

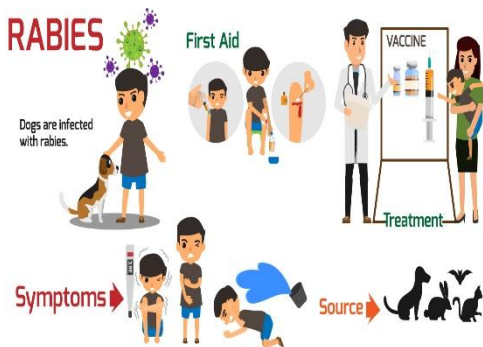
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Rabies pt 2

Currently, there are no WHO-approved diagnostic tools for detecting rabies infection before the onset of clinical disease. Clinical diagnosis of rabies is difficult without a reliable history of contact with a rabid animal or specific symptoms of hydrophobia or aerophobia. Accurate risk assessment is crucial for deciding on PEP administration. Once symptoms emerge, and death is inevitable, offering comprehensive and compassionate palliative care is recommended.



Postmortem confirmation of rabies infection is done by various diagnostic techniques that detect whole viruses, viral antigens, or nucleic acids in infected tissues (brain, skin or saliva). Where possible, the biting animal should be tested. Vaccinating dogs, including puppies, through mass vaccination programs is the most cost-effective strategy for

preventing rabies in people because it stops the transmission at its source. Culling free roaming dogs is not effective in controlling rabies. Public education for both children and adults on dog behaviour and bite prevention, what to do if bitten or scratched by a potentially rabid animal, and responsible pet ownership are essential extensions of rabies vaccination programmes.

Effective vaccines are available to immunize people both before and after potential exposures. As listed under the WHO - Prequalification of Medical Products, as of 2024, there are only 3 WHO pre-qualified human rabies vaccines available globally: RABIVAX-S by Serum Institute of India Pvt. Ltd., VaxiRab N by Zydus Lifesciences Limited, and VERORAB by Sanofi Pasteur.

Pre-exposure prophylaxis (PrEP) is recommended for people in high-risk occupations (laboratory workers handling live rabies and related viruses) and people whose professional or personal activities might lead to direct contact with infected animals (animal disease control staff and wildlife rangers).

PrEP might be indicated before recreation or travel in some areas, and for people living in remote, highly rabies-endemic areas with limited local access to rabies biologicals. Note that PrEP does not replace the need for PEP. Any person exposed to a suspected rabid animal should still seek post exposure care.

Post-exposure prophylaxis (PEP) is the emergency response to a rabies exposure. This prevents the virus from entering the central nervous system.

A well-performed wound risk assessment and PEP protocol consists of:

- extensive wound washing with water and soap for at least 15 minutes soon after an exposure;
- a course of rabies vaccine; and

administration of rabies immunoglobulin or monoclonal antibodies into the wound, if indicated.

EPI WEEK 18



Syndromic Surveillance

Accidents

Violence

Pages 2-4



Class 1 Notifiable Events

Page 5



COVID-19 Surveillance

Page 6



Influenza Surveillance

Page 7



Dengue Surveillance

Page 8



Research Abstract

Page 9

Taken from WHO website on 20/May/2026
<https://www.who.int/news-room/fact-sheets/detail/rabies>

Picture taken from: <https://www.happiesthealth.com/articles/health-conditions/rabies-symptoms-causes-diagnosis-treatment>

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 - 15 to 18 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												
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
17	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
18	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

