WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Congenital Syphilis

Congenital syphilis is Class 1 – reporting is on suspicion within 24 hours of consultation using the Class 1 notification form

A pregnant woman who is infected does not receive early and effective treatment, she can then transmit the infection to her unborn infant. This is known as congenital syphilis. Mother-to-child transmission of syphilis, or congenital syphilis, is usually devastating to the fetus if maternal infection is not detected and treated sufficiently early in the pregnancy. Most untreated primary and secondary syphilis infections in pregnancy result in severe adverse pregnancy outcomes. Latent (asymptomatic) syphilis infections in pregnancy also cause serious adverse pregnancy outcomes in more than half of cases. The fetus can easily be cured with treatment, and the risk of adverse outcomes to the fetus is minimal if the mother receives adequate treatment with benzathine penicillin during early pregnancy – ideally before the second trimester. The burden of morbidity and mortality due to congenital syphilis is high. In 2022, WHO estimated 700 000 congenital syphilis cases and 390 000 adverse birth outcomes globally. These adverse birth outcomes included:

- 150 000 early fetal deaths and stillbirths
- 70 000 neonatal deaths
- 55 000 preterm or low-birth weight births
- 115 000 infants with a clinical diagnosis of congenital syphilis.

Of these adverse birth outcomes, 21% occurred in pregnant women who did not attend antenatal care; 53% in women who attended antenatal care but were not screened for syphilis; 16% in women who tested positive for syphilis but were not treated or received inadequate treatment; and 9% in women who tested positive and were adequately treated. Congenital syphilis is also the second leading cause of preventable stillbirth globally, preceded only by malaria.

Testing and treatment

The number of women and infants affected by syphilis remains unacceptably high. It is crucial that all women are provided with early syphilis screening and treatment as part of high-quality antenatal care, to enable a positive pregnancy experience. In addition, health systems and programmes need to ensure that all women diagnosed with syphilis, as well as their infants, are effectively treated – and that their sexual partners are reached for testing and treatment. Countries can also work to reduce syphilis prevalence across populations, by ensuring that testing, treatment and partner referral for the infection are implemented, beyond antenatal care. Syphilis is inexpensive to detect and treat, making it a possible "easy win" in terms of cost, feasibility and speed of scale-up. Investing in screening and treatment for syphilis in pregnant women ranks as one of the most cost-effective antenatal interventions. Syphilis testing and treatment coverage among pregnant women is still low in many countries – lower than antenatal HIV testing and treatment. While WHO recommends testing at the point of care using rapid diagnostic tests, most countries still rely on laboratory testing for syphilis. WHO recommends a simple, proven and inexpensive dual test for syphilis and HIV to improve the quality, acceptability and uptake of testing and treatment of maternal syphilis. The dual rapid diagnostic tests offer the opportunity to immediately close the gap between HIV and syphilis testing among pregnant women, and to accelerate elimination of mother-to-child transmission of both syphilis and HIV.

Surveillance, monitoring and evaluation

Monitoring the scale-up of screening and treatment for pregnant women remains paramount to measuring progress towards the elimination goal. Measuring how many adults and infants are affected by syphilis with regional- and national-level estimation is crucial to guide the capacity of health systems to strengthen the prevention, detection and treatment of syphilis.

Taken from WHO website on 27/Apr/2026
https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/stis/prevention/mother-to-child-transmission-of-syphilisPicture

EPI WEEK 15

Syndromic Surveillance

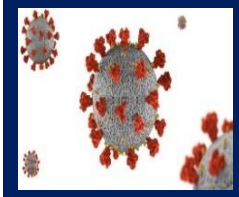
Accidents

Violence

Pages 2-4

Class 1 Notifiable Events

Page 5



COVID-19 Surveillance

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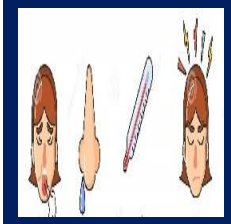

Influenza Surveillance

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Dengue Surveillance

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Research Abstract

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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 – 12 to 15 of 2026.

