

WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Influenza (avian and other zoonotic) (Part 2)



Human infections with avian and other zoonotic influenza viruses, though rare, have been reported sporadically. Direct or indirect contact with infected animals represent a risk for human infection. Current zoonotic influenza viruses have not demonstrated sustained person-to-person transmission.

For avian influenza viruses, the primary risk factor for human infection appears to be exposure to infected live or dead poultry or contaminated environments, such as live bird markets. Slaughtering, defeathering, handling carcasses of infected poultry, and preparing poultry for consumption, especially in household settings, are also likely to be risk factors. There is no evidence to suggest that A(H5), A(H7N9) or other avian influenza viruses can be transmitted to humans through properly prepared and cooked poultry or eggs. A few influenza A(H5N1) human cases have been linked to consumption of dishes made with raw contaminated poultry blood.

In 1997, human infections with A(H5N1) viruses were reported during an outbreak in poultry in Hong Kong SAR, China. Since 2003, this virus has spread in bird populations from Asia to Europe and Africa, and to the Americas in 2021, and has become endemic in poultry populations in many countries. Outbreaks have resulted in millions of poultry infections, several hundred human cases, and many human deaths. Human cases have been reported mostly from countries in Asia, but also from countries in Africa, the Americas and Europe.

In 2013, human infections with A(H7N9) viruses were reported for the first time in China. The virus spread in the poultry population across the country and resulted in over 1500 reported human cases and many human deaths from 2013 to 2019. No further human cases have been reported to WHO since 2019. Since 2014, sporadic human infections with avian influenza A(H5N6) viruses have been reported almost exclusively from China. Other avian influenza viruses have resulted in sporadic human infections.

Taken from WHO website on 07/Oct/2025

[https://www.who.int/news-room/fact-sheets/detail/influenza-\(avian-and-other-zoonotic\)](https://www.who.int/news-room/fact-sheets/detail/influenza-(avian-and-other-zoonotic))

<https://www.who.int/news-room/fact-sheets/detail/influenza-%28avian-and-other-zoonotic%29> (picture)

EPI WEEK 39



Syndromic Surveillance

Accidents

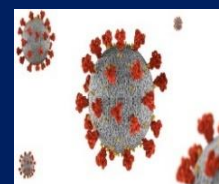
Violence

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Class 1 Notifiable Events

Page 5



COVID-19 Surveillance

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Influenza Surveillance

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Dengue Surveillance

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Research Abstract

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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 – 35 to 38 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													
36	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
37	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
38	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
39	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

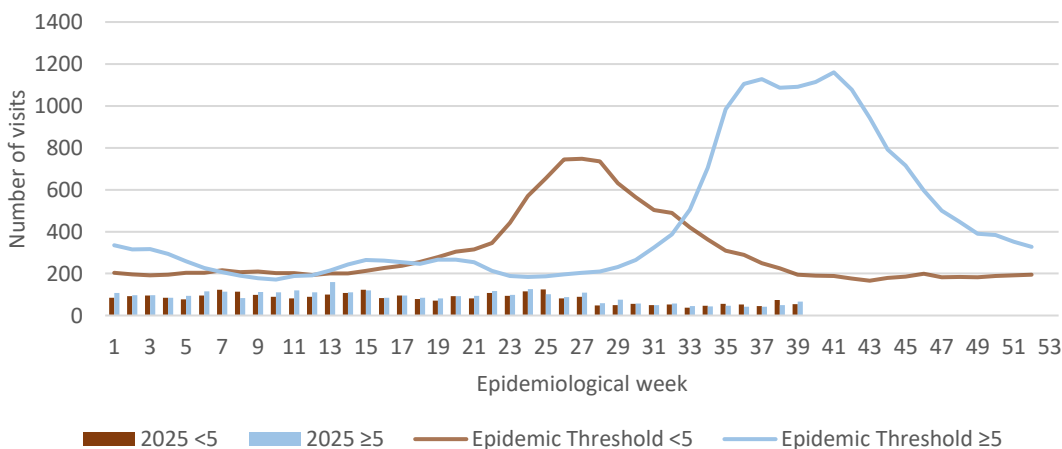
SYNDROMIC SURVEILLANCE

UNDIFFERENTIATED FEVER

Temperature of $>38^{\circ}\text{C}$ / 100.4°F (or recent history of fever) with or without an obvious diagnosis or focus of infection.



