WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Food Safety

Access to enough safe and nutritious food is key to sustaining life and promoting good health. Unsafe food containing harmful bacteria, viruses, parasites or chemical substances can cause more than 200 different diseases, ranging from diarrhoea to cancers. Around the world, an estimated 600 million – almost 1 in 10 people – fall ill after eating contaminated food each year, resulting in 420 000 deaths and the loss of 33 million healthy life years (DALYs). Food safety, nutrition and food security are closely linked. Unsafe food creates a vicious cycle of disease and malnutrition, particularly affecting infants, young children, elderly and the sick. In addition to contributing to food and nutrition security, a safe food supply also supports national economies, trade and tourism, stimulating sustainable development. The globalization of food trade, a growing world population, climate change and rapidly changing food systems have an impact on the safety of food.

Foodborne diseases impede socioeconomic development by straining health care systems and harming national economies, tourism and trade. The burden of foodborne diseases to public health and to economies has often been underestimated due to underreporting and difficulty to establish causal relationships between food contamination and resulting illness or death. Children under 5 years of age carry 40% of the foodborne disease burden, with 125 000 deaths every year. The consumption and production of safe food have immediate and long-term benefits for people, the planet and the economy. Safe food is essential to human health and well-being, only food that is safe can be traded. Safe food allows for the uptake of nutrients and promotes long-term human development. When food is not safe, humans cannot develop, and the Sustainable Development Goals cannot be achieved. The 2019 World Bank report on the economic burden of the foodborne diseases indicated that US$ 110 billion is lost each year in productivity and medical expenses resulting from unsafe food in low- and middle-income countries. Unsafe or contaminated food leads to trade rejections, economic losses and food loss and waste, while safe food production improves economic opportunities by enabling market access and productivity.

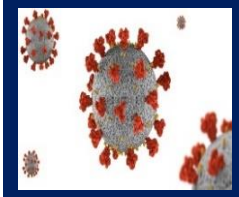
Promoting safe food handling

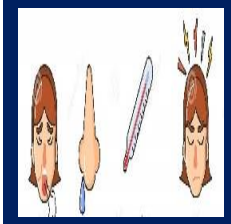
1. Keep clean
2. Separate raw and cooked
3. Cook thoroughly
4. Keep food at safe temperatures
5. Use safe water and raw materials

These are “Five keys to safer food”, which were developed to educate safe food handling behaviours to all consumers and food handlers. Each year, 1 in 10 people get ill by eating unsafe food. While food safety is a shared responsibility, individual consumers and food handlers play a huge role in preventing foodborne diseases. “Five keys to safer food” messages were therefore developed, and validated by an independent body of international scientists in 2001, to empower all consumers worldwide with a simple and applicable set of actions to prevent foodborne diseases.

Taken from WHO website on 13/Aug/2025
https://www.who.int/health-topics/food-safety#tab=tab_1
https://www.who.int/health-topics/food-safety#tab=tab_2
https://www.who.int/activities/promoting-safe-food-handling

EPI WEEK 31





ISSN 0799-3927

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 – 28 to 31 of 2025

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

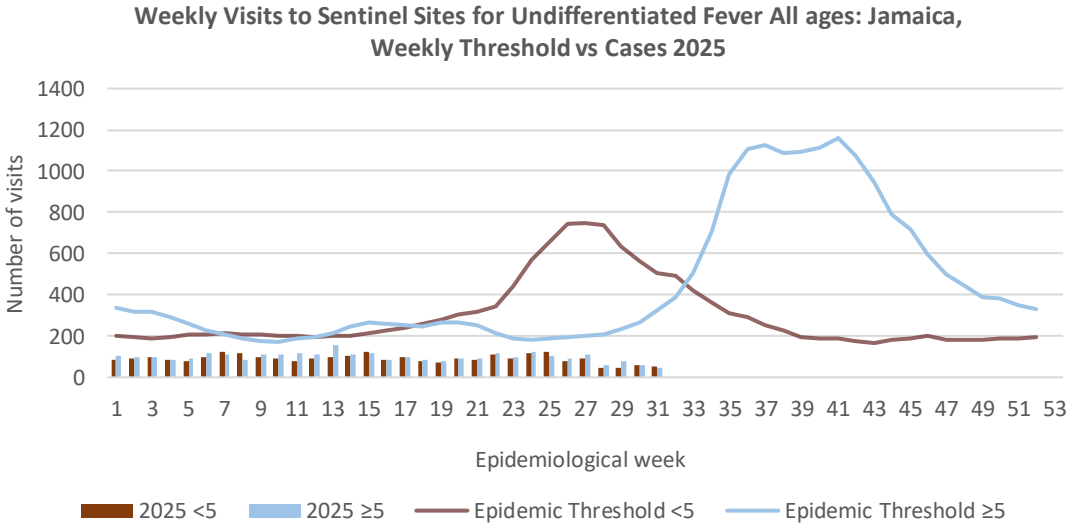
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday

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													
28	Late (T)	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time
29	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
30	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
31	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.



