WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Landslides

Overveiw: Landslides are more widespread than any other geological event, and can occur anywhere in the world. They occur when large masses of soil, rocks or debris move down a slope due to a natural phenomenon or human activity. Mudslides or debris flows are also a common type of fast-moving landslide. Landslides can accompany heavy rains or follow droughts, earthquakes or volcanic eruptions. Areas most vulnerable to landslides include: steep terrain, including areas at the bottom of canyons; land previously burned by wildfires; land that has been modified due to human activity, such as deforestation or construction; channels along a stream or river; any area were surface runoff is directed or land is heavily saturated. Between 1998-2017, landslides affected an estimated 4.8 million people and cause more than 18 000 deaths. Climate change and rising temperatures are expected to trigger more landslides, especially in mountainous areas with snow and ice. As permafrost melts, rocky slopes can become more unstable resulting in a landslide.

Impact: Landslides can cause high mortality and injuries from rapidly flowing water and debris. The most common cause of death in a landslide is trauma or suffocation by entrapment. Broken power, water, gas or sewage pipes can also result in injury or illness in the population affected, such as water-borne diseases, electrocution or lacerations from falling debris. People affected by landslides can also have short- and long-term mental health effects due to loss of family, property, livestock or crops. Landslides can also greatly impact the health system and essential services, such as water, electricity or communication lines.

WHO Response: The magnitude of the physical and human costs from landslides can be reduced if adequate emergency prevention, preparedness, response and recovery measures are implemented in a sustainable and timely manner. WHO works with Member States to build resilient and proactive health systems that can anticipate the needs and challenges during emergencies so that they are more likely to reduce risks and respond effectively when needed. As the health cluster lead for global emergencies, WHO works with partners to respond to: ensure appropriate food supplementation; restore primary care services, like immunization, child and maternal health, and mental health; assemble mobile health teams and outreach; conduct epidemic surveillance, early warning and response; call for emergency funding to support health action.

https://www.who.int/health-topics/landslides#tab=tab_1

EPI WEEK 39

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SENTINEL SYNDROMIC SURVEILLANCE

Sentinel Surveillance in Jamaica

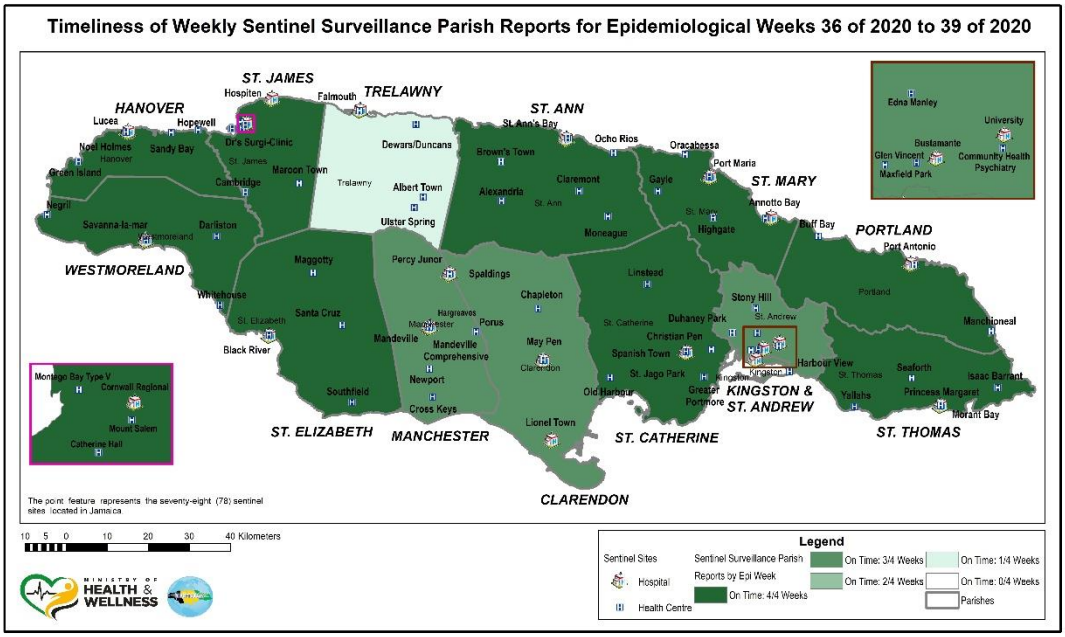
A syndromic surveillance system is good for early detection of and response to public health events.

