WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

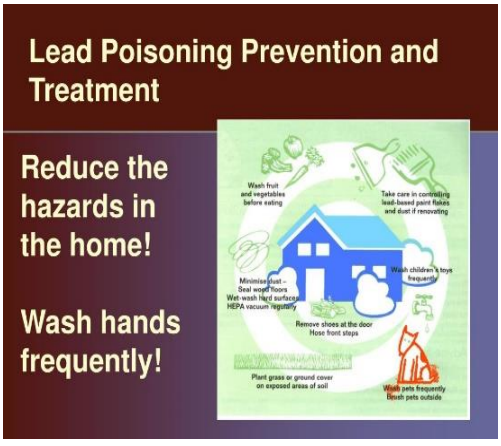
Lead poisoning



Overview: Lead is a naturally occurring toxic metal found in the Earth's crust. Its widespread use has caused extensive environmental contamination, human exposure and significant public health problems globally.

Important sources of environmental contamination include mining, smelting, manufacturing and recycling activities, and lead use in a range of products. Most global lead consumption is for the manufacture of lead-acid batteries for motor vehicles. Lead is used in many products, including pigments, paints, solder, stained glass, lead crystal glassware, ammunition, ceramic glazes, jewellery, toys, some traditional cosmetics, and some traditional medicines. Lead can contaminate drinking water through plumbing systems containing lead pipes, solders and fittings.

Young children are particularly vulnerable to the toxic effects of lead and can suffer permanent adverse health impacts, particularly on the development of the central nervous system. Lead causes long-term harm in adults, including increased risk of high blood pressure, cardiovascular problems and kidney damage. Lead exposure during pregnancy can cause reduced fetal growth and preterm birth.



Sources and routes of exposure: People are exposed to lead through occupational and environmental sources. This mainly results from:

- inhalation of lead particles generated by burning materials containing lead, for example during smelting, recycling, stripping leaded paint and plastic cables; and
- ingestion of contaminated dust, soil, water or food.

Young children are particularly vulnerable to lead poisoning as they may absorb up to 4–5 times as much lead as adults from an ingested dose. Moreover, children's innate curiosity and their age-appropriate and frequent hand-to-mouth and object-to-mouth behaviours increase their risk of exposure to lead-contaminated dust, soil and paint. Children who engage in pica, the compulsive, habitual consumption of non-food items, are at particularly high risk. Exposure to lead-contaminated soil and dust resulting from battery recycling and mining has caused outbreaks of mass lead poisoning, including deaths in young children, in some countries.

Once lead enters the body, it is distributed to organs including the brain, kidneys, liver and bones. Lead is stored in the teeth and bones, where it accumulates over time. Lead stored in bone may be released into the blood during pregnancy and expose the fetus. Malnourished children are more susceptible to lead as they absorb more lead if other nutrients are deficient, especially calcium or iron.

Article:.https://www.who.int/news-room/fact-sheets/detail/lead-poisoning-and-health
Image 1:.https://cdn.unenvironment.org/cep/2020-11/lead-poison_0.jpg?null
Image 2: https://image.slideserve.com/288568/lead-poisoning-prevention-and-treatment-l.jpg

EPI WEEK 30



Syndromic Surveillance

Accidents

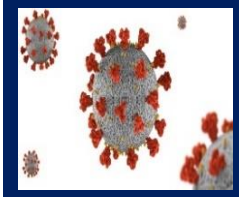
Violence

Pages 2-4



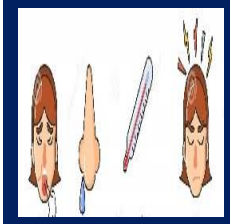
Class 1 Notifiable Events

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COVID-19 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.

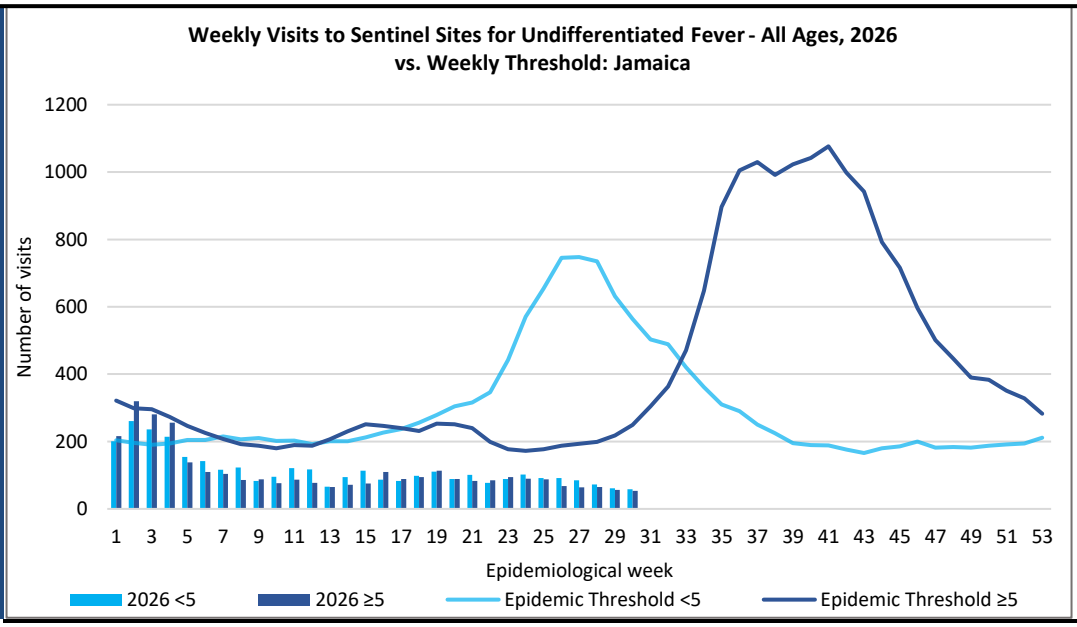
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
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
29	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	Late (T)	On Time	On Time	On Time
30	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