2 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

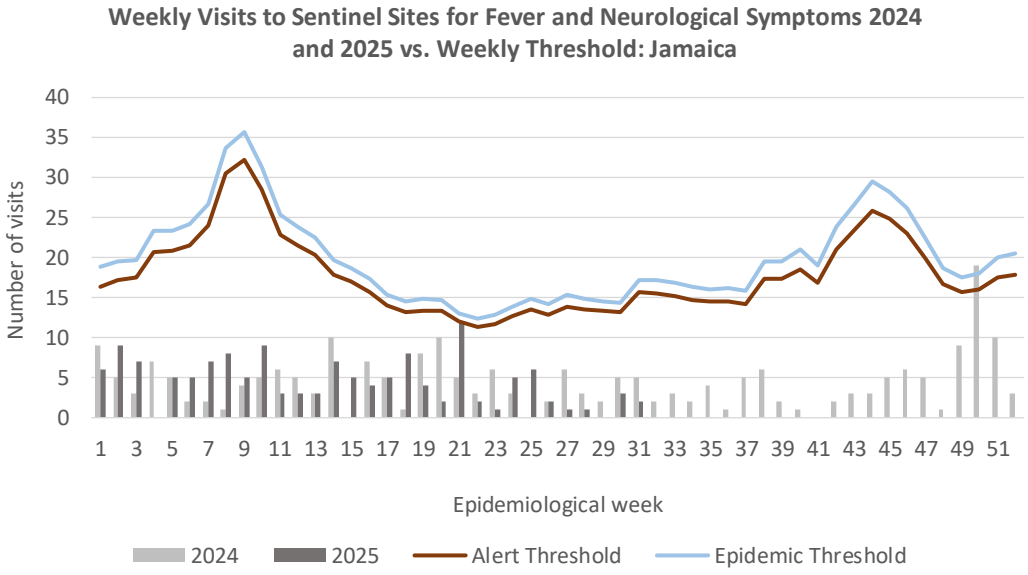
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

