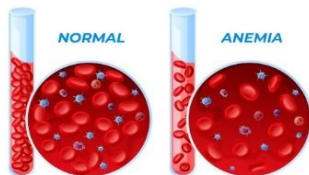


WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Anaemia (Part 3)



Treatment and prevention

The treatment and prevention of anaemia depend on the underlying cause of the condition. There are many effective ways to treat and prevent anaemia. Changes in diet can help reduce anaemia in some cases, including:

- eating foods that are rich in iron, folate, vitamin B12, vitamin A, and other nutrients

- eating a healthy diet with a variety of foods
 - taking supplements if a qualified health-care provider recommends them.
- Other health conditions can cause anaemia. Actions include:

- prevent and treat malaria
- prevent and treat schistosomiasis and other infections caused by soil-transmitted helminths (parasitic worms)
- get vaccinated and practice good hygiene to prevent infections
- manage chronic diseases like obesity and digestive problems
- wait at least 24 months between pregnancies and use birth control to prevent unintended pregnancies
- prevent and treat heavy menstrual bleeding and haemorrhage before or after birth
- delay umbilical cord clamping after childbirth (not earlier than 1 minute)
- treat inherited red blood cell disorders like sickle-cell disease and thalassemia.

Self-care

There are several ways to help prevent and manage anaemia in daily life, including eating a healthy and diverse diet and speaking to a health-care provider early if you have symptoms of anaemia. To keep a healthy and diverse diet:

- eat iron-rich foods, including lean red meats, fish and poultry, legumes (e.g. lentils and beans), fortified cereals and dark green leafy vegetables;
- eat foods rich in vitamin C (such as fruits and vegetables) which help the body absorb iron; and
- avoid foods that slow down iron absorption when consuming iron-rich foods, such as bran in cereals (wholewheat flour, oats), tea, coffee, cocoa and calcium.

If you take calcium and iron supplements, take them at different times during the day. People with heavy menstrual bleeding should see their doctor for treatment. Doctors may recommend iron supplements or hormonal contraceptives. Some infections can cause anaemia. Wash your hands with soap and water and use clean toilets to reduce the risk of infection. Malaria can also cause anaemia. People living in places where malaria is common should follow prevention advice from local health authorities. Seek prompt treatment if you suspect you have malaria.

Taken from WHO website on 10/February/2025

<https://www.who.int/news-room/fact-sheets/detail/anaemia>

<https://healthinfo.healthengine.com.au/anaemia-during-pregnancy-types-causes-treatments> (picture)

EPI WEEK 5



Syndromic Surveillance

Accidents

Violence

Pages 2-4



Class 1 Notifiable Events

Page 5



COVID-19

Page 6



Influenza

Page 7



Dengue Fever

Page 8



Research Paper

Page 9

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 – 2 to 5 of 2025

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

Epi week	Kingston and Saint Andrew	Saint Thomas	Saint Catherine	Portland	Saint Mary	Saint Ann	Trelawny	Saint James	Hanover	Westmoreland	Saint Elizabeth	Manchester	Clarendon
2025													
2	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
3	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
4	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
5	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

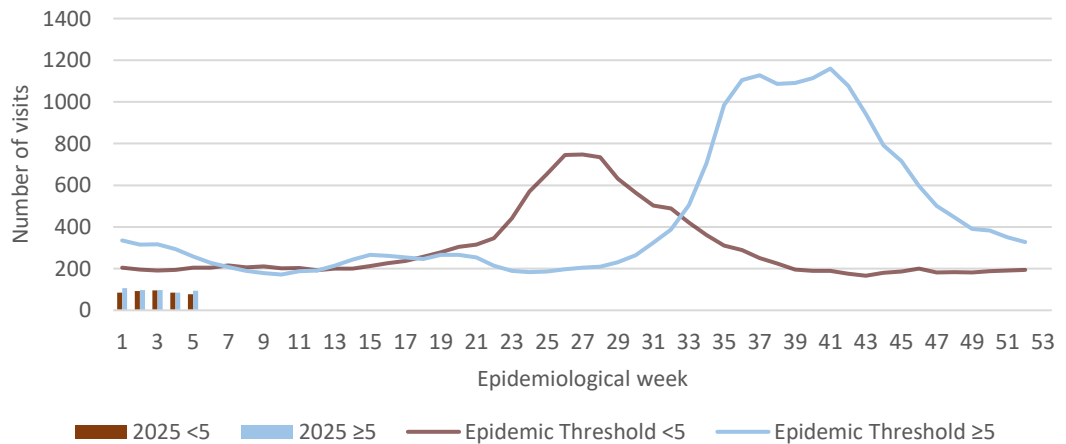
REPORTS FOR SYNDROMIC SURVEILLANCE

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: Jamaica, Weekly Threshold vs Cases 2025



