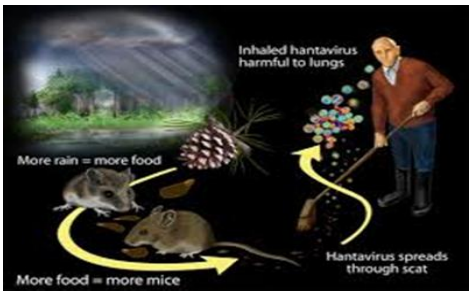
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Hantavirus

Hantavirus cardiopulmonary syndrome (HCPS), also known as hantavirus pulmonary syndrome (HPS), is a zoonotic, viral respiratory disease caused by hantaviruses of the genus *Orthohantavirus*, family *Hantaviridae*, order *Bunyavirales*. More than 20 viral species have been identified within this genus. In the Americas, *Sin Nombre virus* is the predominant cause of HPS in North America, while *Orthohantavirus andesense* is responsible for most cases in South America.



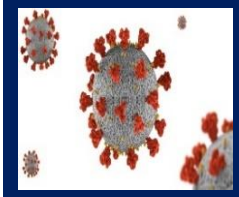
Human Hantavirus infection is primarily acquired through contact with the urine, faeces, or saliva of infected rodents or by touching contaminated surfaces. Exposure typically occurs during activities such as cleaning buildings with rodent infestations, though it may also occur during routine activities in heavily infested areas. Human cases are most commonly reported in rural settings, such as forests, fields, and farms, where rodents are present, and opportunities for exposure are greater. HPS is characterized by headache, dizziness, chills, fever, myalgia, and gastrointestinal problems, such as nausea, vomiting, diarrhoea, and abdominal pain, followed by sudden onset of respiratory distress and hypotension. Symptoms of HPS typically occur from 2-4 weeks after initial exposure to the virus. However, symptoms may appear as early as one week and as late as eight weeks following exposure.

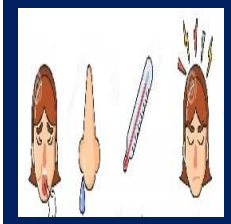
Hantavirus infections are relatively uncommon globally. In 2025 (as of epidemiological week 47), in the Region of the Americas, eight countries reported 229 cases and 59 deaths with a CFR of 25.7%. [1] In the European Region, 1885 hantavirus infection reported in 2023 (0.4 per 100,000), marking the lowest rate observed between 2019 and 2023.[2] In East Asia, particularly China and the Republic of Korea, Hantavirus haemorrhagic fever with renal syndrome (HFRS) continues to account for many thousands of cases annually, although incidence has declined in recent decades.

Hantavirus infections are associated with a case fatality rate of <1–15% in Asia and Europe and up to 50% in the Americas. While there are no specific treatment nor vaccines for hantavirus infections, early supportive care and immediate referral to a facility with a complete ICU can improve survival.
Environmental and ecological factors affecting rodent populations can influence disease trends seasonally. Since hantavirus reservoirs are sylvatic rodents, transmission can occur when people come into contact with rodent habitats.
Although uncommon, limited human-to-human transmission of HPS due to *Andes* virus has been reported in community settings involving close and prolonged contact. Secondary infections among healthcare workers have been previously documented in healthcare facilities, though remain rare.

Taken from WHO website on 6/May/2026
https://www.who.int/emergencies/disease-outbreak-news/item/2026-DON599
Picture taken from: https://rma.venturacounty.gov/divisions/environmental-health/hantavirus/

EPI WEEK 16





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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 – 13 to 16 of 2026.

