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).

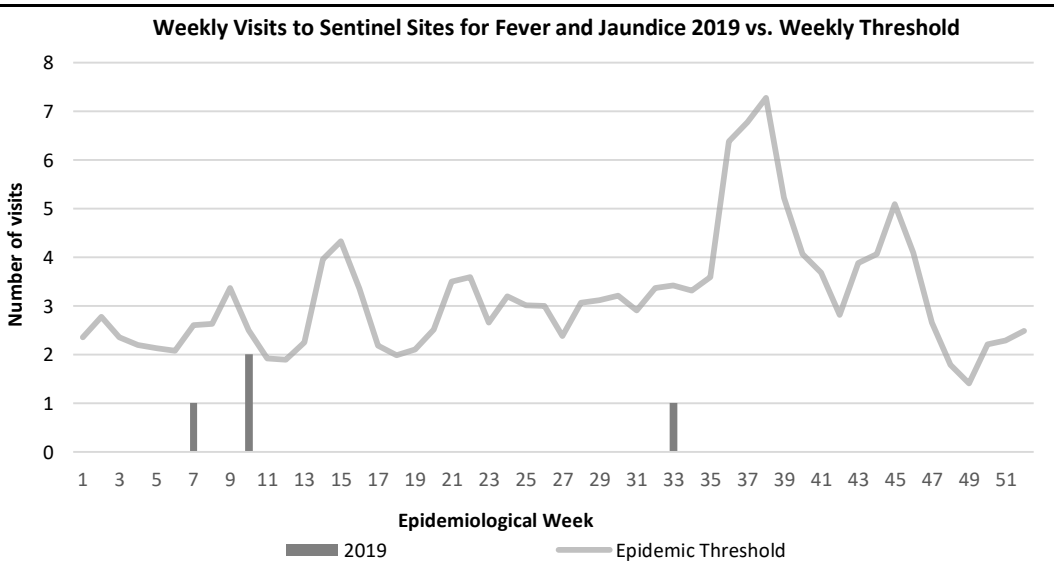


FEVER AND HAEMORRHAGIC
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice. Visits for Fever and Haemorrhagic symptoms were reported in weeks 4 to 8 only, year to date.



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. Visits to sentinel sites for Fever and Jaundice were reported in weeks 7 and 10 only, year to date.



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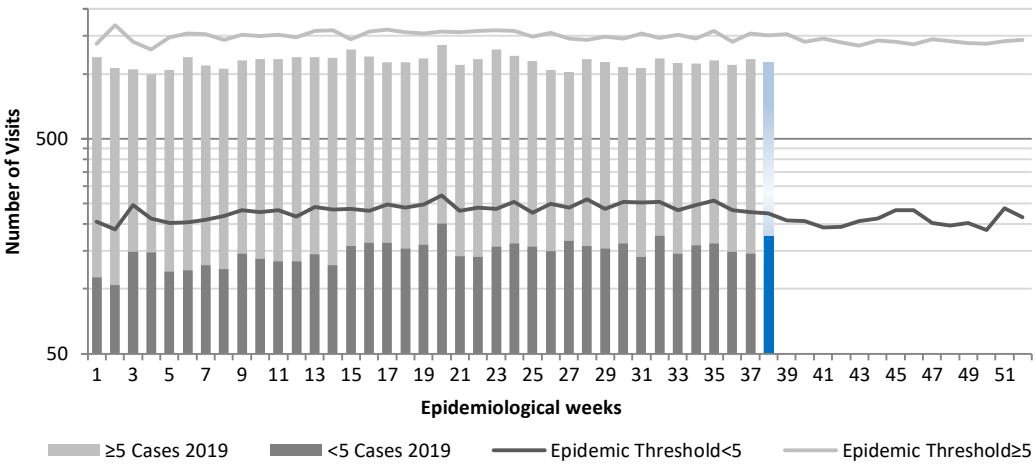
ACCIDENTS

