WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Earthquakes

Earthquakes can strike suddenly and without warning. An earthquake is a violent and abrupt shaking of the ground, caused by movement between tectonic plates along a fault line in the earth's crust. Earthquakes can result in the ground shaking, soil liquefaction, landslides, fissures, avalanches, fires and tsunamis.

The extent of destruction and harm caused by an earthquake depends on:

- magnitude
- intensity and duration
- the local geology
- the time of day that it occurs
- building and industrial plant design and materials
- the risk-management measures put in place.

Between 1998-2017, earthquakes caused nearly 750 000 deaths globally, more than half of all deaths related to natural disasters. More than 125 million people were affected by earthquakes during this time period, meaning they were injured, made homeless, displaced or evacuated during the emergency phase of the disaster.Health threats due to earthquakes can vary according the magnitude of the earthquake, the nature of the built environment (such as poor housing or urban slums), and the secondary effects of the earthquake, like tsunamis or landslides.

Earthquakes can have immediate and long-term impacts on health.
Immediate health impacts include:

- trauma-related deaths and injuries from building collapse;
- trauma-related deaths and injuries from the secondary effects of the earthquake, like drowning from tsunamis or burns from fires.

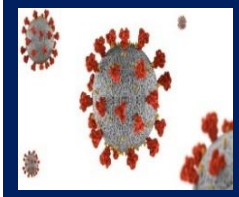
Medium-term health impacts include:

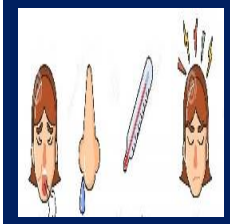
- secondary infection of untreated wounds;
- increased morbidity and risk of complications related to pregnancy and childbirth due to interrupted obstetric and neonatal services;
- potential risk of communicable diseases, particularly in areas affected by overcrowding;
- increased morbidity and risk of complications of chronic diseases due to interruption of treatment;
- increased psychosocial needs;
- potential environmental contamination by chemical/radiological agents following destruction of industrial infrastructure.

Earthquakes can also damage health facilities and transportation, which can disrupt service delivery and access to care. Health workers may not be able to reach health facilities that are still functional and medical supplies may be lost.

Taken from WHO website on 27/May/2026
https://www.who.int/health-topics/earthquakes#tab=tab_2
Picture taken from: https://surefirecpr.com/emergency-tips/how-to-drop-cover-and-hold-on-during-an-earthquake/?srsltid=AfmBOoqKXVy2-l6i8XFo12chFPXSX3oCDK47oI7Wqgxw77DZEboxAeIf

EPI WEEK 19





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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 – 16 to 19 of 2026.

