WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Mpox (Part 1)

Mpox is an infectious disease that can cause a painful rash, enlarged lymph nodes, fever, headache, muscle ache, back pain and low energy. Most people fully recover, but some get very sick. Mpox is caused by the monkeypox virus (MPXV). It is an enveloped double-stranded DNA virus of the *Orthopoxvirus* genus in the *Poxviridae* family, which includes variola, cowpox, vaccinia and other viruses. There are two distinct clades of the virus: clade I (with subclades Ia and Ib) and clade II (with subclades IIa and IIb). A global outbreak of clade IIb began in 2022 and continues to this day, including in some African countries. There are also growing outbreaks of clades Ia and Ib affecting the Democratic Republic of the Congo and other countries in Africa. As of August 2024, clade Ib has also been detected beyond Africa. The natural reservoir of the virus is unknown, but various small mammals such as squirrels and monkeys are susceptible.

Transmission

Mpox spreads from person to person mainly through close contact with someone who has mpox, including members of a household. Close contact includes skin-to-skin (such as touching or sex) and mouth-to-mouth or mouth-to-skin contact (such as kissing), and it can also include being face-to-face with someone who has mpox (such as talking or breathing close to one another, which can generate infectious respiratory particles).

People with multiple sexual partners are at higher risk of acquiring mpox. People can also contract mpox from contaminated objects such as clothing or linen, through needle injuries in health care, or in community settings such as tattoo parlours. During pregnancy or birth, the virus may be passed to the baby. Contracting mpox during pregnancy can be dangerous for the fetus or newborn infant and can lead to loss of the pregnancy, stillbirth, death of the newborn, or complications for the parent.

Animal-to-human transmission of mpox occurs from infected animals to humans from bites or scratches, or during activities such as hunting, skinning, trapping, cooking, playing with carcasses or eating animals. The animal reservoir of the monkeypox virus remains unknown and further studies are underway. More research is needed on how mpox spreads during outbreaks in different settings and under different conditions.

Signs and symptoms

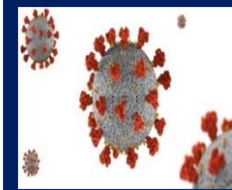
Mpox causes signs and symptoms which usually begin within a week but can start 1–21 days after exposure. Symptoms typically last 2–4 weeks but may last longer in someone with a weakened immune system.

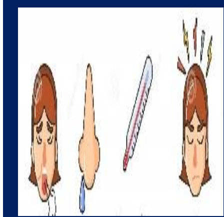
Common symptoms of mpox are:

- rash
- fever
- sore throat
- headache
- muscle aches
- back pain
- low energy
- swollen lymph nodes.

Taken from WHO website on 5/Jan/2026
https://www.who.int/news-room/fact-sheets/detail/mpox
Picture taken from https://www.who.int/health-topics/mpox#tab=tab_1

EPI WEEK 52





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SENTINEL SYNDROMIC SURVEILLANCE

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 – 49 to 52 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												
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
52	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

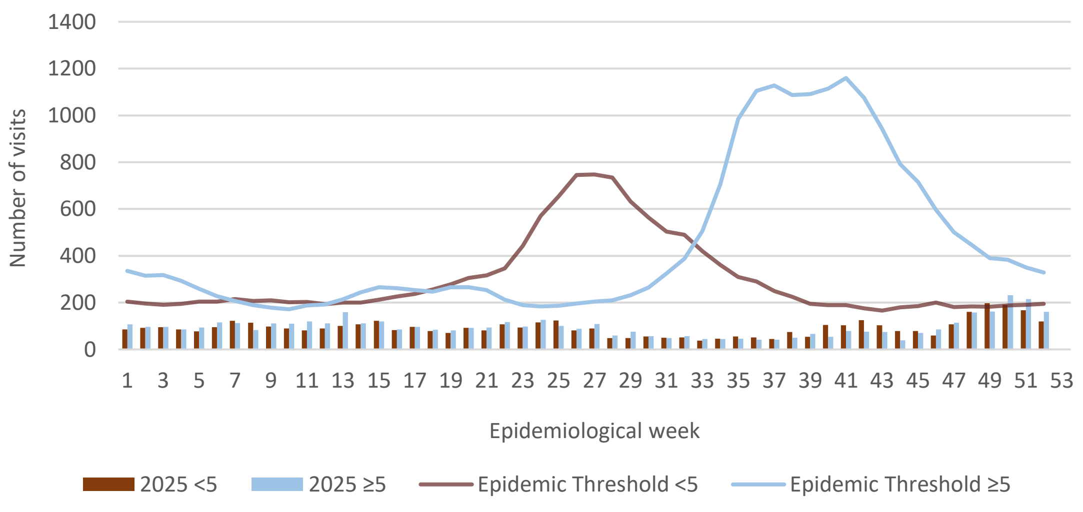
SYNDROMIC SURVEILLANCE

FEVER

UNDIFFERENTIATED FEVER

Temperature of >38⁰C /100.4⁰F (or recent history of fever) with or without an obvious diagnosis or focus of infection.

