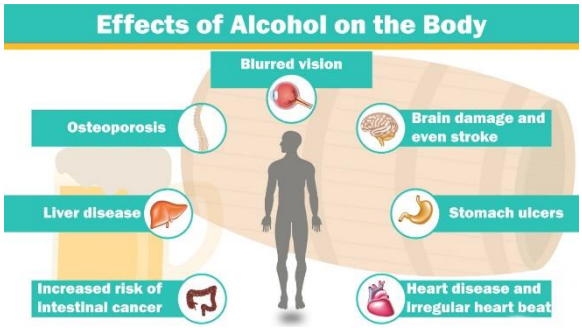
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Alcohol



Key facts

- Worldwide, 3 million deaths every year result from harmful use of alcohol, this represent 5.3 % of all deaths.
- The harmful use of alcohol is a causal factor in more than 200 disease and injury conditions.
- Overall 5.1 % of the global burden of disease and injury is attributable to alcohol, as measured in disability-adjusted life years (DALYs).
- Alcohol consumption causes death and disability relatively early in life. In the age group 20–39 years approximately 13.5 % of the total deaths are alcohol-attributable.
- There is a causal relationship between harmful use of alcohol and a range of mental and behavioural disorders, other noncommunicable conditions as well as injuries.
- The latest causal relationships have been established between harmful drinking and incidence of infectious diseases such as tuberculosis as well as the course of HIV/AIDS.
- Beyond health consequences, the harmful use of alcohol brings significant social and economic losses to individuals and society at large.

Factors affecting alcohol consumption and alcohol-related harm

A variety of factors have been identified at the individual and the societal level, which affect the levels and patterns of alcohol consumption and the magnitude of alcohol-related problems in populations.

Environmental factors include economic development, culture, availability of alcohol, and the comprehensiveness and levels of implementation and enforcement of alcohol policies. For a given level or pattern of drinking, vulnerabilities within a society are likely to have similar differential effects as those between societies. Although there is no single risk factor that is dominant, the more vulnerabilities a person has, the more likely the person is to develop alcohol-related problems as a result of alcohol consumption.

Ways to reduce the burden from harmful use of alcohol

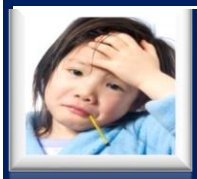
The health, safety and socioeconomic problems attributable to alcohol can be effectively reduced and requires actions on the levels, patterns and contexts of alcohol consumption and the wider social determinants of health.

Countries have a responsibility for formulating, implementing, monitoring and evaluating public policies to reduce the harmful use of alcohol. Substantial scientific knowledge exists for policy-makers on the effectiveness and cost-effectiveness of the following strategies:

- regulating the marketing of alcoholic beverages (in particular to younger people);
- regulating and restricting the availability of alcohol;
- enacting appropriate drink-driving policies;
- reducing demand through taxation and pricing mechanisms;
- raising awareness of public health problems caused by harmful use of alcohol and ensuring support for effective alcohol policies;
- providing accessible and affordable treatment for people with alcohol-use disorders; and
- implementing screening and brief interventions programmes for hazardous and harmful drinking in health services.

For more information on alcohol please visit: https://www.who.int/news-room/fact-sheets/detail/alcohol

EPI WEEK 9



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SENTINEL SYNDROMIC SURVEILLANCE

