WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Poliomyelitis (Part 1)

Overview

In 1988, the World Health Assembly adopted a resolution for the worldwide eradication of polio, marking the launch of the Global Polio Eradication Initiative (GPEI), a unique global public-private partnership. Since then, the incidence of polio worldwide has been reduced by 99%, and the world stands on the threshold of eradicating a human disease globally for only the second time in history, after smallpox in 1980.

Wild poliovirus cases have decreased by over 99% since 1988, from an estimated 350 000 cases in more than 125 endemic countries then, to two endemic countries).

Symptoms and risk

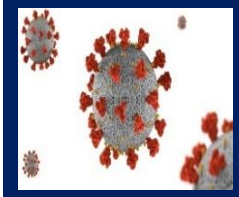
Polio is a highly infectious disease caused by a virus. It invades the nervous system and can cause total paralysis in a matter of hours. The virus is transmitted by person-to-person spread mainly through the faecal-oral route or, less frequently, by a common vehicle (for example, contaminated water or food) and multiplies in the intestine. Initial symptoms are fever, fatigue, headache, vomiting, stiffness of the neck and pain in the limbs. One in 200 infections leads to irreversible paralysis (usually in the legs). Among those paralysed, 5–10% die when their breathing muscles become immobilized.

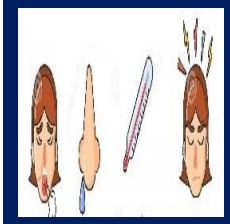
Polio mainly affects children under 5 years of age. However, anyone of any age who is unvaccinated can contract the disease.

There is no cure for polio, it can only be prevented. Polio vaccine, given multiple times, can protect a child for life. There are two vaccines available: oral polio vaccine and inactivated polio vaccine. Both are effective and safe, and both are used in different combinations worldwide, depending on local epidemiological and programmatic circumstances, to ensure the best possible protection to populations can be provided.

Taken from WHO website on 9/April/2025
https://www.who.int/news-room/fact-sheets/detail/poliomyelitis
Pictures taken from https://health.thefuntimesguide.com/getting-tetanus-shot/

EPI WEEK 13





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 – 9 to 12 of 2025

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

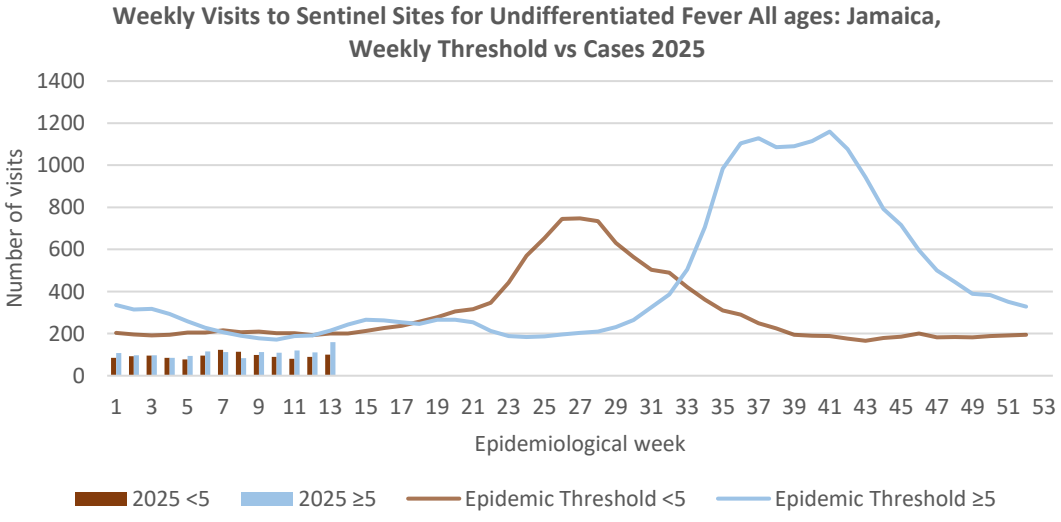
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday

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													
10	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
11	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
12	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
12	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 >38^0C /100.4^0F (or recent history of fever) with or without an obvious diagnosis or focus of infection.