ISSN 0799-3927

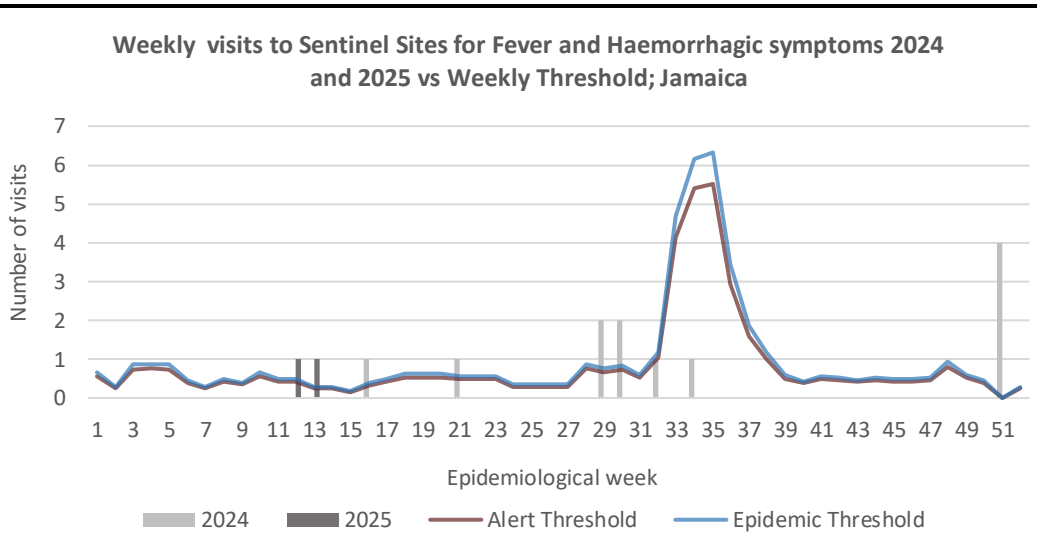
FEVER AND NEUROLOGICAL

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

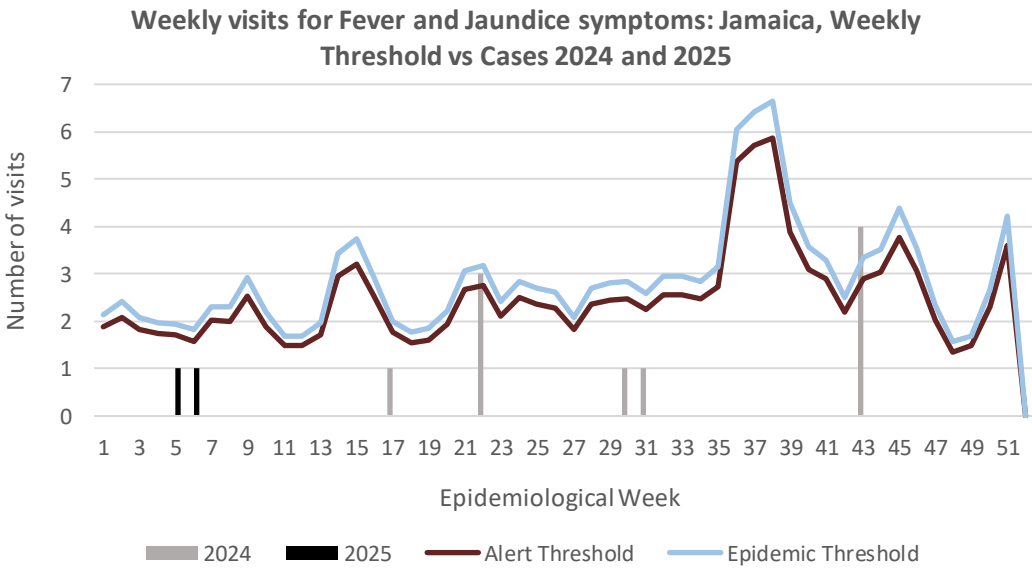
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

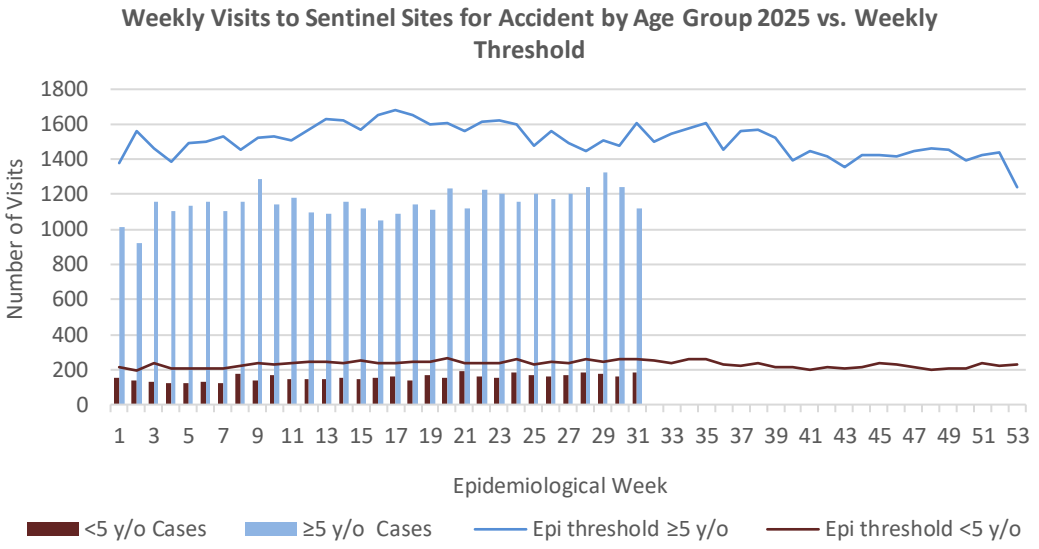
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