2 NOTIFICATIONS- All clinical sites



INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued



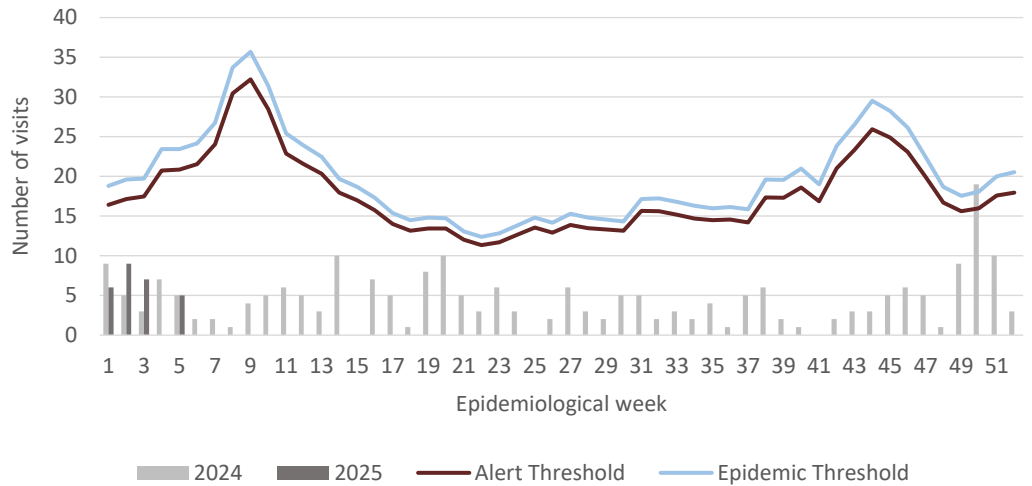
SENTINEL REPORT- 78 sites. Automatic reporting

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 2024 and 2025 vs. Weekly Threshold: Jamaica

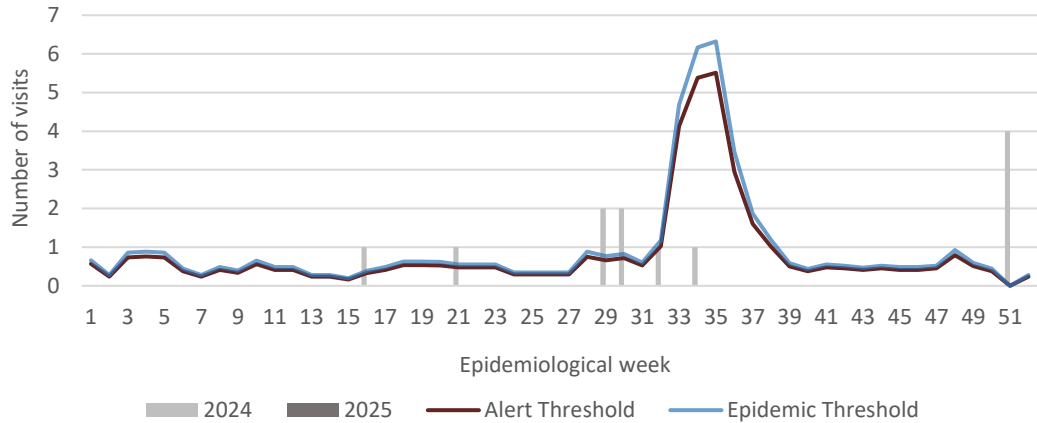


FEVER AND HAEMORRHAGIC

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 2024 and 2025 vs Weekly Threshold; Jamaica



