WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Heat and Health

Heat is an important environmental and occupational health hazard. Heat stress is the leading cause of weather-related deaths and can exacerbate underlying illnesses including cardiovascular disease, diabetes, mental health, asthma, and can increase the risk of accidents and transmission of some infectious diseases. Heatstroke is a medical emergency with a high-case fatality rate.

A heatwave is a period where local excess heat accumulates over a sequence of unusually hot days and nights. Heatwaves and prolonged excess heat conditions are increasing in frequency, duration, intensity and magnitude due to climate change. Even low and moderate intensity heat waves can impact the health and well-being of vulnerable populations.

Awareness among health workers and the public remains insufficient of the health risks posed by heat. Health professionals should adjust their guidance, planning and interventions to account for increasing heat exposures, as well as to manage acute increases in admissions associated with heatwaves. Practical, feasible and often low-cost interventions at the individual, community, organizational, governmental and societal levels can save lives.

What actions should the public take?

Stay out of the heat

- Avoid going outside and doing strenuous activity during the hottest time of day.
- Stay in the shade. Remember that perceived temperatures in the sun can be 10–15 ˚C higher.
- Spend 2–3 hours during the day in a cool place.
- Be aware of the risk of drowning. Never swim alone.
- Stay informed about official heat warnings.

Keep your home cool

- Use the night air to cool down your home by opening windows after dark when the outdoor temperature is lower than the indoor temperature.
- During the day when outdoor temperatures are higher than indoors, close windows and cover them with blinds or shutters to block direct sunlight. Turn off as many electrical devices as possible.
- Use electric fans only when temperatures are below 40 ˚C / 104 ˚F. In temperatures above 40 ˚C / 104 ˚F, fans will heat the body.
- If using air conditioning, set the thermostat to 27 ˚C / 81 ˚F and turn on an electric fan – this will make the room feel 4 ˚C cooler. It can also save up to 70% on your electricity bill for cooling.
- Remember that it may be cooler outdoors in the shade.

Keep your body cool and hydrated

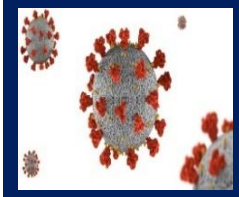
- Use light and loose-fitting clothing and bed linens.
- Take cool showers or baths.
- Wet your skin using a damp cloth, spray, or wet light clothing.
- Drink water regularly (1 cup of water per hour and at least 2–3 litres per day).
- Regularly check in with vulnerable people in your circle – especially people over 65 years old and those with heart, lung or kidney conditions, a disability, and living alone.

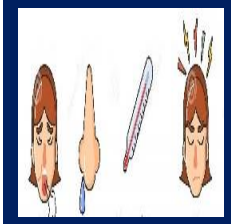
Taken from WHO website on 18/Jul/2025

https://www.who.int/news-room/fact-sheets/detail/climate-change-heat-and-healthpicture from:

https://www.cdc.gov/environmental-health-tracking/php/data-research/tracking-heat-events.html

EPI WEEK 27





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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.

Table showcasing the Timeliness of Weekly Sentinel Surveillance Parish Reports for the Four Most Recent Epidemiological Weeks – 24 to 27 of 2025

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

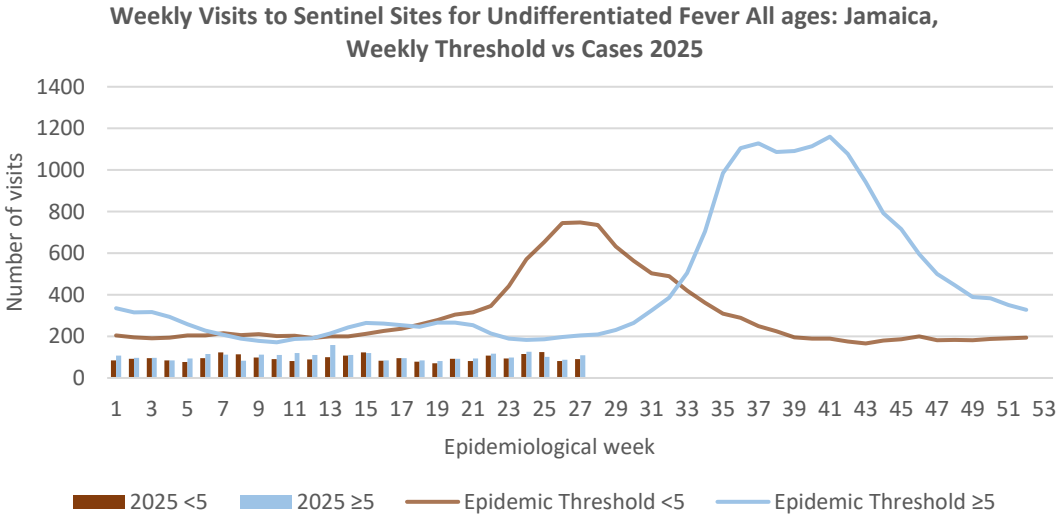
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday

