WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Influenza (seasonal) Part 3

Most cases of human influenza are clinically diagnosed. However, during periods of low influenza activity or outside of epidemics situations, the infection of other respiratory

viruses (e.g. SARS-CoV-2, rhinovirus, respiratory syncytial virus, parainfluenza and adenovirus) can also present as influenza-like illness (ILI), which makes the clinical differentiation of influenza from other pathogens difficult. Collection of appropriate respiratory samples and the application of a laboratory diagnostic test is required to establish a definitive diagnosis. Proper collection, storage and transport of respiratory specimens is the essential first step for laboratory detection of influenza virus infections. Laboratory confirmation is commonly performed using direct antigen detection, virus isolation, or detection of influenza-specific RNA by reverse transcriptase-polymerase chain reaction (RT-PCR Rapid diagnostic tests are used in clinical settings, but they have lower sensitivity compared to RT-PCR methods and their reliability depends largely on the conditions under which they are used.

Treatment

Most people will recover from influenza on their own. People with severe symptoms or other medical conditions should seek medical care. People with mild symptoms should:

- stay home to avoid infecting other people
- rest
- drink plenty of fluids
- treat other symptoms such as fever
- seek medical care if symptoms get worse.

People at high risk or with severe symptoms should be treated with antiviral medications as soon as possible. They include people who are:

- pregnant
- children under 59 months of age
- aged 65 years and older
- living with other chronic illnesses
- receiving chemotherapy
- living with suppressed immune systems due to HIV or other conditions.

The WHO Global Influenza Surveillance and Response System (GISRS) monitors resistance to antivirals among circulating influenza viruses to provide timely evidence for national policies related to antiviral use.

Prevention

Vaccination is the best way to prevent influenza. Safe and effective vaccines have been used for more than 60 years. Immunity from vaccination goes away over time so annual vaccination is recommended to protect against influenza.

The vaccine may be less effective in older people, but it will make the illness less severe and reduces the chance of complications and death. Vaccination is especially important for people at high risk of influenza complications and their careers. Annual vaccination is recommended for:

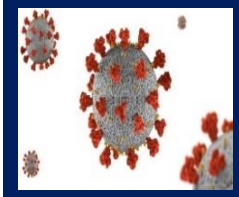
- pregnant women
- children aged 6 months to 5 years
- people over age 65
- people with chronic medical conditions
- health workers.

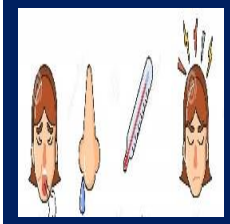
Other ways to prevent influenza:

- wash and dry your hands regularly
- cover your mouth and nose when coughing or sneezing
- dispose of tissues correctly
- stay home when feeling unwell
- avoid close contact with sick people
- avoid touching your eyes, nose or mouth.

Taken from WHO website on 10/Feb/2026
https://www.who.int/news-room/fact-sheets/detail/influenza-(seasonal)
Picture taken from https://www.freepik.com/free-photos-vectors/flu

EPI WEEK 4





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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 – 1 to 4 of 2026.

Parish health departments submit reports weekly by 3 p.m. on Tuesdays. Reports submitted after 3 p.m. are considered late.

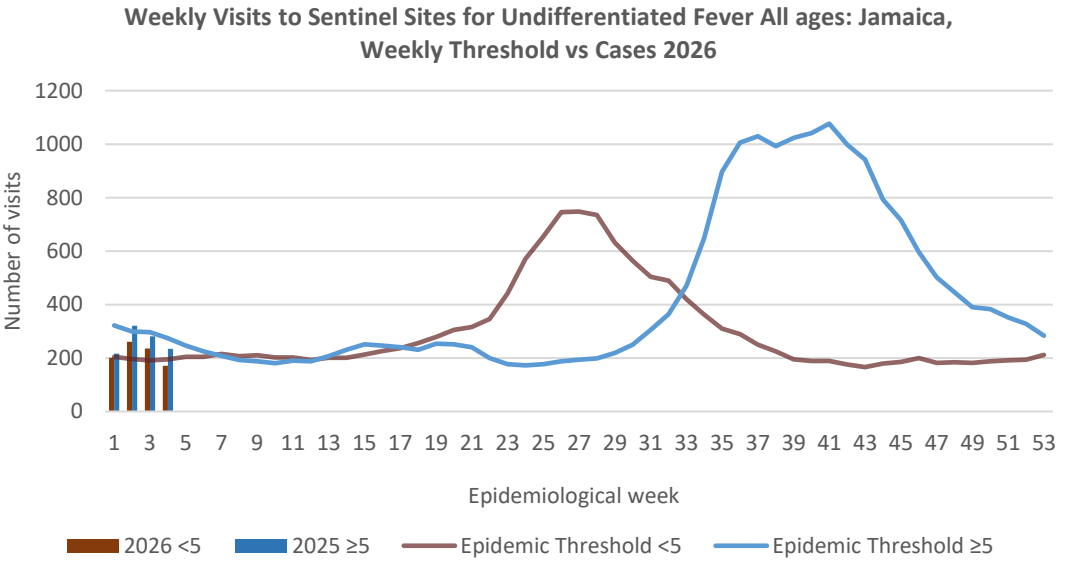
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

