WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Maternal Mortality (Part 2)

Factors that prevent women from receiving or seeking care during pregnancy and childbirth are:

- health system failures that translate to (i) poor quality of care, including disrespect, mistreatment and abuse, (ii); insufficient numbers of and inadequately trained health-care providers, (iii); shortages of essential medical supplies; and (iv) the poor accountability of health systems;.
- social determinants, including income, access to education, race and ethnicity, that put some sub-populations at greater risk;
- harmful gender norms and/or inequalities that result in a low prioritization of the rights of women and girls, including their right to safe, quality and affordable sexual and reproductive health services; and
- external factors contributing to instability and health system fragility, such as climate and humanitarian crises.

To improve maternal health, barriers that limit access to quality maternal health services must be identified and addressed at both health system and societal levels.

What was the impact of COVID-19 pandemic on maternal mortality?

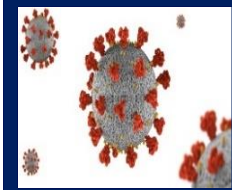
The MMR rose in 2021 (from 282 000 maternal deaths in 2020 to 322 000 maternal deaths in 2021). It is possible that the COVID-19 pandemic contributed to this via two mechanisms: (i) indirect obstetric deaths – where the woman had SARS-CoV-2 infection and died as a result of the interaction between COVID-19 and her pregnant state; and/or (ii) direct obstetric deaths – where disruptions to health services hindered access to and/or quality of care resulting in pregnancy complications that ended in mortality, when they may otherwise have been prevented or managed successfully. The data show that this interruption to the downward trajectory of global MMR was short-lived. In 2022, the global MMR and number of maternal deaths were lower than they had been in the three years immediately prior to the COVID-19 pandemic.

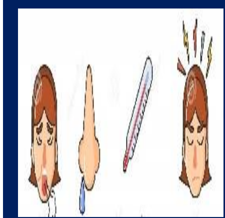
The Sustainable Development Goals and maternal mortality

In the context of the Sustainable Development Goals (SDG), countries have united behind the target to accelerate the decline of maternal mortality by 2030. SDG 3 includes an ambitious target: "reducing the global MMR to less than 70 per 100 000 births, with no country having a maternal mortality rate of more than twice the global average". The global MMR in 2023 was 197 per 100 000 live births; achieving a global MMR below 70 by the year 2030 will require an annual rate of reduction of almost 15%, a rate that has rarely been achieved at the national level. However, scientific and medical knowledge are available to prevent most maternal deaths. As 2030 approaches, the end of the SDG era, now is the time to intensify coordinated efforts, and to mobilize and reinvigorate global, regional, national and community-level commitments to end preventable maternal mortality.

Taken from WHO website on 29/Dec/2025
https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
Picture taken from https://unsplash.com/s/photos/maternity

EPI WEEK 51





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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 – 48 to 51 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

