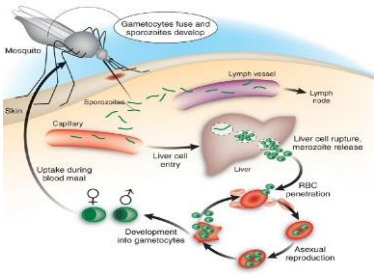
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Malaria (Part 2)



Malaria can be prevented by avoiding mosquito bites and by taking medicines. Talk to a doctor about taking medicines such as chemoprophylaxis before travelling to areas where malaria is common.
Lower the risk of getting malaria by avoiding mosquito bites:

- Use mosquito nets when sleeping in places where malaria is present.
- Use mosquito repellents (containing DEET, IR3535 or Icaridin) after dusk.
- Use coils and vaporizers.
- Wear protective clothing.
- Use window screens.

Vector control

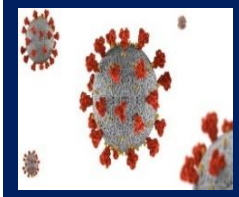
Vector control is a vital component of malaria control and elimination strategies as it is highly effective in preventing infection and reducing disease transmission. The 2 core interventions are insecticide-treated nets (ITNs) and indoor residual spraying (IRS).
Progress in global malaria control is threatened by emerging resistance to insecticides among *Anopheles* mosquitoes. However, new generation nets, which provide better protection against malaria than pyrethroid-only nets, are becoming more widely available and represent an important tool in global efforts to combat malaria.
Anopheles stephensi presents an added challenge for malaria control in Africa. Originally native to parts of south Asia and the Arabian Peninsula, the invasive mosquito species has been expanding its range over the last decade, with detections reported to date in eight African countries. *An. stephensi* thrives in urban settings, endures high temperatures and is resistant to many of the insecticides used in public health.

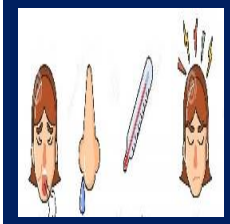
Chemoprophylaxis

Travellers to malaria endemic areas should consult their doctor several weeks before departure. The medical professional will determine which chemoprophylaxis drugs are appropriate for the country of destination. In some cases, chemoprophylaxis drugs must be started 2–3 weeks before departure. All prophylactic drugs should be taken on schedule for the duration of the stay in the malaria risk area and should be continued for 4 weeks after the last possible exposure to infection since parasites may still emerge from the liver during this period.

Taken from WHO website on 06/Nov/2025
https://www.who.int/news-room/fact-sheets/detail/malaria
https://www.google.com/search?q=picture+of+malaria+parasite&rlz=1C1GCEA_enJM1049JM1049&oq=picture+of+malari&gs_lcrp=EgZjaHJvbWUqBwgCEAAYgAQyBwgAEAAYgAQyBggBEEUYOTIHCAIQABiABDIHCAMQABiABDIHCAQQABiABDIHCAUQABiABDIHCAYQABiABDIHCAcQABiABDIHCAgQABiABDIHCAkQABiABNIBCTE5NDg5ajBqN6gCALACAA&sourceid=chrome&ie=UTF-8#vhid=KHf5Veo3S_lx7M&vssid=_Mt7_aJyKE6WZwbkPm4-HsAs_66

EPI WEEK 43





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 – 40 to 43 of 2025.
***Timeliness of submission for EW 43 likely impacted by passage of Hurricane Mellissa.**

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

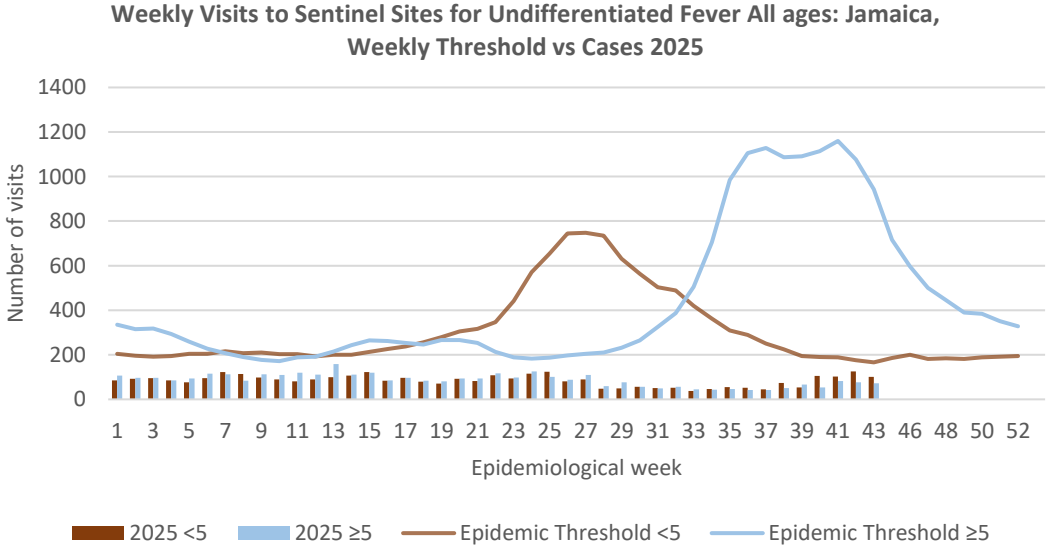
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White – No report received

