WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Mpox (Part 2)

For some people, the first symptom of mpox is a rash, while others may have fever, muscle aches or sore throat first. The mpox rash often begins on the face and spreads over the body, extending to the palms of the hands and soles of the feet. It can also start on other parts of the body where contact was made, such as the genitals. It starts as a flat sore, which develops into a blister filled with liquid that may be itchy or painful. As the rash heals, the lesions dry up, crust over and fall off. Some people may have one or a few skin lesions and others have hundreds or more. These can appear anywhere on the body including:

- palms of hands and soles of feet
- face, mouth and throat
- groin and genital areas
- anus.

Some people also have painful swelling of their rectum (proctitis) or pain and difficulty when peeing (dysuria) or when swallowing. People with mpox can pass the disease on to others until all sores have healed and a new layer of skin has formed. Some people can be infected without developing any symptoms. Although getting mpox from someone who is asymptomatic (not showing symptoms) has been reported, information is still limited on how common it is. Children, pregnant people and people with weak immune systems, including people living with HIV that is not well controlled, are at higher risk for serious illness and death due to complications from mpox. Some people with mpox become very sick. For example, the skin can become infected with bacteria, leading to abscesses or serious skin damage. Other complications include pneumonia; corneal infection with loss of vision; pain or difficulty swallowing; vomiting and diarrhoea causing dehydration or malnutrition; and infections of the blood (sepsis), brain (encephalitis), heart (myocarditis), rectum (proctitis), genital organs (balanitis) or urinary passages (urethritis). Mpox can be fatal in some cases.

Diagnosis

Identifying mpox can be difficult because other infections and conditions can look similar. It is important to distinguish mpox from chickenpox, measles, bacterial skin infections, scabies, herpes, syphilis, other sexually transmitted infections, and medication-associated allergies. Someone with mpox may also have another sexually transmitted infection at the same time, such as syphilis or herpes. Alternatively, a child with suspected mpox may also have chickenpox. For these reasons, testing is key for people to get care as early as possible and prevent severe illness and further spread.

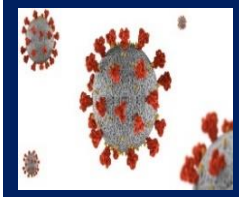
The preferred laboratory test for mpox is detection of viral DNA by polymerase chain reaction (PCR). The best diagnostic specimens are taken directly from the rash – skin, fluid or crusts – collected by vigorous swabbing. In the absence of skin lesions, testing can be done using swabs of the throat or anus. Testing blood is not recommended. Antibody detection methods may not be useful as they do not distinguish between different orthopoxviruses. HIV testing should be offered to adults with mpox, and children as appropriate. Diagnostic tests for other conditions should be considered where feasible, for example, varicella zoster virus (VZV), syphilis and herpes.

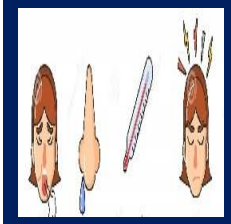
Taken from WHO website on 12/Jan/2026

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 53





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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 – 50 to 53 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.

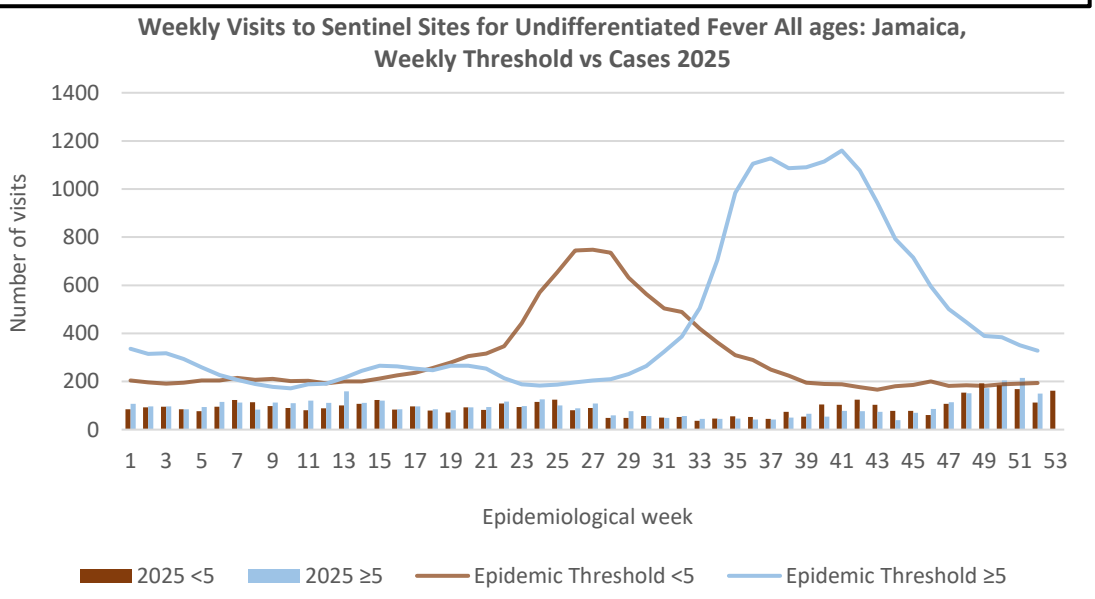
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
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
53	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.