Weekly Visits to Sentinel Sites for Undifferentiated Fever All ages: Jamaica, Weekly Threshold vs Cases 2025



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NOTIFICATIONS-
All clinical
sites



INVESTIGATION
REPORTS- Detailed Follow
up for all Class One Events



HOSPITAL
ACTIVE
SURVEILLANCE-
30 sites. Actively
pursued



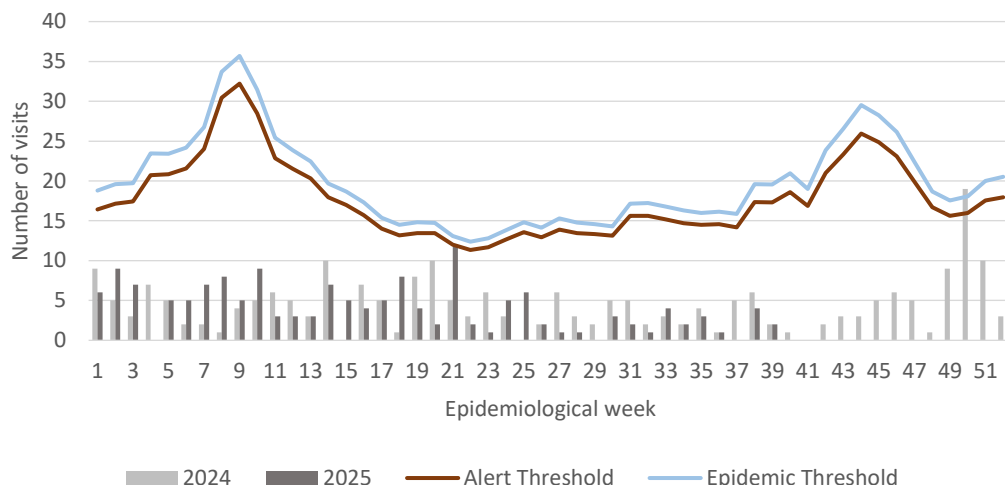
SENTINEL
REPORT- 78 sites.
Automatic reporting

FEVER AND NEUROLOGICAL

Temperature of $>38^{\circ}\text{C}$ / 100.4°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).



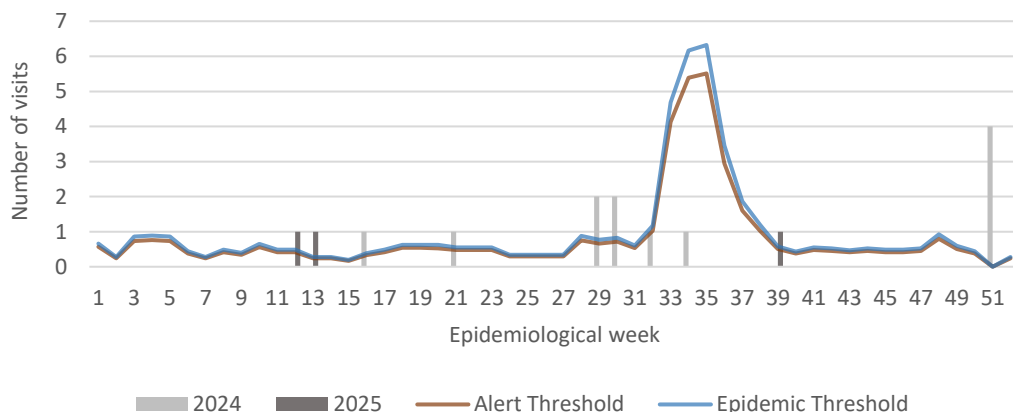
Weekly Visits to Sentinel Sites for Fever and Neurological Symptoms 2024 and 2025 vs. Weekly Threshold: Jamaica

**FEVER AND HAEMORRHAGIC**

Temperature of $>38^{\circ}\text{C}$ / 100.4°F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



Weekly visits to Sentinel Sites for Fever and Haemorrhagic symptoms 2024 and 2025 vs Weekly Threshold; Jamaica

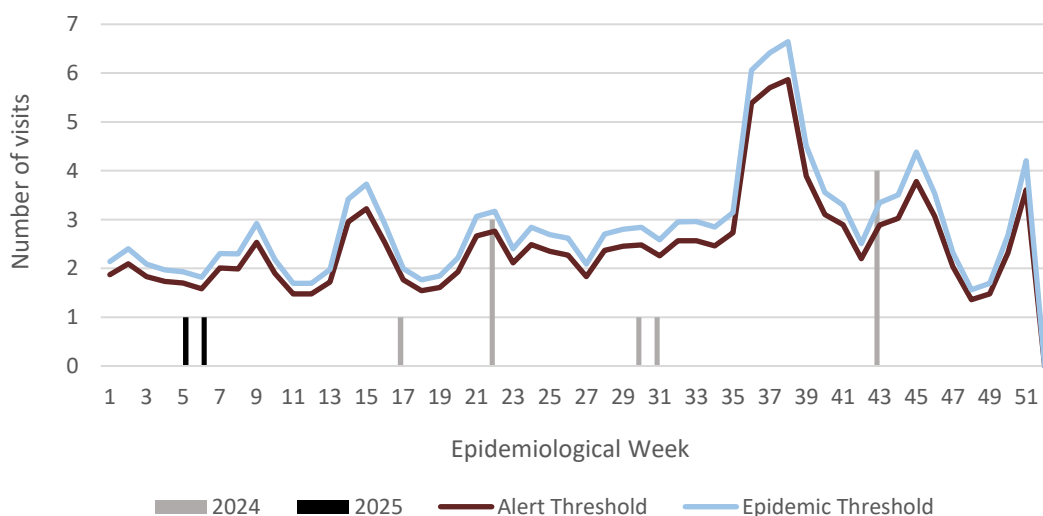
**FEVER AND JAUNDICE**

Temperature of $>38^{\circ}\text{C}$ / 100.4°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.