Epi week	Kingston and Saint Andrew	Saint Thomas	Saint Catherine	Portland	Saint Mary	Saint Ann	Trelawny	Saint James	Hanover	Westmoreland	Saint Elizabeth	Manchester	Clarendon
2025													
24	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time
25	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time
26	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time
27	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time

REPORTS FOR SYNDROMIC SURVEILLANCE

UNDIFFERENTIATED FEVER

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



NOTIFICATIONS- All clinical sites

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HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

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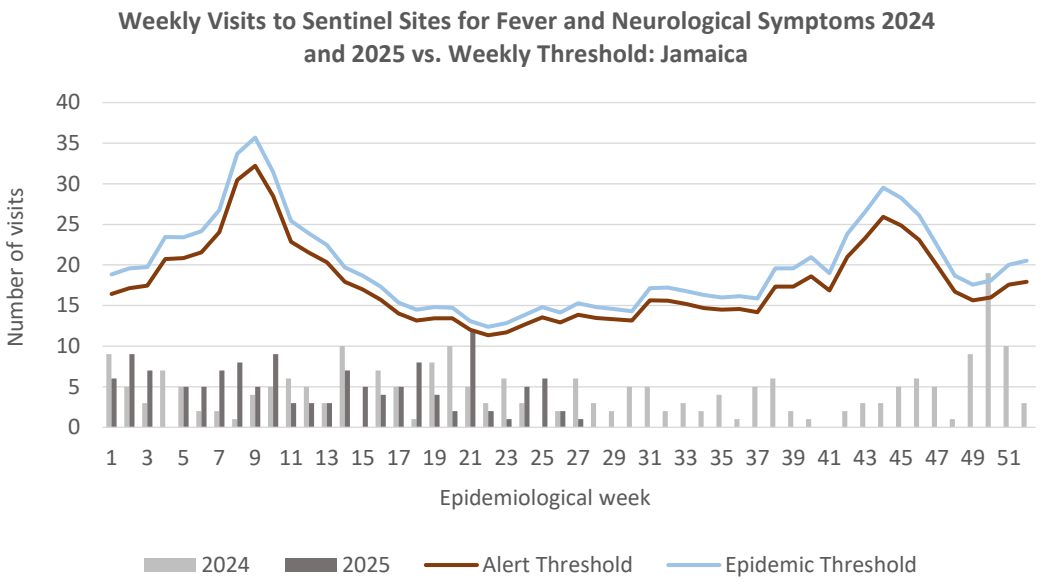
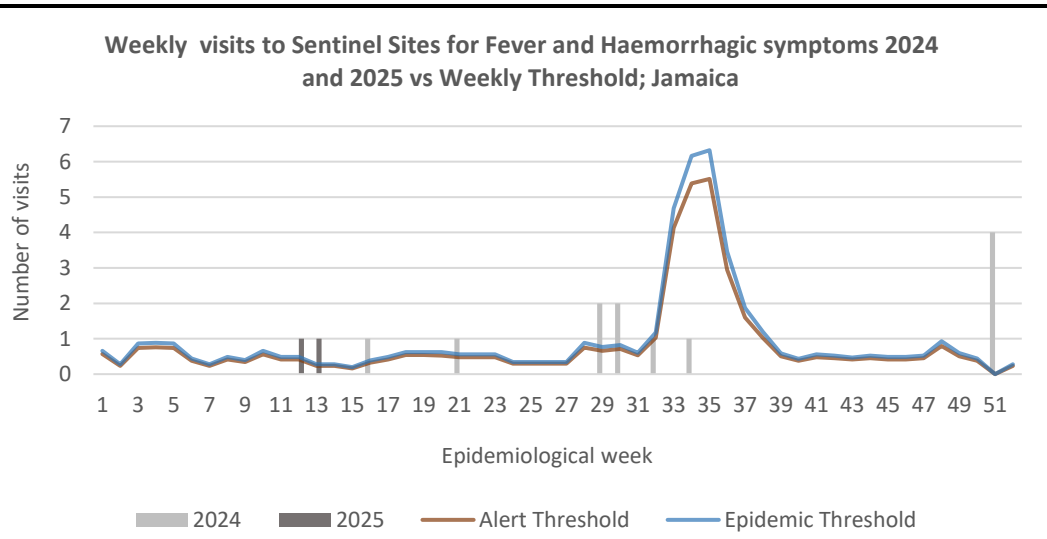
FEVER AND NEUROLOGICAL