2 NOTIFICATIONS- All clinical sites

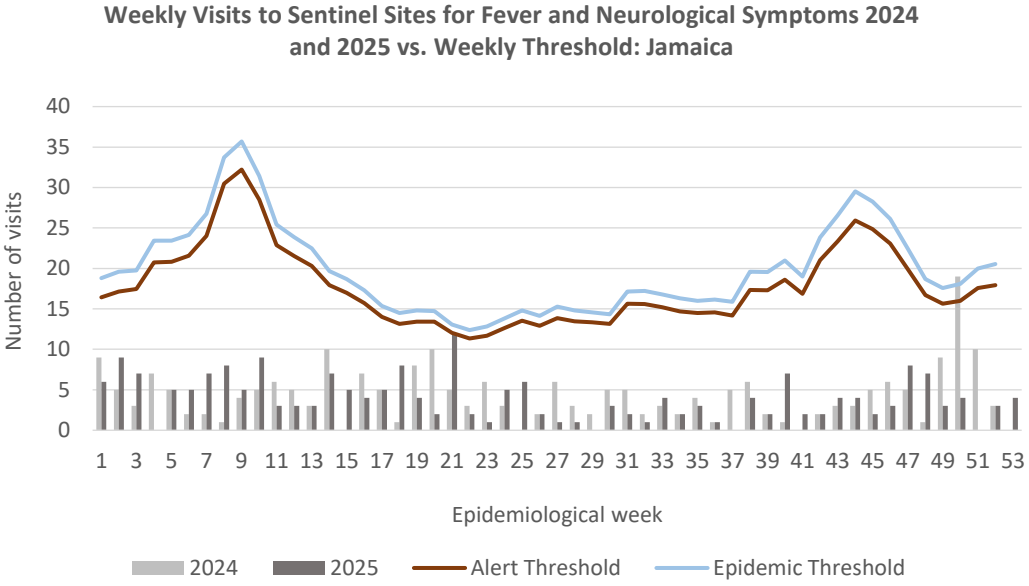
INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