2 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

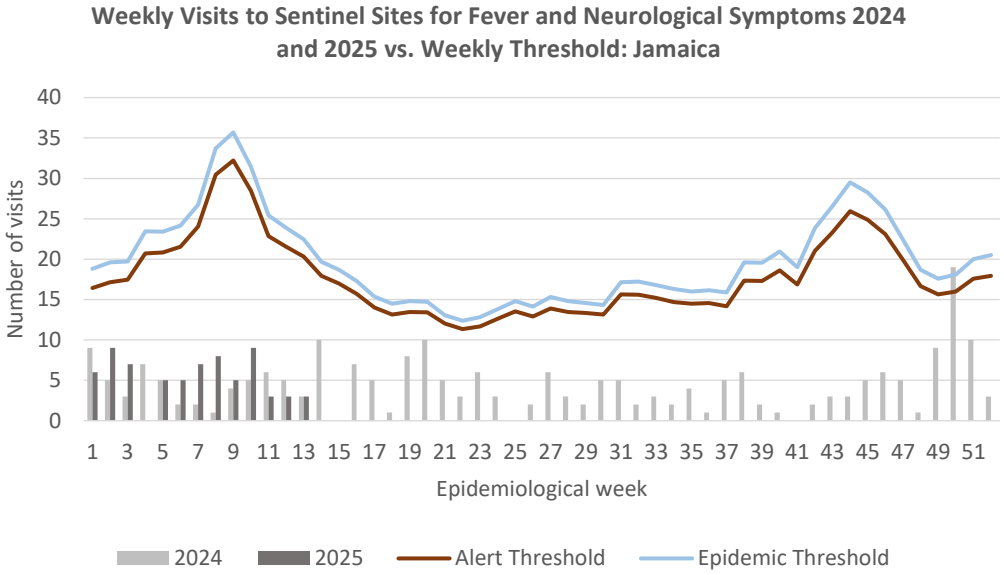
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