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

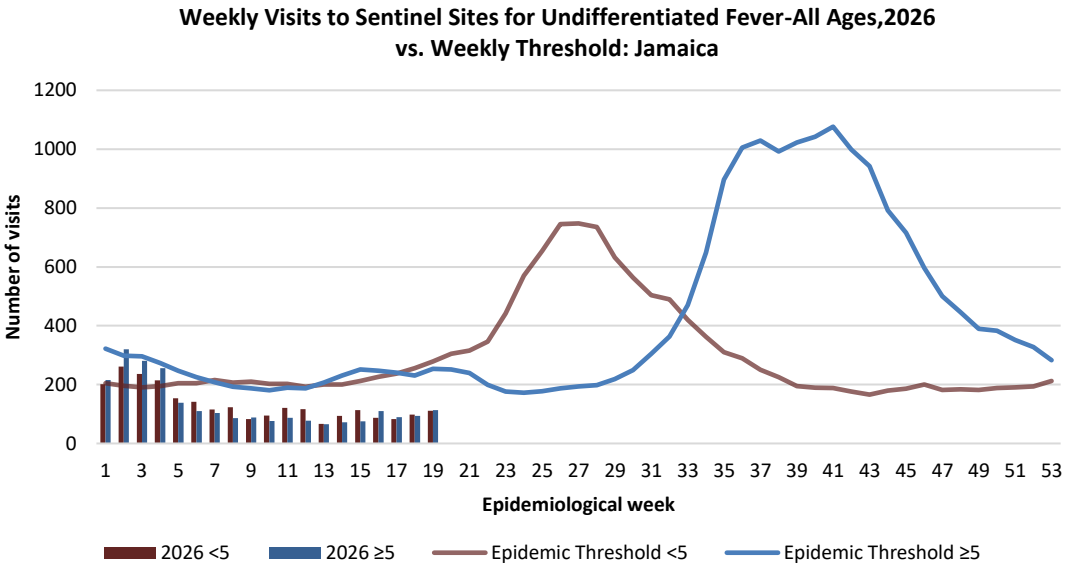
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
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
19	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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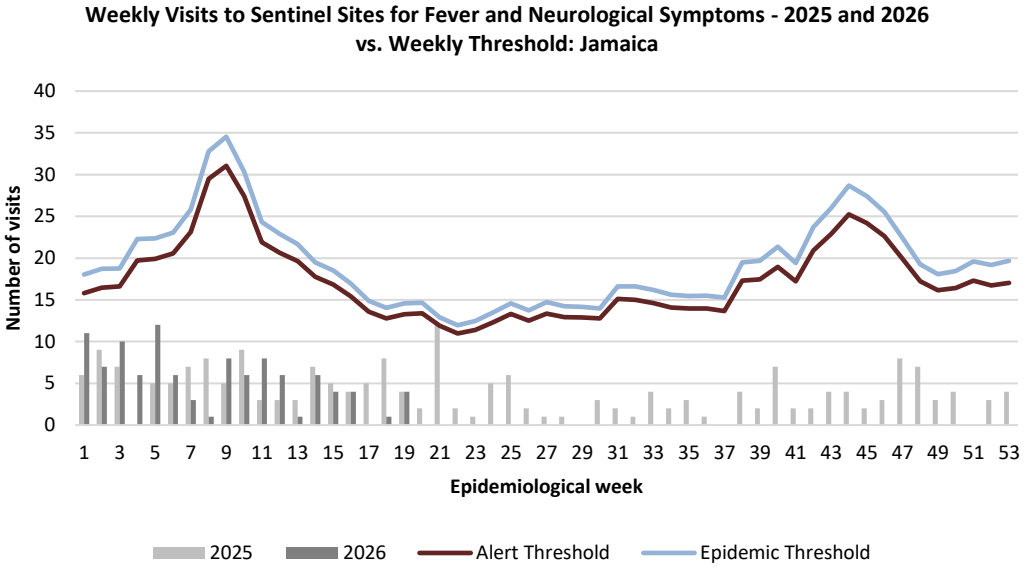
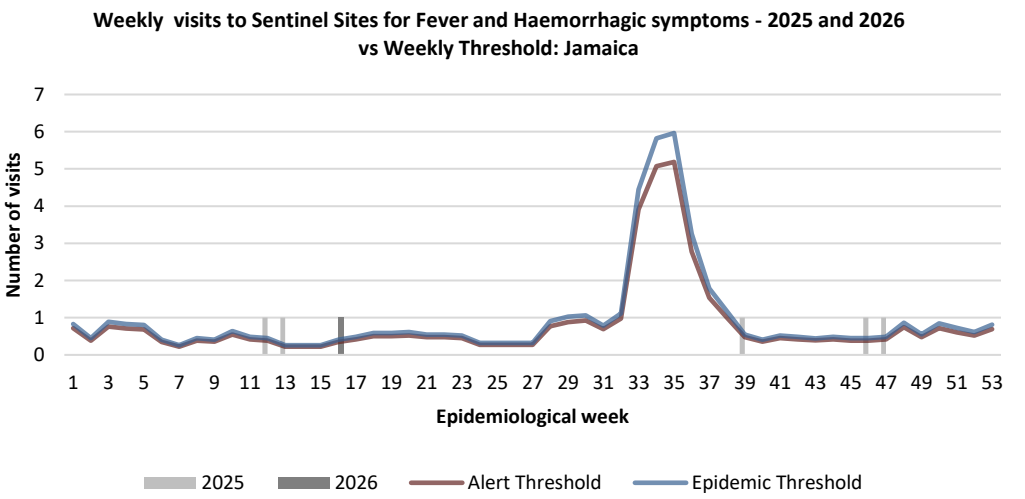
FEVER AND NEUROLOGICAL