ISSN 0799-3927

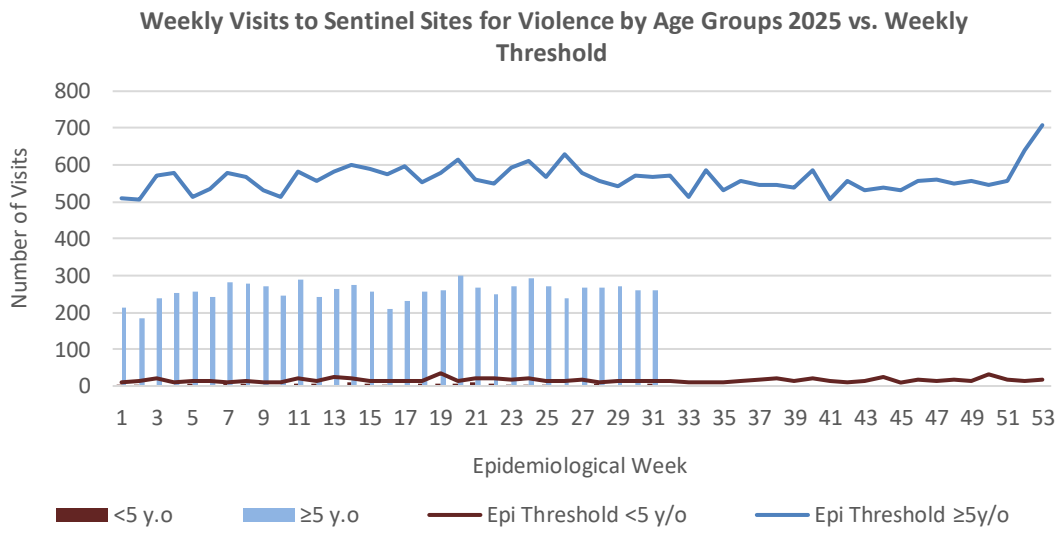
ACCIDENTS

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



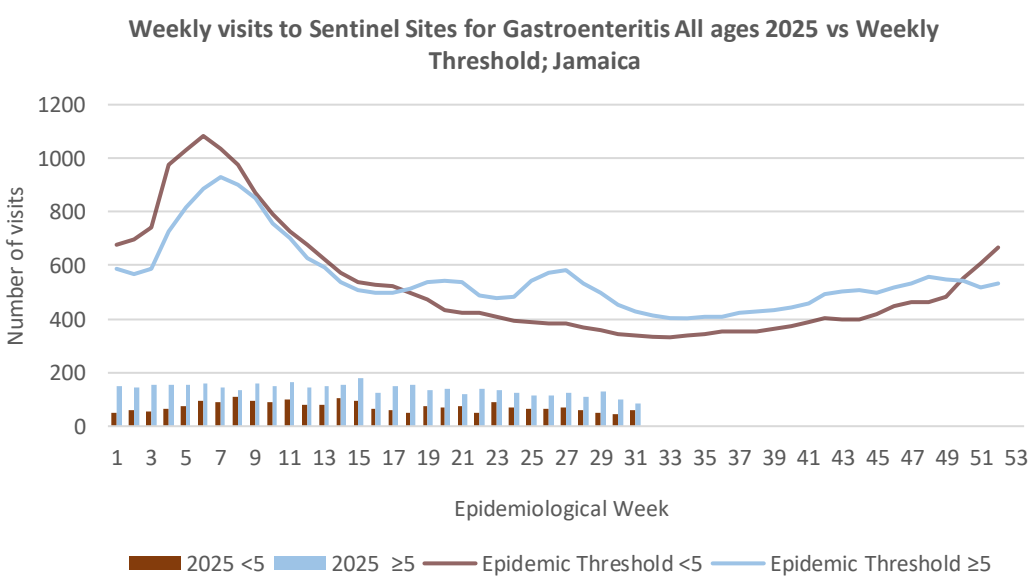
VIOLENCE

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.



4 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

ISSN 0799-3927

CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS		Confirmed YTD[α] CURRENT YEAR 2025	PREVIOUS YEAR 2024
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		84[β]	228[β]
	Cholera		0	0
	Severe Dengue[Y]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		271	548
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		3	30
	Hepatitis C		1	8
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis		8	13
	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]		33	41
	Ophthalmia Neonatorum		33	124
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		2	0
	Tuberculosis		21	33
	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.

