WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Maternal Health

Maternal health refers to the health of women during pregnancy, childbirth and the postnatal period. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and well-being. Although important progress has been made in the last two decades, about 287 000 women died during and following pregnancy and childbirth in 2020. This number is unacceptably high. The most common direct causes of maternal injury and death are excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labour, as well as indirect causes such as anemia, malaria, and heart disease. Most maternal deaths are preventable with timely management by a skilled health professional working in a supportive environment.

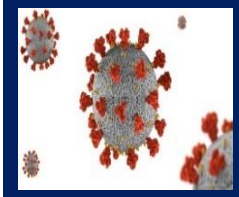
Ending preventable maternal death must remain at the top of the global agenda. At the same time, simply surviving pregnancy and childbirth can never be the marker of successful maternal health care. It is critical to expand efforts reducing maternal injury and disability to promote health and well-being. Every pregnancy and birth is unique. Addressing inequalities that affect health outcomes, especially sexual and reproductive health and rights and gender, is fundamental to ensuring all women have access to respectful and high-quality maternity care.

About 140 million births take place every year and the proportion attended by skilled health personnel has increased: from 58% in 1990 to 81% in 2019. This is mostly due to larger numbers of births taking place at a health facility. Deaths from complications during pregnancy, childbirth, and the postnatal period have declined by 38% in the last two decades, but at an average reduction of just under 3% per year, this pace of progress is far too slow. It also hides vast inequalities within and across countries.

More than half of maternal deaths occur in fragile and humanitarian settings. The Sustainable Development Goals (SDGs) offers an opportunity for the international community to work together and accelerate progress to improve maternal health for all women, in all countries, under all circumstances. SDG targets for maternal health include 3.1, aiming for an average global ratio of less than 70 deaths per 100 000 births by 2030, and 3.8, calling for the achievement of universal health coverage. These cannot be achieved without reproductive, maternal, newborn and child health coverage for all.

Taken from WHO website on 17/Dec/2025
https://www.who.int/health-topics/maternal-health#tab=tab_1
https://www.who.int/health-topics/maternal-health#tab=tab_2
https://www.facebook.com/themohgovjm/photos/d41d8cd9/1262174239268837/

EPI WEEK 49



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 – 46 to 49 of 2025.

***Timeliness of submission from EW 43 onward is 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.

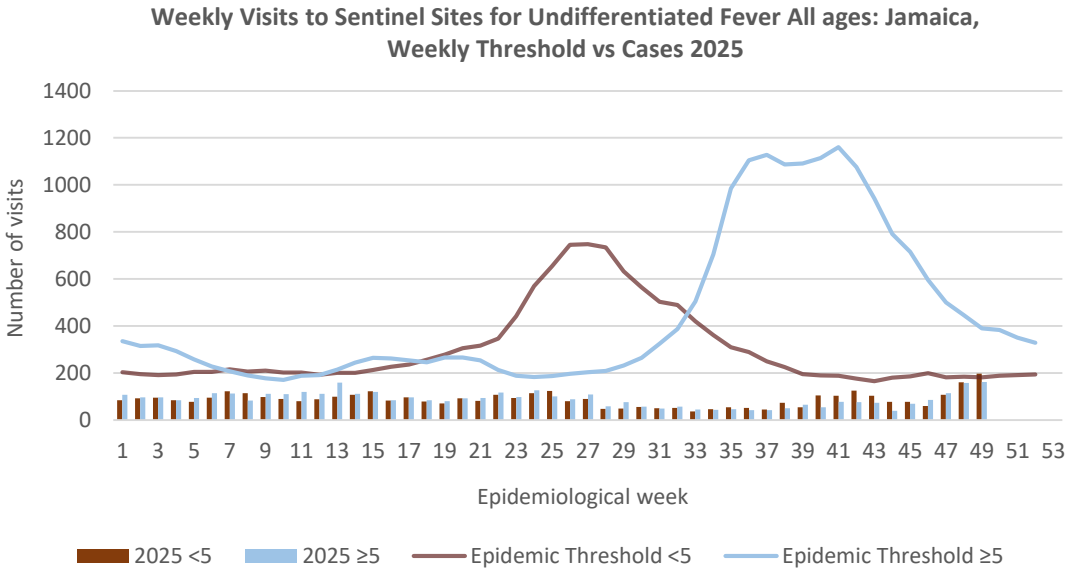
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
46	On Time	On Time	On Time	On Time	On Time	On Time	On Time	Late (T)	Late (W)	On Time	On Time	On Time	On Time
47	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
48	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time		On Time	On Time	On Time	On Time
49	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

