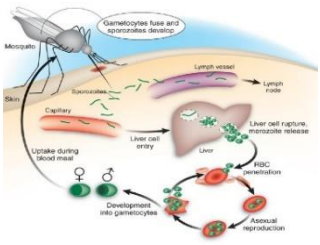
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Malaria (Part 3)



Preventive chemotherapies

Preventive chemotherapy is the use of medicines, either alone or in combination, to prevent malaria infections and their consequences. It requires giving a full treatment course of an antimalarial medicine to vulnerable populations at designated time points during the period of greatest malarial risk, regardless of whether the recipients are infected with malaria. Preventive chemotherapy includes perennial malaria chemoprevention (PMC), seasonal malaria chemoprevention (SMC), intermittent preventive treatment of malaria in pregnancy (IPTp) and school-aged children (IPTsc), post-discharge malaria chemoprevention (PDMC) and mass drug administration (MDA). These safe and cost-effective strategies are intended to complement ongoing malaria control activities, including vector control measures, prompt diagnosis of suspected malaria, and treatment of confirmed cases with antimalarial medicines.

Treatment

Early diagnosis and treatment of malaria reduces disease, prevents deaths and contributes to reducing transmission. WHO recommends that all suspected cases of malaria be confirmed using parasite-based diagnostic testing (through either microscopy or a rapid diagnostic test). Malaria is a serious infection and always requires treatment with medicine. Multiple medicines are used to prevent and treat malaria. Doctors will choose one or more based on:

- the type of malaria
- whether a malaria parasite is resistant to a medicine
- the weight or age of the person infected with malaria
- whether the person is pregnant.

These are the most common medicines for malaria:

- Artemisinin-based combination therapy medicines are the most effective treatment for *P. falciparum* malaria.
- Chloroquine is recommended for treatment of infection with the *P. vivax* parasite only in places where it is still sensitive to this medicine.
- Primaquine should be added to the main treatment to prevent relapses of infection with the *P. vivax* and *P. ovale* parasites.

Most medicines used are in pill form. Some people may need to go to a health centre or hospital for injectable medicines.

Elimination

Malaria elimination is defined as the interruption of local transmission of a specified malaria parasite species in a defined geographical area as a result of deliberate activities. Continued measures to prevent re-establishment of transmission are required. In 2023, 35 countries reported fewer than 1000 indigenous cases of the disease, up from just 13 countries in 2000. Countries that have achieved at least 3 consecutive years of zero indigenous cases of malaria are eligible to apply for the WHO certification of malaria elimination.

Surveillance

Malaria surveillance is the continuous and systematic collection, analysis and interpretation of malaria-related data, and the use of that data in the planning, implementation and evaluation of public health practice. Improved surveillance of malaria cases and deaths helps ministries of health determine which areas or population groups are most affected and enables countries to monitor changing disease patterns. Strong malaria surveillance systems also help countries design effective health interventions and evaluate the impact of their malaria control programmes.

Taken from WHO website on 11/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 44

ISSN 0799-3927

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 – 41 to 44 of 2025.

***Timeliness of submission for EW 43-44 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.

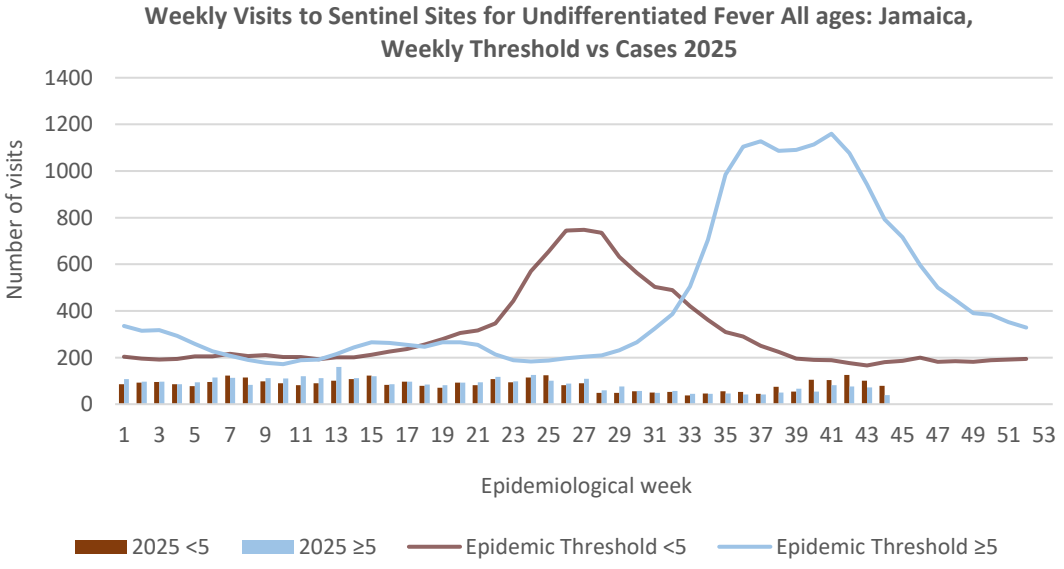
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
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
44	On Time	On Time	On Time	On Time	On Time		On Time		On Time	Late (W)		Late (W)	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

