WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Foodborne Diseases

Over 200 diseases are caused by eating food contaminated with bacteria, viruses, parasites or chemical substances such as heavy metals. This growing public health problem causes considerable socioeconomic impact through strains on health-care systems, lost productivity, and harming tourism and trade. These diseases contribute significantly to the global burden of disease and mortality. Foodborne diseases are caused by contamination of food and occur at any stage of the food production, delivery and consumption chain. They can result from several forms of environmental contamination including pollution in water, soil or air, as well as unsafe food storage and processing.

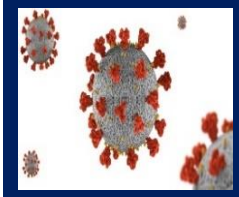
Foodborne diseases encompass a wide range of illnesses from diarrhoea to cancers. Most present as gastrointestinal issues, though they can also produce neurological, gynaecological and immunological symptoms. Diseases causing diarrhoea are a major problem in all countries of the world, though the burden is carried disproportionately by low- and middle-income countries and by children under 5 years of age.

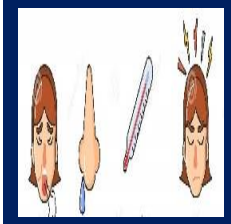
Every year, nearly one in 10 people around the world fall ill after eating contaminated food, leading to over 420 000 deaths. Children are disproportionately affected, with 125 000 deaths every year in people under 5 years of age. The majority of these cases are caused by diarrhoeal diseases. Other serious consequences of foodborne diseases include kidney and liver failure, brain and neural disorders, reactive arthritis, cancer, and death.

Foodborne diseases are closely linked to poverty in low- and middle-income countries but are a growing public health issue around the world. Increasing international trade and longer, more complex food chains increase the risk of food contamination and the transport of infected food products across national borders. Growing cities, climate change, migration and growing international travel compound these issues and expose people to new hazards.

Taken from WHO website on 18/Aug/2025
https://www.who.int/health-topics/foodborne-diseases#tab=tab_1
https://www.who.int/health-topics/foodborne-diseases#tab=tab_2
https://stock.adobe.com/search?k=food+poisoning&asset_id=196917858 (picture)

EPI WEEK 32





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 – 29 to 32 of 2025

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

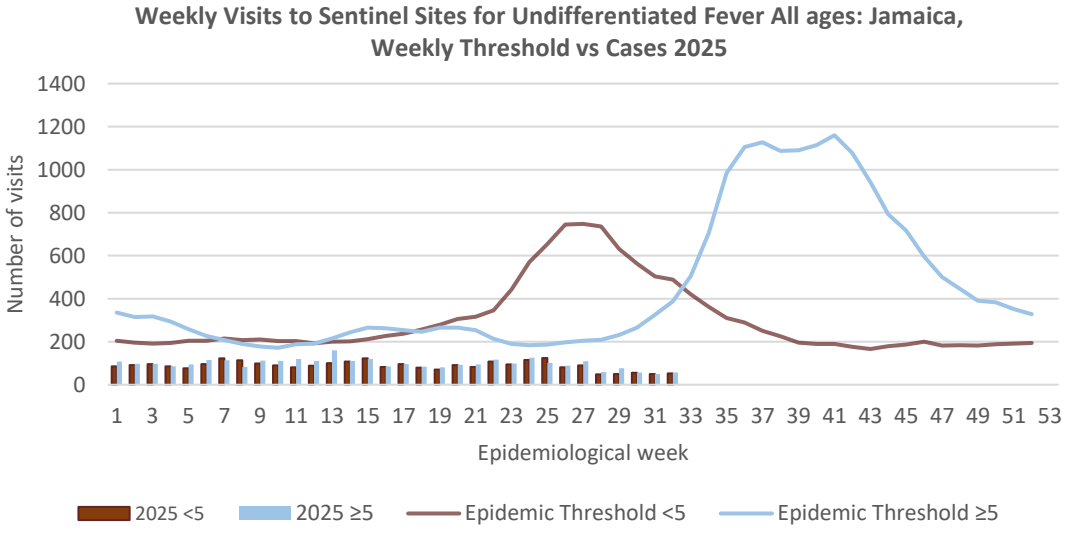
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday

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													
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
32	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