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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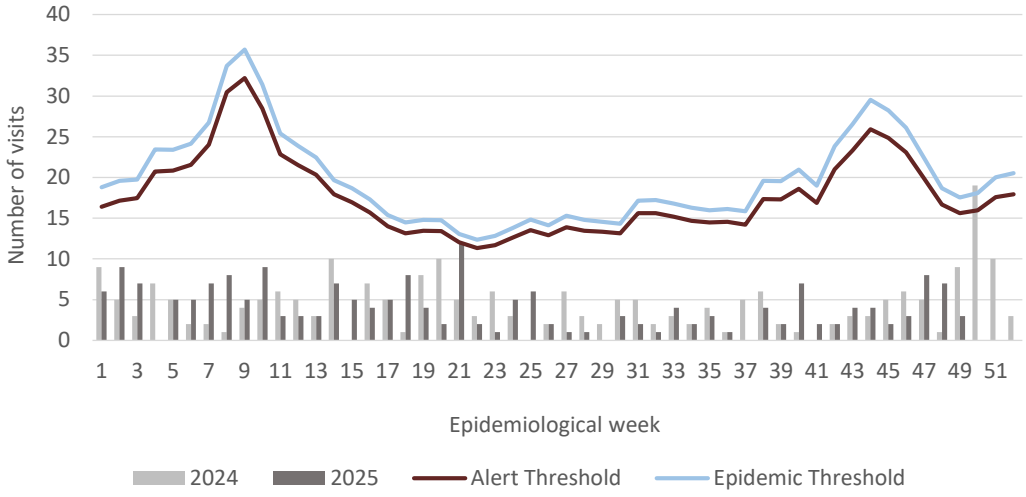
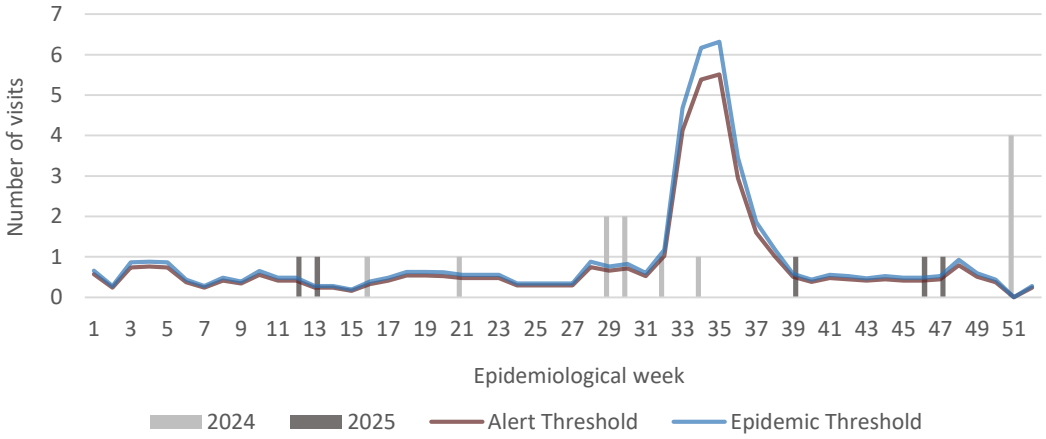
FEVER AND NEUROLOGICAL