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 – 36 to 39 of 2020

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

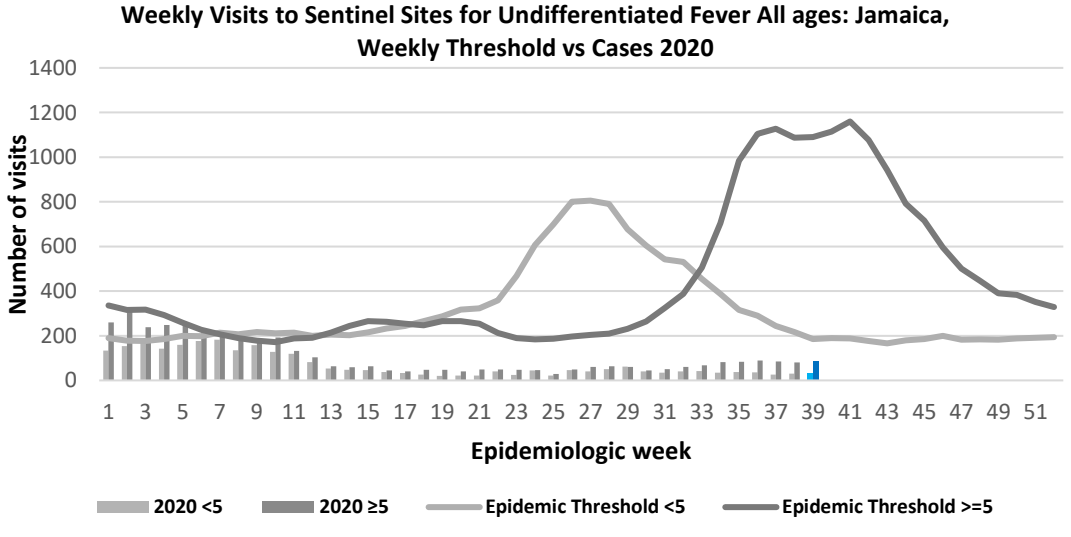


REPORTS FOR SYNDROMIC SURVEILLANCE

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