Weekly visits for Fever and Jaundice symptoms: Jamaica, Weekly Threshold vs Cases 2024 and 2025



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NOTIFICATIONS-
All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued



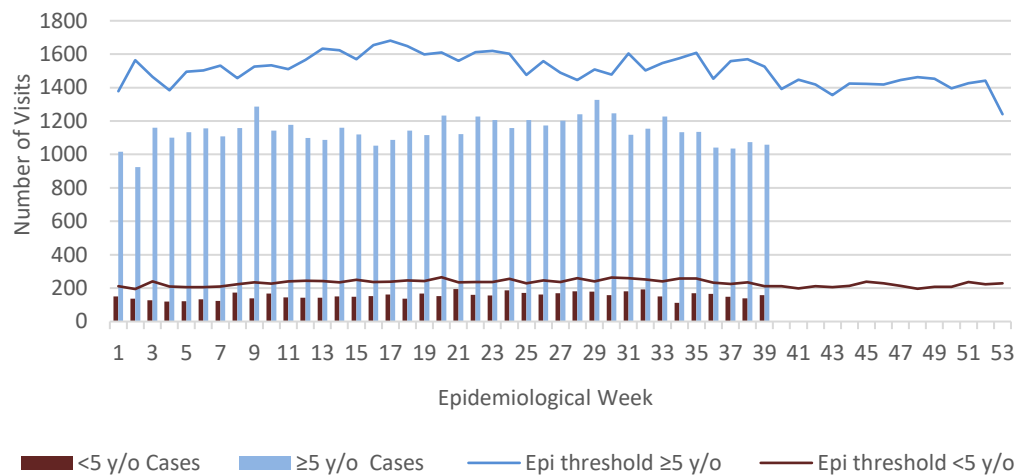
SENTINEL REPORT- 78 sites. Automatic reporting

ACCIDENTS

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



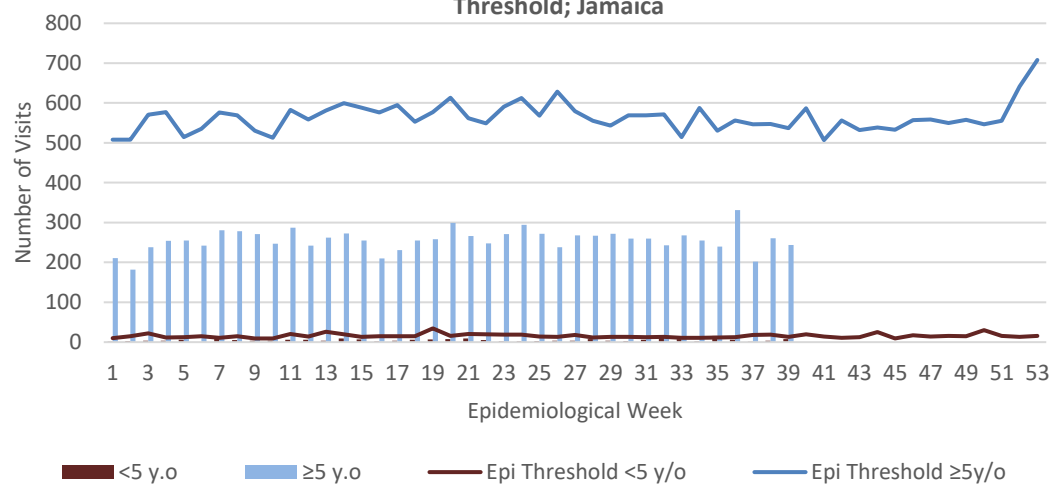
Weekly Visits to Sentinel Sites for Accident by Age Group 2025 vs. Weekly Threshold

**VIOLENCE**

Any injury for which the cause is intentional, e.g. gunshot wounds, stab wounds, etc.