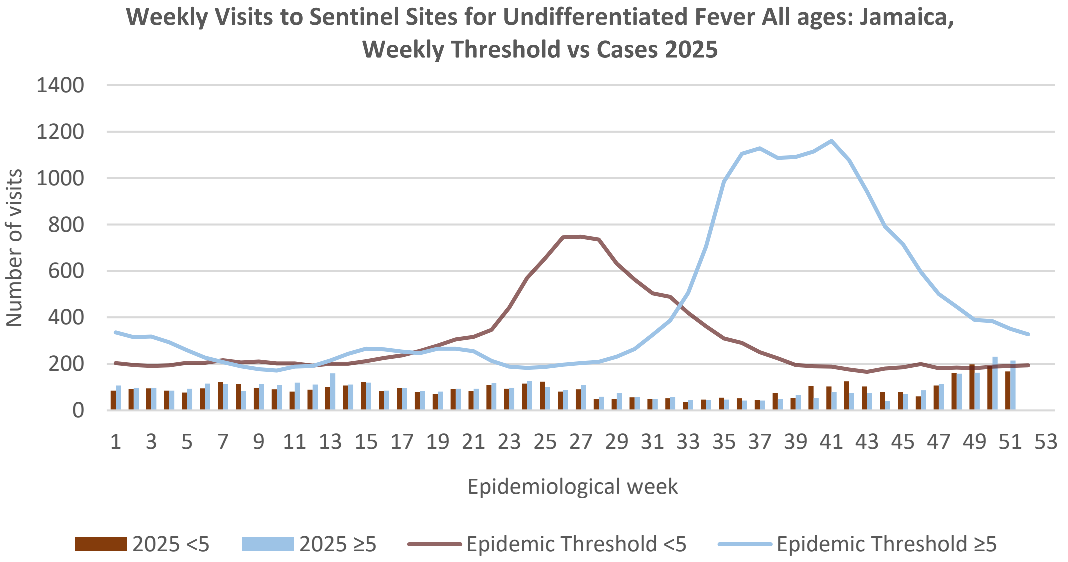
Epi week	Kingston and Saint Andrew	Saint Thomas	Saint Catherine	Portland	Saint Mary	Saint Ann	Trelawny	Saint James	Hanover	Westmoreland	Saint Elizabeth	Manchester	Clarendon
2025													
48	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	Late (W)	On Time	On Time	On Time	On Time
49	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
50	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	Late (T)	On Time	On Time	On Time
51	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 >38⁰C /100.4⁰F (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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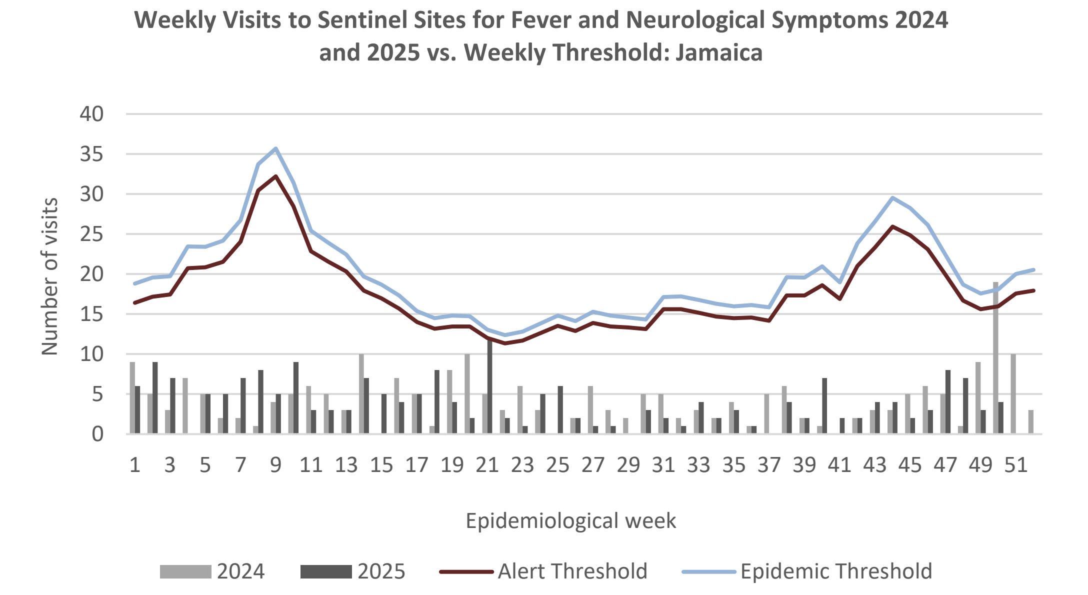
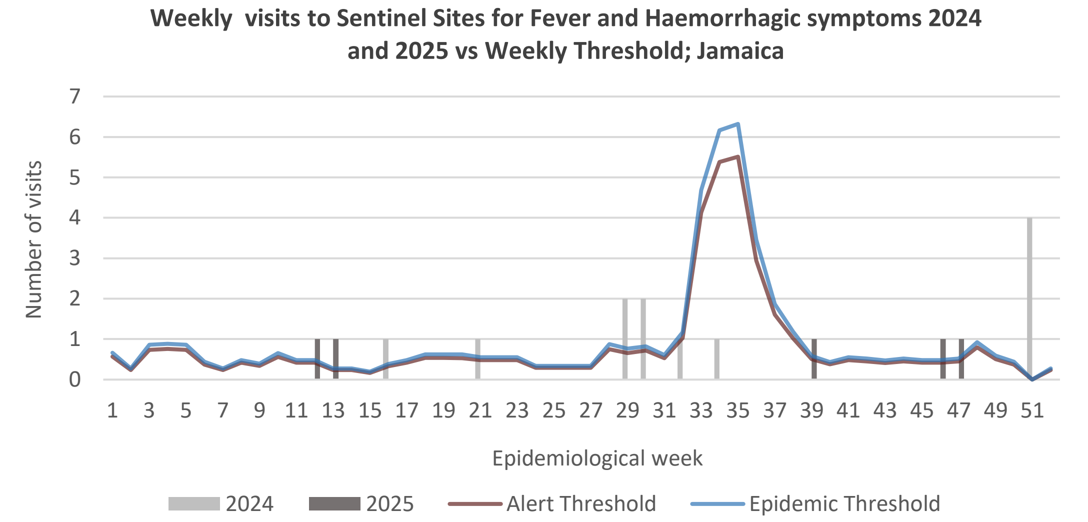
FEVER AND NEUROLOGICAL