ISSN 0799-3927

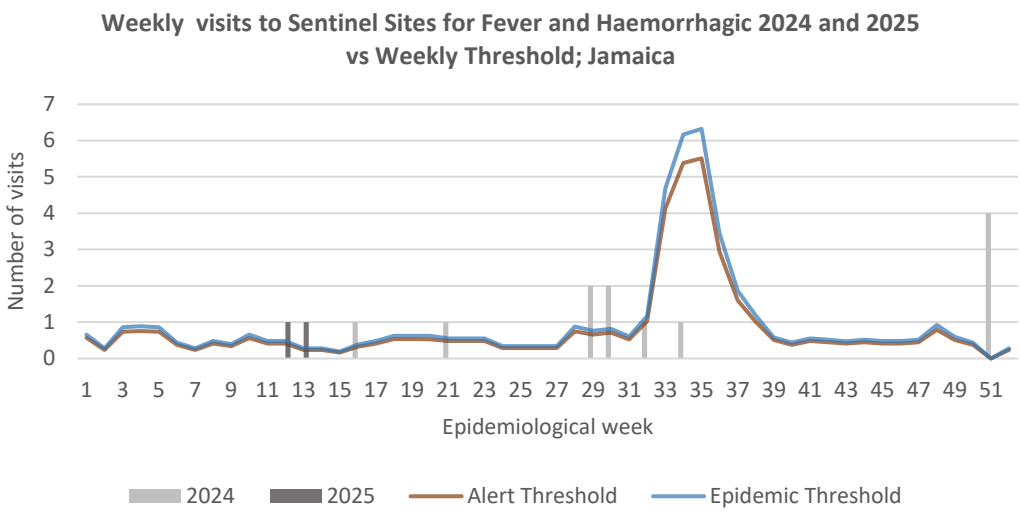
FEVER AND NEUROLOGICAL

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

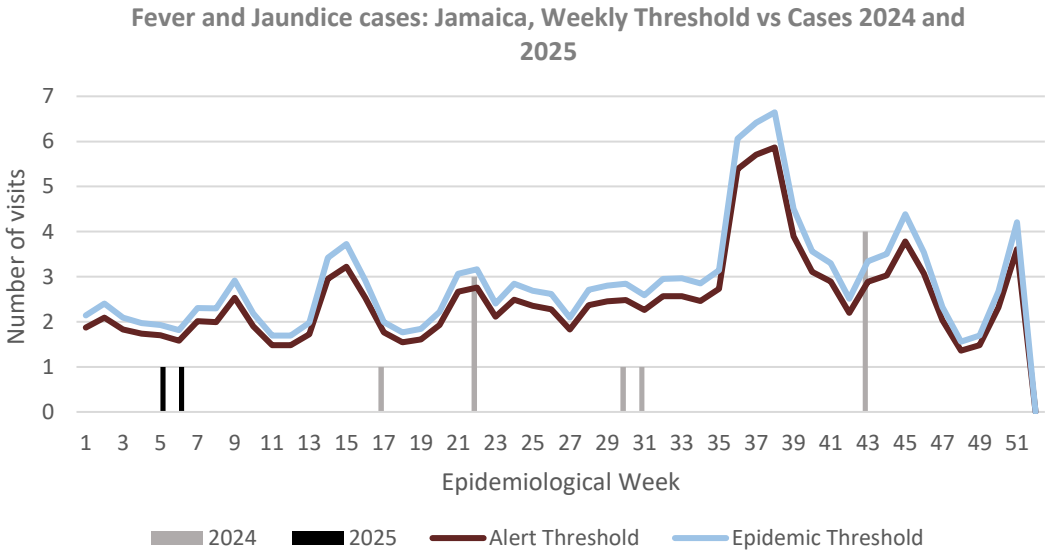
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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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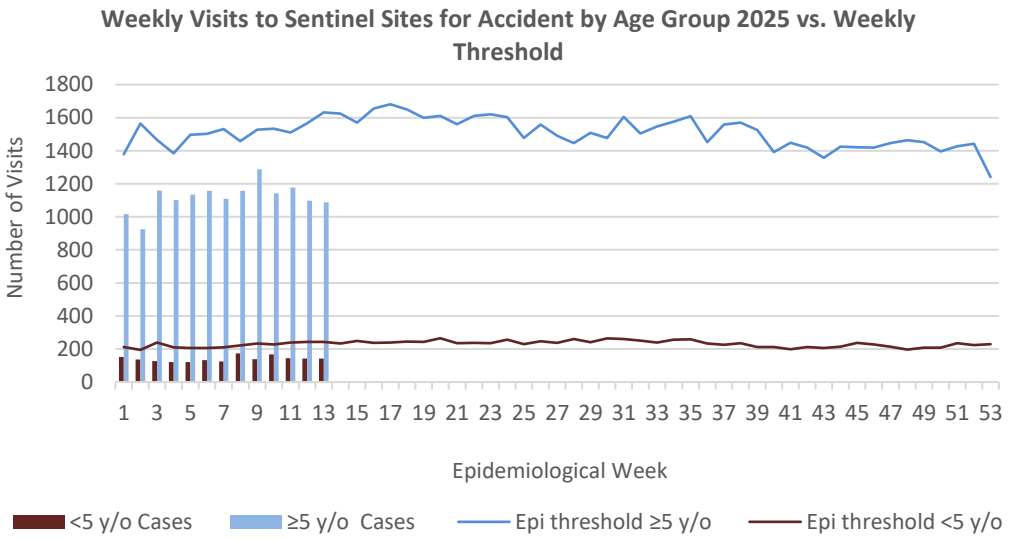
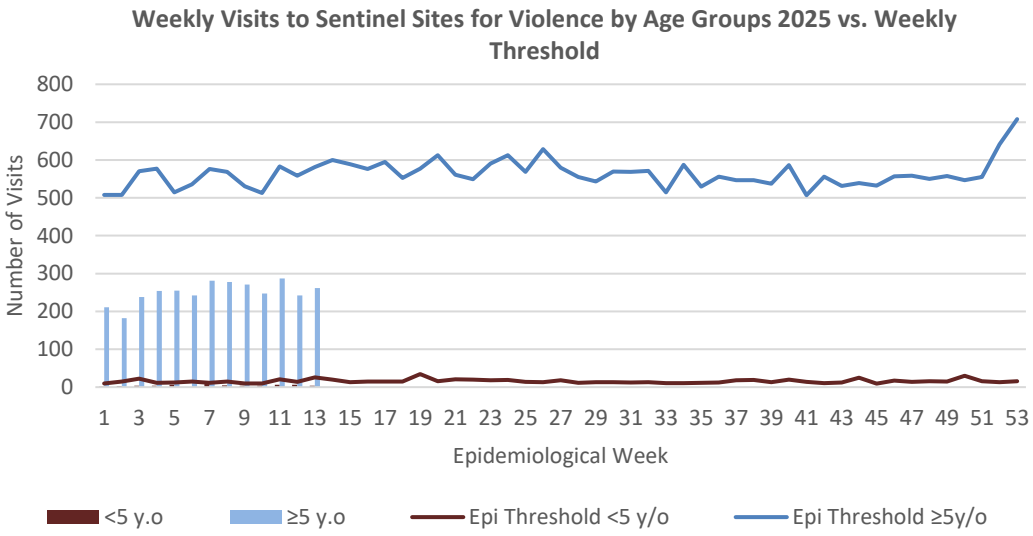
ACCIDENTS