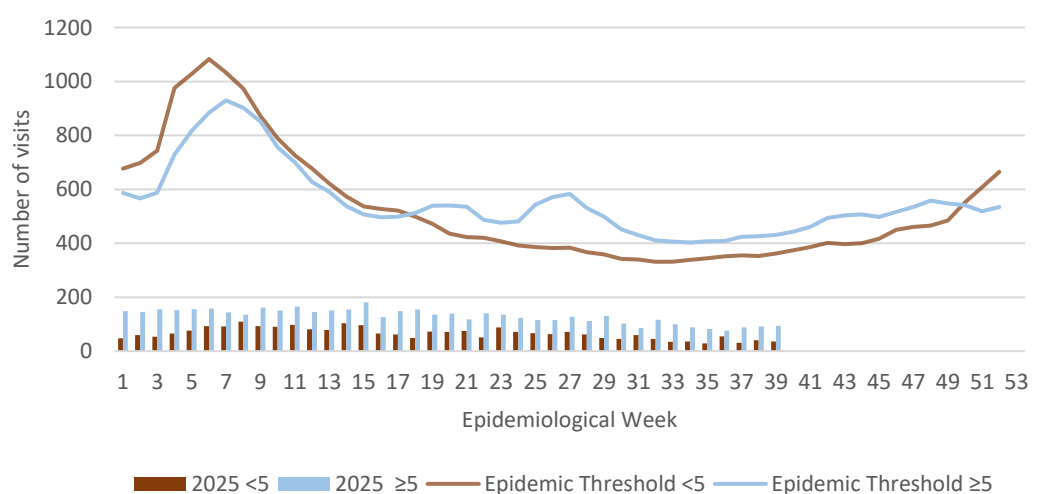
Weekly Visits to Sentinel Sites for Violence by Age Groups 2025 vs. Weekly Threshold; Jamaica

**GASTROENTERITIS**

Inflammation of the stomach and intestines, typically resulting from bacterial toxins or viral infection and causing vomiting and diarrhoea.



Weekly visits to Sentinel Sites for Gastroenteritis All ages 2025 vs Weekly Threshold; Jamaica



4 NOTIFICATIONS-
All clinical
sites



INVESTIGATION
REPORTS- Detailed Follow
up for all Class One Events



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ACTIVE
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30 sites. Actively
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SENTINEL
REPORT- 78 sites.
Automatic reporting

CLASS ONE NOTIFIABLE EVENTS					Comments	
			Confirmed YTD ^α		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.	
	CLASS 1 EVENTS		CURRENT YEAR 2025	PREVIOUS YEAR 2024		
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		106 ^β	254 ^β	Pertussis-like syndrome and Tetanus are clinically confirmed classifications.	
	Cholera		0	0		
	Severe Dengue ^γ		See Dengue page below	See Dengue page below		
	COVID-19 (SARS-CoV-2)		302	656	^γ Dengue Hemorrhagic Fever data include Dengue related deaths;	
	Hansen’s Disease (Leprosy)		0	0		
	Hepatitis B		5	35		
	Hepatitis C		1	9	^δ Figures include all deaths associated with pregnancy reported for the period.	
	HIV/AIDS		NA	NA		
	Malaria (Imported)		1	2		
	Meningitis		11	17	^ε CHIKV IgM positive cases	
	Monkeypox		1	0		
EXOTIC/ UNUSUAL	Plague		0	0		
HIGH MORBIDITY/ MORTALITY	Meningococcal Meningitis		0	0	^θ Zika PCR positive cases	
	Neonatal Tetanus		0	0		
	Typhoid Fever		0	0		^β Updates made to prior weeks.
	Meningitis H/Flu		0	0		
SPECIAL PROGRAMMES	AFP/Polio		0	0	^α Figures are cumulative totals for all epidemiological weeks year to date.	
	Congenital Rubella Syndrome		0	0		
	Congenital Syphilis		0	0		
	Fever and Rash	Measles	0	0		
		Rubella	0	0		
	Maternal Deaths ^δ		45	52		
	Ophthalmia Neonatorum		35	148		
	Pertussis-like syndrome		0	0		
	Rheumatic Fever		0	0		
	Tetanus		2	0		
	Tuberculosis		39	38		
	Yellow Fever		0	0		
	Chikungunya ^ε		0	0	NA- Not Available	
	Zika Virus ^θ		0	0		



5 NOTIFICATIONS-
All clinical
sites



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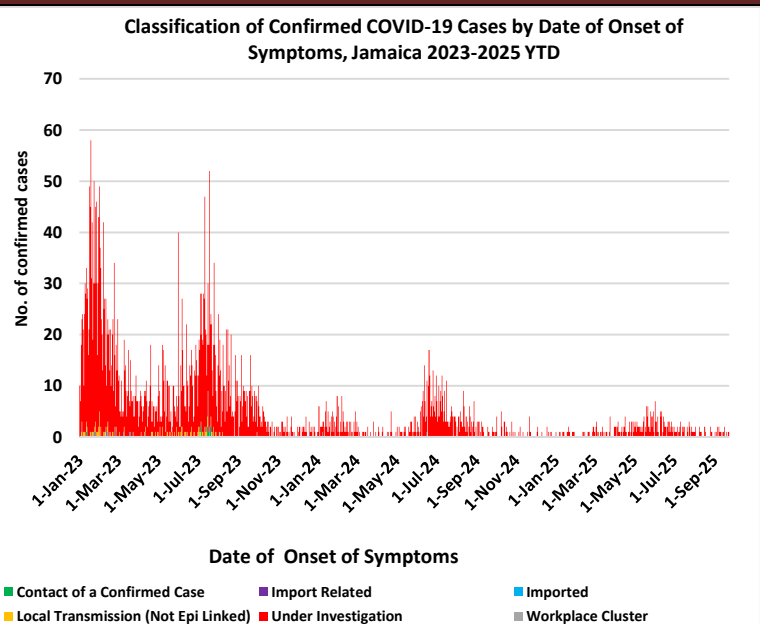