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

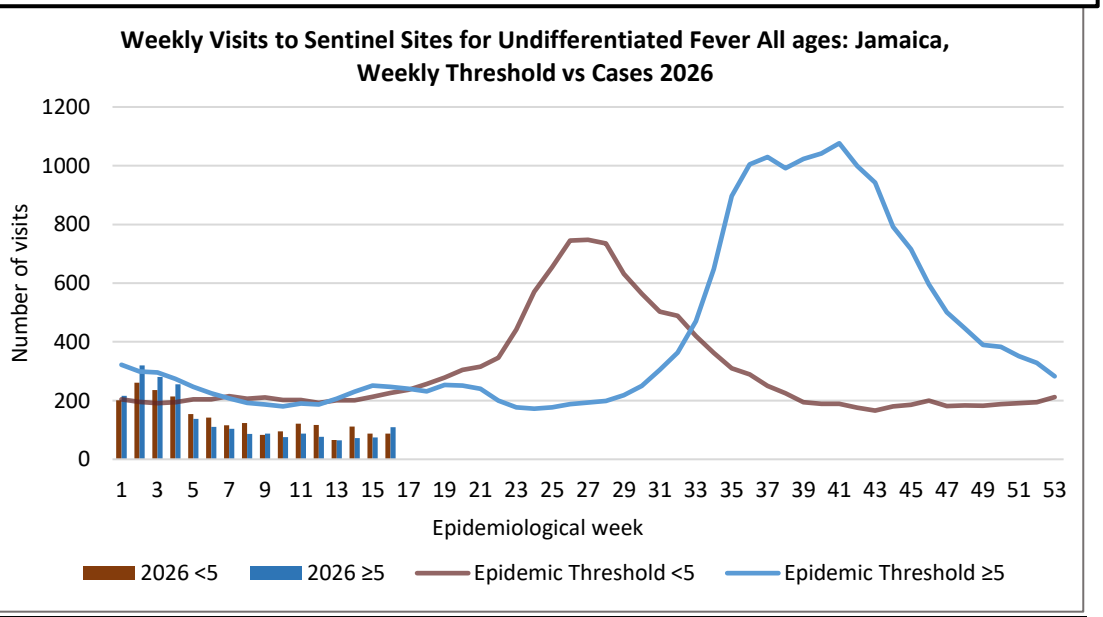
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
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
16	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

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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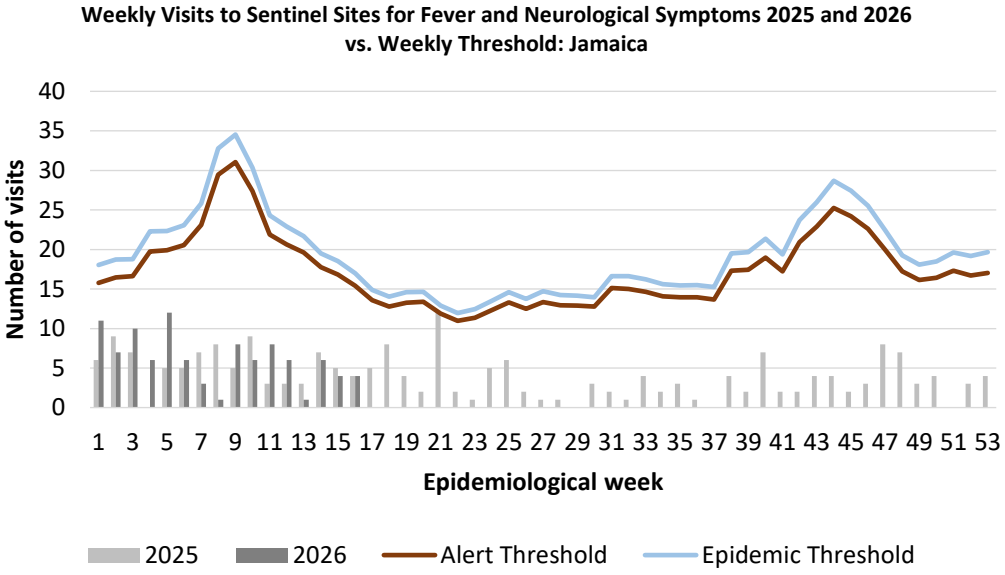
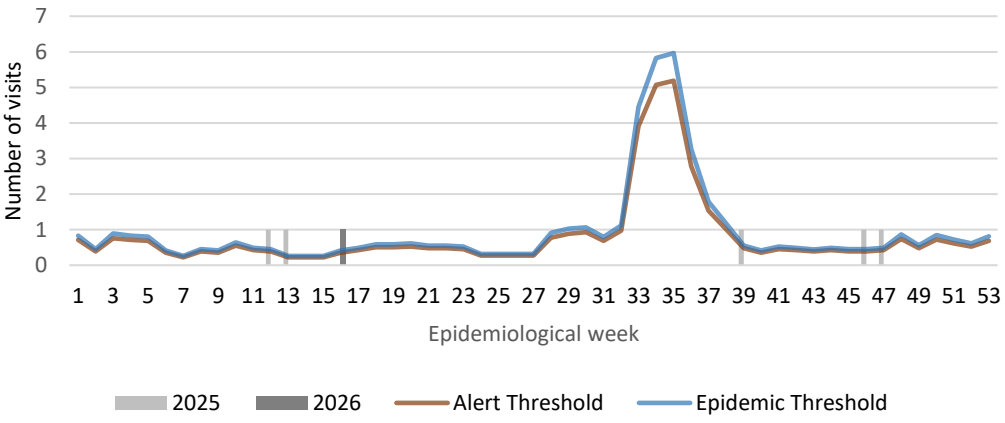
FEVER AND NEUROLOGICAL