Temperature of >38⁰C /100.4⁰F (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

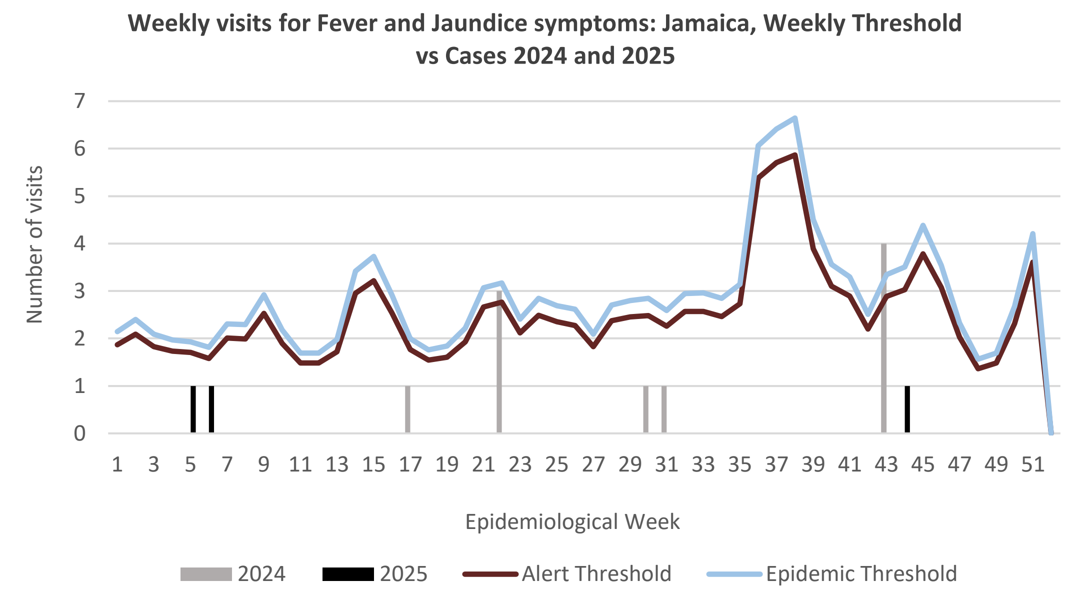
Temperature of >38⁰*C* /100.4⁰*F* (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



FEVER AND JAUNDICE

Temperature of >38⁰*C* /100.4⁰*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.



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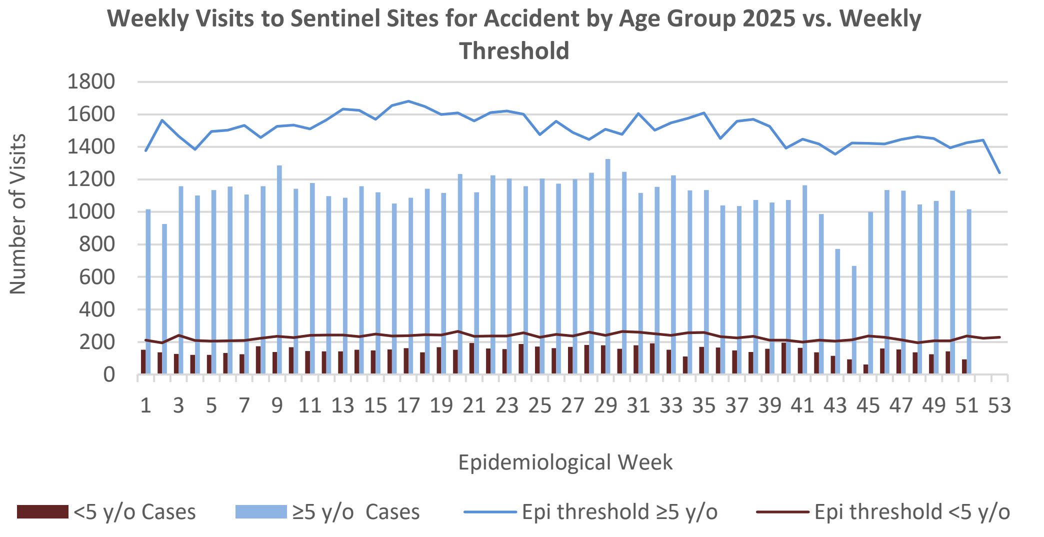
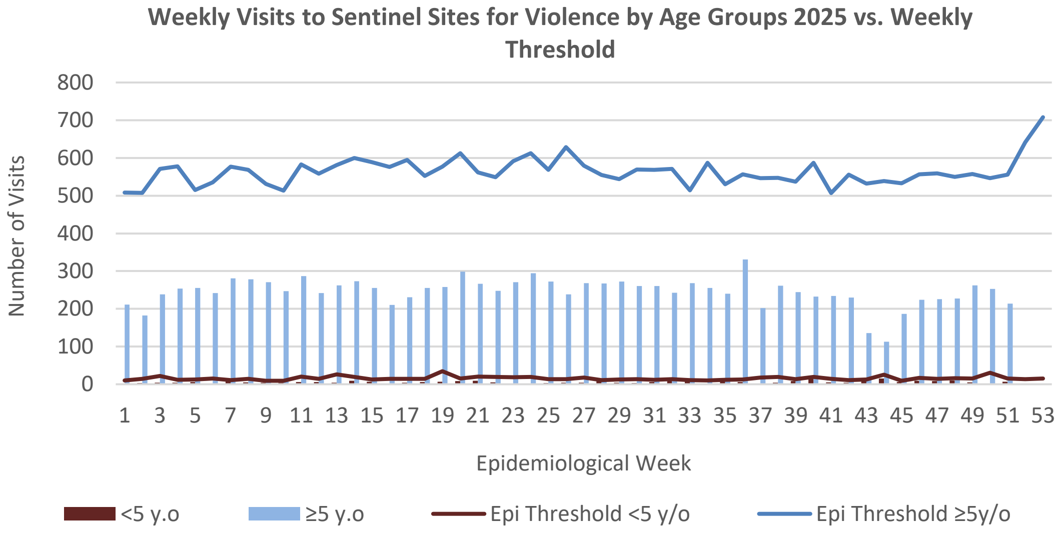
ACCIDENTS