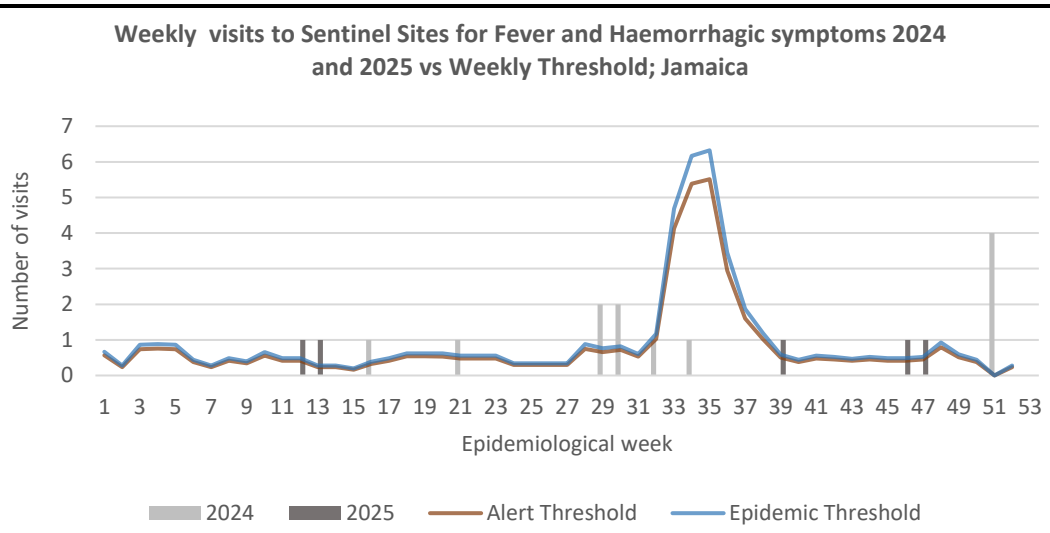
FEVER AND NEUROLOGICAL

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

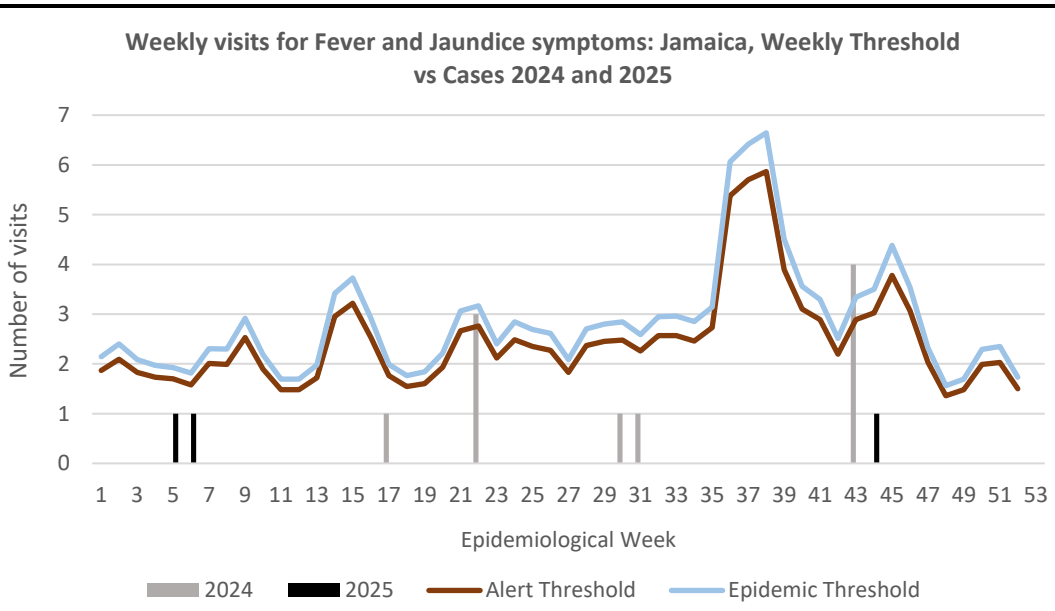