Weekly Visits to Sentinel Sites for Undifferentiated Fever All ages: Jamaica, Weekly Threshold vs Cases 2025



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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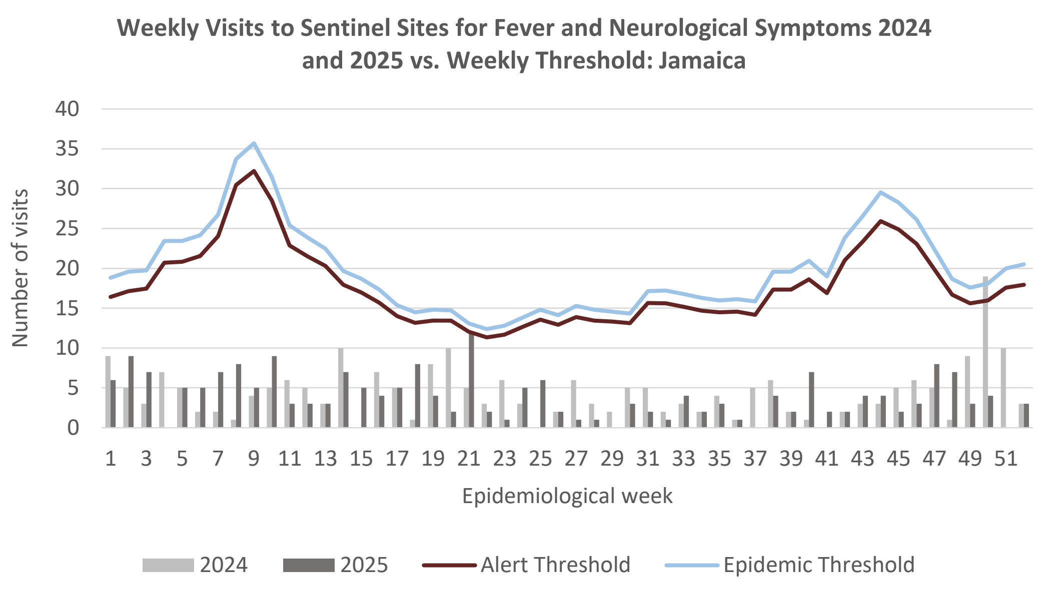
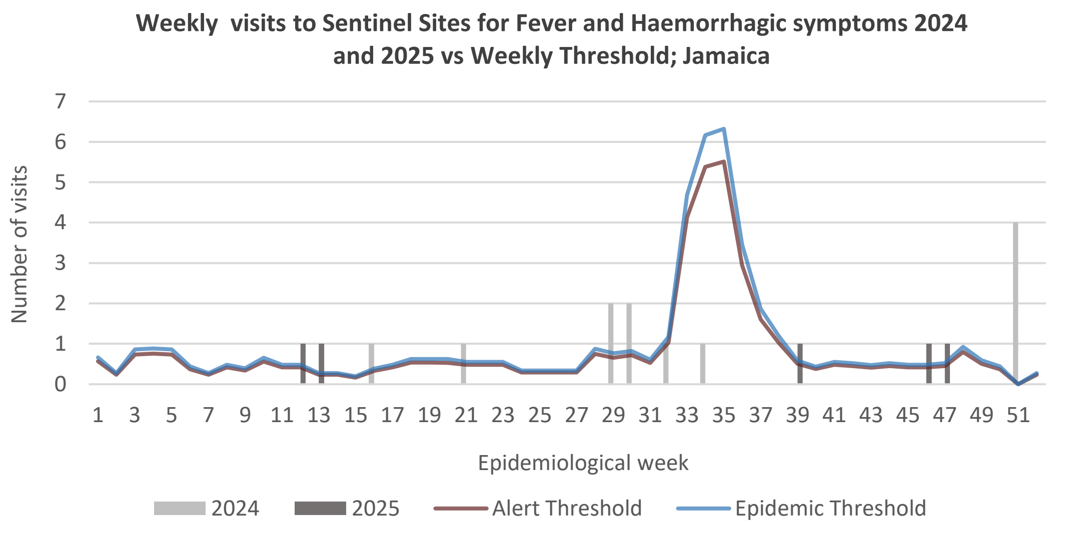
FEVER AND NEUROLOGICAL