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													
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
41	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
42	On Time	On Time	On Time	Late (T)	On Time	On Time	On Time	Late (T)	On Time	On Time	On Time	On Time	On Time
43	On Time	On Time	On Time	On Time	Late (W)	Late (W)	On Time		On Time	On Time		On Time	On Time

SYNDROMIC SURVEILLANCE

FEVER
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

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

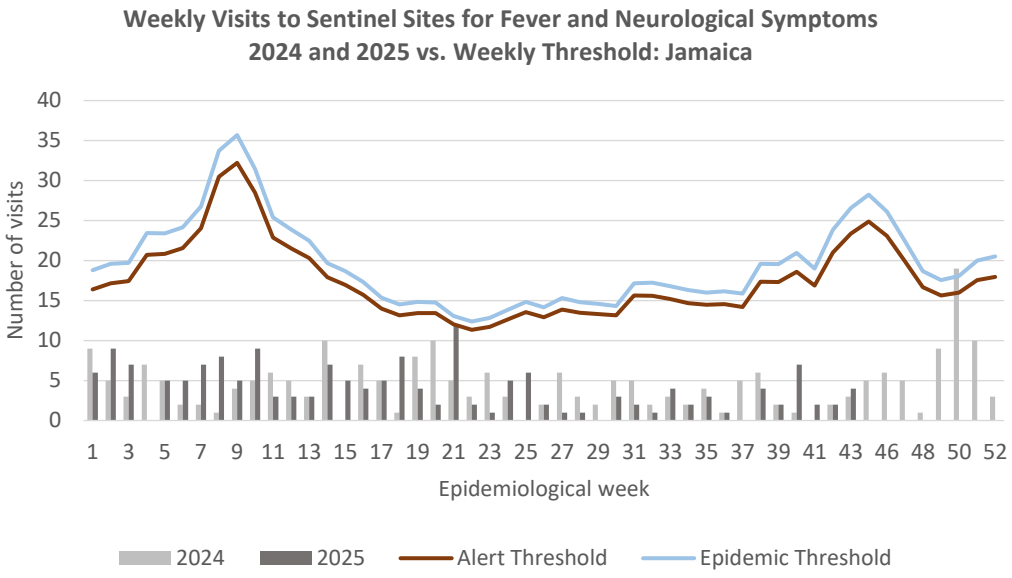
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