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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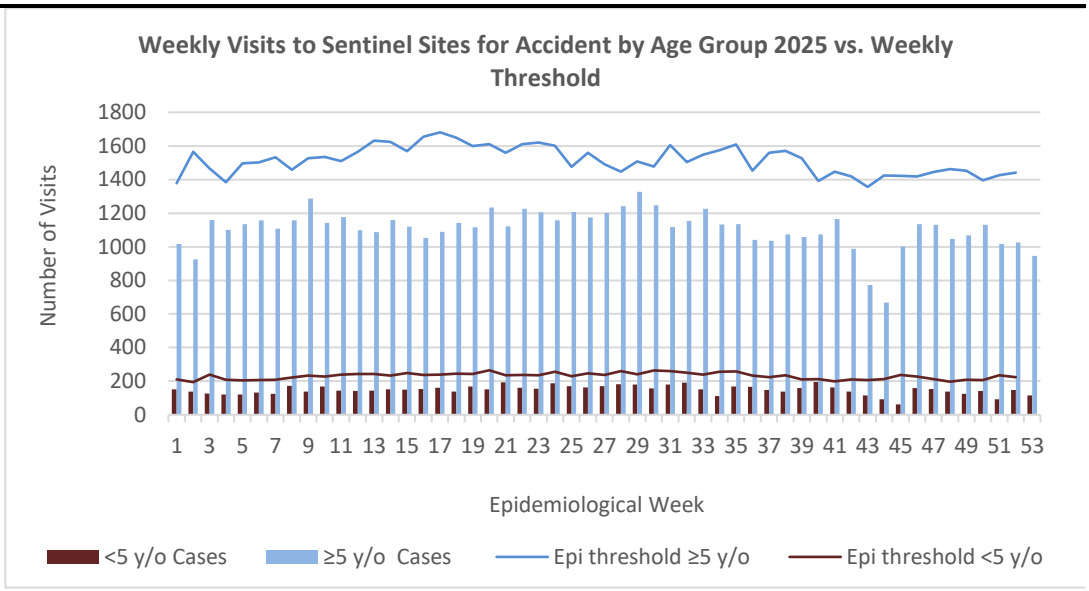
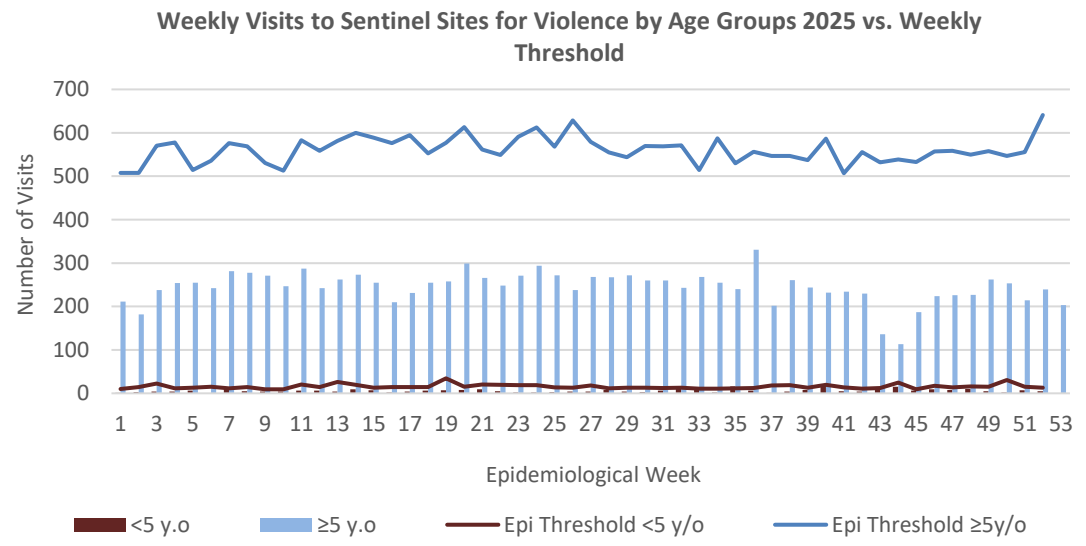
ACCIDENTS