SENTINEL
REPORT- 78 sites.
Automatic reporting

COVID-19 SURVEILLANCE

CASES	EW 39	Total
Confirmed	4	157737
Females	3	90875
Males	1	66859
Age Range	0 days to 66 years	1 day to 108 years

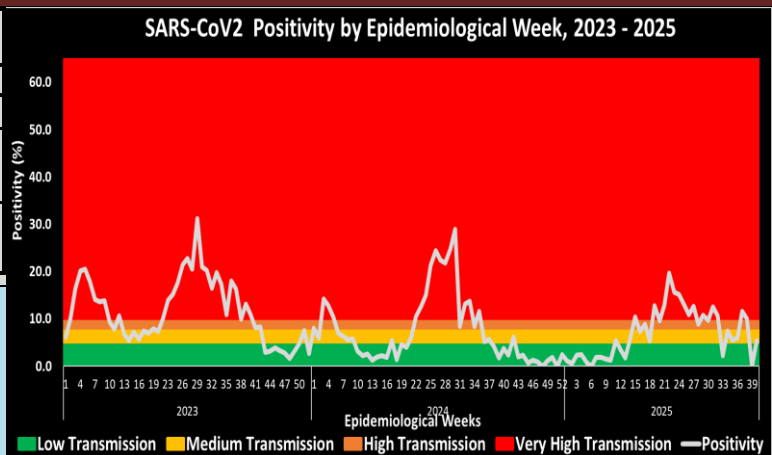
* 3 positive cases had no gender specification
 * PCR or Antigen tests are used to confirm cases
 * Total represents all cases confirmed from 10 Mar 2020 to the current Epi-Week.



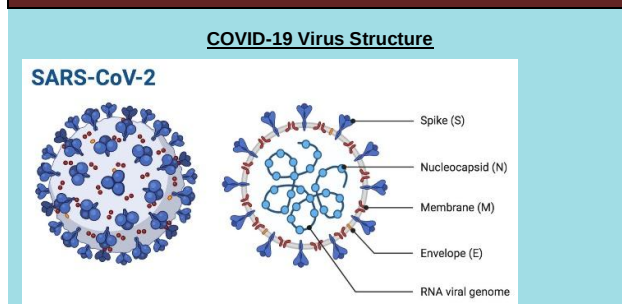
COVID-19 Outcomes

Number of Confirmed COVID-19 cases and deaths, Jamaica 2020-2025							
COVID-19	Year						
	2020	2021	2022	2023	2024	2025	Total
Cases	13352	83814	45920	3842	705	302	157737
Deaths	332	2790	620	111	24	13	3890

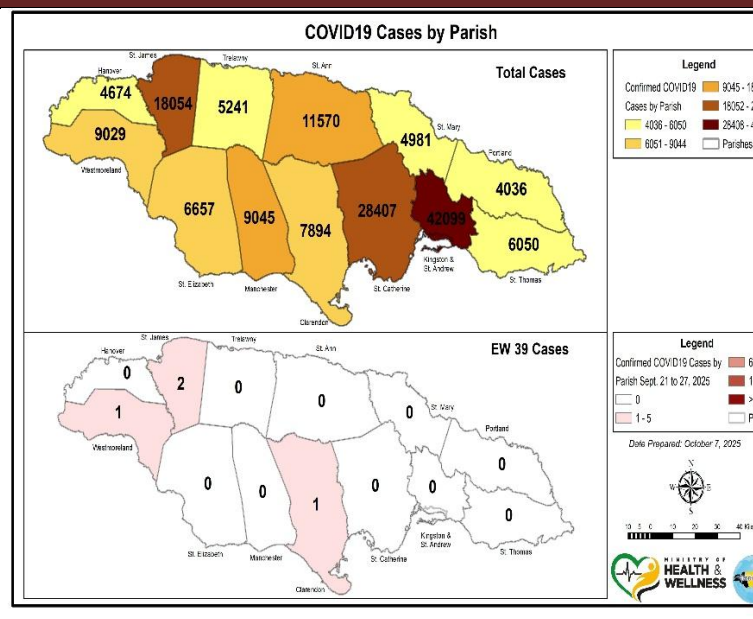
*Current positivity rate 5.4%
 - (positive samples/total samples tested)
 * Medium transmission for infection