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

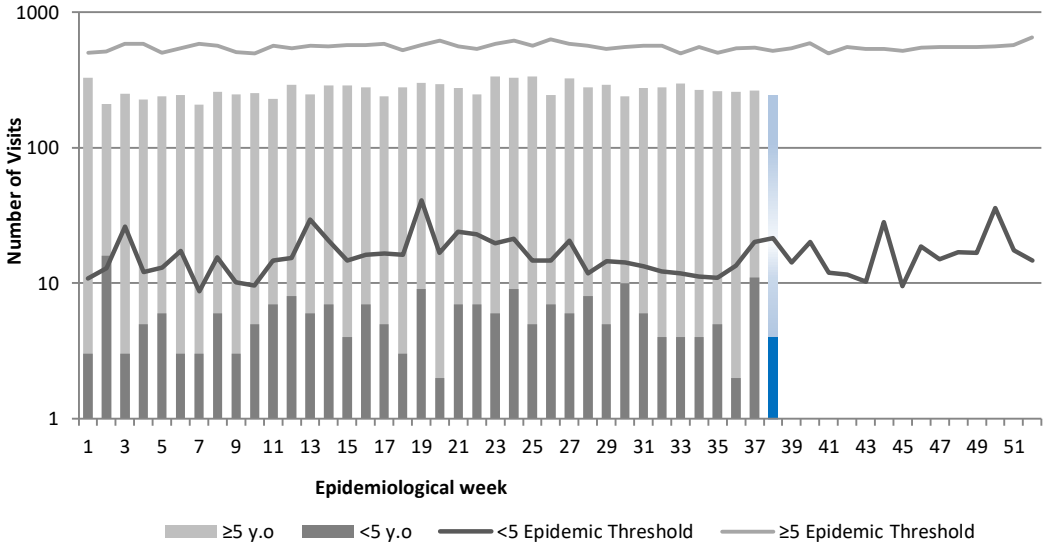
KEY

VARIATIONS Of BLUE SHOW CURRENT WEEK



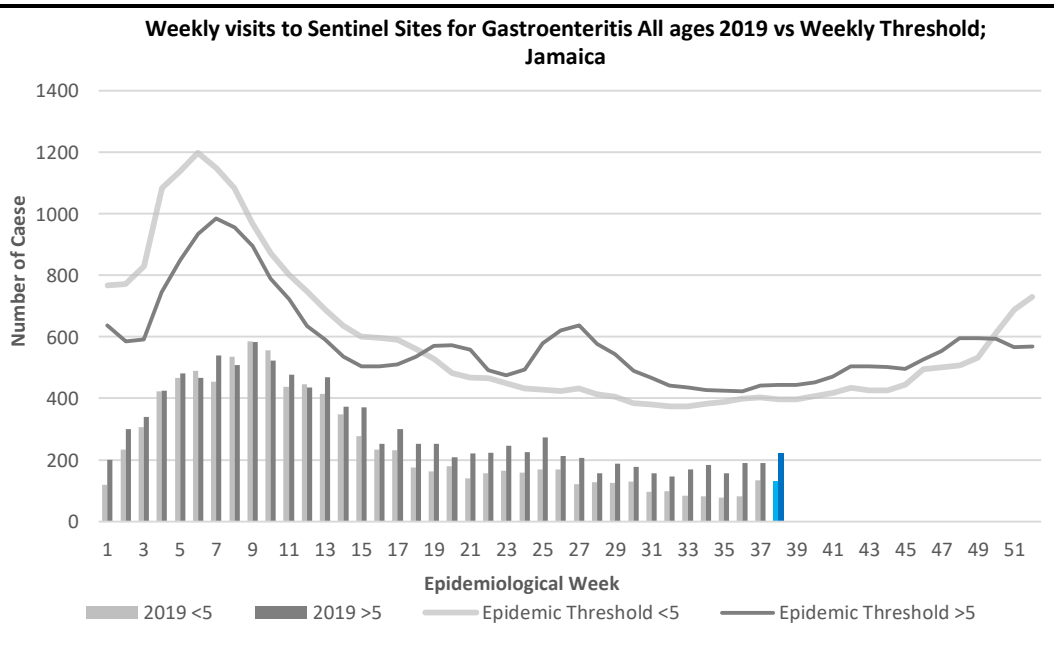
VIOLENCE

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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- CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS		Confirmed YTD CURRENT YEAR	Confirmed YTD PREVIOUS YEAR
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		57	160
	Cholera		0	0
	Dengue Hemorrhagic Fever*		NA	NA
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		11	34
	Hepatitis C		2	6
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	2
	Meningitis (Clinically confirmed)		18	37
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**		45	49
	Ophthalmia Neonatorum		161	234
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		0	0
	Tuberculosis		44	58
	Yellow Fever		0	0
	Chikungunya***		1	10
	Zika Virus****		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.