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

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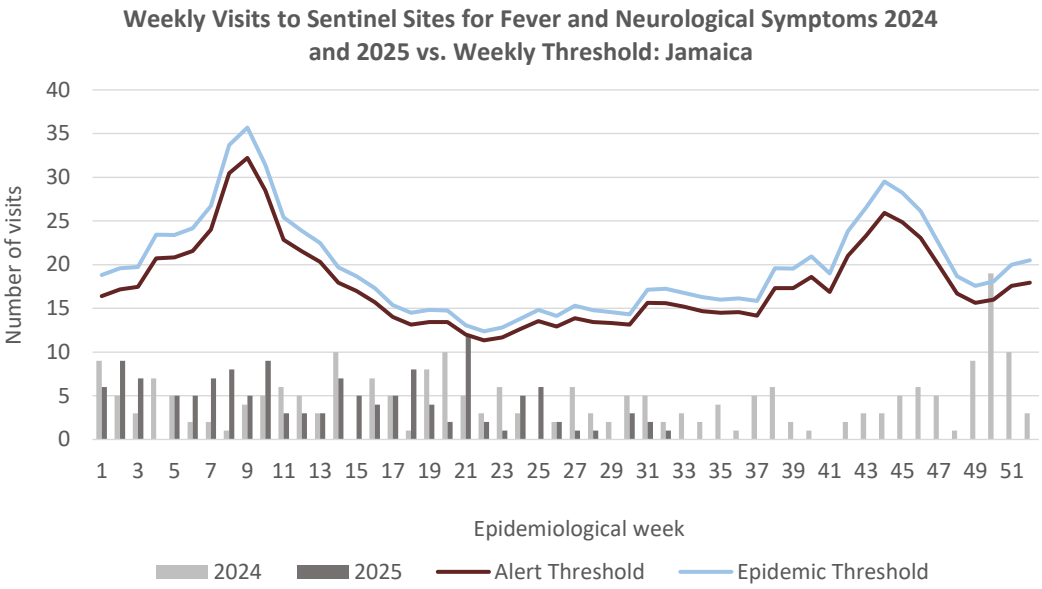
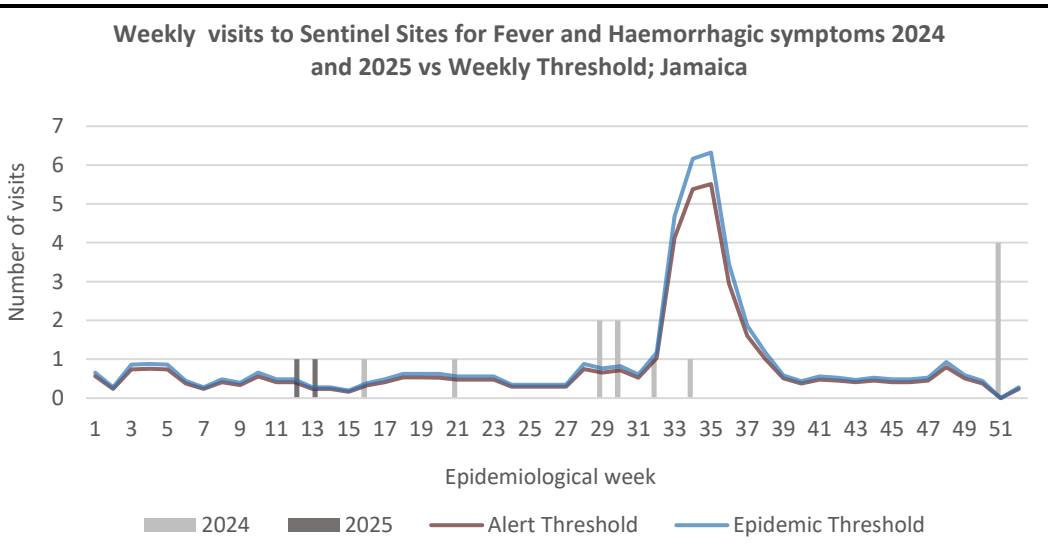
FEVER AND NEUROLOGICAL

