WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Influenza (avian and other zoonotic) (Part 3)

Diagnosis and Treatment

Laboratory tests are required to diagnose human infection and testing should be done at a lab capable of safely processing and confirming zoonotic infections.

The collection of appropriate specimens from suspected human cases for virus identification and the rapid and precise characterization of the virus and/or its isolate is done at specialized reference laboratories. This is essential for proper response measures. If a person is suspected of having zoonotic influenza, the health authorities should be notified and appropriate clinical case management provided, including testing, triage, clinical assessment for disease severity classification, assessment of risk factors for severe disease, and isolation and treatment (for example, with antivirals and supportive care). Patients with influenza should be managed properly to prevent severe illness and death.

Pevention

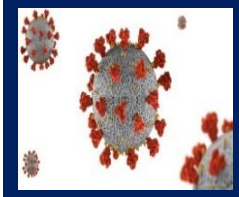
Influenza viruses are impossible to eradicate and zoonotic infections will continue to occur. To minimize public health risk, quality surveillance in both animal and human populations, thorough investigation of every human infection and risk-based pandemic planning are essential. Public health and animal health authorities should work together and share information during investigations of human cases of zoonotic influenza.

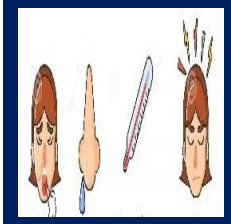
The public should minimize contact with animals in areas known to be affected by animal influenza viruses, including farms and settings where live animals may be sold or slaughtered, and avoid contact with any surfaces that appear to be contaminated with animal faeces. Children, older people, pregnant and postpartum women (up to 6 weeks) or people with suppressed immune systems should neither collect eggs nor assist with slaughtering or food preparation.

The public should strictly avoid contact with sick or dead animals, including wild birds, and should report dead animals or request their removal by contacting local wildlife or veterinary authorities.

Taken from WHO website on 15/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-%28avian-and-other-zoonotic%29 (picture)

EPI WEEK 40





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 – 37 to 40 of 2025

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

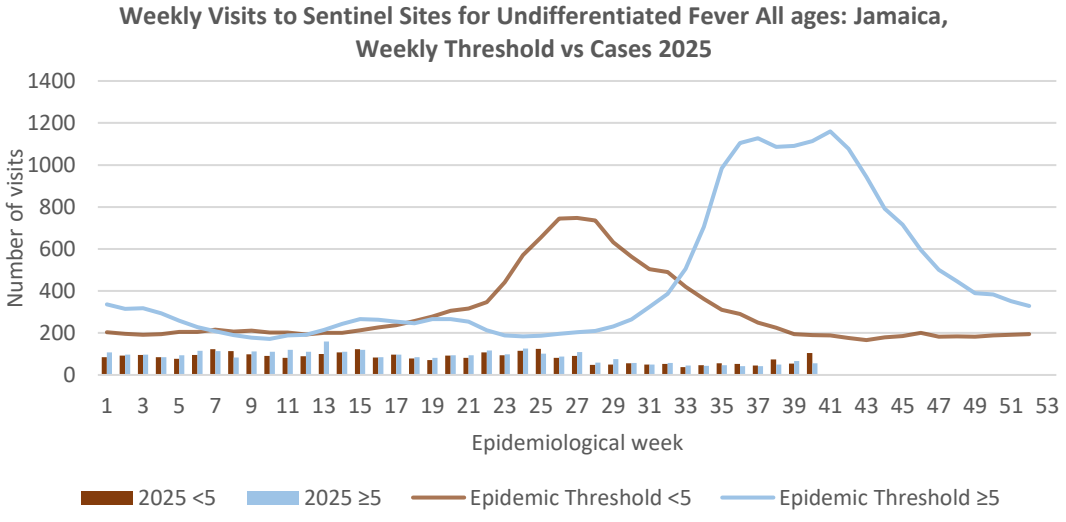
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday