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



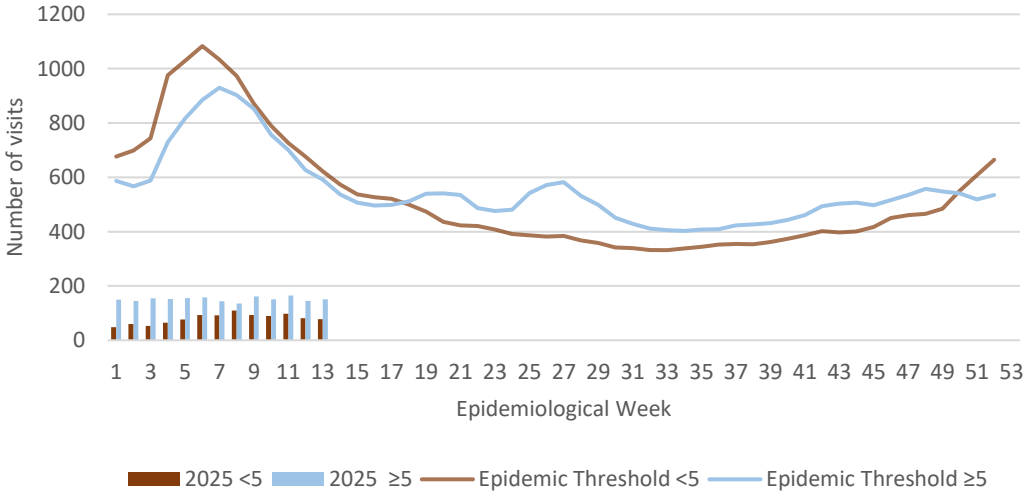
VIOLENCE

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 2025	PREVIOUS YEAR 2024
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		12[β]	110[β]
	Cholera		0	0
	Severe Dengue[Y]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		49	160
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		0	11
	Hepatitis C		1	4
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis		4	8
	Monkeypox		0	0
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
		Rubella	0	0
	Maternal Deaths[δ]		18	14
	Ophthalmia Neonatorum		7	43
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		1	0
	Tuberculosis		0	17
	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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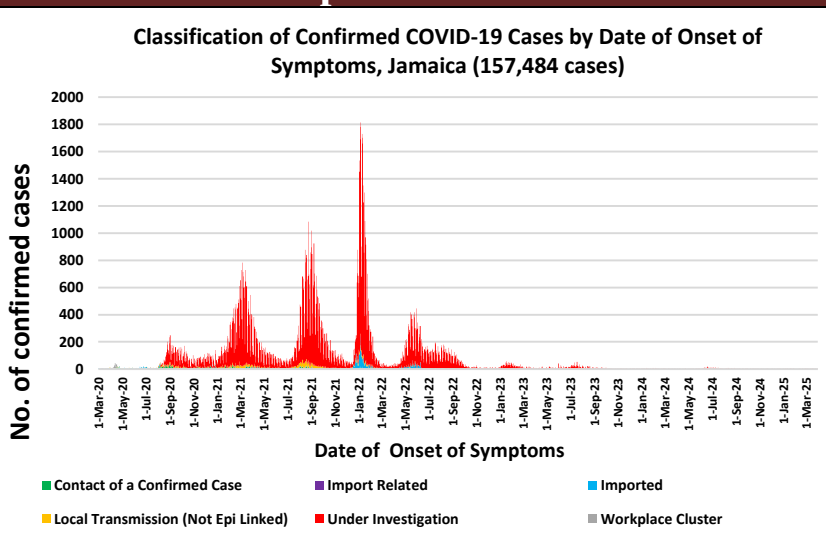
COVID-19 Surveillance Update