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

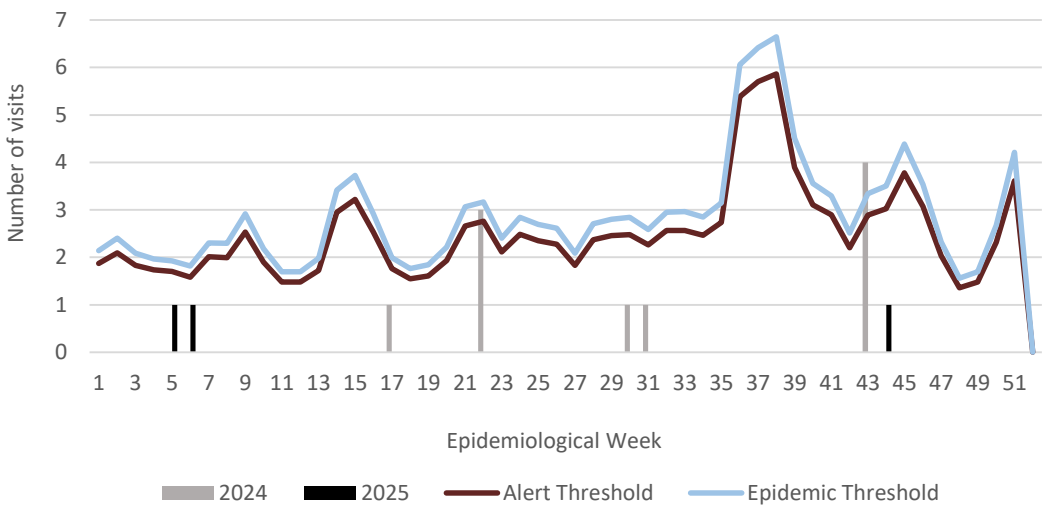
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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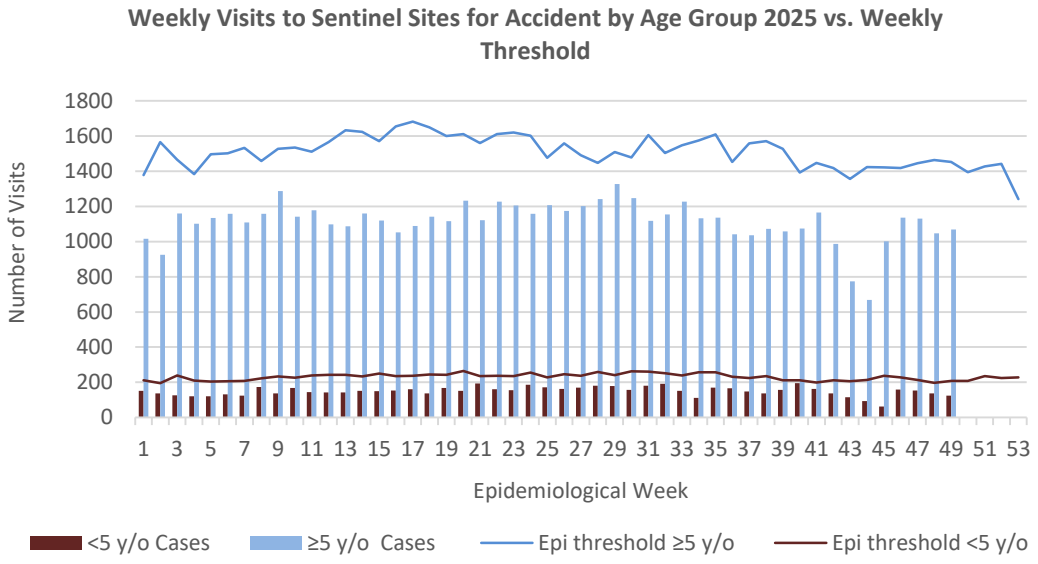
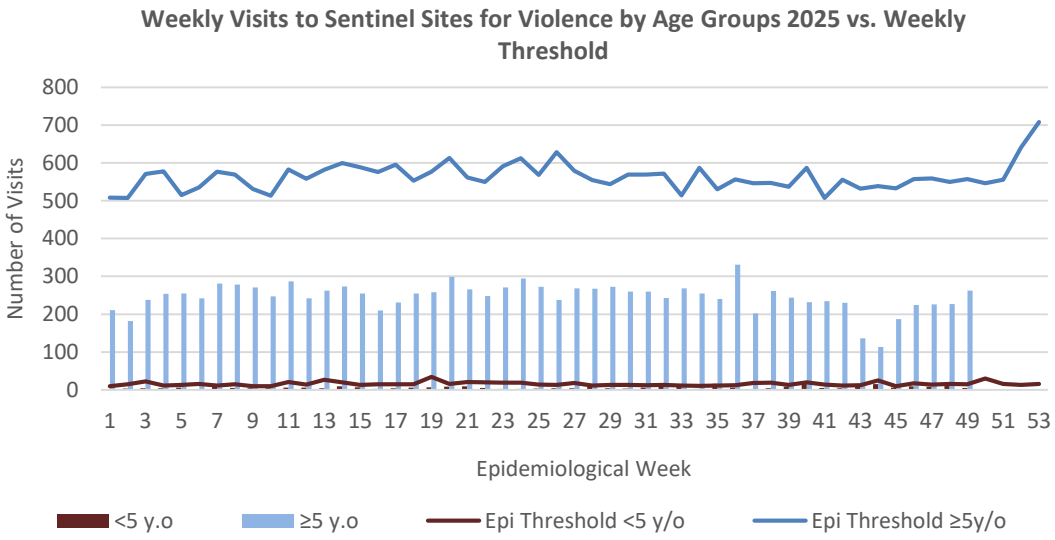
ACCIDENTS