Sentinel Surveillance in Jamaica

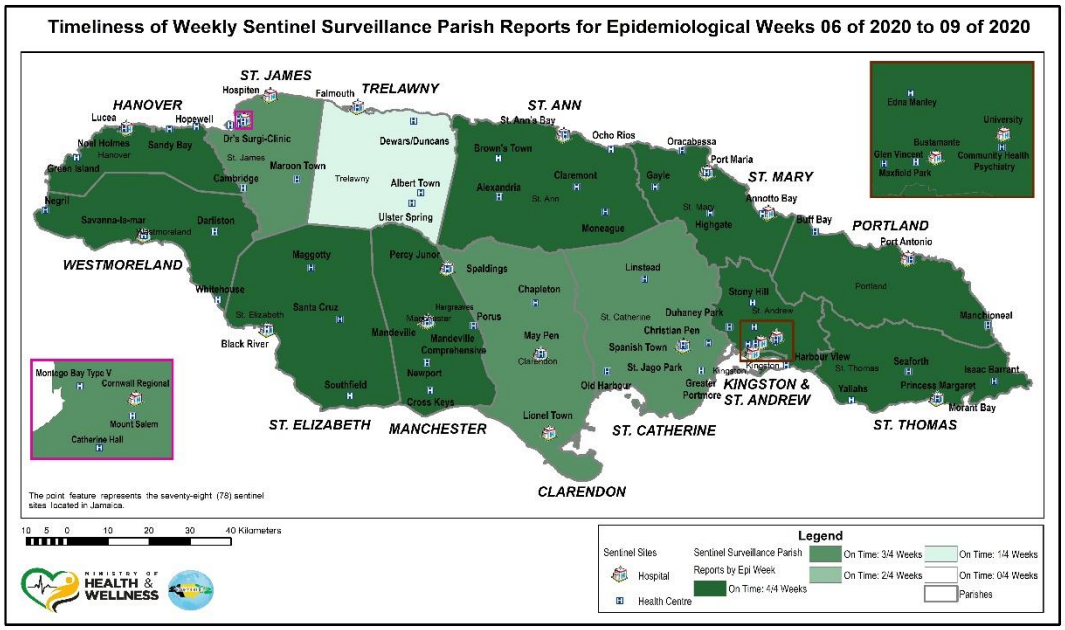
A syndromic surveillance system is good for early detection of and response to public health events.

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 - 6 to 9 of 2020

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

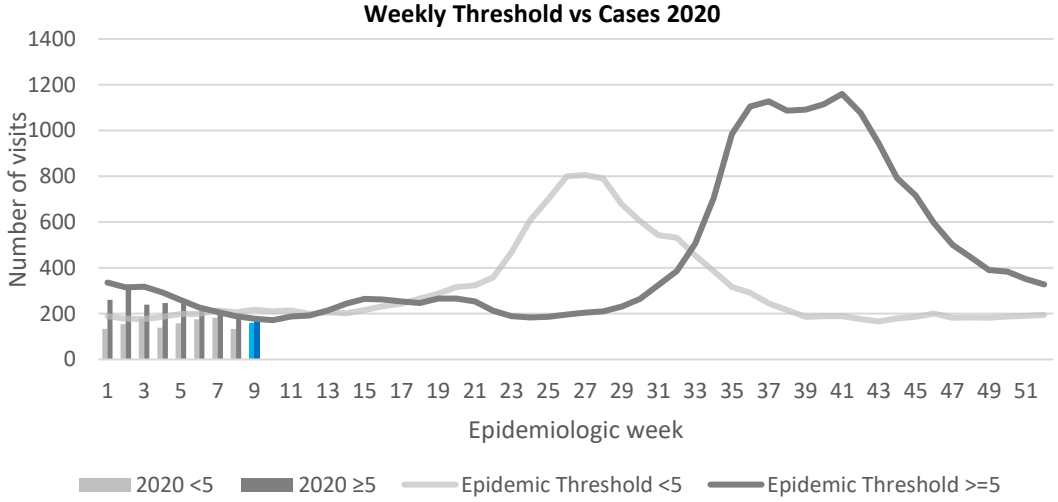
FEVER

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 Undifferentiated Fever All ages: Jamaica, Weekly Threshold vs Cases 2020



