WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Pneumonia in children

Overview

Pneumonia is a form of acute respiratory infection that affects the lungs. The lungs are made up of small sacs called alveoli, which fill with air when a healthy person breathes. When an individual has pneumonia, the alveoli are filled with pus and fluid, which makes breathing painful and limits oxygen intake.

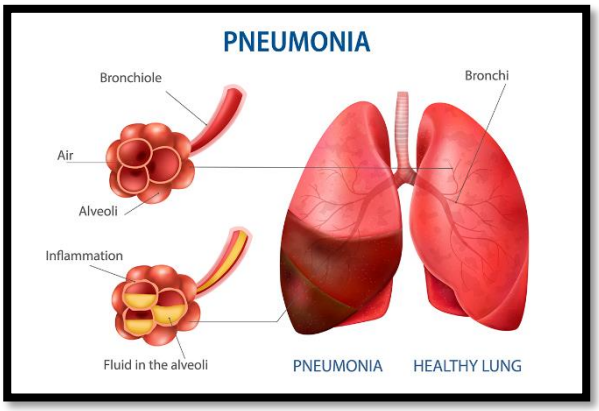
Pneumonia is the single largest infectious cause of death in children worldwide. Pneumonia killed 740 180 children under the age of 5 in 2019, accounting for 14% of all deaths of children under 5 years old but 22% of all deaths in children aged 1 to 5 years. Pneumonia affects children and families everywhere, but deaths are highest in southern Asia and sub-Saharan Africa. Children can be protected from pneumonia, it can be prevented with simple interventions, and it can be treated with low-cost, low-tech medication and care.

Causes

Pneumonia is caused by several infectious agents, including viruses, bacteria and fungi. The most common are the following.

- *Streptococcus pneumoniae* is the most common cause of bacterial pneumonia in children.
- *Haemophilus influenzae* type b (Hib) is the second most common cause of bacterial pneumonia.
- Respiratory syncytial virus is the most common viral cause of pneumonia.
- In infants infected with HIV, *Pneumocystis jiroveci* is one of the most common causes of pneumonia, responsible for at least one quarter of all pneumonia deaths in HIV-infected infants.

Transmission



Pneumonia can be spread in several ways. The viruses and bacteria that are commonly found in a child's nose or throat can infect the lungs if they are inhaled. They may also spread via air-borne droplets from a cough or sneeze. In addition, pneumonia may spread through blood, especially during and shortly after birth. More research needs to be done on the different pathogens causing pneumonia and the ways they are transmitted, as this is of critical importance for treatment and prevention.

Presenting features

The presenting features of viral and bacterial pneumonia are similar. However, the symptoms of viral pneumonia may be more numerous than the symptoms of bacterial pneumonia. In children under 5 years of age who have cough and/or difficult breathing, with or without fever, pneumonia is diagnosed by the presence of either fast breathing or lower chest wall indrawing where their chest moves in or retracts during inhalation (in a healthy person, the chest expands during inhalation). Wheezing is more common in viral infections.

Very severely ill infants may be unable to feed or drink and may also experience unconsciousness, hypothermia and convulsions.

Article: https://www.who.int/news-room/fact-sheets/detail/pneumonia
Image :https://ssbhealthcare.com/blog/how-to-win-against-pneumonia/

EPI WEEK 28



Syndromic Surveillance

Accidents

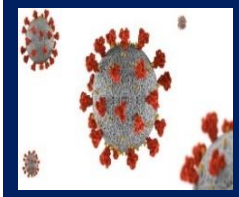
Violence

Pages 2-4



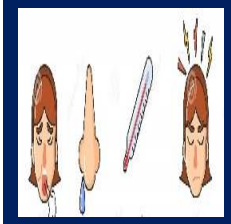
Class 1 Notifiable Events

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COVID-19 Surveillance

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Influenza Surveillance

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Dengue Surveillance

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Research Abstract

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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.

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

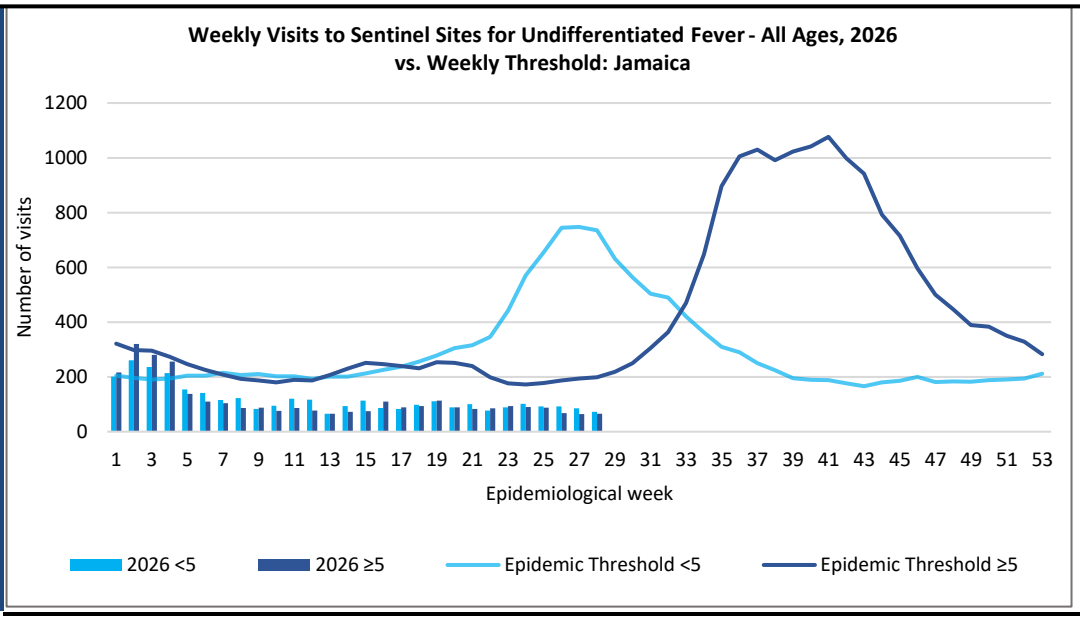
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
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
26	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
27	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
28	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.