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

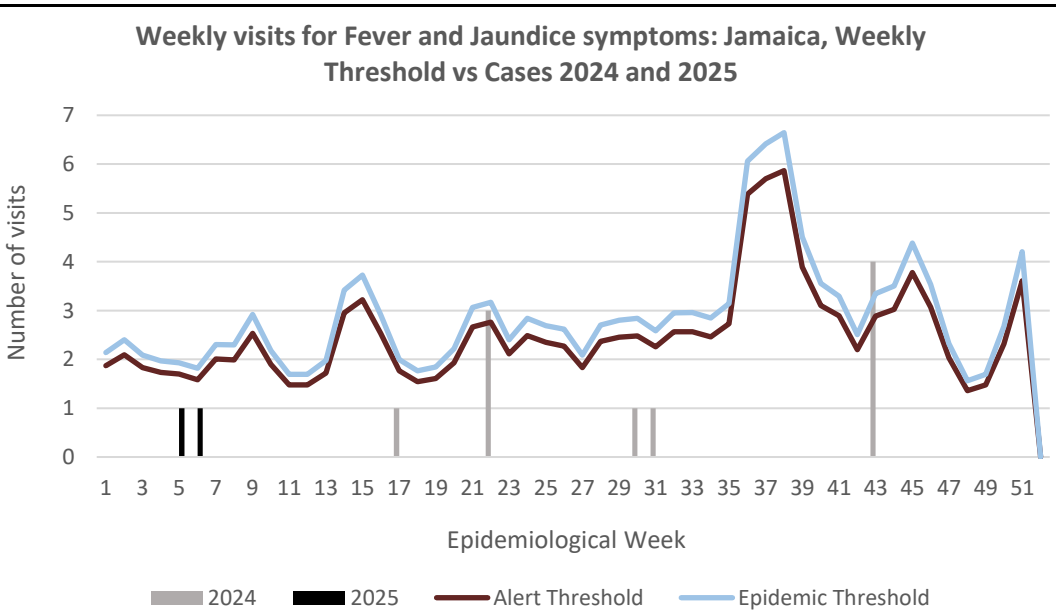
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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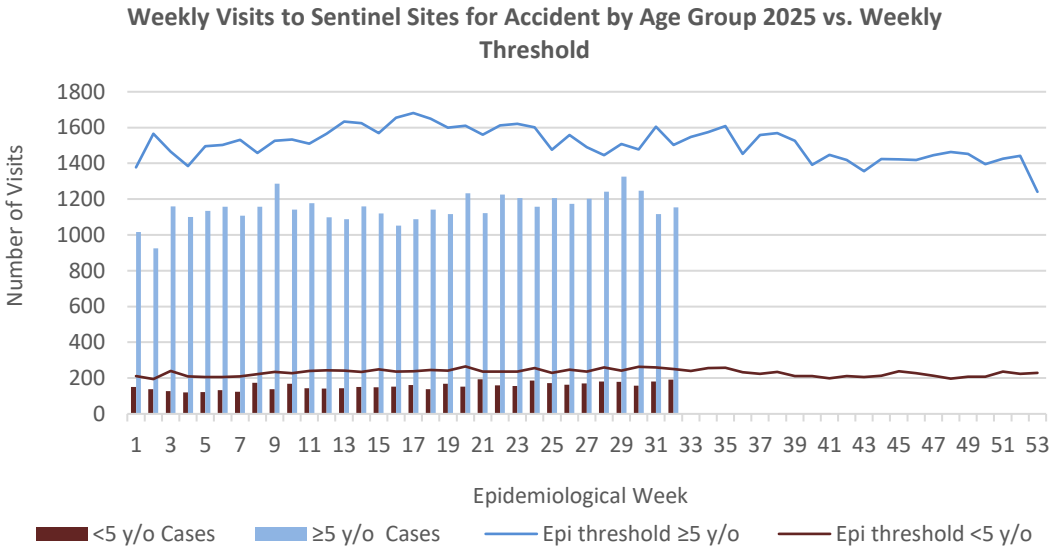
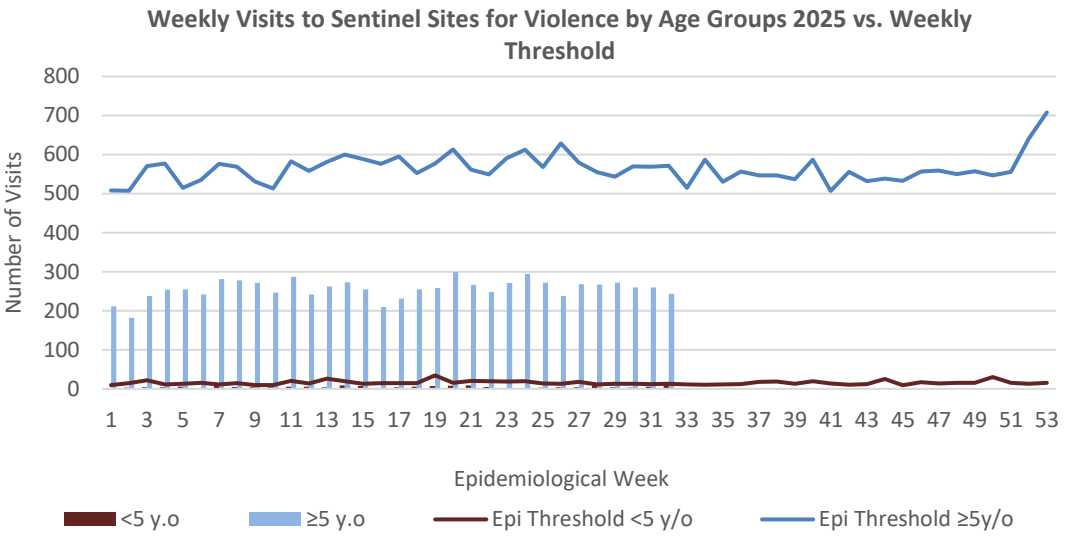
ACCIDENTS