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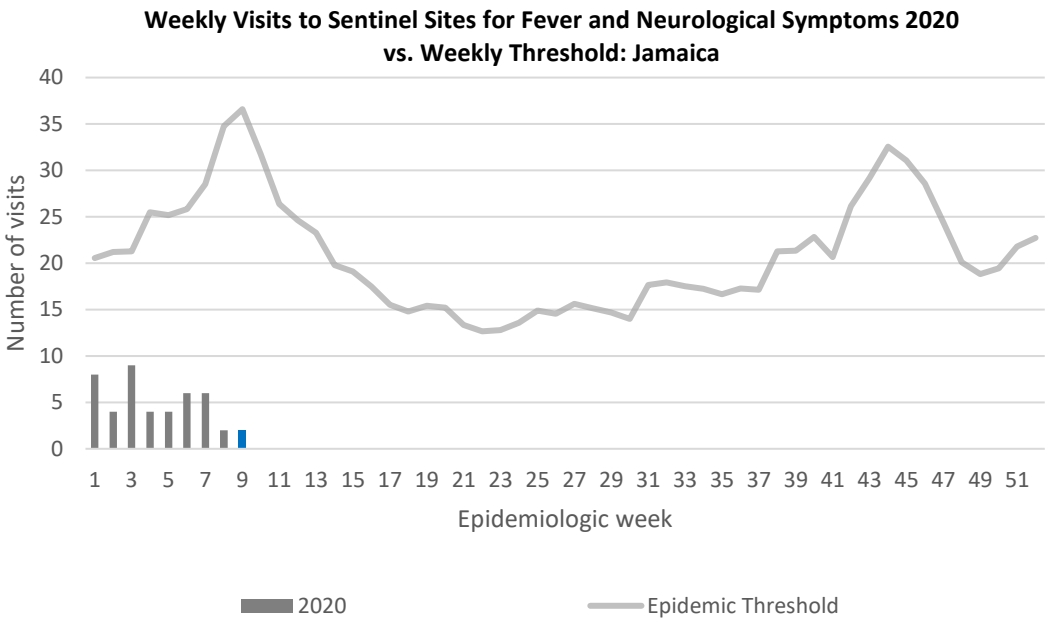
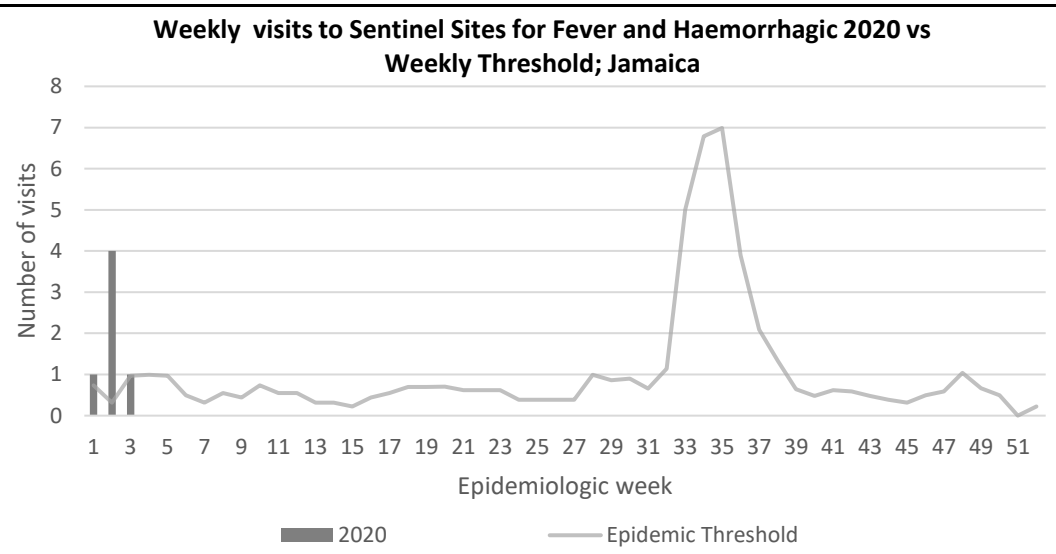
FEVER AND NEUROLOGICAL
Temperature of >38^{0}C /100.4^{0}F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).

