



HEALTH SURVEILLANCE BULLETIN

Week 34, 2024

Acute Flaccid Paralysis

0

Fever & Rash

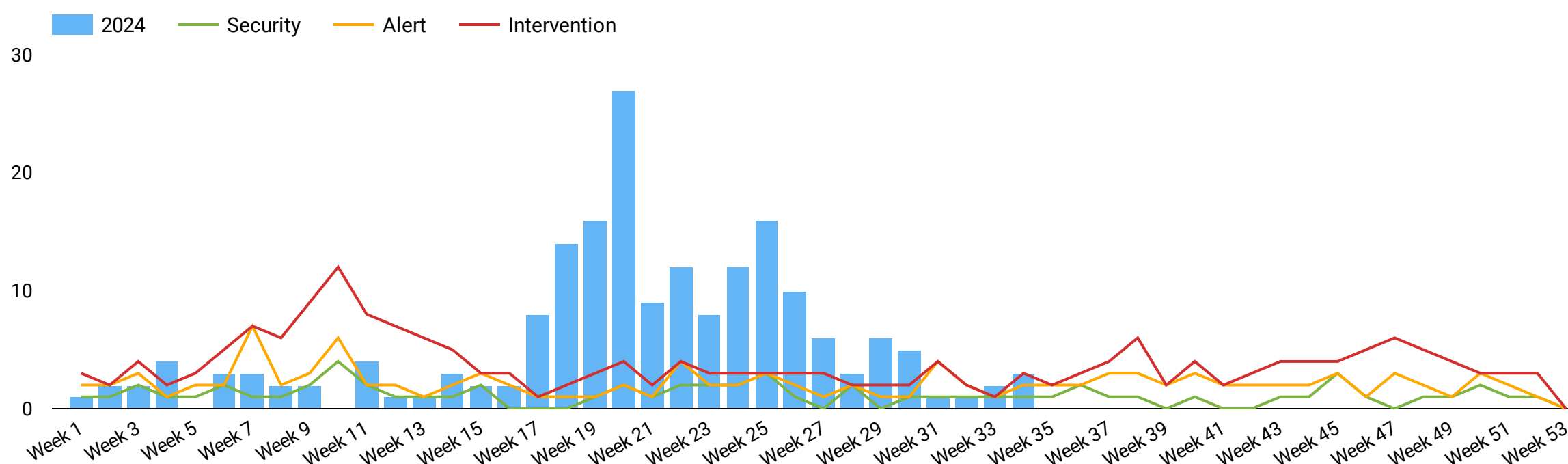
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Fever & Neurological Symptoms

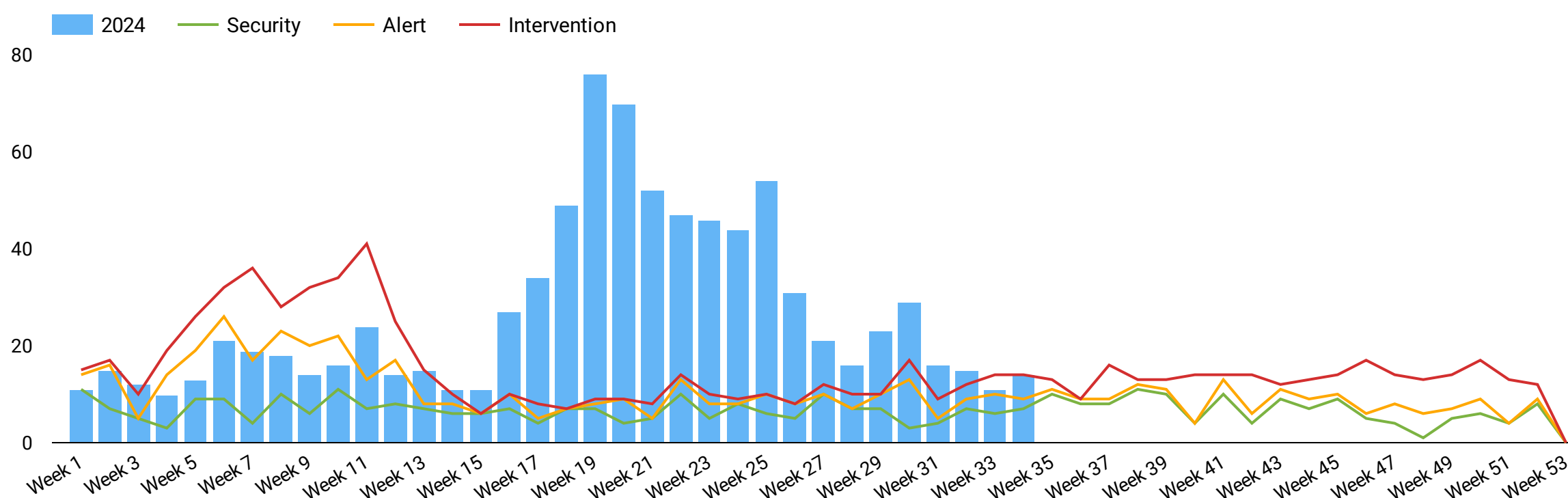
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COVID-19 cases have declined with 27 cases reported for Epi Week 34, in comparison to 74 cases for Epi Week 33. Undifferentiated fever notifications have increased and we will continue to monitor as this may be signaling the start of an outbreak, e.g. an arbovirus outbreak. Good public health practice - hand washing, and personal hygiene, is advised.