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

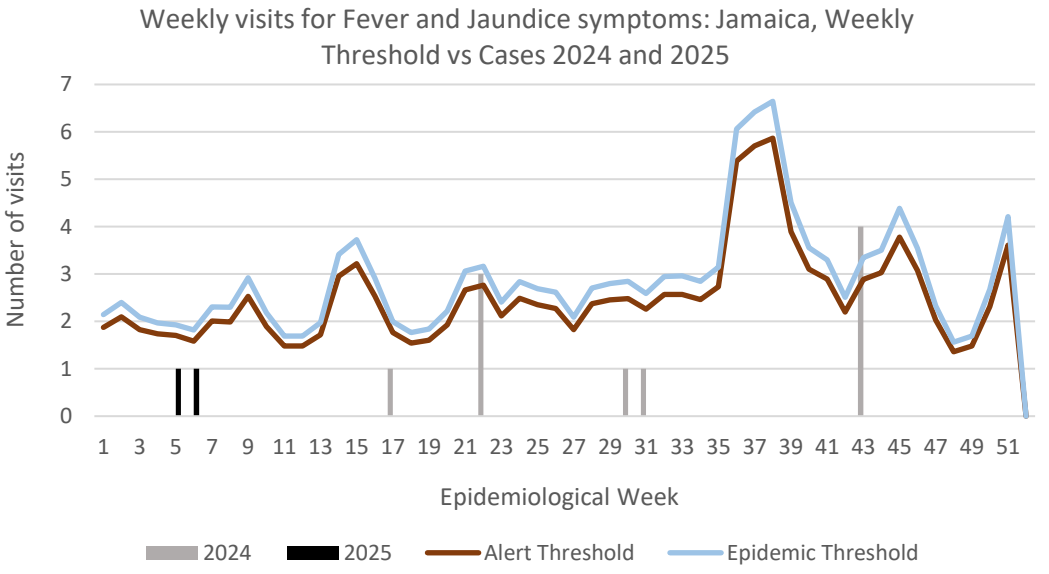
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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.



3 NOTIFICATIONS- All clinical sites

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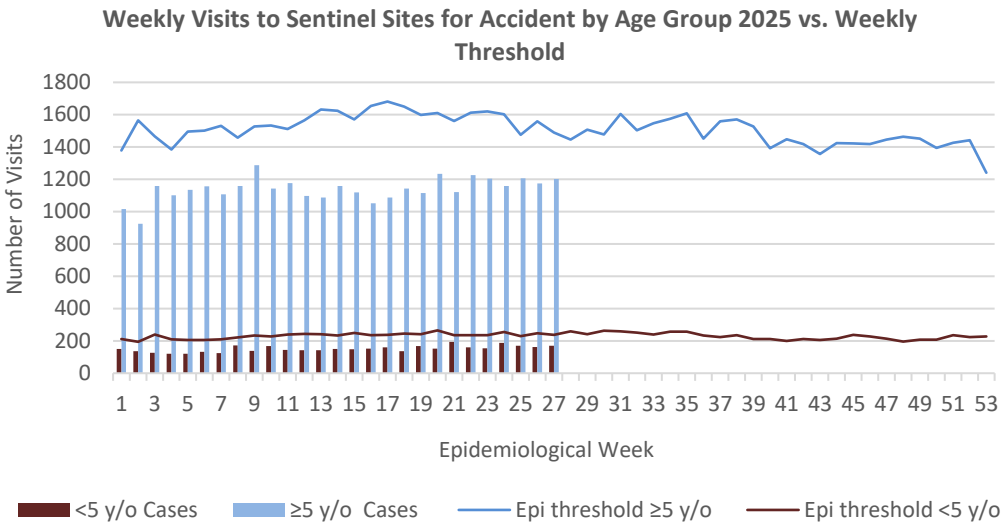
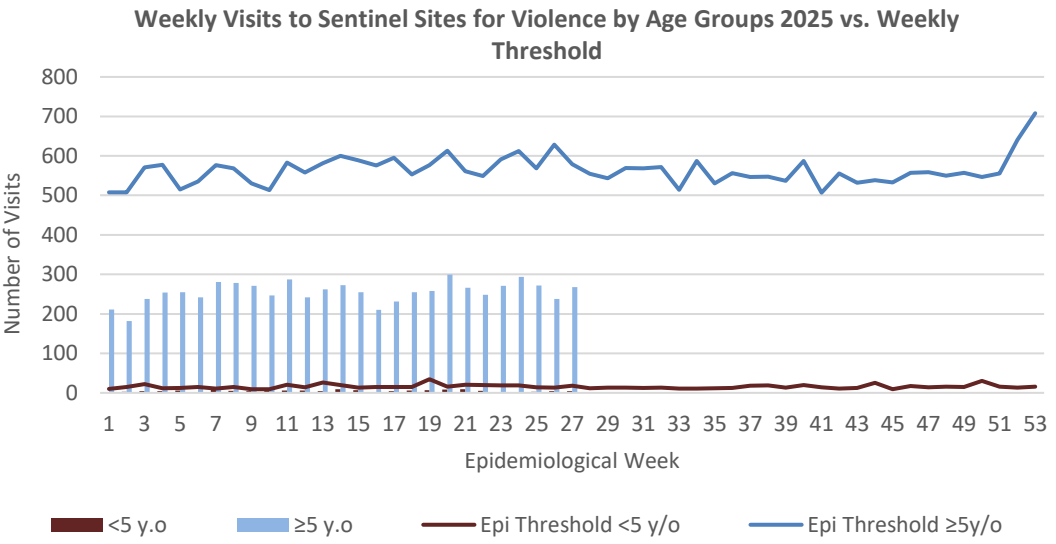
ACCIDENTS