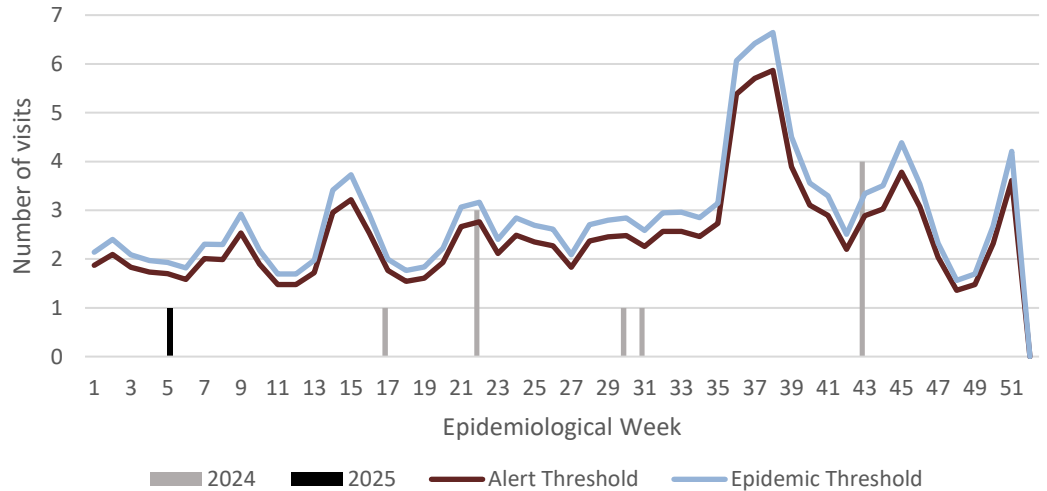
FEVER AND JAUNDICE

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.



Fever and Jaundice cases: Jamaica, Weekly Threshold vs Cases 2024 and 2025



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

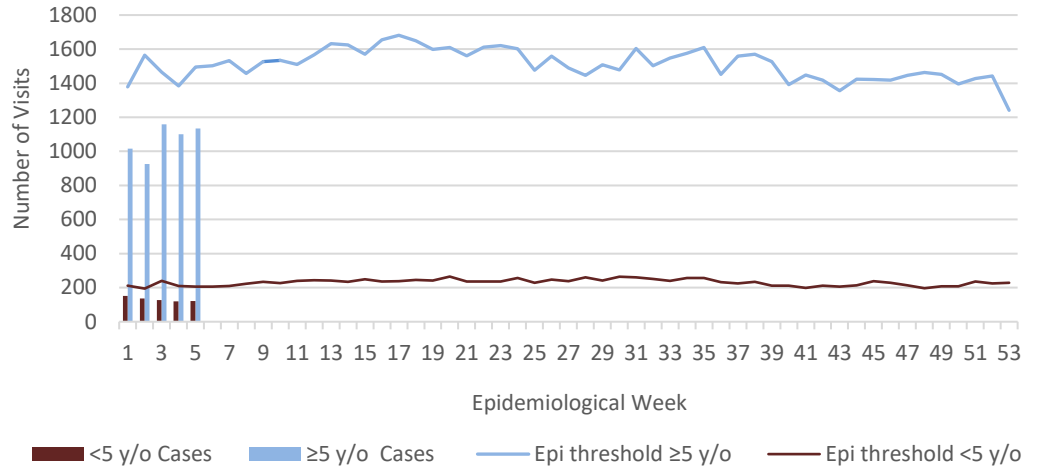


ACCIDENTS

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



Weekly Visits to Sentinel Sites for Accident by Age Group 2025 vs. Weekly Threshold

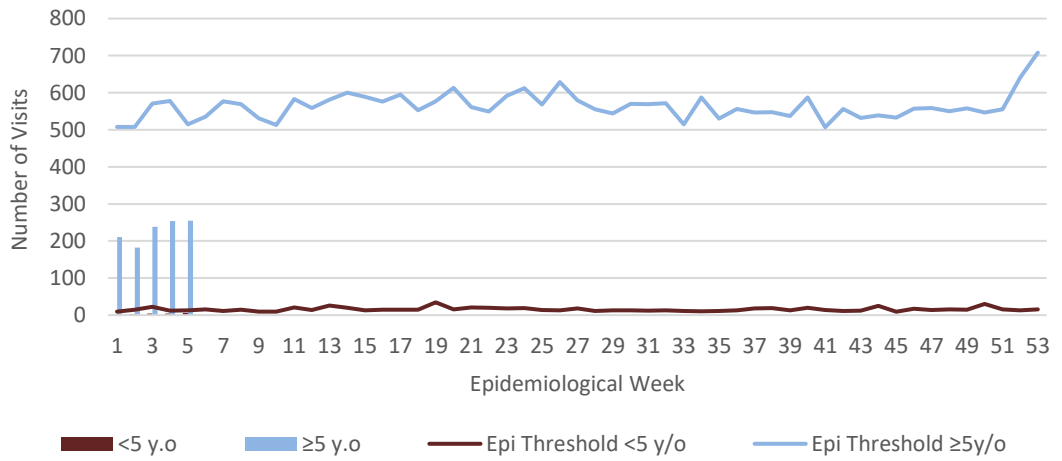


VIOLENCE

Any injury for which the cause is intentional, e.g. gunshot wounds, stab wounds, etc.