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



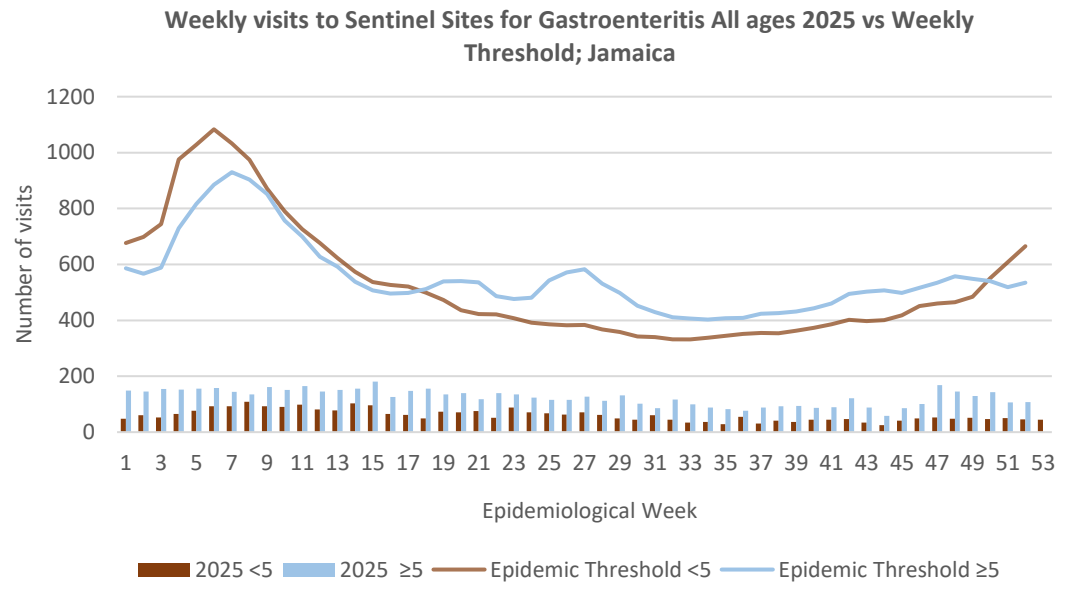
VIOLENCE

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		144[β]	274[β]
	Cholera		0	0
	Severe Dengue[Y]		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[δ]		57	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[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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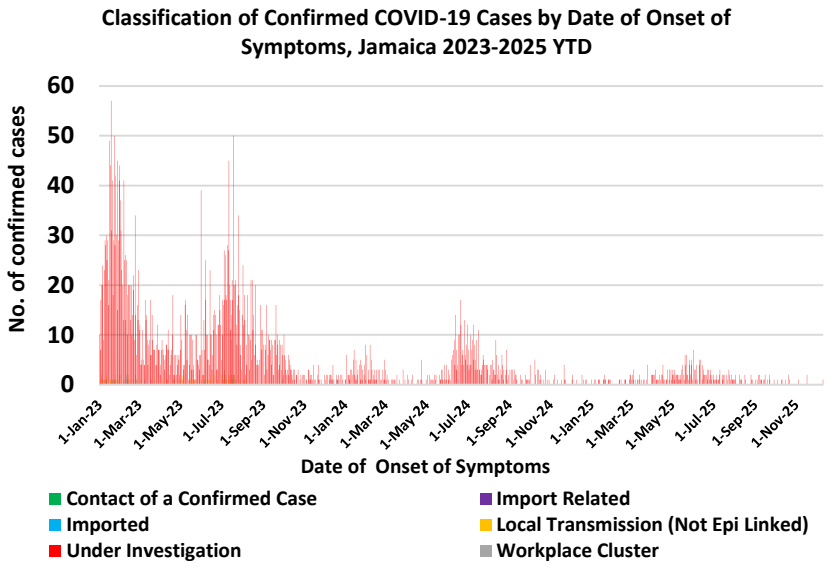
COVID-19 SURVEILLANCE

CASES	EW 53	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.

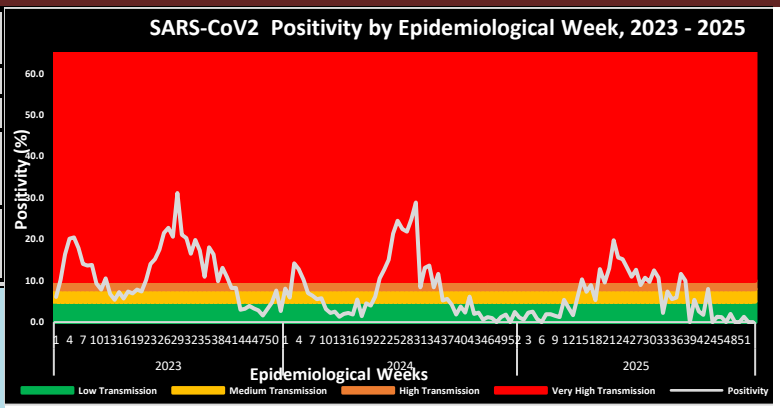


COVID-19 Outcomes

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

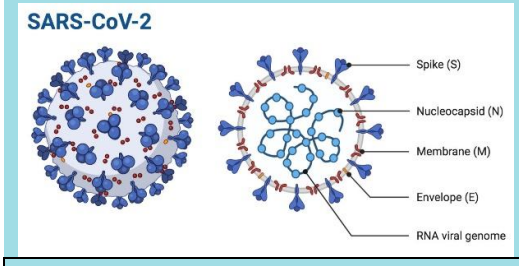
COVID-19	Year						
	2020	2021	2022	2023	2024	2025	Total
Cases	13,352	83,815	55,721	3,842	705	315	157,750
Deaths	332	2,815	621	116	24	13	3,921