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

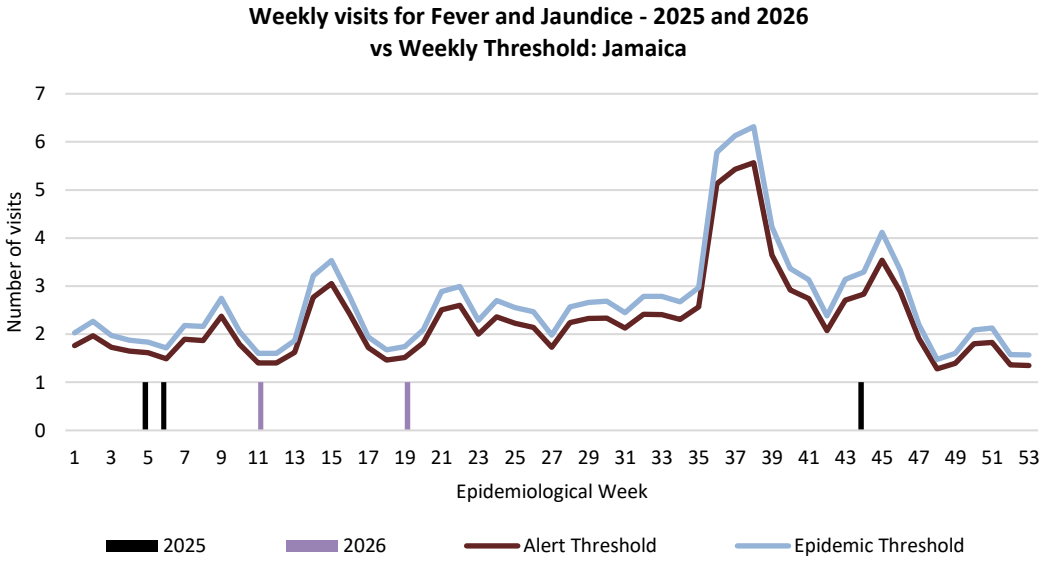
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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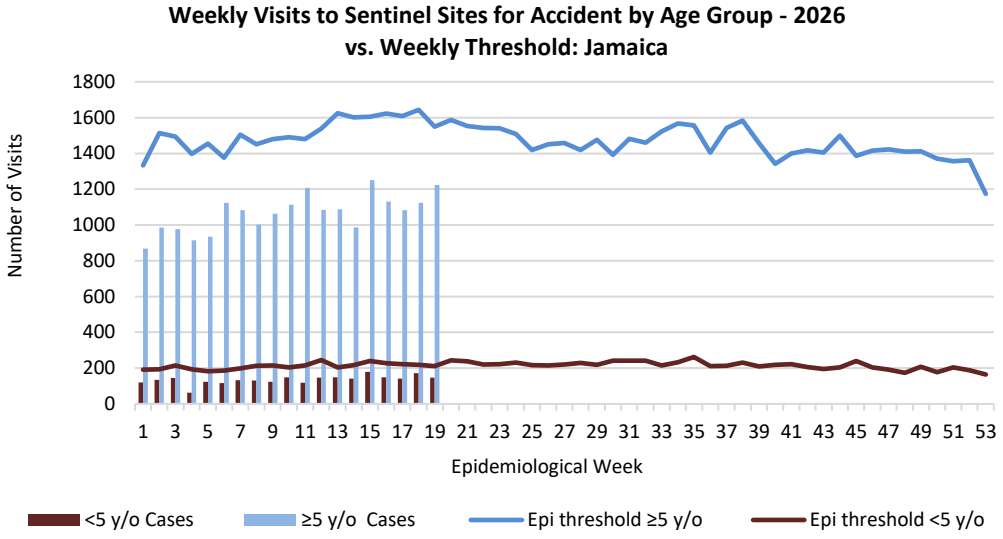
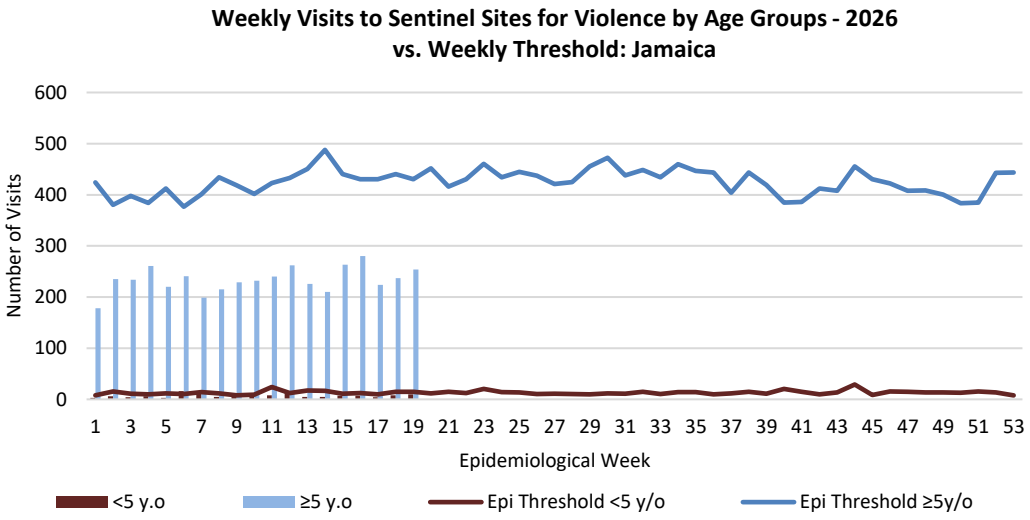
ACCIDENTS