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

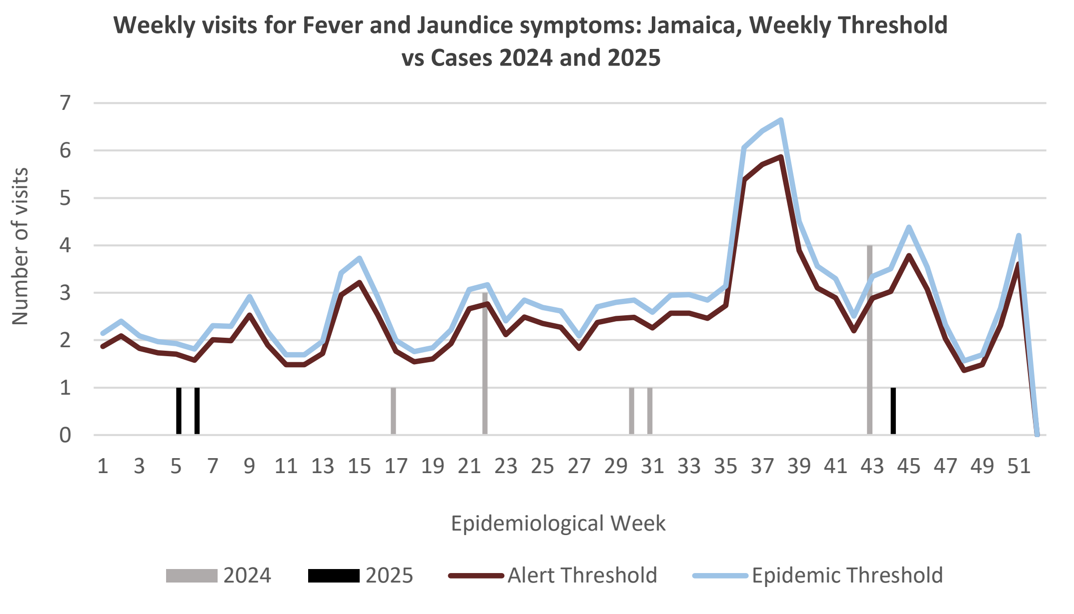
Temperature of >38⁰*C* /100.4⁰*F* (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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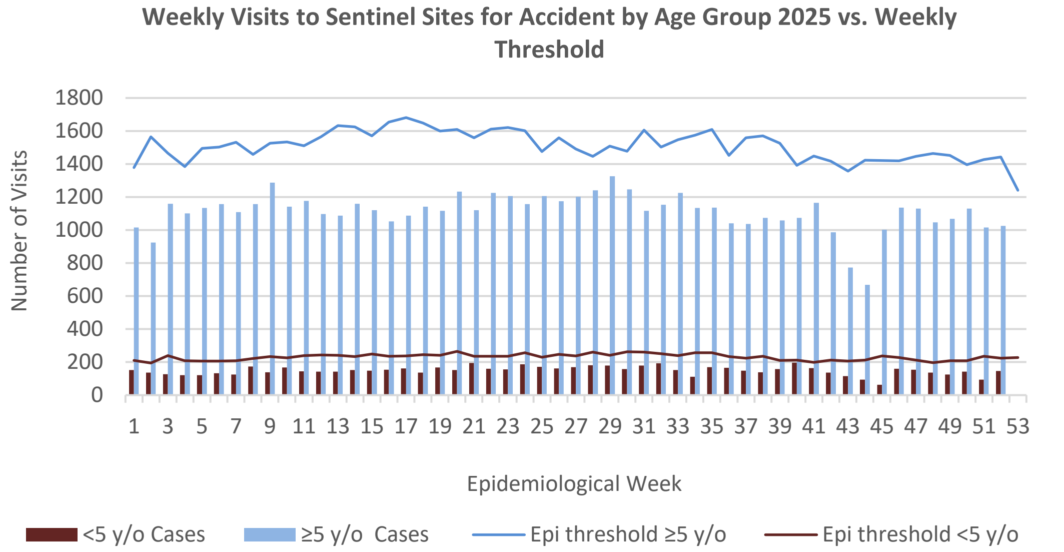
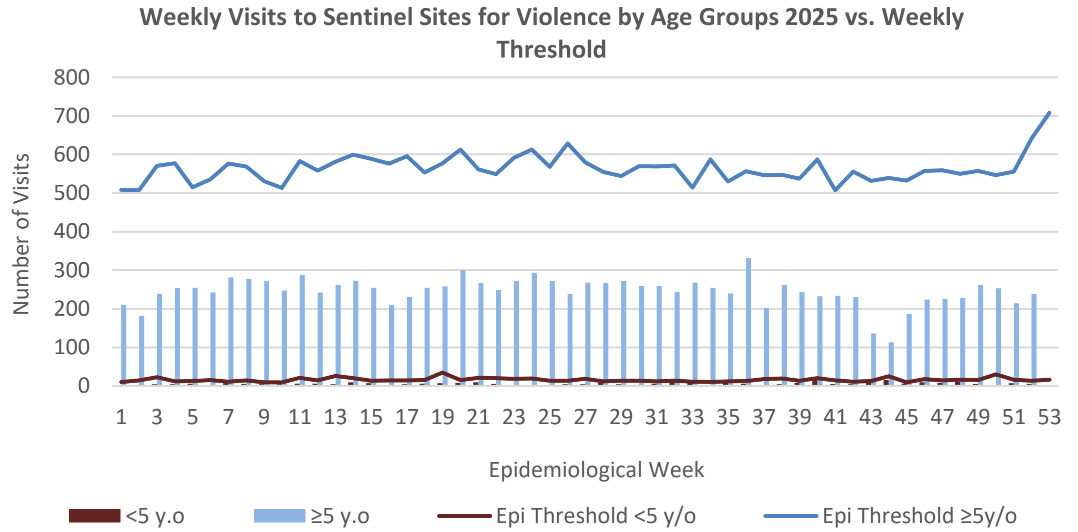
ACCIDENTS