Epi week	Kingston and Saint Andrew	Saint Thomas	Saint Catherine	Portland	Saint Mary	Saint Ann	Trelawny	Saint James	Hanover	Westmoreland	Saint Elizabeth	Manchester	Clarendon
2026													
1	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
2	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
3	On Time	On Time	On Time	Late (W)	On Time	Late (W)	On Time	On Time	On Time	On Time	On Time	On Time	On Time
4	Late (W)	Late (W)	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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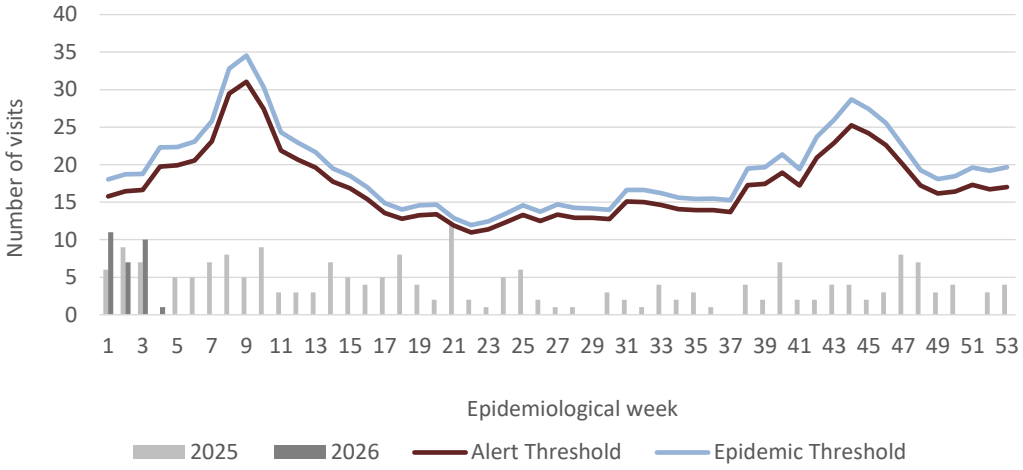
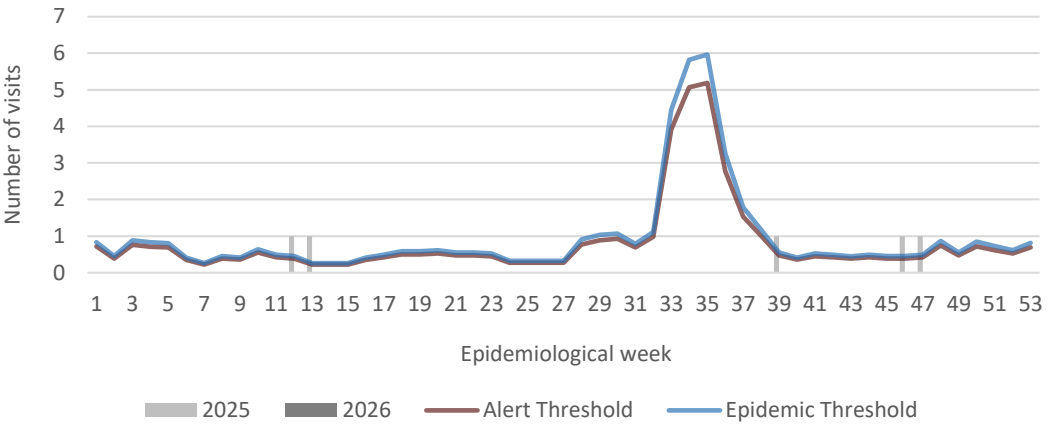
FEVER AND NEUROLOGICAL