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

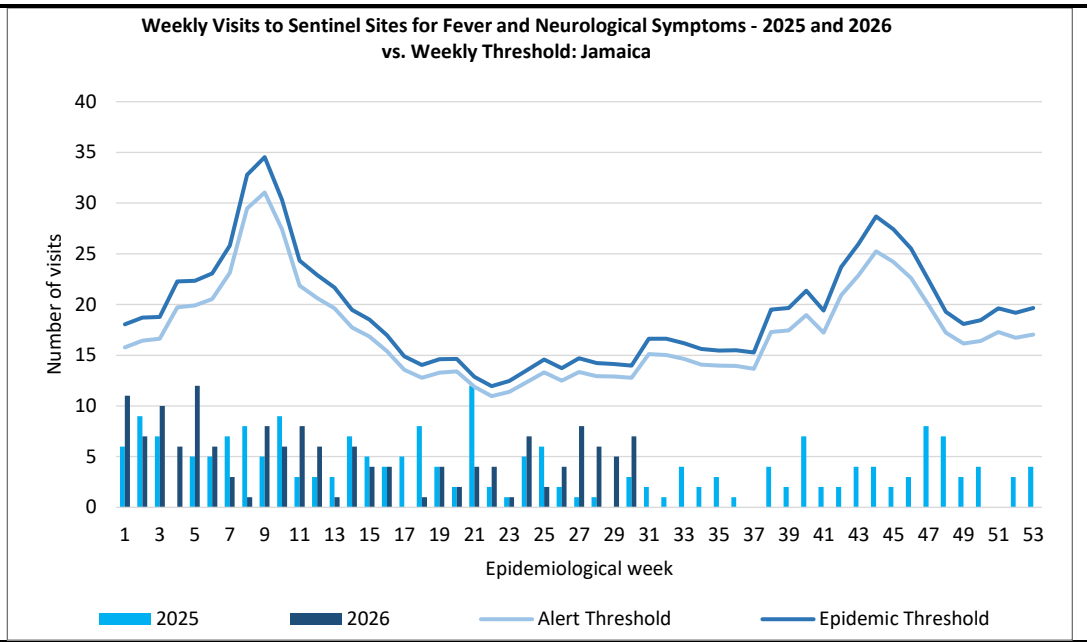
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

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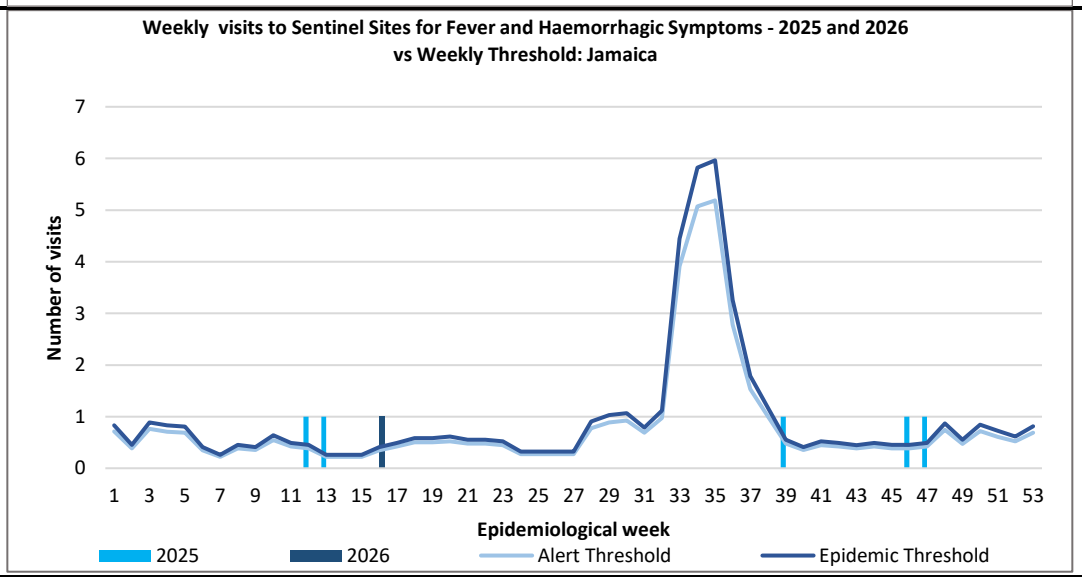
FEVER AND NEUROLOGICAL