COVID-19 Parish Distribution and Global Statistics



COVID-19 WHO Global Statistics EW 36 -39 2025		
Epi Week	Confirmed Cases	Deaths
36	28900	423
37	40800	485
38	37400	418
39	38500	273
Total (4weeks)	145600	1599



6 NOTIFICATIONS-
All clinical sites

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INFLUENZA SURVEILLANCE

EW 39

September 21, 2025 – September 27, 2025 Epidemiological Week 39

	EW 39	YTD
SARI cases	3	325
Total Influenza positive Samples	2	178
Influenza A	2	153
H1N1pdm09	2	82
H3N2	0	71
Not subtyped	0	0
Influenza B	0	25
B lineage not determined	0	0
B Victoria	0	25
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	30

Epi Week Summary

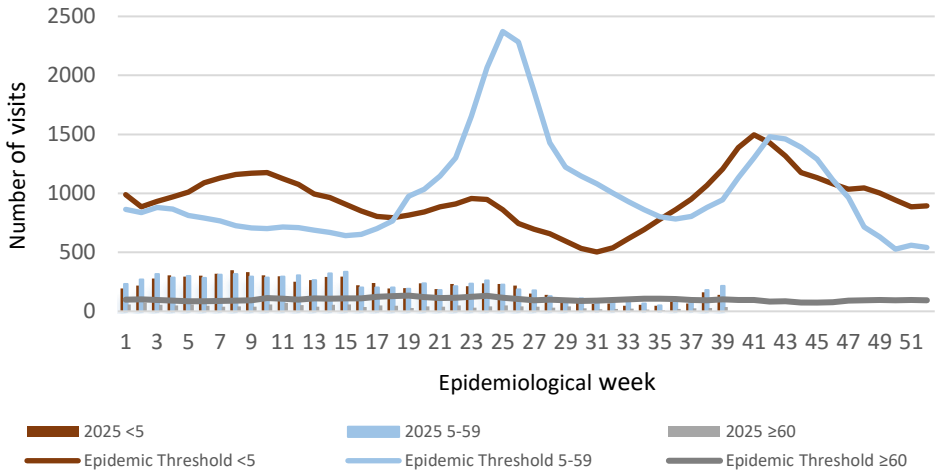
During EW 39, three (3) SARI admissions was reported.

Caribbean Update EW 39

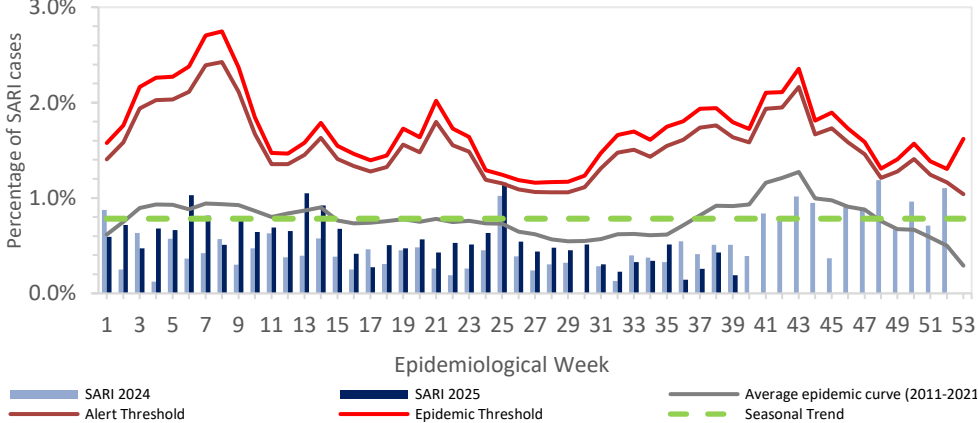
Influenza activity, primarily driven by subtype A(H1N1)pdm09, decreased in the last EW, with a subregional positivity rate of 6%. RSV circulation increased compared to the previous EW, reaching a positivity rate of 6.2%. Meanwhile, Sars-CoV-2 activity continues to decline, with a subregional positivity of 7%. SARI cases show a downward trend, mainly associated with influenza. In contrast, ILI cases present a slight increase, also predominantly linked to influenza. At the country level, influenza activity is at epidemic levels in Haiti, the Dominican Republic, and Belize, although showing a downward trend. In Cuba, Jamaica, and Guyana, activity increased compared to previous EW, with a positivity rates of 13.8%, 3.3%, and 2.8% respectively. Barbados, the Cayman Islands, and Saint Vincent and the Grenadines report low levels of circulation. Regarding RSV, circulation decreased in Cuba, Guyana, and Saint Lucia compared to the Previous EW. In Belize, Haiti, Suriname, and Saint Vincent and the Grenadines, it remains low, while increases are observed in the Dominican Republic, Barbados, and the Cayman Islands. As for SARS-CoV-2, activity decreased in Saint Lucia, Guyana, and Jamaica dring the last EW.