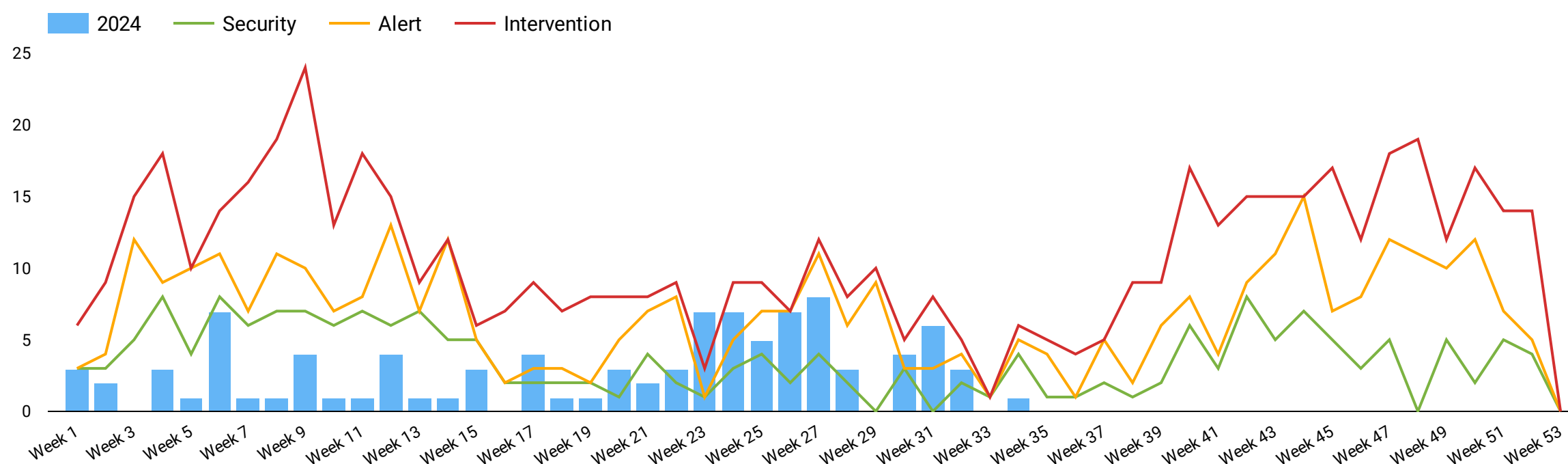
Gastroenteritis in <5 years old by Epidemiological Week