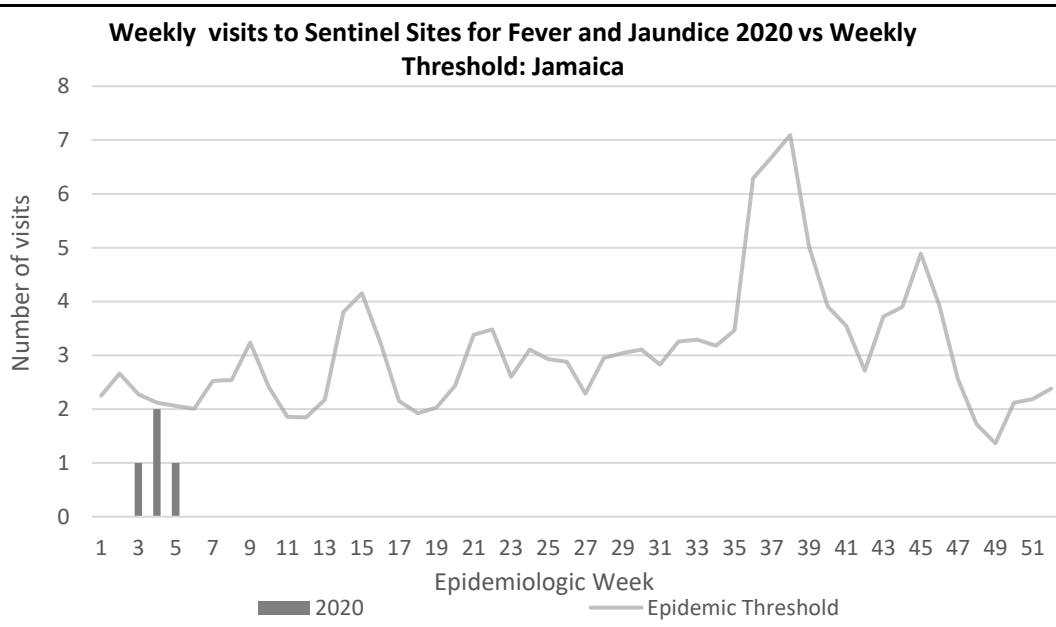


FEVER AND HAEMORRHAGIC
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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.



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ACCIDENTS

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

KEY

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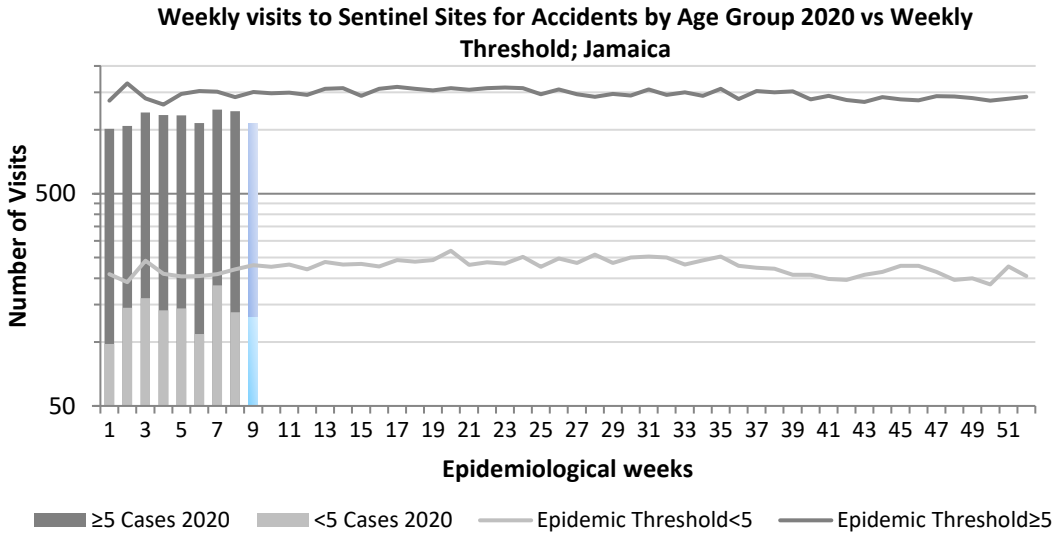
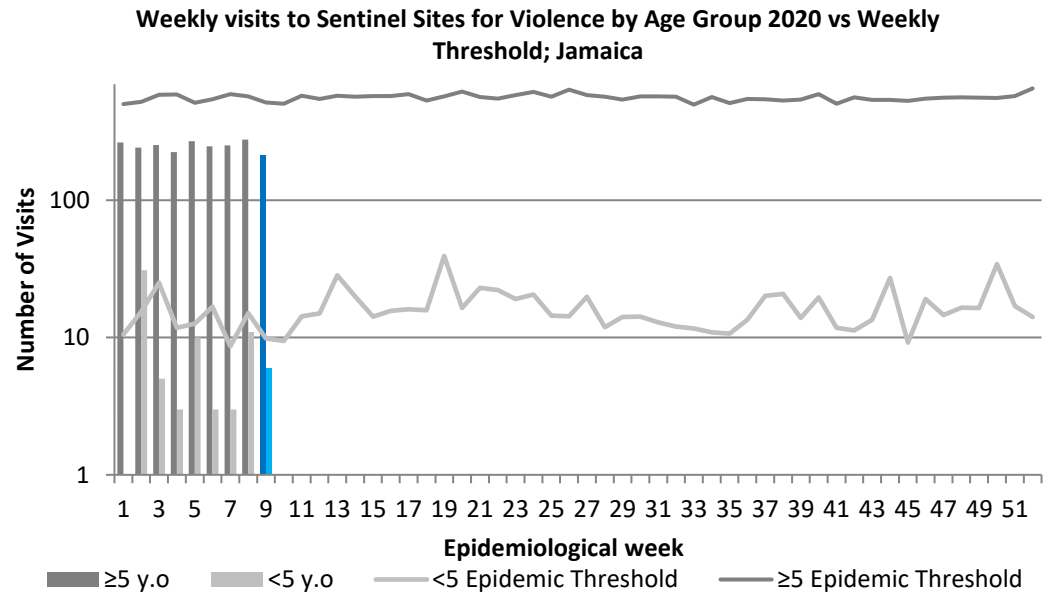