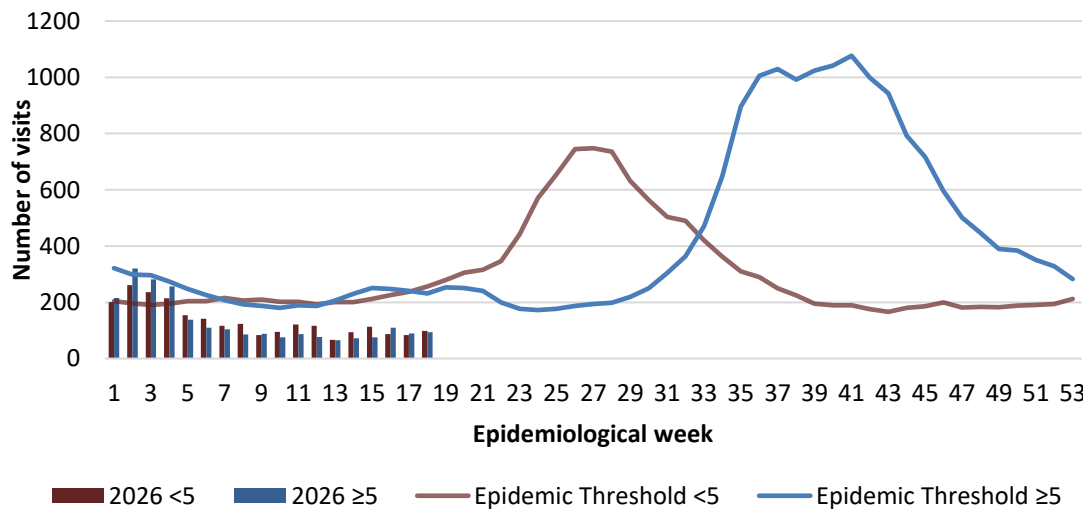
SYNDROMIC SURVEILLANCE

FEVER
 UNDIFFERENTIATED FEVER

Temperature of >38°C /100.4°F (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 2026 vs Weekly Threshold: Jamaica



2 NOTIFICATIONS- All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued



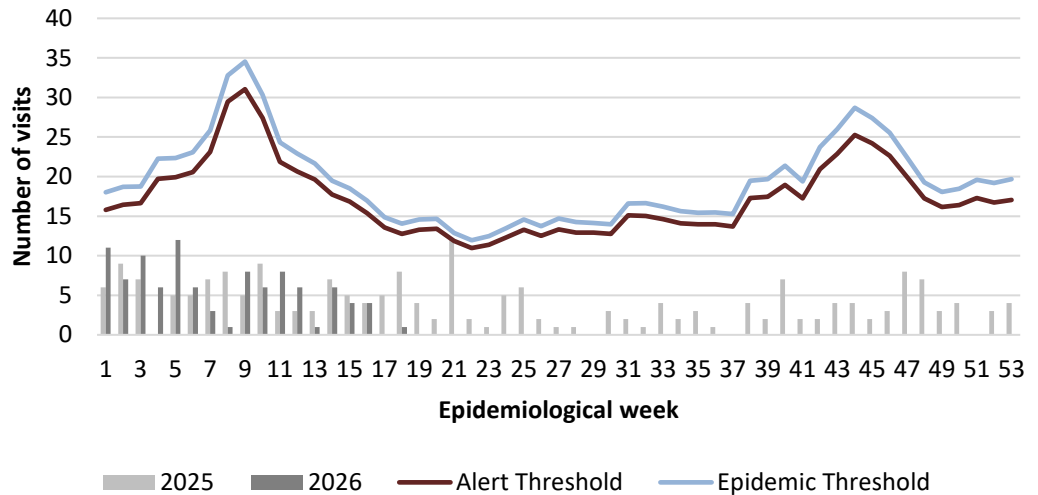
SENTINEL REPORT- 78 sites. Automatic reporting

FEVER AND NEUROLOGICAL

Temperature of $>38^{\circ}\text{C}$ / 100.4°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).



Weekly Visits to Sentinel Sites for Fever and Neurological Symptoms 2025 and 2026 vs. Weekly Threshold: Jamaica

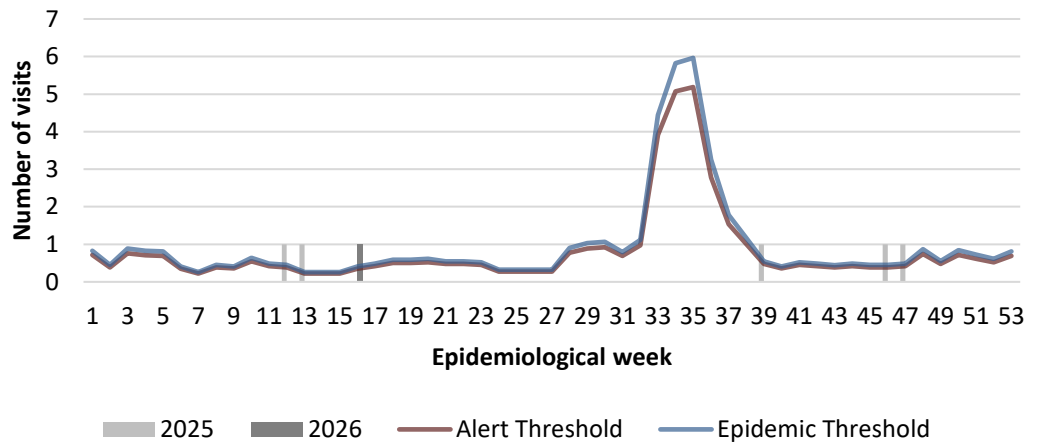


FEVER AND HAEMORRHAGIC

Temperature of $>38^{\circ}\text{C}$ / 100.4°F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



Weekly visits to Sentinel Sites for Fever and Haemorrhagic symptoms 2025 and 2026 vs Weekly Threshold: Jamaica



