WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Deafness and Hearing Loss

A person is said to have hearing loss if they are not able to hear as well as someone with normal hearing, meaning hearing thresholds of 20 dB or better in both ears. It can be mild, moderate, moderately severe, severe or profound, and can affect one or both ears. Major causes of hearing loss include congenital or early onset childhood hearing loss, chronic middle ear infections, noise-induced hearing loss, age-related hearing loss, and ototoxic drugs that damage the inner ear.

The impacts of hearing loss are broad and can be profound. They include a loss of the ability to communicate with others delayed language development in children, which can lead to social isolation, loneliness and frustration, particularly among older people with hearing loss. Many areas lack sufficient accommodations for hearing loss, which effect academic performance and options for employment. Children with hearing loss and deafness in developing countries rarely receive any schooling. WHO estimates that unaddressed hearing loss costs the global economy US$ 980 billion annually due to health sector costs (excluding the cost of hearing devices), costs of educational support, loss of productivity and societal costs.

Deafness and hearing loss are widespread and found in every region and country. Currently more than 1.5 billion people (nearly 20% of the global population) live with hearing loss; 430 million of them have disabling hearing loss. It is expected that by 2050, there could be over 700 million people with disabling hearing loss.
Globally, 34 million children have deafness or hearing loss, of which 60% of cases are due to preventable causes. At the other end of the lifespan, approximately 30% of people over 60 years of age have hearing loss.

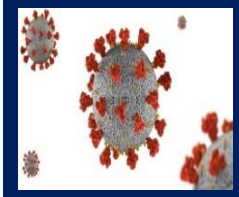
Many of the impacts of hearing loss can be mitigated through early detection and interventions. These include specialized education programs and sign language instruction for young children and their families. Assistive technologies, including hearing aids, cochlear implants, closed captioning and other devices can help people with hearing loss at any age. People may also benefit from speech therapy, aural rehabilitation and other related services.
Low- and middle-income countries bear a disproportionate burden from hearing loss. WHO estimates that global hearing aid production covers just 3% of the need in these countries.

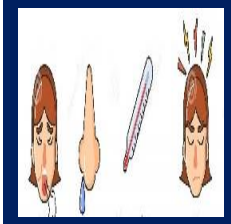
WHO estimates that 50% of hearing loss can be prevented through public health measures. Some prevention strategies target individual lifestyle choices such as exposure to loud sounds and music or wearing protective equipment such as earplugs. This can be assisted through implementing audio standards for personal audio systems and devices.
Further reductions in hearing loss can be gained through screening and early interventions in childhood, including application of assistive technologies or surgical options. Screenings can also prevent the use of damaging pharmaceuticals in high-risk cases.
Hearing loss and deafness can also occur as a complication of other diseases such as measles, meningitis, rubella and mumps. Work to prevent these diseases through vaccination and hygiene programs can have a beneficial impact on rates of hearing loss and deafness. Immunizing adolescent girls and women of reproductive age against rubella before pregnancy, and preventing cytomegalovirus infections in pregnant women, can reduce the risk of babies born with congenital hearing loss or deafness.

This week marks the celebration of Hellen Keller DeafBlind Awareness Week which runs from June 25 – July 1and honors her birthday, June 27,2026.

Taken from WHO website on 6/July/2026
https://www.who.int/health-topics/hearing-loss#tab=tab_1
Picture taken from:https://newsnetwork.mayoclinic.org/n7-mcnn/7bcc9724adf7b803/uploads/2014/05/shutterstock_48282802.jpg

EPI WEEK 25





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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 – 22 to 25 of 2026.