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

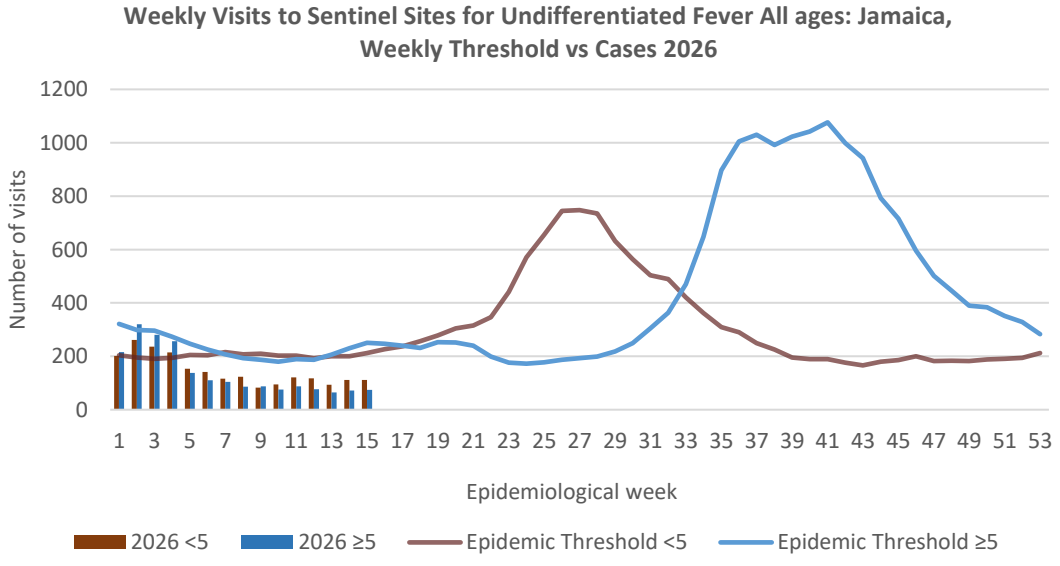
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
12	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
13	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
14	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
15	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

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HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

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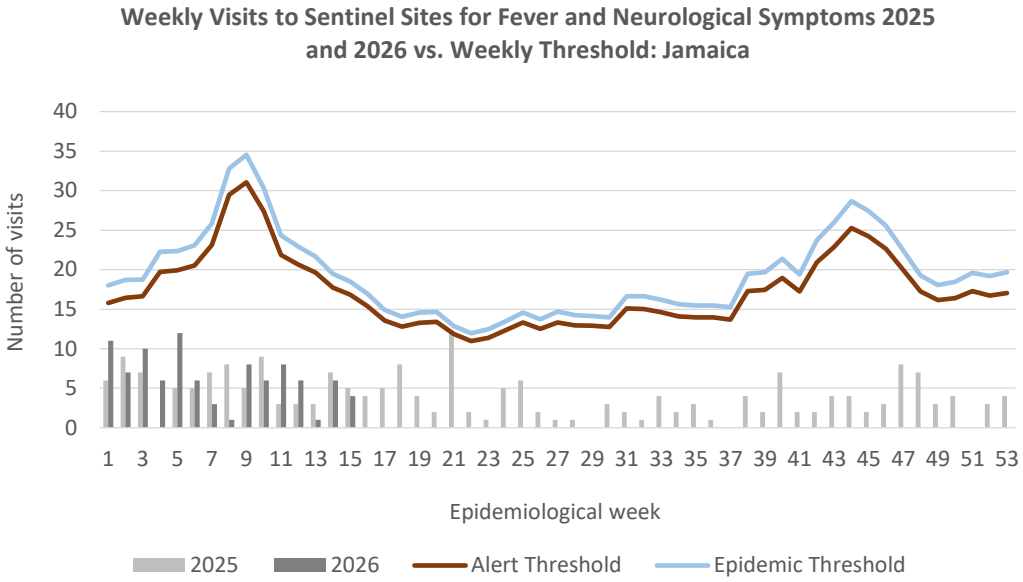
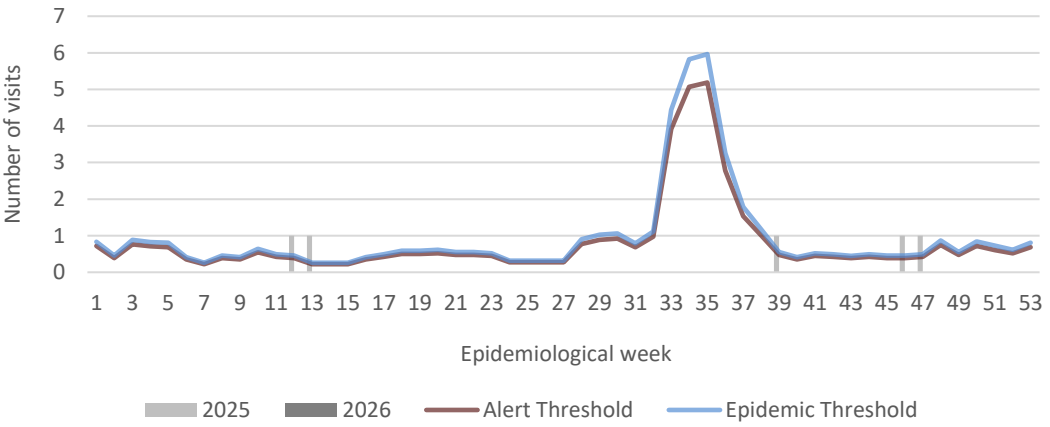
FEVER AND NEUROLOGICAL