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

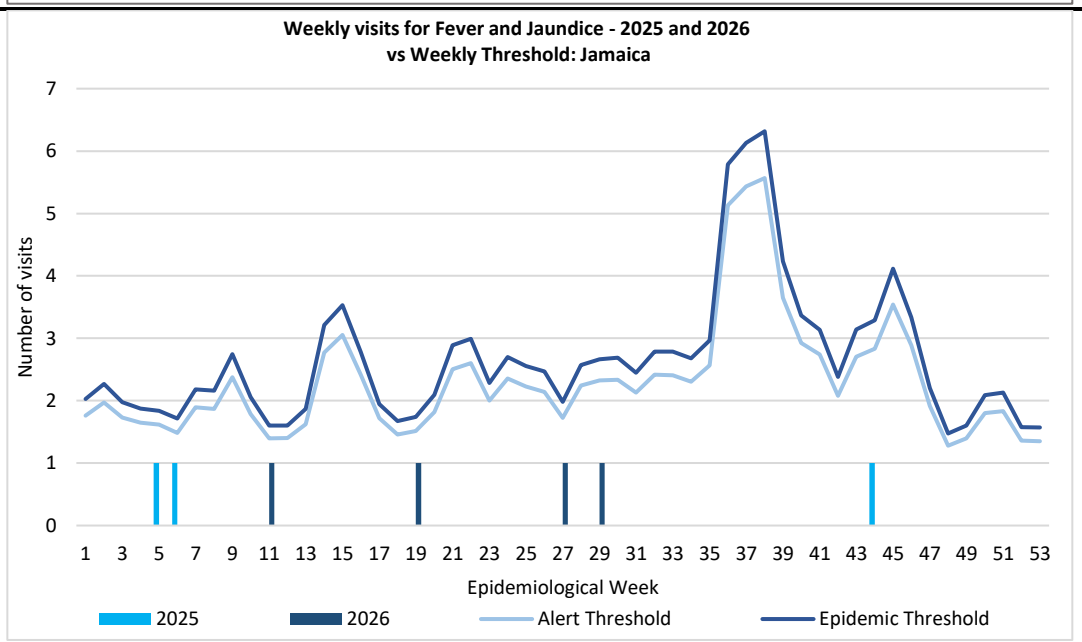
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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.