ISSN 0799-3927

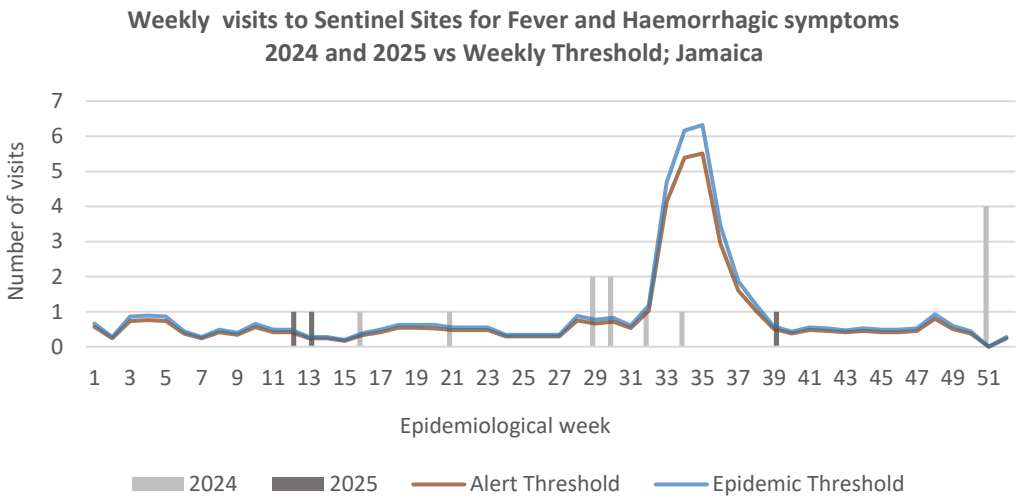
FEVER AND NEUROLOGICAL

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

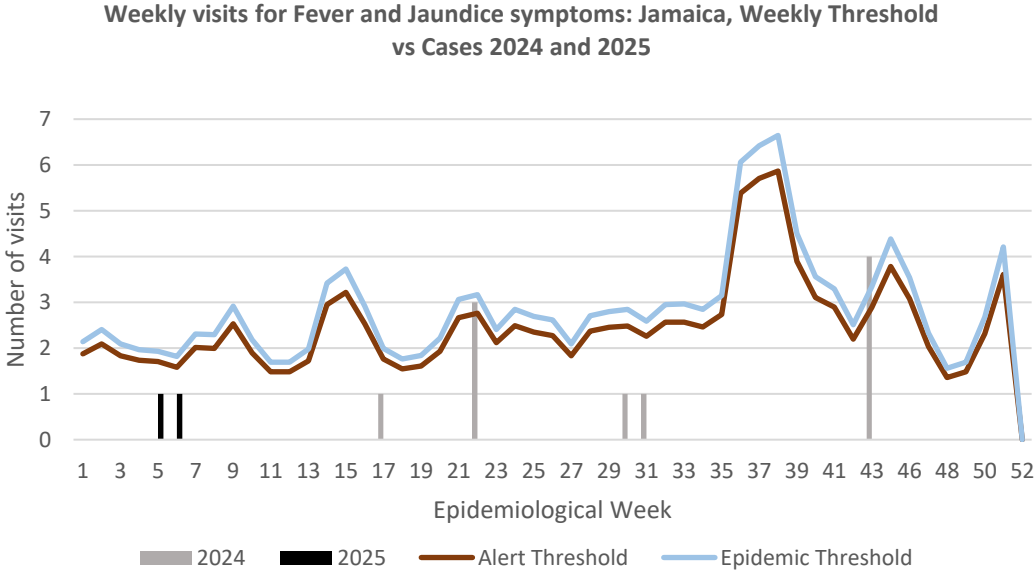
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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.



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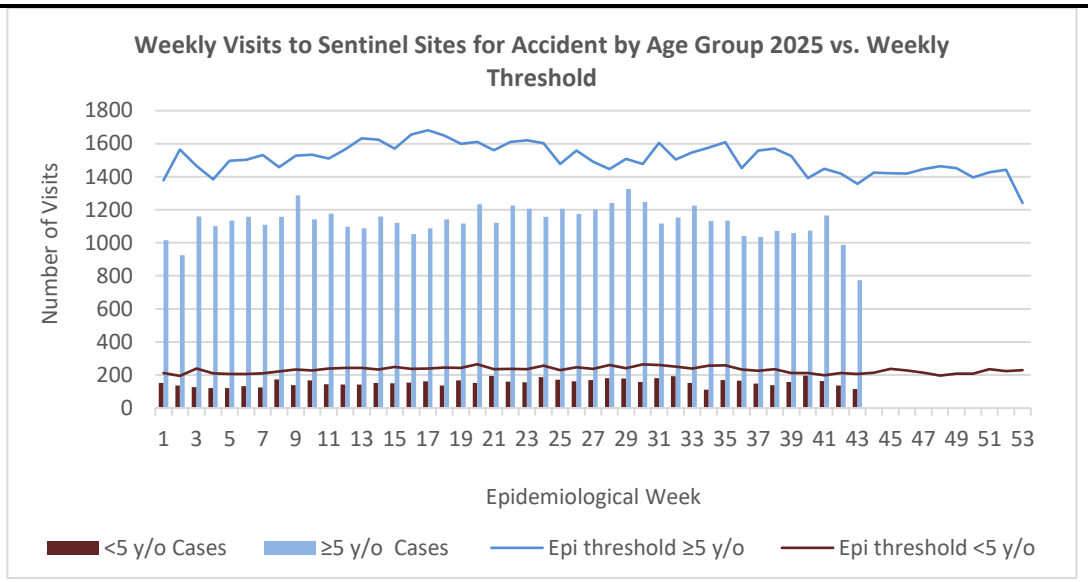
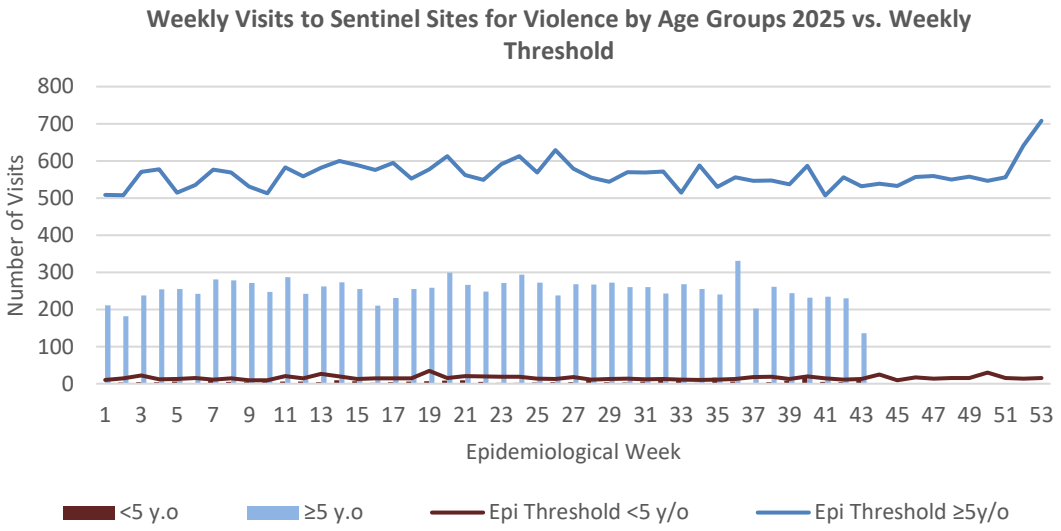
ACCIDENTS