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													
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
40	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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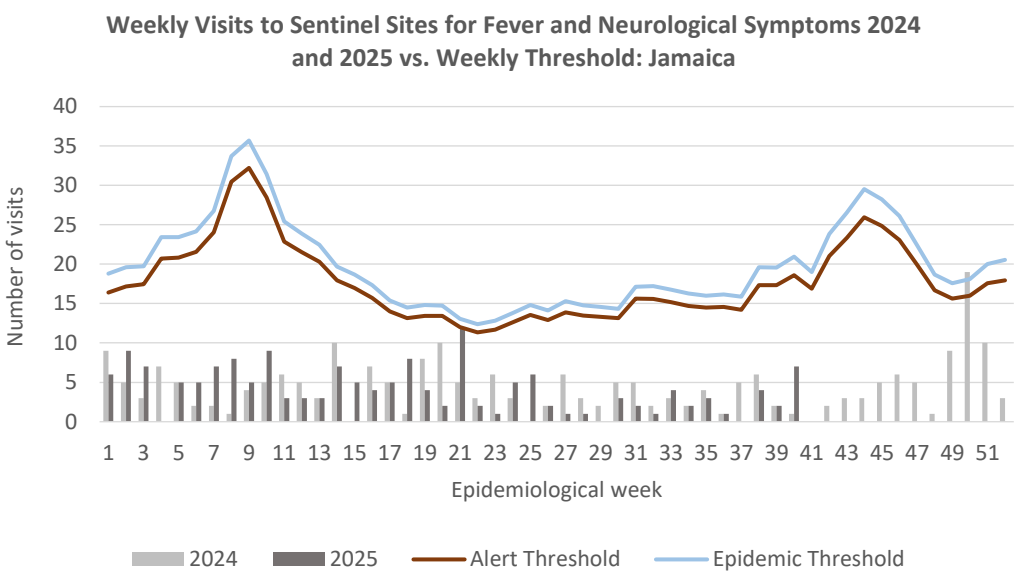
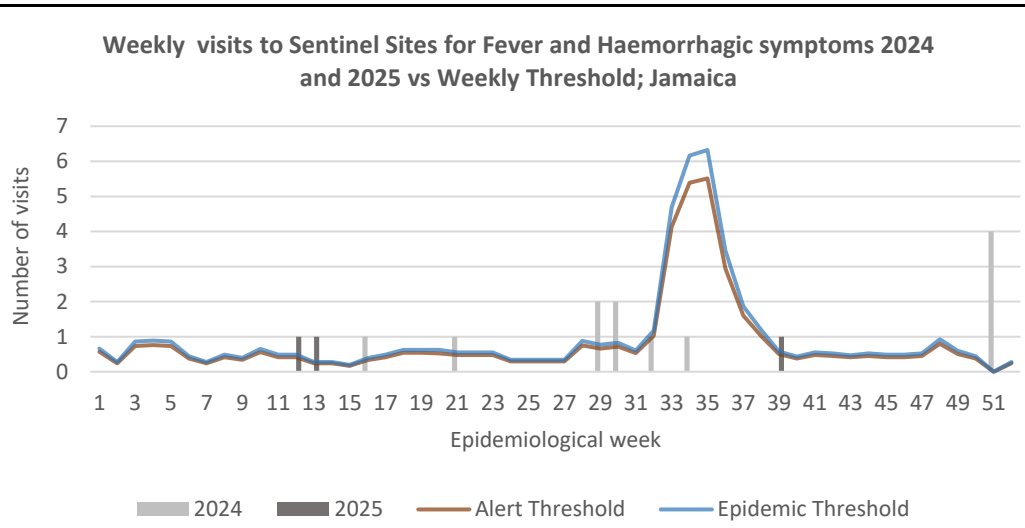
FEVER AND NEUROLOGICAL