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

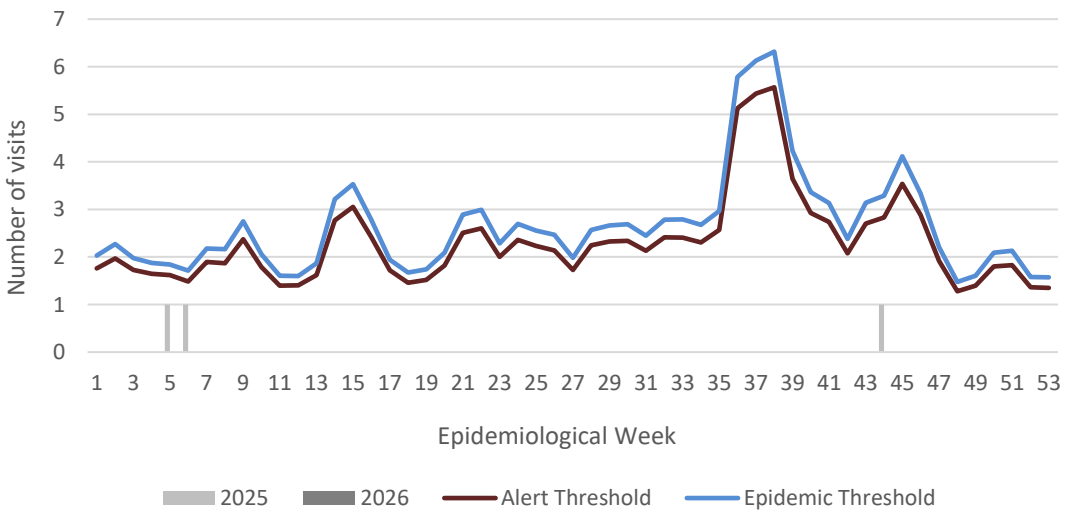
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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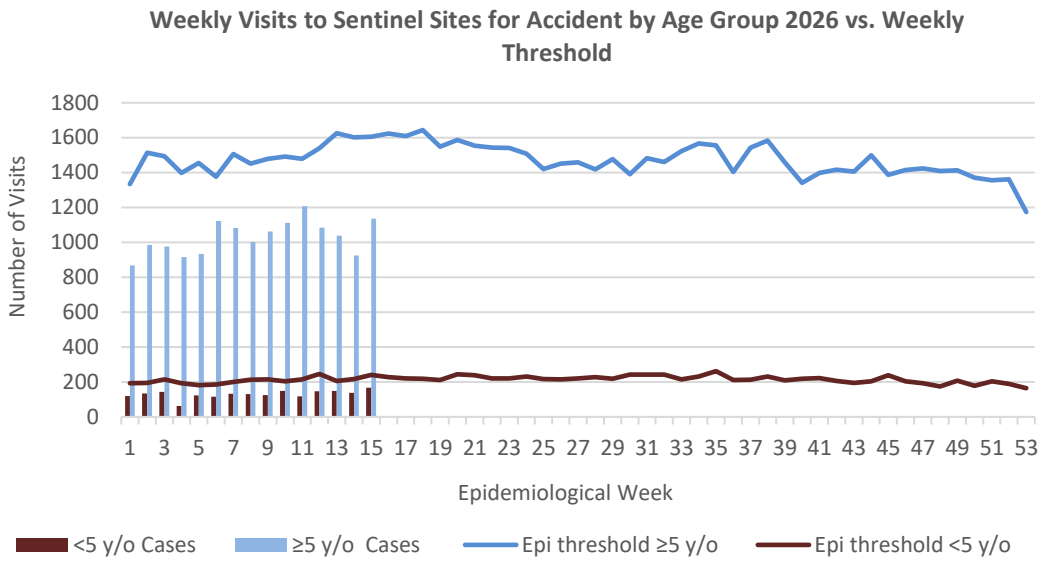
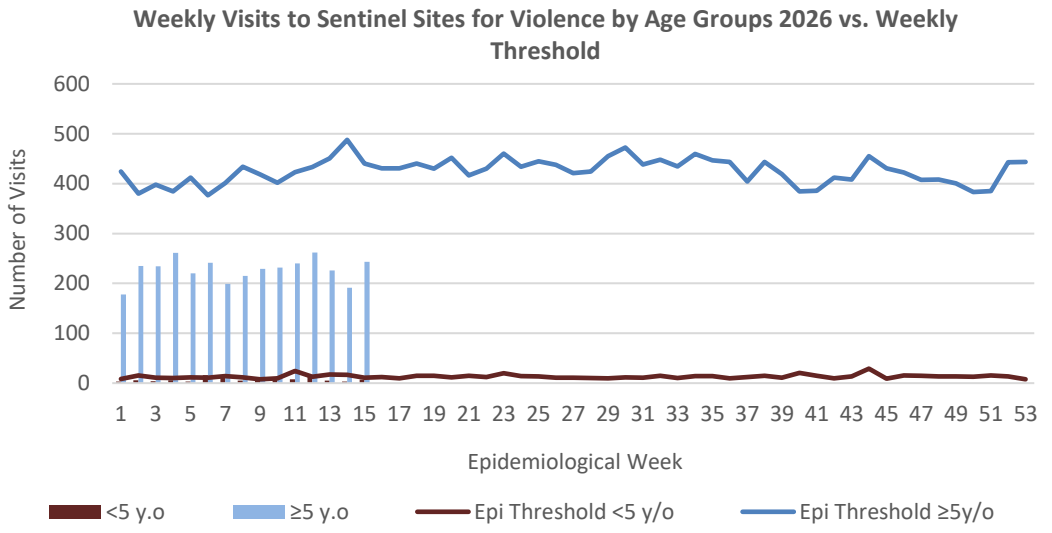
ACCIDENTS