2 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

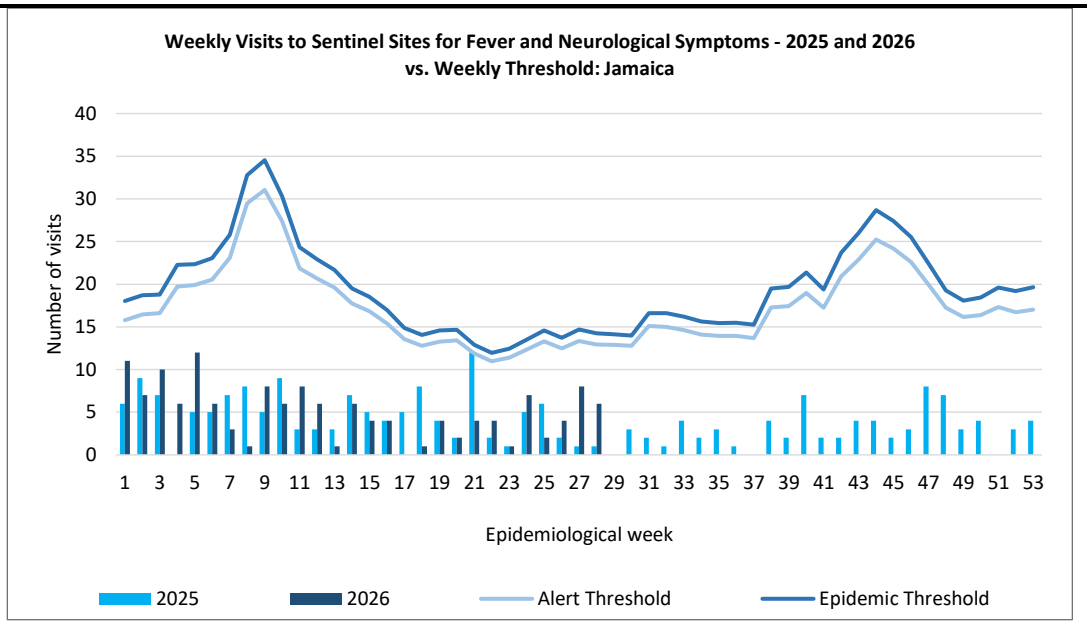
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

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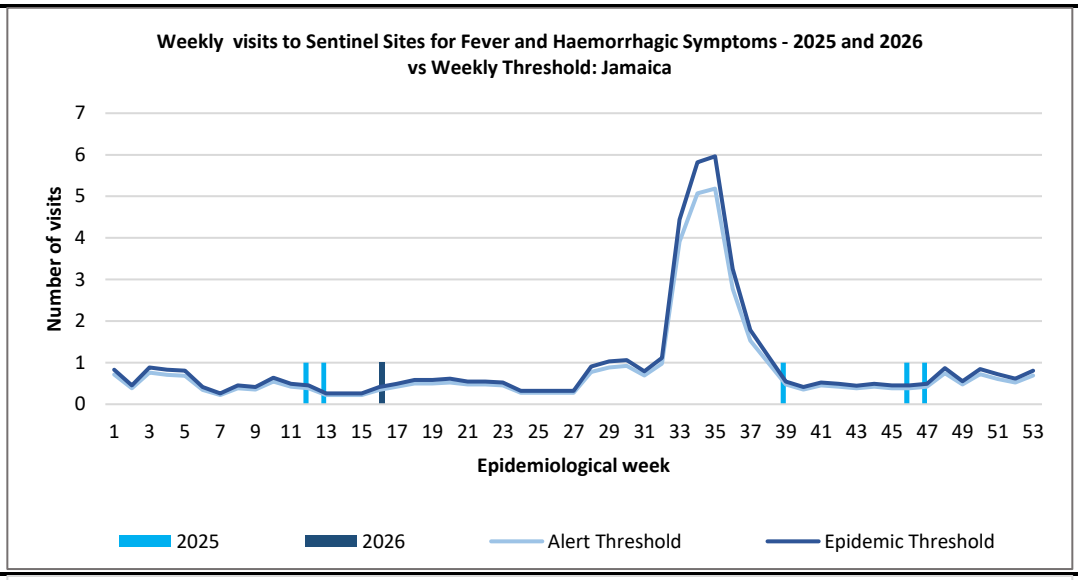
FEVER AND NEUROLOGICAL