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

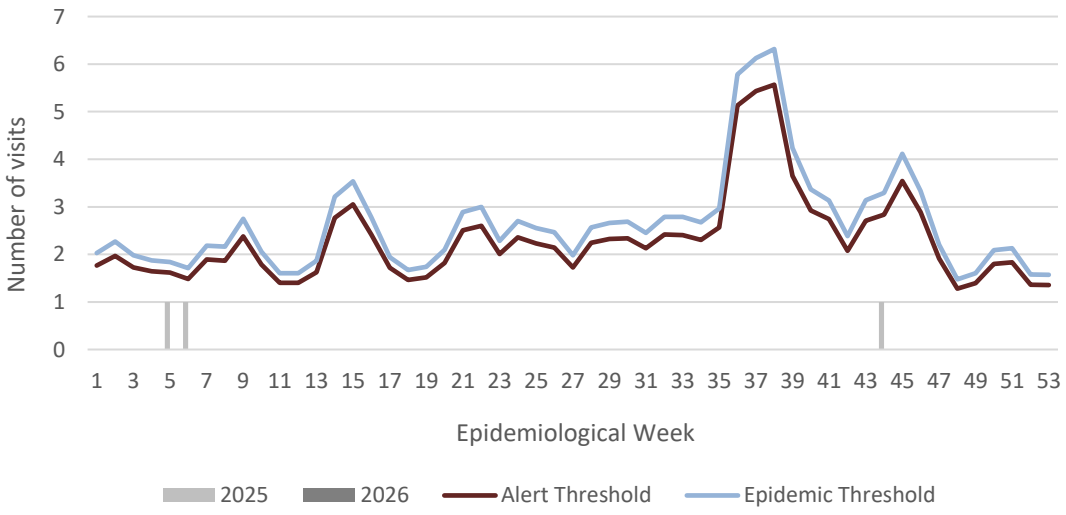
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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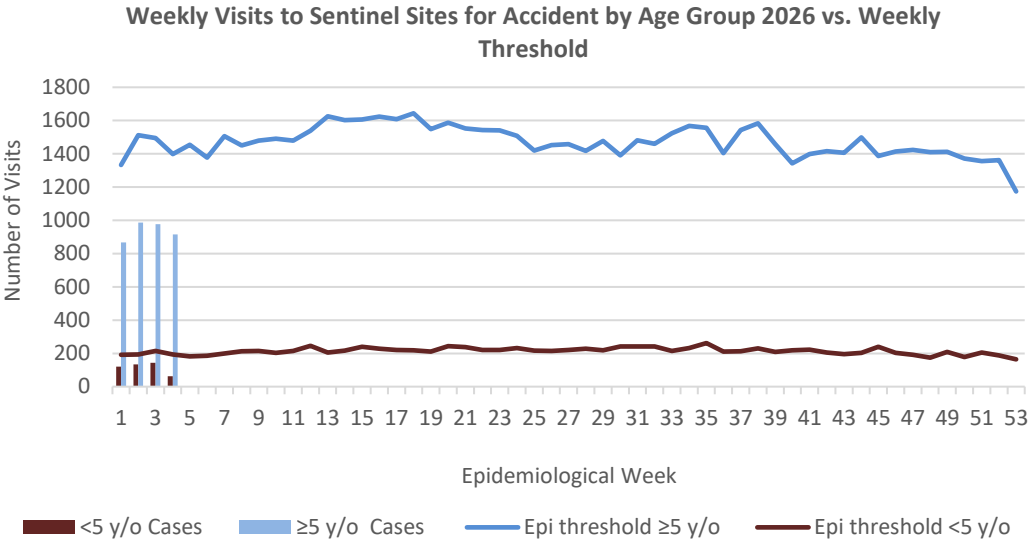
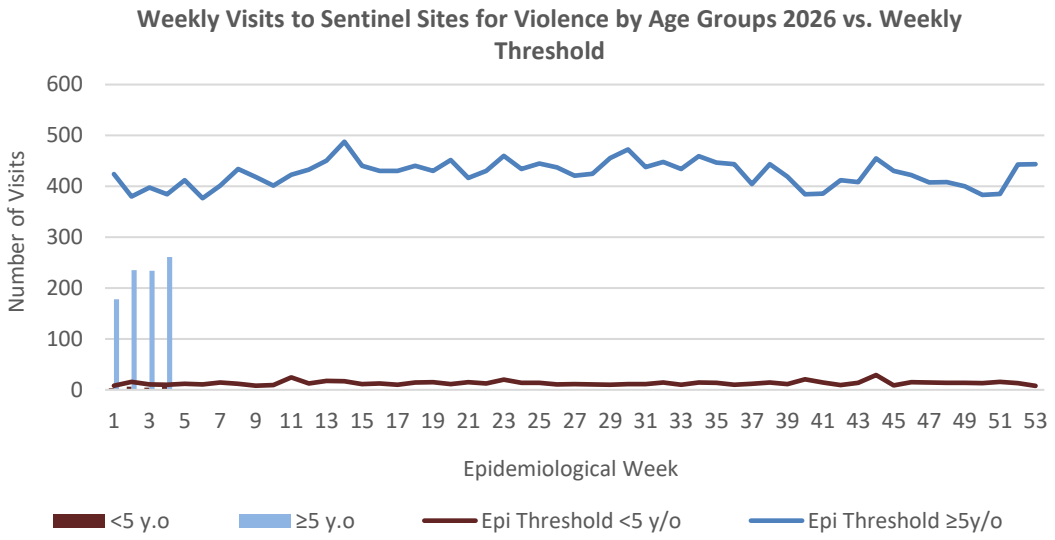
ACCIDENTS