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



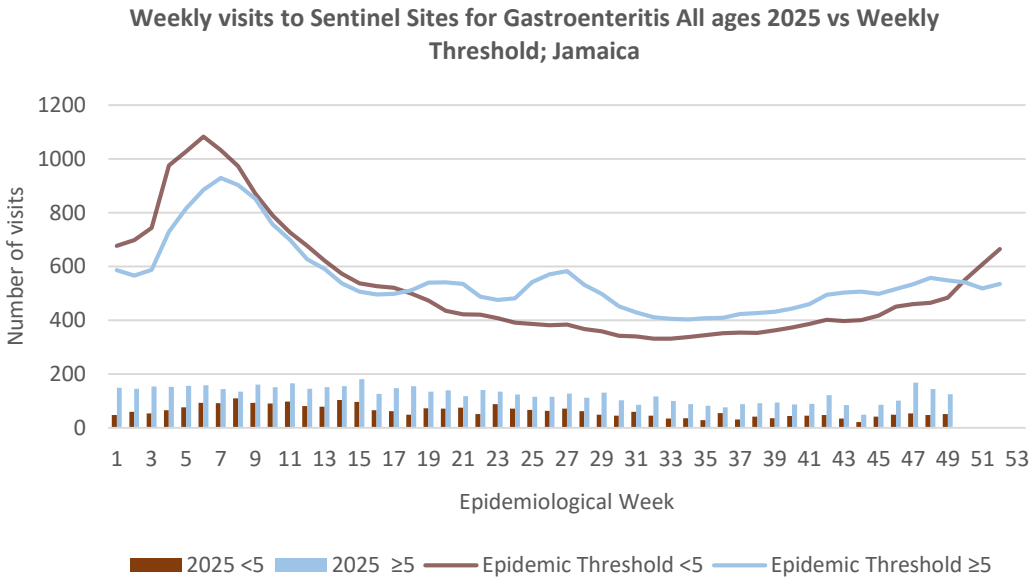
VIOLENCE

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	127[β]	271[β]
	Cholera	0	0
	Severe Dengue[Y]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	314	699
	Hansen's Disease (Leprosy)	0	1
	Hepatitis B	8	51
	Hepatitis C	1	10
	HIV/AIDS	NA	NA
	Malaria (Imported)	1	3
	Meningitis	12	21
	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]	54	67
	Ophthalmia Neonatorum	41	159
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	0
	Tetanus	3	0
	Tuberculosis	47	59
	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

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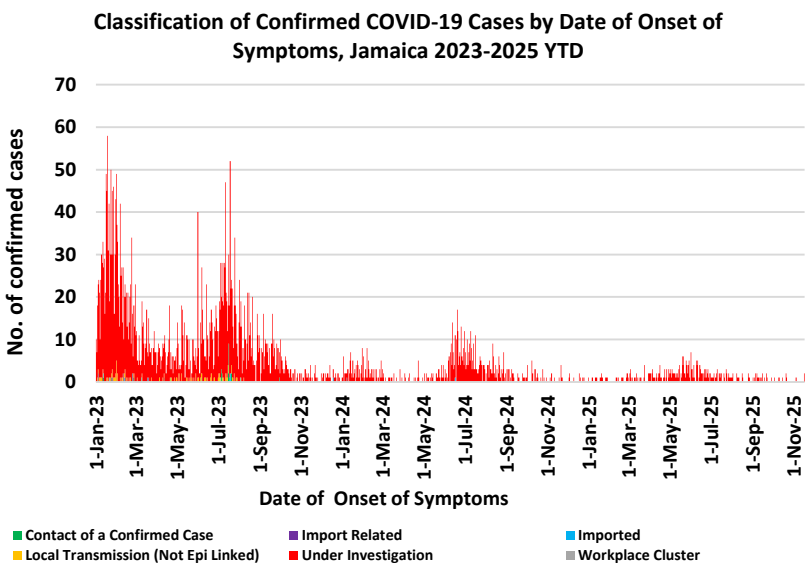
COVID-19 SURVEILLANCE

CASES	EW 49	Total
Confirmed	0	157749
Females	0	90882
Males	0	66864
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.