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



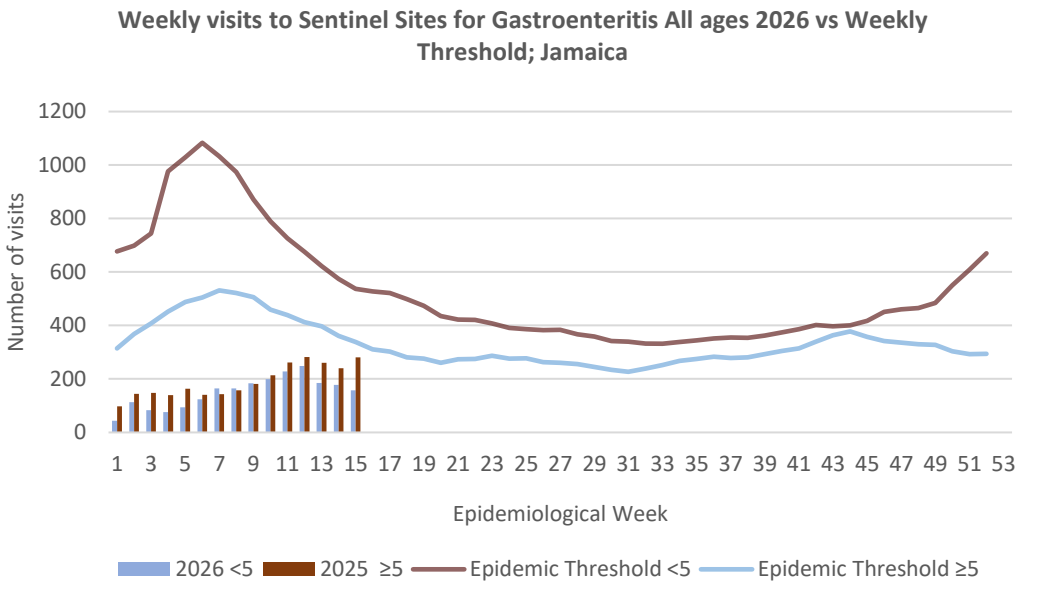
VIOLENCE

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		14[β]	66[β]
	Cholera		0	0
	Severe Dengue[Y]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		3	67
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		2	5
	Hepatitis C		0	2
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis		2	6
	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
		Rubella	0	0
	Maternal Deaths (notified pregnanacy related deaths) [δ]		12	20
	Ophthalmia Neonatorum		0	21
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		1	0
	Tuberculosis		7	21
	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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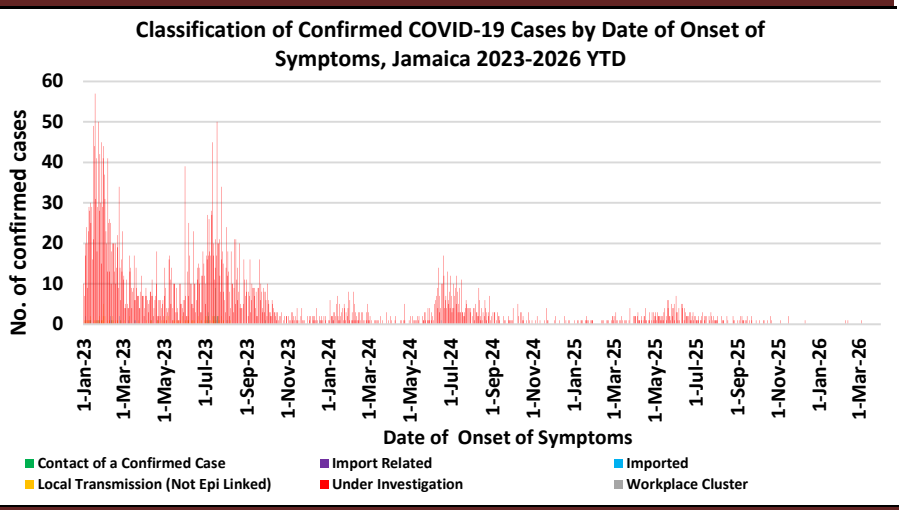
COVID-19 SURVEILLANCE

CASES	EW 15	Total
Confirmed	0	157753
Females	0	90885
Males	0	66865
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.