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



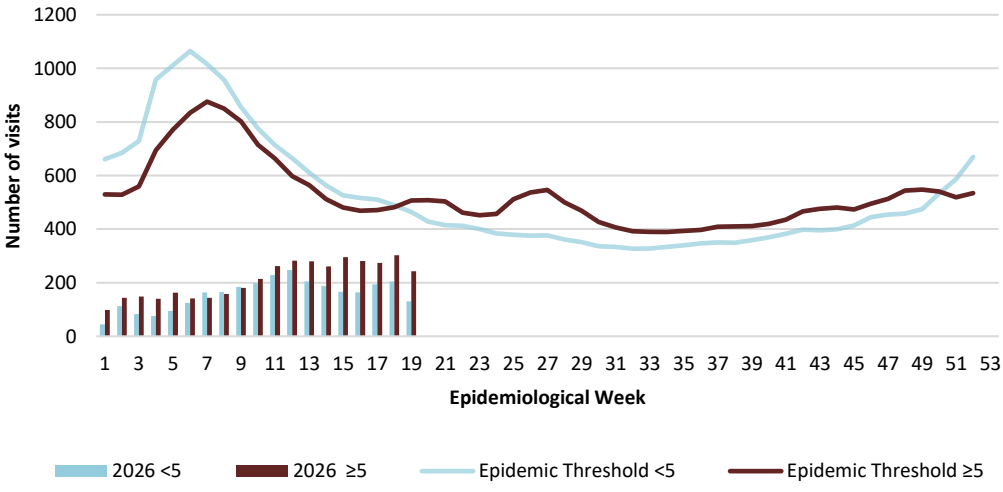
VIOLENCE

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	15[β]	80[β]
	Cholera	0	0
	Severe Dengue[Y]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	4	102
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	3	6
	Hepatitis C	0	2
	HIV/AIDS	NA	NA
	Malaria (Imported)	0	0
	Meningitis	2	7
	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]	16	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

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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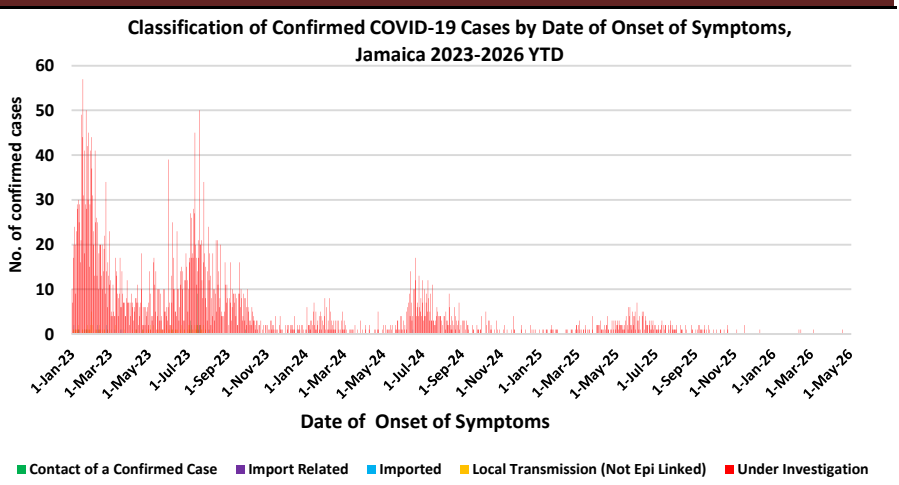
COVID-19 SURVEILLANCE

CASES	EW 19	Total
Confirmed	0	157,754
Females	0	90,885
Males	0	66,866
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.