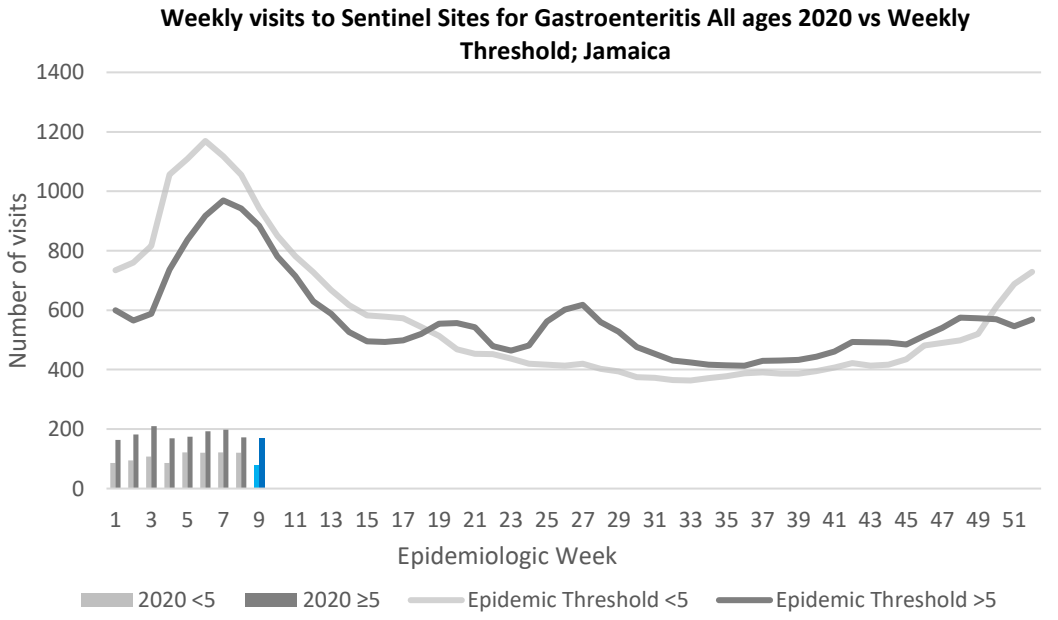
VIOLENCE

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 2020	Confirmed YTD PREVIOUS YEAR 2019
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		5	20
	Cholera		0	0
	Dengue Hemorrhagic Fever*		NA	NA
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		0	1
	Hepatitis C		0	1
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis (Clinically confirmed)		1	1
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**		5	9
	Ophthalmia Neonatorum		12	62
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		0	0
	Tuberculosis		0	11
	Yellow Fever		0	0
	Chikungunya***		0	0
	Zika Virus****		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.