Weekly Visits to Sentinel Sites for Violence by Age Groups 2025 vs. Weekly Threshold

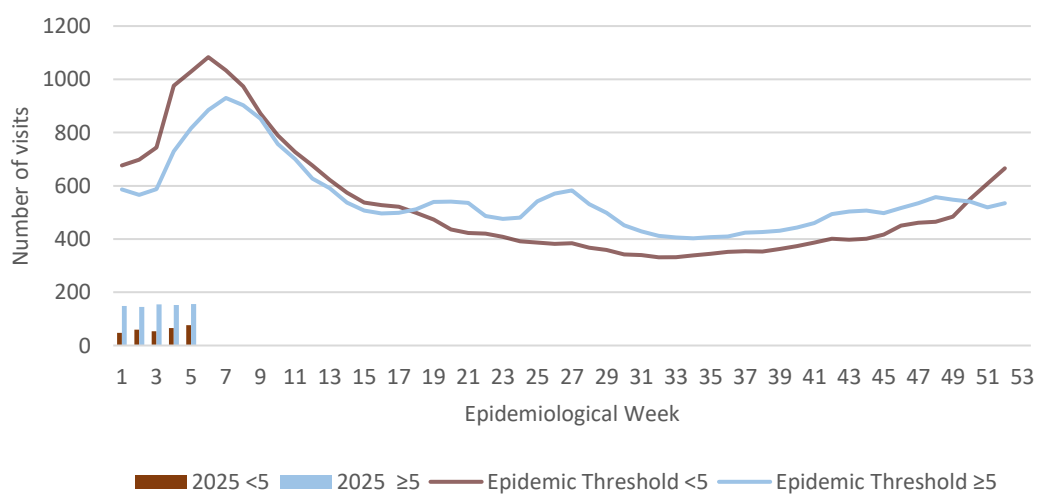


GASTROENTERITIS

Inflammation of the stomach and intestines, typically resulting from bacterial toxins or viral infection and causing vomiting and diarrhoea.



Weekly visits to Sentinel Sites for Gastroenteritis All ages 2025 vs Weekly Threshold; Jamaica



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	
	CLASS 1 EVENTS	Confirmed YTD ^α			
		CURRENT YEAR 2025	PREVIOUS YEAR 2024		
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	5 ^β	37 ^β	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.	
	Cholera	0	0		
	Severe Dengue ^γ	See Dengue page below	See Dengue page below		
	COVID-19 (SARS-CoV-2)	11	89		
	Hansen’s Disease (Leprosy)	0	0		
	Hepatitis B	0	6		
	Hepatitis C	0	1		
	HIV/AIDS	NA	NA		
	Malaria (Imported)	0	0		
	Meningitis	1	0		
	Monkeypox	0	0		
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 ^δ	7	7		
	Ophthalmia Neonatorum	0	22		
	Pertussis-like syndrome	0	0		
	Rheumatic Fever	0	0		
	Tetanus	0	0		
	Tuberculosis	0	9		
	Yellow Fever	0	0		
	Chikungunya ^ε	0	0		
Zika Virus ^θ	0	0			

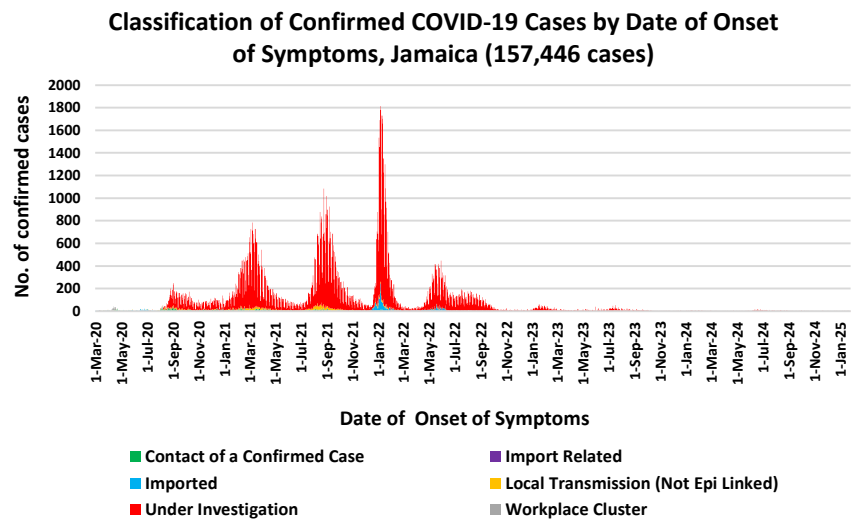
NA- Not Available

 <p>5 NOTIFICATIONS- All clinical sites</p>	 <p>INVESTIGATION REPORTS- Detailed Follow up for all Class One Events</p>	 <p>HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued</p>	 <p>SENTINEL REPORT- 78 sites. Automatic reporting</p>
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COVID-19 Surveillance Update