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



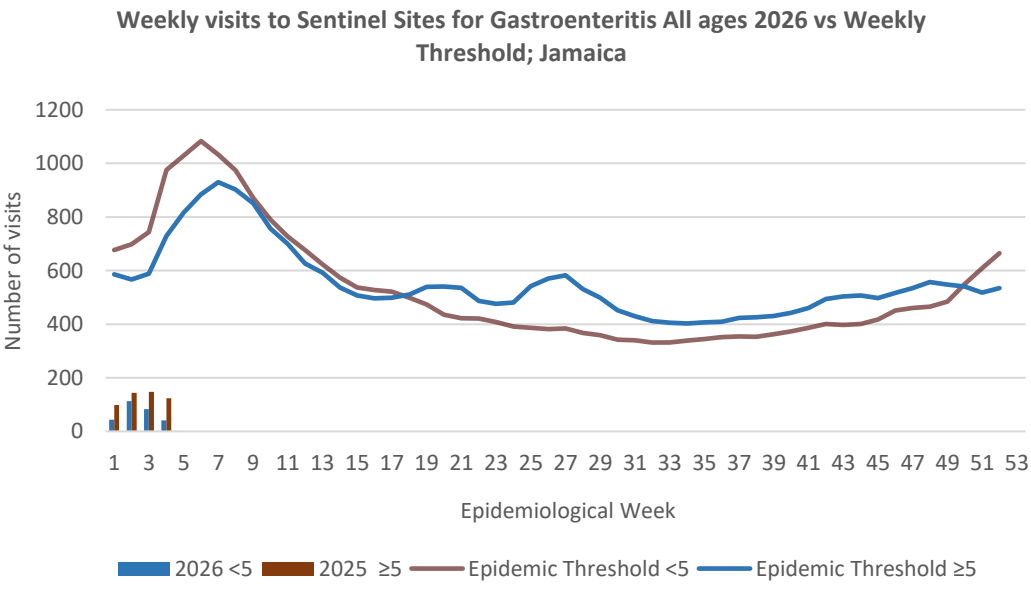
VIOLENCE

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 2026	PREVIOUS YEAR 2025
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	1[β]	18[β]
	Cholera	0	0
	Severe Dengue[Y]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	0	12
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	0	0
	Hepatitis C	0	1
	HIV/AIDS	NA	NA
	Malaria (Imported)	0	0
	Meningitis	0	4
	Mpox	0	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 (pregnanacy related deaths)[δ]	1	6
	Ophthalmia Neonatorum	0	8
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	0
	Tetanus	0	0
	Tuberculosis	0	1