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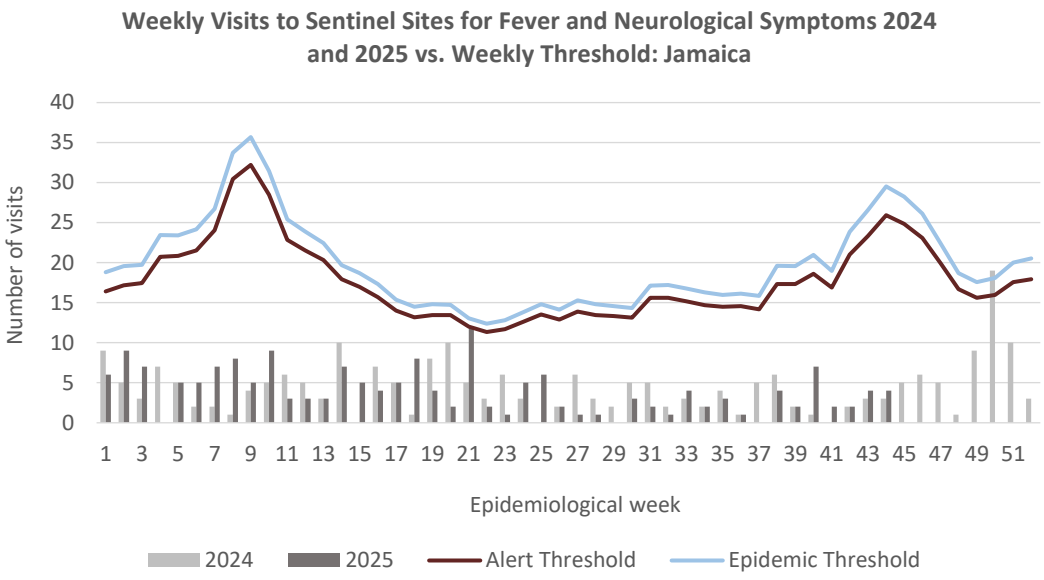
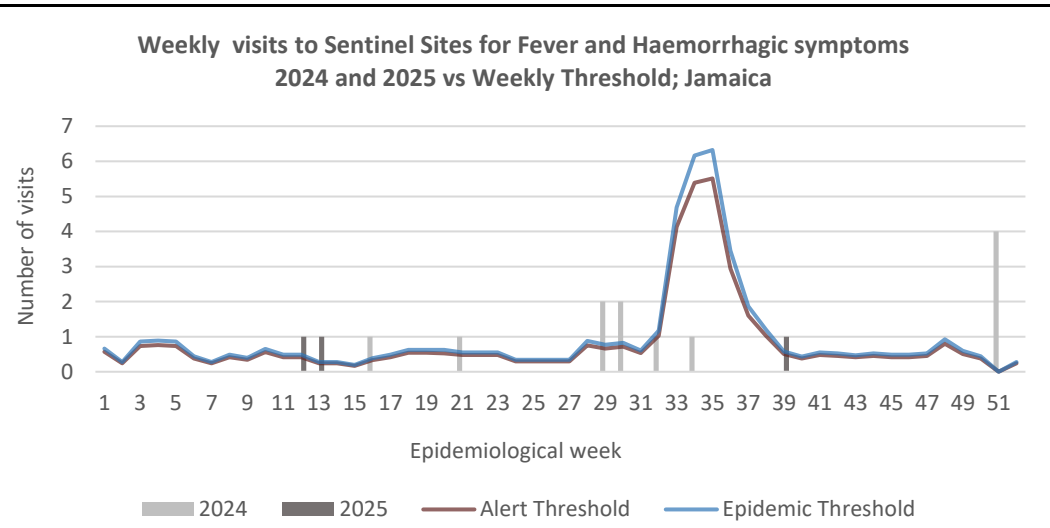
FEVER AND NEUROLOGICAL