CASES	EW 5	Total
Confirmed	1	157446
Females	1	90717
Males	0	66726
Age Range	49 years	1 day to 108 years

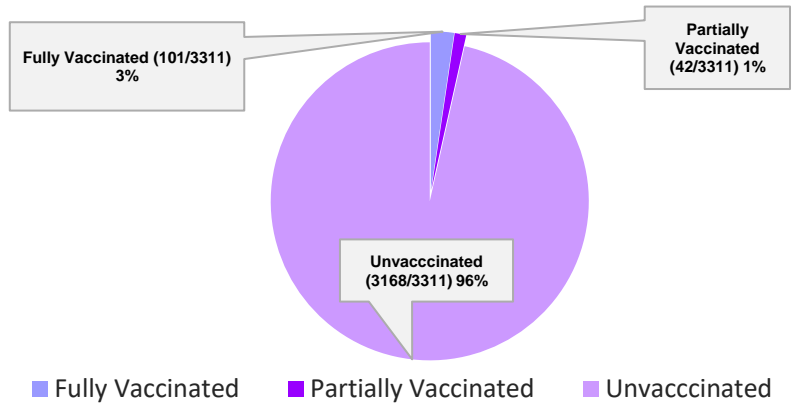
* 3 positive cases had no gender specification
 * PCR or Antigen tests are used to confirm cases
 * Total represents all cases confirmed from 10 Mar 2020 to the current Epi-Week.



COVID-19 Outcomes

Outcomes	EW 5	Total
ACTIVE *2 weeks*		5
DIED – COVID Related	0	3875
Died - NON COVID	0	396
Died - Under Investigation	0	142
Recovered and discharged	0	103226
Repatriated	0	93
Total		157446

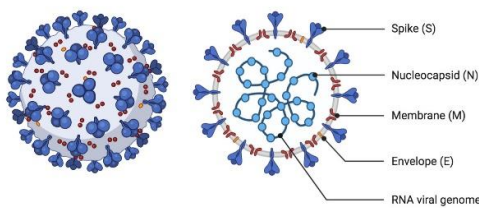
3311 COVID-19 Related Deaths since March 1, 2021 – YTD Vaccination Status among COVID-19 Deaths



COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure

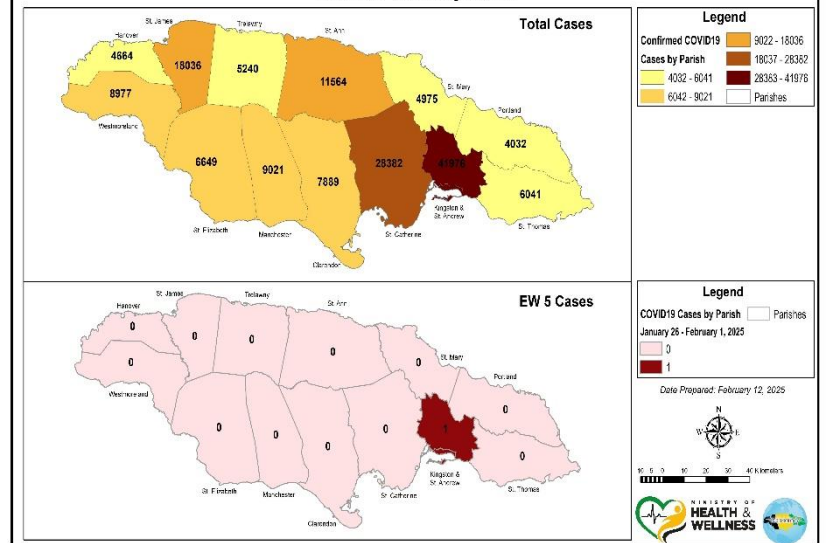
SARS-CoV-2



COVID-19 WHO Global Statistics EW 2 - 5, 2025

Epi Week	Confirmed Cases	Deaths
2	23900	1000
3	23000	1100
4	19200	986
5	15600	772
Total (4weeks)	81700	3858