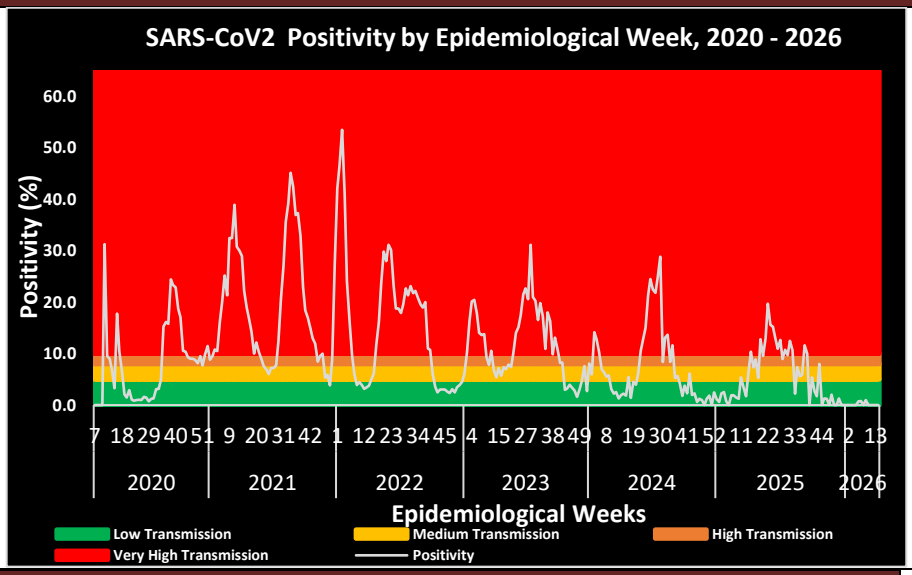


COVID-19 Outcomes

Number of Confirmed COVID-19 cases and deaths, Jamaica 2022-2026

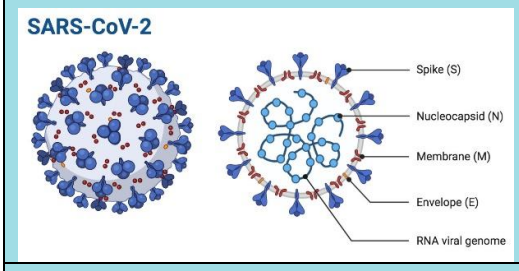
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	3	157,753
Deaths	621	116	24	13	0	3,921

*Current positivity rate: 0 %
- (positive samples/total samples tested)
* Low transmission for infection



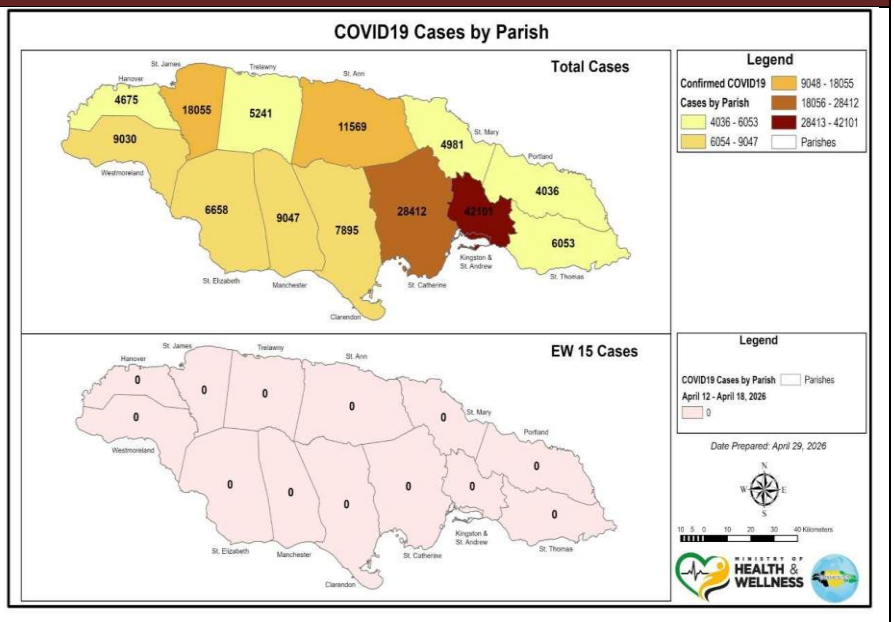
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 12 -15 2026