	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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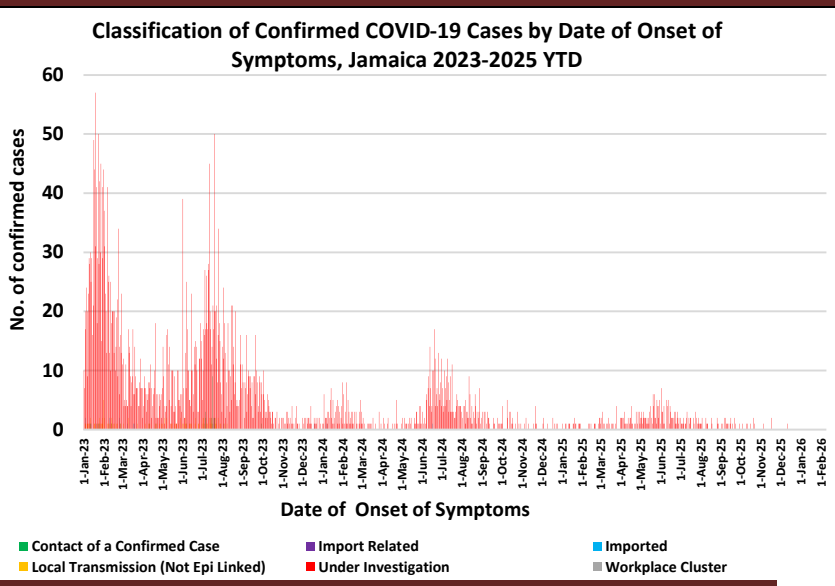
COVID-19 SURVEILLANCE

CASES	EW 4	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.

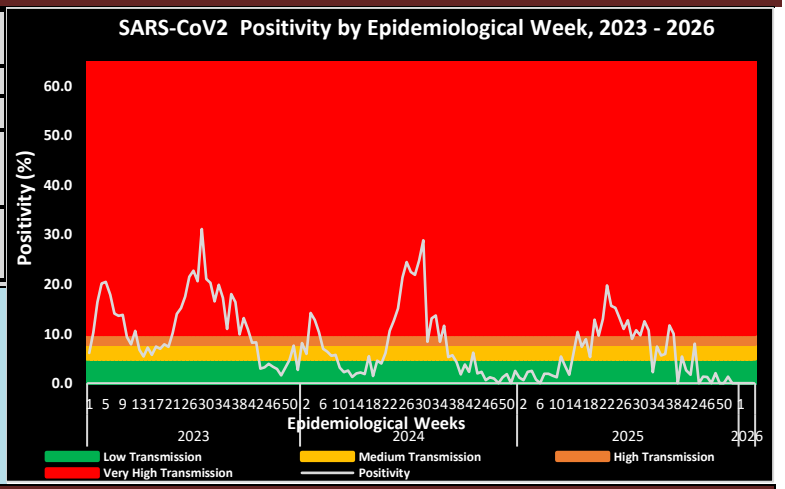


COVID-19 Outcomes

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

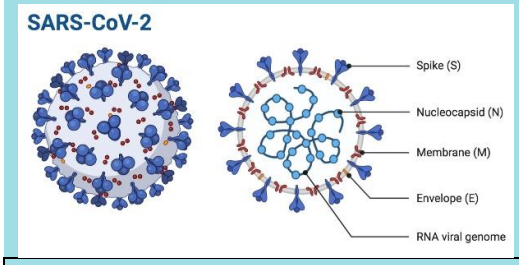
COVID-19	Year						
	2020	2021	2022	2023	2024	2025	Total
Cases	13,352	83,815	55,721	3,842	705	315	157,750
Deaths	332	2,815	621	116	24	13	3,921

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



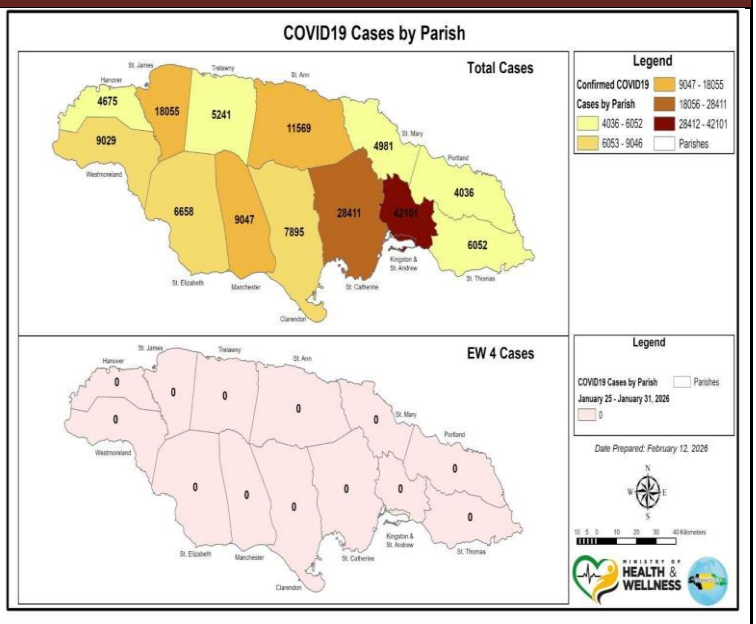
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 1 -4 2026