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



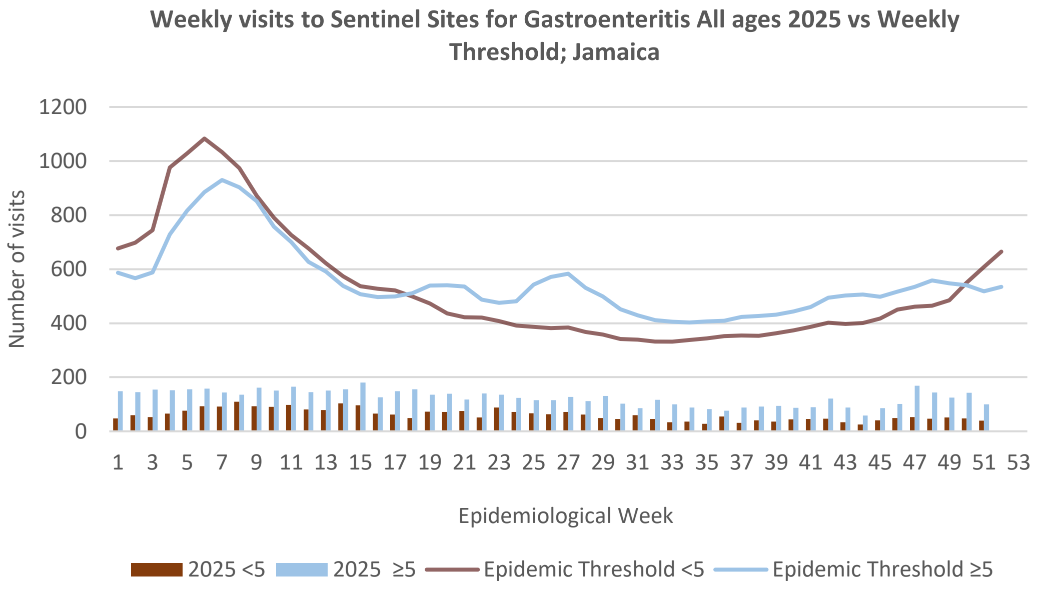
VIOLENCE

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	Confirmed YTD[α] PREVIOUS YEAR 2024
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	127[β]	273[β]
	Cholera	0	0
	Severe Dengue[ϒ]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	315	703
	Hansen's Disease (Leprosy)	0	1
	Hepatitis B	8	51
	Hepatitis C	1	10
	HIV/AIDS	NA	NA
	Malaria (Imported)	1	3
	Meningitis	13	22
	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]	55	69
	Ophthalmia Neonatorum	54	159
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	0
	Tetanus	3	0
	Tuberculosis	49	59
	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.