Epi Week	Confirmed Cases	Deaths
12	7300	240
13	5800	187
14	4200	153
15	3200	73
Total (4weeks)	**20500**	**653**



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May 1, 2026 ISSN 0799-3927

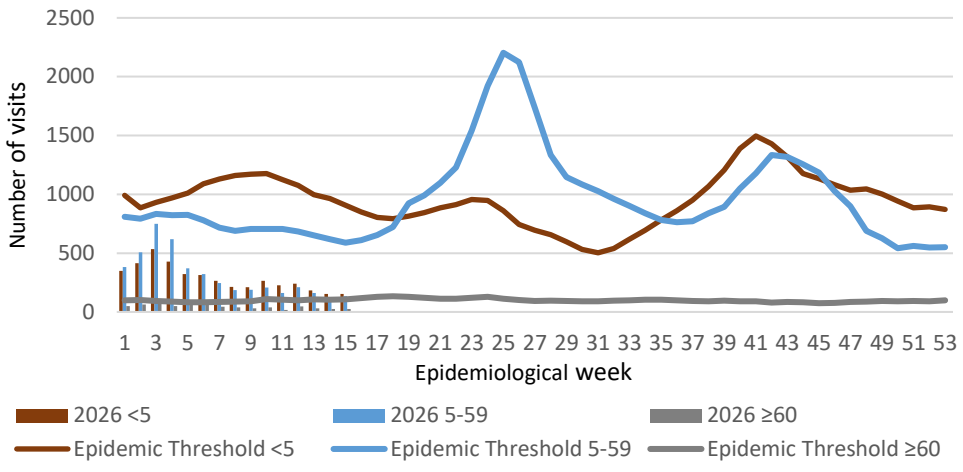
INFLUENZA SURVEILLANCE

EW 15

April 12, 2026 – April 18, 2026 Epidemiological Week 15

	EW 15	*YTD*
SARI cases	7	260
Total Influenza positive Samples	**0**	**238**
Influenza A	**0**	**223**
H1N1pdm09	0	18
H3N2	0	205
Not subtyped	0	0
Influenza B	**0**	**15**
B lineage not determined	0	0
B Victoria	0	15
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	34

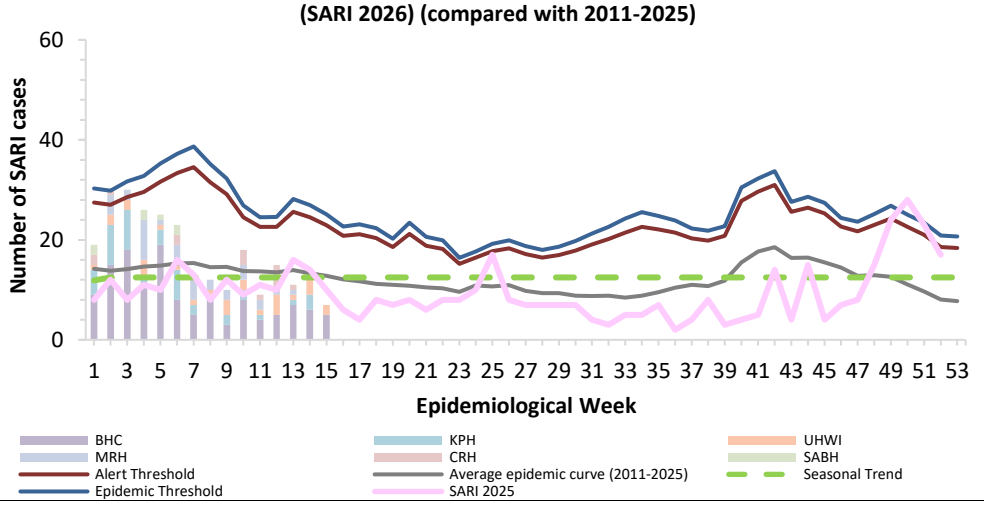
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2026 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 15, seven (7) SARI admissions were reported.