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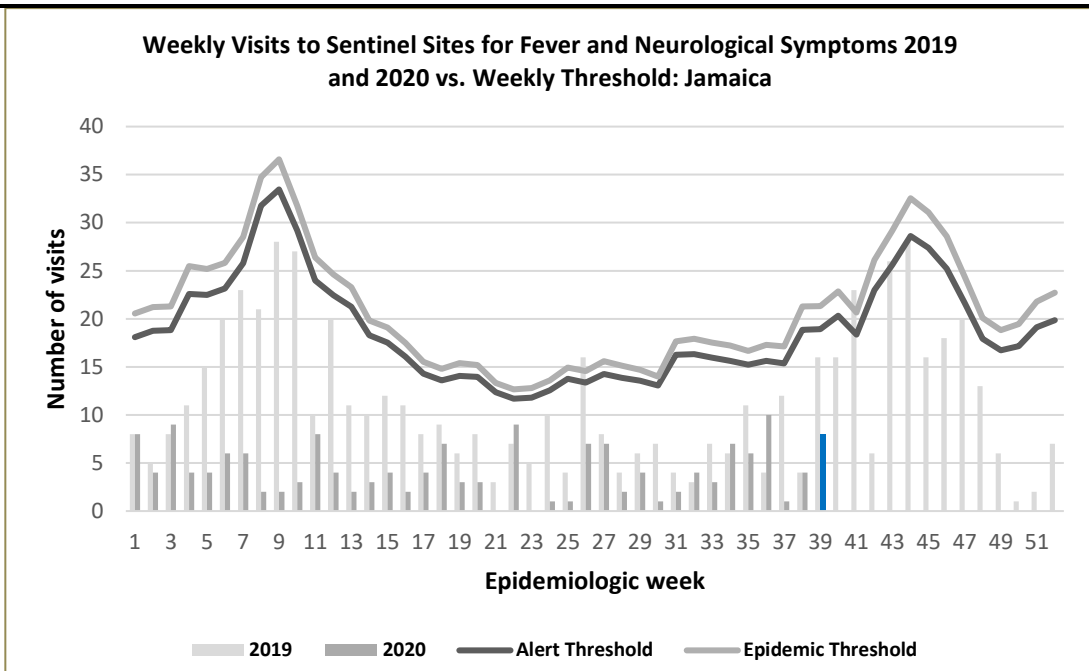
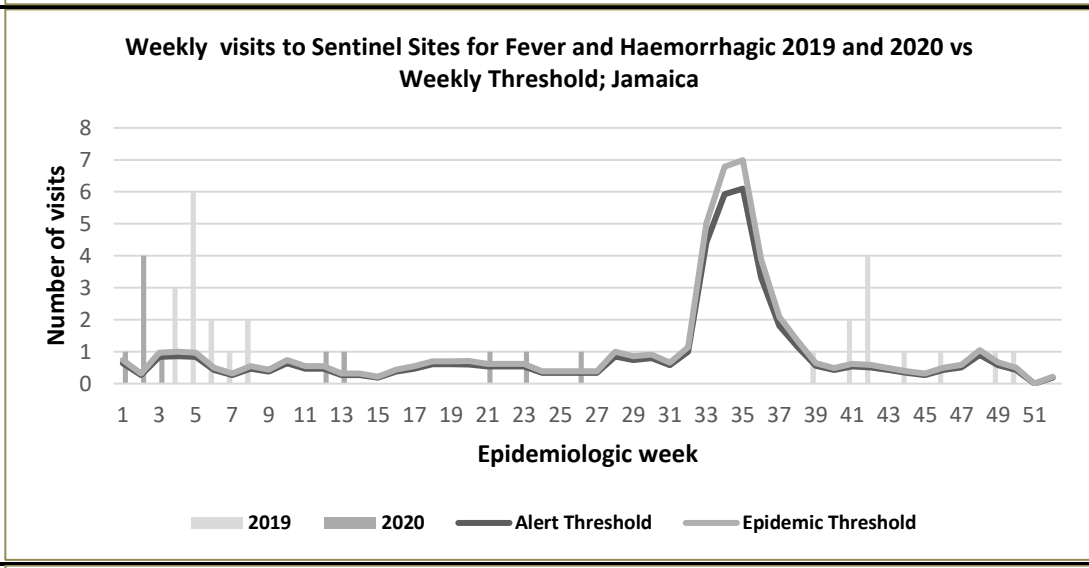
FEVER AND NEUROLOGICAL
Temperature of >38^{0}C /100.4^{0}F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).