3 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

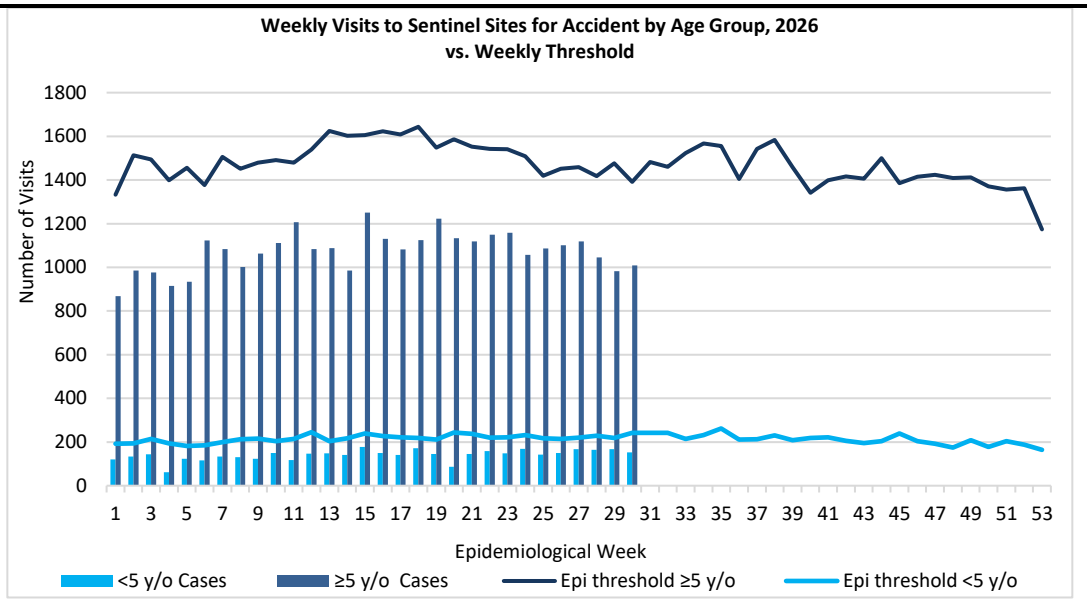
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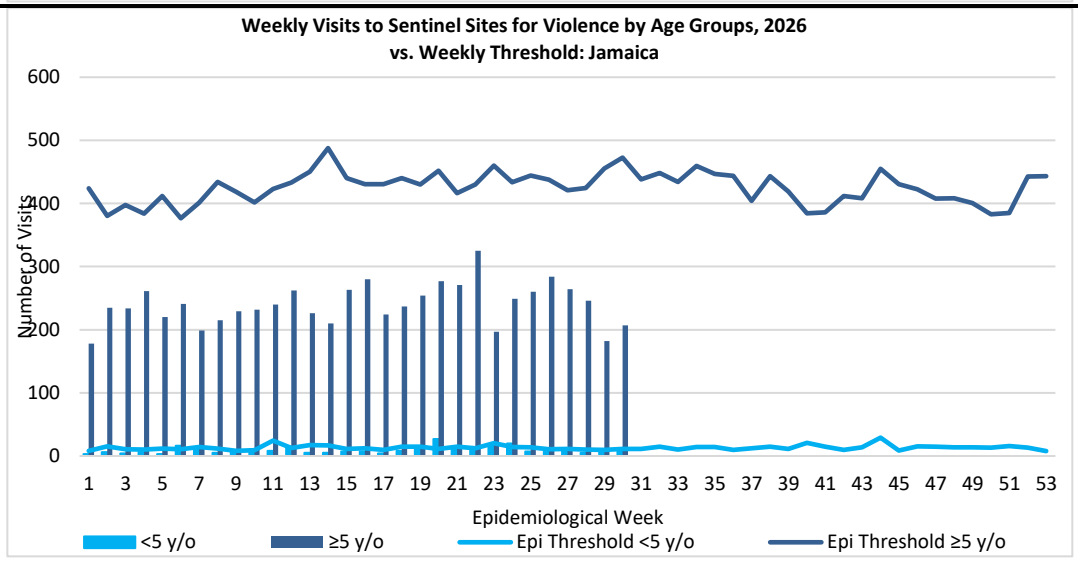
ACCIDENTS

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



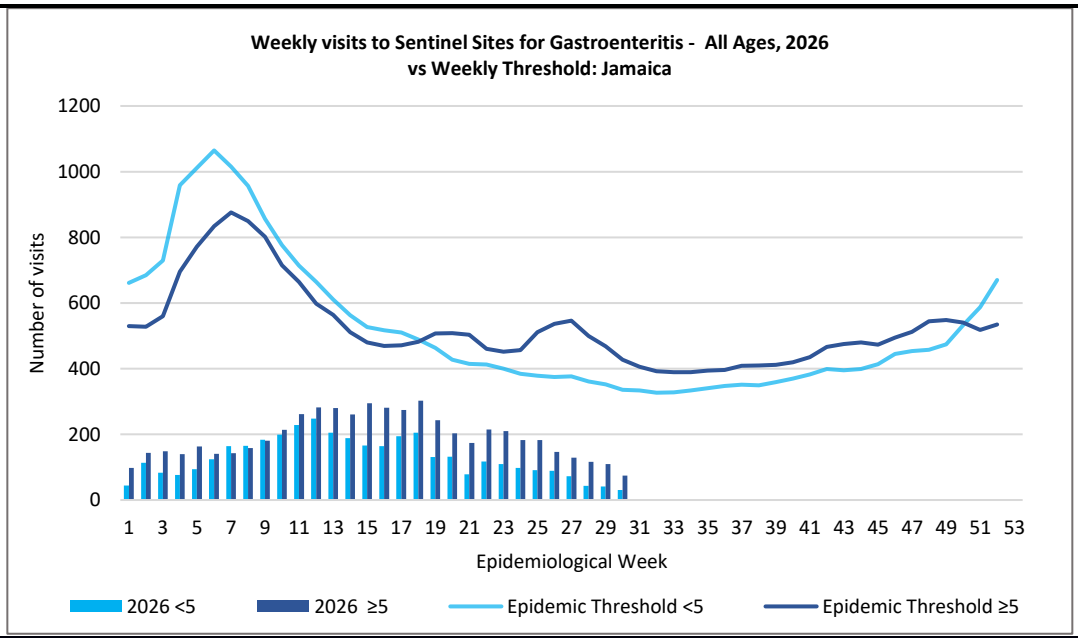
VIOLENCE

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

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CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS		Confirmed YTD[α] CURRENT YEAR 2026	Confirmed YTD[α] PREVIOUS YEAR 2025
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		50[β]	126[β]
	Cholera		0	0
	Severe Dengue[γ]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		26	264
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		7	8
	Hepatitis C		0	2
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis		4	12
	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	35
	Ophthalmia Neonatorum		22	49
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		1	1
	Tuberculosis		43	39
	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