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



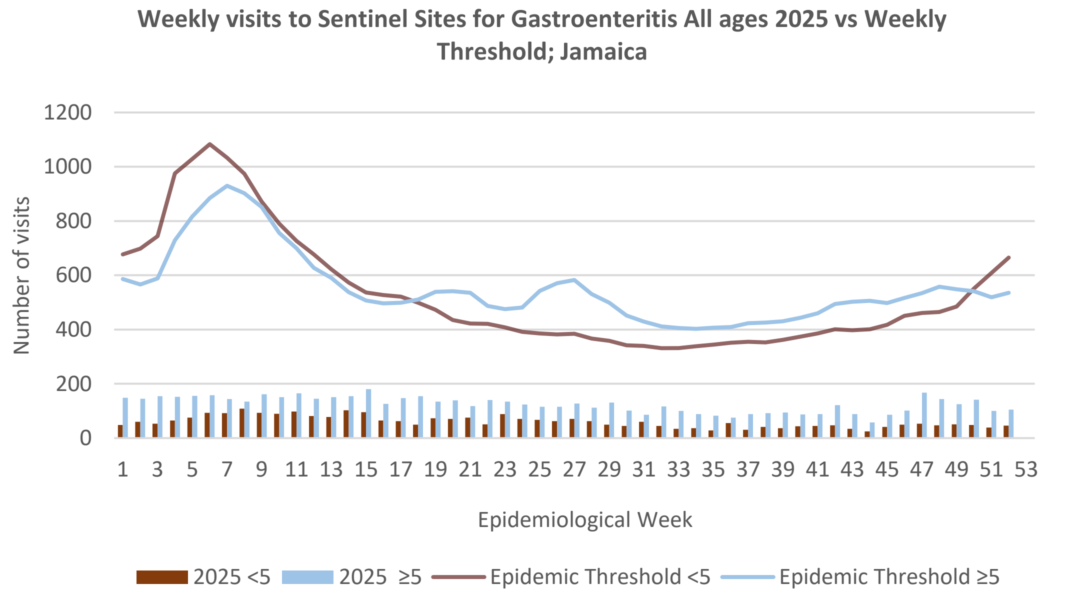
VIOLENCE

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$^{\alpha}$ CURRENT YEAR 2025	Confirmed YTD$^{\alpha}$ PREVIOUS YEAR 2024
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		127^{β}	274^{β}
	Cholera		0	0
	Severe Dengue$^{\gamma}$		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		315	705
	Hansen's Disease (Leprosy)		0	1
	Hepatitis B		8	59
	Hepatitis C		1	10
	HIV/AIDS		NA	NA
	Malaria (Imported)		2	3
	Meningitis		14	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
		Rubella	0	0
	Maternal Deaths$^{\delta}$		56	70
	Ophthalmia Neonatorum		54	170
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		3	0
	Tuberculosis		53	60
	Yellow Fever		0	0
	Chikungunya$^{\varepsilon}$		0	0
	Zika Virus$^{\theta}$		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.