COVID19 Cases by Parish



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

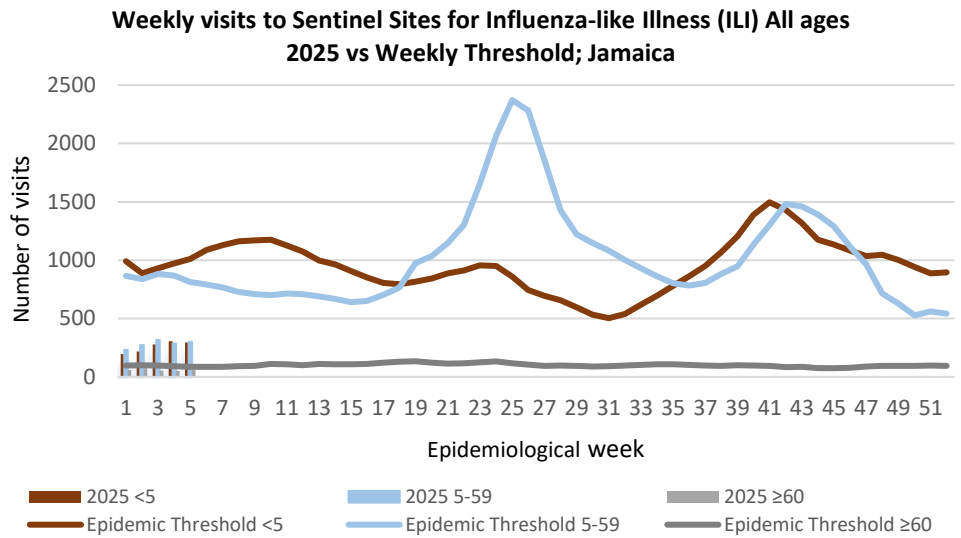


NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 5

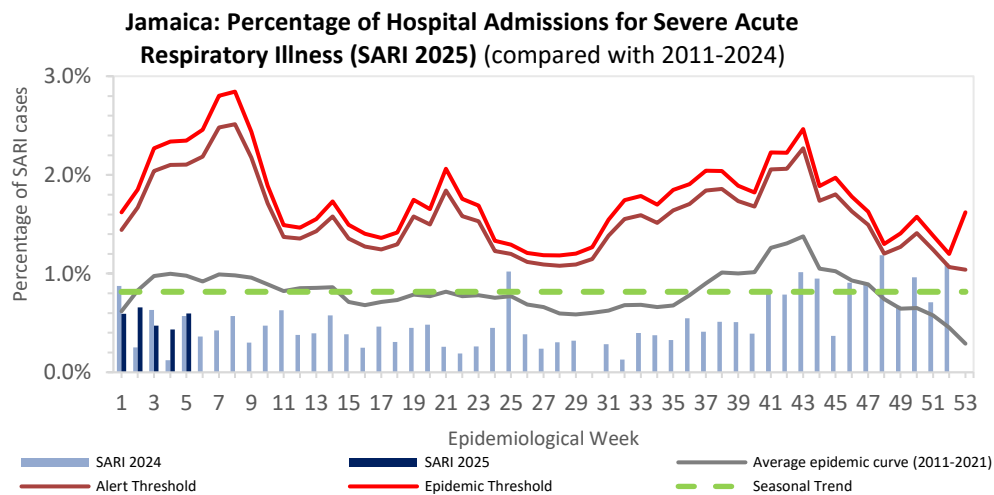
January 26, 2025 – February 1, 2025 Epidemiological Week 5

	EW 5	YTD
SARI cases	9	43
Total Influenza positive Samples	2	49
Influenza A	2	47
H3N2	1	18
H1N1pdm09	1	29
Not subtyped	0	0
Influenza B	0	2
B lineage not determined	0	0
B Victoria	0	2
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	17



Epi Week Summary

During EW 5, nine (9) SARI admissions were reported.