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



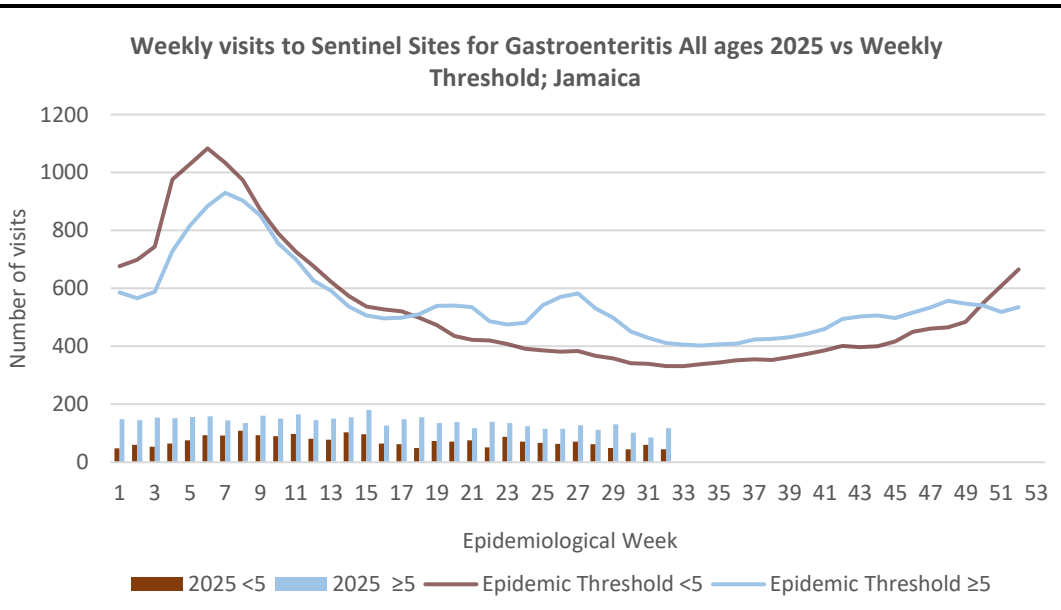
VIOLENCE

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		84[β]	234[β]
	Cholera		0	0
	Severe Dengue[Y]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		273	570
	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]		37	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

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

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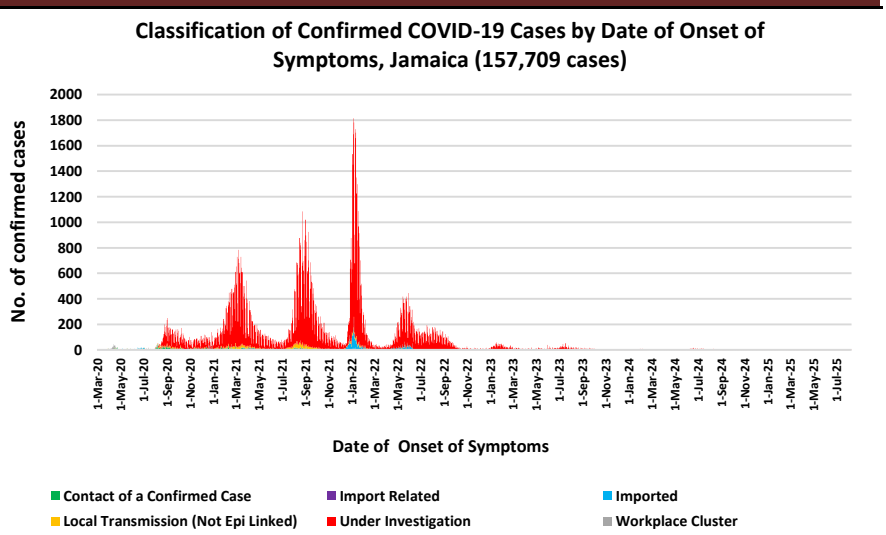
COVID-19 SURVEILLANCE