CASES	EW 13	Total
Confirmed	4	157484
Females	1	90736
Males	3	66745
Age Range	0 to 75 years	1 day to 108 years

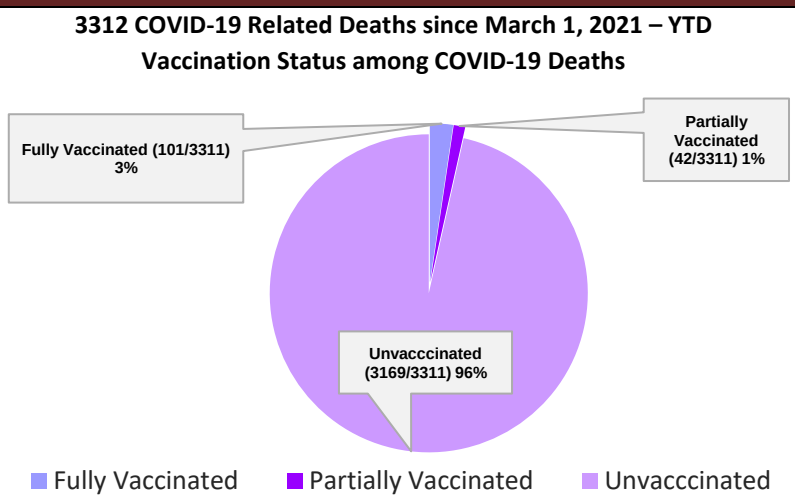
* 3 positive cases had no gender specification
* PCR or Antigen tests are used to confirm cases
* Total represents all cases confirmed from 10 Mar 2020 to the current Epi-Week.



COVID-19 Outcomes

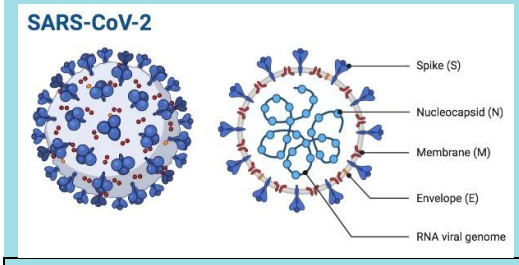
Outcomes	EW 13	Total
ACTIVE *2 weeks*		10
DIED – COVID Related	0	3876
Died - NON COVID	0	396
Died - Under Investigation	0	142
Recovered and discharged	0	103226
Repatriated	0	93
Total		157484

*Vaccination programme March 2021 – YTD
* Total as at current Epi week



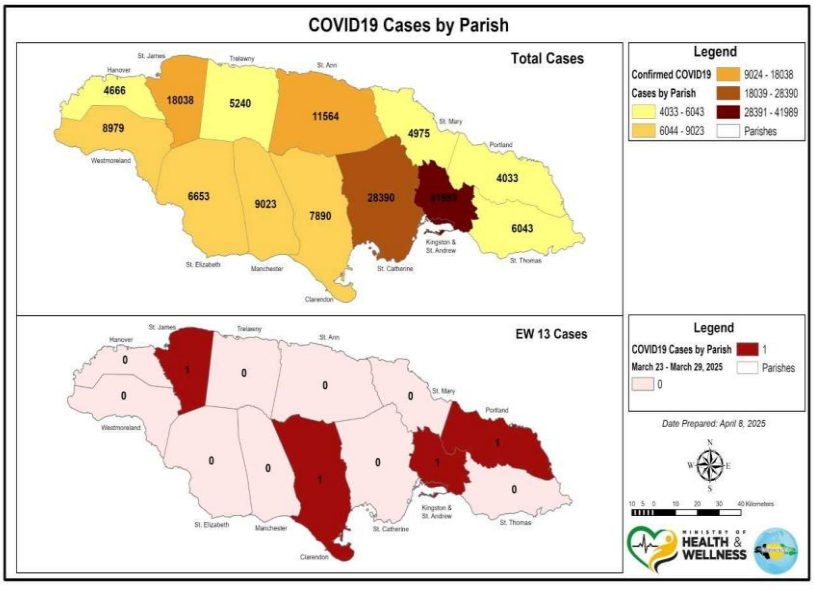
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics EW 10 -13, 2025