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



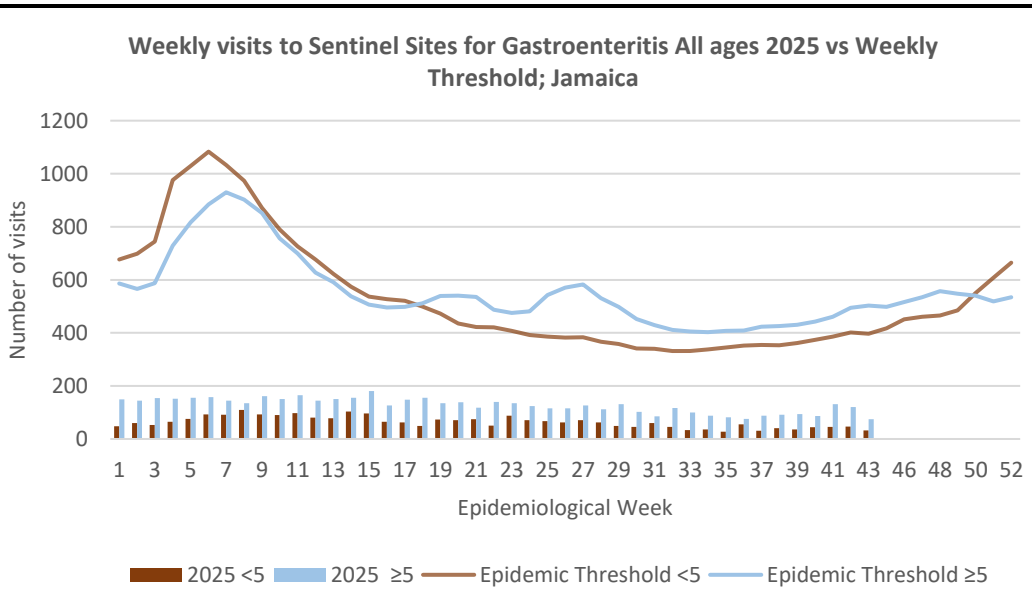
VIOLENCE

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		115[β]	259[β]
	Cholera		0	0
	Severe Dengue[Y]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		310	683
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		5	37
	Hepatitis C		1	9
	HIV/AIDS		NA	NA
	Malaria (Imported)		1	2
	Meningitis		11	19
	Mpox		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]		47	56
	Ophthalmia Neonatorum		36	159
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		2	0
	Tuberculosis		42	44
	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

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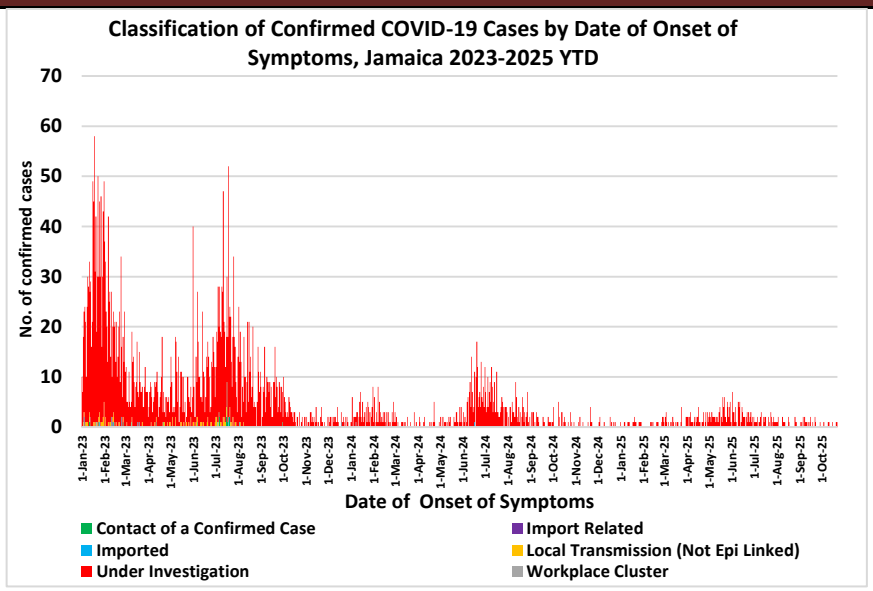
COVID-19 SURVEILLANCE