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

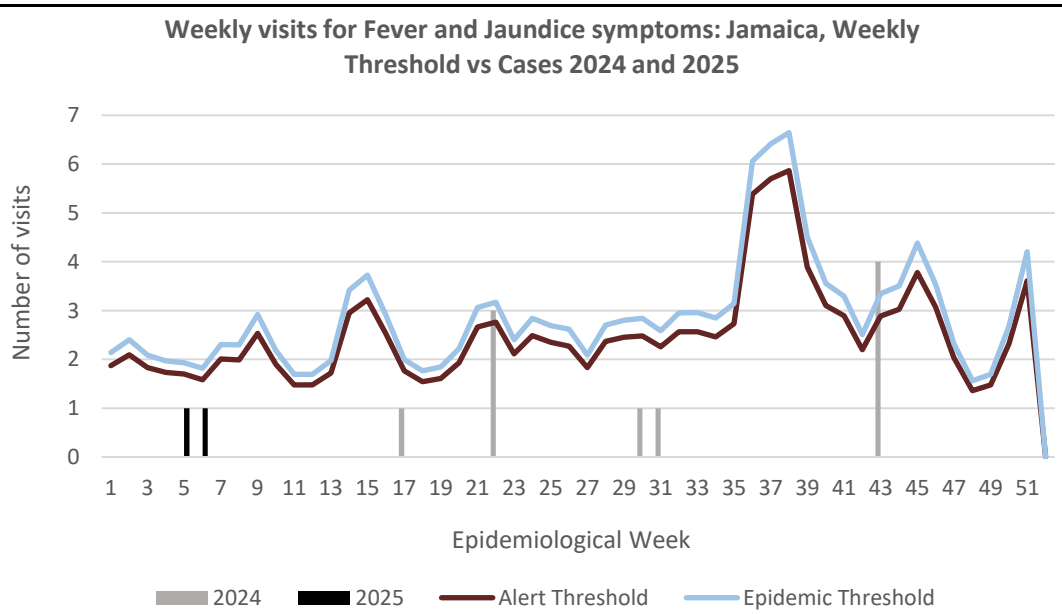
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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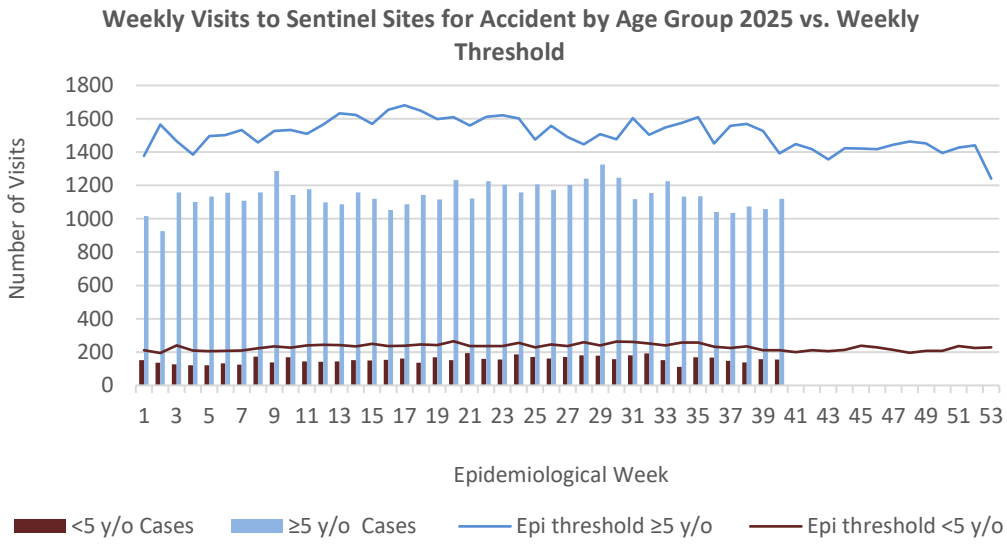
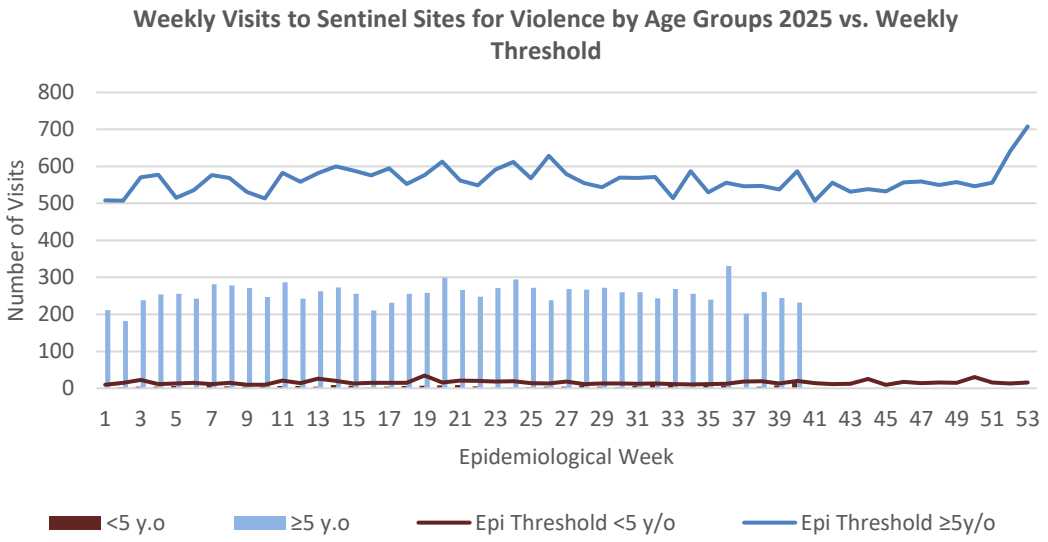
ACCIDENTS