Epi Week	Confirmed Cases	Deaths
10	26100	784
11	19600	669
12	16500	508
13	9200	380
Total (4weeks)	**71400**	**2341**



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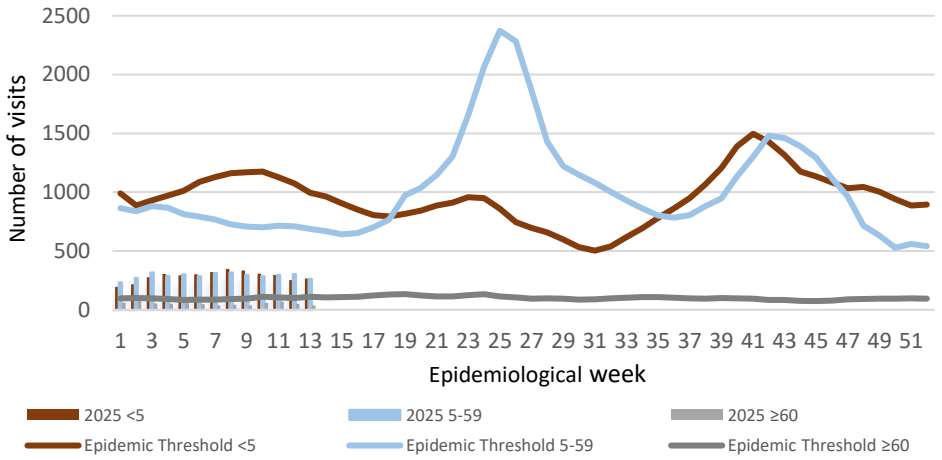
NATIONAL SURVEILLANCE UNIT INFLUENZA REPORT

EW 13

March 23, 2025 – March 29, 2025 Epidemiological Week 13

	EW 13	*YTD*
SARI cases	11	136
Total Influenza positive Samples	1	121
Influenza A	1	110
H1N1pdm09	0	70
H3N2	1	40
Not subtyped	0	0
Influenza B	0	11
B lineage not determined	0	0
B Victoria	0	11
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	28

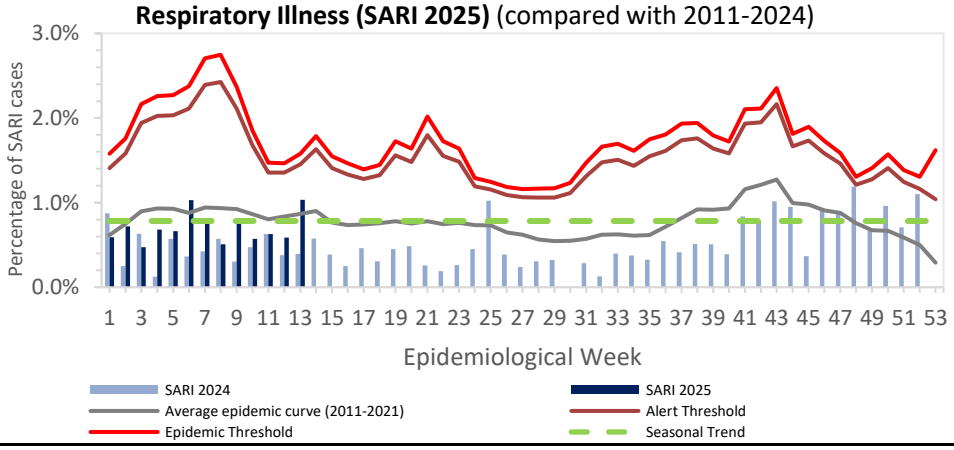
Weekly visits to Sentinel Sites for Influenza-like Illness (ILI) All ages 2025 vs Weekly Threshold; Jamaica



Epi Week Summary

During EW 13, eleven (11) SARI admissions were reported.

Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2025) (compared with 2011-2024)



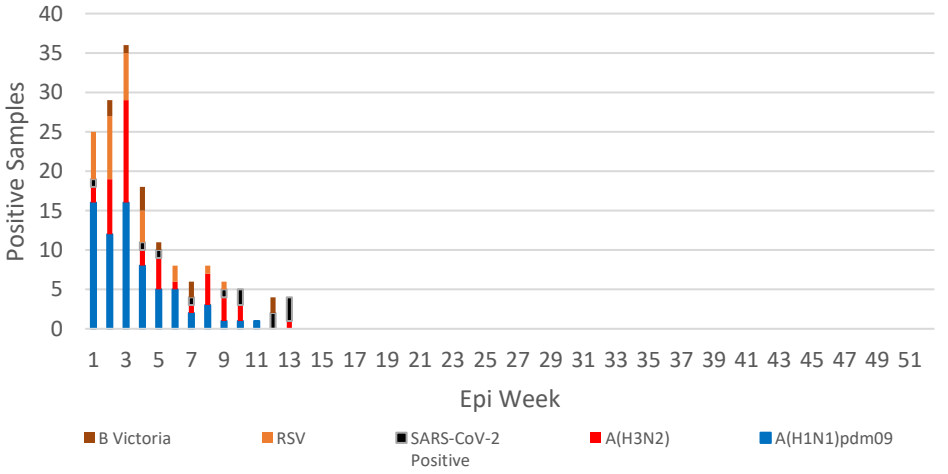
Caribbean Update EW 13

Caribbean: Influenza activity remains high for ILI and decreasing for SARI. The predominant influenza subtype reported was A(H1N1)pdm09. RSV cases remain low. SARS-CoV-2 shows and increae in detection for ILI cases

By country: In the last 4 epidemiological weeks (EWs), influenza activity has increased in Cuba, Suriname, Barbados, Guyana and Saint Vincent and the Grenadines, while it has decreased in Belize, the Dominican Republic, Jamaica and Saint Lucia. An increase in RSV activity was observed in Belize, Suriname and Guyana, as well as an increase in SARS-CoV-2 detection in the Dominican Republic and Guyana.

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

Distribution of Influenza and Other Respiratory Viruses Under Surveillance by EW, Jamaica - 2025



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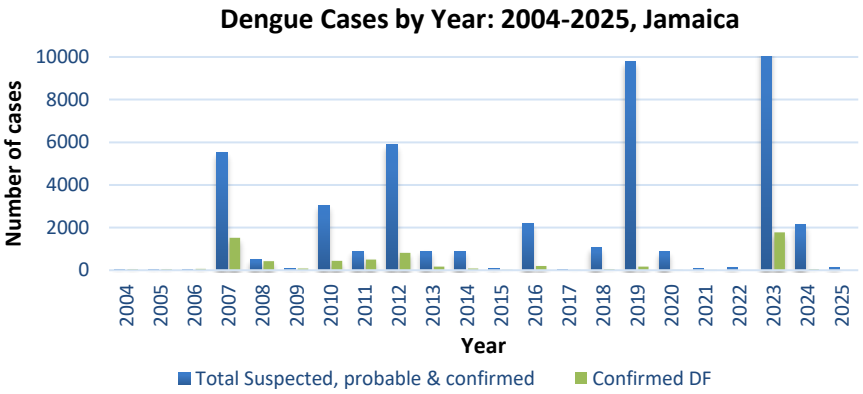
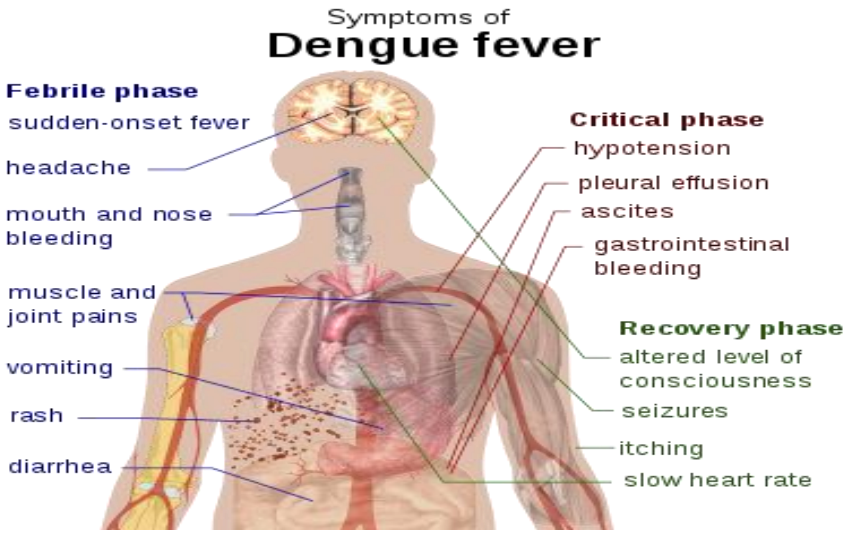
Dengue Bulletin