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

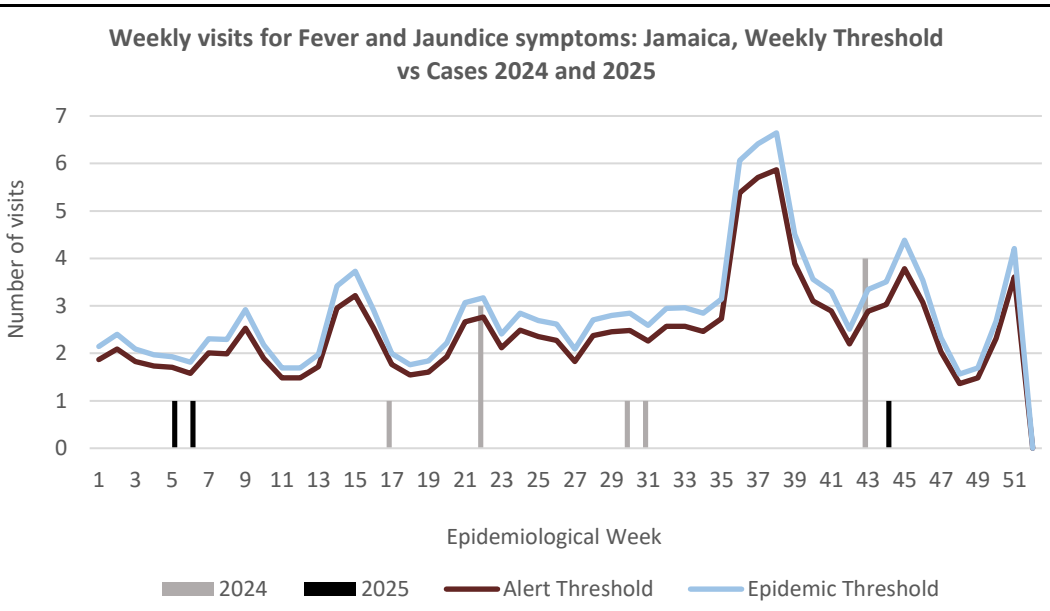
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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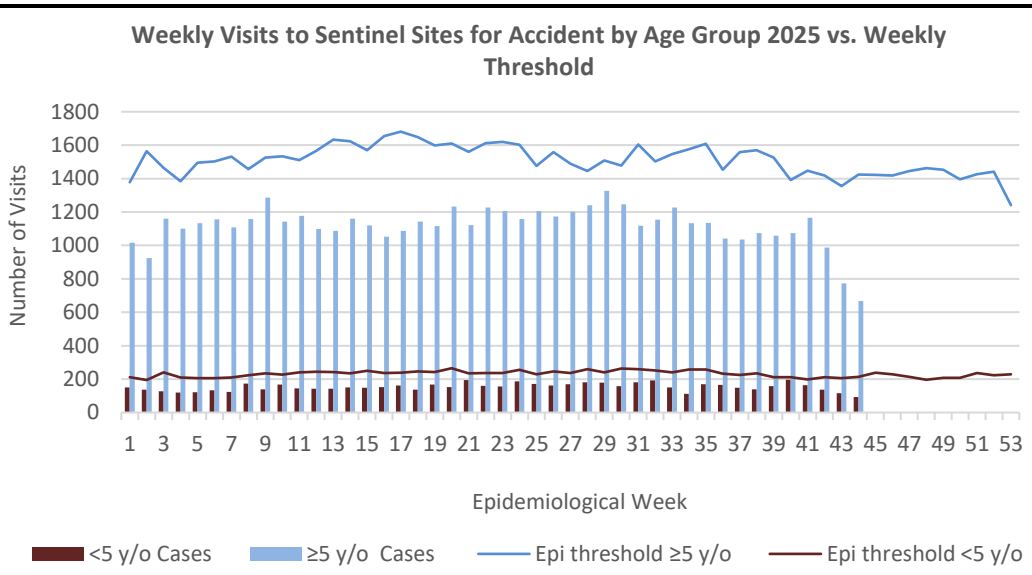
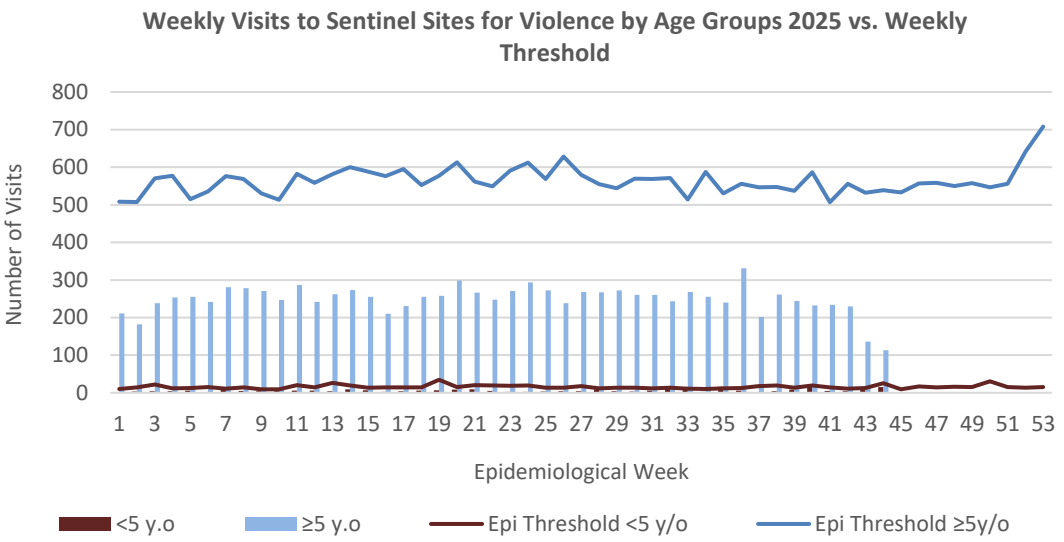
ACCIDENTS