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

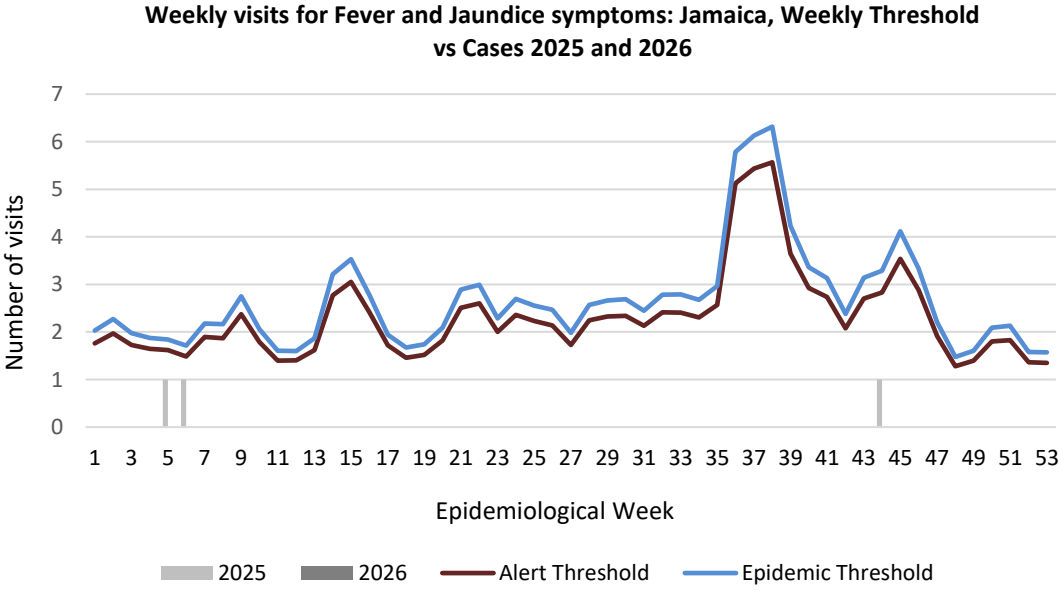
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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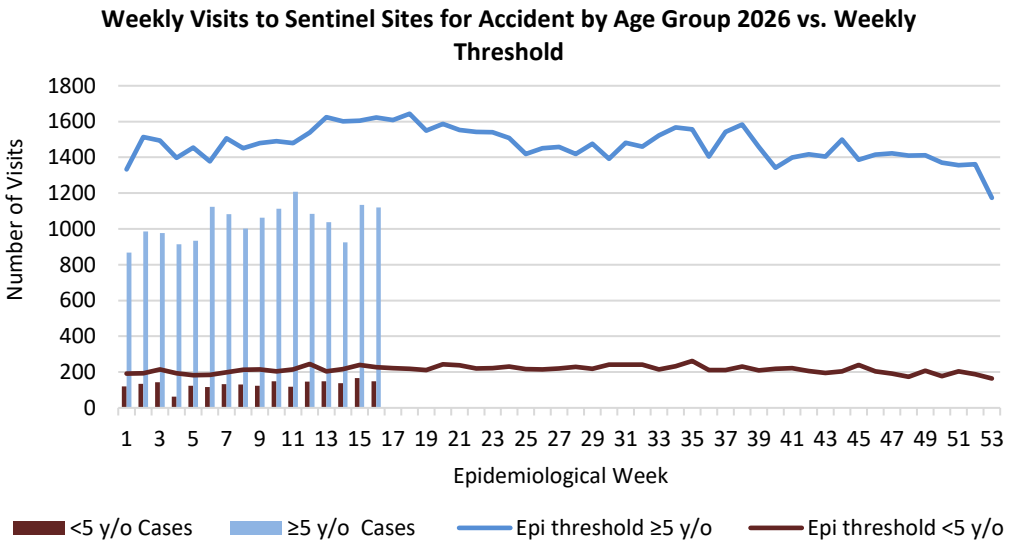
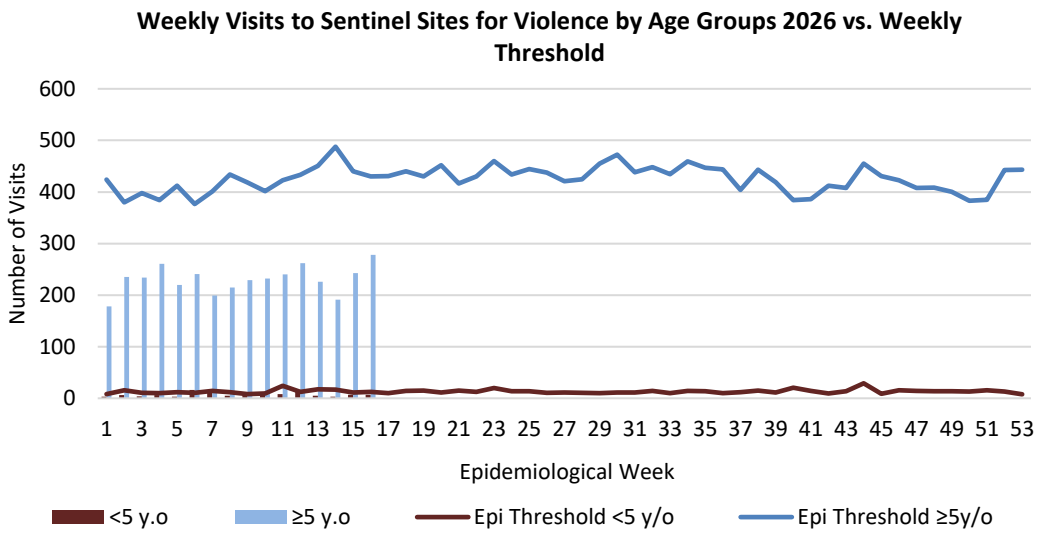
ACCIDENTS