[Y]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

NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

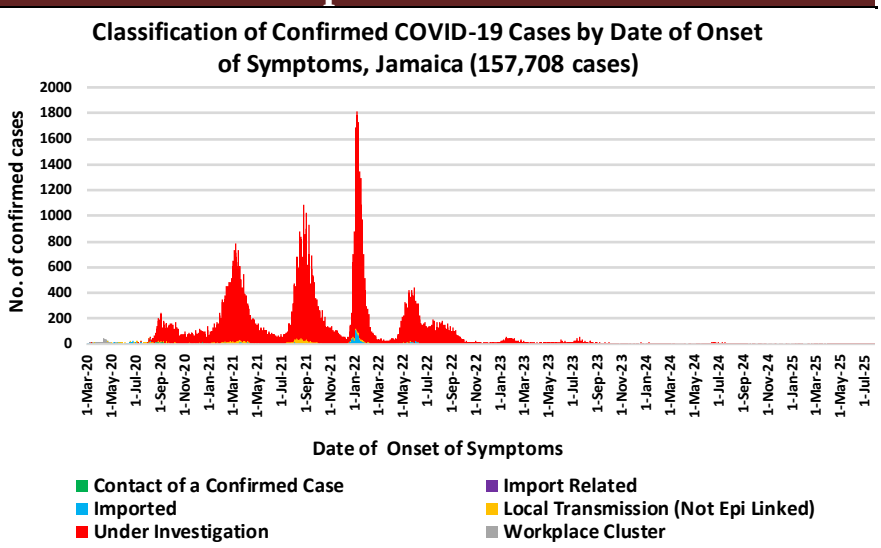
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

COVID-19 Surveillance Update

CASES	EW 31	Total
Confirmed	8	157708
Females	1	90857
Males	7	66848
Age Range	5 years to 73 years	1 day to 108 years

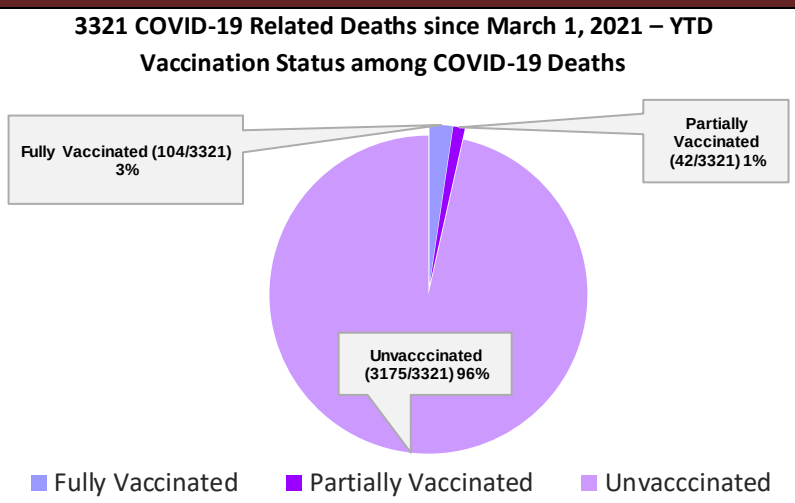
* 3 positive cases had no gender specification
* PCR or Antigen tests are used to confirm cases
* Total represents all cases confirmed from 10 Mar 2020 to the current Epi-Week.



COVID-19 Outcomes

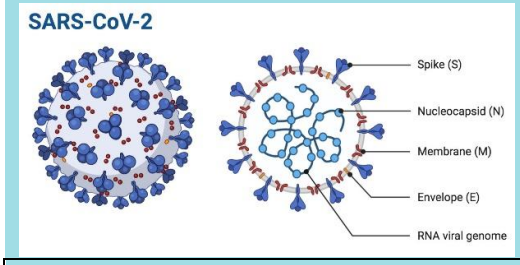
Outcomes	EW 31	Total
ACTIVE *2 weeks*		14
DIED – COVID Related	0	3885
Died - NON COVID	0	400
Died - Under Investigation	0	142
Recovered and discharged	0	103226
Repatriated	0	93
Total		157708

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



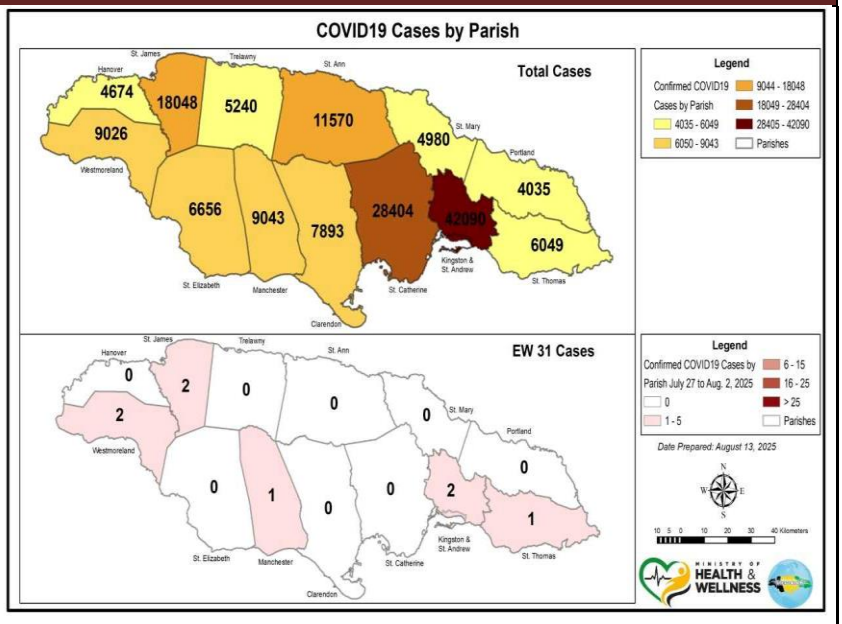
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 28 -31 2025