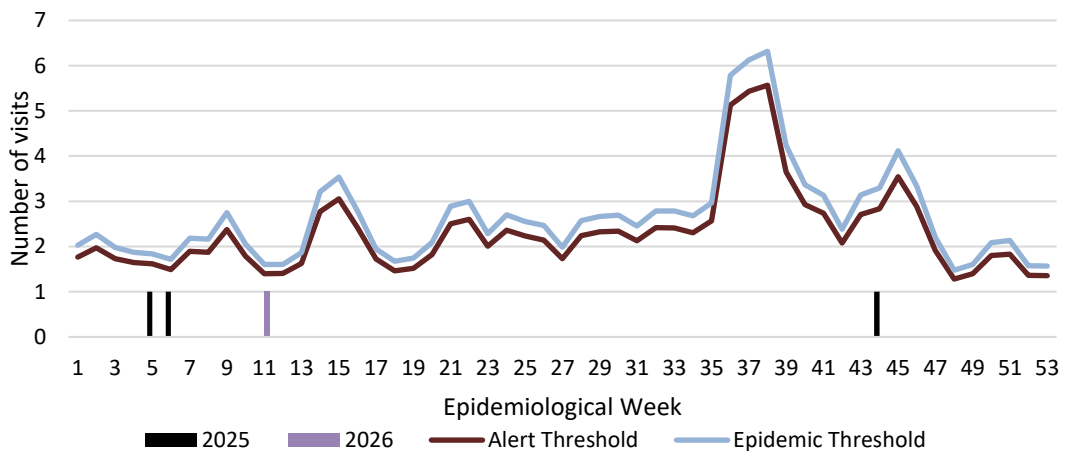
FEVER AND JAUNDICE

Temperature of $>38^{\circ}\text{C}$ / 100.4°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.



Weekly visits for Fever and Jaundice symptoms: Cases 2025 and 2026 vs Weekly Threshold : Jamaica



3 NOTIFICATIONS-
All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



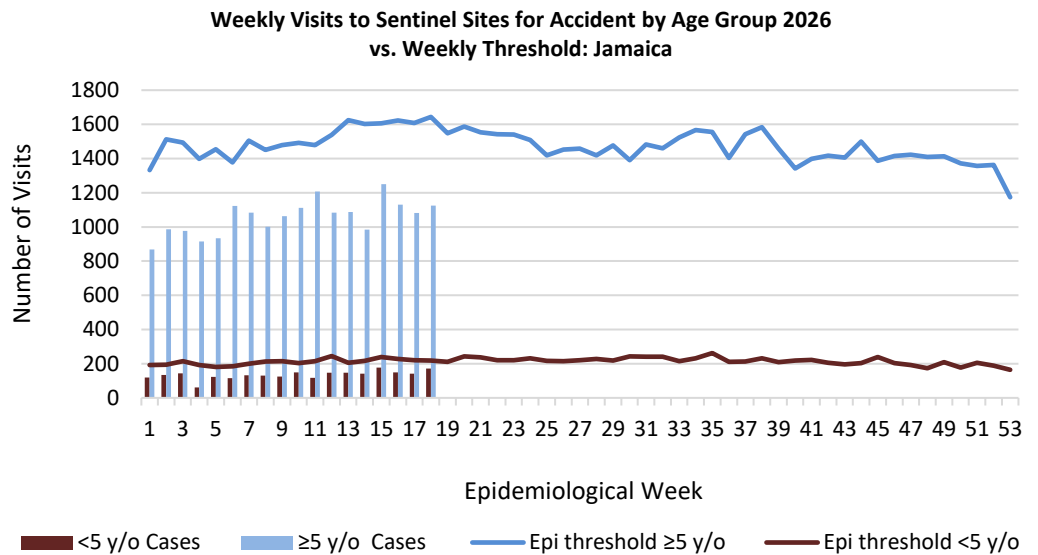
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued



SENTINEL REPORT- 78 sites. Automatic reporting

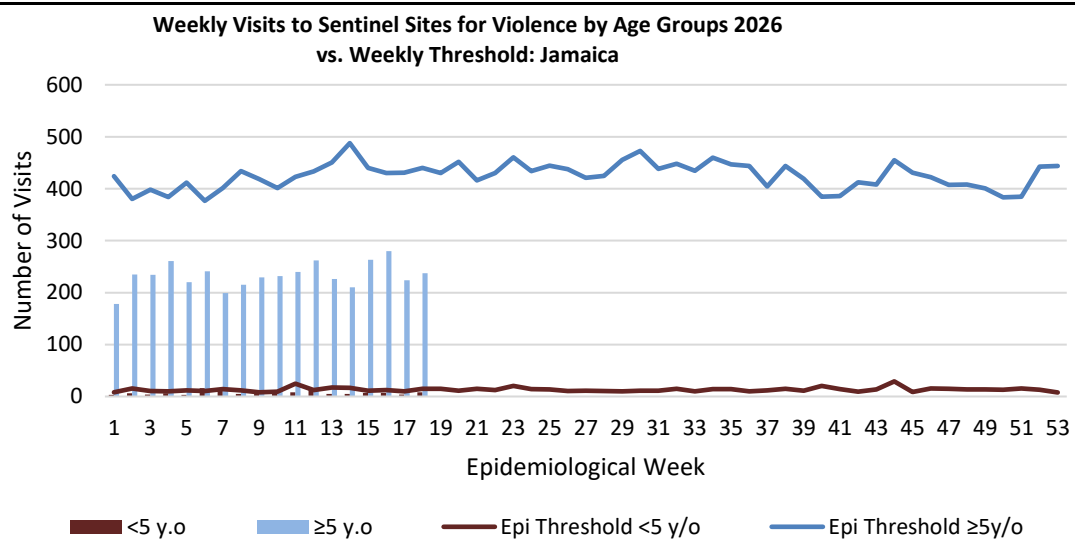
ACCIDENTS

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



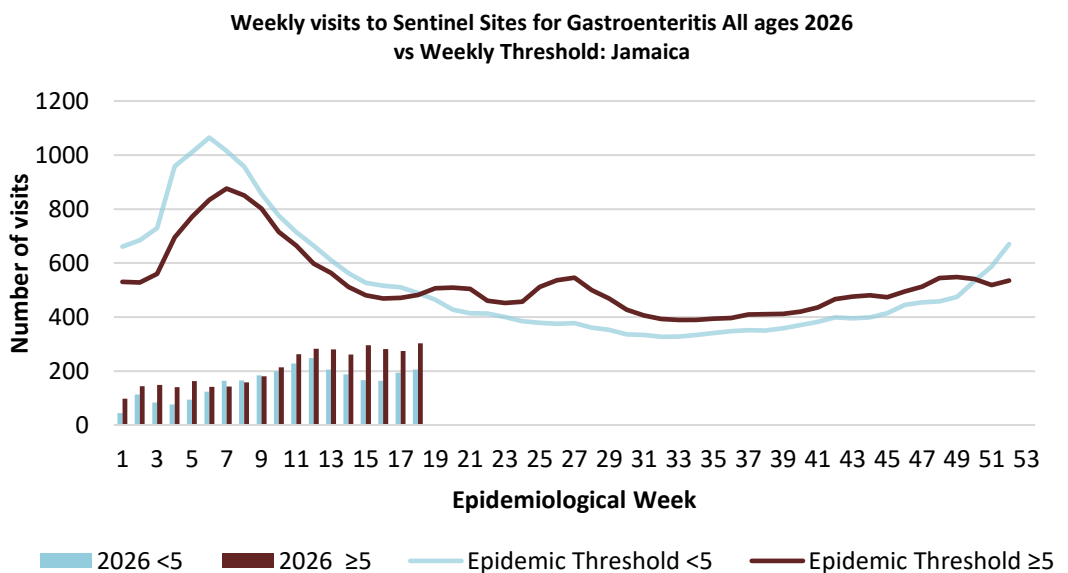
VIOLENCE

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.



4 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

CLASS ONE NOTIFIABLE EVENTS				Comments
			Confirmed YTD ^α	
	CLASS 1 EVENTS		CURRENT YEAR 2026	PREVIOUS YEAR 2025
NATIONAL/INTERNATIONAL INTEREST	Accidental Poisoning		15 ^β	77 ^β
	Cholera		0	0
	Severe Dengue ^γ		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		4	89
	Hansen’s Disease (Leprosy)		0	0
	Hepatitis B		3	6
	Hepatitis C		0	2
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis		2	6
	Mpox		0	1
EXOTIC/ UNUSUAL	Plague		0	0
HIGH 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 <small>(notified pregnancy related deaths)</small> ^δ		15	25
	Ophthalmia Neonatorum		20	30
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		1	0
	Tuberculosis		22	28
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.