Epi Week	Confirmed Cases	Deaths
1	8900	454
2	11900	480
3	8800	390
4	10900	349
Total (4weeks)	**40500**	**1673**



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February 13, 2026 ISSN 0799-3927

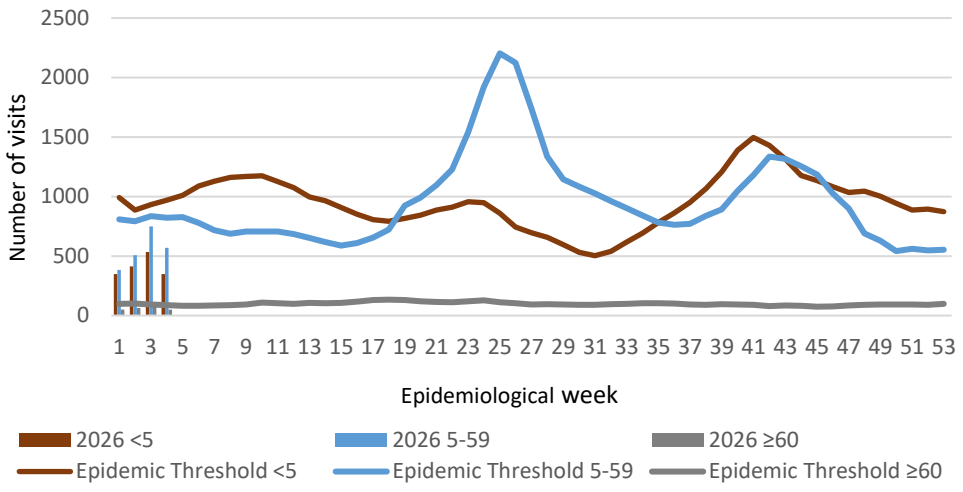
INFLUENZA SURVEILLANCE

EW 4

January 25, 2026 – January 31, 2026 Epidemiological Week 4

	EW 4	*YTD*
SARI cases	25	103
Total Influenza positive Samples	**4**	**39**
Influenza A	**4**	**39**
H1N1pdm09	0	2
H3N2	4	37
Not subtyped	0	0
Influenza B	**0**	**0**
B lineage not determined	0	0
B Victoria	0	0
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	2

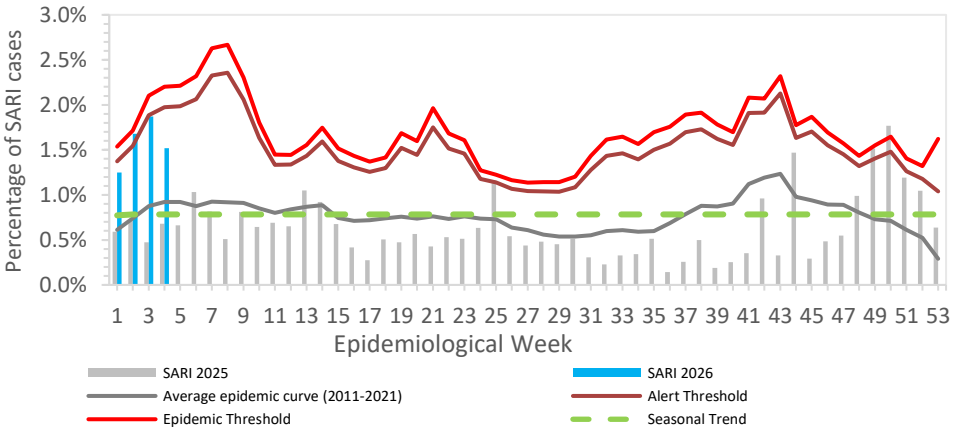
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 4, twenty five (25) SARI admissions were reported.

Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2026) (compared with 2011-2025)



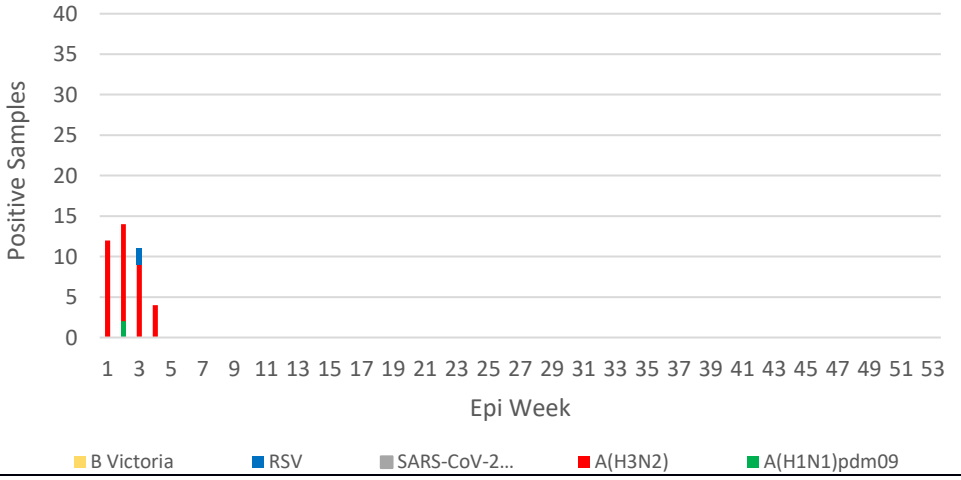
Caribbean Update EW 4

(Updates as at EW 3)

Influenza activity decreased, with a subregional positivity rate of 16.4% and a high prevalence of influenza A(H3N2). RSV circulation also decreased, reaching a positivity rate of 3.4%, while SARS-CoV-2 activity remained low and stable.

(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 - 2026



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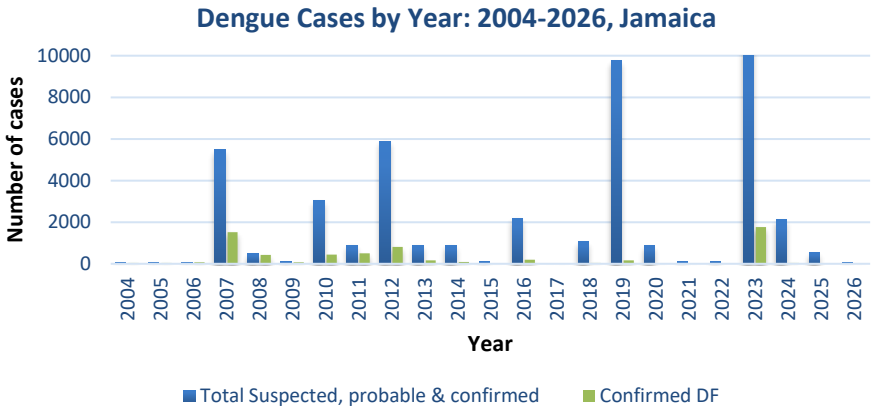
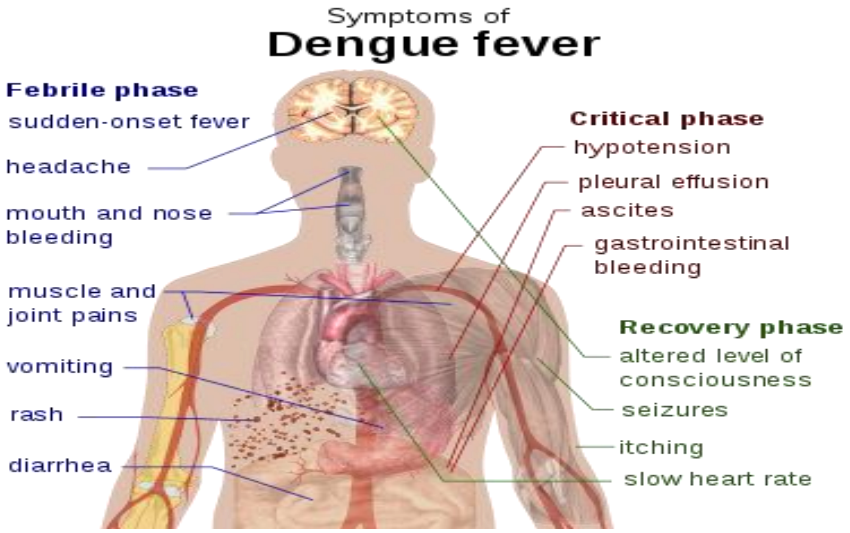
DENGUE SURVEILLANCE