Epi Week	Confirmed Cases	Deaths
28	39800	251
29	9100	228
30	9400	201
31	22500	166
Total (4weeks)	**80800**	**846**



6 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

August 15, 2025 ISSN 0799-3927

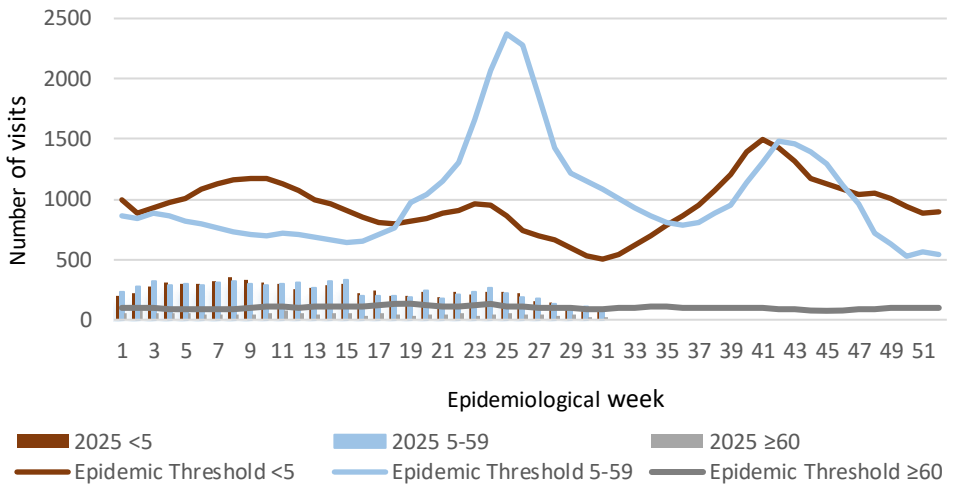
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 31

July 27, 2025 – August 2, 2025 Epidemiological Week 31

	EW 31	*YTD*
SARI cases	4	281
Total Influenza positive Samples	**0**	**169**
Influenza A	**0**	**145**
H1N1pdm09	0	78
H3N2	0	67
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

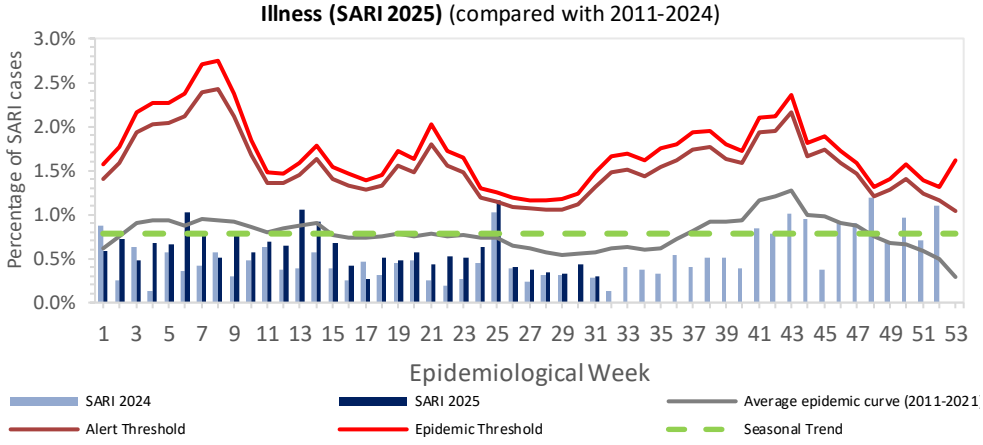
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 31, four(4) SARI admissions were reported.