[ϒ]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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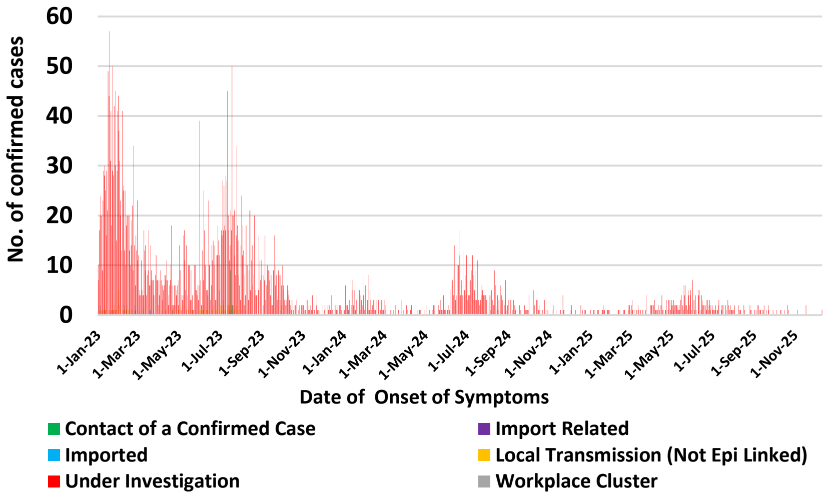
COVID-19 SURVEILLANCE

CASES	EW 51	Total
Confirmed	1	157750
Females	1	90883
Males	0	66864
Age Range	3 months	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.

Classification of Confirmed COVID-19 Cases by Date of Onset of Symptoms, Jamaica 2023-2025 YTD



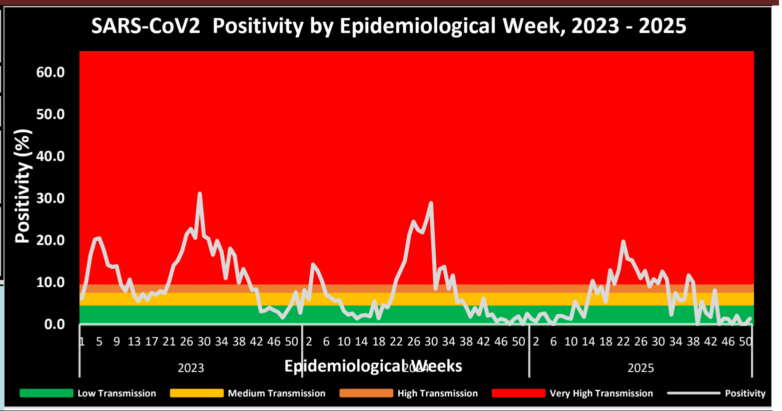
COVID-19 Outcomes

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	315	157,750
Deaths	332	2,815	621	116	24	13	3,921

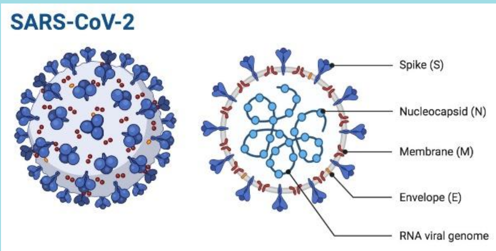
*Current positivity rate: 0.0%
- (positive samples/total samples tested)

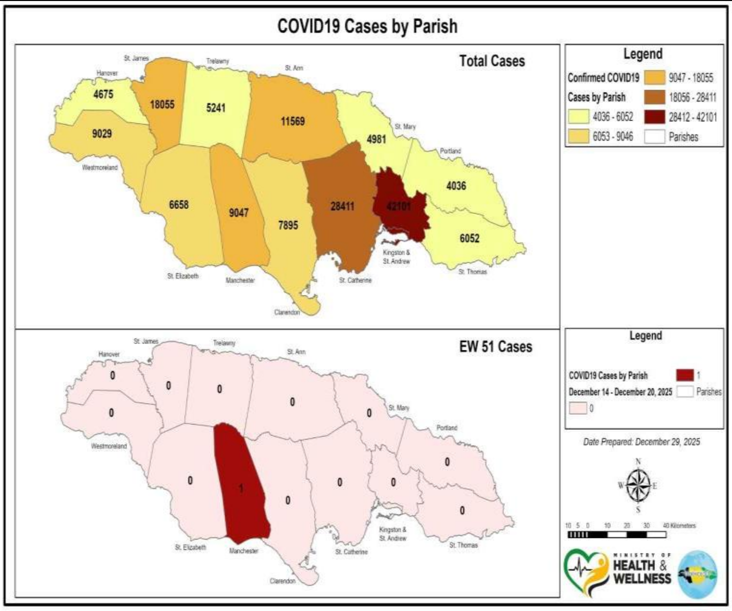
* Low transmission for infection



COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure





COVID-19 WHO Global Statistics EW 48 -51 2025

Epi Week	Confirmed Cases	Deaths
48	15800	262
49	13600	204
50	10900	185
51	No updates	No updates
Total (4weeks)		