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



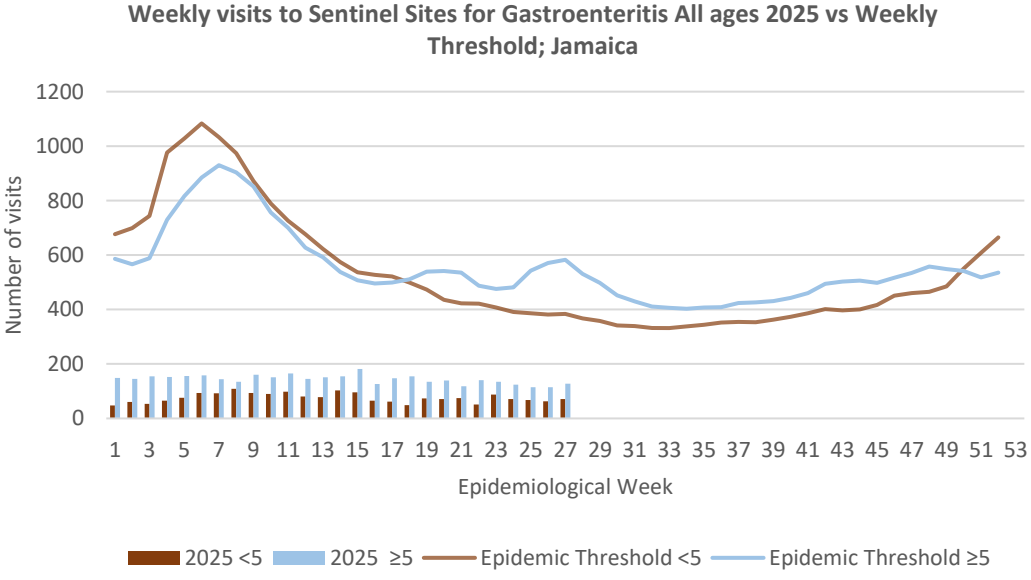
VIOLENCE

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[α] CURRENT YEAR 2025	PREVIOUS YEAR 2024
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		63[β]	210[β]
	Cholera		0	0
	Severe Dengue[γ]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		239	424
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		3	21
	Hepatitis C		1	7
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis		7	11
	Monkeypox		1	0
EXOTIC/ UNUSUAL	Plague		0	0
H IGH MORBIDITY/ MORTALITY	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[δ]		31	35
	Ophthalmia Neonatorum		19	93
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		1	0
	Tuberculosis		20	30
	Yellow Fever		0	0
	Chikungunya[ε]		0	0
	Zika Virus[θ]		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.

[γ] Dengue Hemorrhagic Fever data include Dengue related deaths;

[δ] Figures include all deaths associated with pregnancy reported for the period.

[ε] CHIKV IgM positive cases

[θ] Zika PCR positive cases

[β] Updates made to prior weeks.

[α] Figures are cumulative totals for all epidemiological weeks year to date.