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

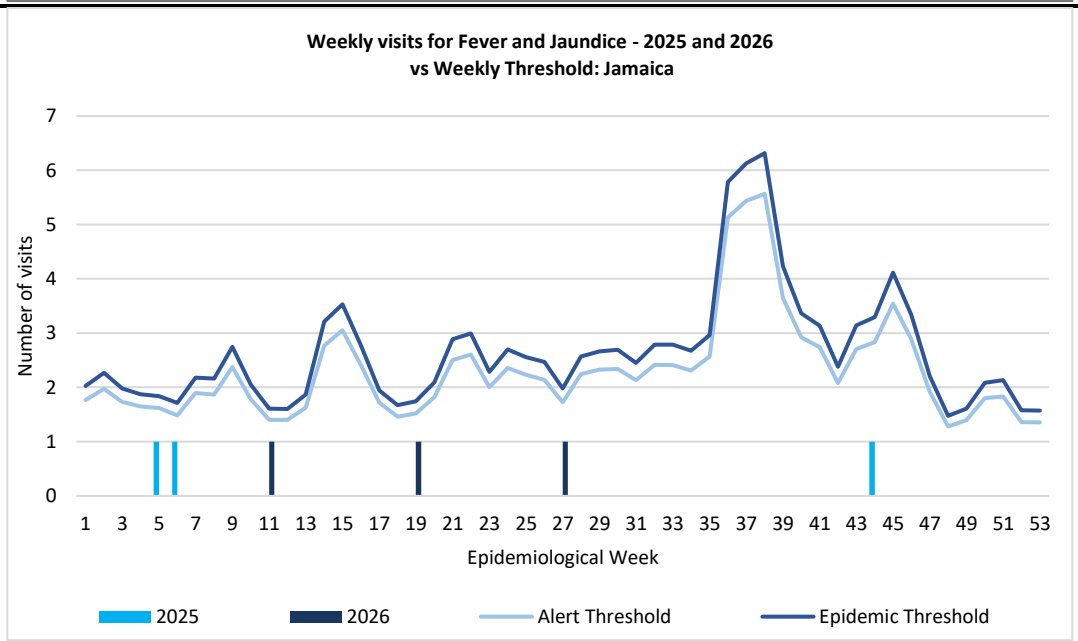
Temperature of >38^0*C* /100.4^0*F* (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



FEVER AND JAUNDICE

Temperature of >38^0*C* /100.4^0*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.



3 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

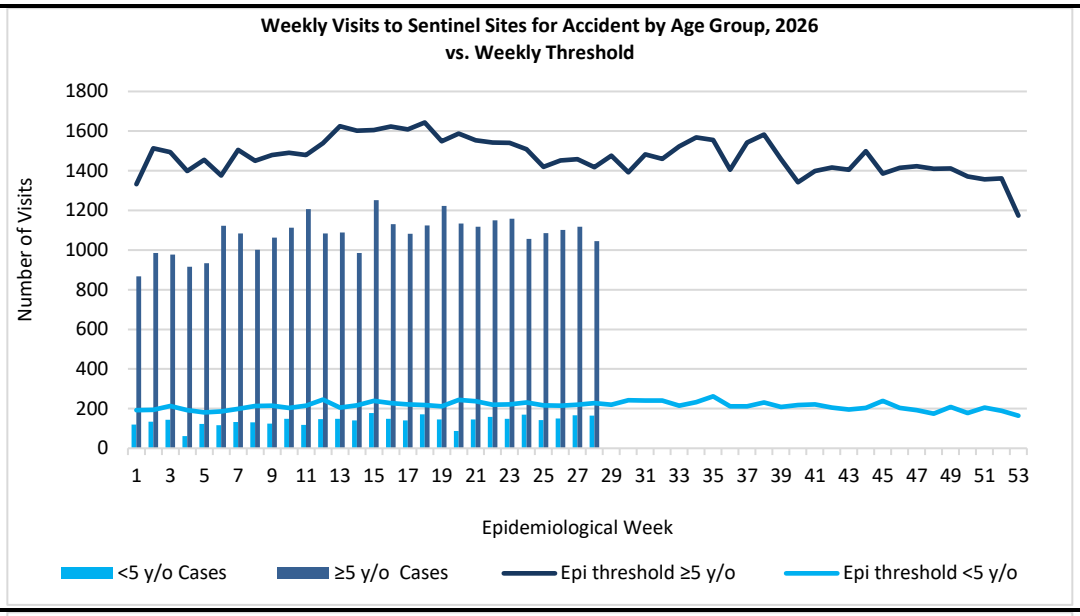
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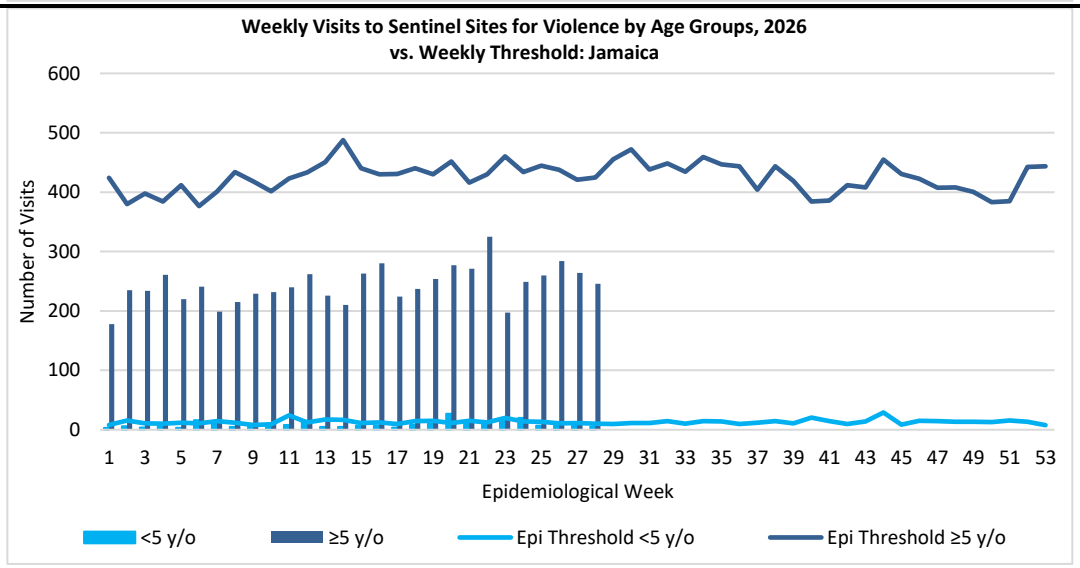
ACCIDENTS