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HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

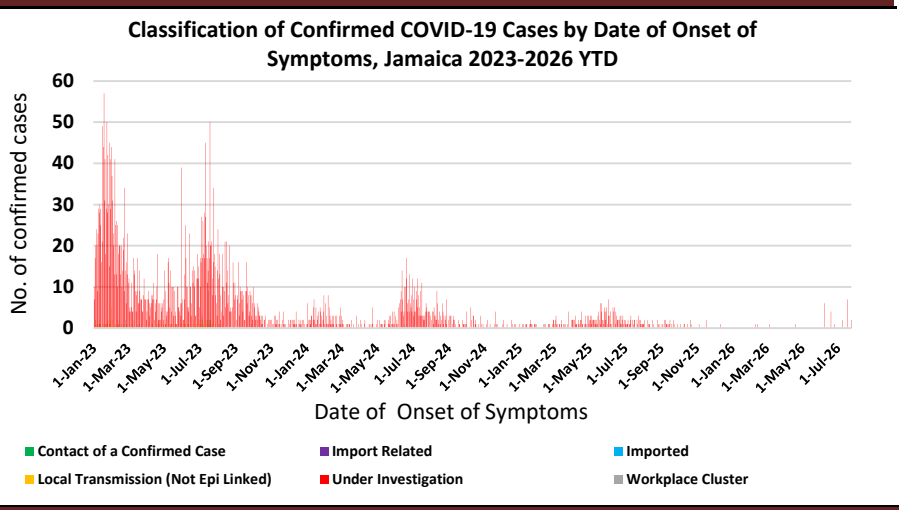
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COVID-19 SURVEILLANCE

CASES	EW 30	Total
Confirmed	0	157,776
Females	0	90,895
Males	0	66,878
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.

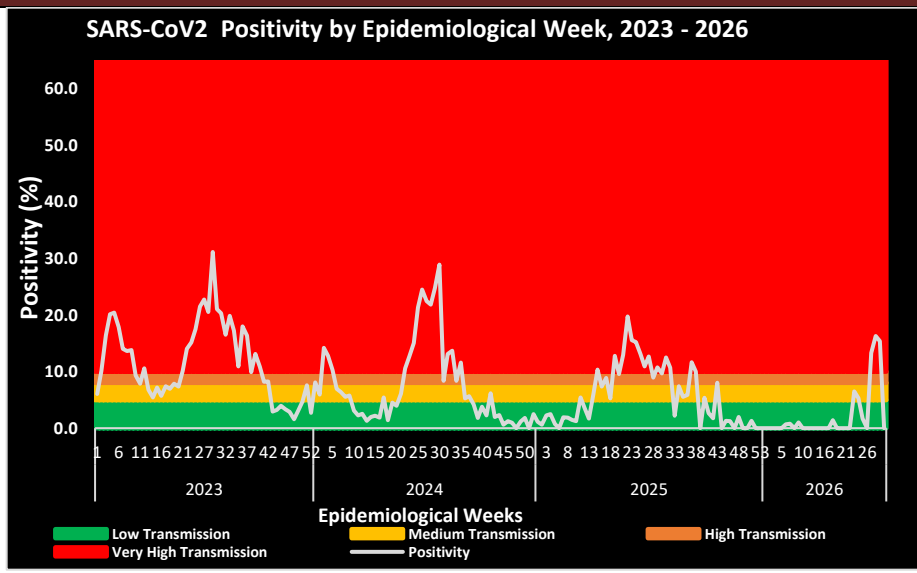


COVID-19 Outcomes

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

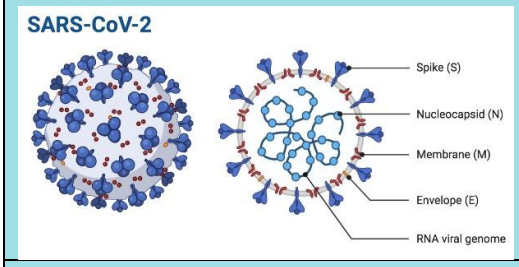
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	26	157,776
Deaths	621	116	24	13	0	3,921

- **Current positivity rate: 0.0%**
- **Positivity = (positive samples/total samples tested)**
- **High transmission for infection**