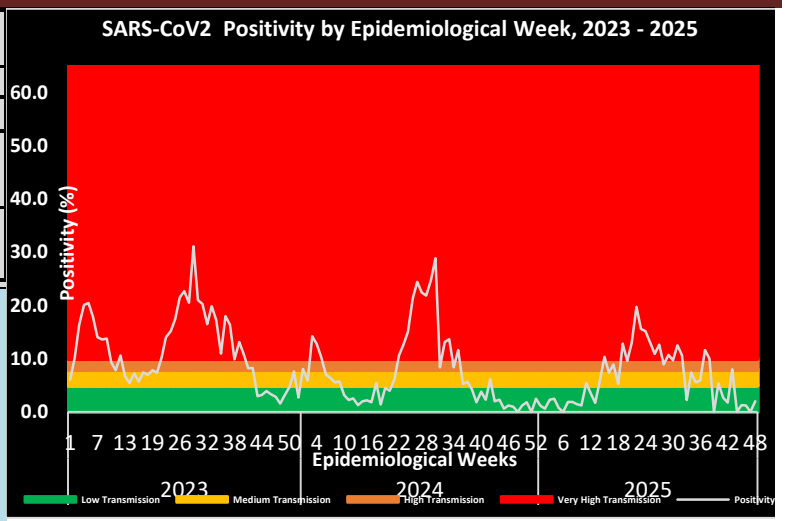


COVID-19 Outcomes

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

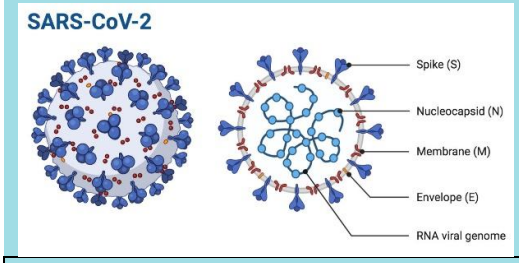
COVID-19	Year						
	2020	2021	2022	2023	2024	2025	Total
Cases	13,352	83,815	55,721	3,842	705	314	157,749
Deaths	332	2,815	621	116	24	13	3,921

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



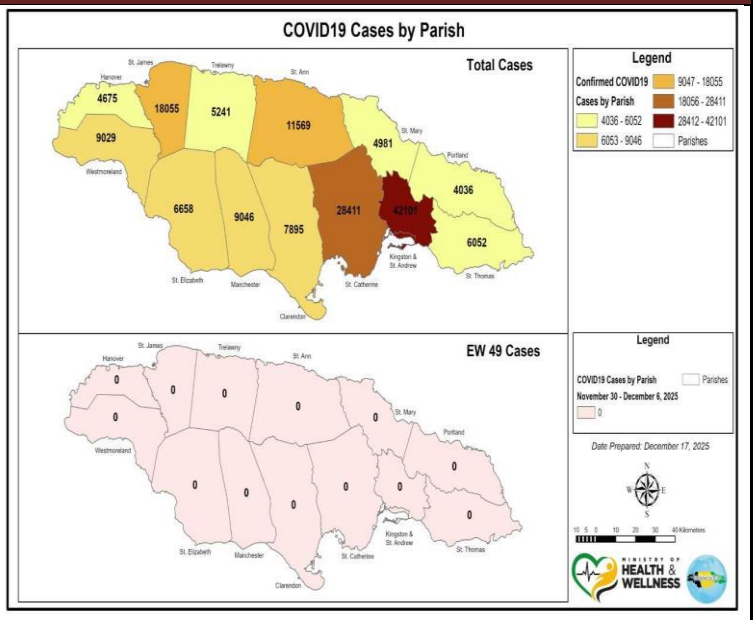
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 46 -49 2025

Epi Week	Confirmed Cases	Deaths
46	21500	260
47	18600	228
48	15400	225
49	11900	172
Total (4weeks)	**67400**	**885**