^γ 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

5 NOTIFICATIONS- All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

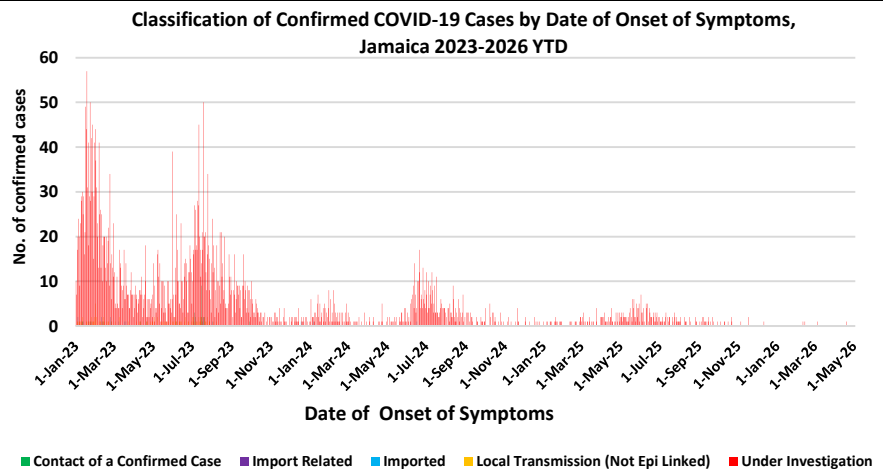


SENTINEL REPORT- 78 sites. Automatic reporting

COVID-19 SURVEILLANCE

CASES	EW 18	Total
Confirmed	0	157754
Females	0	90885
Males	0	66866
Age Range	-	1 day to 108 years

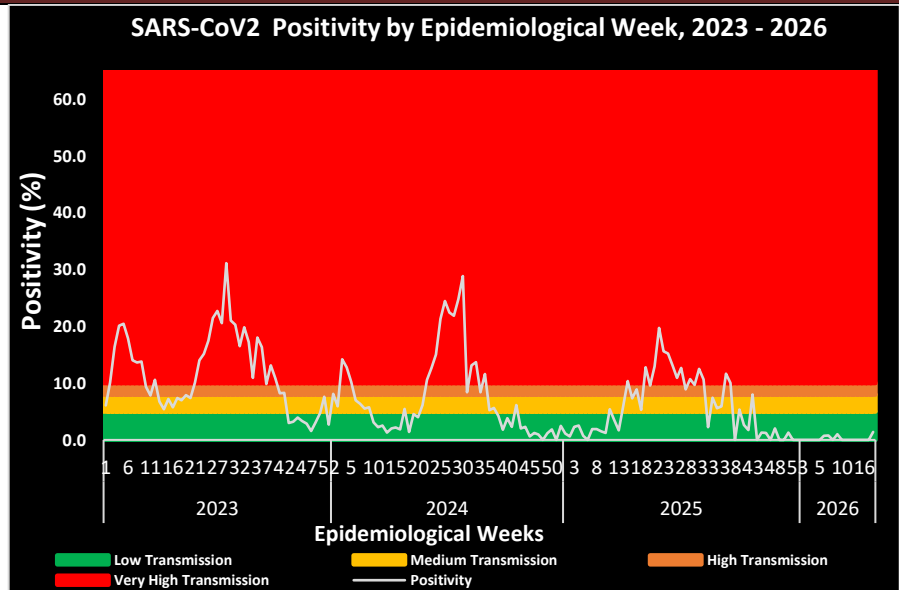
- 3 positive cases had no gender specification
- PCR or Antigen tests are used to confirm cases
- Total represents all cases confirmed from 10 Mar 2020 to the current Epi-Week.



COVID-19 Outcomes

Number of Confirmed COVID-19 cases and deaths, Jamaica 2022-2026						
COVID-19	Year					Total (2020-2026)
	2022	2023	2024	2025	2026	
Cases	55,721	3,842	705	315	4	157,754
Deaths	621	116	24	13	0	3,921

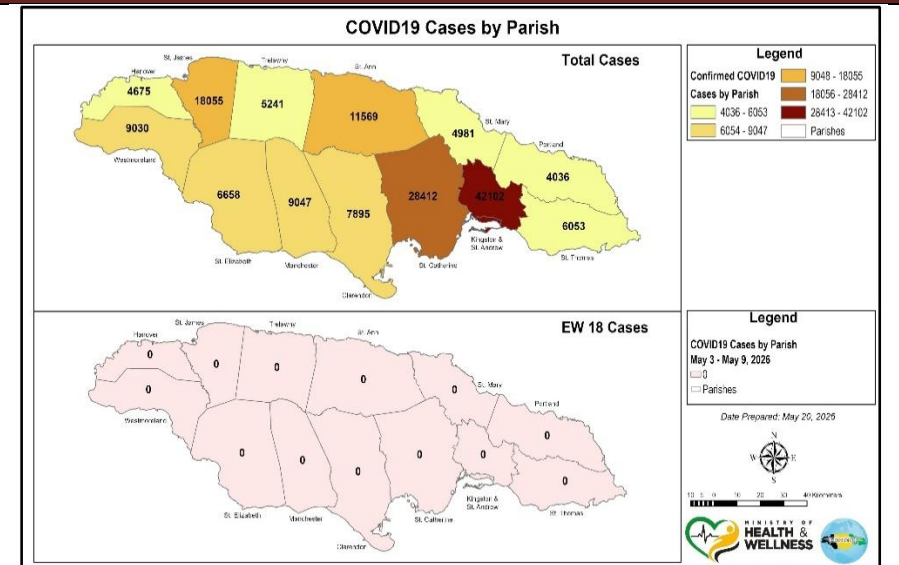
- Current positivity rate: 0%
- Positivity = (positive samples/total samples tested)
- Low transmission for infection



COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure

COVID-19 WHO Global Statistics EW 15 -18 2026		
Epi Week	Confirmed Cases	Deaths
15	3900	159
16	3200	153
17	3100	117
18	2100	88
Total (4weeks)	12300	517



6 NOTIFICATIONS-
All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

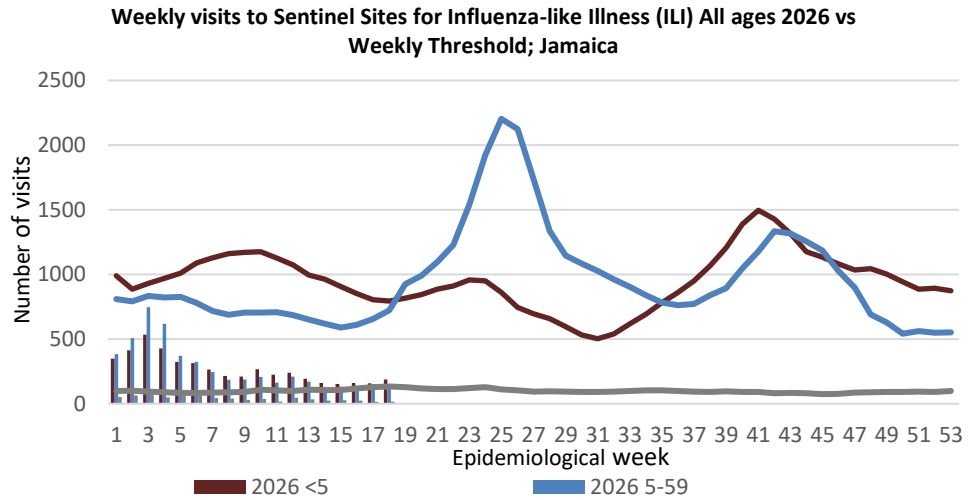
SENTINEL REPORT- 78 sites. Automatic reporting

INFLUENZA SURVEILLANCE

EW 18

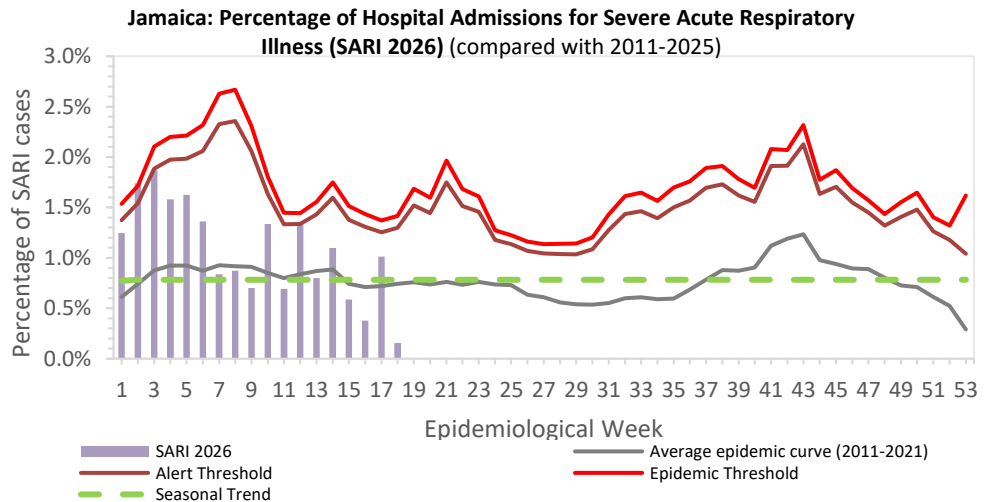
May 3, 2026 – May 9, 2026 Epidemiological Week 18

	<i>EW 18</i>	<i>YTD</i>
SARI cases	1	285
Total Influenza positive Samples	0	251
Influenza A	0	224
H1N1pdm09	0	21
H3N2	0	212
Not subtyped	0	0
Influenza B	0	18
B lineage not determined	0	0
B Victoria	0	18
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	37



Epi Week Summary

During EW 18, one (1) SARI admission was reported.