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



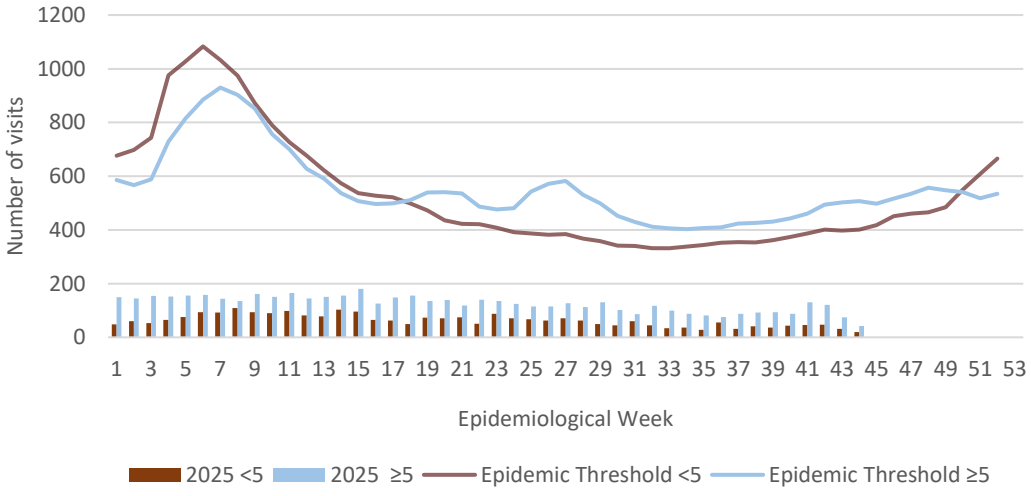
VIOLENCE

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	115[β]	264[β]
	Cholera	0	0
	Severe Dengue[Y]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	310	685
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	7	51
	Hepatitis C	1	10
	HIV/AIDS	NA	NA
	Malaria (Imported)	1	2
	Meningitis	11	20
	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
	Fever and Rash – Rubella	0	0
	Maternal Deaths[δ]	51	60
	Ophthalmia Neonatorum	36	159
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	0
	Tetanus	3	0
	Tuberculosis	42	49
	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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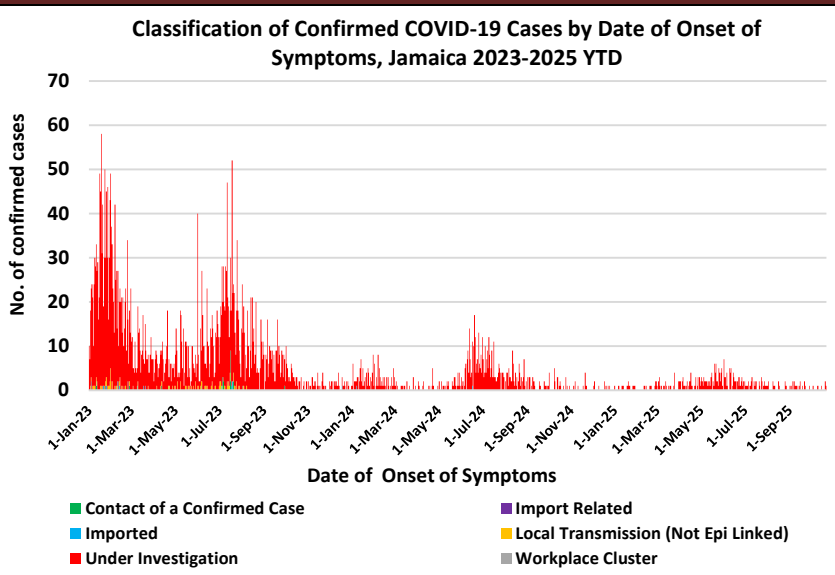
COVID-19 SURVEILLANCE