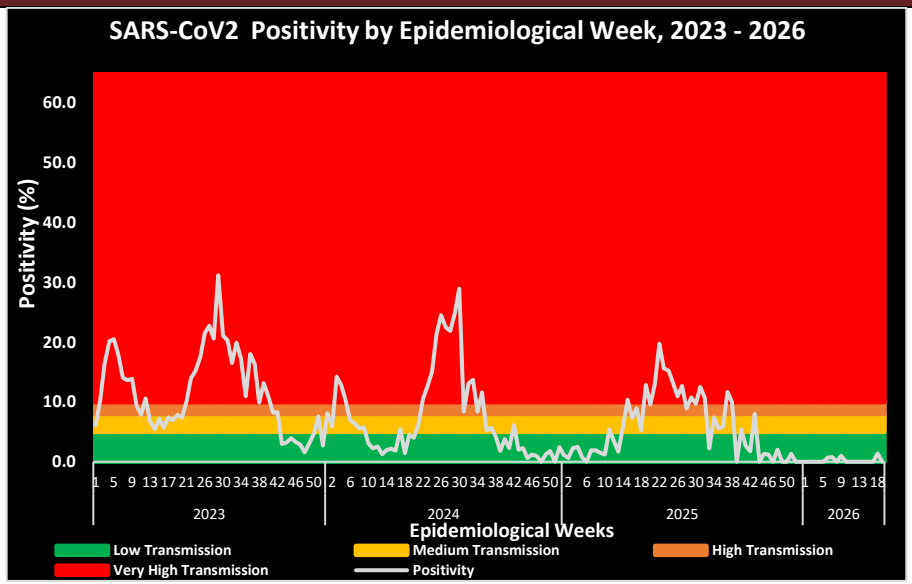


COVID-19 Outcomes

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

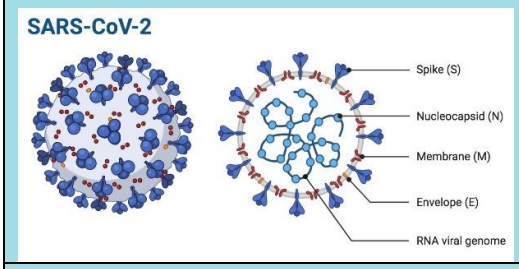
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	4	157,754
Deaths	621	116	24	13	0	3,921

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



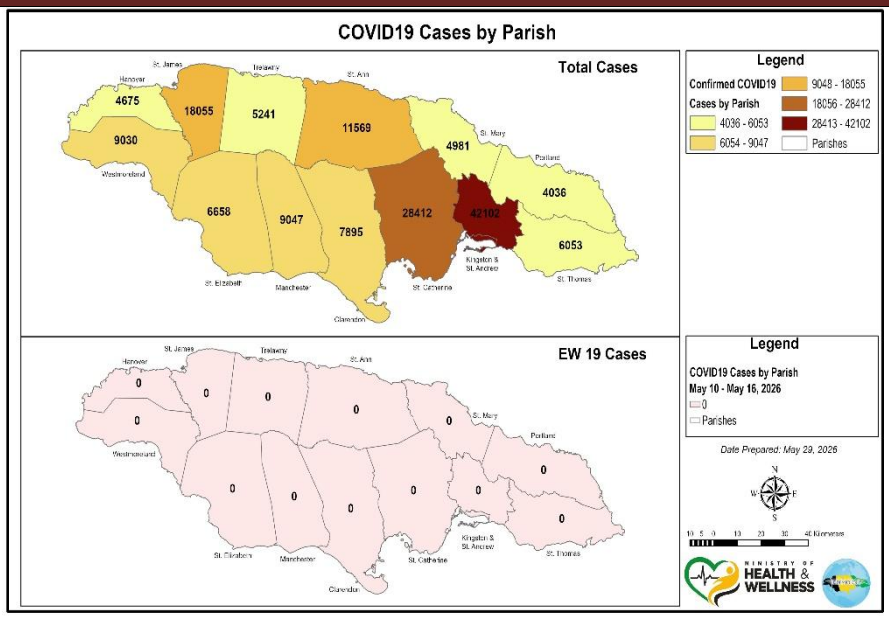
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 16 -19 2026

Epi Week	Confirmed Cases	Deaths
16	3,400	159
17	3,300	129
18	2,600	104
19	2,600	77
Total (4weeks)	**11,900**	**469**