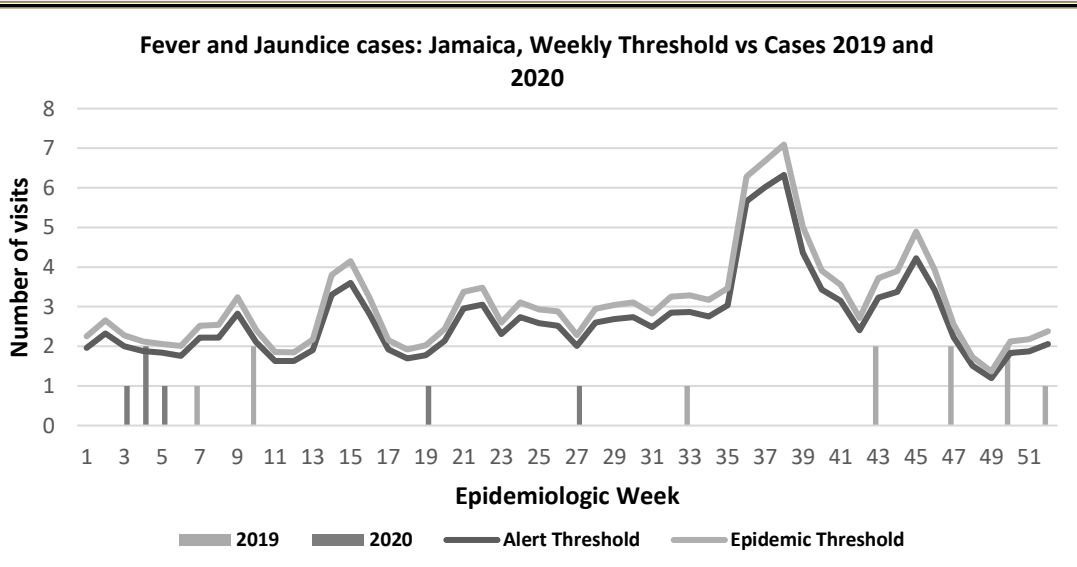


FEVER AND HAEMORRHAGIC
Temperature of >38^0*C* /100.4^0*F* (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



FEVER AND JAUNDICE
Temperature of >38^0*C* /100.4^0*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.



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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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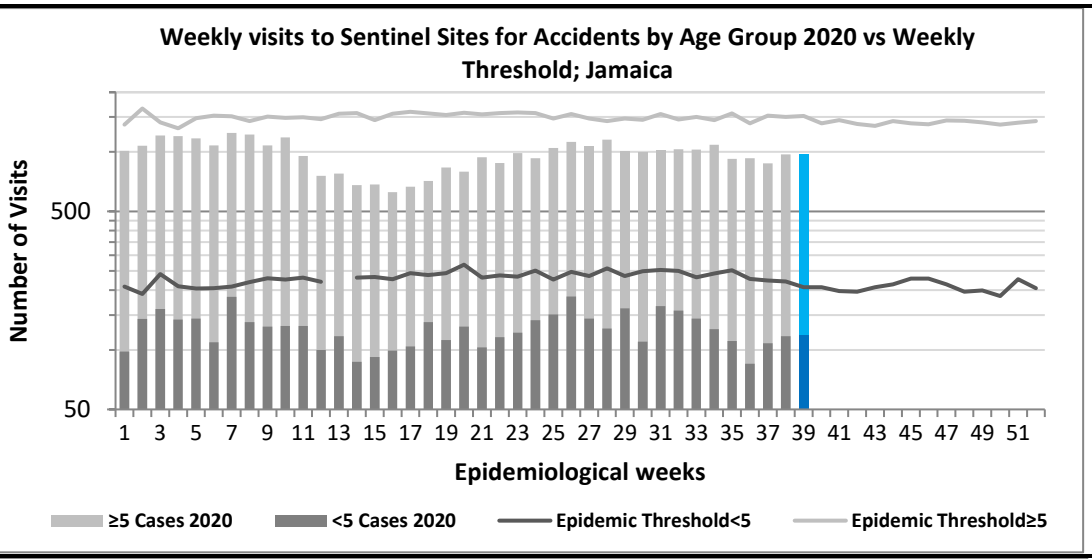
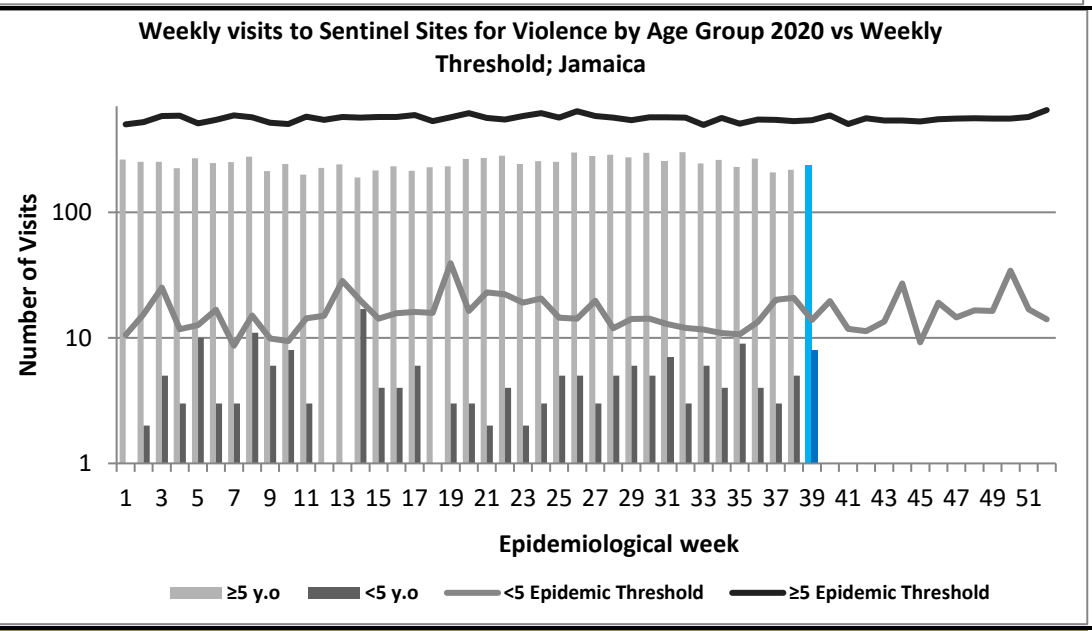