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



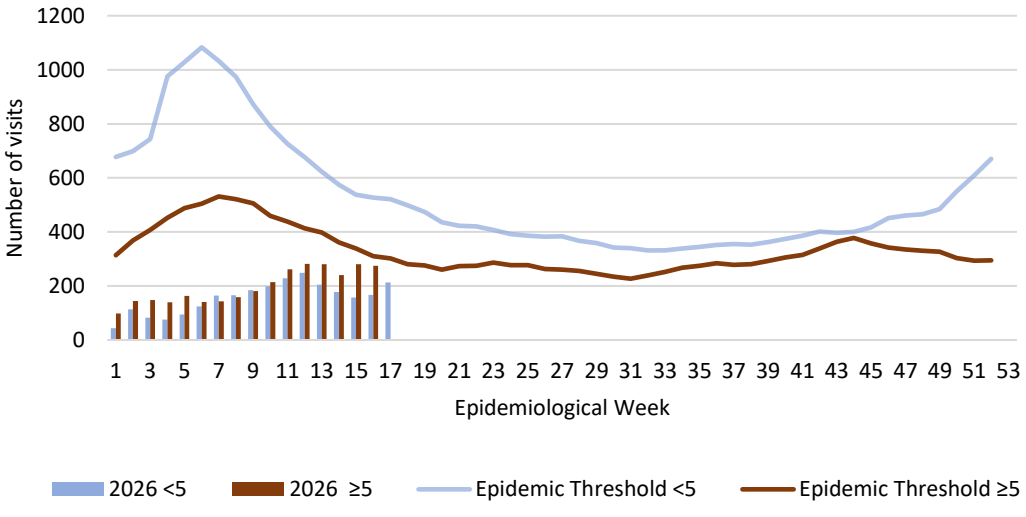
VIOLENCE

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	14[β]	68[β]
	Cholera	0	0
	Severe Dengue[Y]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	3	78
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	3	5
	Hepatitis C	0	2
	HIV/AIDS	NA	NA
	Malaria (Imported)	0	0
	Meningitis	2	6
	Mpox	0	1
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 (notified pregnanacy related deaths)[δ]	14	22
	Ophthalmia Neonatorum	0	21
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	0
	Tetanus	1	0
	Tuberculosis	22	22
	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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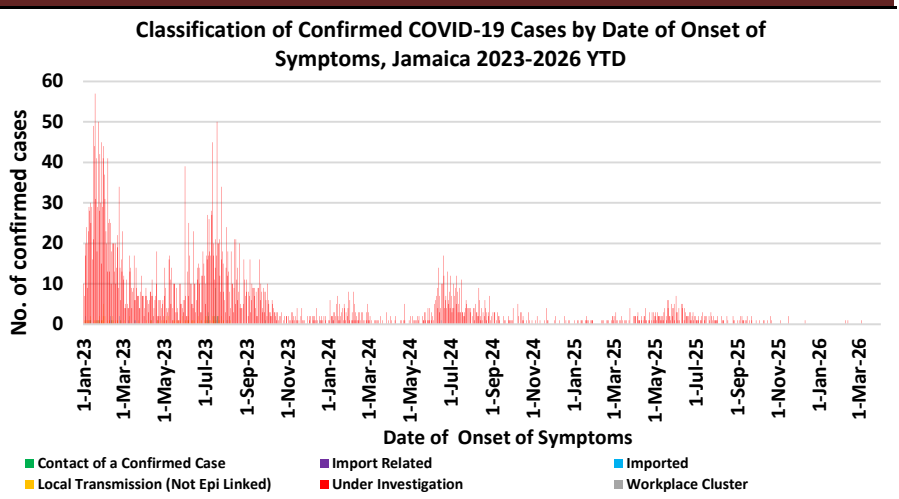
COVID-19 SURVEILLANCE

CASES	EW 16	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.