NA- Not Available

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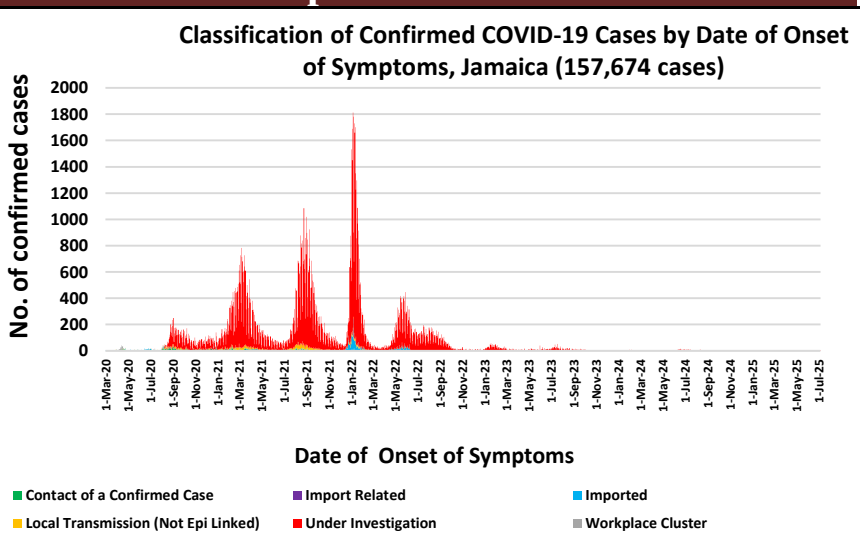
COVID-19 Surveillance Update

CASES	EW 27	Total
Confirmed	9	157674
Females	5	90845
Males	4	66826
Age Range	8 months to 71 years	1 day to 108 years

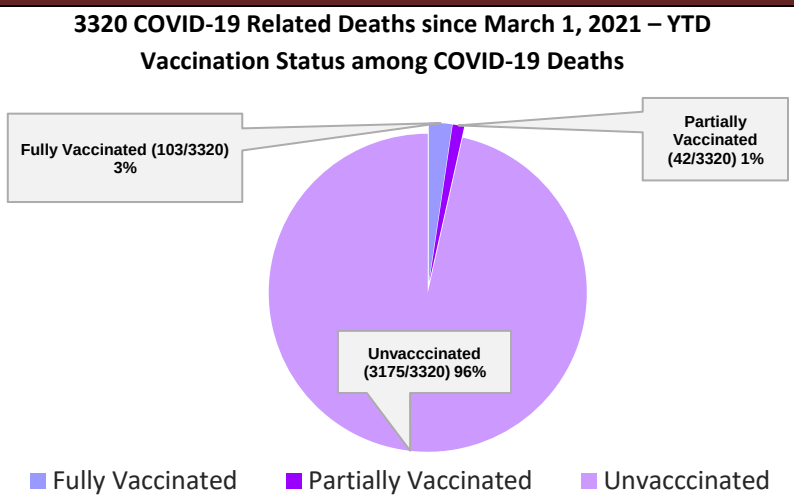
* 3 positive cases had no gender specification
* PCR or Antigen tests are used to confirm cases
* Total represents all cases confirmed from 10 Mar 2020 to the current Epi-Week.



COVID-19 Outcomes

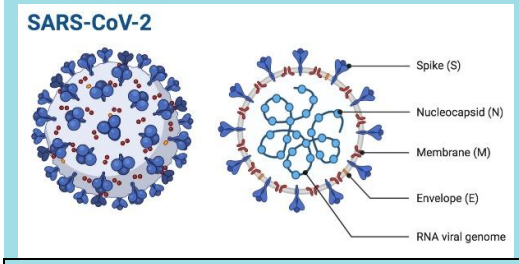
Outcomes	EW 27	Total
ACTIVE *2 weeks*	24	49933
DIED – COVID Related	0	3883
Died - NON COVID	0	397
Died - Under Investigation	0	142
Recovered and discharged	0	103226
Repatriated	0	93
Total		157674