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



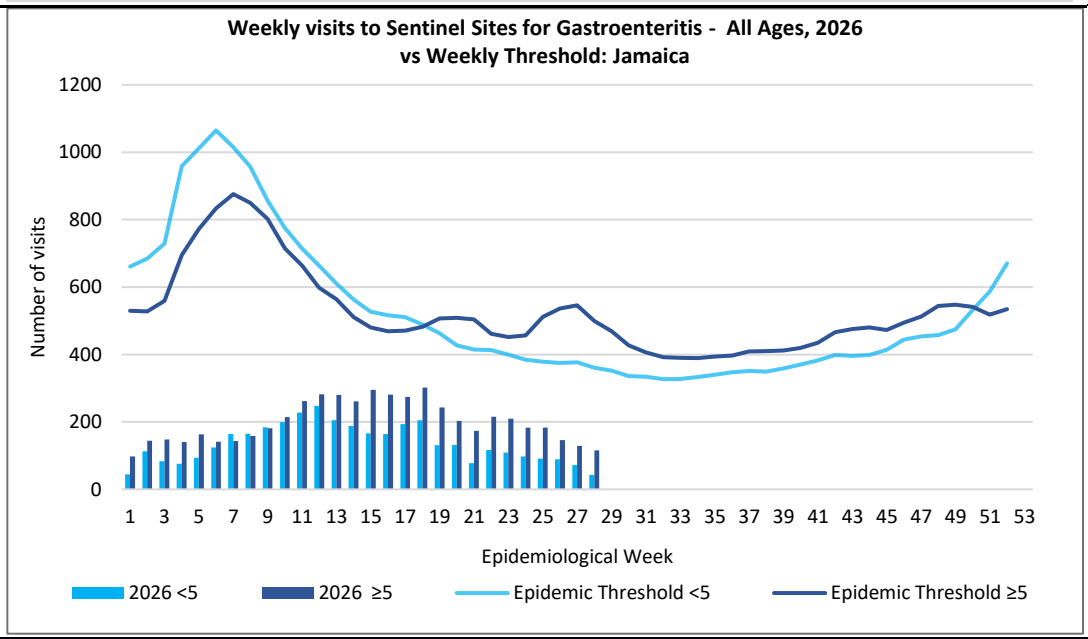
VIOLENCE

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.



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

	CLASS 1 EVENTS		Confirmed YTD[α] CURRENT YEAR 2026	PREVIOUS YEAR 2025
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		45[β]	116[β]
	Cholera		0	0
	Severe Dengue[γ]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		24	249
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		7	8
	Hepatitis C		0	2
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis		3	11
	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
		Rubella	0	0
	Maternal Deaths (notified pregnanacy related deaths)[δ]		29	33
	Ophthalmia Neonatorum		22	49
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		1	1
	Tuberculosis		45	43
	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.