CASES	EW 43	Total
Confirmed	0	157745
Females	0	90879
Males	0	66863
Age Range	-	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.

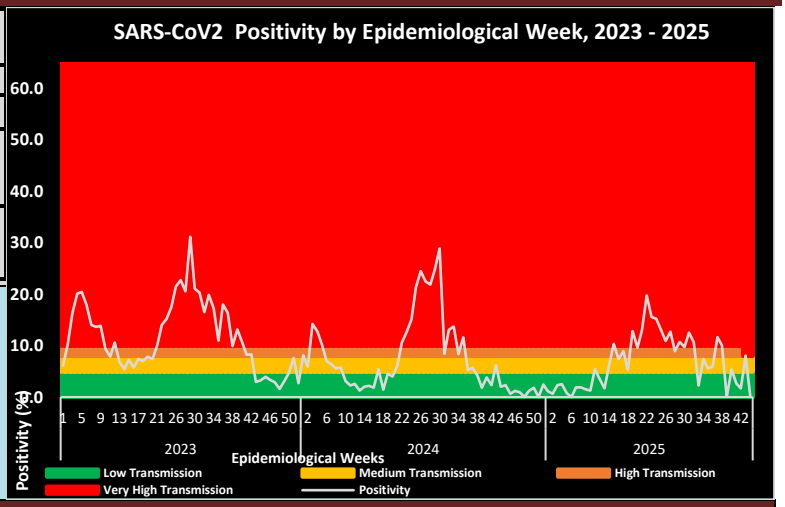


COVID-19 Outcomes

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

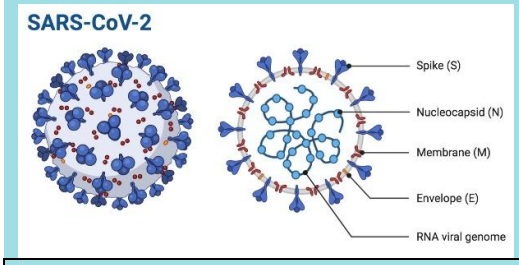
COVID-19	Year						
	2020	2021	2022	2023	2024	2025	Total
Cases	13352	83,815	55721	3842	705	310	157745
Deaths	332	2815	621	116	24	13	3921

*Current positivity rate 0.0%
- (positive samples/total samples tested)
* Low transmission for infection



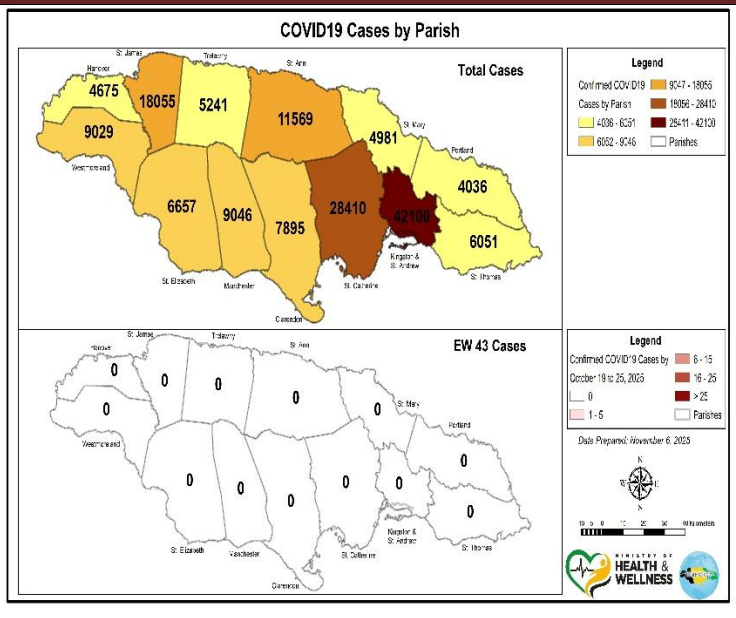
OVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 40 -43 2025