INFLUENZA SURVEILLANCE

NOTIFICATIONS- All clinical sites

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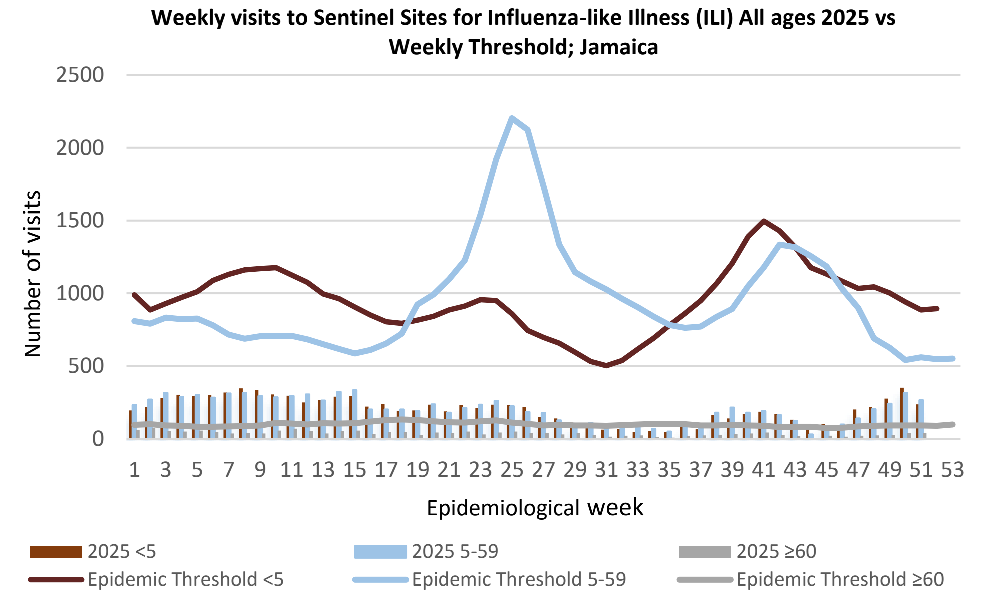
EW 51

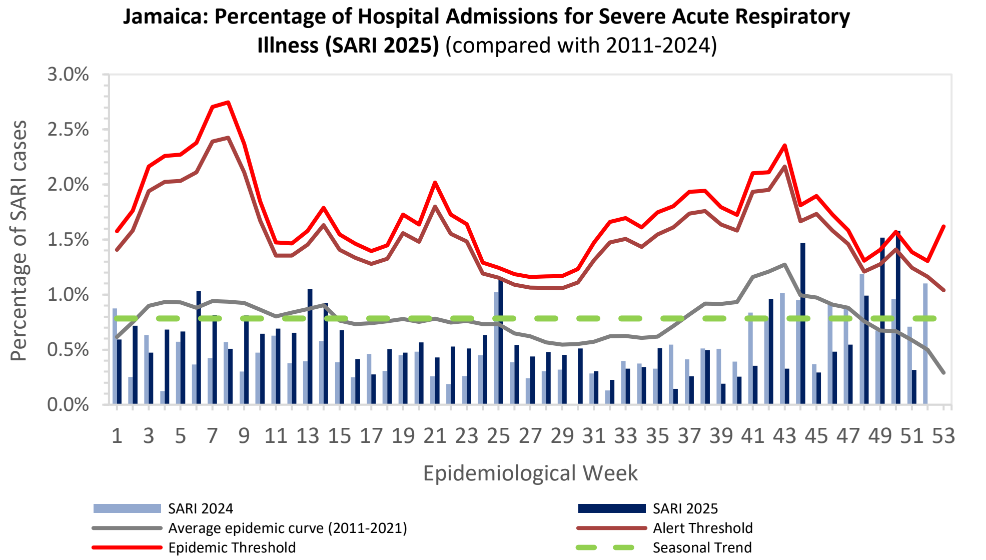
December 14, 2025 – December 20, 2025 Epidemiological Week 51

	EW 51	YTD
SARI cases	2	454
Total Influenza positive Samples	**1**	**214**
Influenza A	**1**	**181**
H1N1pdm09	0	93
H3N2	1	87
Not subtyped	0	1
Influenza B	**0**	**33**
B lineage not determined	0	0
B Victoria	0	33
Parainfluenza	0	0
Adenovirus	0	0
RSV	3	65