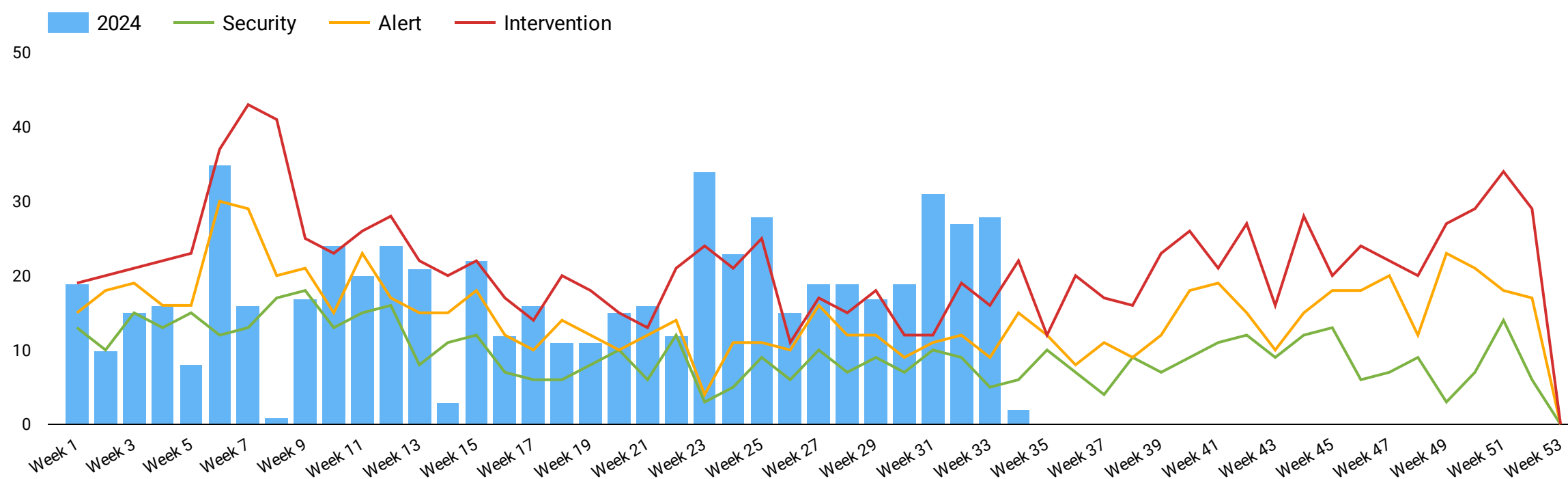
Gastroenteritis in 5 years and older by Epidemiological Week



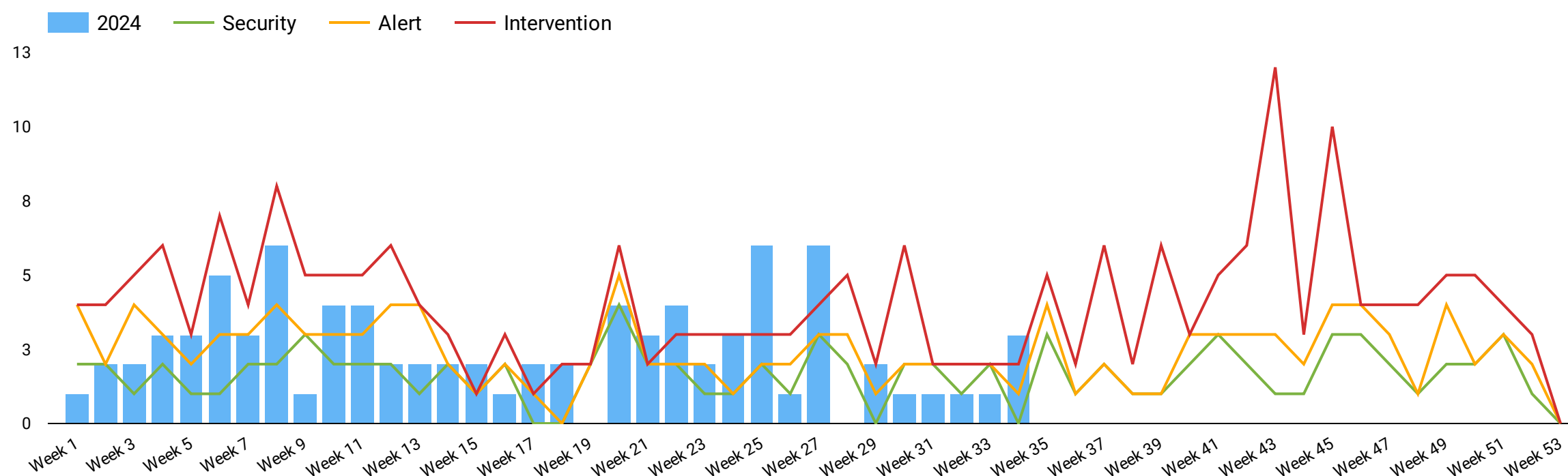
Fever & Respiratory symptoms in <5 years old by Epidemiological Week