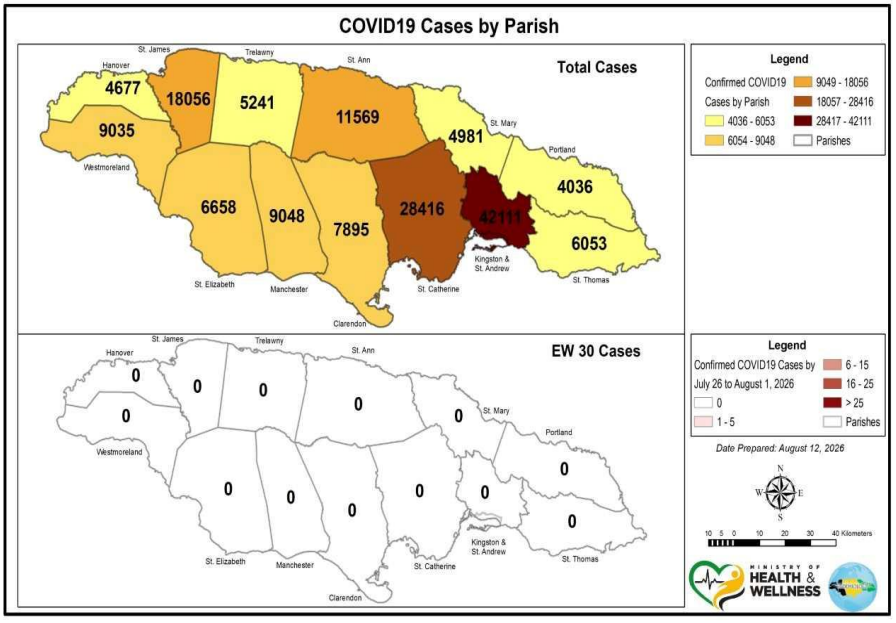
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics Epi Week 27-30, 2026

Epi Week	Confirmed Cases	Deaths
27	6,000	45
28	8,100	47
29	9,400	49
30	10,700	23
Total (4weeks)	34,200	164



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

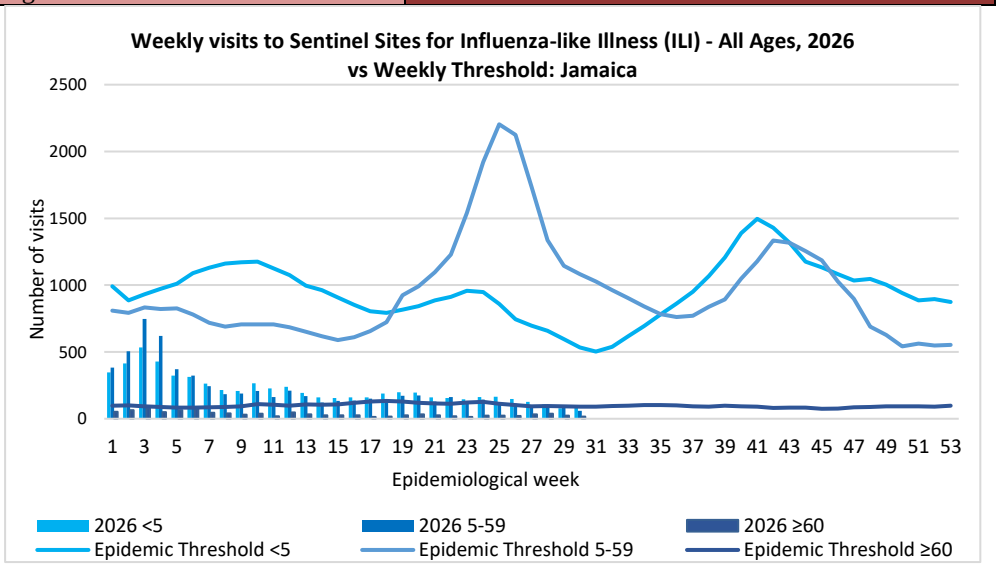
August 14, 2026 ISSN 0799-3927

INFLUENZA SURVEILLANCE

EW 30

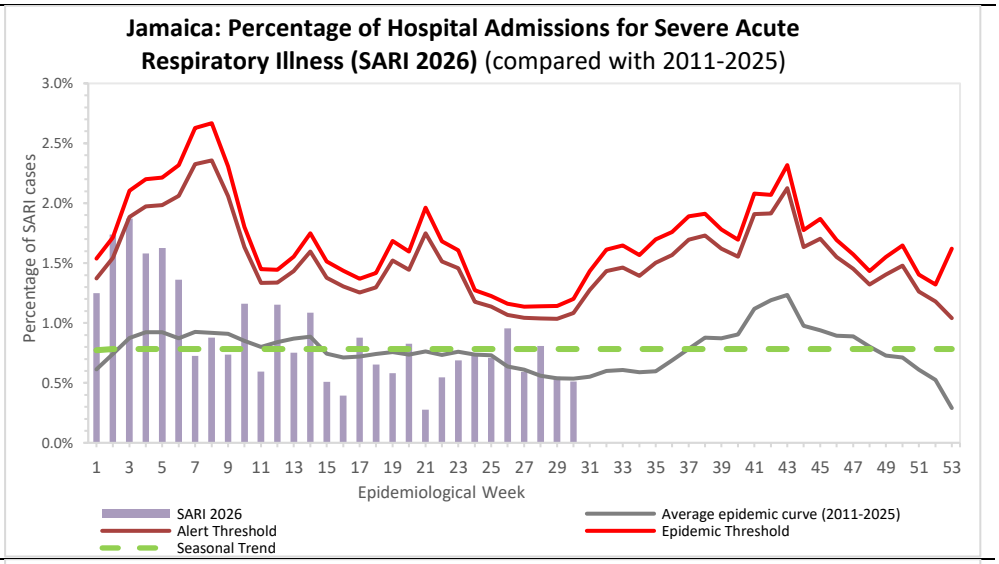
July 26, 2026 – August 01, 2026 Epidemiological Week 30