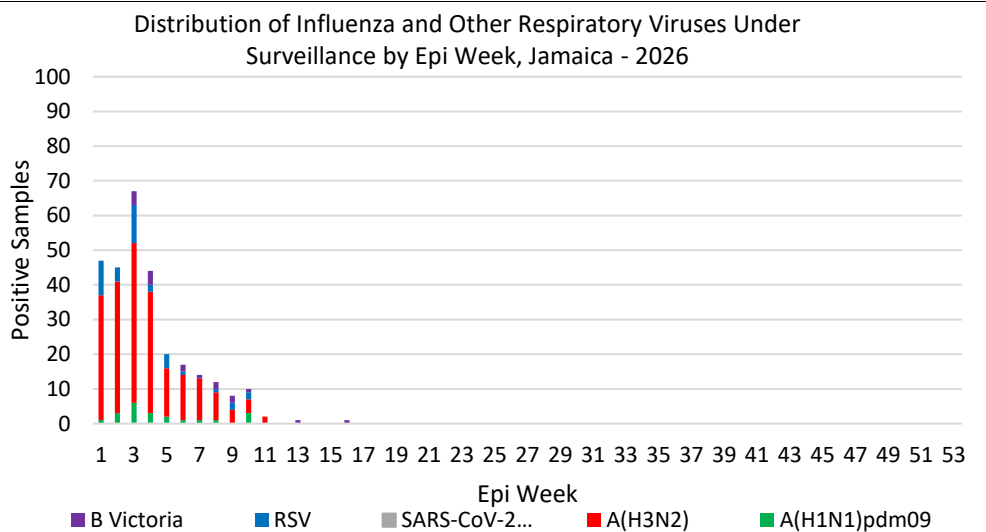


Caribbean Update EW 18

Update as of EW 17

The Caribbean continues the post-peak decline, consolidating the end of the Northern Hemisphere season, with subregional positivity of approximately 4.5% in the reporting period. The predominance of A(H3N2) persists (47.6% in the last 4 EWs) with cocirculation of A(H1N1) (17.5%) and B Victoria (22.2%). SARI and ILI indicators show consistent decline. RSV and SARS-CoV-2 remain at low inter-seasonal levels.

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



5

7 NOTIFICATIONS-
All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

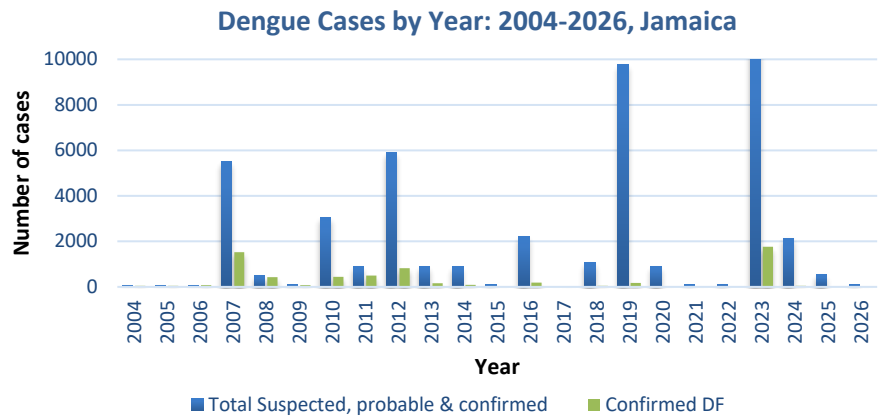
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

DENGUE SURVEILLANCE

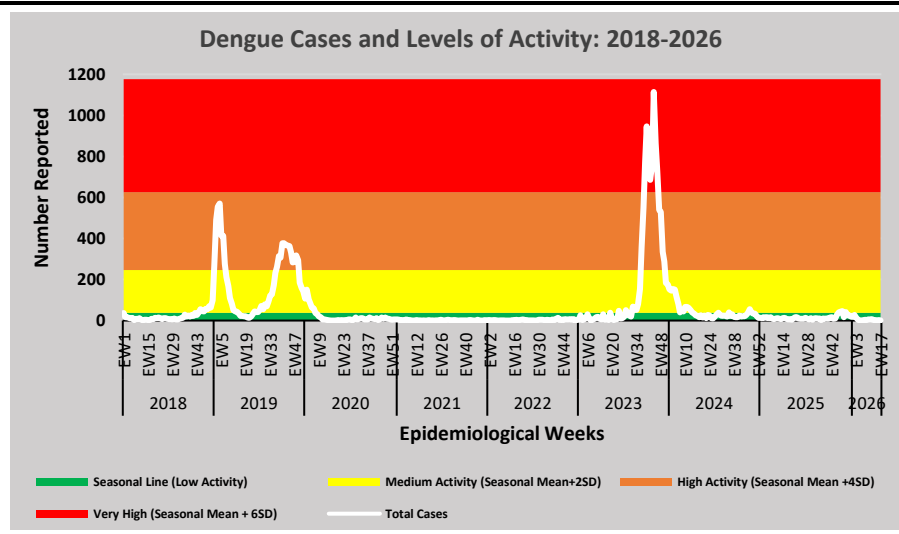
May 3, 2026 – May 9, 2026 Epidemiological Week 18