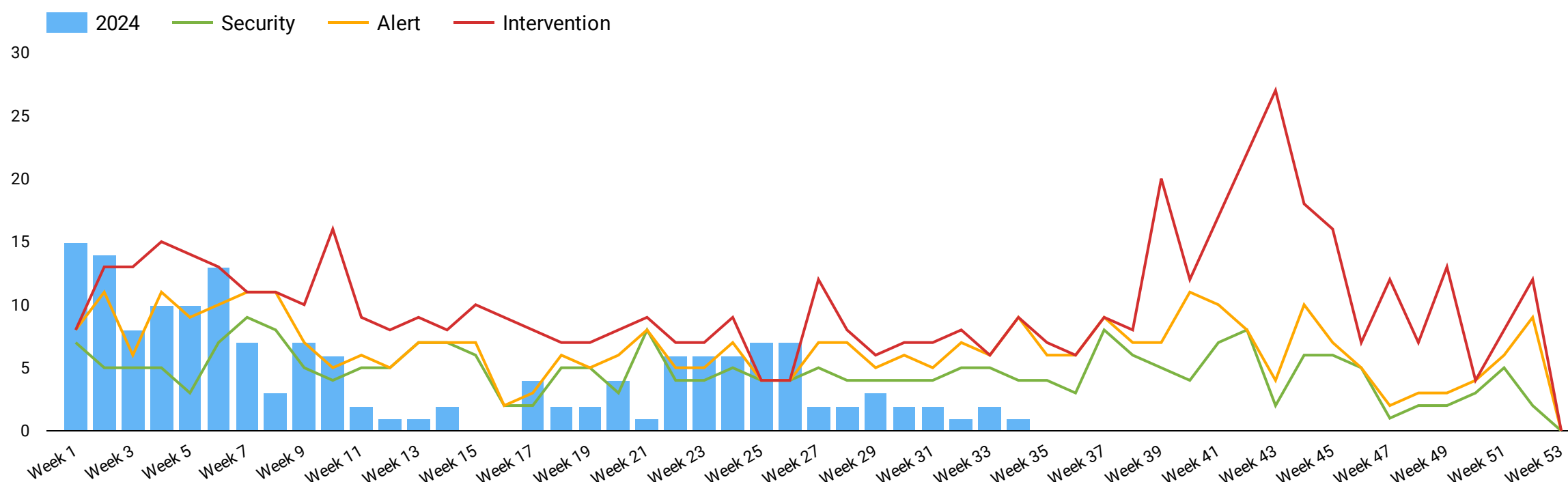
Fever & Respiratory symptoms in 5 years and older by Epidemiological Week