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

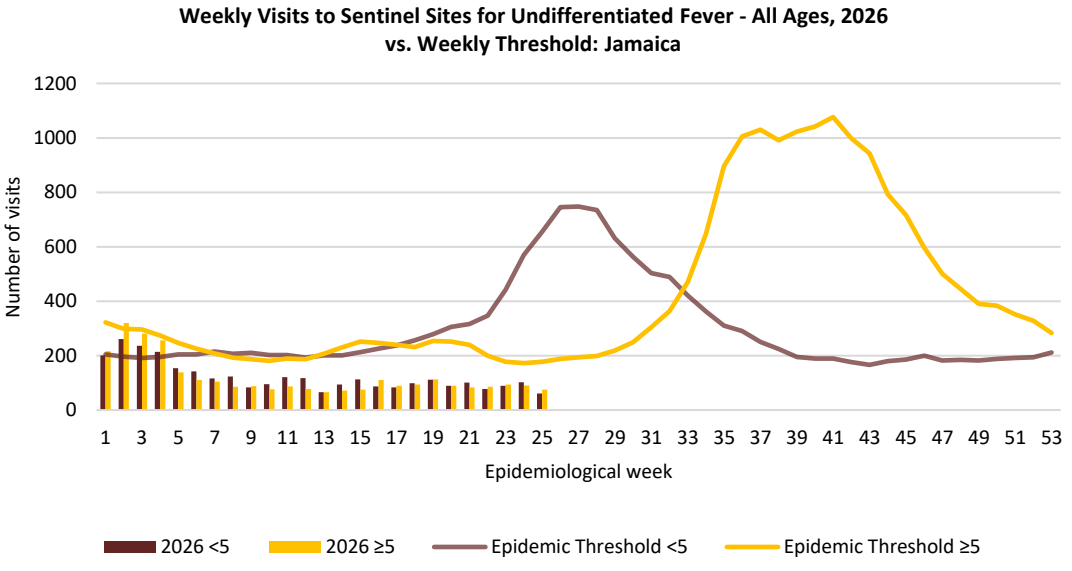
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
22	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
23	On Time	On Time	On Time	On Time	On Time	Late (W)	On Time	On Time	On Time	On Time	On Time	On Time	On Time
24	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
25	On Time	On Time	On Time	On Time	Late (W)	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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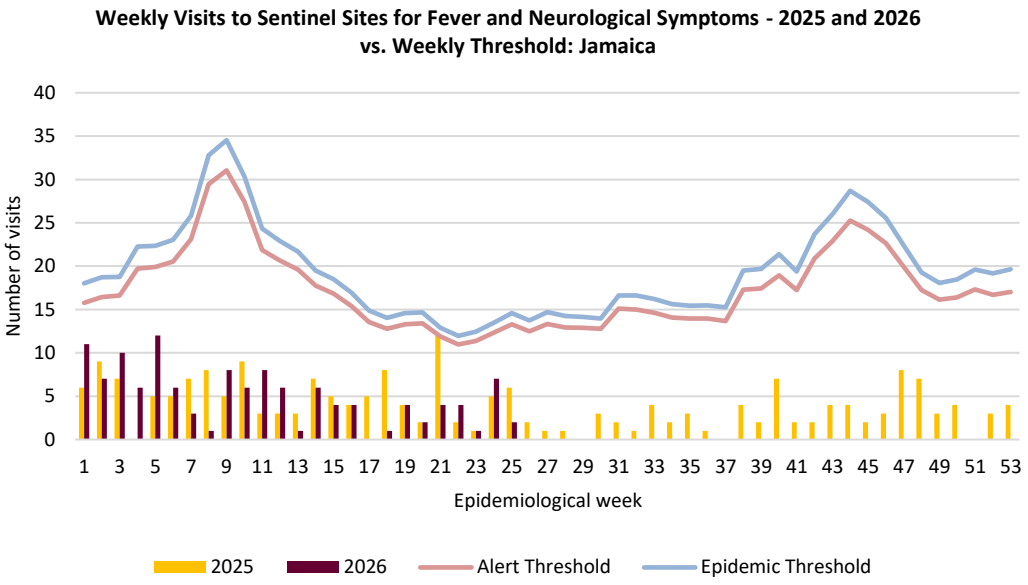
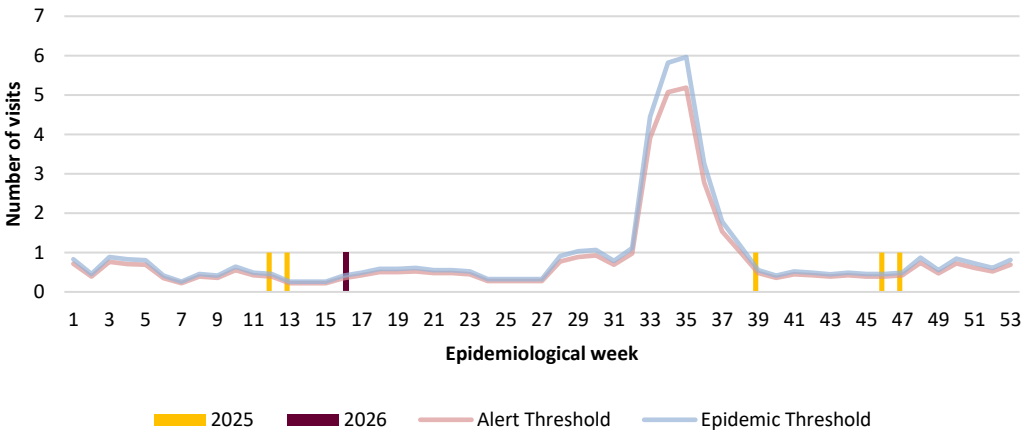
FEVER AND NEUROLOGICAL