Epidemiological Week 18



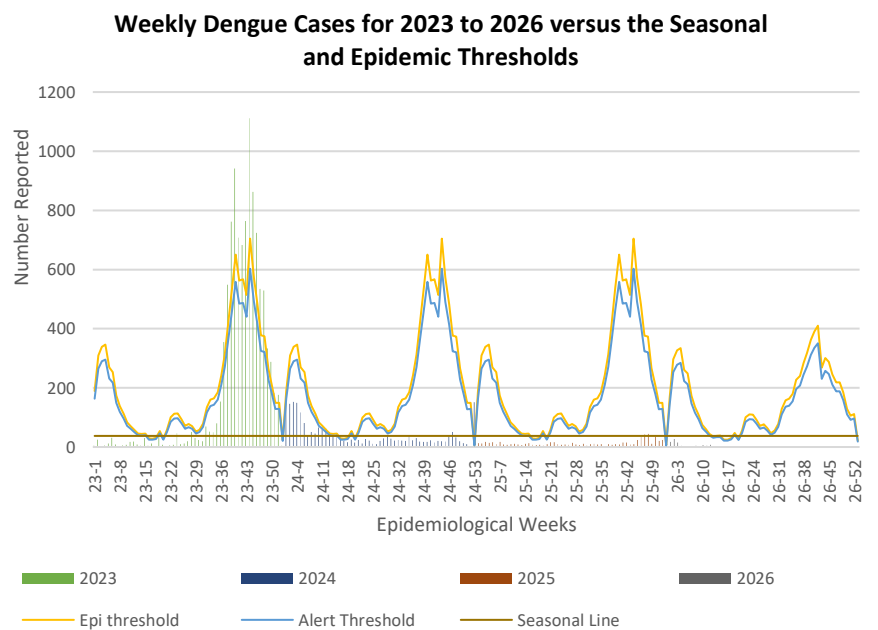
Reported suspected, probable and confirmed dengue with symptom onset in week 18 of 2026

	2026*	
	EW 18	YTD
Total Suspected, Probable & Confirmed Dengue Cases	1	103
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 19, 2026
- Only PCR positive dengue cases are reported as confirmed.
- IgM positive cases are classified as probable dengue.



8 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

RESEARCH ABSTRACT

Abstract

NHRC-25-O

Improving Maternal Survival Factors associated with Hypertensive Disorders of Pregnancy (HDP), in the South East Region (SERHA), Jamaica 2015-2019.

Lord, C¹, Grant, A¹, Harris MA³, Duncan J², Yaw- Alfred B⁴, McCaw Binns, A²

¹ Ministry of Health & Wellness, Jamaica ² University of the West Indies, Jamaica ³ Pan American Health Organization, Trinidad and Tobago, ⁴ Victoria Jubilee Hospital

Objective: To assess factors associated with HDP among women delivering at public hospitals in SERHA, Jamaica, 2015-2019.

Methods: This retrospective cohort study reviewed 917 medical records of patients. Data were extracted from 194 eclampsia patients (100%), 443 preeclampsia (1 in 4 records), 129 gestational hypertension and 151 normotensive controls. Chi-square analysis and logistic regression were used to determine factors associated with HDP. Logistic Regression models considered predictors of HDP and maternal complications. Eighteen interviews were conducted with surviving eclampsia patients and senior obstetricians.

Results: Of 76,668 deliveries, 2,814 (3.7%) were complicated by HDP. Eclampsia risk was significantly higher among multigravida women (OR 12.56; 95% CI 1.19 – 132.33). Protective factors included ≥ 4 antenatal visits (OR 0.17; 95% CI 0.04 – 0.66) and referral from private practitioners (OR 0.08; 95% CI 0.01 – 0.53). Women with gestational hypertension were eleven times more likely to undergo caesarean section compared with normotensive women ($p < 0.001$; OR 10.73; 95% CI 4.26 – 27.04). Major maternal complications included postpartum haemorrhage (30.4%), HELLP syndrome (8.6%), pulmonary oedema (3.8%), and Posterior Reversible Encephalopathy Syndrome (2.7%). The case fatality rate for preeclampsia was 3.2%. Health system factors revealed delays in accessing emergency obstetric care and inadequate provider-patient communication. Qualitative interviews highlighted women's limited awareness of preeclampsia warning signs, contributing to delays in seeking care.

Conclusion: Hypertensive disorders remain a major contributor to maternal morbidity and mortality in Jamaica. Improved antenatal surveillance, targeted patient education on the warning symptoms and strengthened referral and emergency care systems are critical to improving maternal survival.

Keywords: Maternal factors; Risks; Hypertensive Disorders of Pregnancy



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

9 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