Undifferentiated Fever <5 years old by Epidemiological Week



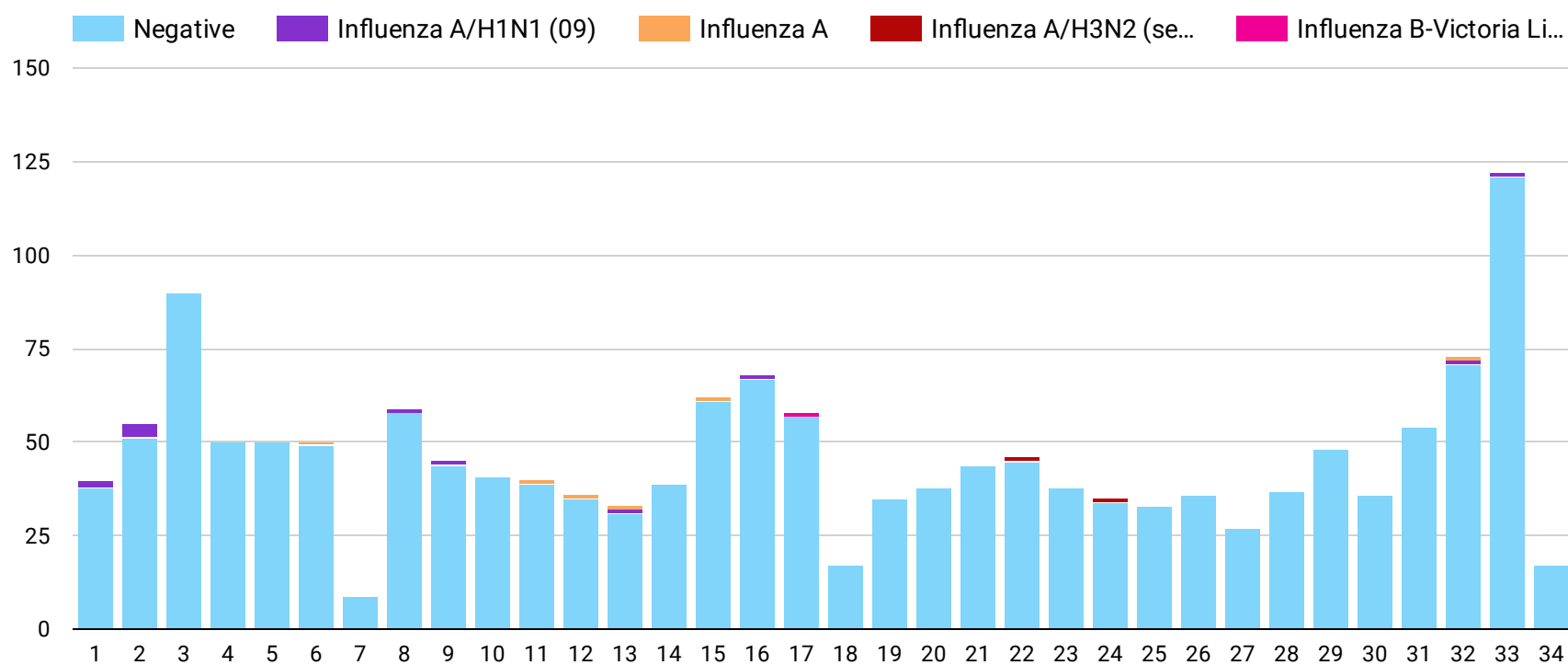
Undifferentiated Fever in 5 years and older by Epidemiological Week



Distribution of syndromes under surveillance by relative periods

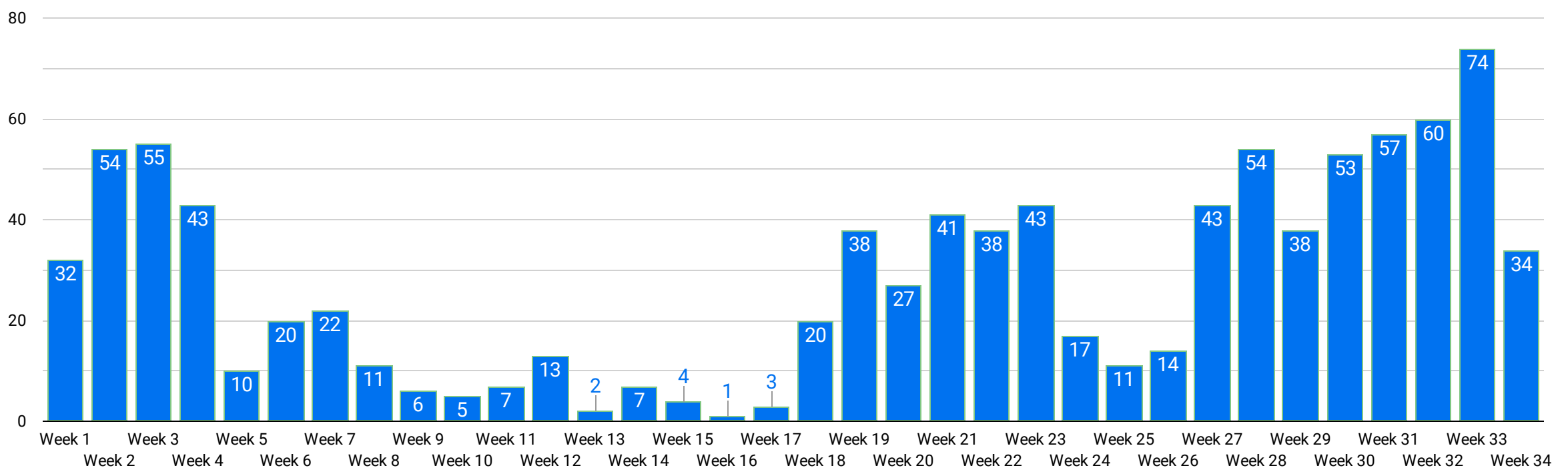
Syndrome ^	Current Week (CW)	Last Week	2024 till CW	2023 till CW	2022 till CW
Acute Flaccid Paralysis	0	0	2	1	0
Chicken Pox	0	0	7	4	1
Conjunctivitis	6	7	269	378	88
Fever and Haemorrhagic symptoms	0	0	2	2	0
Fever and Jaundice	0	0	2	1	1
Fever and Myalgia	0	1	25	9	5
Fever and Neurological symptoms	0	0	2	5	3
Fever and Rash	0	0	21	30	2
Fever and Respiratory	3	28	704	301	371
Gastroenteritis	17	13	1,090	816	173
Influenza like Illness	2	1	68	0	0
Injuries	42	68	2,109	2,658	2,288
Undifferentiated Fever	4	3	244	395	299