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

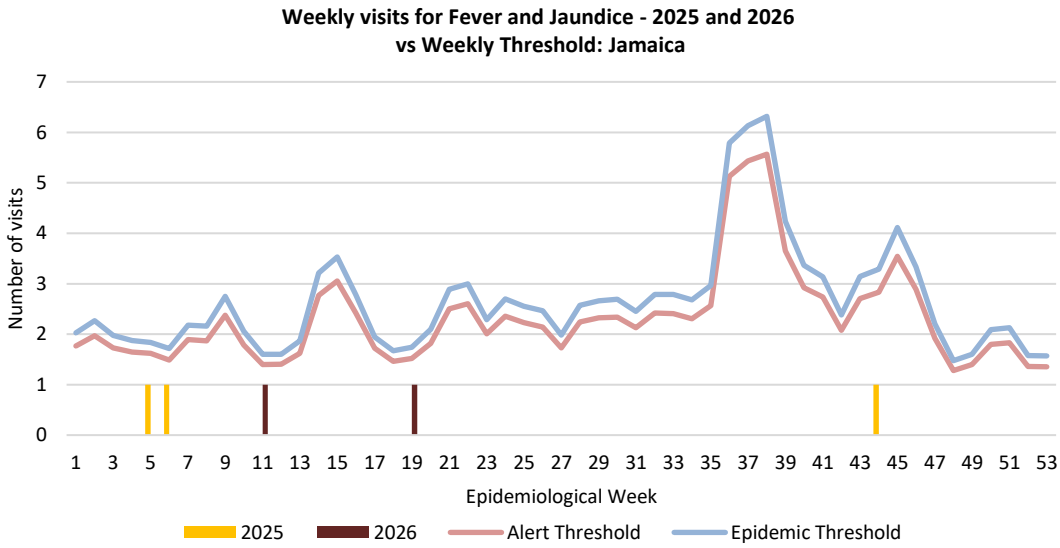
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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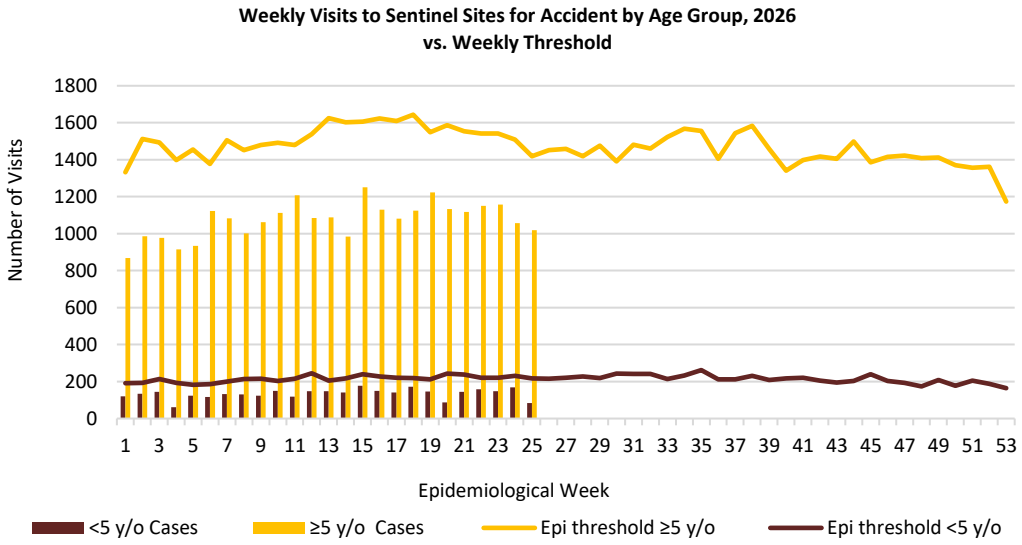
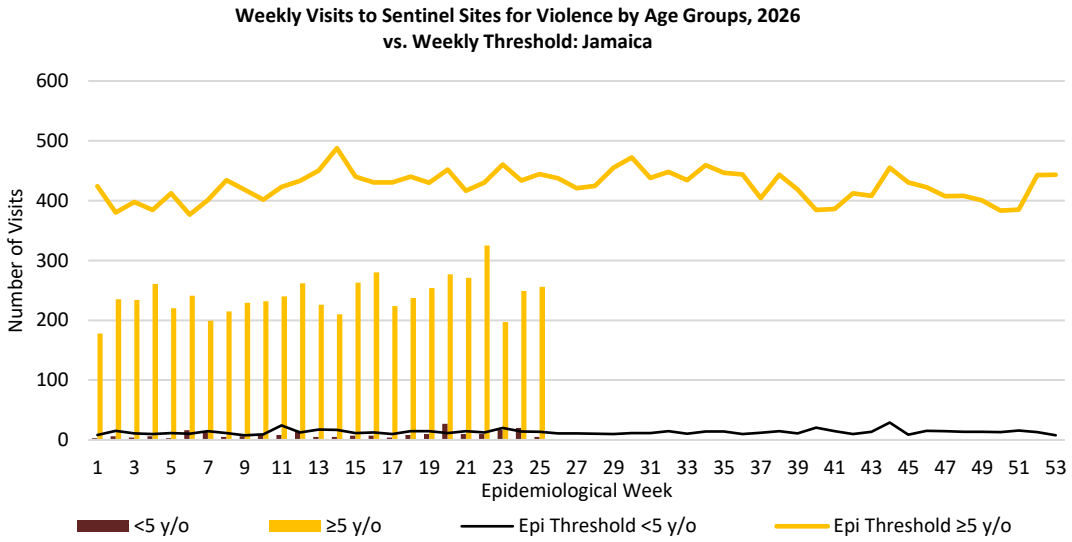
ACCIDENTS