* 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

NA- Not Available

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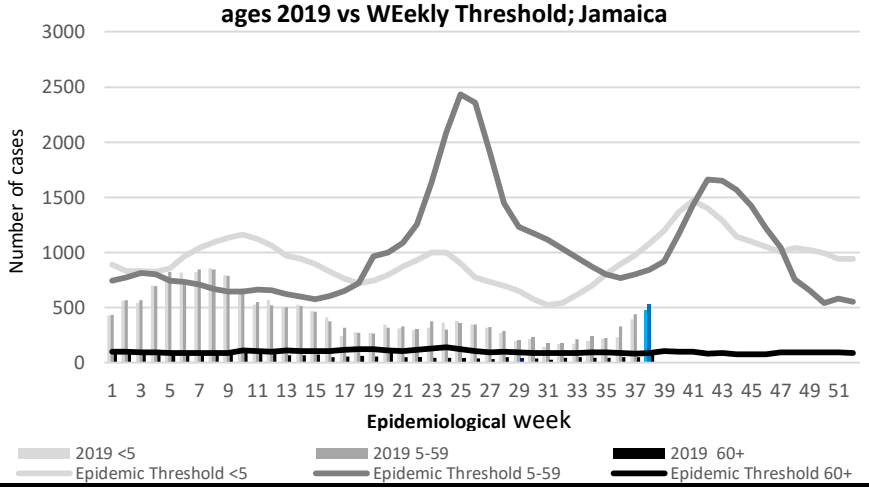
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 38

September 15 – September 21, 2019 Epidemiological Week 38

	EW 38	*YTD*
SARI cases	*8*	*378*
Total Influenza positive Samples	*4*	*372*
Influenza A	*4*	*330*
H3N2	*0*	*91*
H1N1pdm09	*0*	*226*
Not subtyped	*4*	*10*
Influenza B	*0*	*42*
Parainfluenza	*0*	*6*

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

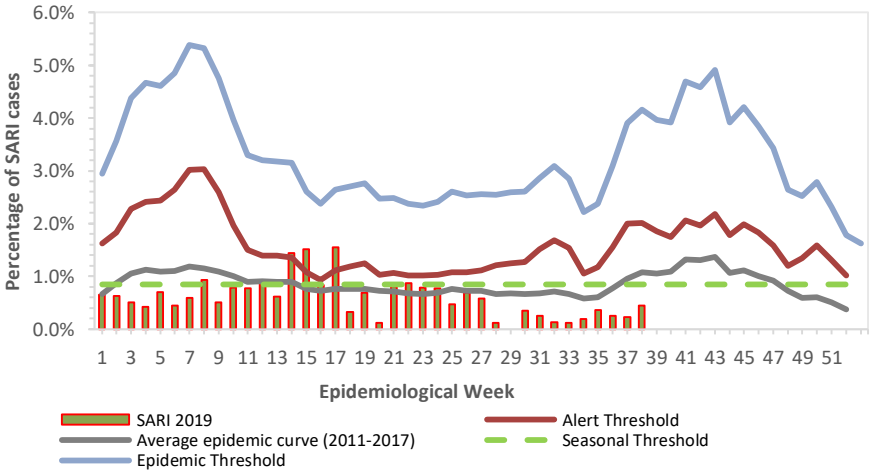


Epi Week Summary

During EW 38, 4 cases of influenza (all were Influenza A) were detected. Percent positivity is 26.7%.

During EW 38, 8 (eight) SARI admissions were reported.