Jamaica: Number of Cases of Severe Acute Respiratory Illness (SARI 2026) (compared with 2011-2025)



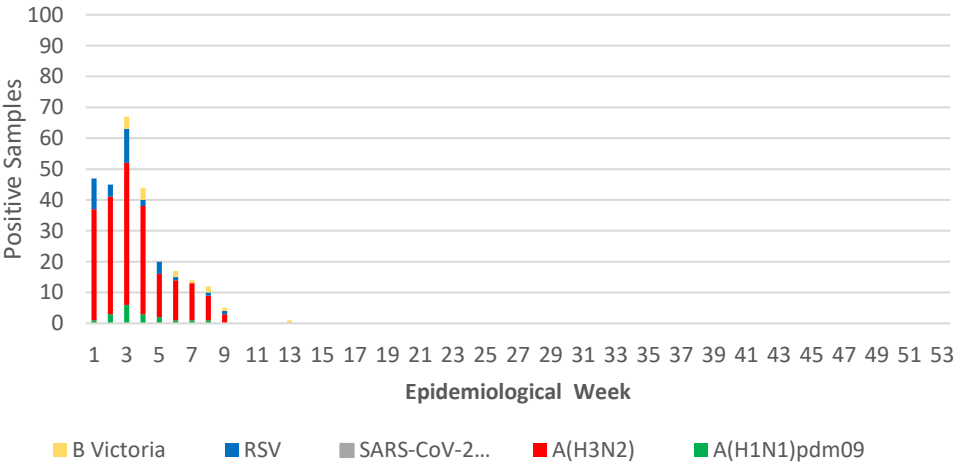
Caribbean Update EW 15

(Updates as at EW 14)

Influenza positivity in the Caribbean during EW 14 of 2026 stands at 7.2%, with a sustained downward trend consistent with the end of he epidemic period in countries of the subregion, although it still predominates over RSV and SARS-CoV-2. Over the last 4 weeks, co-circulation of influenza A(H3), A(H1N1)pdm09 and B (Victoria) is observed. Overall, countries report a low number of influenza positive samples between 1 and 4 per country. RSV activity shows a positivity of 1.69% with few reported cases remaining at low levels regionally. SARS-CoV-2 circulation remains low (overall positivity of 0.11%) with a stable 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 - 2026



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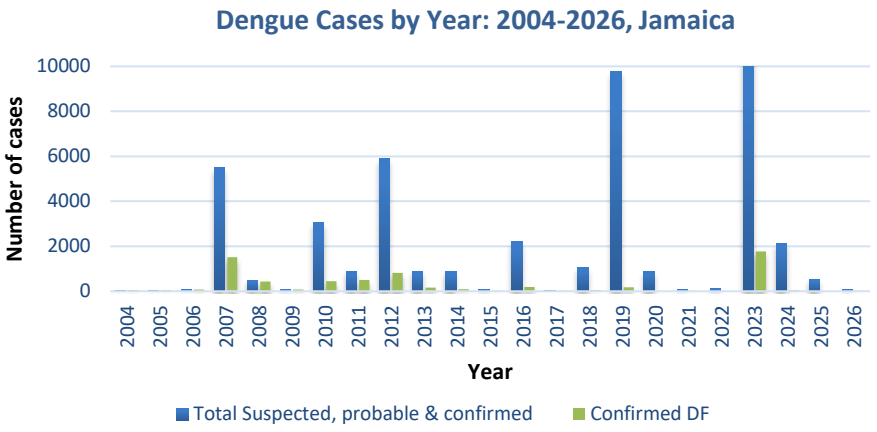
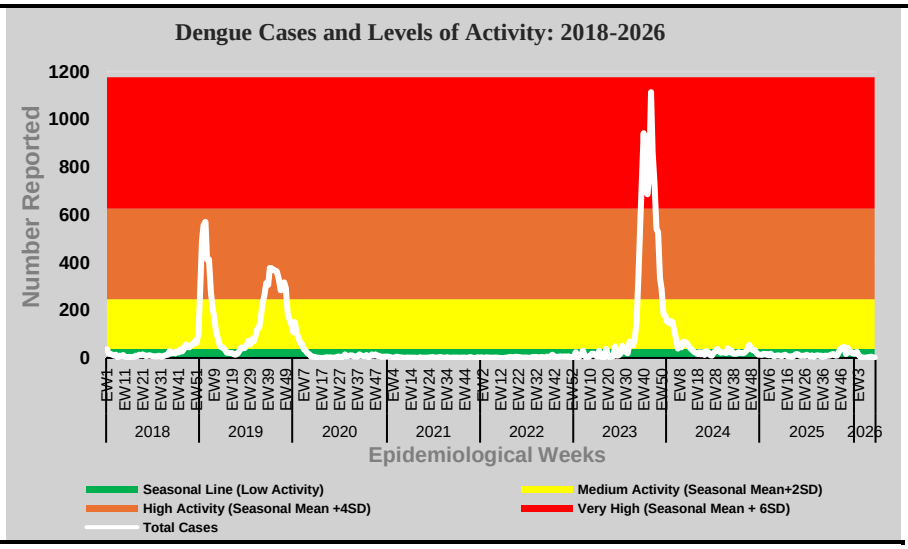
DENGUE SURVEILLANCE