[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

NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

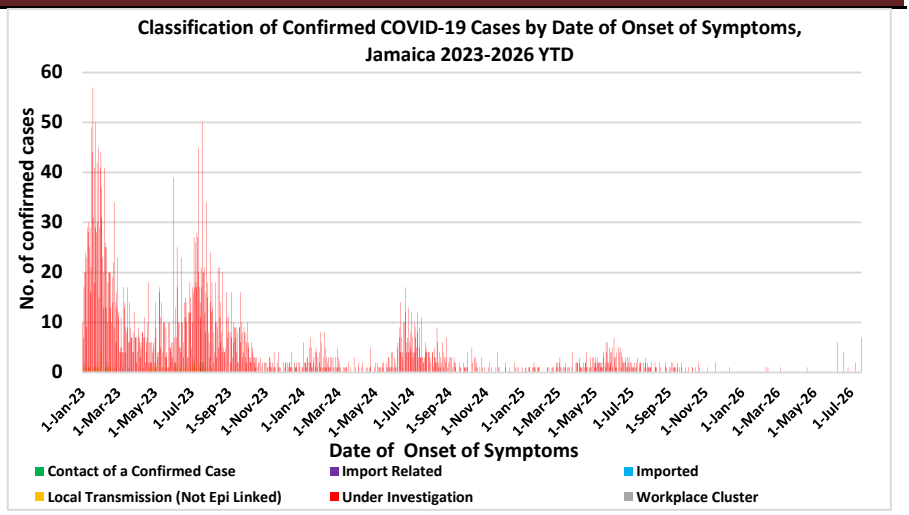
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COVID-19 SURVEILLANCE

CASES	EW 28	Total
Confirmed	7	157,774
Females	4	90,894
Males	3	66,877
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.

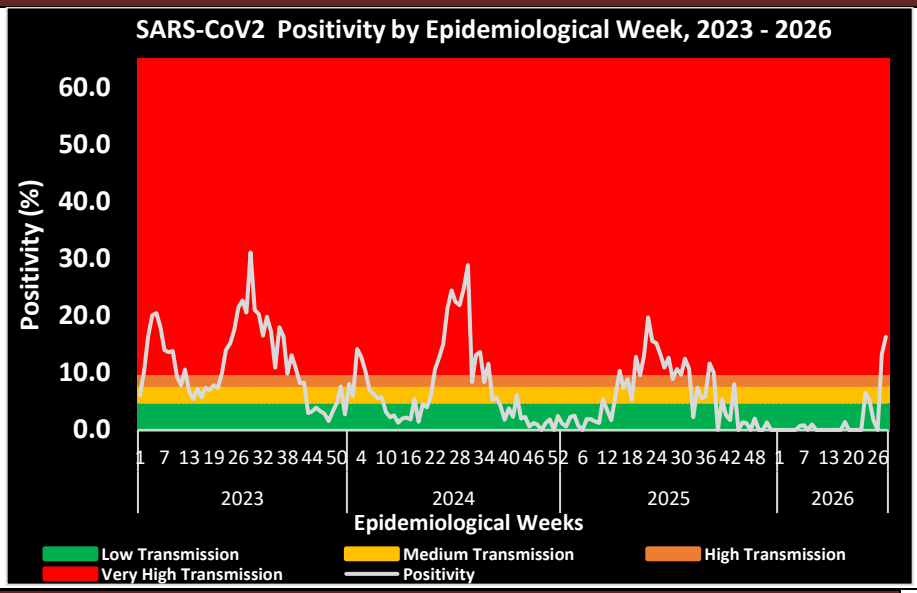


COVID-19 Outcomes

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

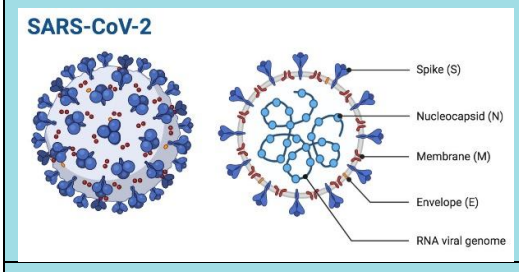
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	24	157,774
Deaths	621	116	24	13	0	3,921

- **Current positivity rate: 16.3%**
- **Positivity = (positive samples/total samples tested)**
- **High transmission for infection**



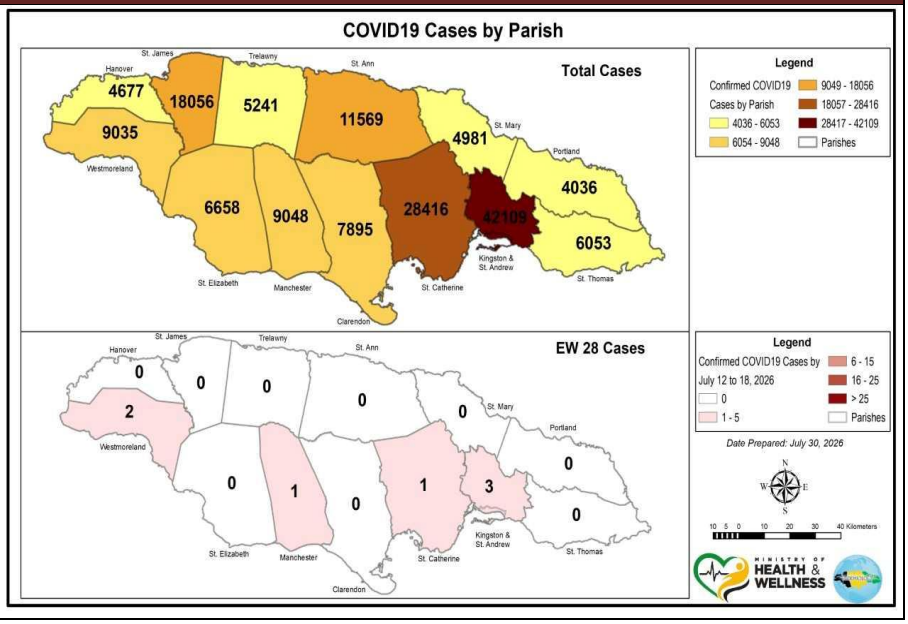
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics Epi Week 25-28, 2026