Respiratory Viruses by Epidemiological Week, 2024

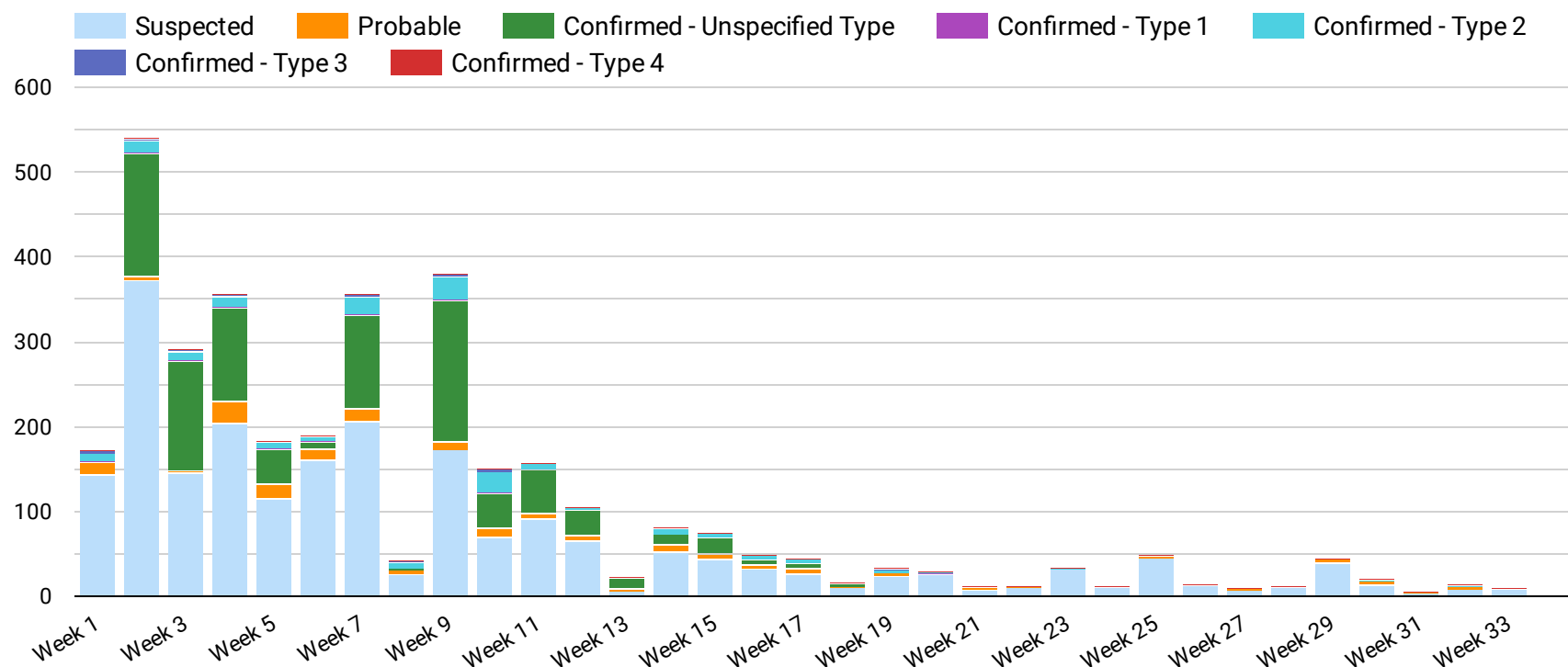


FINAL RESULT	Number
Negative	1,540
Influenza A/H1...	12
Influenza A	6
Influenza A/H3...	2
Influenza B-Vict...	1