CASES	EW 44	Total
Confirmed	0	157746
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.

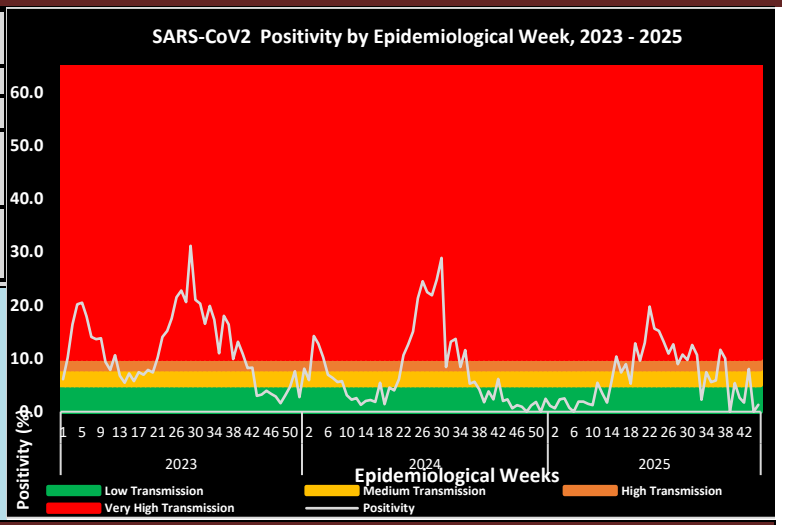


COVID-19 Outcomes

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

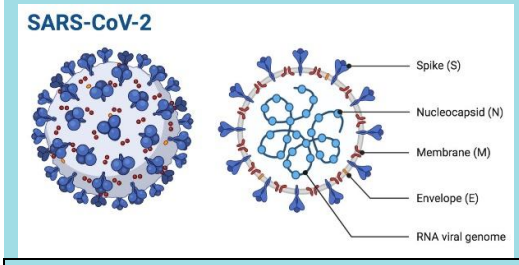
COVID-19	Year						
	2020	2021	2022	2023	2024	2025	Total
Cases	13352	83815	55721	3842	705	311	157746
Deaths	332	2815	621	116	24	13	3921

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



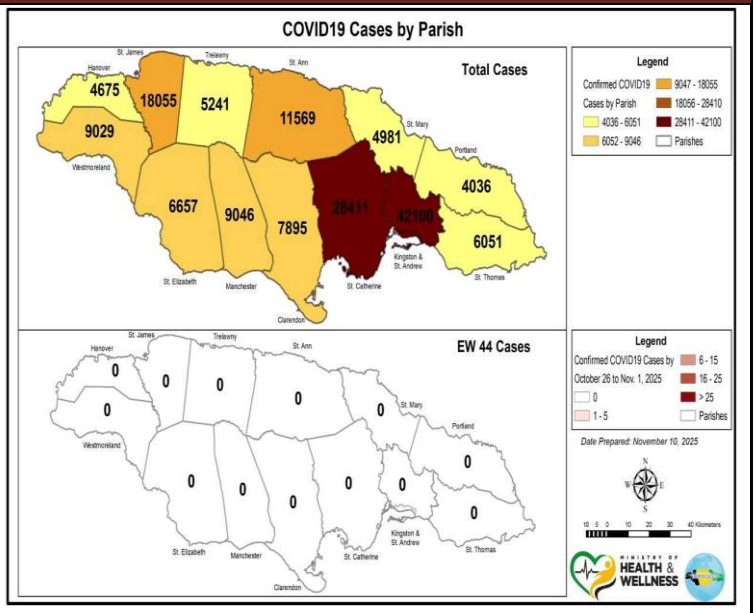
OVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 41 -44 2025

Epi Week	Confirmed Cases	Deaths
41	38700	130
42	37800	91
43	31800	78
44	27700	55
Total (4weeks)	**136000**	**154**