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



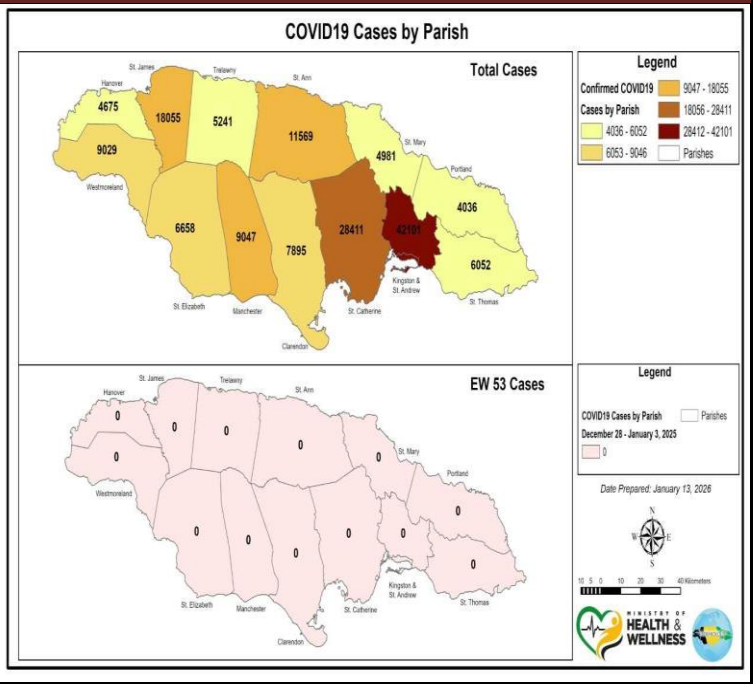
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 50 -53 2025

Epi Week	Confirmed Cases	Deaths
50	17100	234
51	15700	244
52	10300	239
53	9400	260
Total (4weeks)	**52500**	**977**



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January 16, 2025 ISSN 0799-3927

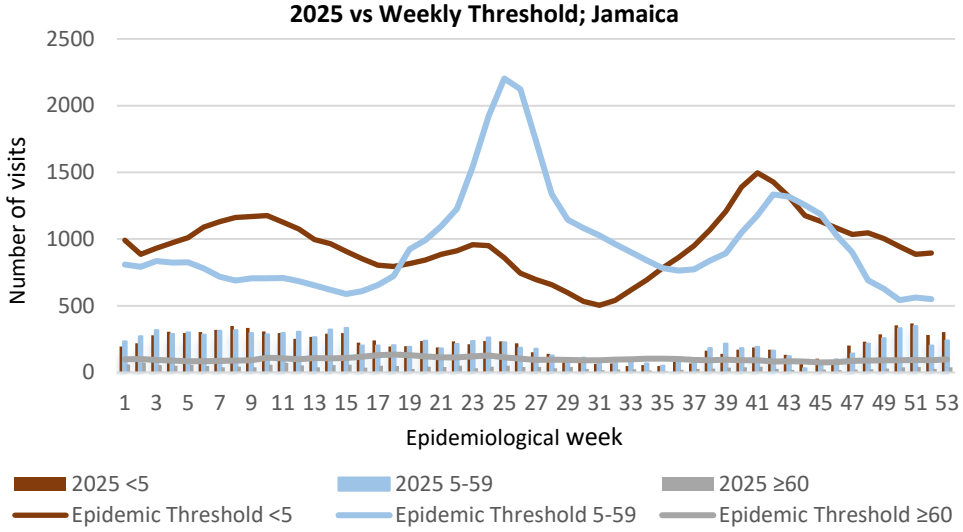
INFLUENZA SURVEILLANCE

EW 53

December 28, 2025 – January 3, 2025 Epidemiological Week 53

	EW 53	*YTD*
SARI cases	9	498
Total Influenza positive Samples	**3**	**222**
Influenza A	**3**	**188**
H1N1pdm09	0	93
H3N2	3	94
Not subtyped	0	1
Influenza B	**0**	**34**
B lineage not determined	0	0
B Victoria	0	34
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	65

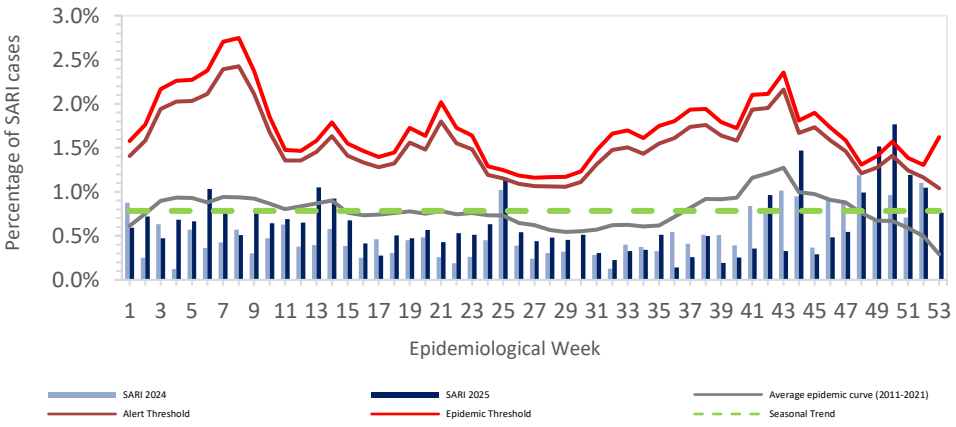
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 53, nine (9) SARI admissions were reported.