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

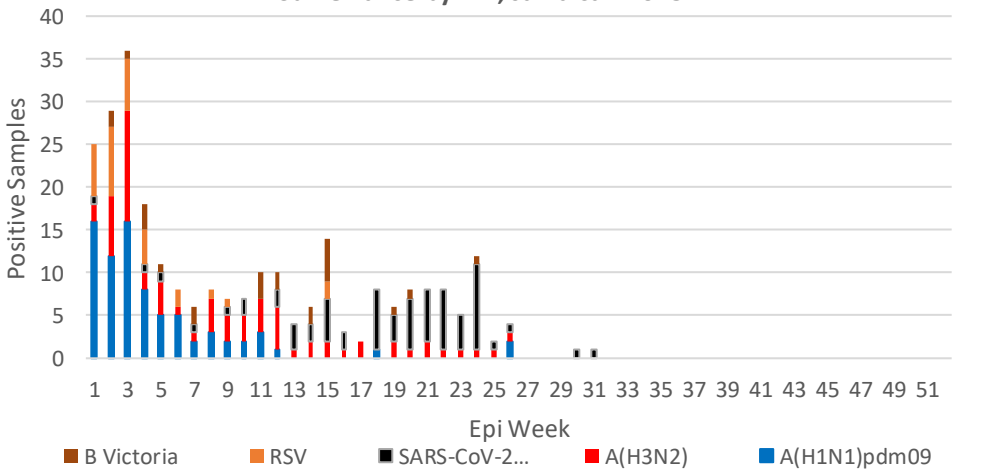


Caribbean Update EW 31

Influenza activity, primarily driven by A(H1N1)pdm09, declined in the latest EW, with a subregional positivity rate of 14.4%. In Haiti and Belize, influenza activity remains at epidemic levels. In contrast, in Cuba, Jamaica, Barbados and the Dominican Republic, it continues at interseasonal levels. In Guyana, influenza activity decreased compared to the previous EW. RSV circulation is declining in the subregion, with a positivity rate of 6.9%, especially in Saint Lucia, Guyana and the Dominican Republic. SARS-CoV-2 activity increased compared to the previous week, with a subregional positivity rate of 16.8%. In Cuba, saint Lucia and Guyana, activity decreased. In Belize, the Dominican Republic, Haiti, Jamaica, Barbados and Saint Vincent and the Grenadines, positivity increased.

(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



7 NOTIFICATIONS- All clinical sites

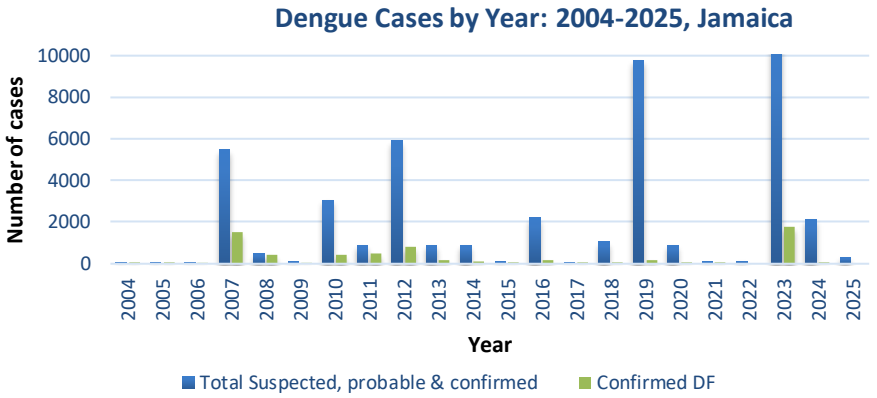
INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

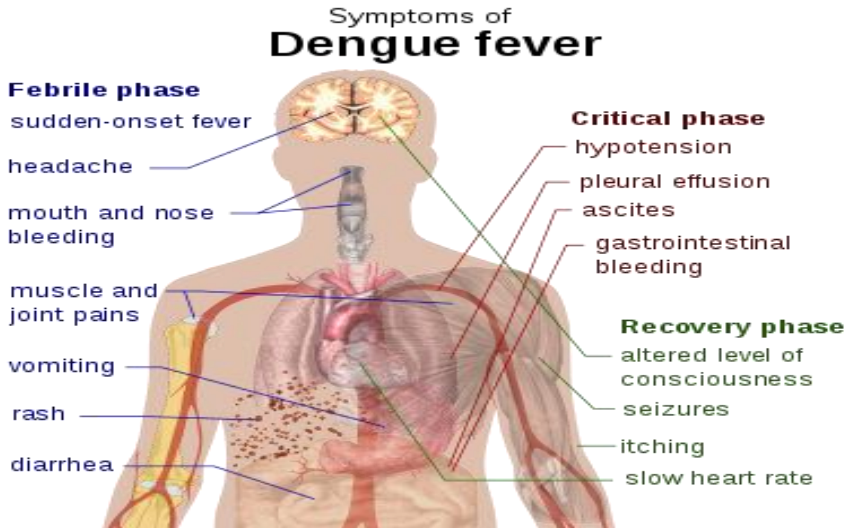
Dengue Bulletin

July 27, 2025 – August 2, 2025 Epidemiological Week 31 | Epidemiological Week 31



Reported suspected, probable and confirmed dengue with symptom onset in week 31 of 2025