CASES	EW 32	Total
Confirmed	5	157709
Females	2	90857
Males	3	66849
Age Range	9 months to 57 years	1 day to 108 years

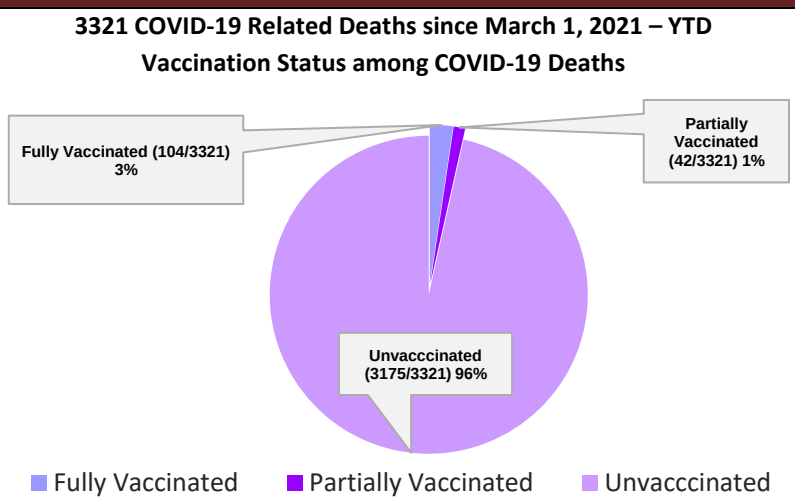
* 3 positive cases had no gender specification
* PCR or Antigen tests are used to confirm cases
* Total represents all cases confirmed from 10 Mar 2020 to the current Epi-Week.



COVID-19 Outcomes

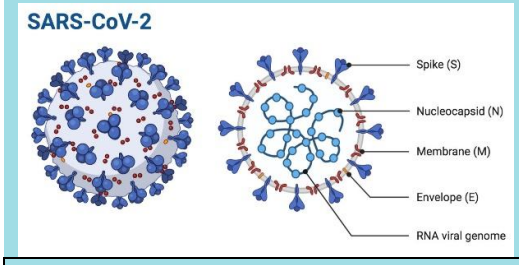
Outcomes	EW 32	Total
ACTIVE *2 weeks*		13
DIED – COVID Related	0	3885
Died - NON COVID	0	400
Died - Under Investigation	0	142
Recovered and discharged	0	103226
Repatriated	0	93
Total		157709

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



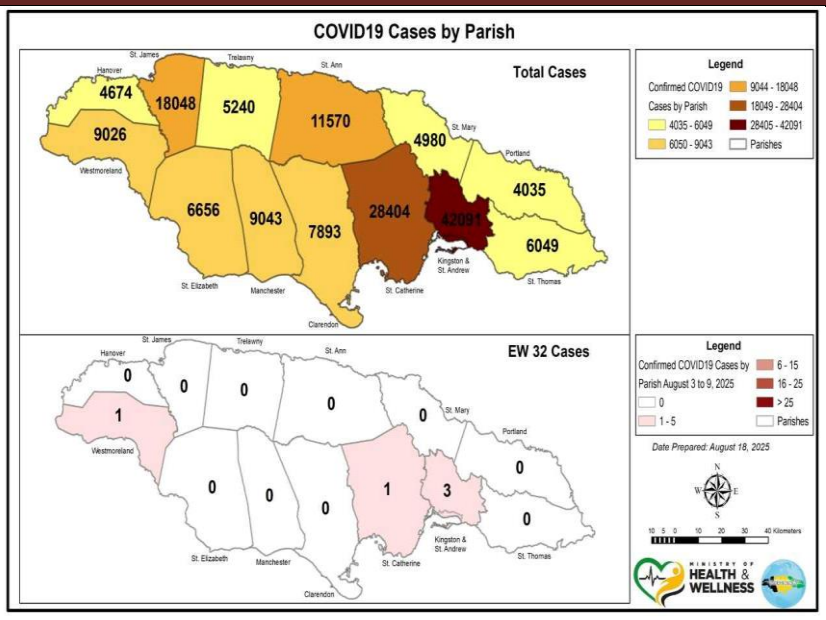
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 29 -32 2025