$^{\gamma}$Dengue Hemorrhagic Fever data include Dengue related deaths;

$^{\delta}$ Figures include all deaths associated with pregnancy reported for the period.

$^{\varepsilon}$ CHIKV IgM positive cases

$^{\theta}$ Zika PCR positive cases

$^{\beta}$ Updates made to prior weeks.

$^{\alpha}$ Figures are cumulative totals for all epidemiological weeks year to date.

NA- Not Available

NOTIFICATIONS- All clinical sites

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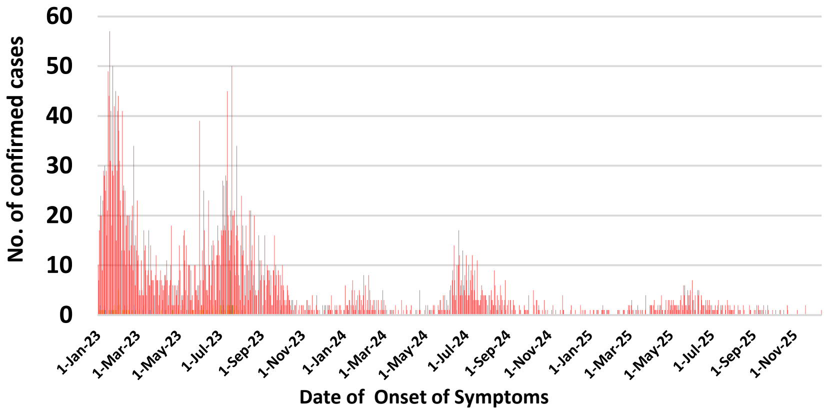
January 9, 2025 ISSN 0799-3927

COVID-19 SURVEILLANCE

CASES	EW 52	Total
Confirmed	0	157750
Females	0	90883
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.

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

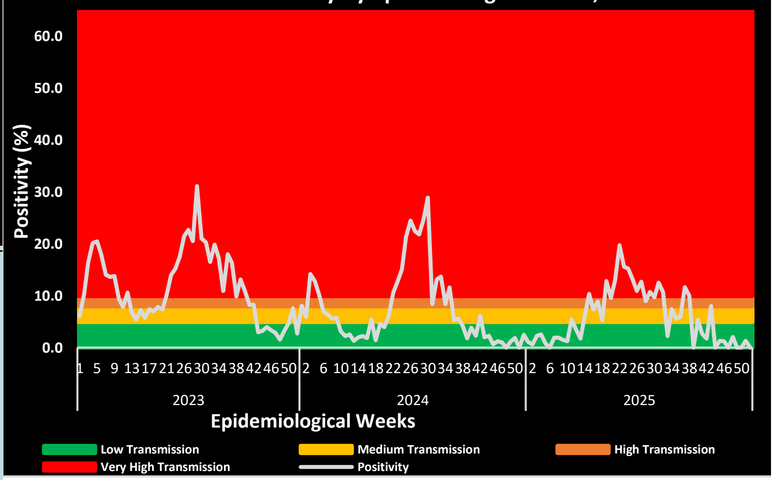


COVID-19 Outcomes

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

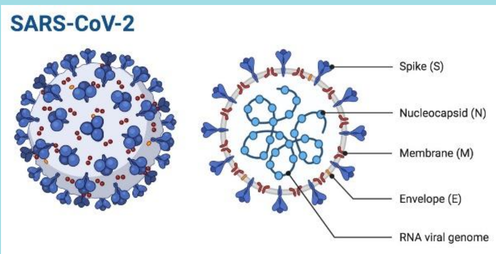
COVID-19	2020	2021	2022	2023	2024	2025	Total
	Year						
Cases	13,352	83,815	55,721	3,842	705	315	157,750
Deaths	332	2,815	621	116	24	13	3,921