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



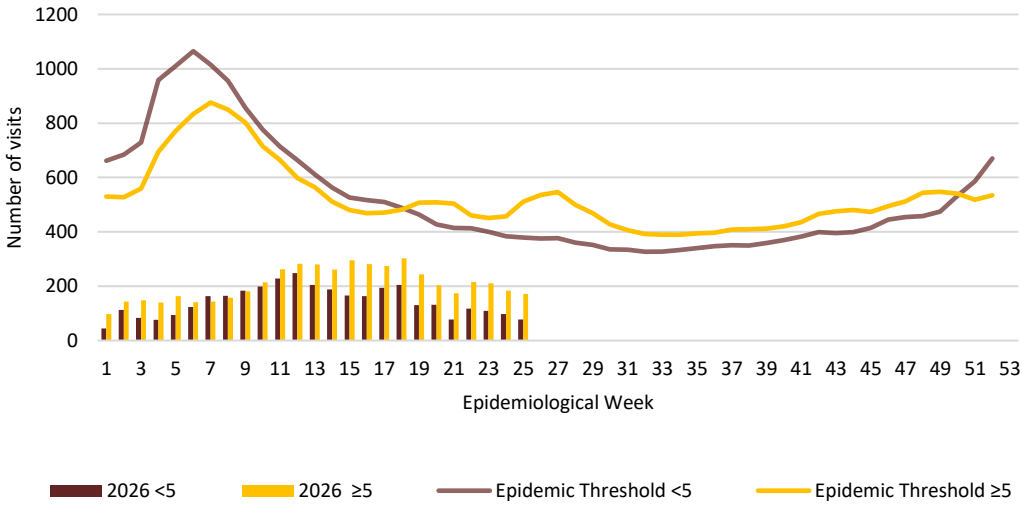
VIOLENCE

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	34[β]	103[β]
	Cholera	0	0
	Severe Dengue[Y]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	15	225
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	4	8
	Hepatitis C	0	2
	HIV/AIDS	NA	NA
	Malaria (Imported)	0	0
	Meningitis	3	9
	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]	22	31
	Ophthalmia Neonatorum	22	40
	Pertussis-like syndrome	0	0
	Rheumatic Fever	0	0
	Tetanus	1	1
	Tuberculosis	33	34
	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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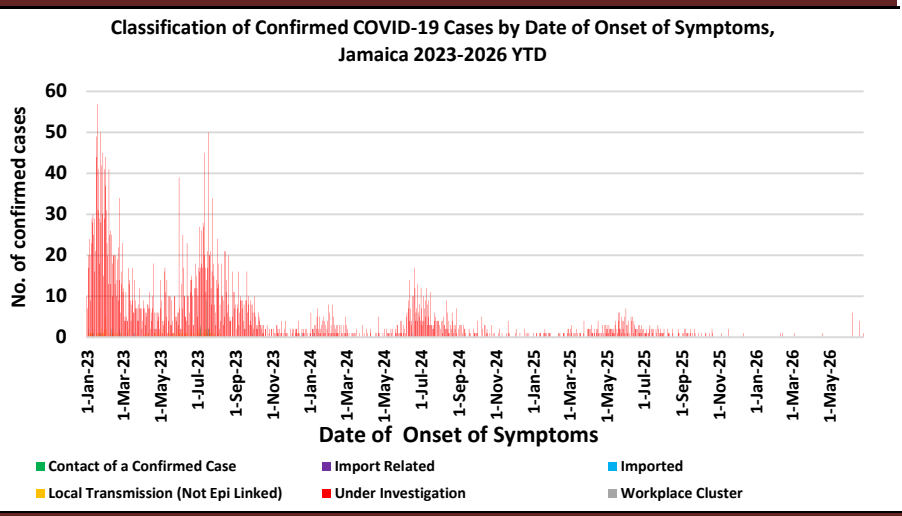
COVID-19 SURVEILLANCE

CASES	EW 25	Total
Confirmed	1	157,765
Females	0	90,889
Males	1	66,873
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.