Epi Week	Confirmed Cases	Deaths
40	41200	107
41	38400	127
42	37300	91
43	30300	74
Total (4weeks)	**147200**	**399**



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November 7, 2025 ISSN 0799-3927

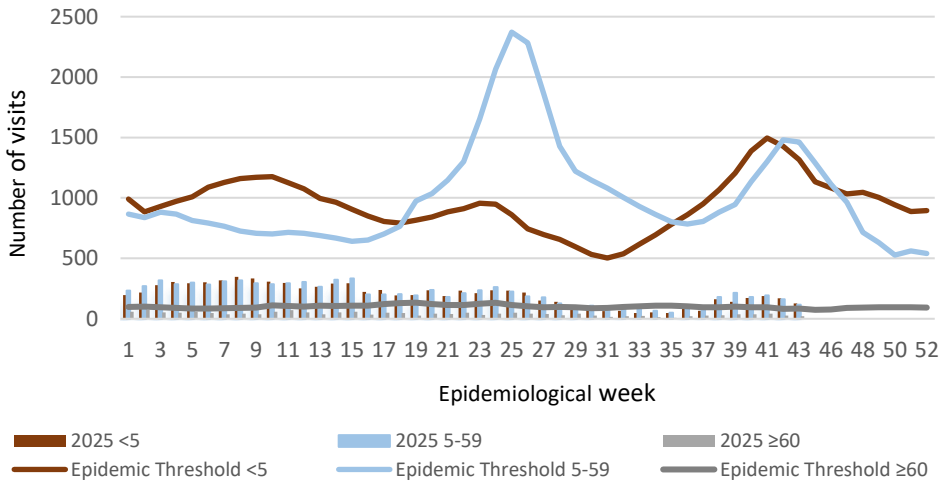
INFLUENZA SURVEILLANCE

EW 43

October 19, 2025 – October 25, 2025 Epidemiological Week 43

	EW 43	*YTD*
SARI cases	2	348
Total Influenza positive Samples	**0**	**184**
Influenza A	**0**	**157**
H1N1pdm09	0	86
H3N2	0	71
Not subtyped	0	0
Influenza B	**0**	**27**
B lineage not determined	0	0
B Victoria	0	27
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	34

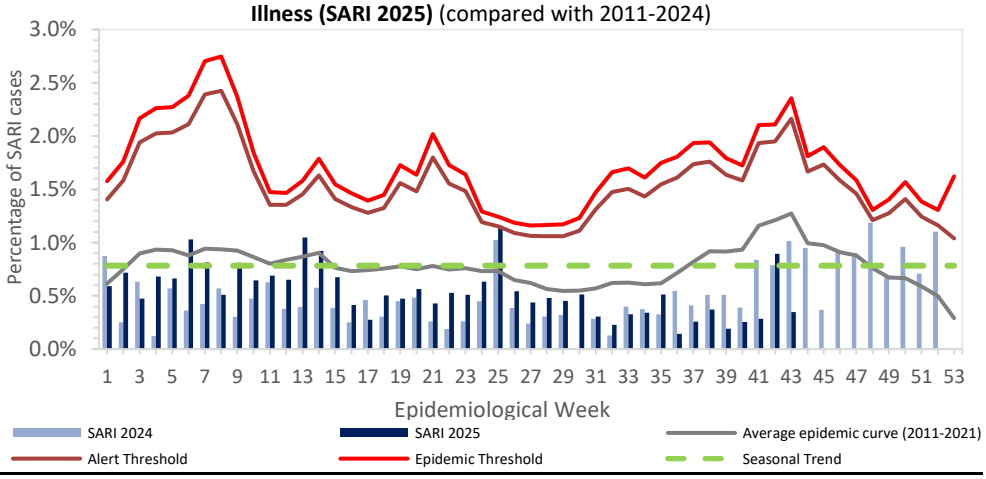
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 43, two (2) SARI admissions was reported.