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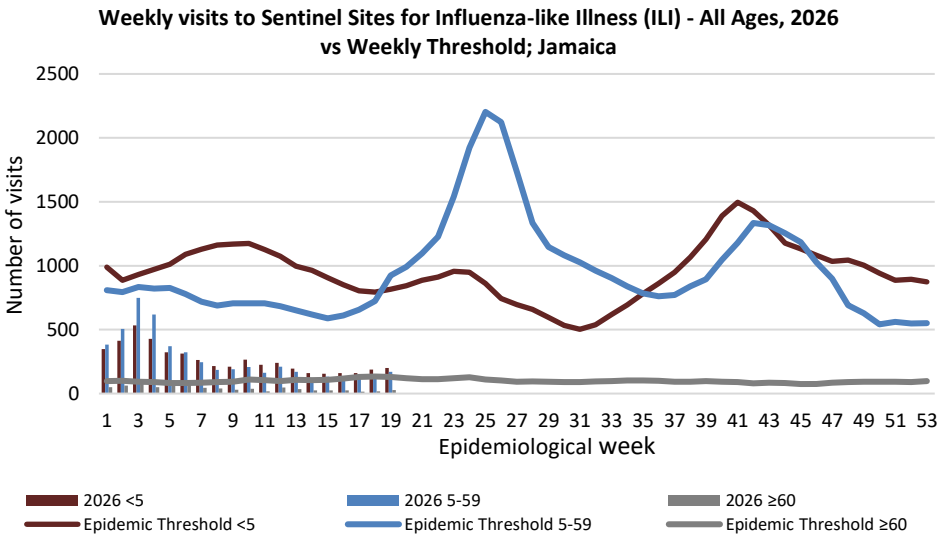
INFLUENZA SURVEILLANCE

EW 19

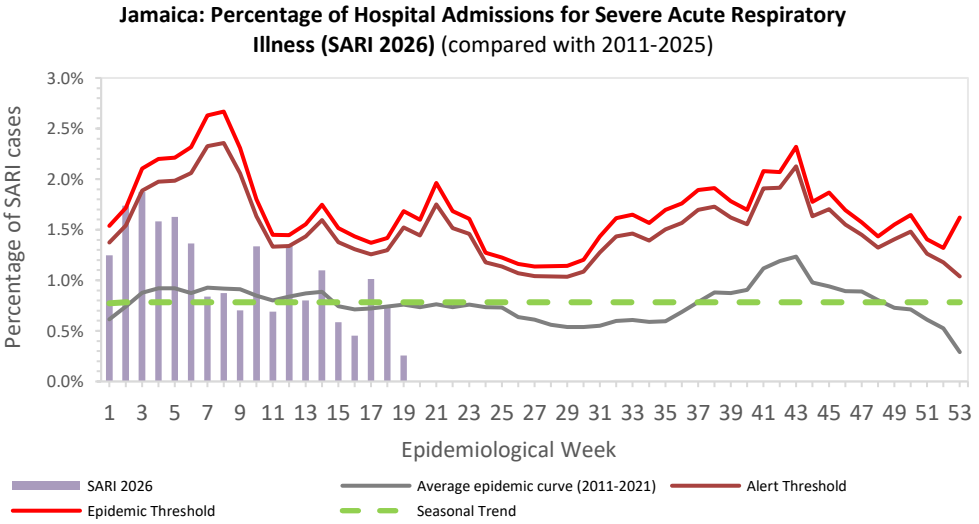
May 10,2026 – May 16, 2026 Epidemiological Week 19

	EW 19	*YTD*
SARI cases	2	293
Total Influenza positive Samples	**0**	**255**
Influenza A	**0**	**233**
H1N1pdm09	0	21
H3N2	0	212
Not subtyped	0	0
Influenza B	**0**	**22**
B lineage not determined	0	0
B Victoria	0	22
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	37