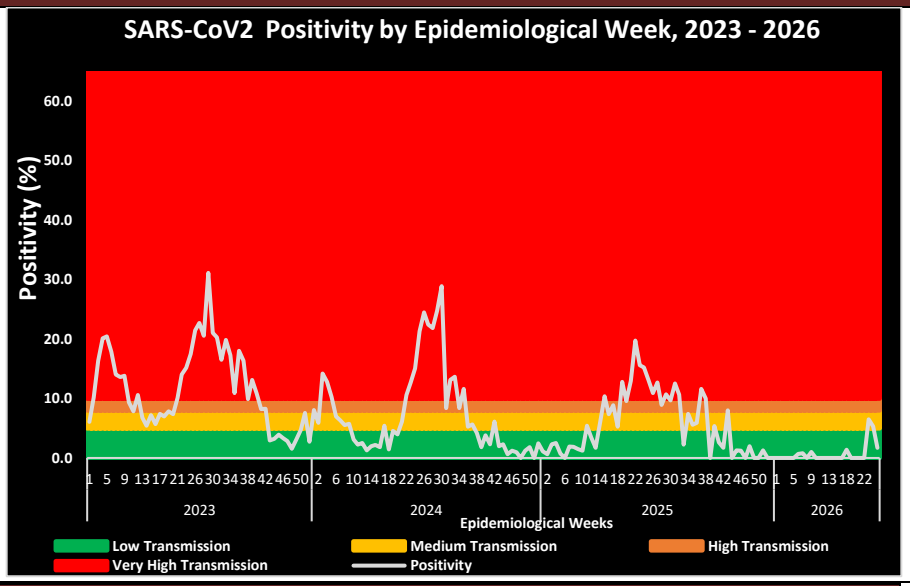


COVID-19 Outcomes

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

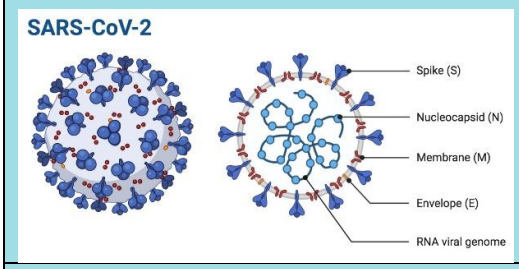
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	15	157,765
Deaths	621	116	24	13	0	3,921

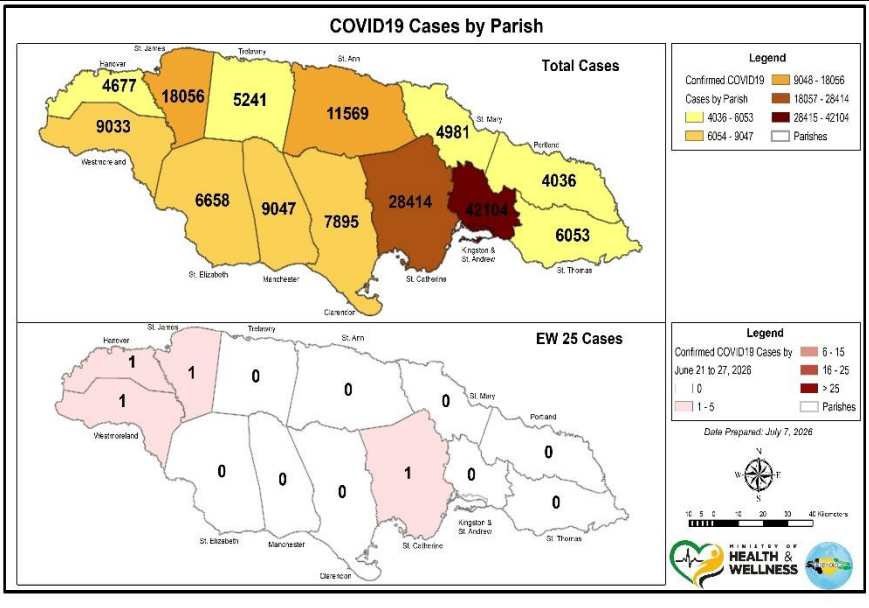
- Current positivity rate: 1.7%
- Positivity = (positive samples/total samples tested)
- Low transmission for infection



COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure





COVID-19 WHO Global Statistics EW 22-25, 2026

Epi Week	Confirmed Cases	Deaths
22	3,500	79
23	3,500	58
24	3,800	27
25	3,900	16
Total (4weeks)	**14,700**	**180**

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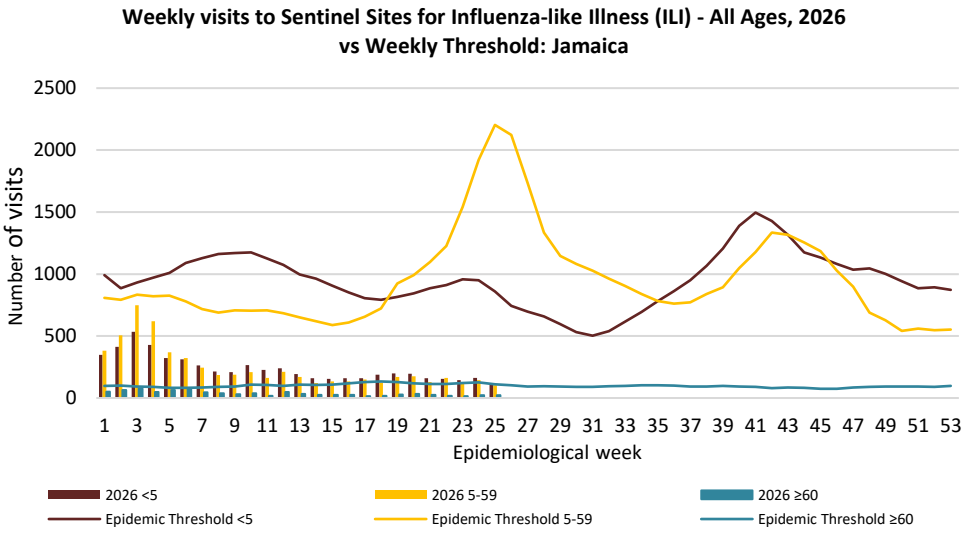
July 10, 2026 ISSN 0799-3927

INFLUENZA SURVEILLANCE

EW 25

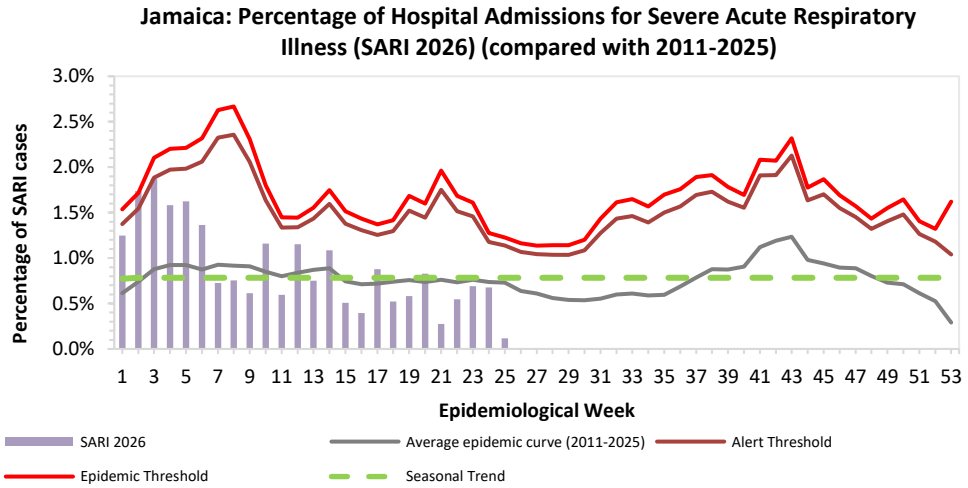
June 21, 2026 – June 27, 2026 Epidemiological Week 25

	EW 25	*YTD*
SARI cases	1	350
Total Influenza positive Samples	**0**	**263**
Influenza A	**0**	**234**
H1N1pdm09	0	21
H3N2	0	213
Not subtyped	0	0
Influenza B	**0**	**29**
B lineage not determined	0	0
B Victoria	0	29
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	48



Epi Week Summary

During Epi Week 25, one (1) SARI admission was reported.