*Vaccination programme March 2021 – YTD
* Total as at current Epi week



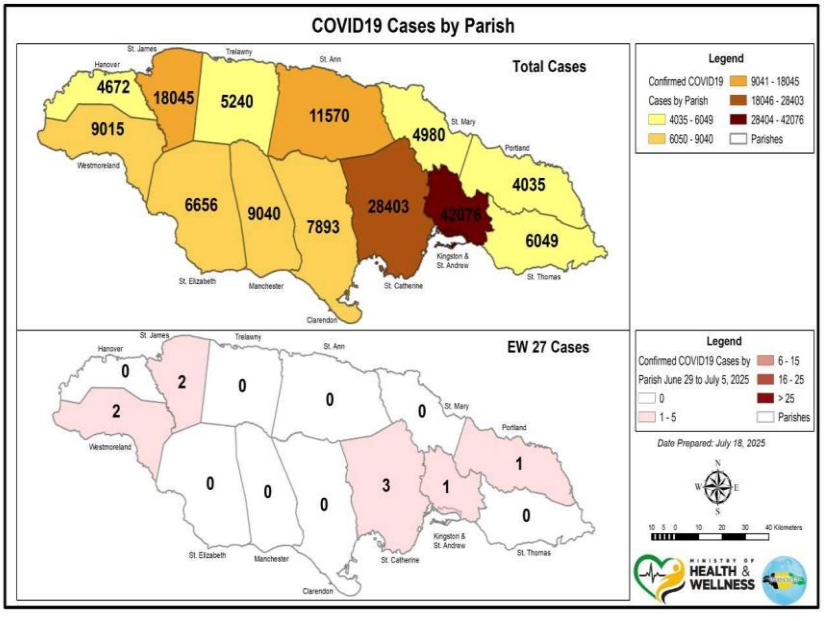
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 24 -27 2025

Epi Week	Confirmed Cases	Deaths
24	167,000	302
25	67,500	275
26	41,900	253
27	31,300	180
Total (4weeks)	**307,700**	**1,010**



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July 18, 2025 ISSN 0799-3927

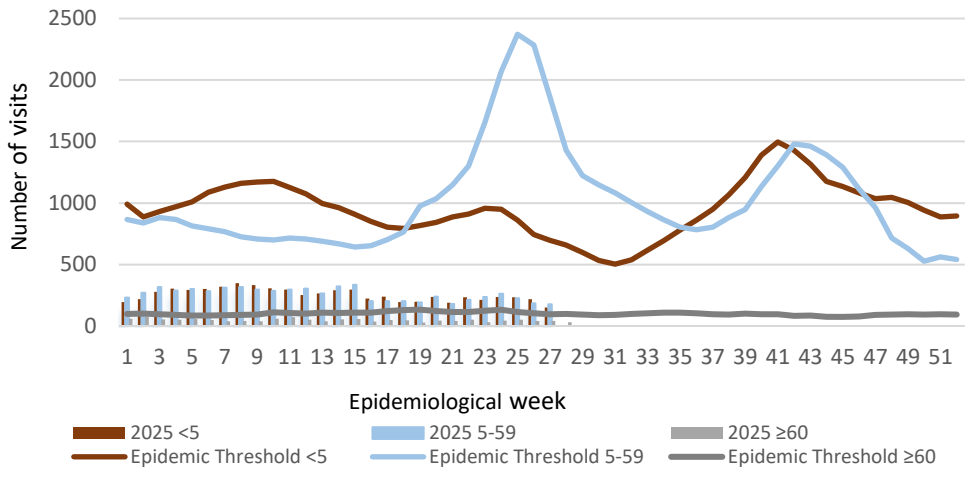
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 27

June 29, 2025 – July 05, 2025 Epidemiological Week 27

	EW 27	*YTD*
SARI cases	3	254
Total Influenza positive Samples	**0**	**166**
Influenza A	**0**	**142**
H1N1pdm09	0	77
H3N2	0	65
Not subtyped	0	0
Influenza B	**0**	**24**
B lineage not determined	0	0
B Victoria	0	24
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	30

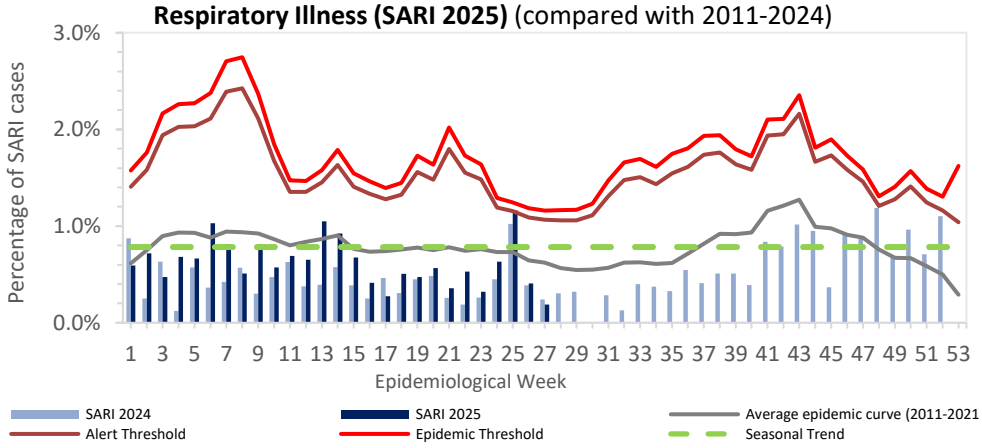
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 27, three (3) SARI admissions were reported.

Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2025) (compared with 2011-2024)

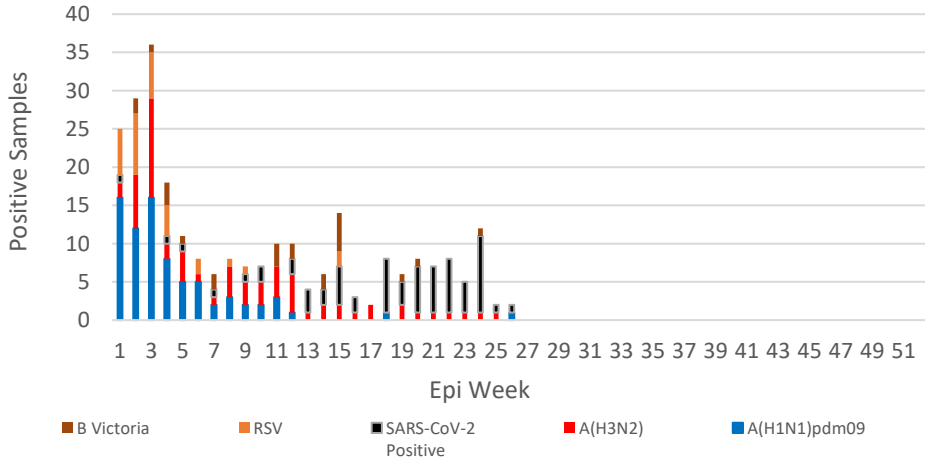


Caribbean Update EW 27

Caribbean: Influenza activity, primarily driven by A(H1N1)pdm09, decreased compared to the previous two EWs, with a subregional positivity rate of 6.3.%. In Haiti, influenza activity continues at moderate levels with an upward trend, reaching a positivity rate of 47.0%. In contrast ,activity remains at interseasonal levels remaining at interseasonal levels in Jamaica and the Dominican Republic, although both countries reported increases in positivity compared to previous EWs, reaching 4.5% and 10.1%, respectively.In Barbados,activity has increased in recent weeks, reaching a positivity rate of 34.4%. SARS-CoV-2 positivity also remains elevated in the Dominican Republic ,Jamaica, Saint Lucia, and Guyana, where a large proportion of SARI cases have been associated with SARS-CoV-2. In Jamaica, however,SARS-CoV-2 activity declined compared to the pervious EW,reaching a positivity rate of 12.3%.

(taken from PAHO Respiratory viruses weekly report) https://www.paho.org/en/influenza-situation-report

Distribution of Influenza and Other Respiratory Viruses Under Surveillance by EW, Jamaica - 2025



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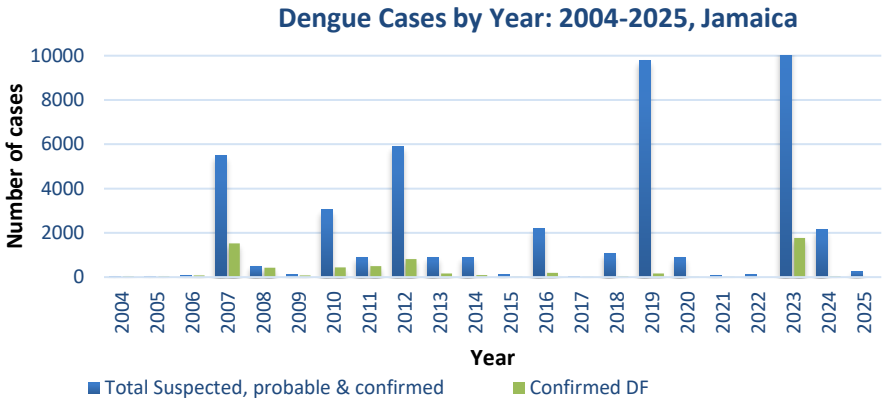
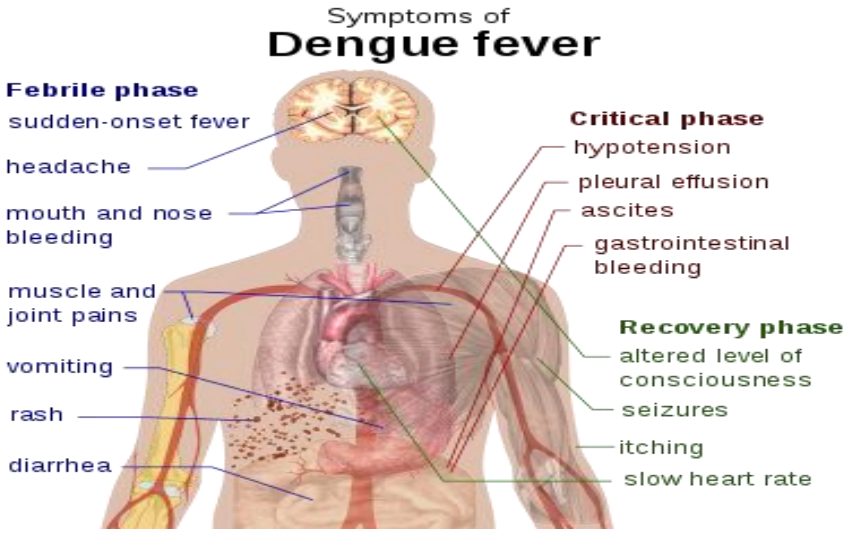
Dengue Bulletin