COVID-19 by Epidemiological Week, 2024



Dengue by Epidemiological Week, 2024



Variable	Cases
Dengue Confirmed - 1	0
Dengue Confirmed - 2	188
Dengue Confirmed - 3	20
Dengue Confirmed - 4	0
Dengue Confirmed - Un...	901
Dengue Probable	183
Dengue Suspected	2,201

Grand total 3,493

MPox

Since WHO declared mpox a public health emergency of international concern (PHEIC) on August 14, 2024, cases of mpox Clade Ib virus have been detected outside Africa for the first time- Sweden, Thailand.

No cases of clade I mpox have been reported in Barbados at this time.

The risk of mpox coming into Barbados is low. The risk might change as more information becomes available, or if more cases appear outside central and eastern Africa.

Notably Mpox needs close or intimate contact to spread, so casual contact like you might have during travel is not likely to cause the disease to spread.

MPox, previously known as Monkeypox, is an infectious disease that can occur in humans and some animals. It is caused by MPox viruses which exist in two main Clades endemic in 9 African countries and largely unremarked until a multi-country outbreak of the Clade II virus in non-endemic countries in 2022. That multicountry outbreak in 2022 triggered declaration of a PHEIC by WHO in July 23, 2022 which was lifted May 2023. The global outbreak was seen in mostly (but not only) in gay, bisexual and other MSMs through networks. Family members and other contacts were also affected. Some protection was seen from smallpox vaccination but control depended on recognition and isolation of infected persons. A new, largely Clade 1, outbreak is currently progressing through African countries in children and adults and has registered some fatalities to date. WHO has declared this African continental outbreak a PHEIC from August 14, 2024

Transmission is by contact with vesicles or pox, respiratory droplets or contact with contaminated materials including bedding and utensils. It can also be had from infected animals in countries where the disease is endemic. The disease is highly infectious and spreads efficiently from the phase of onset of flu-like symptoms until the rash dries up and new skin is formed. Mother to child (in -utero) transmission can occur

Symptoms can occur 1-21 days after exposure, most commonly **5-7 days after exposure** and classically begins with flu-like illness with fever, headache, muscle aches and low energy before the rash appears. Swollen lymph nodes are often present. However, in some persons, rash may be the first symptom. The rash is typically papules which become vesicular, crusted with exudate and eventually dry. Rash may be painful or itchy and widespread over the body, including palms and soles, cornea or limited e.g. to groin or genital areas. Complications may include vomiting and diarrhoea, pneumonia, corneal scarring, sepsis, encephalitis, myocarditis and death. **Resolution typically occurs 2-4 weeks** after onset but may be prolonged in the immunocompromised. Children, pregnant women and the immuno-compromised are more likely to experience severe disease.

Treatment is largely supportive for pain and for any superinfection of the skin lesions or for any complications. There is no specifically approved treatment for MPox infections but some antiviral medications have been used with severe disease.

Diagnosis is initially clinical but should be confirmed from PCR analysis of **polyester dry swabs of the mucosal or skin lesions** transported in universal transport medium or as dry swabs in tightly closed containers. Lab confirmation is needed to differentiate from other pox virus diseases such as Herpes or chickenpox. This disease is notifiable. Contact tracing is necessary and **isolation of contacts from other persons** for up to 21 days to determine if illness will occur.

Prevention of infection is by avoidance of contact with lesions or potentially contaminated materials or objects used by the ill persons and use of contact and droplet precautions and PPE in a health care setting. For exposed persons, use of a vaccine also used to prevent smallpox within 4 days of exposure may prevent illness. Infected persons should be isolated from others until all the rash has dried and normal skin and mucosa has reappeared.



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