Epi Week Summary

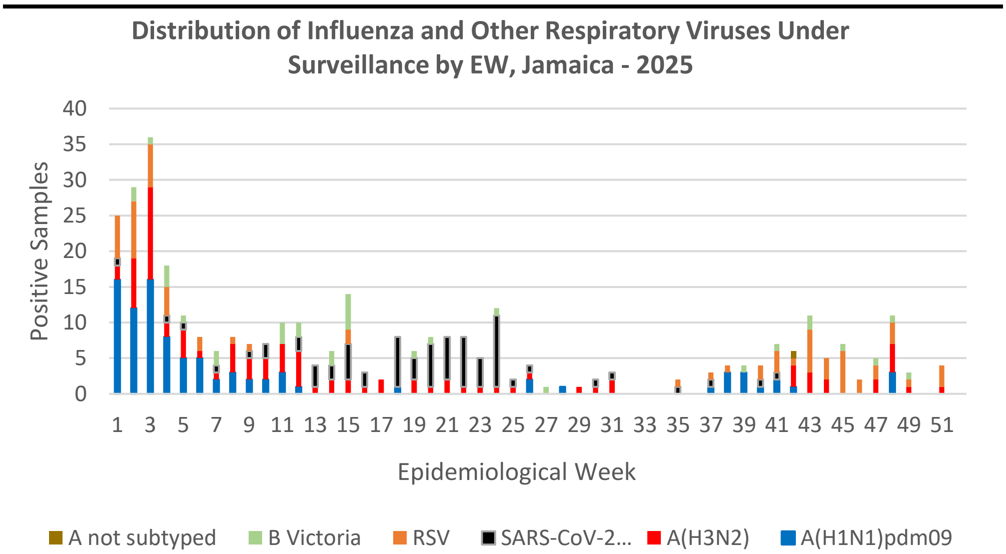
During EW 51, two (2) SARI admissions were reported.



Caribbean Update EW 51

Influenza activity increased over recent EWs, reaching a subregional positivity of 34.0%, with influenza A(H3N2) accounting for 76% of subtyped samples. RSV circulation continued to decrease over the past four EWs, reaching a positivity of 7%, while SARS-CoV-2 activity remains low and stable at 0.9%. SARI and ILI cases remained low.

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



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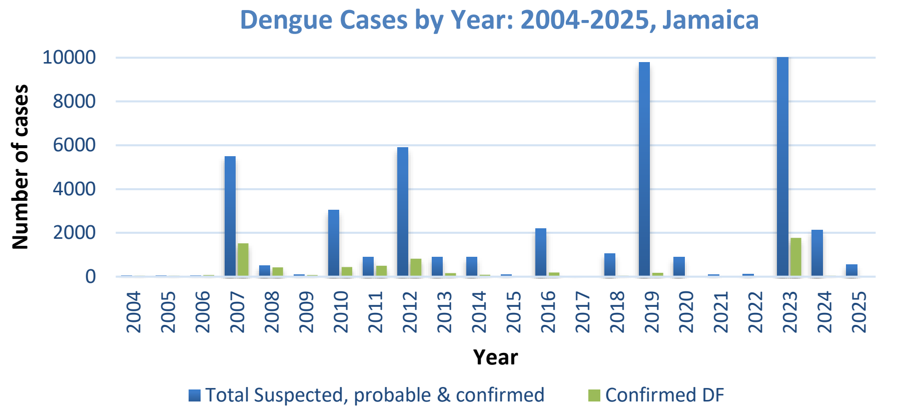
DENGUE SURVEILLANCE

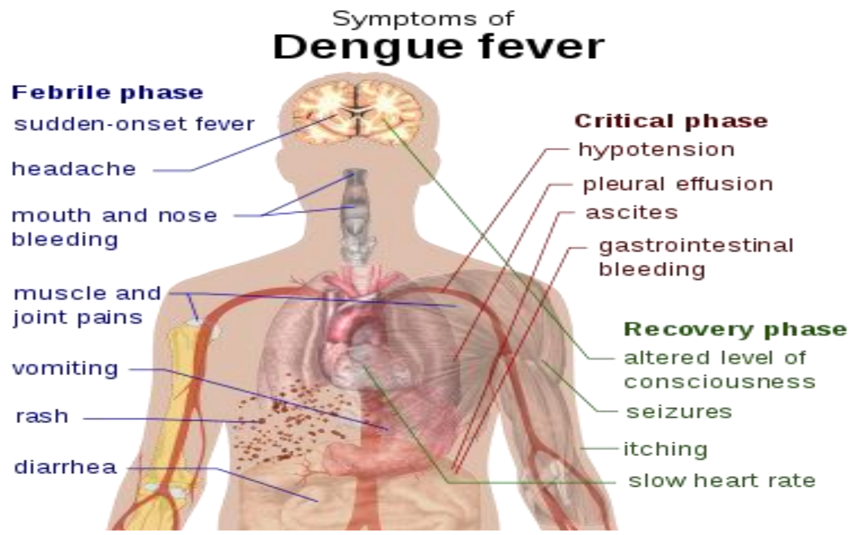
December 14, 2025 – December 20, 2025 Epidemiological Week 51