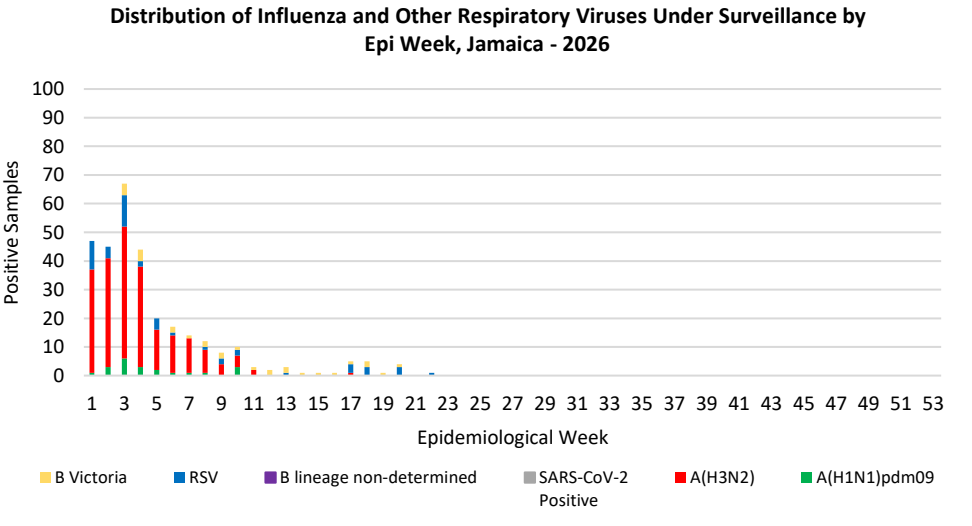


Caribbean Update Epi Week 25

Influenza activity is trending upward, with a regional positivity rate of 3.8% in EW 22, with Influenza B Victoria predominating (61.9%) and A(H3N2) co-circulating (30.9%). Indicators for SARI and ILI remain at low levels. The circulation of RSV and SARS-CoV-2 remains low but is trending upward, with positivity rates of 7.5% and 4.9% respectively.*

*Update as of Epi Week 22

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



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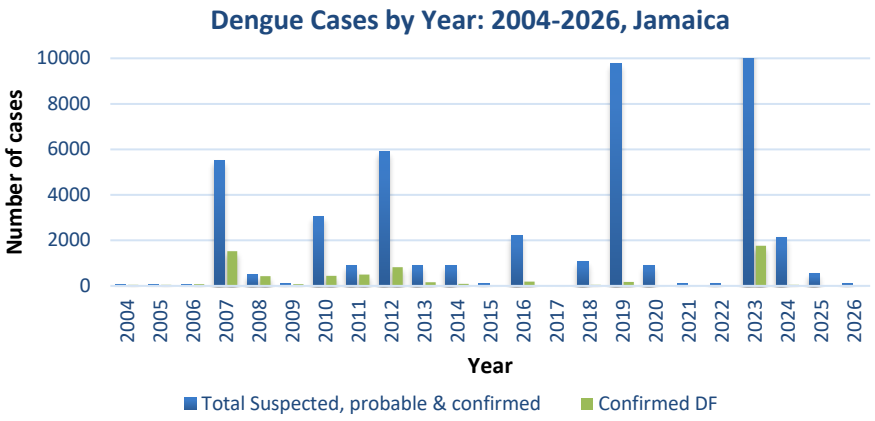
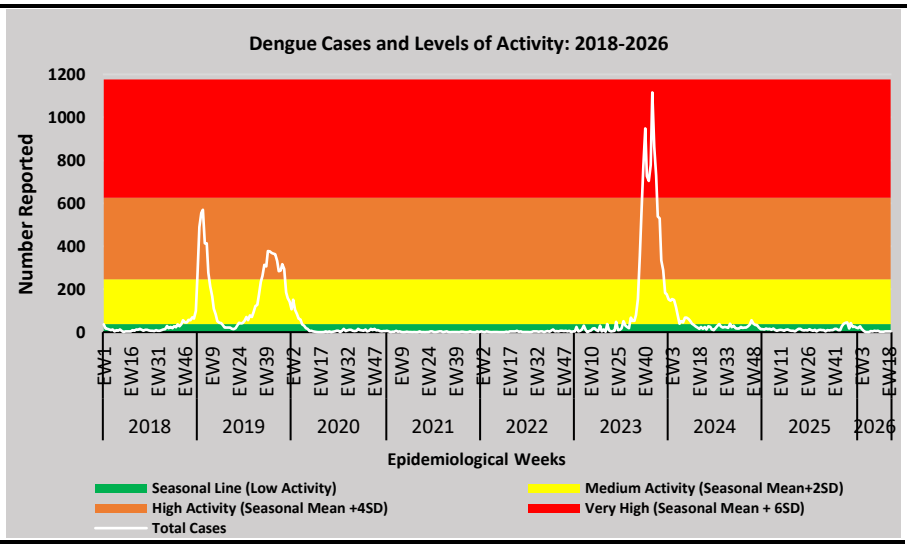
DENGUE SURVEILLANCE