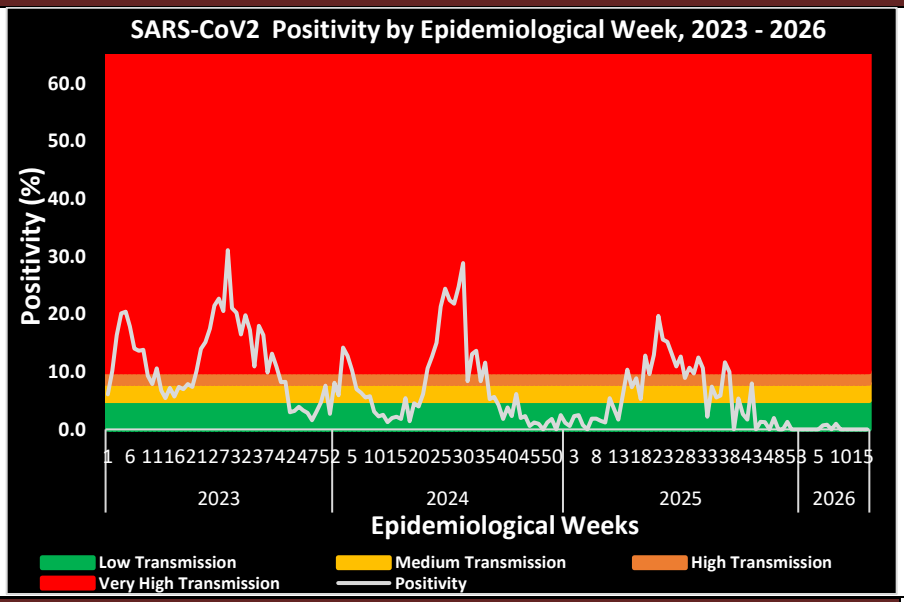


COVID-19 Outcomes

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

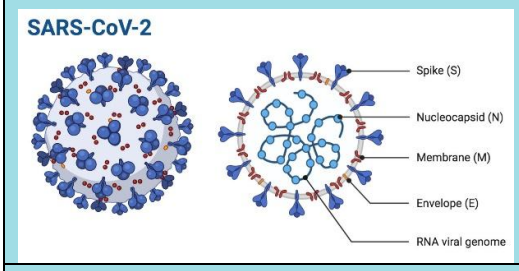
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	3	157,753
Deaths	621	116	24	13	0	3,921

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



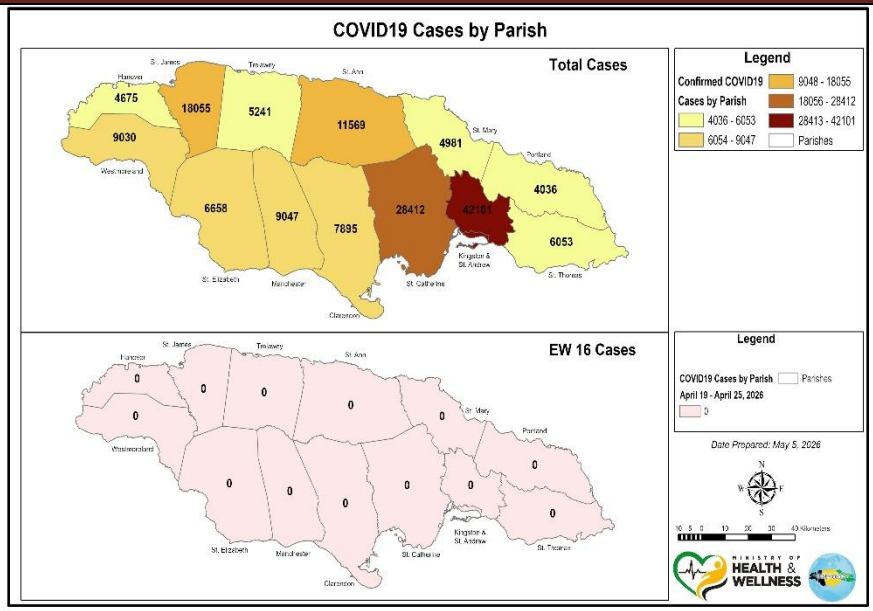
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 13 -16 2026