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



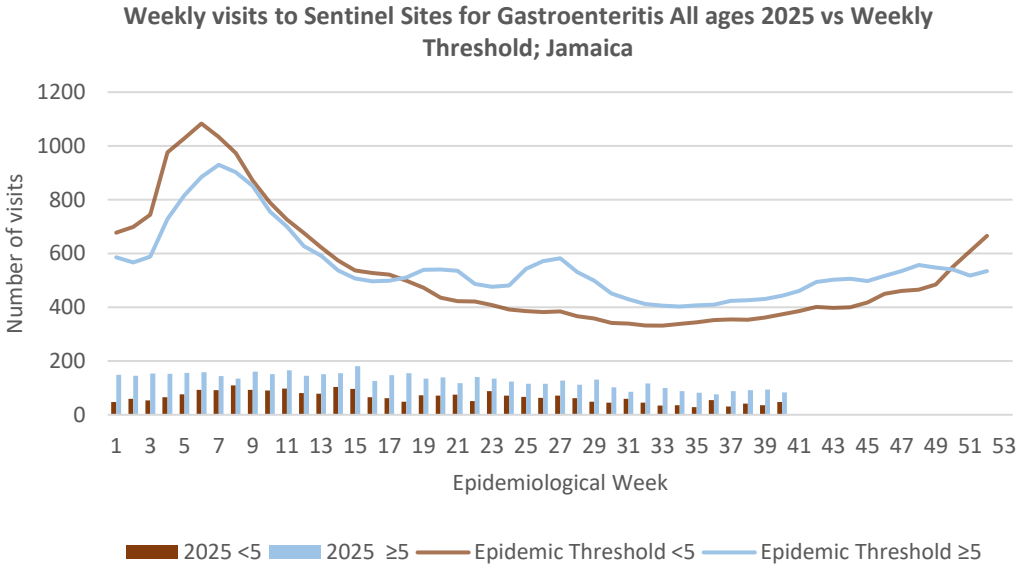
VIOLENCE

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	114[β]	256[β]
	Cholera	0	0
	Severe Dengue[Y]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	304	662
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	5	35
	Hepatitis C	1	9
	HIV/AIDS	NA	NA
	Malaria (Imported)	1	2
	Meningitis	11	17
	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
	Fever and Rash – Rubella	0	0
	Maternal Deaths[δ]	47	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
	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