Epi Week	Confirmed Cases	Deaths
25	4,100	49
26	4,900	33
27	5,700	42
28	7,300	38
Total (4weeks)	22,000	162



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

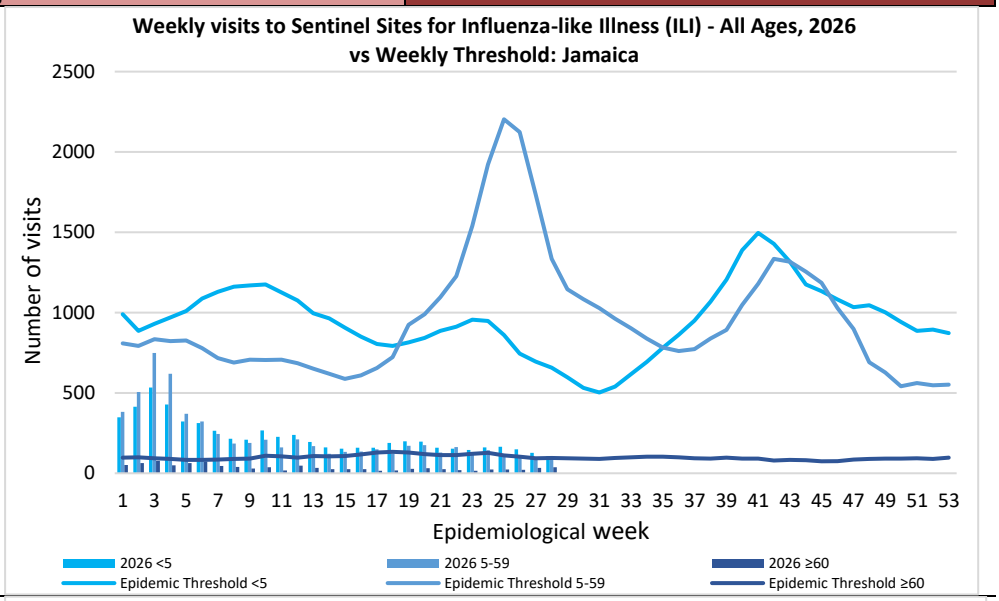
July 31, 2026 ISSN 0799-3927

INFLUENZA SURVEILLANCE

EW 28

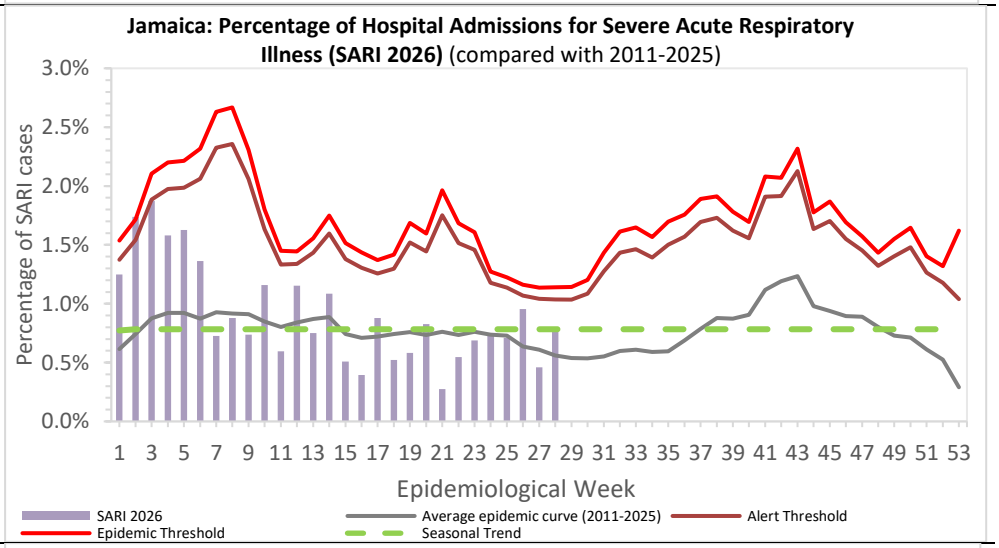
July 12, 2026 – July 18, 2026 Epidemiological Week 28

	EW 28	*YTD*
SARI cases	8	394
Total Influenza positive Samples	**0**	**268**
Influenza A	**0**	**234**
H1N1pdm09	0	21
H3N2	0	213
Not subtyped	0	0
Influenza B	**0**	**34**
B lineage not determined	0	1
B Victoria	0	33
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	53



Epi Week Summary

During Epi Week 28, eight (8) SARI admissions were reported.