Epi Week	Confirmed Cases	Deaths
13	5800	187
14	4200	153
15	3200	73
16	Not available	
Total (4weeks)		



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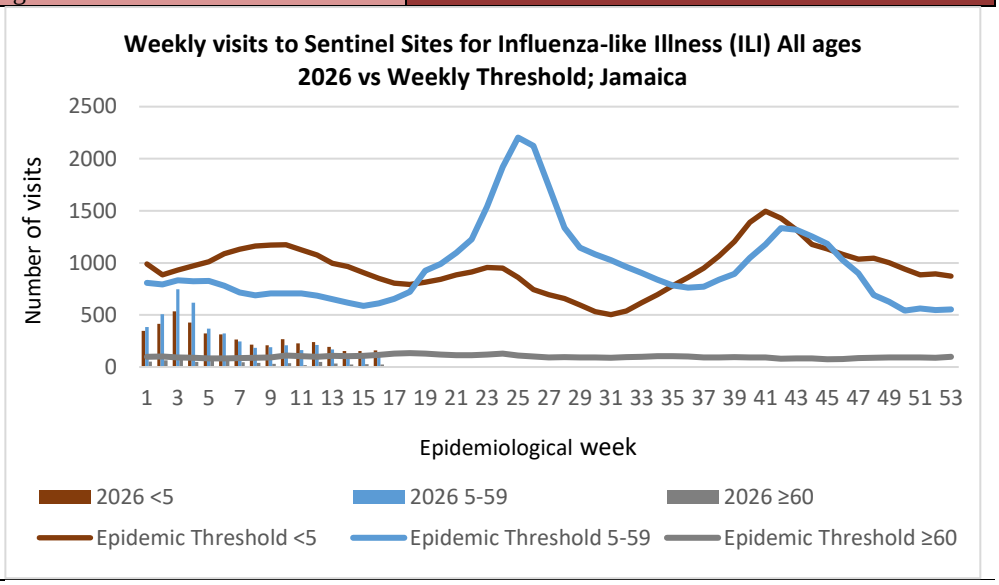
INFLUENZA SURVEILLANCE

EW 16

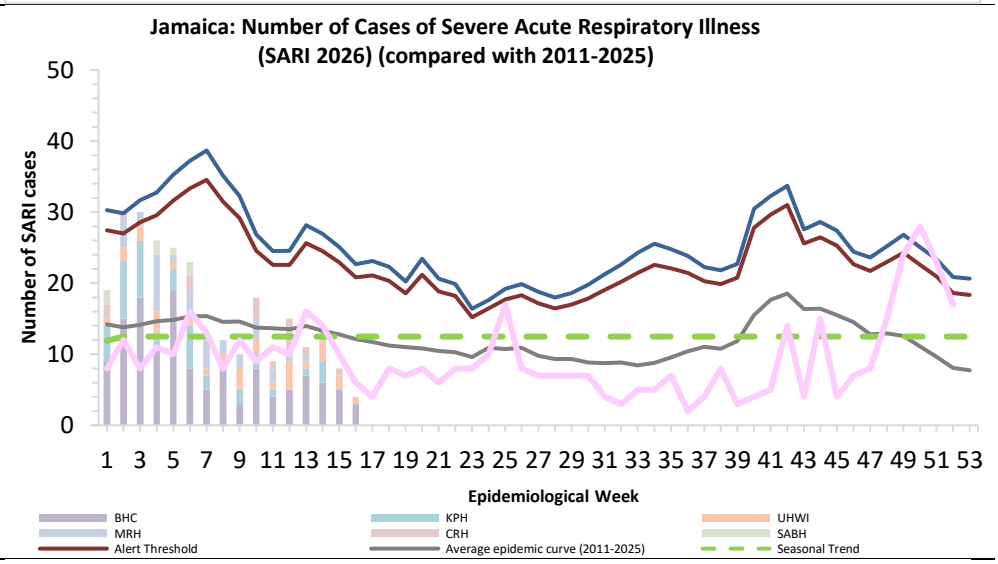
April 19, 2026 – April 25, 2026 Epidemiological Week 16

	EW 16	*YTD*
SARI cases	4	265
Total Influenza positive Samples	**0**	**240**
Influenza A	**0**	**224**
H1N1pdm09	0	18
H3N2	0	206
Not subtyped	0	0
Influenza B	**0**	**16**
B lineage not determined	0	0
B Victoria	0	16
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	34



Epi Week Summary

During EW 16, four (4) SARI admissions were reported.