Epidemiological Week 51



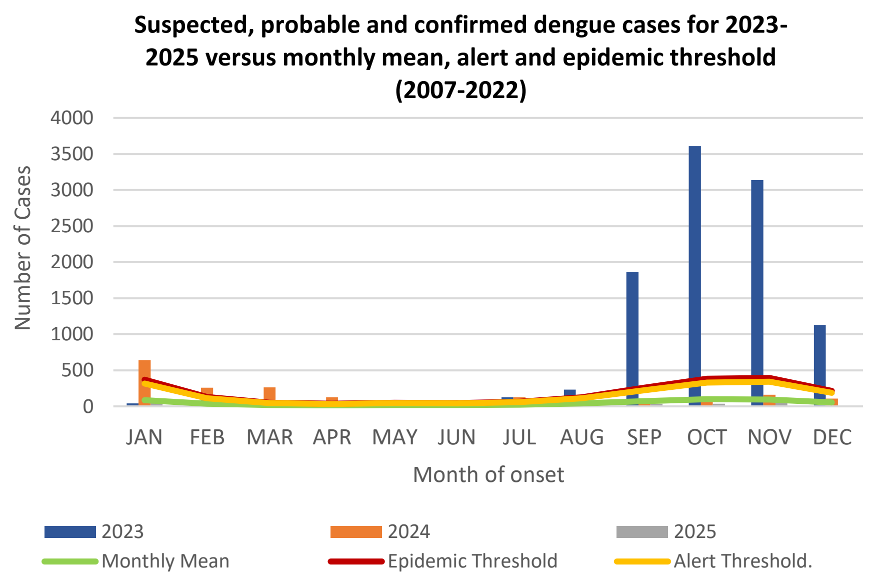
Reported suspected, probable and confirmed dengue with symptom onset in week 51 of 2025

	2025*	
	EW 51	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	544
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 24, 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-06

Frequency of high salt consumption and associations with sociodemographic and health factors among Jamaican adults: The Jamaica Salt Consumption Study

Ferguson T[1], McNeil S[1], Soares-Wynter S[2], Bennett N[1], Webster-Kerr K[3], Tulloch-Reid M[1], Davidson T[3], Grant A[3], Gordon-Johnson K[4], McKenzie J[1], Walker E[1], Blake A[5], Anderson S[6], Spence S[3], Younger-Coleman N[1]

[1]Epidemiology Research Unit, Caribbean Institute for Health Research, University of the West Indies, Mona, Kingston 7, Jamaica, [2]Tropical Metabolism Research Unit, Caribbean Institute for Health Research, University of the West Indies, Mona, Jamaica, [3]Ministry of Health and Wellness, Kingston Jamaica, [4]United States Centers for Disease Control and Prevention, Caribbean Office, Kingston, Jamaica, [5]School of Clinical Medicine and Research, Faculty of Medical Sciences, University of the West Indies, Nassau, Bahamas, [6]George Alleyne Chronic Disease Research Centre, Caribbean Institute for Health Research, University of the West Indies, Cave Hill, Barbados

Objectives: To estimate the frequency of consumption of high salt foods (HSF) among Jamaican adults and evaluate associations between sociodemographic and health factors.

Methods: We conducted a cross-sectional study among a nationally representative sample of persons ≥18 years between 2022-2023. Trained interviewers collected data, including a 60-item food frequency questionnaire with 39 HSF. Scores were created to estimate the daily intake of HSF items and then categorised into tertiles. Multivariable multinomial logistic regression was used to obtain odds ratios (OR) for associations comparing participants in the highest tertile of HSF to those in the lowest tertile. Estimates were weighted for survey design.

Results: Analyses included 952 participants (374 males, 578 females; mean age 40.9 years). Mean consumption of HSF was 6.4 items/day (males 6.7, female 6.2, $p=0.022$). Among males, those in the upper tertile of HSF consumption were more likely to be younger (OR 0.94, $p<0.001$), had higher education (OR 2.07, $p=0.047$ for high school and 3.02, $p=0.004$ more than high school) and were more likely to be current smokers (OR 1.62, $p=0.046$). Among females, those in the upper tertile for HSF consumption were more likely to be younger (OR 0.95, $p<0.001$), report overweight/obesity (OR 1.80, $p=0.015$), had higher education (OR 2.98, $p=0.004$ for more than high school), but were less likely to report high cholesterol (OR 0.52, $p=0.042$).

Conclusion: Jamaicans consume approximately six HSF items daily. HSF consumption was higher among younger persons and those with higher education. Health promotion activities to reduce sodium intake should target these groups.

National Surveillance Unit
Ministry of Health and Wellness
15 Knutsford Boulevard, Kingston 5, Jamaica
Telephone: (876) 633-7924
Email: surveillance@moh.gov.jm