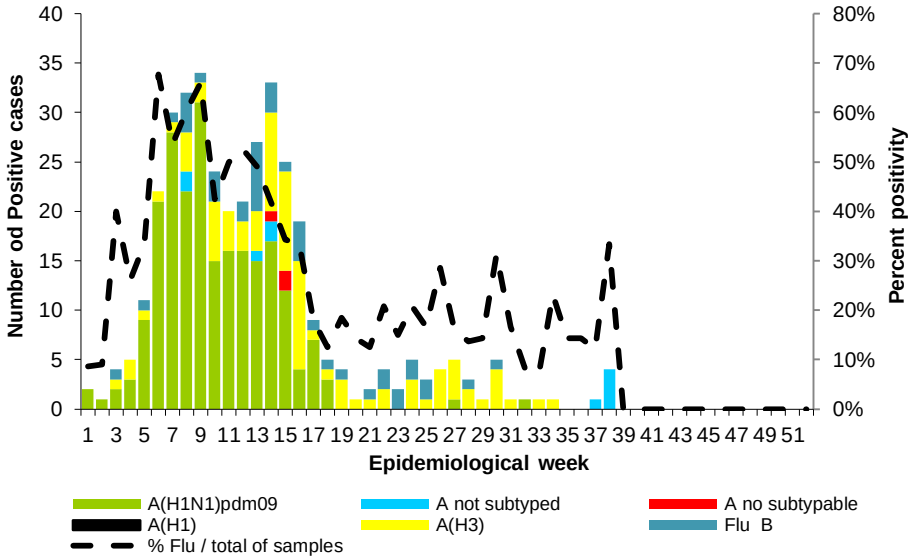
Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2019) (compared with 2011-2018)



Caribbean Update EW 38

Influenza and SARI activity was low and continue to decrease in the sub-region. Cuba and Dominican Republic continued to report low influenza activity and increased RSV activity. In Puerto Rico, influenza-positive cases were slightly above the historical average, with influenza A(H3N2) predominance.

Distribution of influenza and subtype



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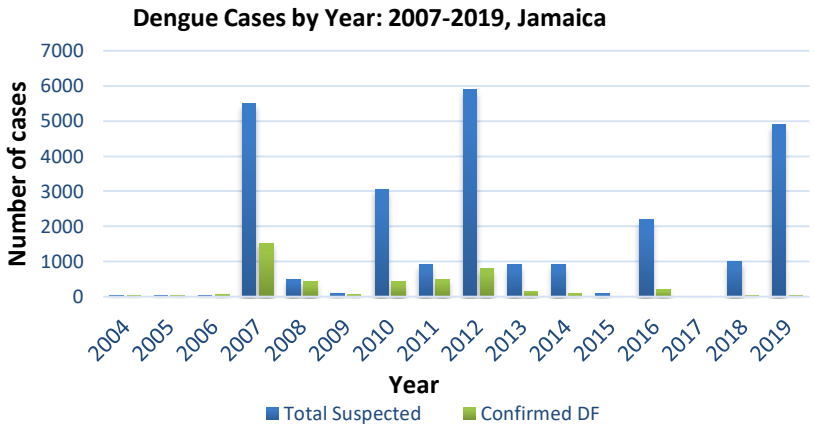
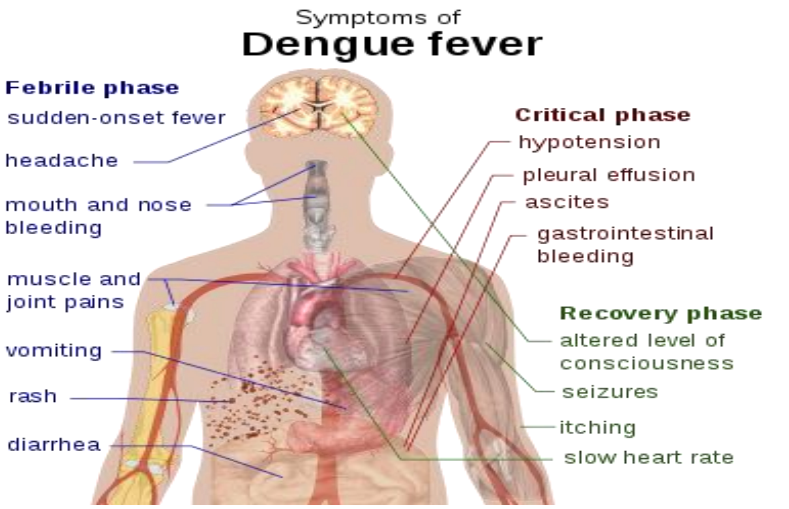
Dengue Bulletin