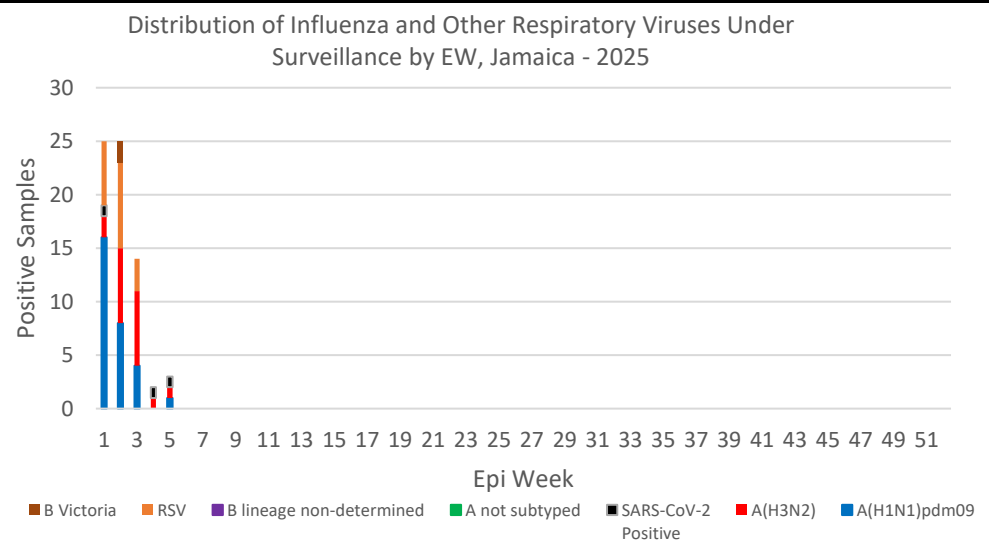


Caribbean Update EW 5

Caribbean: ILI and SARI cases have continued to decline over the past four EWs. Influenza activity, after increasing in previous weeks, has now started to decline, with A(H1N1)pdm09 as the predominant subtype. RSV activity has also maintained a downward trend over the past four EWs. Meanwhile, SARS-CoV-2 activity remains low.

By country: In the last four EWs, influenza activity has been reported in Saint Lucia, Barbados, the Cayman Islands, Guyana and Saint Vincent and the Grenadines. RSV activity has been detected in Belize, the Dominican Republic and Suriname.

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



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

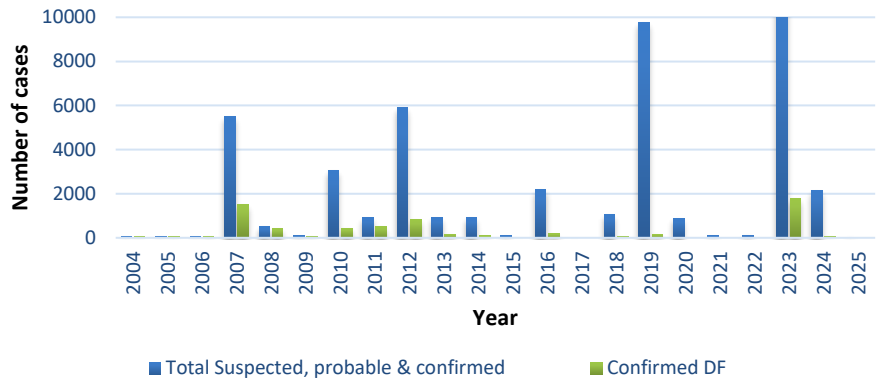
Dengue Bulletin

January 26, 2024 – February 1, 2025 Epidemiological Week 5


Epidemiological Week 5

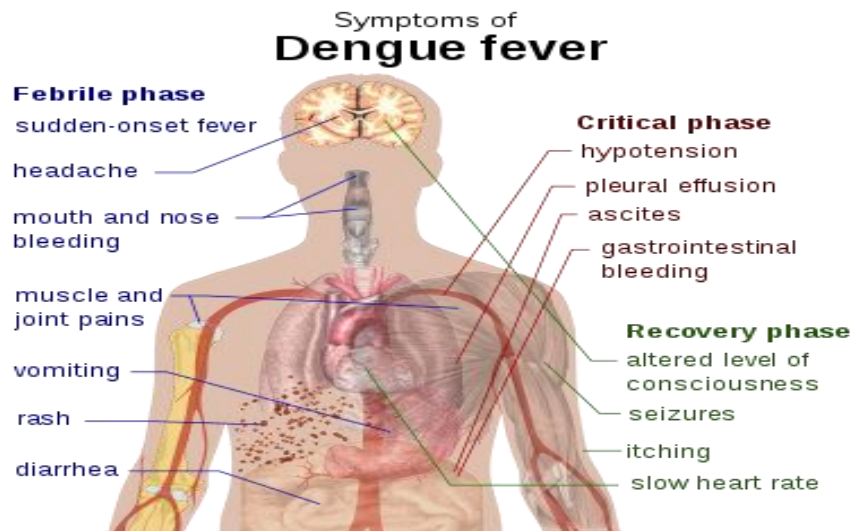


Dengue Cases by Year: 2004-2025, Jamaica



Reported suspected, probable and confirmed dengue with symptom onset in week 5 of 2025