	EW 30	*YTD*
SARI cases	4	414
Total Influenza positive Samples	**0**	**270**
Influenza A	**0**	**234**
H1N1pdm09	0	21
H3N2	0	213
Not subtyped	0	0
Influenza B	**0**	**36**
B lineage not determined	0	1
B Victoria	0	35
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	53



Epi Week Summary

During Epi Week 30, four (4) SARI admissions were reported.

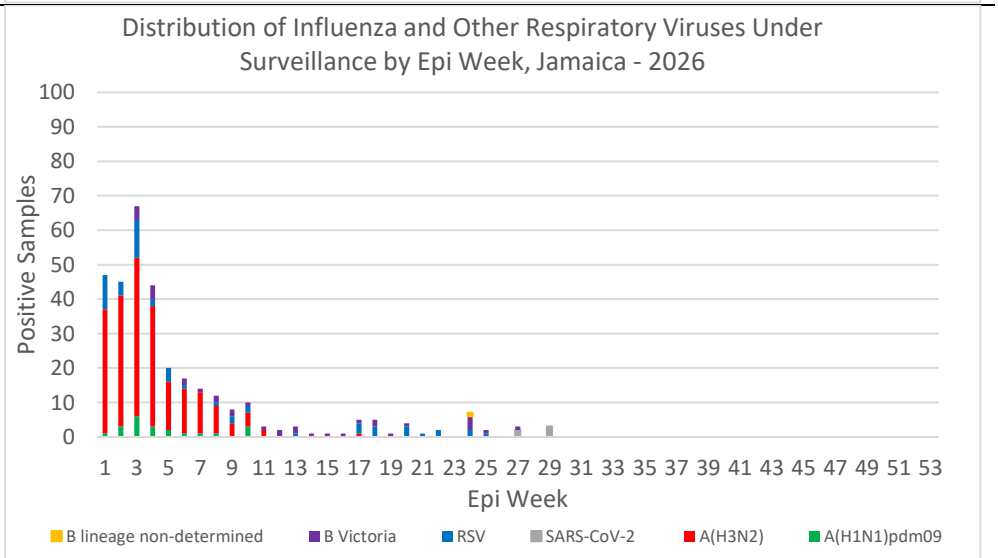


Caribbean Update Epi Week 30

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 ILI 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



7 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

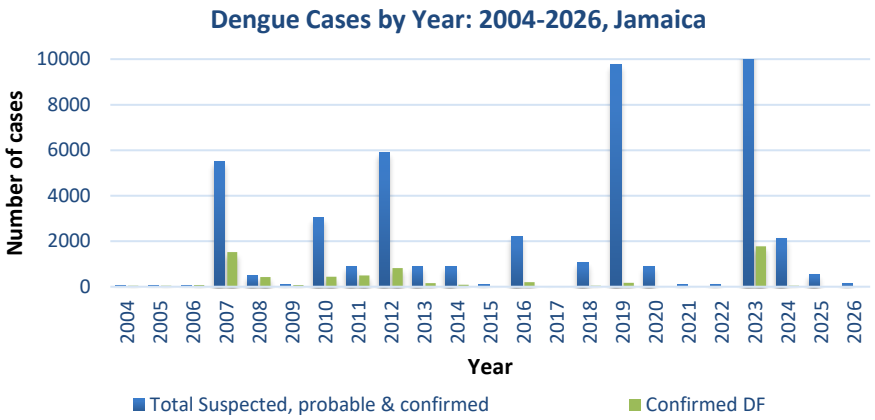
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DENGUE SURVEILLANCE