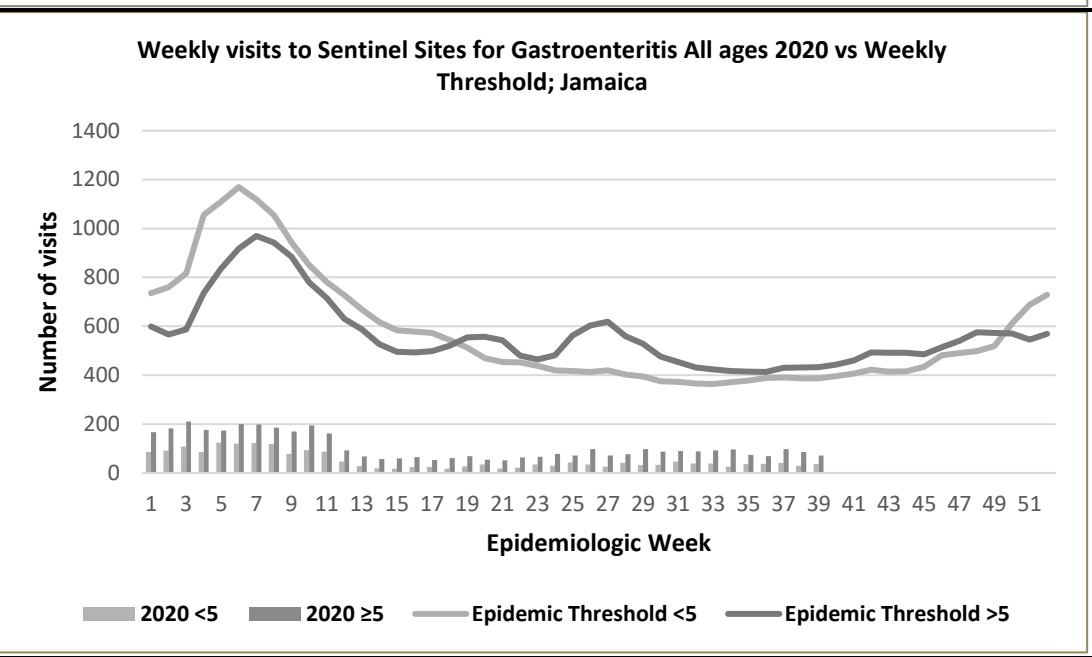
VIOLENCE

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		18	57
	Cholera		0	0
	Dengue Hemorrhagic Fever*		NA	NA
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		0	11
	Hepatitis C		0	2
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis (Clinically confirmed)		1	20
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**		30	51
	Ophthalmia Neonatorum		23	161
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		0	0
	Tuberculosis		26	44
	Yellow Fever		0	0
	Chikungunya***		0	2
	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