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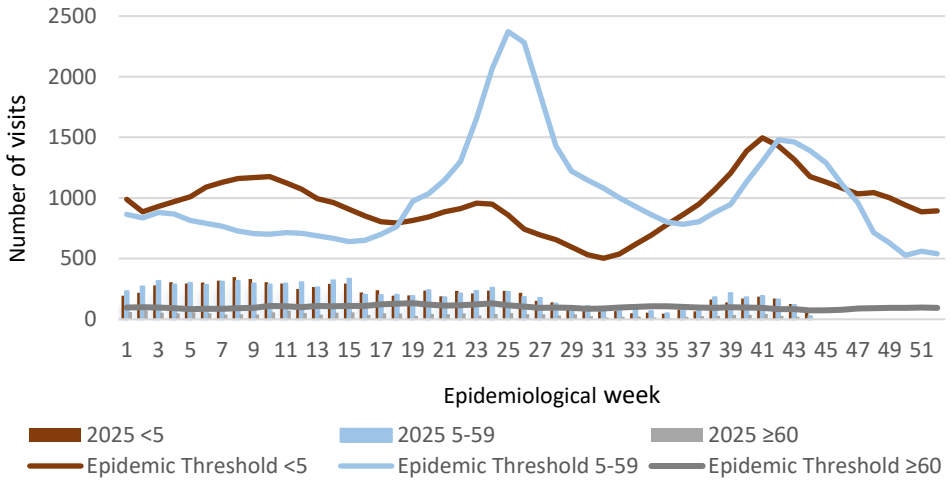
INFLUENZA SURVEILLANCE

EW 44

October 26, 2025 – November 1, 2025 Epidemiological Week 44

	EW 44	*YTD*
SARI cases	15	366
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	1	35

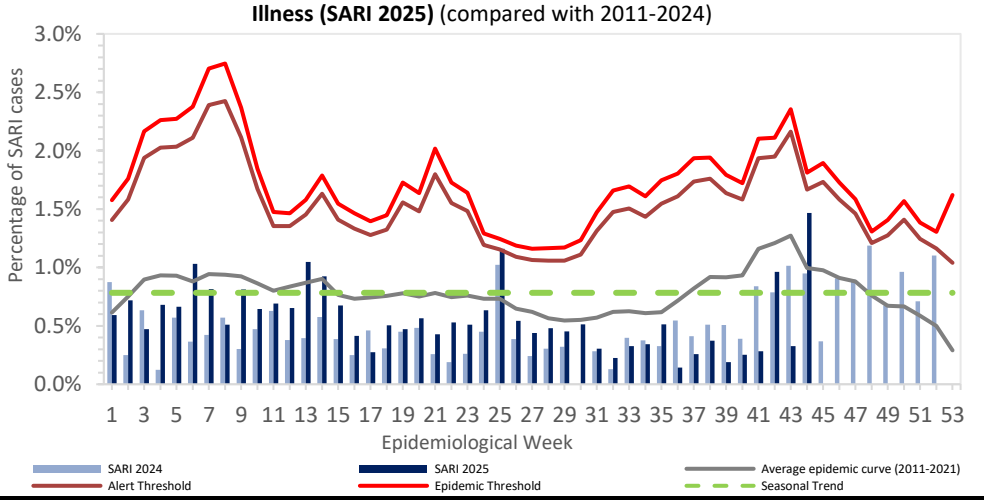
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 44, fifteen (15) SARI admissions was reported.