* Dengue Hemorrhagic Fever data include Dengue related deaths;

** Figures include all deaths associated with pregnancy reported for the period. * 2019 YTD figure was updated.

*** CHIKV IgM positive cases

**** Zika PCR positive cases

NA- Not Available

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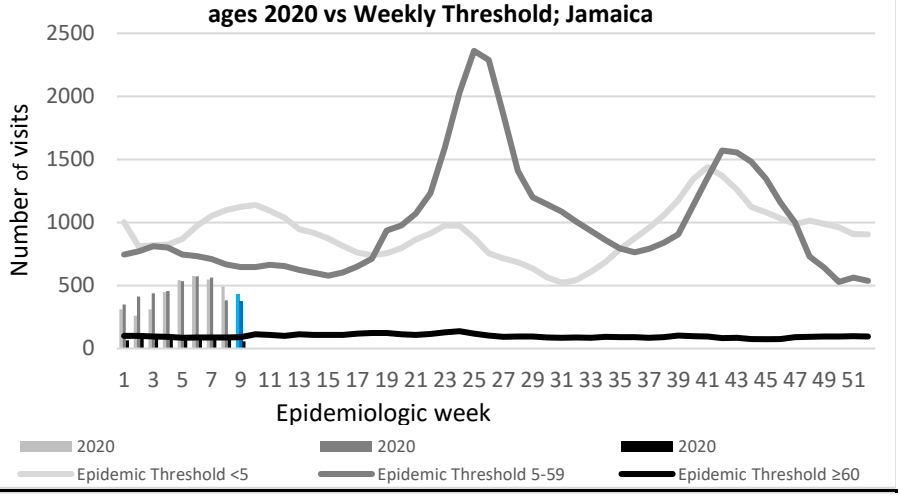
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 09

February 23, 2020– February 29, 2020 Epidemiological Week 09

	EW 09	*YTD*
SARI cases	*4*	*64*
Total Influenza positive Samples	*5*	*49*
Influenza A	*4*	*31*
H3N2	*0*	*2*
H1N1pdm09	*4*	*29*
Not subtyped	*0*	*0*
Influenza B	*1*	*18*
Parainfluenza	*0*	*0*

Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2020 vs Weekly Threshold; Jamaica

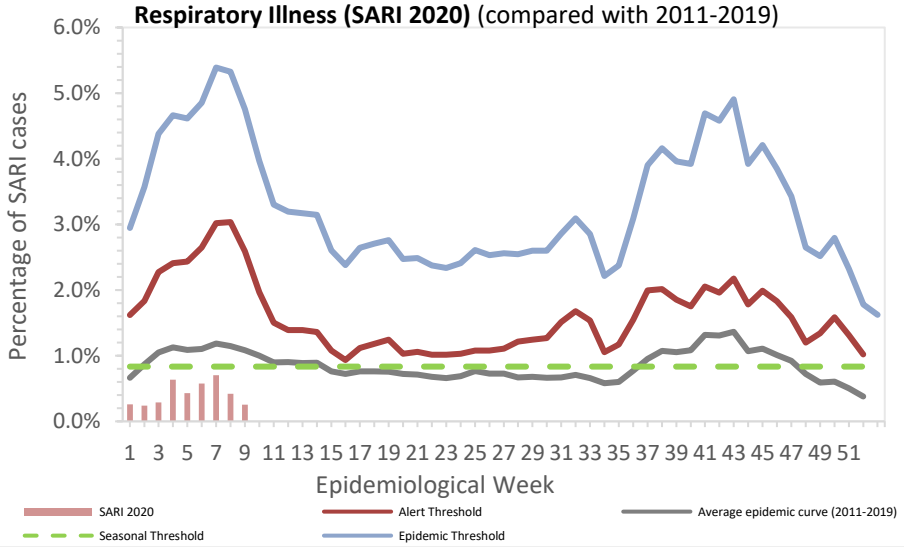


Epi Week Summary

During EW 09, 4 (four) SARI admissions were reported.