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

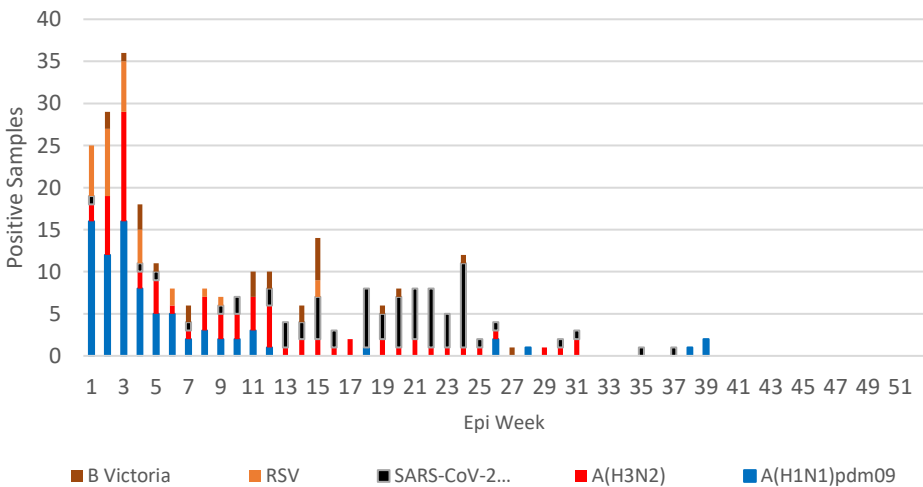
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages
2025 vs Weekly Threshold; Jamaica



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



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



7 NOTIFICATIONS-
All clinical
sites

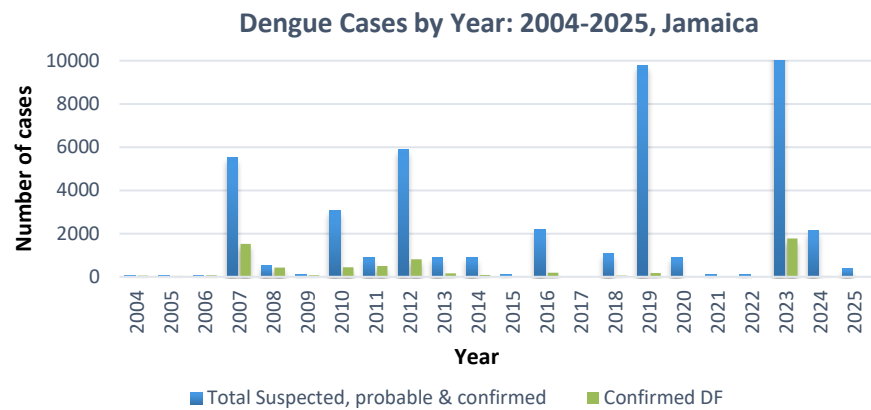
INVESTIGATION
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SENTINEL
REPORT- 78 sites.
Automatic reporting

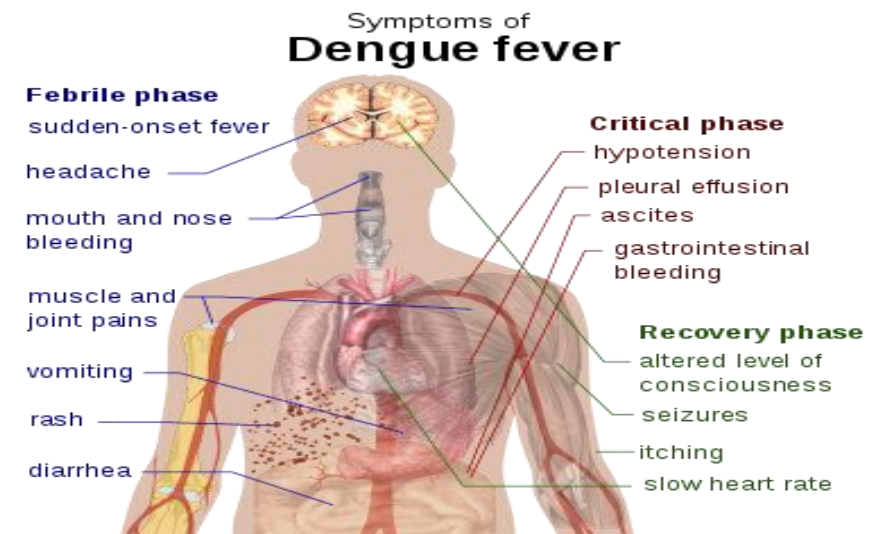
DENGUE SURVEILLANCE

September 21, 2025 – September 27, 2025 Epidemiological Week 39 Epidemiological Week 39