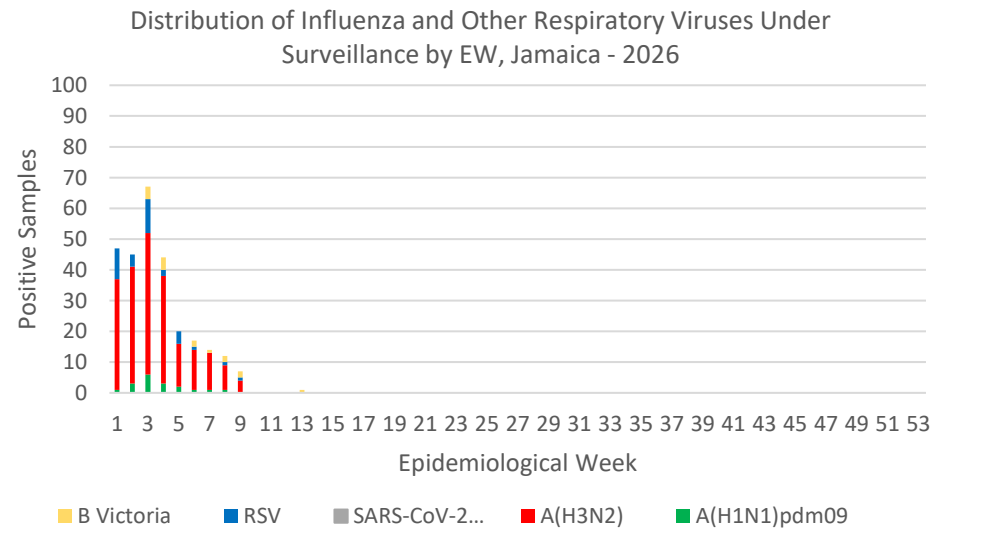


Caribbean Update EW 16

(Updates as at EW 15)

Influenza activity is declining, with subregional positivity falling from approximately 9.0% to 7.7% over the last four weeks. A(H3N2) remains the defining subtype at 68.4%. RSV activity has showed a discreet increase with positivity reaching 1.9%. SARS-CoV-2 circulation has remained low.

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



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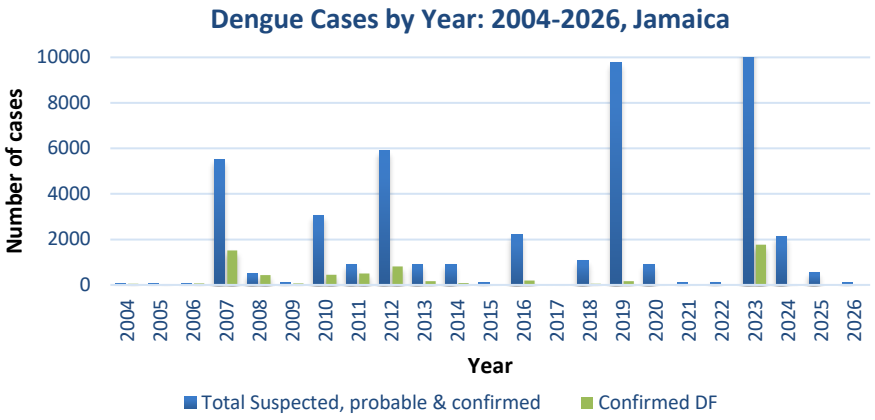
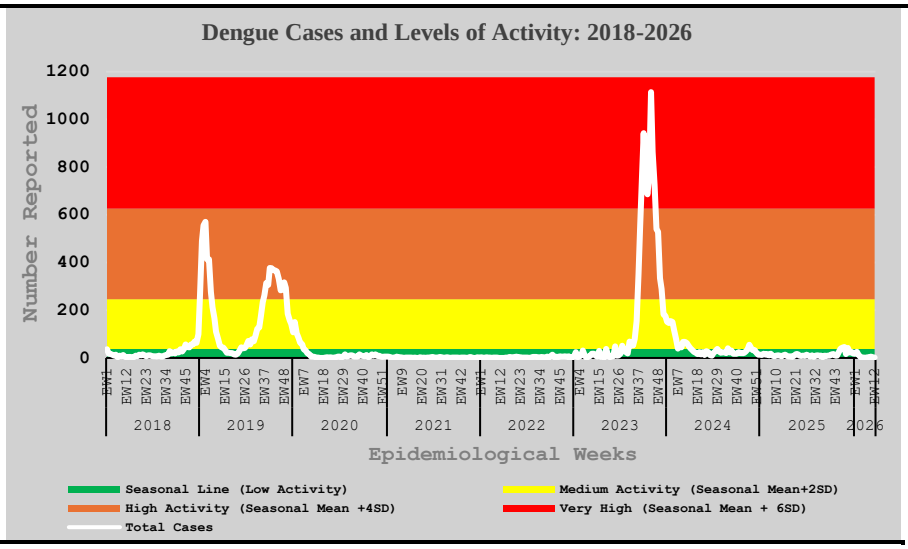
DENGUE SURVEILLANCE