September 15– September 21, 2019 Epidemiological Week 38 | Epidemiological Week 38



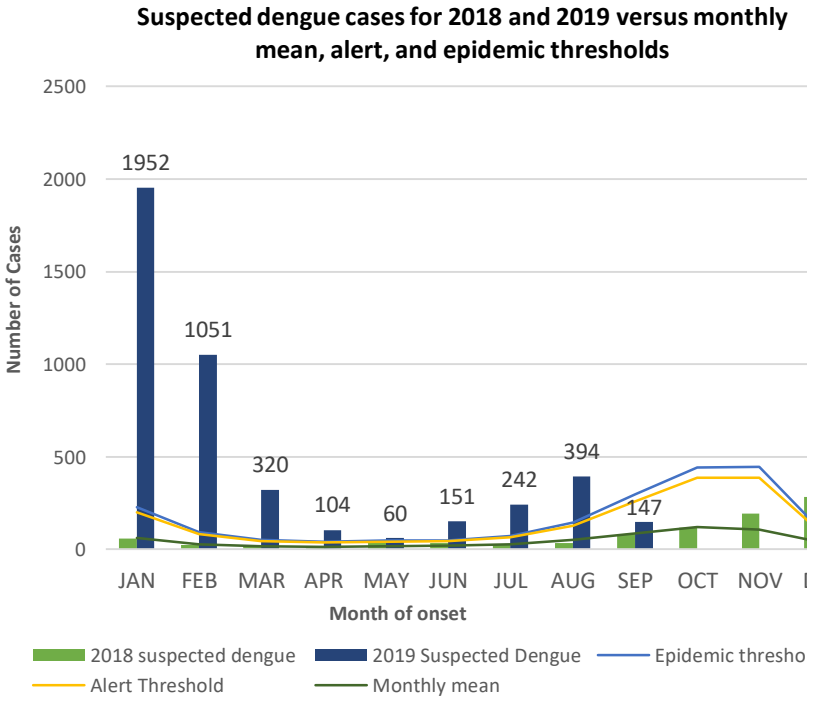
Reported suspected and confirmed dengue with symptom onset in weeks 1-38 2019

		2019		2018 YTD
		EW 38	YTD	
Total Suspected Dengue Cases		3	**4886	265
Lab Confirmed Dengue cases		0	37	2
CONFIRMED	Dengue Related Deaths	0	8	0



Points to note:

- **figure as at September 30, 2019
- Only PCR positive dengue cases are reported as confirmed.
- IgM positive cases are classified as presumed dengue.



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RESEARCH PAPER

Title:

" *Anthropometry and food frequency in chronic non-communicable disease: associations in a clinic population"*

Authors: *S. Robinson, S. Dawson*

Objective:
To investigate the relation of body mass index (BMI) and waist circumference (WC) to frequency of consumption of commonly consumed foods, in patients enrolled at a Type V Health Centre in Kingston.

Method:
Twenty –four adult patients (22 females) attending the CNCD Clinic were conveniently selected for the study, with a cross-sectional analysis being conducted on these patients. Participants were selected if they were diagnosed with at least one CNCD. Their weights, heights, and waist circumferences were measured and data on the frequency of consumption of selected foods acquired utilizing an administered questionnaire. The main outcome measure was a correlation between anthropometry and food frequency.

Results:
Of the 24 subjects, 23 had a BMI >25.0 with 22 having a waist circumference exceeding the recommended limit (Females= 89 cm and Males =101 cm). Mean BMI was 34.3 ± 7.4 with mean WC being 104.9 ± 17.7 cm.

Neither BMI nor WC was significantly associated with frequency of consumption of any food item from the different Food Groups, but positive correlations were identified between BMI and age ($p<0.0001$), and BMI and WC ($p=0.00051$).

Conclusion:
No statistically significant associations were found between BMI, Waist Circumference and food frequency in this population. A follow-up study (larger sample size, other food intake measures) is recommended to demystify whatever link may exist between anthropometry and food intake. Alongside BMI measurements, WC could be used routinely in the nutritional assessment of CNCD patients at Health facilities.

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