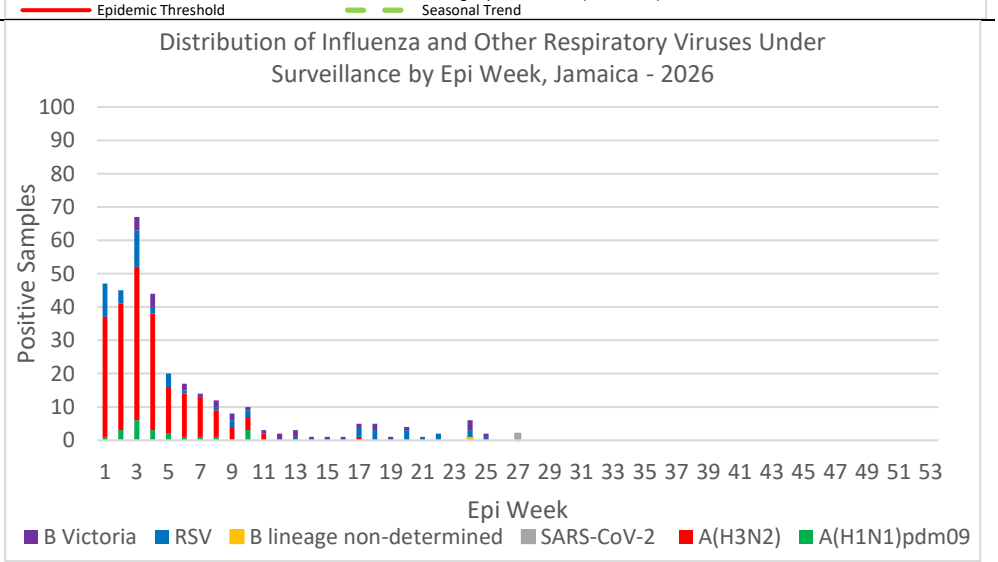


Caribbean Update Epi Week 28

Influenza activity shows a slight upward trend, with a regional positivity rate of 5.2% in EW26, with influenza B Victoria predominating (38.7%) and A(H3N2) co-circulating (24%). SARI indicators remain at low levels, while ILl have increased in recent weeks. RSV circulation remains low, while SARS-CoV-2 levels remain high, though trending downward, with a positivity rate of 10.1% for EW26.

*Update as of Epi Week 26

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



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HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

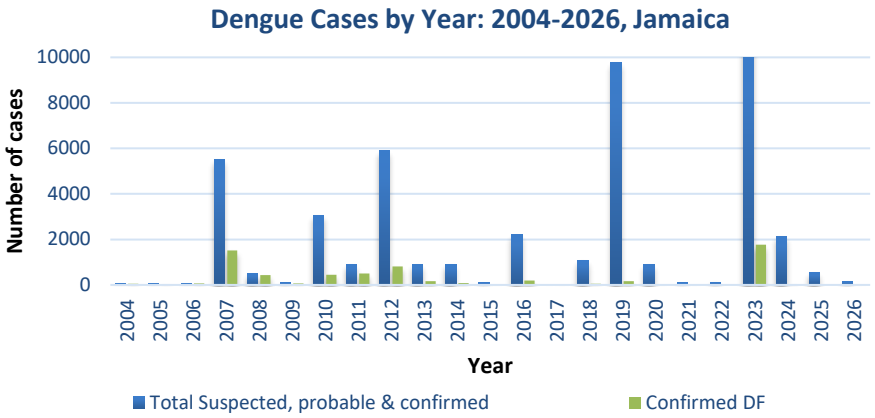
SENTINEL REPORT- 78 sites. Automatic reporting

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DENGUE SURVEILLANCE

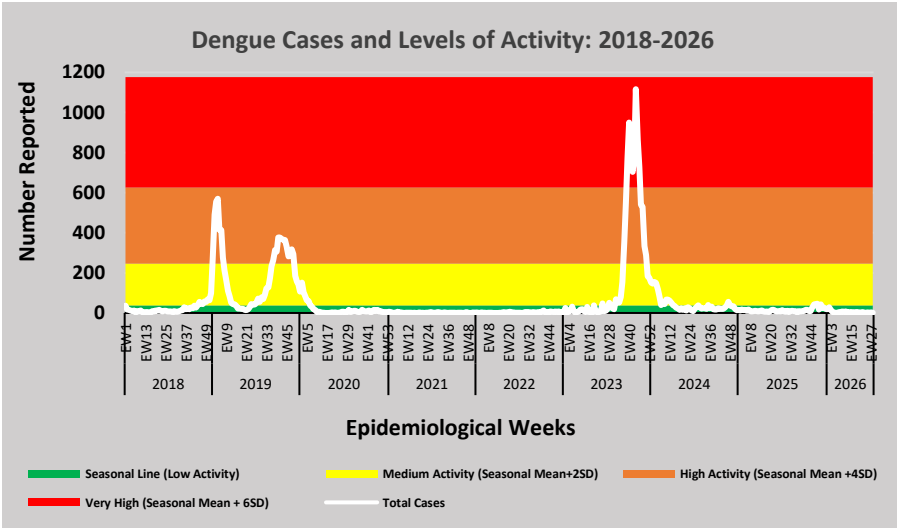
July 12, 2026 – July 18, 2026 Epidemiological Week 28 | Epidemiological Week 28