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

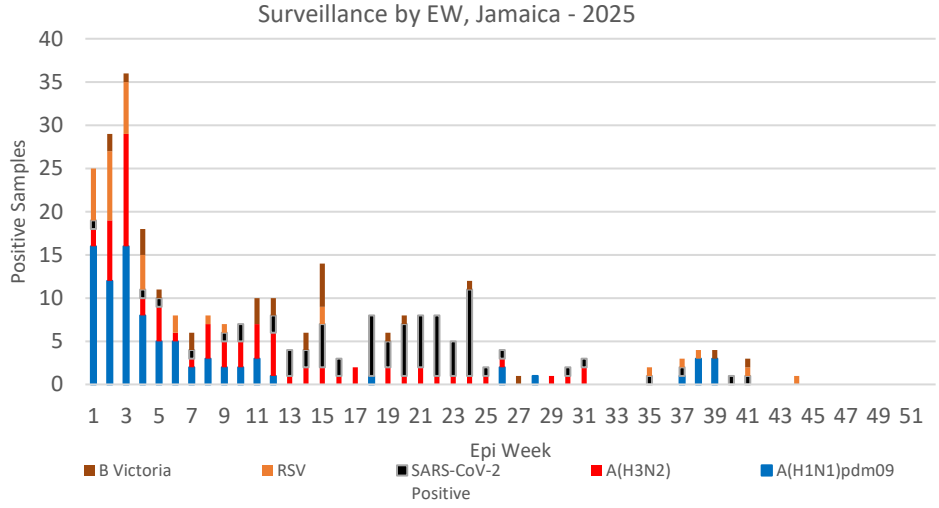


Caribbean Update EW 44

Influenza activity, primarily driven by circulation of subtype A(H1N1)pdm09, increased during the latest EW, with a subregional positivity rate of 9.5%. RSV circulation rose compared to the previous EW, reaching a positivity rate of 17.4%. In contrast, SARS-CoV-2 activity declined, with a subregional positivity rate of 3.2%. SARI cases show a decreasing trend, mainly associated with influenza and RSV. ILI cases also decreased, mostly linked to influenza followed by SARS-CoV-2. At the country level, influenza activity reached epidemic levels in Belize and Haiti, with an upward trend observed in Cayman Islands. A stable trend was noted in Barbados and Guyana (influenza B). Countries reporting a decline in influenza circulation include Cuba, the Dominican Republic and Jamaica. Regarding RSV, circulation decreased in Cuba and Guyana compared to the previous EW. It also declined in Dominican Republic and Haiti, although both maintain high positivity rates of 33% and 18.4%, respectively. RSV circulation increased in Belize (24.7% positivity) and the Cayman Island (19.6 positivity). Lastly, Barbados remained stable compared to the previous EW, with a positivity rate of 3.9%. SARS-CoV-2 decreased in Guyana, Jamaica and Saint Vincent and the Grenadines during the latest EW. Barbados also shows a downward trend, with a positivity rate of 11.7%. Haiti, Cuba, the Dominican Republic, Suriname and Saint Lucia continues to report low and stable circulation over the past several weeks. The Cayman Islands show stable circulation with a positivity rate of 7.8%, while Belize reports an increase of 2.3% positivity.

(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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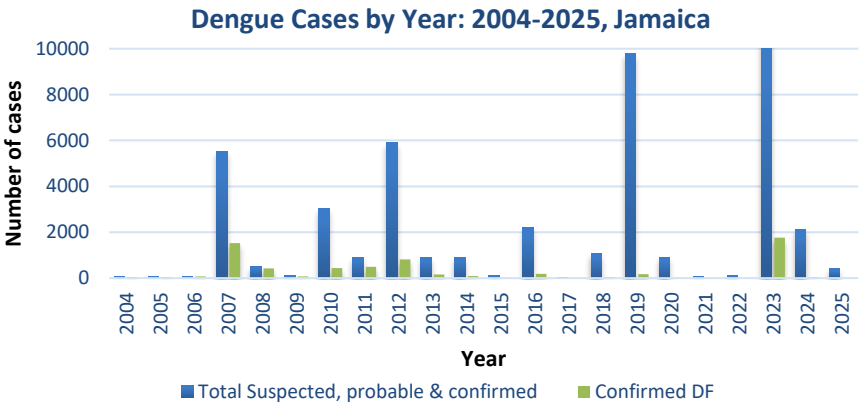
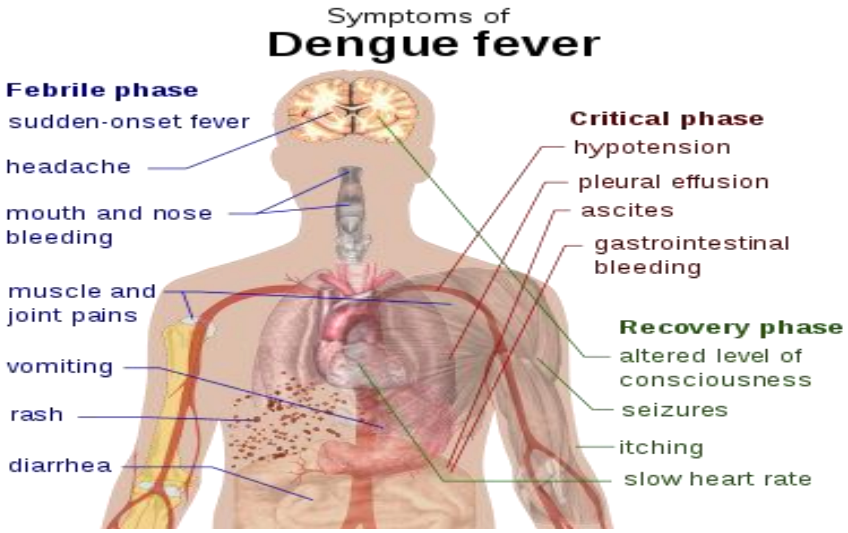
DENGUE SURVEILLANCE