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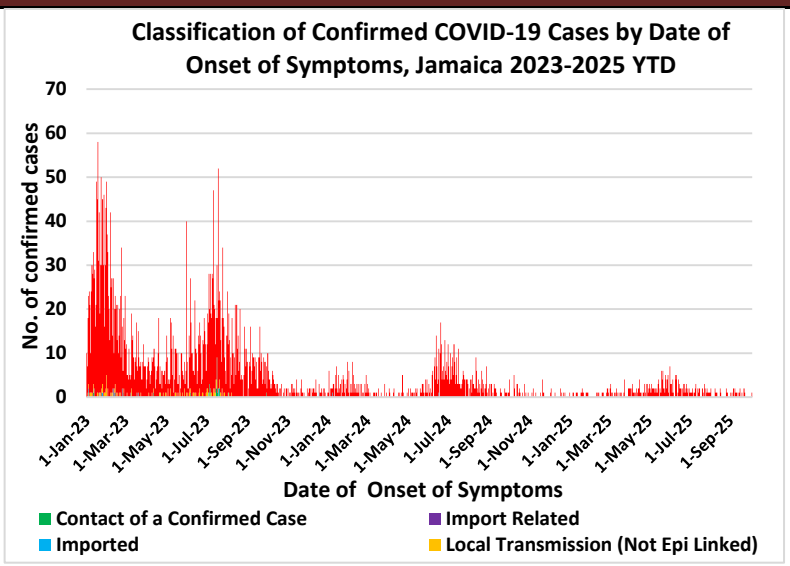
COVID-19 SURVEILLANCE

CASES	EW 40	Total
Confirmed	2	157739
Females	1	90876
Males	1	66860
Age Range	40 years to 52 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.

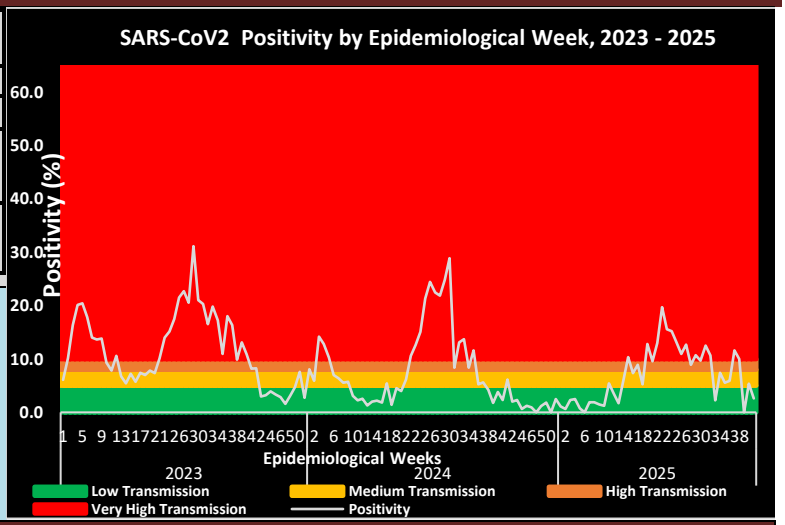


COVID-19 Outcomes

Number of Confirmed COVID-19 cases and deaths, Jamaica 2020-2025

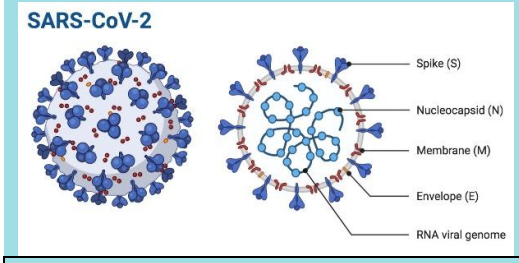
COVID-19	Year						
	2020	2021	2022	2023	2024	2025	Total
Cases	13352	83814	45920	3842	705	304	157739
Deaths	332	2815	621	116	24	13	3921

*Current positivity rate 2.6%
- (positive samples/total samples tested)
* Low transmission for infection



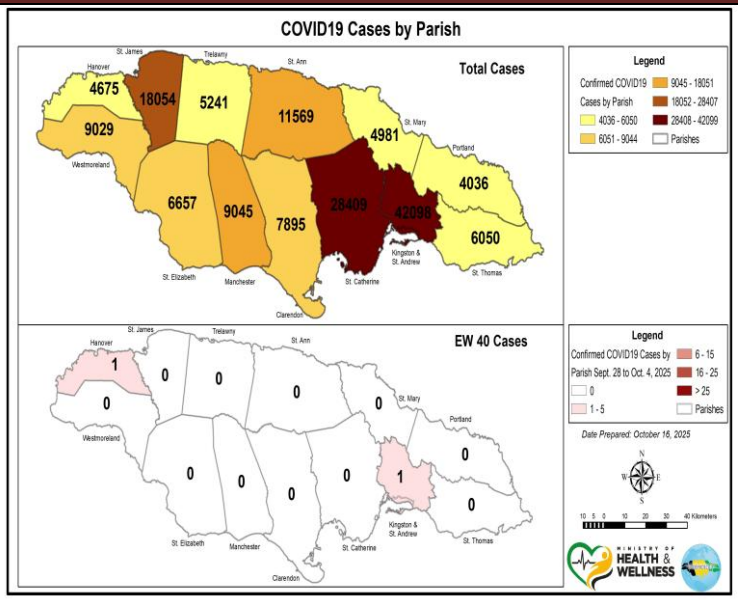
OVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 37 -40 2025