January 25, 2026 – January 31, 2026 Epidemiological Week 4 | Epidemiological Week 4



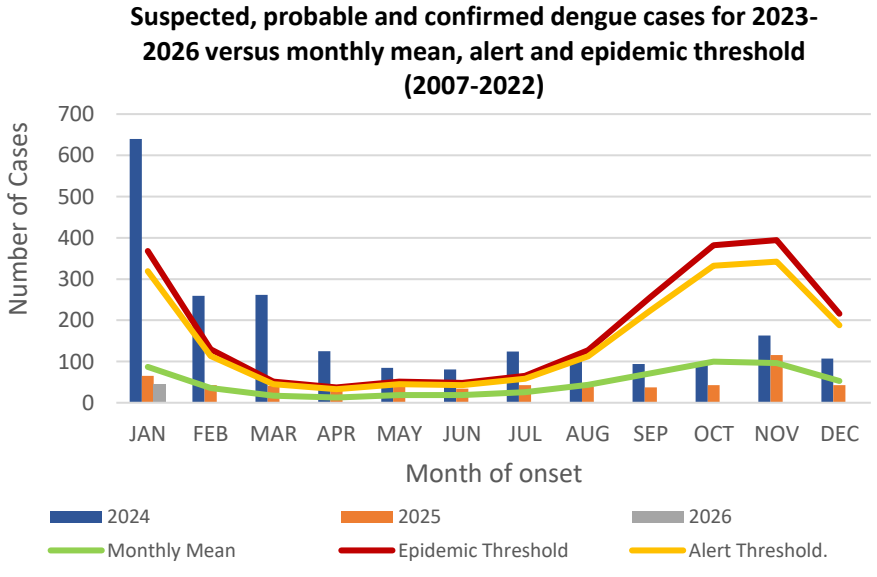
Reported suspected, probable and confirmed dengue with symptom onset in week 4 of 2026

	2026*	
	EW 4	YTD
Total Suspected, Probable & Confirmed Dengue Cases	2	40
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 February 12, 2026**
- **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-11

Antibacterial and antifungal analysis of extracts from the leaves of *Malpighia glabra* in Jamaica

Leach V[1], Porter R[2], Rodriguez C[1, 3]

[1]Department of Microbiology, University of the West Indies, Mona, Kingston, Jamaica, [2] Department of Chemistry, University of the West Indies, Mona, Kingston, Jamaica, [3] Department of Microbiology, University Hospital of the West Indies, Kingston, Jamaica

Objectives: To investigate the antibacterial and antifungal activities of extracts from the leaves of *Malpighia glabra*.

Methods: Verified leaves of *Malpighia glabra* known as "wild crapemyrtle" were dried at 70 °C for 3 days, milled,and sequentially extracted with hexane, dichloromethane and methanol. Extracts were collected via gravity percolation, and concentrated in *vacuo* on a rotary evaporator, then stored in a desiccator. For qualitative analysis, extracts were screened using the agar well diffusion method. Extracts showing activity were subsequently tested using the broth dilution assay in order to determine the minimum inhibitory concentration(MIC) and minimum bactericidal concentration (MBC). Experiments were conducted in triplicate with controls.Isolates against which the extracts were tested include: *Staphylococcus aureus* (ATCC-25923), *Streptococcus pyogenes*- (ATCC-19615), *Enterococcus faecalis* (ATCC-29212) *Escherichia coli* (ATCC-25922), *Klebsiella pneumoniae* (ATC-1705 and ATCC-1706), *Pseudomonas aeruginosa* (ATCC-27853) and clinical strains validated for use as quality control strains of *Neisseria gonorrhoeae*, Methicillin-Resistant *Staphylococcus aureus* (MRSA), extended-spectrum beta- lactamase producing *Escherichia coli* and *Candida albicans*.

Results: *Neisseria gonorrhoeae* was the only organism against which the extracts showed activity. The methanol extract was most effective against *Neisseria gonorrhoeae* (MIC and MBC 0.0156 mg/mL)while the hexane extract showed partial activity with initial qualitative screening but with the tube dilution, both MIC and MBC >1mg/mL. The dichloromethane extract was active with a MIC 0.03125mg/mL and MBC 0.0078 mg/mL.

Conclusion: The methanol extract showed significant antimicrobial activity against *Neisseria gonorrhoeae* and may be possible in treating gonorrhoea, developing antiseptics, disinfectants, moisturisers, and cleansers upon further investigations.

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