Epi Week Summary

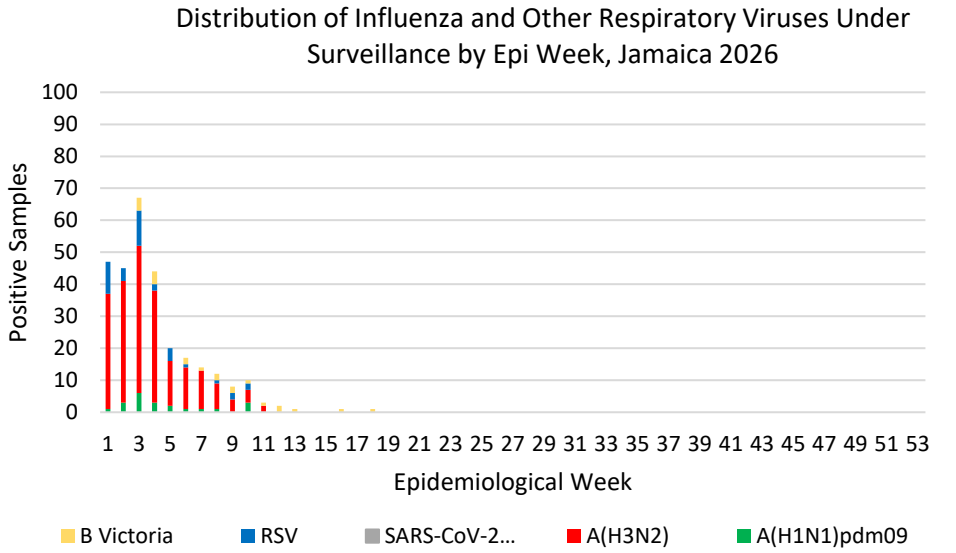
During EW 19, two (2) SARI admissions were reported.



Caribbean Update EW 19

The subregion is consolidating the end of the Northern Hemisphere season, with subregional influenza positivity stabilised at low levels. In continuity with the post-peak decline (2.3%) and close to interseasonal levels. In the last 4 weeks, the cocirculation characteristics of the subregion persists, with B Victoria and A(H3N2) as the majority components and A(H1N1)pmd09 in a smaller proportion. SARI and ILI indicators maintain the decline consistent with the end of the season. RSV and SARS-CoV-2 remain at low interseasonal levels. The low volume of samples notified by the countries of the subregion (in several cases, between 1 and 3 positive samples per country, or with data reflecting residual circulation) limits the specificity of the analysis at the country level; trends should be interpreted in an aggregate manner and with caution.

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



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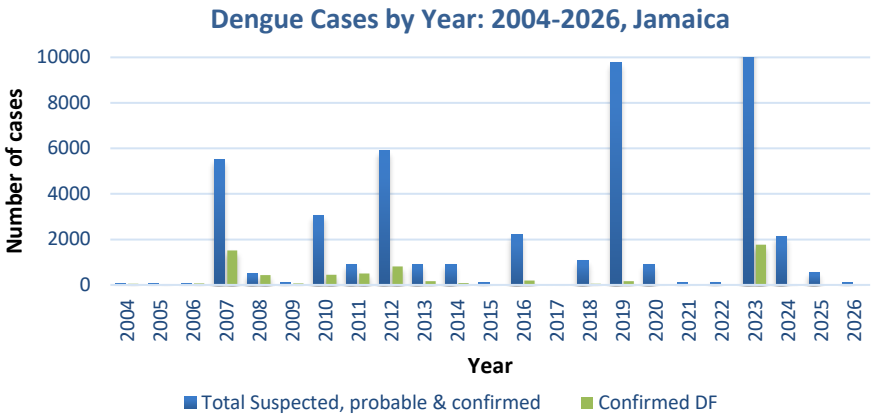
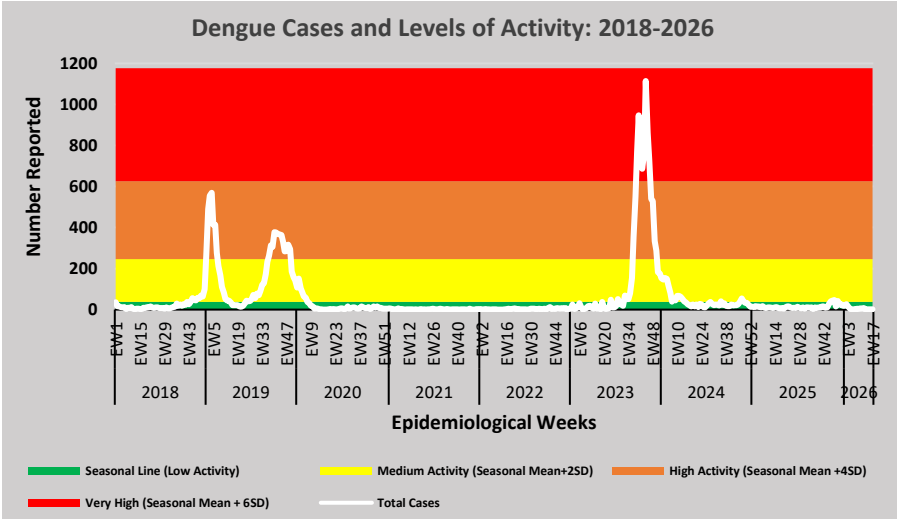
DENGUE SURVEILLANCE