Epi Week	Confirmed Cases	Deaths
37	41400	490
38	38700	422
39	41300	280
40	**39300**	**79**
Total (4weeks)	**161200**	**1271**



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October 17, 2025 ISSN 0799-3927

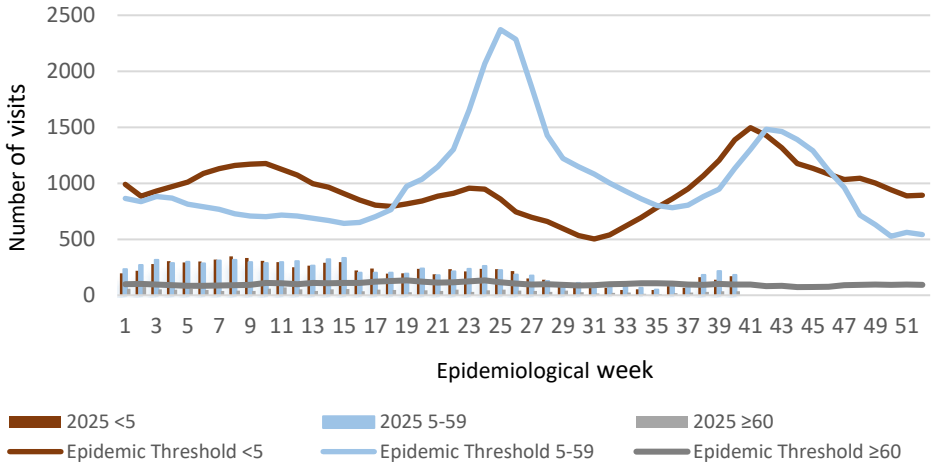
INFLUENZA SURVEILLANCE

EW 40

September 28, 2025 – October 04, 2025 Epidemiological Week 40

	EW 40	*YTD*
SARI cases	2	327
Total Influenza positive Samples	**0**	**178**
Influenza A	**0**	**153**
H1N1pdm09	0	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	31

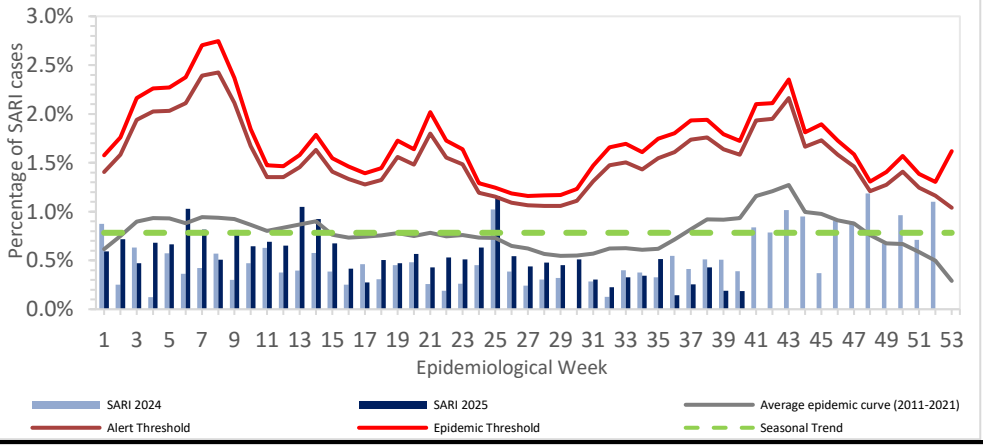
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 40, two (2) SARI admissions was reported.