35.7% positivity for EW 09

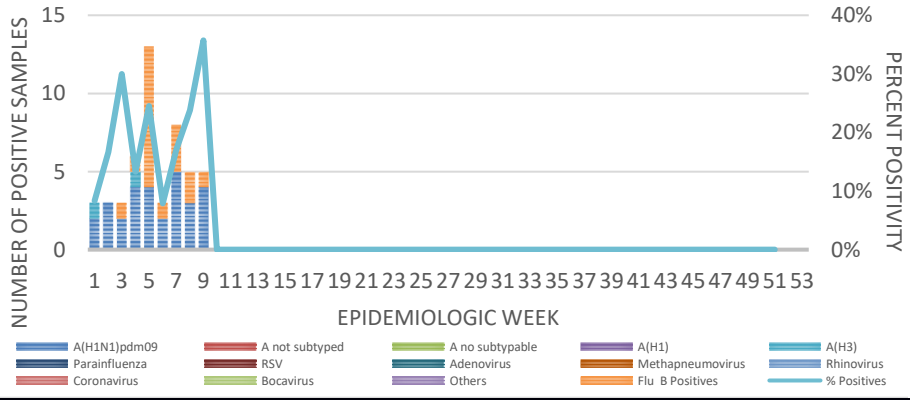
Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2020) (compared with 2011-2019)



Caribbean Update EW 09

Overall, influenza activity is elevated in the sub-region. In Cuba, influenza activity increased with influenza A and B viruses co-circulating. Influenza activity continued increased in Belize with influenza A(H1N1)pdm09 and influenza B viruses co-circulating. All the French Territories are in the epidemic phase with a continued increase in influenza activity observed in Guadeloupe and Martinique..

DISTRIBUTION OF INFLUENZA AND OTHER RESPIRATORY VIRUSES IN SURVEILLANCE BY EW



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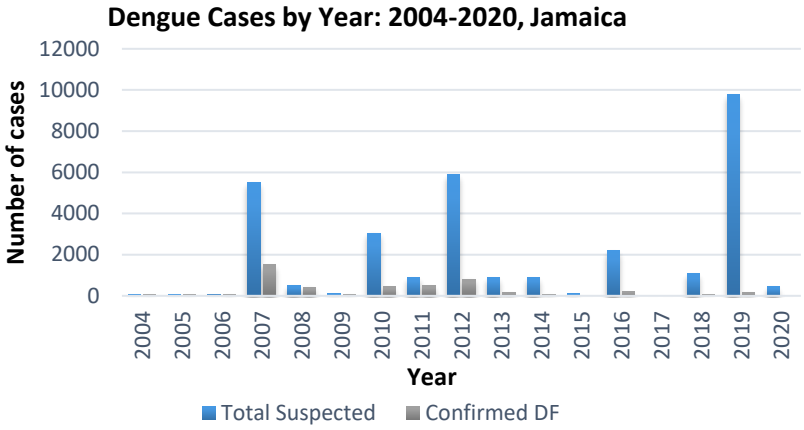
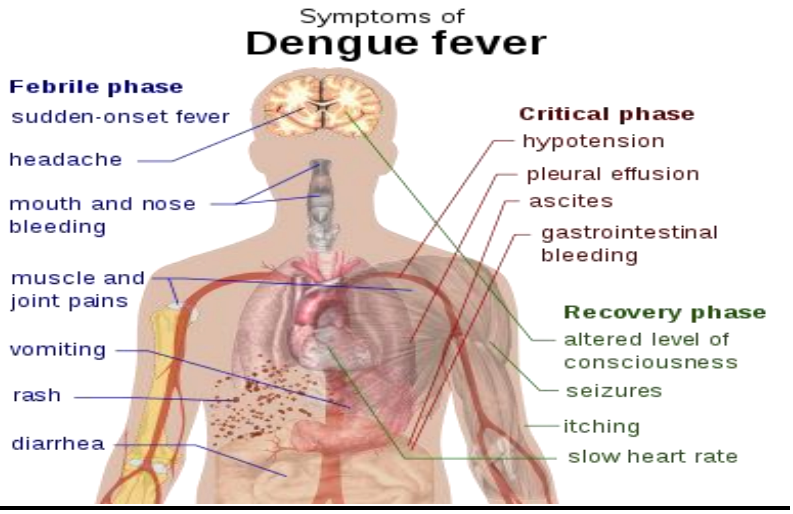
Dengue Bulletin