Erratum

EW 38 YTD – Accidental Poisoning -18

NA- Not Available

5 NOTIFICATIONS- All clinical sites

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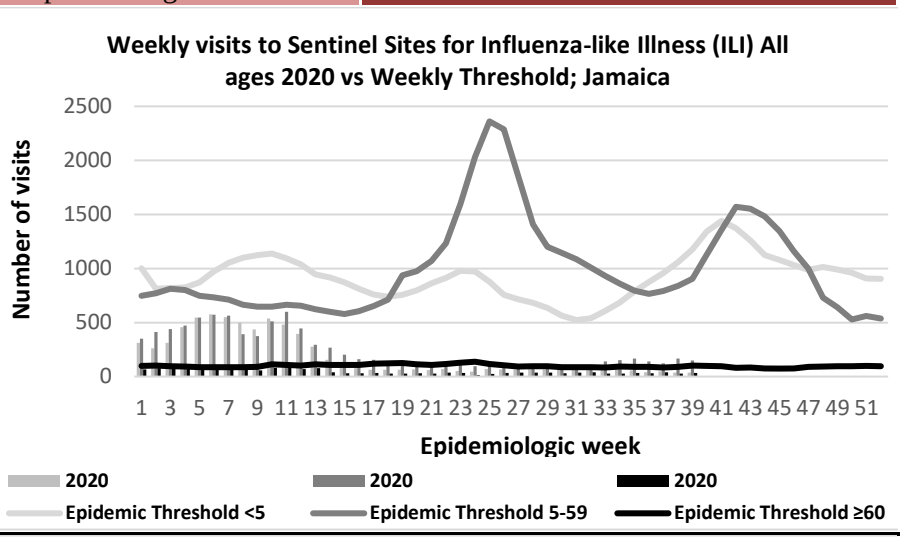
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 39

September 20, 2020 -September 26, 2020 Epidemiological Week 39

	EW 39	*YTD*
SARI cases	*10*	*523*
Total Influenza positive Samples	*0*	*69*
Influenza A	*0*	*45*
H3N2	*0*	*4*
H1N1pdm09	*0*	*38*
Not subtyped	*0*	*3*
Influenza B	*0*	*24*
Parainfluenza	*0*	*0*

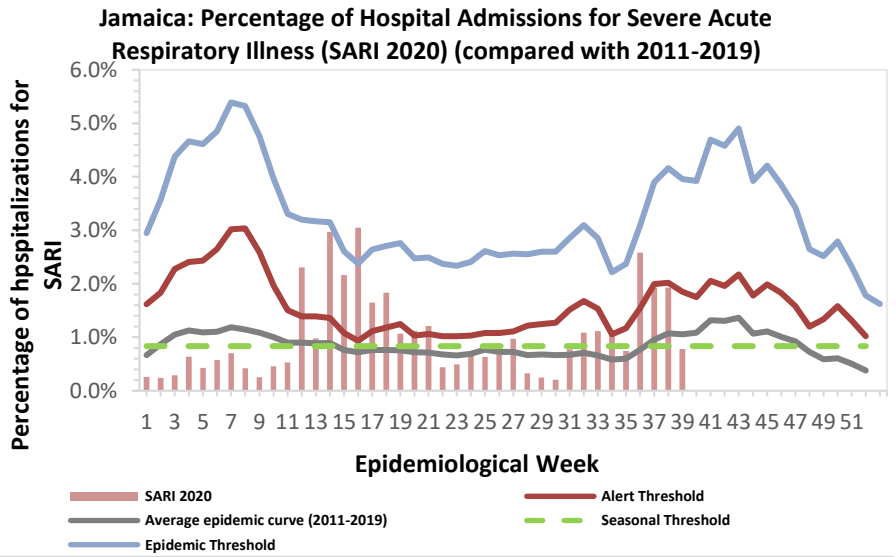


Epi Week Summary

During EW 39, 10 (ten) SARI admissions were reported.