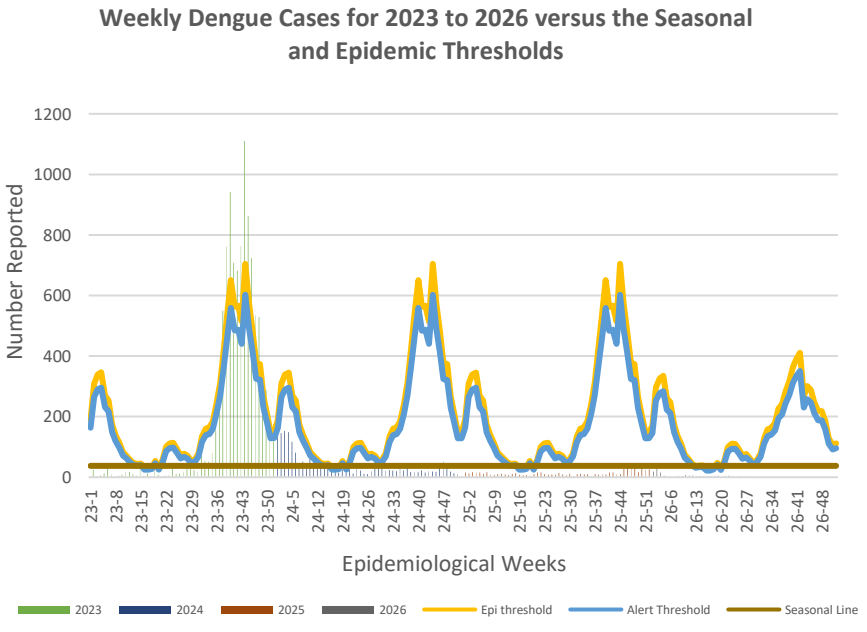
Reported suspected, probable and confirmed dengue with symptom onset in week 28 of 2026

	2026*	
	Epi Week 28	YTD
Total Suspected, Probable & Confirmed Dengue Cases	2	145
Lab Confirmed Dengue cases	0	1
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- **Dengue deaths are reported based on date of death.**
- **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

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SENTINEL REPORT- 78 sites. Automatic reporting

RESEARCH ABSTRACT

Abstract

NHRC-25-O

Menstrual Health Crisis among Women with Sickle Cell Disease: Investigating the Associations between Menstrual Abnormalities and the Risk of Depression and Anxiety

Ramsay, Z[1], Chin, N[1], Sharma, D[2,3], Wisdom-Phipps, M[1], Campbell, L[4], Knight-Madden, J[1], Asnani, M[1]

[1]Caribbean Institute for Health Research – Sickle Cell Unit, The University of the West Indies Mona Campus, Kingston 7, Jamaica; [2]Division of Transfusion Medicine, Department of Pathology, Microbiology and Immunology, Vanderbilt University Medical Center, Nashville, TN, USA; [3]Division of Hematology-Oncology, Department of Medicine, Vanderbilt University Medical Center, Nashville, TN, USA; [4]Department of Obstetrics and Gynecology, Faculty of Medical Sciences, The University of the West Indies Mona Campus, Kingston 7, Jamaica

Aims/Objectives: Women with sickle cell disease (SCD) often experience higher prevalence of depression and anxiety than men with SCD and healthy women; and frequently report abnormal menses. This study investigated if heavy menstrual bleeding (HMB) and dysmenorrhea are associated with increased risk of major depression and generalized anxiety disorder (GAD) among these women.

Methods: This study recruited women with SCD aged 18 years and older with regular menses and without acute illness, pregnancy, oophorectomy, or recent hormonal contraceptive use. Prospective follicular and luteal phase study visits were conducted to identify participants at risk of major depression and GAD using the Patient Health Questionnaire-9 and Generalized Anxiety Disorder-7, respectively. The Adult Sickle-Cell Quality-of-Life Measurement Information System, Menstrual Bleeding Questionnaire, and Menstrual Symptom Questionnaire measured quality-of-life, HMB, and dysmenorrhea, respectively.

Results: Among 125 women (mean age 29.0±7.6), 56 (44.8%) met criteria for major depression risk and 49 (39.2%) for GAD risk, without significant differences between menstrual phases. Forty women (32%) reported passive suicidal or self-harm ideations. In mixed-effects models, worse dysmenorrhea was associated with higher odds of major depression risk (odds ratio, OR=1.1), while better quality-of-life in pain (OR=0.9) and sleep (OR=0.8) domains were associated with lower odds. Severe genotypes (OR=0.1) and better quality-of-life in stiffness (OR=0.9) and sleep (OR=0.9) were associated with lower odds of GAD risk.

Conclusion: Women with SCD and severe dysmenorrhea are at significant risk of major depression. Routine screening and multidisciplinary treatment may improve outcomes in this vulnerable population.

Keywords: menstrual health, depression, anxiety, dysmenorrhea, sickle cell disease

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