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

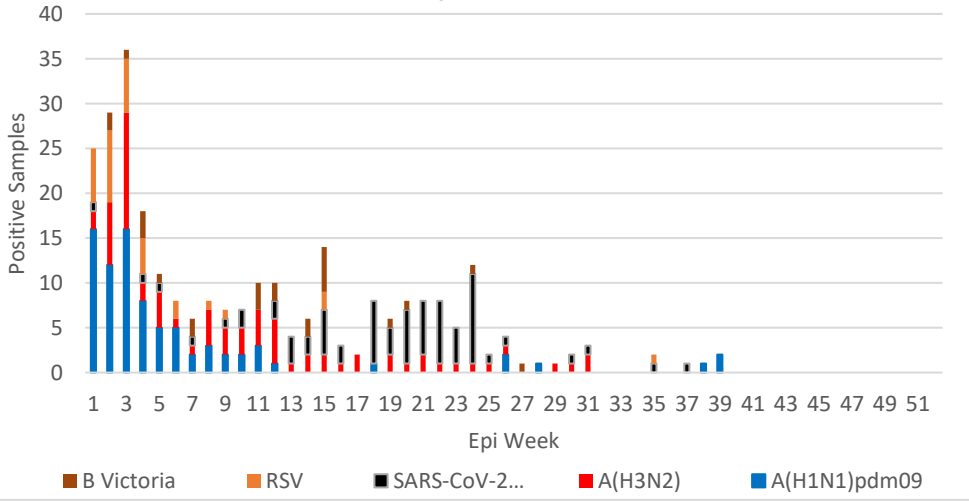


Caribbean Update EW 40 (This update is at EW 39)

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 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

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



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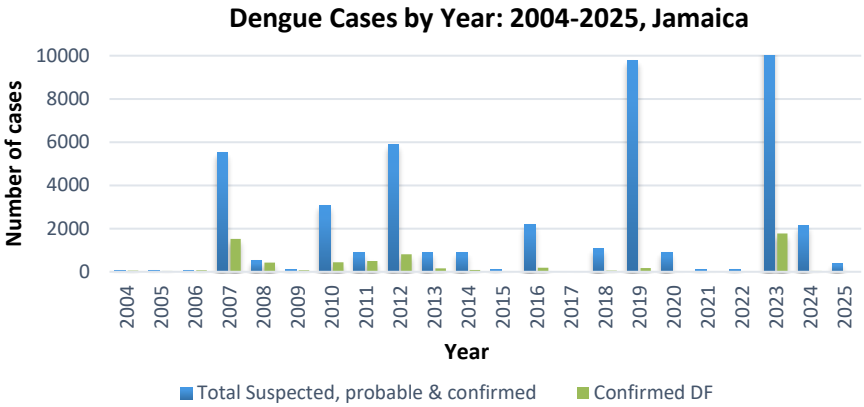
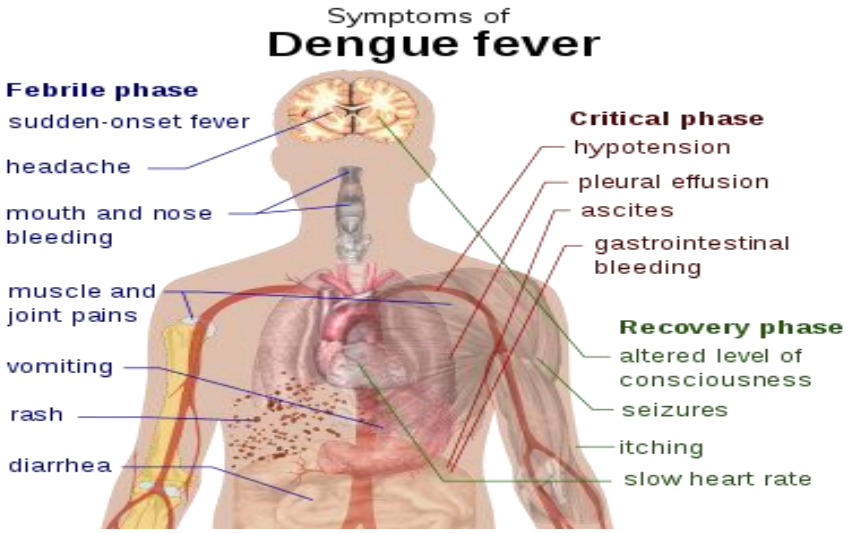
DENGUE SURVEILLANCE