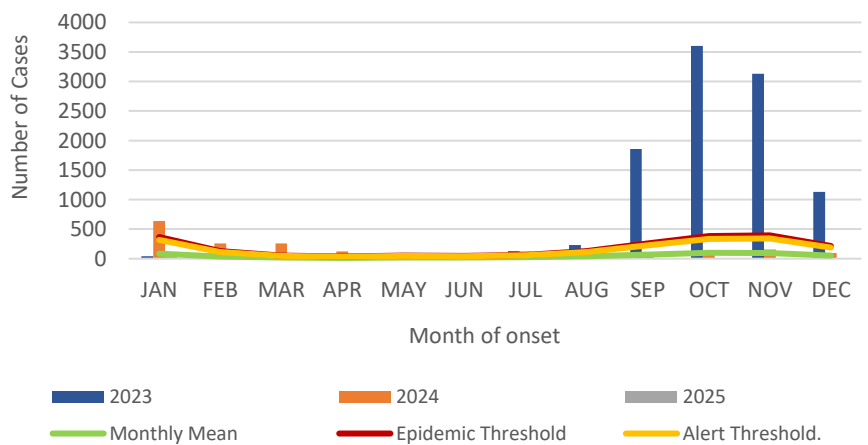
	2025*	
	EW 5	YTD
 Total Suspected, Probable & Confirmed Dengue Cases	6	46
Lab Confirmed Dengue cases	0	0
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- Dengue deaths are reported based on date of death.
- *Figure as at February 11, 2025
- Only PCR positive dengue cases are reported as confirmed.
- IgM positive cases are classified as presumed dengue.

Suspected, probable and confirmed dengue cases for 2023-2025 versus monthly mean, alert and epidemic threshold (2007-2022)



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 PAPER

Abstract

NHRC-23-002

Chronic Kidney Disease in Jamaica: Updated National Prevalence Estimates and Associated Factors using the CKD-EPI 2021 Formula

Fisher L-A^{1,2}, Ferguson TS², Rocke K³, Younger-Coleman N², Guthrie-Dixon N², Tulloch-Reid MK², McFarlane SR⁴, Bennett NR², Cunningham-Myrie C⁵, Aiken W⁶, Wiggan J⁷, Grant A⁷, Davidson T⁷, Webster-Kerr K⁷, Wilks RJ², and the Jamaica Health and Lifestyle Survey III Investigators*

¹Department of Medicine, The University of the West Indies, Mona, Jamaica, ²Epidemiology Research Unit, Caribbean Institute for Health Research, The University of the West Indies, Mona, Jamaica, ³George Alleyne Chronic Disease Research Centre, Caribbean Institute for Health Research, The University of the West Indies, Cave Hill, Barbados, ⁴Tropical Metabolism Research Unit, Caribbean Institute for Health Research, The University of the West Indies, Mona, Jamaica, ⁵Department of Community Health & Psychiatry, The University of the West Indies, Mona, Jamaica, ⁶Department of Surgery, The University of the West Indies, Mona, Jamaica, ⁷Ministry of Health and Wellness, Jamaica, ⁸Chronic Disease and Injury Department, Surveillance, Disease Prevention & Control Division, Caribbean Public Health Agency

Objectives: Little is known of the prevalence of Chronic Kidney Disease (CKD) in Jamaica. We aimed to estimate the prevalence of CKD and explore associations with known risk factors in a nationally representative population based survey.

Methods: A cross-sectional analysis of 1189 Jamaican residents aged ≥ 15 years from the Jamaica Health and Lifestyle Survey 2016-2017, was performed. CKD was defined as an estimated glomerular filtration rate (eGFR) $< 60 \text{ mL/min/1.73m}^2$, using the race-free CKD-EPI-2021 and Schwartz-Lyon equations. Associated factors included age, sex, socio-economic status, education level, smoking habits, body mass index (BMI), hypertension, diabetes mellitus, and self-reported sickle cell trait. Weighted prevalence estimates were determined and logistic regression models were used to evaluate associations.

Results: Of 1189 participants, 446 males and 743 females (mean[\pm SD] age was 49.1 \pm 18.3 years). Based on weighted estimates, the prevalence of CKD was 7.6% [95%CI 6.1%-9.6%]. The majority was CKD Stage 3a (6.0%), Stage 3b 1.0%, Stage 4 0.2%, and Stage 5 0.4%. Compared to persons with normal eGFR, CKD participants were older (mean age 65.6 versus 46.8 years, $p < 0.001$), with no significant male: female difference (7.3% vs 8.0%, $p = 0.667$), and had higher mean systolic blood pressure (142.0 versus 130.7 mmHg, $p < 0.001$). In a multivariable logistic regression model adjusting for a priori risk factors, age (OR[95%CI] 1.07, [1.05-1.10]), sickle cell trait (OR[95%CI] 4.87 [1.08-21.94]) and diabetes mellitus (OR[95%CI] 1.85, [1.00-3.42]) but not hypertension (OR[95%CI]: 1.0, 0.54-1.90) were associated with CKD.

Conclusion: Based on reduced eGFR, national CKD prevalence is approximately 8%. This may translate to increased health care burden on the Jamaican public system.



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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