June 21, 2026 – June 27, 2026 Epidemiological Week 25 | Epidemiological Week 25



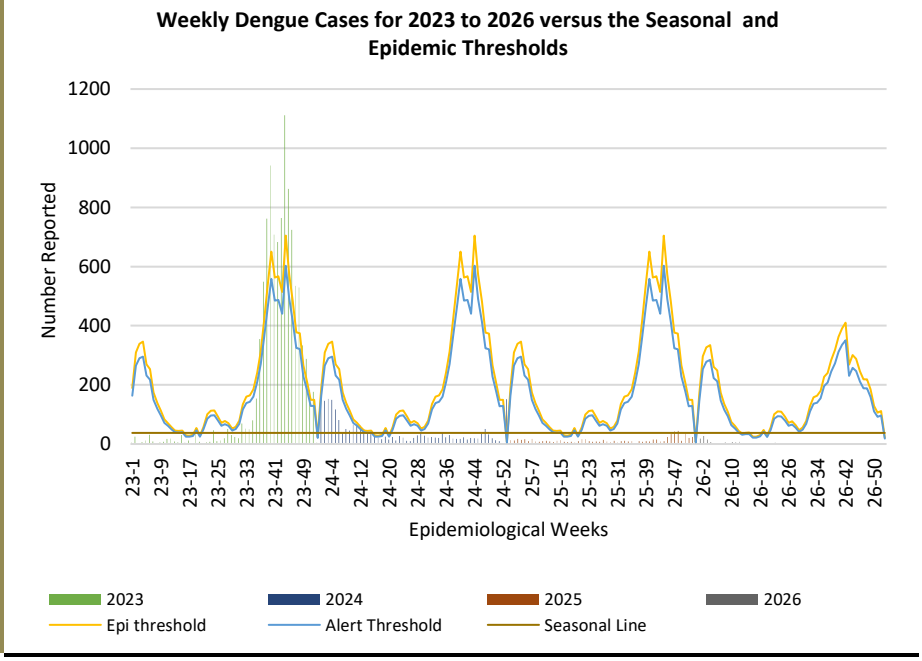
Reported suspected, probable and confirmed dengue with symptom onset in week 25 of 2026

	2026*	
	EW 25	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	125
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 July 10, 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

Assessment of Delays to Diagnosis and Treatment of Breast Cancer among Patients Accessing Care at the Cornwall Regional Hospital in Western Jamaica: A Mixed Methods Study

Johnson – Campbell M[1,2], East J[3], Duncan J[1], Figueroa JP[1], Bailey A[1]

[1]Department of Community Health & Psychiatry, University of the West Indies, Mona, Jamaica, [2]Western Regional Health Authority, St James, Jamaica, [3]Department of Surgery, Radiology, Anaesthesia and Intensive Care, University of the West Indies, Mona, Jamaica

Objective: Delays in breast cancer diagnosis and treatment may contribute to the generally poorer prognosis and late-stage disease observed in Jamaican women. We aimed to assess these delays against international benchmarks and explore perspectives of patients and healthcare providers in Western Jamaica.

Methods: Medical records of 87 breast cancer patients at Cornwall Regional Hospital's Oncology Clinic (2012-2016) were reviewed in the quantitative component of this mixed-methods study. Timelines from symptom onset to treatment, and data potentially impacting health system delay within patient pathway intervals were extracted and analyzed. In the qualitative component, in-depth interviews were conducted with six patients and six healthcare providers. Total interval (symptom discovery to treatment - TI), patient interval (symptom discovery to first medical consultation - PI), and health system interval (first medical consultation to treatment - HSI) and sub-intervals were calculated.

Results: Mean TI was 44.4 weeks, with 57.5% of patients experiencing delays exceeding the six-month international benchmark. For PI, 24.4% exceeded the 13-week benchmark, with a mean of 17.9 weeks. For HSI, 73.6% exceeded 13 weeks, averaging 26.8 weeks. Major HSI components were pre-hospital interval (13.9 weeks) and biopsy-to-histology time (6.58 weeks). Lack of awareness, symptom misinterpretation, and competing priorities drove high PI.

Conclusion: Patient and health system delays impede timely breast cancer diagnosis and treatment in Western Jamaica. Increasing awareness and improving available services may reduce PI. Accelerated referral pathways to medical specialists and enhanced public sector diagnostic services (mammography, biopsy, pathology and laboratory) are needed to reduce the HSI.

Keywords: breast cancer; delays; intervals; western Jamaica