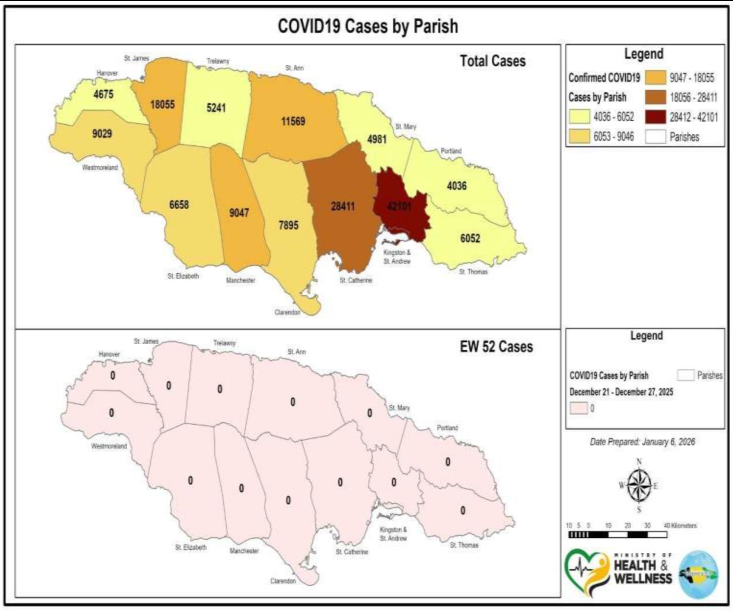
*Current positivity rate: 0.0%
- (positive samples/total samples tested)
* Low transmission for infection



COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure





COVID-19 WHO Global Statistics EW 49 -52 2025

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

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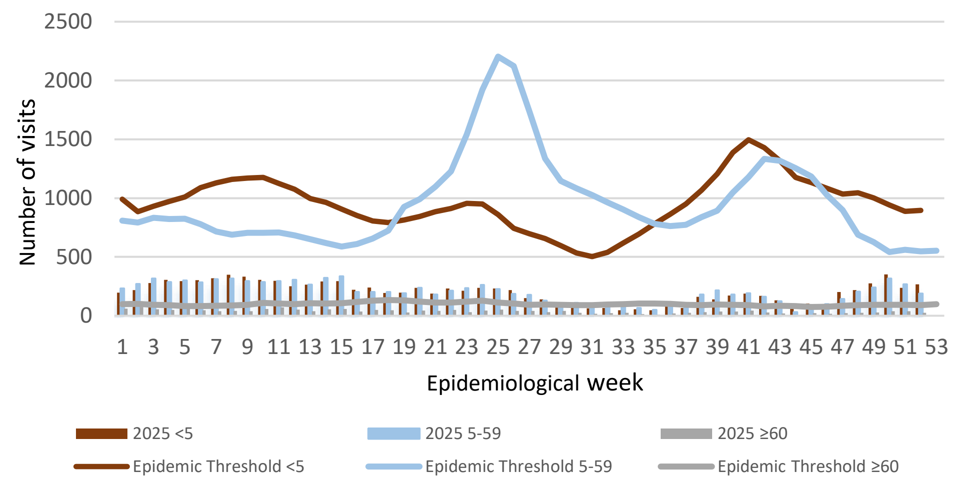
INFLUENZA SURVEILLANCE

EW 52

December 21, 2025 – December 27, 2025 Epidemiological Week 52

	EW 52	*YTD*
SARI cases	7	474
Total Influenza positive Samples	**2**	**216**
Influenza A	**1**	**182**
H1N1pdm09	0	93
H3N2	1	88
Not subtyped	0	1
Influenza B	**1**	**34**
B lineage not determined	0	0
B Victoria	1	34
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	65

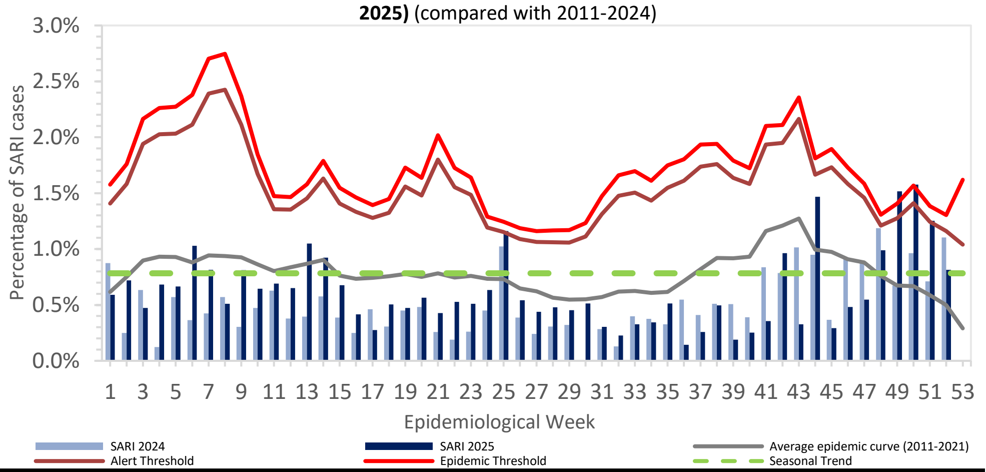
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 52, seven (7) SARI admissions were reported.