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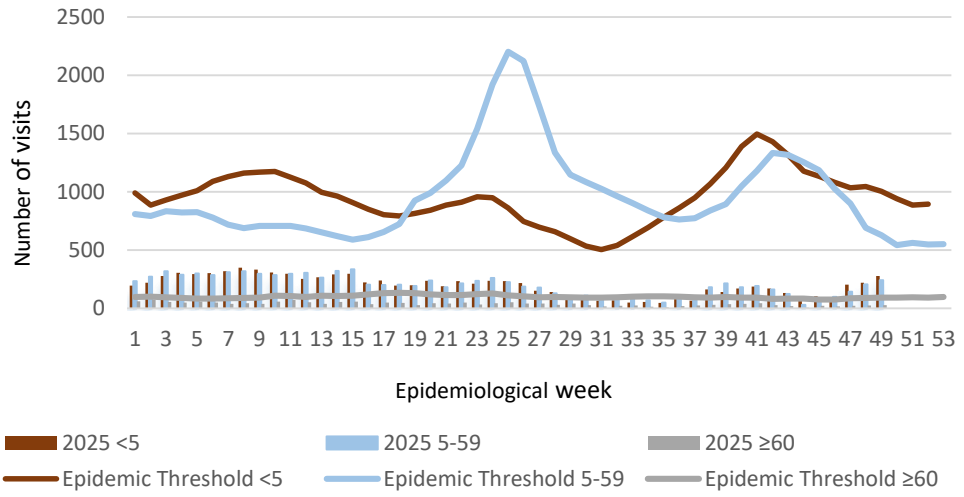
INFLUENZA SURVEILLANCE

EW 49

November 30, 2025 – December 6, 2025 Epidemiological Week 49

	EW 49	*YTD*
SARI cases	22	423
Total Influenza positive Samples	**0**	**196**
Influenza A	**0**	**166**
H1N1pdm09	0	90
H3N2	0	75
Not subtyped	0	1
Influenza B	**1**	**30**
B lineage not determined	0	0
B Victoria	1	30
Parainfluenza	0	0
Adenovirus	0	0
RSV	1	53

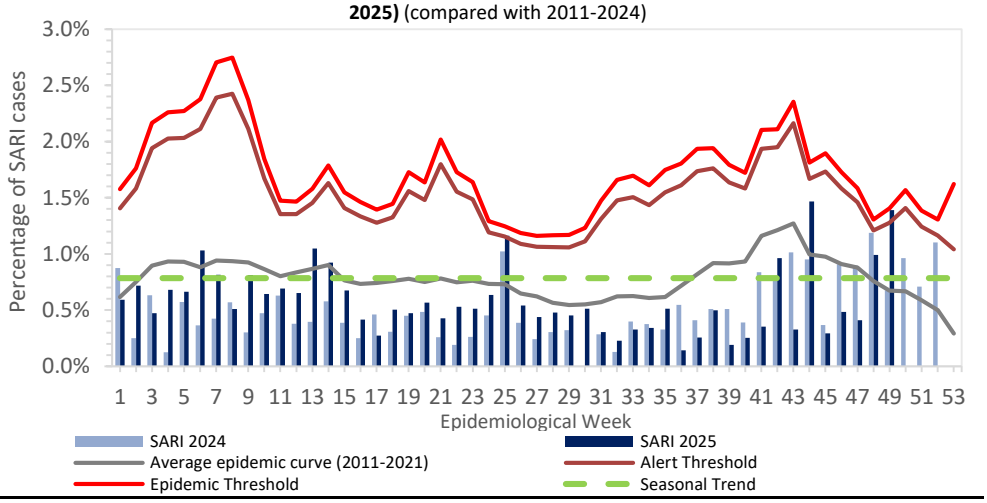
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 49, twenty-two (22) SARI admissions were reported.