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



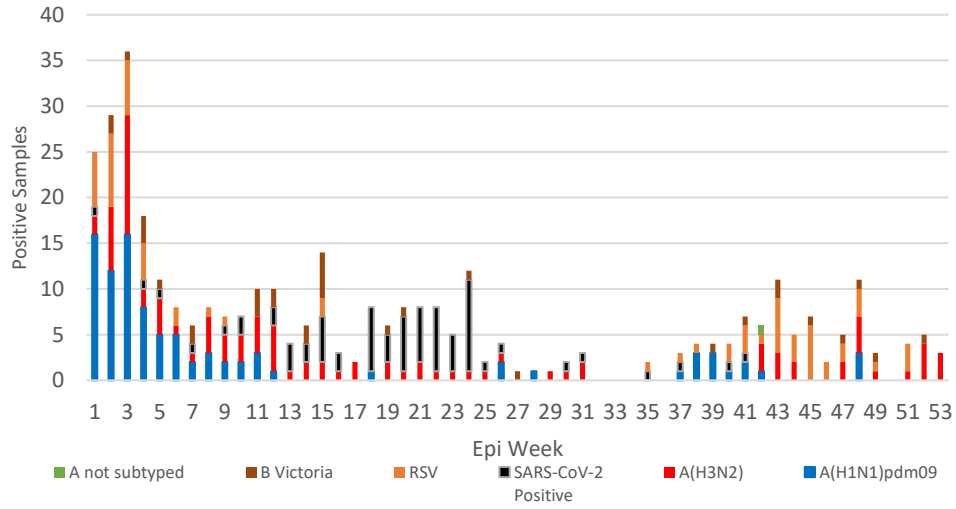
Caribbean Update EW 53

*Update at EW 49 Remains.

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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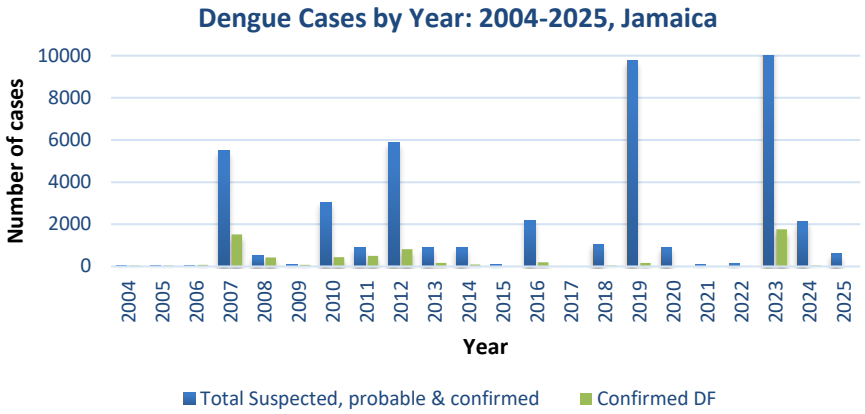
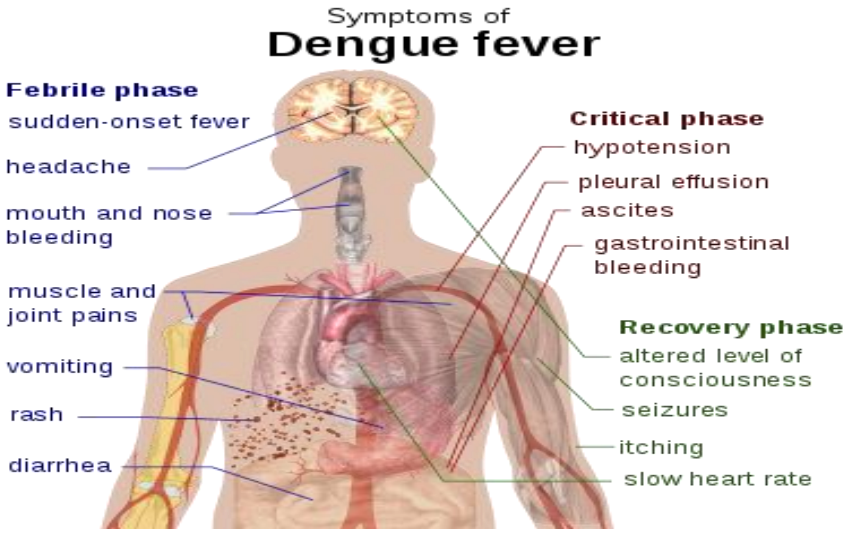
DENGUE SURVEILLANCE