June 29, 2025 – July 5, 2025 Epidemiological Week 27 | Epidemiological Week 27



Reported suspected, probable and confirmed dengue with symptom onset in week 27 of 2025

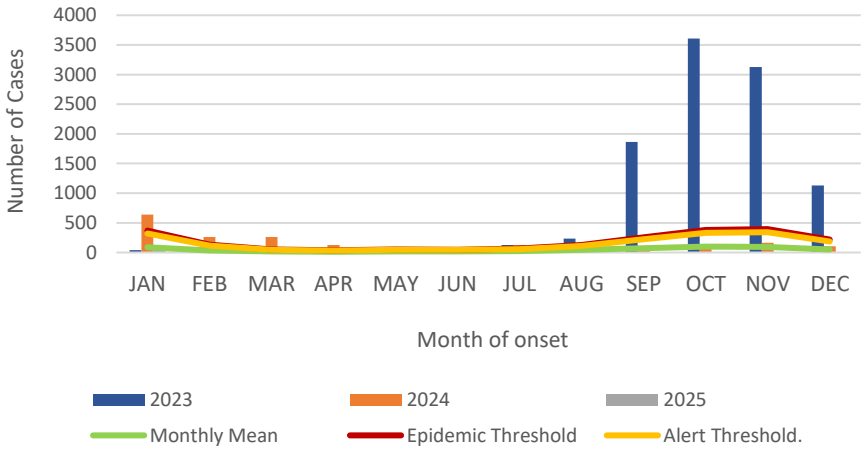
	2025*	
	EW 27	YTD
Total Suspected, Probable & Confirmed Dengue Cases	3	260
Lab Confirmed Dengue cases	0	0
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- **Dengue deaths are reported based on date of death.**
- ***Figure as at July 18 , 2025**
- **Only PCR positive dengue cases are reported as confirmed.**
- **IgM positive cases are classified as presumed dengue.**

Suspected, probable and confirmed dengue cases for 2023-2025 versus monthly mean, alert and epidemic threshold (2007-2022)



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RESEARCH PAPER

Abstract

NHRC-23-P13

Enablers and barriers of public healthcare access for people with serious mental illness and chronic physical illnesses in Jamaica

Whitehorne-Smith P[1], Lalwani K[2], Martin R[3], Mitchell G[1], Abel W[2], Milbourn, Burns S[1]

[1]Curtin University, Western Australia, Australia, [2]University of the West Indies, Mona, Jamaica, [3]RMIT University, Victoria, Australia

Objective: This study explored the enablers and barriers to public healthcare access for people with serious mental illnesses (PWSMI) and chronic physical illnesses (CPI) from the viewpoint of health professionals as well as service users and their caregivers in Jamaica.

Methods: This was a qualitative study, which utilised a constructivist, grounded theory approach to gather and analyse data. Fifty-seven participants were engaged in the study including, health policymakers, primary care physicians, psychiatrists, mental health nurses, PWSMI & CPI, and their caregivers.

Results: Enablers and barriers to healthcare access were present based across a socio-ecological model consisting of five levels, namely the wider society, health system, clinician, family and community, and individual levels. The presence of a free public healthcare system was the most prominent enabler of healthcare access for PWSMI & CPI, while, poverty, stigma, and discrimination were the most pronounced barriers. Factors such as time; clinician beliefs, attitudes and training; social support, and individual characteristics were identified as both enablers and barriers to healthcare access.

Conclusion: The findings of the study revealed that the factors that shape healthcare access for PWSMI & CPI in Jamaica were largely socially based. An improvement in healthcare access for PWSMI & CPI necessitates strategies that incorporate a multi-sectoral approach to address social and environmental factors that bar healthcare access across all levels of the socio-ecological model.