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

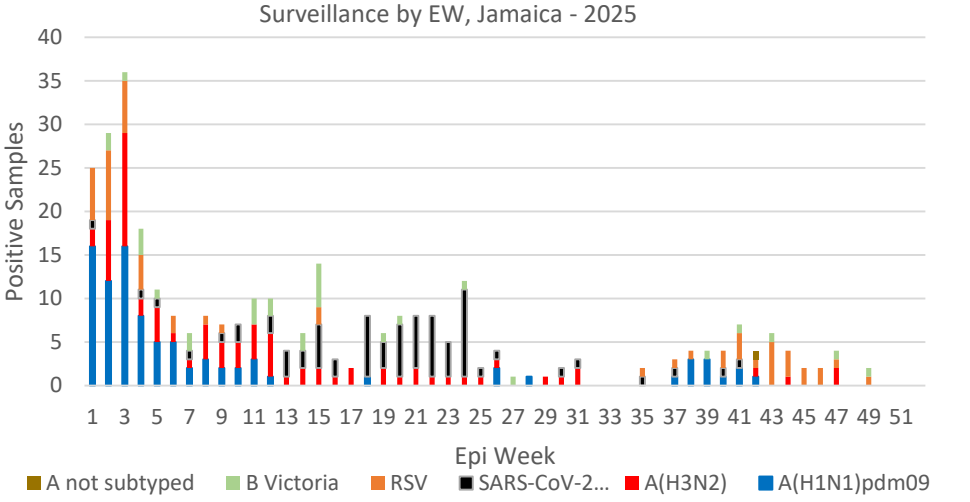


Caribbean Update EW 49

Influenza activity increased over recent EWs, reaching a subregional positivity of 18.7%, with influenza A(H3N2) accounting for 66% of subtyped samples. RSV circulation decreased compared with the previous two EWs, reaching a positivity of 15.7%, while SARS-CoV-2 activity also decreased, with a subregional positivity of 0.2%. SARI and ILI cases show a downward trend.

(Retrieved 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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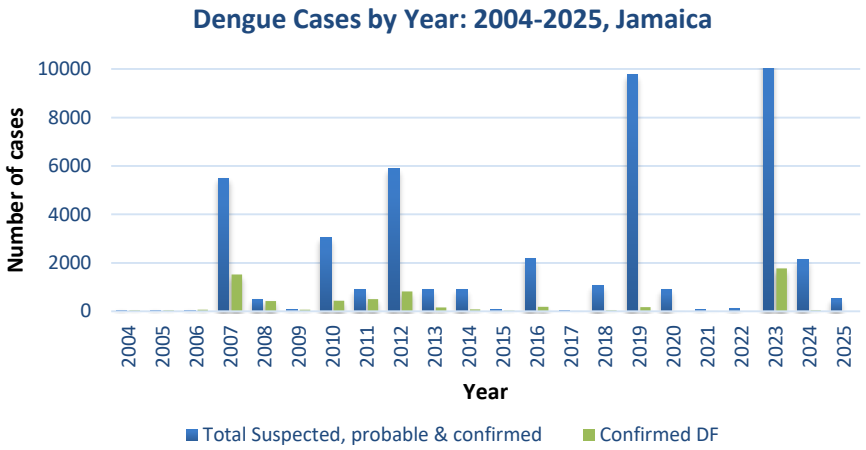
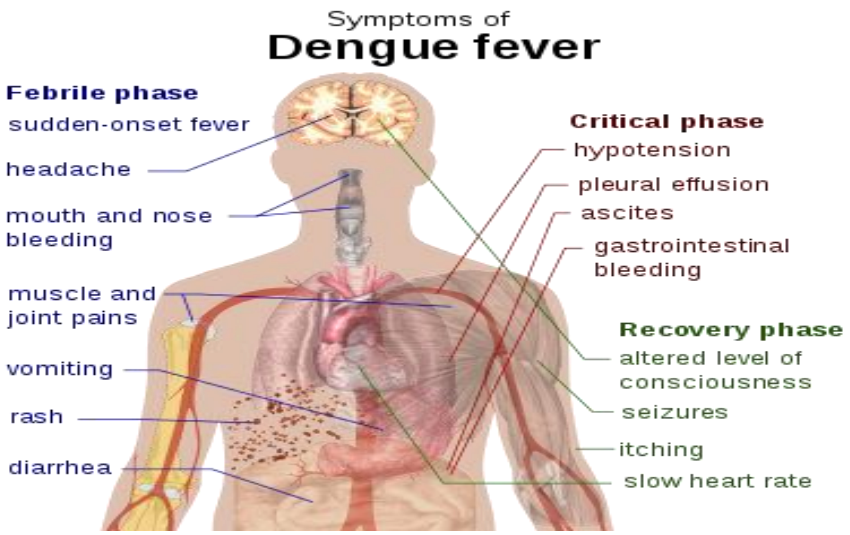
DENGUE SURVEILLANCE