September 28, 2025 – October 4, 2025 Epidemiological Week 40 | Epidemiological Week 40



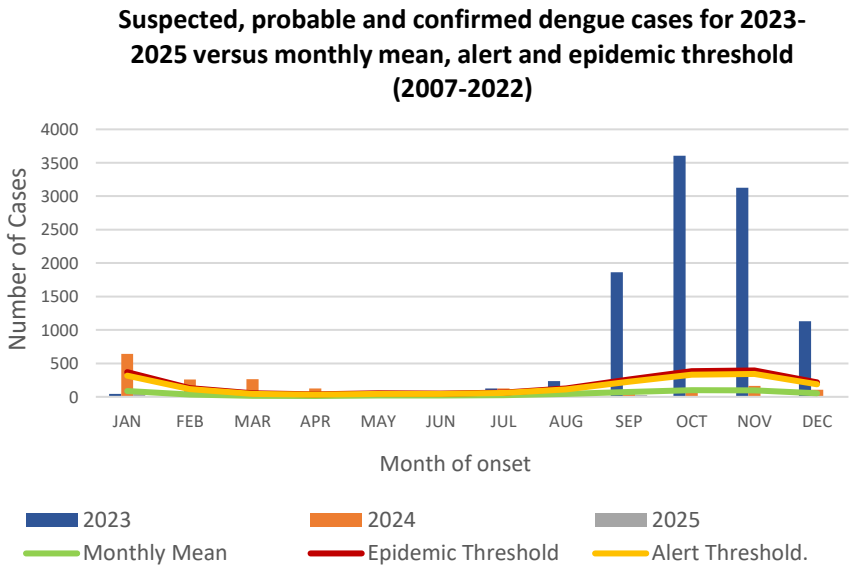
Reported suspected, probable and confirmed dengue with symptom onset in week 40of 2025

	2025*	
	EW 40	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	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 16, 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-O13

Impact of the COVID-19 Pandemic on the Utilization of Jamaican Health Clinics

Smikle J[1], Gordon-Strachan G[2]

[1]Faculty of Medical Sciences, University of the West Indies, Mona, Jamaica [2]Tropical Metabolism Research Unit, Caribbean Institute for Health Research, University of the West Indies, Mona, Jamaica

Objective: The objective of this study was to determine the impact of COVID-19 Family Planning (FP), Antenatal (ANC), Postnatal (PNC), Child Health (CHC) Psychiatry, and NCD- Curative Clinics by comparing their utilisations during the first ten months of the pandemic March-December 2020, with the corresponding non-COVID reference period March-December 2019.

Method: Retrospective data from the MCSR was extracted for the clinics evaluated, and patient count was compared between the COVID-19 and non-COVID-19 reference period by calculating the per cent change in utilisation. Utilisation was analysed by Parish, Health Region, Age, Sex, and Service. Bivariate (X2) and multivariate analyses (Poisson regression models) were conducted to test statistical significance and to calculate incidence risk ratios (IRR).

Results: There was a significant decline in CHC (-19.3%) and PNC (-4.77%) attendance. All other clinics showed an increase in utilisation. This increase was not seen across all parishes and Regions. For Curative Clinics, marginal differences were observed for Diabetes and Hypertension Clinics. However, there was an increase in patients presenting with Uncontrolled Diabetes and Uncontrolled Hypertension.

The results of the bivariate analyses were corroborated by the IRR for Child Health (0.74 (C.I. 0.74-0.75)), indicating a 26% decline.

Conclusion: The COVID-19 pandemic affected healthcare utilisation in Jamaica, and Child Health Clinics were the most affected. Increases in the utilisation of family planning, antenatal and psychiatric services are notable. The declines in utilisation of clinic services found by Region and Parish require further investigation.

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