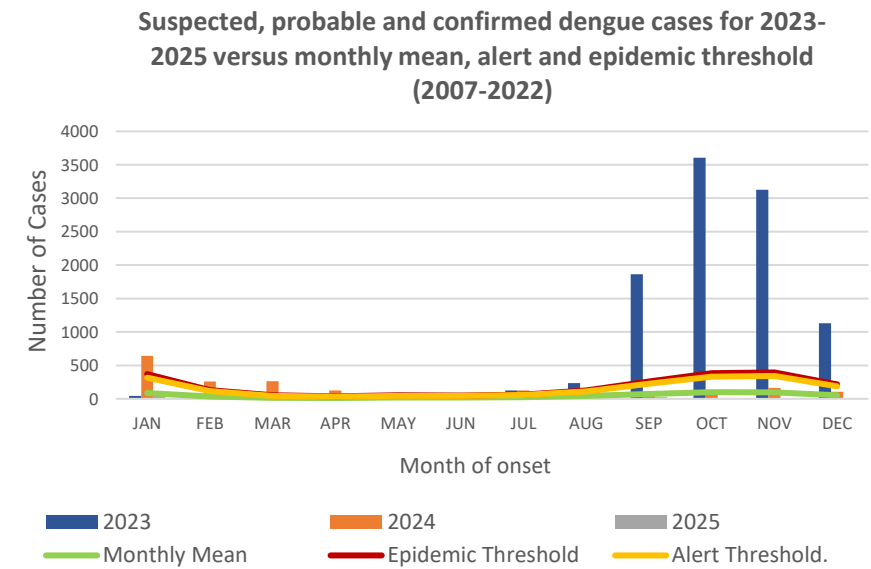


Reported suspected, probable and confirmed dengue with symptom onset in week 39 of 2025

	2025*	
	EW 39	YTD
Total Suspected, Probable & Confirmed Dengue Cases	2	379
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 October 9, 2025
 - Only PCR positive dengue cases are reported as confirmed.
 - IgM positive cases are classified as probable dengue.



RESEARCH ABSTRACT

Abstract

NHRC-23-O12

Time to Viral Clearance of COVID-19: Analysis of National Surveillance Data, Jamaica

Webster-Kerr K¹, Grant A¹, Harris A¹, Wiggan J¹, Henningham D¹, Rowe D¹, Azille-Lewis J⁴, Thorpe R¹, Mullings T¹, Lord C², Dawkins-Beharie T³, Wellington I¹, Gordon-Johnson K¹, Martin-Chen N¹, Campbell E¹, Brown M¹, Roberts T¹, Duncan J⁵

¹National Epidemiology, Ministry of Health and Wellness, Jamaica W.I., ²Family Health Unit, Ministry of Health and Wellness, Jamaica W.I., ³St. Elizabeth Health Department, Southern Regional Health Authority, Ministry of Health and Wellness, Jamaica W.I., ⁴Child Abuse Prevention Unit, Ministry of Youth Development & Empowerment, Youth at Risk, Gender Affairs, Seniors Security and Dominicans with Disabilities, Commonwealth of Dominica, ⁵Department of Community Health and Psychiatry, University of the West Indies, Mona, Jamaica, W.I.

Objective: To estimate time to viral clearance for COVID-19 cases occurring from March to June 2020.

Methods: Cross-sectional analysis was conducted on National Surveillance data. Viral clearance was defined as time from first positive nasopharyngeal swab to the first of two consecutive negative tests. Clinical severity (mild, moderate, severe, critical) was based on WHO definition. PCR tests were used for confirmation of COVID-19 cases. Frequency distributions, median and interquartile range (IQR) were computed. Kruskal Wallis and Mann-Whitney tests evaluated differences by age, sex, and severity. A p-value of < 0.05 was considered statistically significant.

Results: Data were available for 431 cases. Median time to viral clearance (days) was 28.0 (IQR: 18.0). Viral clearance differed by age ($p < 0.05$), sex ($p < 0.0001$) and clinical severity ($p < 0.05$). For clinical severity, mildly ill cases had longest time (median: 29.0, IQR: 17.0). Females had a longer time (median: 30.0, IQR: 15.0) than males (median: 23.0, IQR: 20.0). Viral clearance was greater in cases < 60 years (median: 28.0, IQR: 19.0) than those ≥ 60 years (median: 19.0, IQR: 21.0). 44.8% of cases were from a workplace cluster with median age of 23 years. Viral clearance for workplace cluster cases versus non-workplace cluster was 33.0, (IQR: 10.0) versus 20.0, (IQR: 19.0).

Conclusion: Median time to viral clearance was 28 days and was influenced by age, sex, clinical severity and time of testing. More viral clearance studies are needed to guide response in future public health events.



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9 NOTIFICATIONS-
All clinical
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