November 30, 2025 – December 6, 2025 Epidemiological Week 49 | Epidemiological Week 49



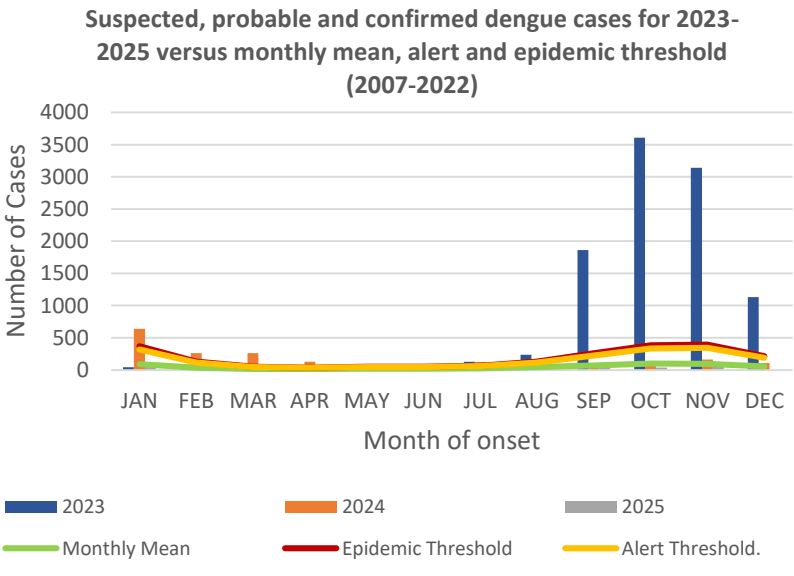
Reported suspected, probable and confirmed dengue with symptom onset in week 49 of 2025

	2025*	
	EW 49	YTD
Total Suspected, Probable & Confirmed Dengue Cases	2	531
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 December 18, 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-24-O-04

Exploring the associations between severe malnutrition in childhood, rehabilitation weight gain and adult adiposity: A prospective cohort study

Thompson D[1], McKenzie K[1], Badaloo A[1], Opondo C[2], Kerac M[3,4], Boyne M[5]

[1]Caribbean Institute for Health Research, University of the West Indies, Kingston, Jamaica, [2]Department of Medical Statistics, Faculty of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine, London, UK, [3]Department of Population Health, Faculty of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine, London, UK, [4]Centre for Maternal, Adolescent and Reproductive Child Health (MARCH), London School of Hygiene and Tropical Medicine, London, UK, [5]Department of Medicine, University of the West Indies, Mona, Jamaica

Objectives: The relationships between severe malnutrition (SM), the rate of weight gain during nutritional rehabilitation and adult cardio metabolic risk in survivors have not been fully elucidated. This study explored these associations in a cohort of adult SM survivors hospitalised as children between 1963-1993.

Methods: In sex-aggregated and sex-disaggregated regression analyses, minimum weight-for-age z-scores (minWAZ) during hospitalisation was analysed against adult body composition (D-EXA) (2009-2012) in models adjusting for oedema, rehabilitation weight gain and adult age.

Results: 278 adult SM survivors were studied (60% male, mean age (SD) 28.2 (7.7) years, mean BMI (SD) 23.6 (5.2) kg/m^2). In univariate analyses, minWAZ was associated with adult waist circumference (difference 1.8, 95% CI 0.7, 2.9, p=0.001), fat mass (difference 2.4, 95% CI 0.17, 1.06, p=0.007) and android fat mass (difference 0.19, 95% CI 0.09, 0.29, p<0.001). Roughly 13% of the effect of minWAZ on adult fat mass was mediated by rehabilitation weight gain in g/kg/day (Sobel's p=0.053) and rehabilitation weight gain >12.9 g/kg/day was associated with adult fat mass (difference 5.1 kg, 95% CI 2, 9, p=0.006) and android fat (difference 0.5 kg, 95% CI 0.1, 0.8, p=0.006) in men only.

Conclusion: Children who were least underweight on admission for SM had greater adult adiposity, and this association was mediated by weight gain during nutritional rehabilitation. Faster weight gain during nutritional rehabilitation was shown to be a risk factor for adiposity in male adult SM survivors and may be a target of future early-life interventions to reduce the risk of adult cardio metabolic disease.

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