May 10, 2026 – May 16, 2026 Epidemiological Week 19 | Epidemiological Week 19



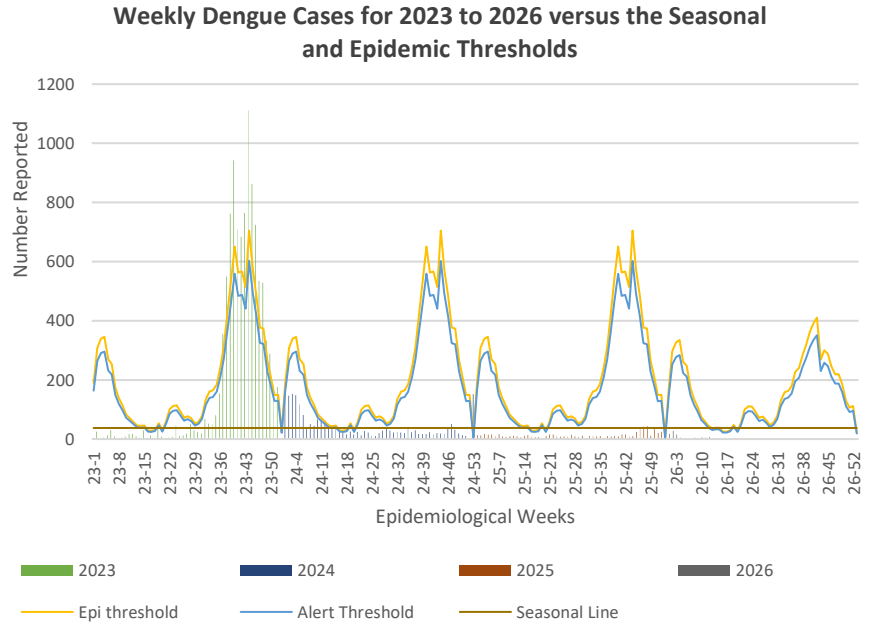
Reported suspected, probable and confirmed dengue cases with symptom onset in week 19 of 2026.

	2026*	
	EW 19	YTD
Total Suspected, Probable & Confirmed Dengue Cases	1	108
Lab Confirmed Dengue cases	0	1
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- **Dengue deaths are reported based on date of death.**
- ***Figures as at May 29, 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

Awareness, attitudes, and practices relating to anti-diabetic and anti-hypertensive medication adherence among patients attending health centres in Kingston and St. Andrew, Jamaica

Brewster D M[1], Thompson C[1]

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

Objectives: To describe the sociodemographic profile of adults on pharmacotherapy for diabetes and/or hypertension, determine adherence rates, assess awareness, attitudes, and practices (AAP) regarding these medications, and identify independent predictors of adherence among patients attending two public primary healthcare facilities in Kingston and St. Andrew, Jamaica.

Methods: A cross-sectional design was implemented at two health centres, with consecutive sampling yielding 304 participants diagnosed with diabetes and/or hypertension. Data were collected using a 53-item interviewer-administered questionnaire incorporating the Adherence to Refills and Medications Scale (ARMS). Analyses included descriptive statistics, chi-square tests, and multivariate logistic regression, with significance set at $p < 0.05$.

Results: Non-adherence was prevalent, affecting 68.1% of participants. Sociodemographic and awareness variables were not independently predictive of adherence. Four factors emerged as independent predictors: following a routine (*aOR* = 3.09, 95% *CI* [1.46, 6.51], $p = .003$) promoted adherence, while adjusting medication due to side effects (*aOR* = 0.33, 95% *CI* [0.13, 0.79], $p = .013$), stopping when the condition was perceived as controlled (*aOR* = 0.26, 95% *CI* [0.11, 0.63], $p = .003$), and perceiving one's medication regimen as complex (*aOR* = 0.37, 95% *CI* [0.16, 0.83], $p = .016$) reduced adherence.

Conclusion: High non-adherence among patients reflects behavioural and perceptual barriers rather than sociodemographic or awareness factors. Interventions that strengthen daily routines, address medication perceptions and cultural practices, and enhance clinician–patient communication are essential to improving adherence and chronic-disease outcomes within Jamaica's primary healthcare system.

Keywords: medication adherence; diabetes; hypertension; Jamaica; primary healthcare

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