Epi Week	Confirmed Cases	Deaths
29	9100	228
30	9400	201
31	22500	166
32	13700	203
Total (4weeks)	**54700**	**798**



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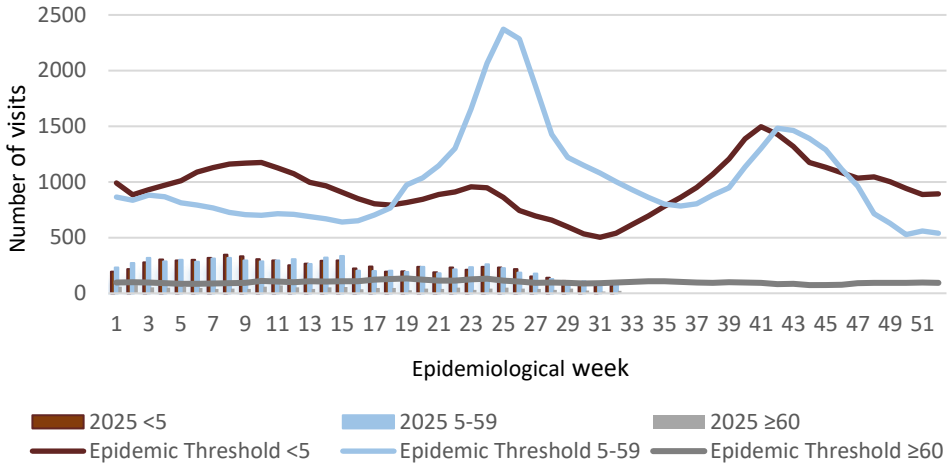
INFLUENZA SURVEILLANCE

EW 32

August 3, 2025 – August 9, 2025 Epidemiological Week 32

	EW 32	*YTD*
SARI cases	1	282
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

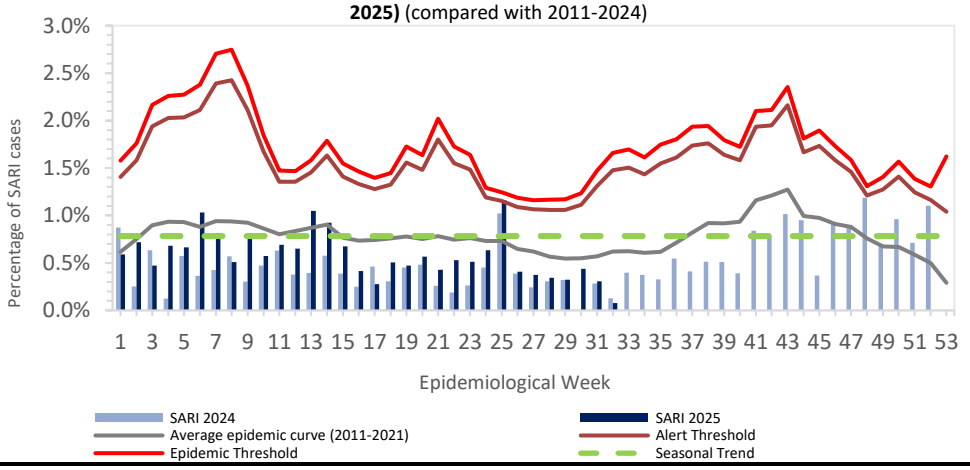
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 32, one (1) SARI admissions was reported.