February 23– February 29, 2020 Epidemiological Week 09 | Epidemiological Week 09



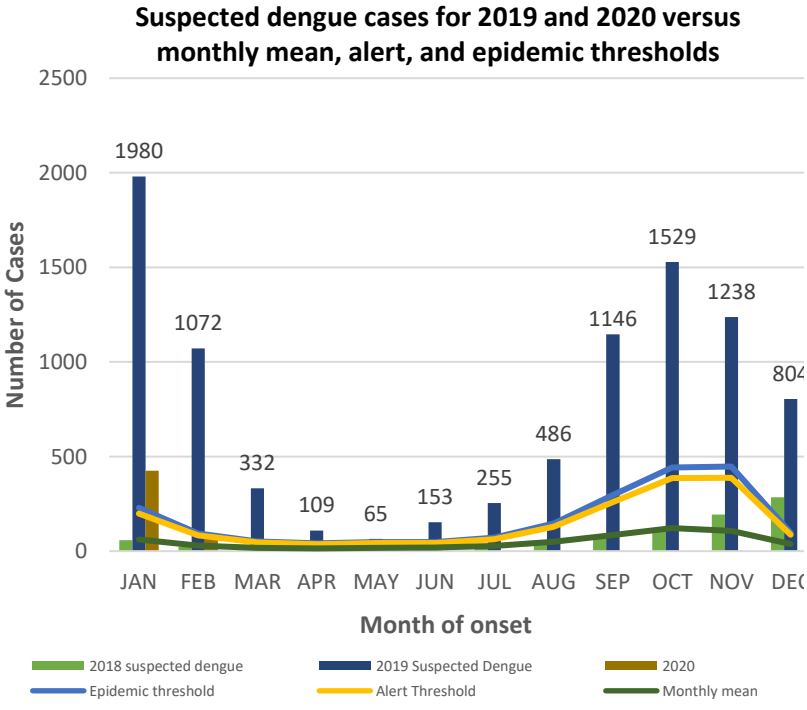
Reported suspected and confirmed dengue with symptom onset in week 9 of 2020

	2020	
	EW 8	YTD
Total Suspected Dengue Cases	4**	521**
Lab Confirmed Dengue cases	0**	1**
CONFIRMED Dengue Related Deaths	0**	1**



Points to note:

- ** figure as at March 6, 2020
- Only PCR positive dengue cases are reported as confirmed.
- IgM positive cases are classified as presumed dengue.



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RESEARCH PAPER

ABSTRACT

Using the Beck Depression Inventory to Identify Depressive Symptoms in Jamaican Youths

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Mr. Kenneth Barnes - Citizen Security and Justice Programme, Ministry of National Security

***Objectives*:**
This study examined the prevalence of depressive symptoms in youths and seeks to find the symptoms that tend to occur most frequently within this sample. The assessments were done at a treatment site within the Central Region of the Citizen, Security and Justice Program (CSJP) under the Ministry of National Security (MNS).

Methods:
Participants ages 18 to 30 years completed the Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996), over the period January 2017 to December 2018. Other measures of socio-demographic background were also collected. Data gathered from the 21 categories of the BDI-II instrument were then entered into SPSS for analysis.

Results:
A wide cross-section of at risk youths from four (4) parishes in rural Jamaica were sampled (n=154; 61% male, 39% females; mean age =22.7. An analysis of the data showed that approximately seven in every ten participant (71.4%) reported some symptoms of depression with 16.9% reporting mild symptoms; 22.7% reporting moderate symptoms and 31.8% reporting severe symptoms of depression. Symptoms that were most prevalent in this sample included sadness (73.9%); punishment feelings (70.7%); and guilty feelings (67.5%)
Results also show that there were significant differences in gender in their prevalence of depressive symptoms. Females were more likely to report depressive symptoms than males (p=.004). Additionally, the analysis revealed significant differences in educational levels for depressive symptoms. Participants who reported having primary/all age as the highest level of education were more likely to report depressive symptoms than those who reported having secondary/high school education (p=.024).

Conclusion:
The use of the Beck Depression Inventory II (BDI-II) to assess depressive symptoms in youths in Jamaica is an effective way to identify prevalent symptoms that impact mental health for that population. Gender differences in depression scores are consistent with studies in other countries (Lowe, 2005). In comparison to previous studies (Beck 1967) this sample had a higher percentage of youths scoring in the "none to minimal" depressive and severely depressed ranges.
These findings warrant closer examination of the contributing factors of depression among Jamaican youths. This information should be useful for practitioners working with similar populations.

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