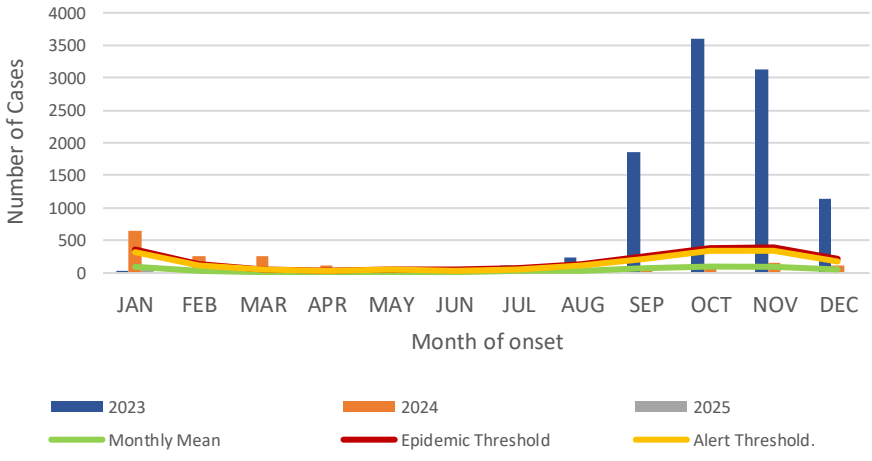
	2025*	
	EW 31	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	308
Lab Confirmed Dengue cases	0	0
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- **Dengue deaths are reported based on date of death.**
- ***Figure as at August 14, 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)



8 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

RESEARCH PAPER

Abstract

NHRC-23-O04

The Association between Social Factors and the Prevalence of Diabetes Mellitus in Urban Jamaica

McGrath, H[1], Blake AL[2], Guthrie-Dixon N[3], Williams A[1], McKenzie JA[3], Younger-Coleman NOM[3], Tulloch-Reid MK[3], Wilks RJ[3], Williams D[4], Ferguson TS[3]

[1]The University of the West Indies, Open Campus, [2] School of Clinical Medicine and Research, The Faculty of Medical Sciences, The University of theWest Indies, Mona, Nassau, The Bahamas,
[3]The Epidemiology Research Unit, Caribbean Institute for Health Research, The University of theWest Indies, Mona, Kingston, Jamaica, [4] Department of Social and Behavioral Sciences, Harvard T.H, School of Public Health, Boston,MA, USA

Objective: To evaluate the associations of social support, education, and community property value with prevalent diabetes mellitus (DM) in urban Jamaica.

Methods: A secondary cross-sectional analysis was conducted using data collected in 2018 – 2019 from the Cardiovascular Health in Urban Communities Study. Height, weight, blood pressure and fasting blood glucose were measured. Education, doctor-diagnosed diabetes and hypertension were self-reported. Data on community property value were obtained from the National Land Agency. Social support (SS) was determined from responses on the number of friends: 1) in their social network, 2) willing to offer a small loan, and 3) who provide advice. Summary statistics and prevalence estimates were determined. Multivariable logistic regressionwas used to assess the association between social factors and prevalent DM. Statistical significance was defined as $p<0.05$.

Results: The analyzed sample consisted of 763 participants (512 females, 251 males) with mean(SD) age of 47.9 (18.3) years. Overall prevalence of DM was 17.5% (95% CI: 15%-20%). Males whoattained more than high school education were less likely to have DM (OR=0.24; p=0.028). Among females; older age (OR=1.03; p=0.001), higher BMI (OR=1.03; p=0.007), and hypertension (OR=3.40; p=0.001) were associated with higher odds of DM. No associations were found with SSor community property value.

Conclusion: Higher educational attainment was inversely associated with DM in urban Jamaica, but social factors such as community property value and SS were not. Further researchis warranted to explore these associations in rural settings and their impact on other outcomes including diabetes complications and survivorship.

The Ministry of Health and Wellness
15 Knutsford Boulevard, Kingston 5, Jamaica
Tele: (876) 633-7924
Email: surveillance@moh.gov.jm