March 23, 2024 – March 29, 2025 Epidemiological Week 13 | Epidemiological Week 12



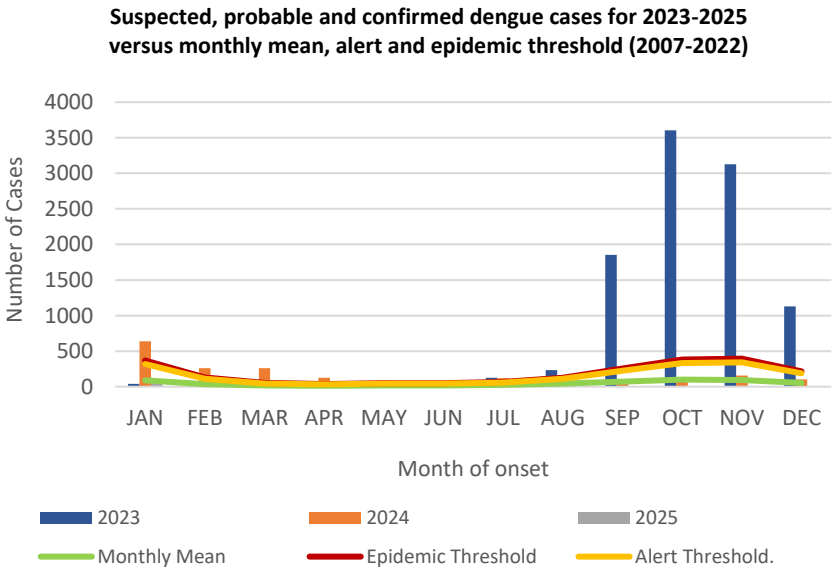
Reported suspected, probable and confirmed dengue with symptom onset in week 13 of 2025

	2025*	
	EW 13	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	121
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, April 11, 2025**
- **Only PCR positive dengue cases are reported as confirmed.**
- **IgM positive cases are classified as presumed dengue.**



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RESEARCH PAPER

Abstract

NHRC-23-O10

Fruit and vegetable intake among Jamaican school-aged children

Gray Brown A[1], Findlay L[1], Soares-Wynter S.[1]

[1]*Caribbean Institute for Health Research, The University of the West Indies, Kingston, Jamaica.*

Objective: To describe the weekday fruit and vegetable intakes of Jamaican school-aged children.

Methods: A cross-sectional survey of children (n=729), aged 7-11 years, from 30 primary schools in Kingston and St. Andrew was conducted in 2019. Fruit and vegetable intakes were reported using a modified 24-hour recall administered by trained nutrition personnel with the aid of food models. Intake estimates were converted to grams and compared to World Health Organization (WHO) requirements. Data were presented as means and frequencies where appropriate.

Results: Fruits and vegetables were consumed by 35% (262) and 52% (377) of children, respectively. Among the consumers, fruits eaten were obtained mostly from home (174, 66%), street vendors (50, 19%), school (45, 17%), or other locations (27, 10%). Vegetables were also obtained from home (229, 61%), school (197, 52%) or other locations (15, 4%). The most frequently reported items were ripe bananas, otaheite apples, and oranges; and cabbage, lettuce, and mixed vegetables (green peas, carrot, corn). Most fruits were consumed at breakfast meals (111, 42%) or as snacks throughout the day (117, 45%). In contrast, vegetables were consumed mostly for lunch (209, 55%) and dinner (203, 54%) meals. The mean amounts consumed were 38.4±63.4g fruits and 76.3±140.8g vegetables, and only 9% of children met their age-specific WHO fruit and vegetable requirement.

Conclusion: Many Jamaican school children report eating fruits and vegetables but intakes are inadequate. A comprehensive school nutrition policy provides a unique opportunity to incorporate fruits and vegetables in school meal programmes.

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