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

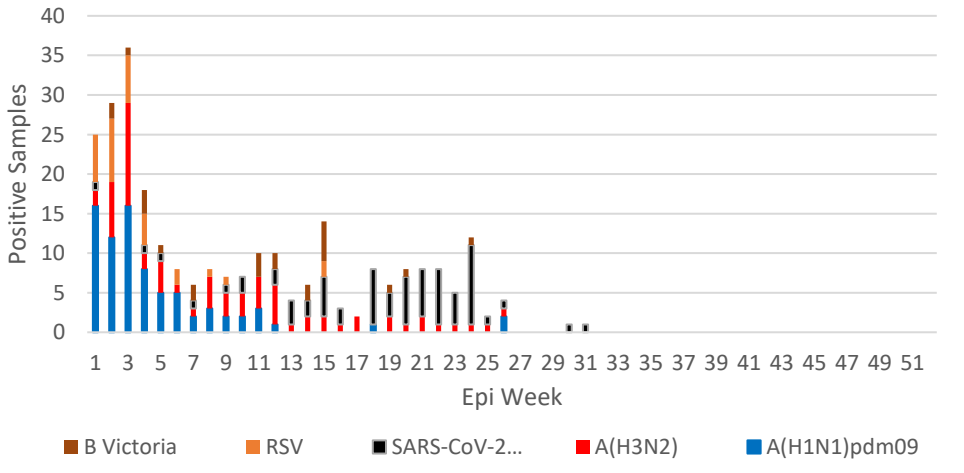


Caribbean Update EW 32

Influenza activity, primarily driven by A(H1N1)pd09, declined in the latest EW, with a subregional positivity rate of 11.8%. 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 remains stable across the subregion with a positivity rate of 6.7%, however, circulation increased in Belize, Saint Lucia, Barbados and Guyana compared to the previous EW. SARS-CoV-2 activity continues to trend upwards, with a subregional positivity rate of 20%. In Belize, 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



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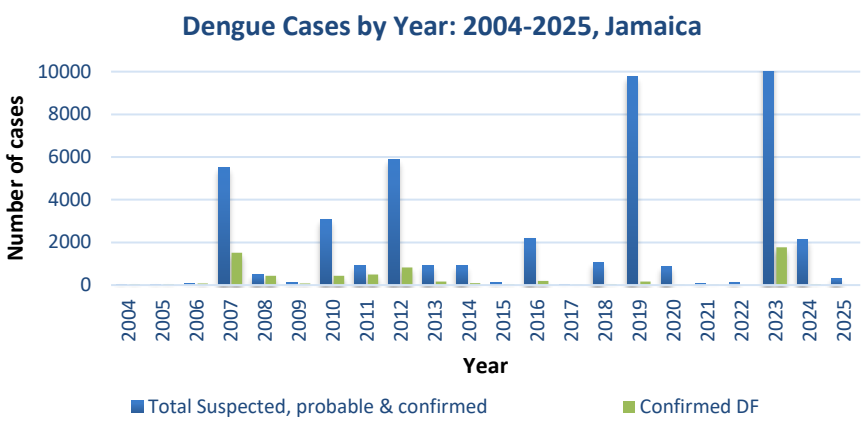
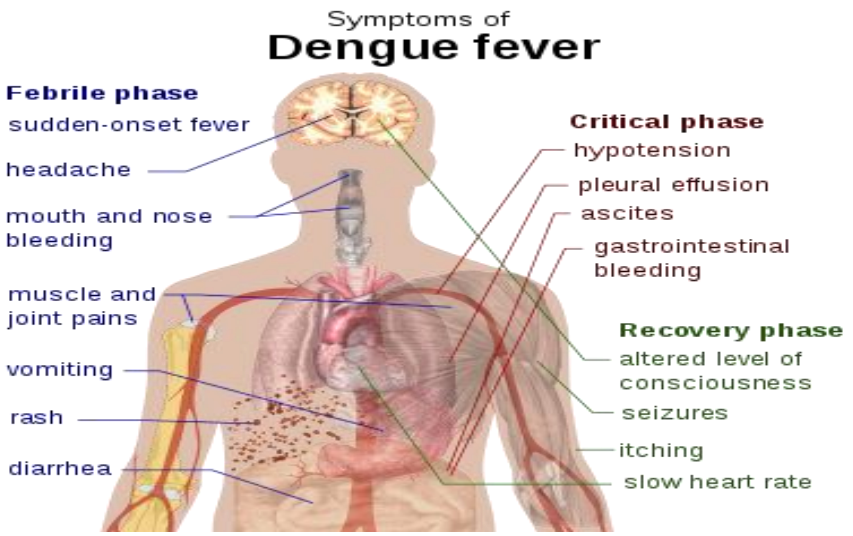
DENGUE SURVEILLANCE

August 3, 2025 – August 9, 2025 Epidemiological Week 32 | Epidemiological Week 32