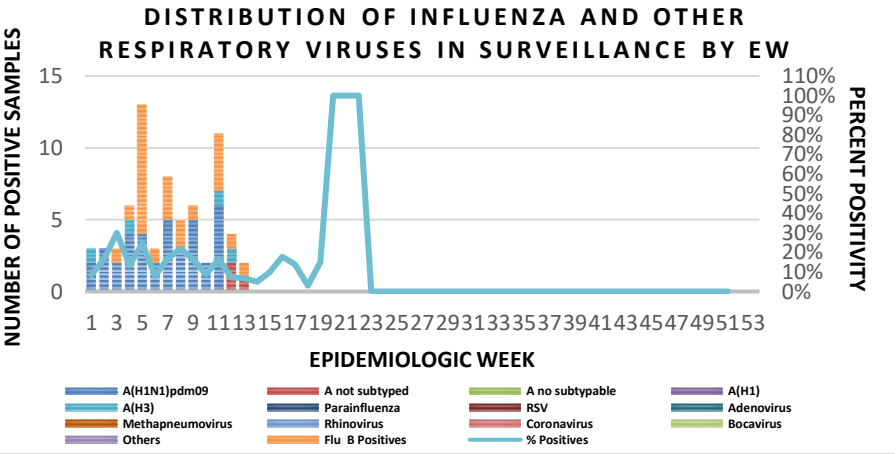
Errata*

EW 38 – SARI cases 31, YTD 513
EW 37 – SARI cases 28, YTD 482



Caribbean Update EW 39

Caribbean: Influenza and other respiratory virus activity remained low in the subregion. In Haiti and Jamaica SARI activity continue at epidemic levels.



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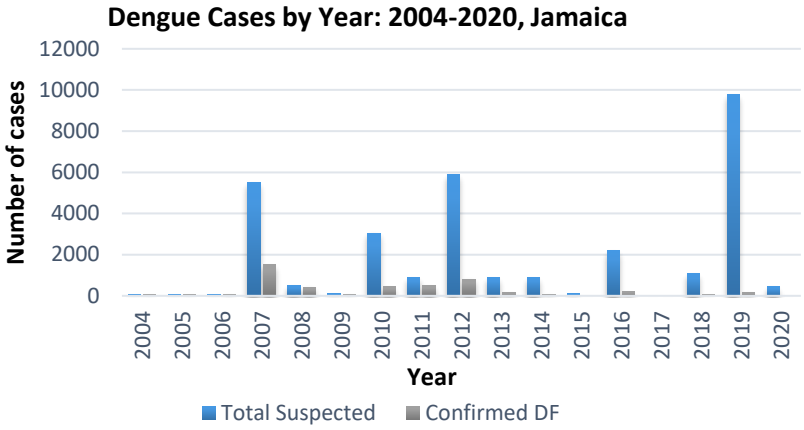
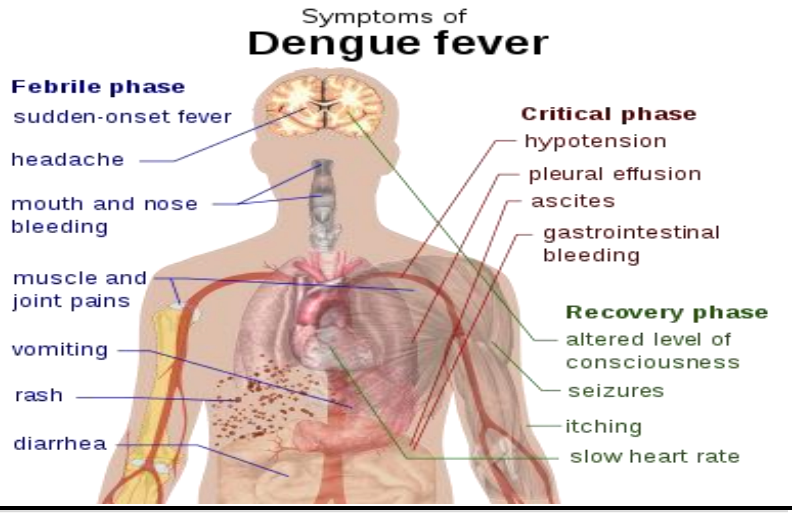
Dengue Bulletin

September 20, 2020 – September 30, 2020 Epidemiological Week 39 | Epidemiological Week 39