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

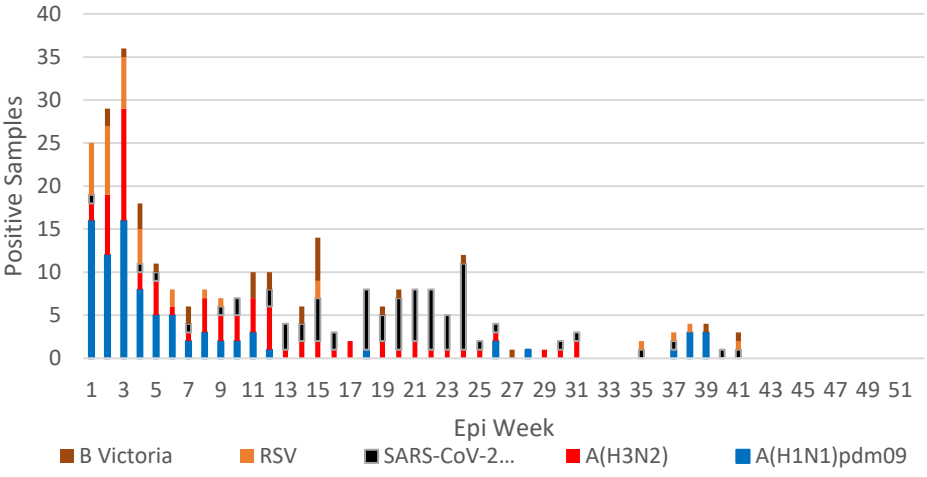


Caribbean Update EW 43

Influenza activity, driven primarily by the concurrent circulation of subtype A(H1N1)pdm09 and influenza B, increased during the latest epidemiological week (EW), with a subregional positivity rate of 9%. RSV circulation rose compared to the previous EW, reaching a positivity rate of 16.4%. Meanwhile, SARS-CoV-2 activity declined during the latest EW, with a subregional positivity rate of 5%. SARI cases show a downward trend, mainly associated with influenza and RSV. In constrast, ILI cases present a slight increase, also mostly linked to influenza, followed by SARS-CoV-2. At the country level, influenza activity is at epidemic levels in Belize and Haiti, with an upward trend observed in Barbados (influenza B Victoria), the Cayman Islands and Guyana (influenza B). Countries showing a downward trend. In influenza circulation include Cuba, the Domincan Republic and Jamaica. Regarding RSV, circulation decreased in Cuba and Guyana compared to the previous EW. It also declined in Cayman Islands, although positivity remains high (15%). Circulation increased in Belize (13.2% positivity), Haiti (27.7%), and Barbados (3.9%). High circulation, persists in the Dominican Republic, with a positivity rate of 43.1%. Lastly, SARS-CoV-2 activity decreased in Suriname, Jamaica, and Saint Vincent and the Grenadines during the latest EW. Haiti, Belize, Cuba, the Dominican Republic and Saint Lucia have maintained low and stable circulation for several weeks. The Cayman Islands show stable circulation with a positivity rate of 7.8%, Guyana's circulation increased to 2.4%, and Barbados maintains a high positivity rate, though with a downward trend, currently at 15%.

(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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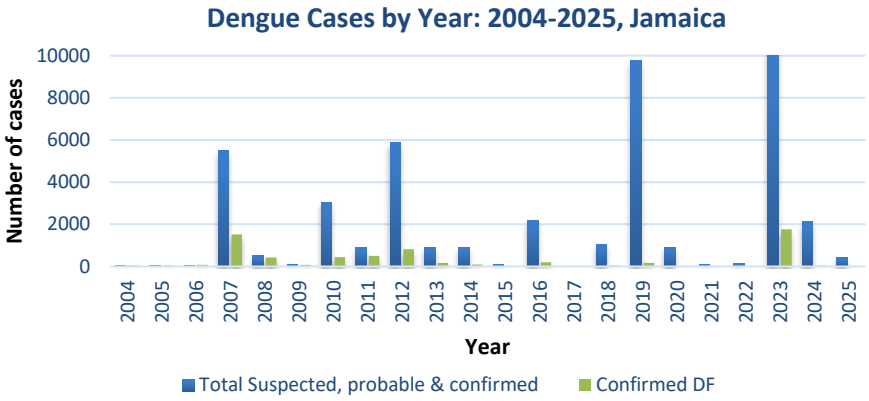
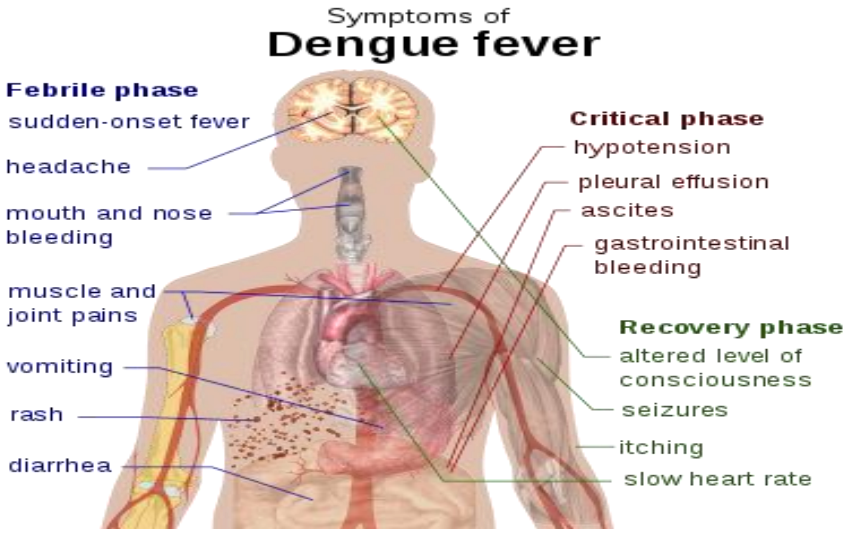
DENGUE SURVEILLANCE