April 12, 2026 – April 18, 2026 Epidemiological Week 15 | Epidemiological Week 15



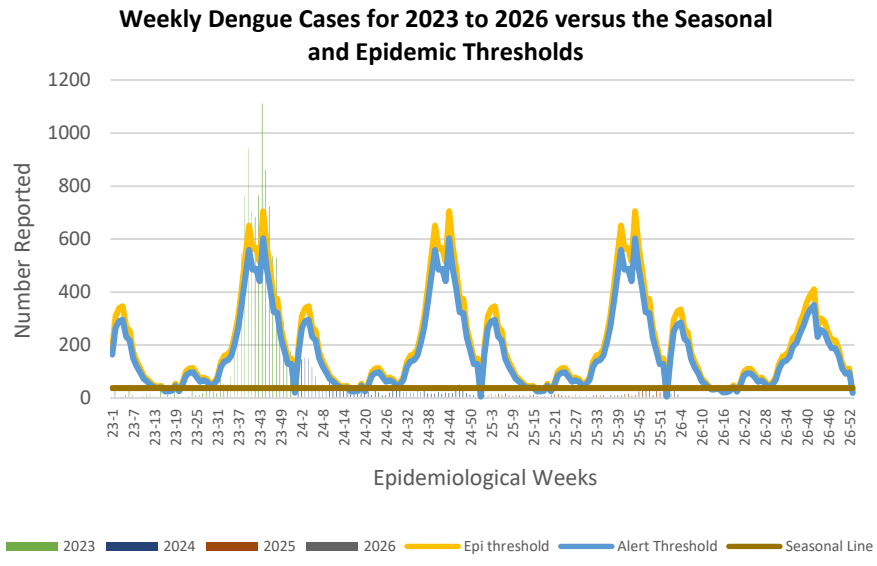
Reported suspected, probable and confirmed dengue with symptom onset in week 15 of 2026

	2026*	
	EW 15	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	78
Lab Confirmed Dengue cases	0	1
CONFIRMED Dengue Related Deaths	0	0



nts to note:

- **Dengue deaths are reported based on date of death.**
- ***Figure as at May 1, 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-25-O-01

The effect of early life socioeconomic factors on rates of vaso-occlusive crisis and hospitalization in Jamaicans with Sickle Cell Disease

Blake A.L.[1,2,4], Ferguson T.S[2], Harding S[3], Younger-Coleman N[2], Asnani M[4]
[1]The School of Clinical Medicine and Research, The Bahamas, The University of the West Indies, Nassau, The Bahamas, [2]Epidemiology Research Unit, Caribbean Institute for Health Research, The University of the West Indies, Mona, Jamaica., [3]School of Life Course Sciences, Faculty of Life Sciences & Medicine, King's College London, London, UK., [4]Sickle Cell Unit, Caribbean Institute for Health Research, University of the West Indies, Mona, Jamaica.

Aim: We aimed to assess the effect of early life socioeconomic factors on rates of hospitalization and painful vaso-occlusive crisis (VOC) among Jamaicans with sickle cell disease (SCD) born 1973-1981.

Methods: We used a retrospective cohort of 535 patients. Outcome variables were lifetime rates of hospitalization and VOC. Exposure variables included social amenities rating scores (SARS) classified into tertiles, birthweight and parental occupation at birth. Data were entered into REDCap and analysed using STATA version 19. Negative binomial regression was used to estimate the association between socioeconomic status and outcomes. We reported the incidence rate ratio (IRR), related 95% confidence limits and p-values. Final multivariable analysis used complete case on 378 participants.

Results: Analyses included 277 males and 253 females. Overall, 56.5% (n=302) had the HbSS genotype, 57% (n=300) lived with both parents at birth, and 59.5% (n=279) of participant's parents had manual professions. Mean SARS at birth was 10.0±4.7 (max=18); birthweight 7.0±1.1 lbs (max=12.0 lbs). Overall, 75.8% (n=406) of persons were hospitalized and 64.1% (n=343) had at least one VOC. Final multivariable analysis revealed that those in the second tertile of SARS (IRR = 0.63, 95% CI [0.42, 0.92], p=0.018) (vs. lower tertile) and with higher birthweight (IRR=0.83, 95% CI [0.69,0.99], p=0.036) had significantly lower rates of VOC. No social variables were significantly associated with hospitalization rates.

Conclusion: Higher birthweight and being in the second SARS tertile were associated with significantly lower painful VOC rates. These findings highlight the potential role of early-life socioeconomic factors in long term outcomes of SCD.

Keywords: Sickle Cell Disease, Birth Cohort, Early life exposures, Hospitalization rates, Vaso-occlusive crisis rates

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