April 19, 2026 – April 25, 2026 Epidemiological Week 16 | Epidemiological Week 16



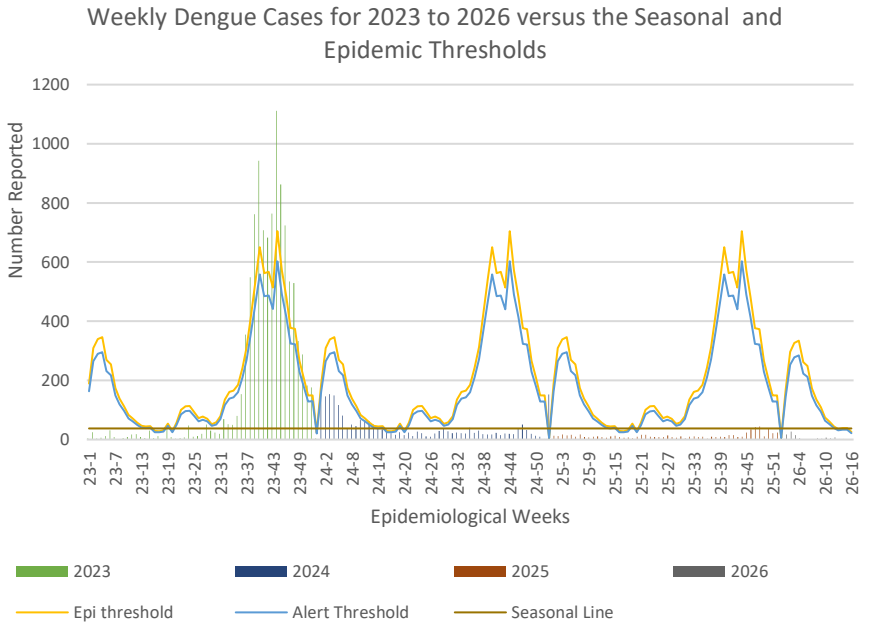
Reported suspected, probable and confirmed dengue with symptom onset in week 16 of 2026

	2026*	
	EW 16	YTD
Total Suspected, Probable & Confirmed Dengue Cases	1	95
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 May 8, 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

Cost-effectiveness of abemaciclib plus endocrine therapy in high-risk HR+HER2- early breast cancer in Jamaica

Lynch, H[1], Johnson, J[1], Campbell, E[1], Keith, D[1], Barnett, J[1], Gooden, M[1], Brown, S[1], Thompson, P[1]

[1] *Policy Planning and Development Division, Ministry of Health and Wellness, Jamaica*

Objective: This study aimed to evaluate the cost-effectiveness of abemaciclib plus endocrine therapy (ET) versus ET-alone as adjuvant treatment for node-positive, high-risk of disease recurrence, hormone-receptor-positive, and human epidermal growth factor receptor 2-negative (HR+HER2-) early breast cancer in Jamaica.

Methods: A 4-state Markov model estimated the lifetime costs, life-years (LYs) and quality-adjusted life years (QALYs) for a hypothetical cohort of HR+HER2- patients from the Jamaican government perspective. Clinical and safety data from the MonarchE trial informed transition probabilities for invasive disease-free survival, nonmetastatic recurrence, metastatic recurrence, and death. Costs were derived from national data sources, expert opinion, and published literature, expressed in Jamaican dollars (JA$) and discounted at 6.25%. Utility and disutility values were sourced from the literature. Incremental cost-effectiveness ratios (ICERs) per LY and QALY gained were calculated against the World Health Organisation's willingness-to-pay (WTP) threshold of three times gross domestic product (GDP) per capita. Deterministic and probabilistic sensitivity analyses tested model robustness.

Results: Base case analysis estimated lifetime costs of JA$23,955,423.92 for abemaciclib plus ET and JA$16,326,642.21 for ET-alone, yielding an incremental cost of JA$7,628,781.71 per patient. Abemaciclib plus ET improved outcomes (0.89 additional QALYs; 0.71 LYs), but with ICERs of JA$10,818,534.47 per QALY and JA$8,590,755.67 per LY, which exceeded the WTP threshold. Sensitivity analyses indicated only a 2.3% probability of cost-effectiveness at three times the GDP capita.

Conclusion: In Jamaica, adjuvant abemaciclib plus ET for high-risk, node-positive early breast cancer is unlikely to be cost-effective compared with ET alone at a WTP threshold of three times GDP.

Keywords: Adjuvant treatment, Abemaciclib, Cancer recurrence, cost-effectiveness

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