October 19, 2025 – October 25, 2025 Epidemiological Week 43 | Epidemiological Week 43



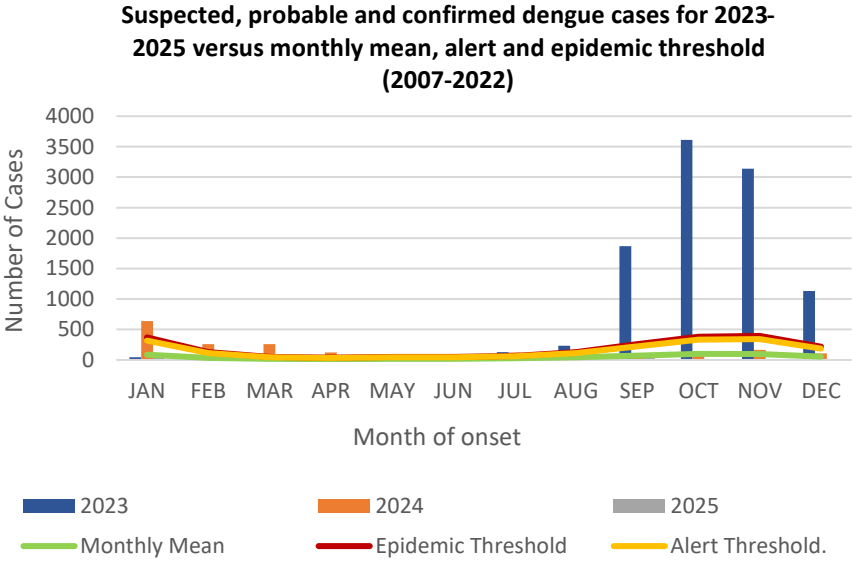
Reported suspected, probable and confirmed dengue with symptom onset in week 43 of 2025

	2025*	
	EW 43	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	411
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 November 6, 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-O16
The Impact of COVID-19 on Maternal Mortality in Jamaica

Gordon-Strachan G,[1] McCaw-Binns A[2]

[1]Tropical Metabolism Research Unit, Caribbean Institute for Health Research, University of the West Indies, Mona, Kingston 7, Jamaica [2]Adjunct Professor, Department of Community Health and Psychiatry, University of the West Indies, Mona, Kingston 7, Jamaica

Objective: To determine the impact of COVID-19 on maternal mortality by comparing the causes of and Maternal Mortality Ratio (MMR) per 100,000 live births for Jan-2020-Dec-2021 (COVID-19 period) and a pre-COVID-19 reference period (Jan-2018-Dec-2019).

Methods: Registered deaths for 1-Jan-2018 to 31-Dec-2021 in women 10-49 years with evidence of pregnancy were combined with MOHW-Maternal Mortality Surveillance data to create a master-list of maternal deaths. The master-list was cleaned and coded using WHO guidelines for maternal and COVID-19 deaths. Maternal deaths (pregnancy to 42 days post-partum) were disaggregated by year and period of occurrence, comparing the COVID-19 (2020-21) and pre-COVID-19 (2018-19) periods.

Results: The MMR increased from 136.8 in 2018/2019 to 172.2 during the COVID-19 period. The COVID-19 cause-specific MMR was 61.4 and was the leading cause of death during the period. Most COVID-19 deaths (39/41) occurred in 2021. The direct mortality ratio was unchanged at 86.8 for both periods, however obstetric haemorrhage replaced the hypertensive disorders of pregnancy as the leading direct cause of death in the latest period. The pregnancy mortality ratio for accidents and violence declined 54 percent between the two periods due to fewer violent deaths (8.8 versus 1.5/100,000). Mortality rates from accidents were unchanged (4.4).

Conclusion: The COVID-19 pandemic adversely affected the Jamaican MMR. The 2018-21 MMR of 154 represents an upward MMR trend from 92 (1998-03). Exclusion of COVID-19 deaths would reduce the 2018-21 ratio to 111, which was still above the 102 for 2010-15. Jamaica is unlikely to meet the SDG MMR goal of 70/100,000.

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