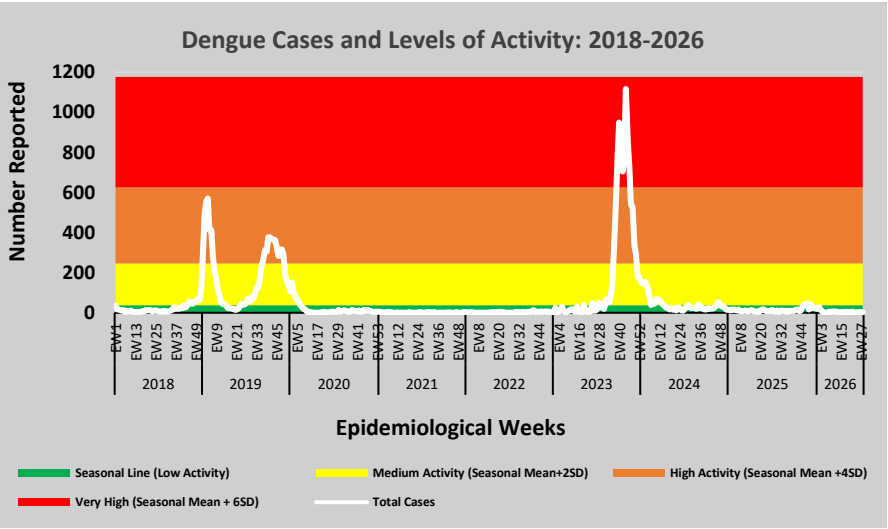
July 16, 2026 – August 01, 2026 Epidemiological Week 30 | Epidemiological Week 30





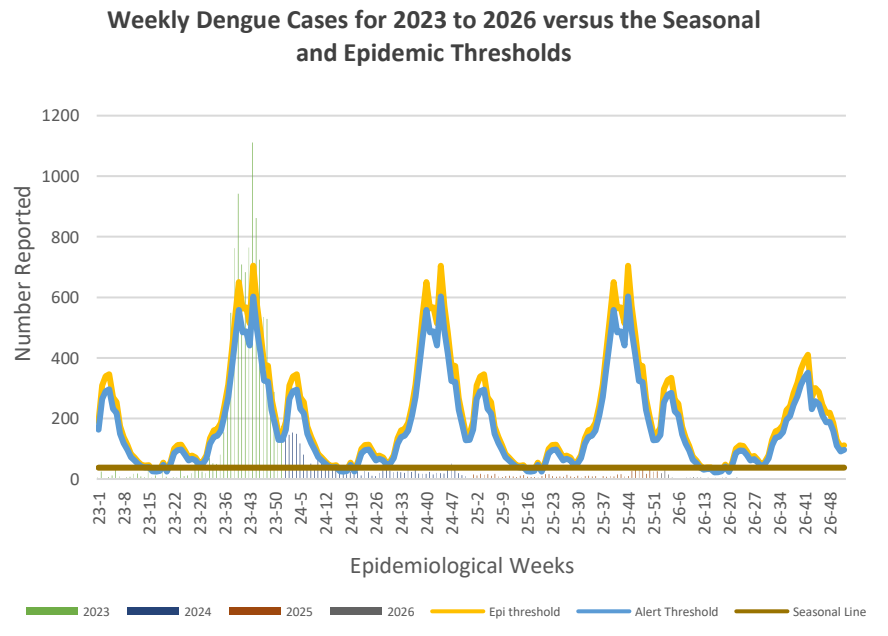
Reported suspected, probable and confirmed dengue with symptom onset in week 30 of 2026

	2026*	
	Epi Week 30	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	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

Impact of Oral Health Status on Oral Health-Related Quality Of Life among Geriatric Population of Mehsana District, Gujarat, India

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[1] *Narsinhbhai Patel Dental College and Hospital, Sankalchand Patel University, Visnagar, Mehsana, Gujrat, India*

Aim/Objectives: India is experiencing a rapid demographic transition, with the proportion of individuals aged 60 years and above increasing markedly. Oral health is integral to overall well-being and quality of life, particularly in the geriatric population. To assess the impact of oral health status on oral health-related quality of life among the geriatric population of Mehsana district, Gujarat.

Method: A descriptive cross-sectional study was conducted among 400 community-dwelling adults aged 60 years and above in Mehsana district. Oral health status was recorded using the WHO 2013 proforma, including assessments of dental caries, periodontal disease, enamel fluorosis, dental erosion, oral mucosal lesions, and prosthetic status. Oral health-related quality of life was measured using the GOHAI questionnaire. Data were analyzed to determine prevalence, treatment needs, and associations between clinical findings and GOHAI scores. The statistical analysis was conducted utilizing SPSS version 20.0, with a significance level established at ≤ 0.05.

Results: The study found a 92.8% prevalence of untreated dental caries and 68.3% prevalence of moderate to severe periodontal disease (pocket depth ≥4 mm). Enamel fluorosis was observed in 47.7% and dental erosion in 22.2% of participants. Over half (51.2%) required prompt treatment and 11.3% needed immediate care. The mean GOHAI score was 21.33 ± 2.95, with lower scores significantly associated with untreated caries ($p < 0.001$) and periodontal bleeding ($p < 0.001$), indicating impaired quality of life.

Conclusion: The high burden of oral diseases and their significant impact on quality of life in the rural geriatric population of Gujarat underscore the need for targeted preventive and curative interventions.

Keywords: Geriatrics, Oral Health, Quality of Life Geriatric, Oral Health Assessment Index