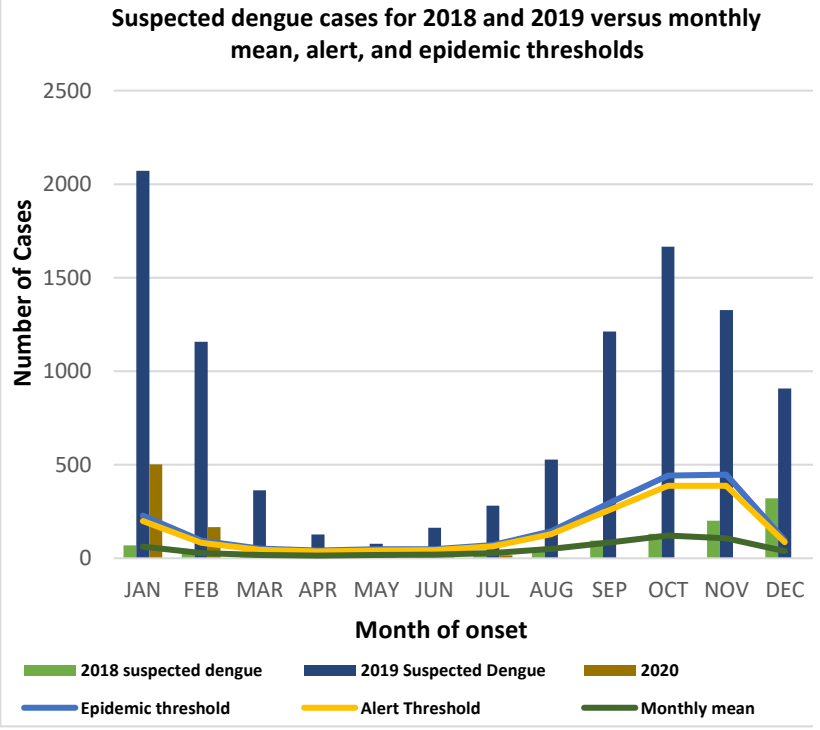
Reported suspected and confirmed dengue with symptom onset in week 39 of 2020

	2020	
	EW 38	YTD
Total Suspected Dengue Cases	0**	748**
Lab Confirmed Dengue cases	0**	1**
CONFIRMED Dengue Related Deaths	0**	1**



Points to note:

- ** figure as at October 8 , 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

Title: Determinants of Health-Seeking Behaviour in Patients with Sexually Transmitted Infections

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***Institution**: Department of Community Health and Psychiatry, University of the West Indies, Mona*
***Corresponding Author / Presenter:** Dr. Ardene Harris at ardene.harris@yahoo.com*

Objectives: Persons with sexually transmitted infections (STIs) often do not seek medical care. In some countries, studies show that patients with STIs feel stigmatized. This study seeks to examine factors that influence the decision by patients with recurrent STIs to seek medical attention, and to determine the role played by stigma or the attitudes of health-care workers.

Method: Using a convergent parallel mixed-methods design, quantitative data were collected via a cross-sectional survey, utilizing an interviewer-administered structured questionnaire, while in-depth interviews were used to gather qualitative data. The study population consisted of 201 patients who attended public health centres served by the Kingston and St. Andrew Health Department for STI symptoms.

Results: Lack of time and the use of alternative medications were the two main reasons reported for delays in seeking care. Females were three times more likely than males to delay seeking care for STI symptoms (OR = 3.1, CI [1.6–6.1]). The STI patients felt stigmatized with a mean score of 61 ± 8.8%. There was an association between STI-related stigma and a willingness to disclose one's STI status to partners ($p < 0.001$). Overall, patients had positive impressions of health-care workers' attitudes towards them (mean patient satisfaction score = 82.2%).

Conclusion: STI patients may delay seeking care or disclosing their status to sexual partners owing to STI-related stigma. Health-care workers are viewed favourably by STI patients and can be used as agents of change, through health promotion to reduce stigma and motivate patients to seek medical attention early.

Key Words: Sexually transmitted infections; STI; stigma; disclosure; health-care worker