December 28, 2025 – January 3, 2025 Epidemiological Week 53 | Epidemiological Week 53



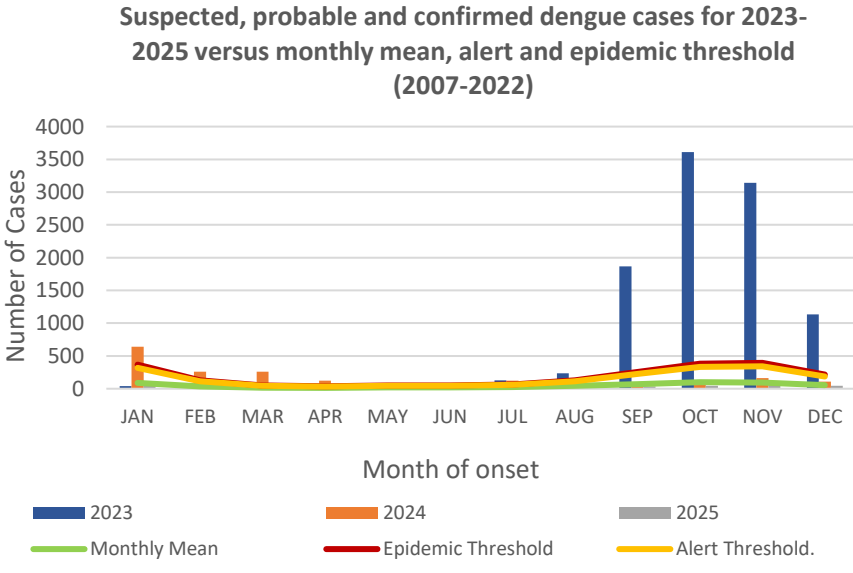
Reported suspected, probable and confirmed dengue with symptom onset in week 53 of 2025

	2025*	
	EW 53	YTD
Total Suspected, Probable & Confirmed Dengue Cases	10	602
Lab Confirmed Dengue cases	0	1
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- **Dengue deaths are reported based on date of death.**
- ***Figure as at January 16, 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-08

Bacteraemia in the critical care unit of a tertiary care hospital in the Caribbean; before and during the COVID-19 pandemic

Gordon O[1], Ehikhametalor K[1], Thoms-Rodriguez C[1]

[1]*University of the West Indies, Mona, Jamaica*

Objectives: To determine and compare the prevalence and causative agents of culture positive bacteraemia between: (1) ICU patients admitted at the UHWI the year prior to the COVID-19 pandemic and those admitted during the COVID-19 pandemic and (2) COVID-19 positive ICU patients and COVID-19 negative ICU patients. Including comparing mortality outcomes between COVID-19 and non-COVID-19 ICU patients with bactereamia.

Methods: A retrospective cohort study of 810 patients admitted to the UHWI ICU between March 2019-Feb 2021was done. Comparison was made of the prevalence, causative agents and mortality in patients with bacteraemia one year before and one year after the outbreak of the COVID-19 pandemic, using independent samples T-test, the chi-squared test of homogeneity and Fisher's exact test where appropriate, to assess the potential impact on bacteraemia of COVID-19.

Results: Prevalence of bacteraemia in the year after the onset of the COVID-19 pandemic was significantly higher than in the year before. (28% vs 17%). Prevalence of bacteraemia was significantly higher in COVID-19 positive ICU patients than in COVID-19 negative ICU patients. (46.5% vs 22.1%). The predominant organisms present in the ICU were *Coagulase Negative Staphylococcus, Enterococcus spp., K. pneumonia, Pseudomonas aeruginosa, Acinetobacter* and *Enterobacter spp.* There was no statistical difference in 30-Day Mortality, 60-Day Mortality and Length of ICU stay.

Conclusion: The prevalence of bacteraemia in ICU patients increased significantly during the COVID-19 pandemic with markedly increased bacteraemia seen in COVID-19 positive patients. Further studies are required to determine if this is due to the pathophysiology of COVID-19, COVID-19's treatment, contamination or patient/environmental factors.

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