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

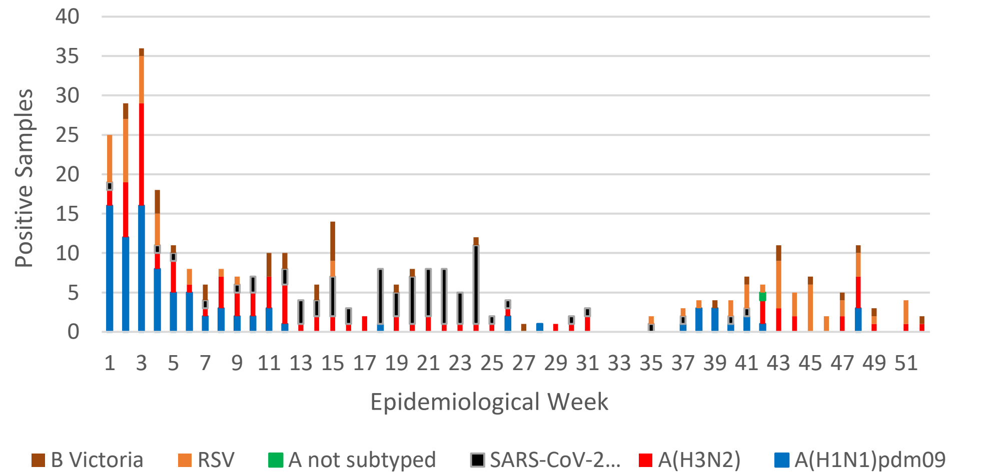


Caribbean Update EW 52

Influenza activity increased during recent weeks, reaching a subregional positivity rate of 26.8%, with influenza A(H3N2) accounting for 73.2% of subtype samples. RSV circulation increased compared to the previous two weeks, reaching a positivity rate of 12%. SARS-CoV-2 activity remains stable, with a subregional positivity rate of 0.6%. Cases of ARI and ILI 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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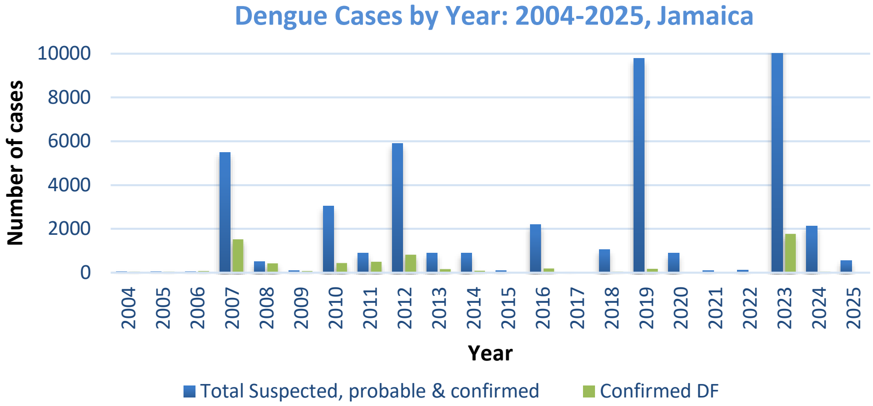
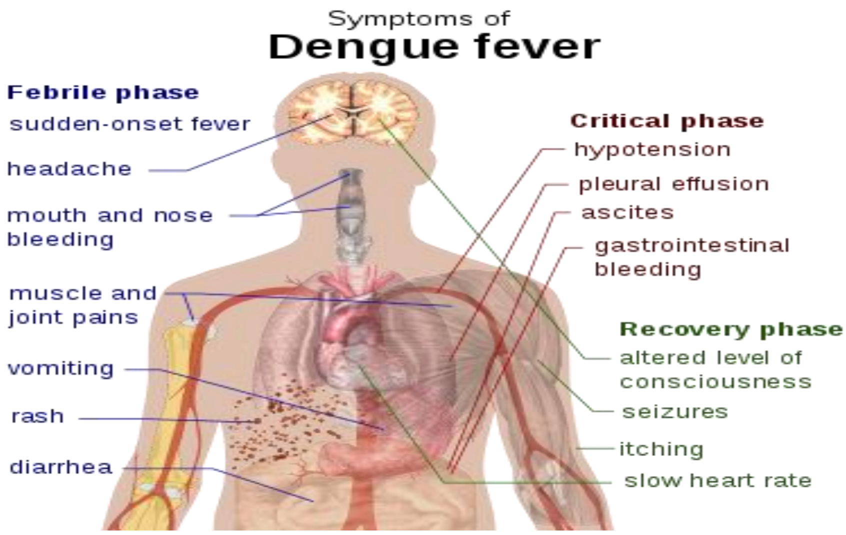
DENGUE SURVEILLANCE