October 26, 2025 – November 1, 2025 Epidemiological Week 44 | Epidemiological Week 44



Reported suspected, probable and confirmed dengue with symptom onset in week 44 of 2025

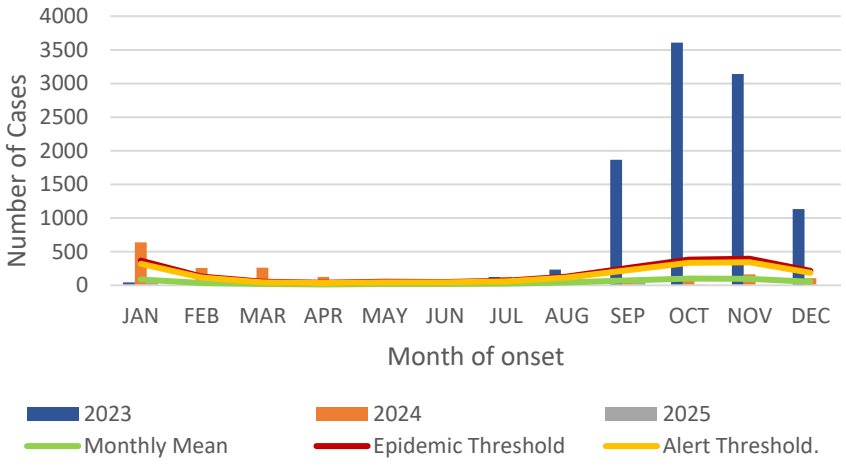
	2025*	
	EW 44	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	412
Lab Confirmed Dengue cases	0	0
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- **Dengue deaths are reported based on date of death.**
- ***Figure as at November 13, 2025**
- **Only PCR positive dengue cases are reported as confirmed.**
- **IgM positive cases are classified as probable dengue.**

Suspected, probable and confirmed dengue cases for 2023-2025 versus monthly mean, alert and epidemic threshold (2007-2022)



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RESEARCH ABSTRACT

Abstract

NHRC-23-17

Maternal and perinatal outcomes of eclampsia and preeclampsia at public hospitals in the South East Region (SERHA) Jamaica, a five-year review.

Lord, C [1], Grant, A[1], Reid, M [2], Harris MA[3], McCaw Binns, A[2]

[1] *Ministry of Health & Wellness, Jamaica* [2] *University of the West Indies, Jamaica* [3] *Pan American Health Organization, Trinidad and Tobago*

Objective: To describe maternal and perinatal outcomes associated with eclampsia and preeclampsia at public hospitals in SERHA, 2015–2019.

Methods: This retrospective cohort study reviewed medical records of patients and their neonates. Data were extracted from 788 records. (194 eclampsia patients (100%), 443 pre-eclampsia patients (1 in 4 records) and 151 normotensive women). Chi-square analysis tested for associations with eclampsia/preeclampsia. Logistic regression was used to determine factors associated with these conditions. Regression models considered: eclampsia/preeclampsia vs. no hypertension.

Results: Of the 788 records reviewed, the median age for eclampsia was 22 years (IQR 18, 27) and preeclampsia, 29 years (IQR 22, 35). Mean number of antenatal visits for women diagnosed with eclampsia was 5.6 ± 2.8 and preeclampsia 7.0 ± 3.5. The most common prodromal symptoms were headache for eclampsia (70.6%) and epigastric pain for preeclampsia (38.2%). Significant common maternal complications were postpartum haemorrhage (eclampsia 23% and preeclampsia 30.4%) and HELLP Syndrome (eclampsia 8.6% and preeclampsia 7.1%). Babies delivered by eclampsia women were nineteen times more likely to be premature (OR 19.3, 95%CI, 8.1, 46.0). Those delivered by preeclampsia women were twenty two times more likely to be premature (OR 22.0, 95%CI, 9.7, 52.1). Neonates were fourteen times more likely to be admitted to the nursery for mothers with eclampsia (OR 13.8, 95%CI, 7.9, 24.0) seven times for preeclampsia (OR 7.3, 95%CI, 4.48, 12.0).

Conclusion: Eclampsia and preeclampsia are associated with obstetric complications and adverse maternal and perinatal outcomes. Improved antenatal monitoring and early intervention are necessary for better outcomes.

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