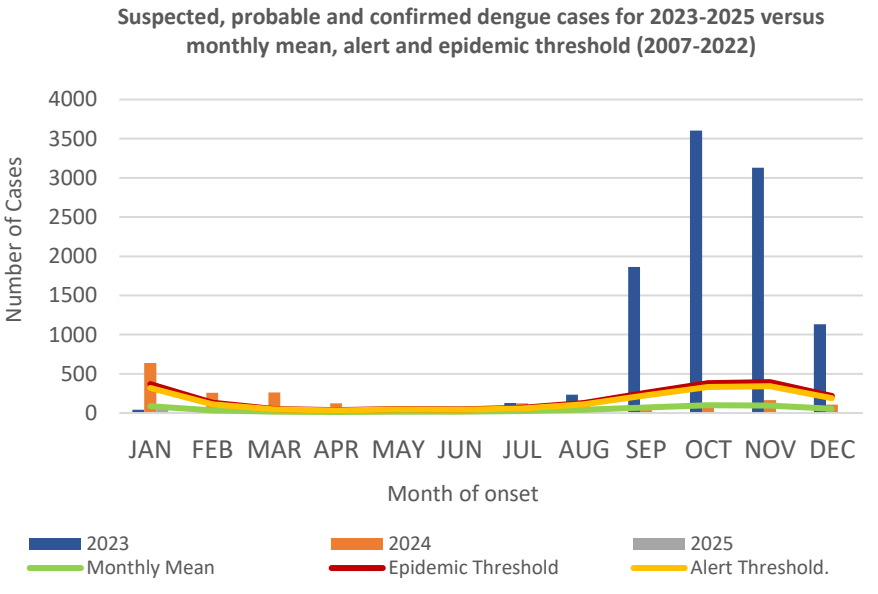
Reported suspected, probable and confirmed dengue with symptom onset in week 32 of 2025

	2025*	
	EW 32	YTD
Total Suspected, Probable & Confirmed Dengue Cases	5	313
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 20, 2025**
- **Only PCR positive dengue cases are reported as confirmed.**
- **IgM positive cases are classified as probable dengue.**



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RESEARCH ABSTRACT

Abstract

NHRC-23-O05

The relationship between social determinants (socioeconomic status, and access to food), and medication adherence and lifestyle practices among persons with hypertension in Colombia and Jamaica

[1]Bennett N, [2]Duncan J, [2]Bailey A, [3]Hahne M, [3]Mills K, [3]Whelton P, [4]Anderson A, [5]Natacha Lanza Mora P, [5]Otero J, [5]Castaneda Hernandez A, [5]Lopez Jaramillo J, [4]Lopez-Lopez J, [6]Williams M, [6]Tutse-Tonwe V, [1]Ferguson T, [1]Tulloch-Reid M.

[1]Caribbean Institute for Health Research, The University of the West Indies, Mona, Jamaica; [2]Department of Community Health and Psychiatry, The University of the West indies, Mona, Jamaica; [3]Department of Epidemiology, Tulane University School of Public Health and Tropical Medicine, New Orleans, USA; [4]University of Alabama at Birmingham, Birmingham, AL USA [5] Masira Research Institute, Universidad de Santander, Colombia; [6] Center for Translation Research and Implementation Science, National Heart, Lung and Blood Institute (NHLBI), NIH, Bethesda, Maryland, USA;

Objectives: To examine associations between food insecurity and medication adherence and healthy lifestyle practices among hypertensive patients in Colombia and Jamaica

Methods: A Cross-sectional survey of hypertensive patients in primary care clinics using interviewer-administered-questionnaires was conducted. Medication adherence was measured using the IMPACT-MAS questionnaire and patients classified as having high or low/medium adherence. Unfavourable (≤2points) or favourable (≥3 points) lifestyle was on a 5-point scale–1 point for eating less salt, exercising regularly, none or were reducing alcohol consumption, adequate fruits (≥2 servings) and vegetables (≥3 servings) daily. Patients were food insecure based on a modified USDA food security instrument if there was uncertainty about money for food or their ability to obtain healthy foods. Logistic regression was used to assess the relationship between food insecurity and low/medium medication adherence & unfavourable lifestyle practices.

Results: Of the 576 participants (50% Colombian, 31% male), Columbian patients were older (64.6 vs 62.5 years), had higher educational attainment and longer duration of hypertension. They also reported lower levels of food-insecurity (63.8% vs 70.1% p=<0.0001), better medication adherence (88% vs. 50.7% p=<0.0001) and more favorable lifestyle adherence scores (86.2% vs 47.2% p<0.0001). When adjusting for age, sex, country, employment, and hypertension duration those who were food-insecure had increased odds of unfavourable lifestyle adherence OR 2.0[95%CI(1.2 3.5)] but there was no association with medication adherence.

Conclusion: Food-insecure participants had increased odds of unfavourable lifestyle adherence but not medication adherence. Understanding the role of food-insecurity in hypertensive patients is critical to improving their health outcomes.

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