December 21, 2025 – December 27, 2025 Epidemiological Week 52 | Epidemiological Week 52



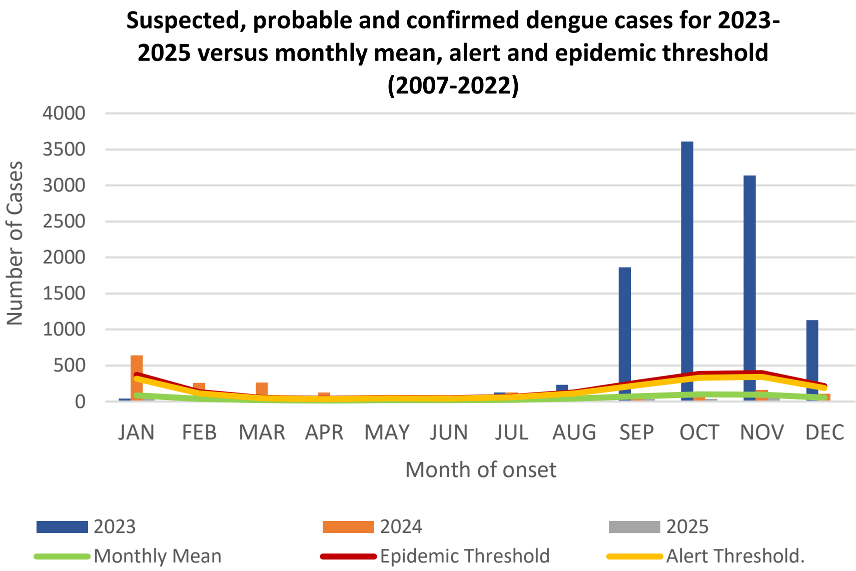
Reported suspected, probable and confirmed dengue with symptom onset in week 52 of 2025

	2025*	
	EW 52	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-07

The accuracy of spot urine sodium as a measure of dietary sodium intake in Jamaicans compared to 24-hour urinary sodium excretion: A validation study

Bennett R[1], Younger-Coleman N[1], McNeil T[1], Soares-Wynter S[2], 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], Ferguson T[1]

[1]Epidemiology Research Unit, Caribbean Institute for Health Research, University of the West Indies, Mona, 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

Objective: To determine the validity of 24-hour urine sodium excretion estimated from spot urine samples using the INTERSALT and WHO/PAHO formulae versus a 24-hr urine collection.

Methods: Spot-urine samples and 24-hour urine collections and were obtained from 109 participants recruited to the Jamaica Salt Consumption Study. Analyses were restricted to those with 24-hour urine collection volumes $\geq$400 ml, collection times of 22-27 hours and spot urine collection $\leq$24 hours from a 24-hour collection. INTERSALT and WHO/PAHO formulae were used to estimate 24-hour sodium from the spot urine samples, while 24-hour sodium was calculated as sodium concentration multiplied by urine volume adjusted for collection time. High sodium consumption was defined as $\geq$2g/day. Paired t-tests and kappa statistics were used to assess agreement between sodium estimates.

Results: There were 60 matched samples using the INTERSALT formula and 58 using the WHO/PAHO formula. Mean sodium was 2532mg/day [24-hour], 2802mg/day [INTERSALT], 2420mg/day [WHO/PAHO]. The prevalence of high sodium was 65.6% [24-hour], 81.7% [INTERSALT], 55.2% [WHO/PAHO]. Compared to 24-hour urine collection, neither the mean difference in sodium using the INTERSALT formula [270.1±1309.1(95%CI:–68.0 to 608.3)mg] nor the WHO/PAHO protocol [-161.1±2059.63(95%CI:-702.7 to 380.4)mg] was significantly different from zero. Agreement for classification as high sodium using the kappa statistic was 0.48 for the INTERSALT formula and 0.29 for the WHO/PAHO formula.

Conclusion: Mean sodium intake estimated using the INTERSALT or WHO/PAHO formula was not significantly different from that obtained using 24-hour collections. However, there was low/moderate agreement in classifying participants as having high sodium intake.

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