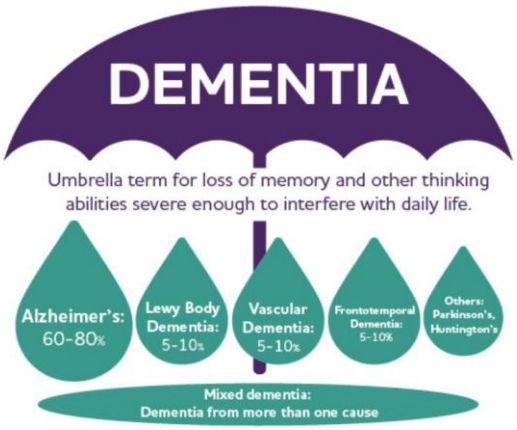
WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Dementia



Overview

Dementia is a condition that affects memory, thinking and the ability to perform daily activities. It can be caused by many different diseases that damage the brain.

Dementia gets worse over time. Although more common after age 65, it is not an inevitable part of ageing.

Things that increase the risk of developing dementia include:

- health conditions such as high blood pressure (hypertension), high blood sugar (diabetes), being overweight or obese, depression, vision and hearing loss, poor sleep, traumatic brain injury and stroke;
- lifestyle factors such as smoking tobacco, harmful alcohol use, physical inactivity, social isolation, and low educational attainment; and
- environmental factors such as air pollution.

Dementia can be caused by several diseases which over time damage the brain, typically leading to deterioration in cognitive function beyond what might be expected from the usual consequences of biological ageing. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by changes in mood, emotional control, behaviour or motivation.

Dementia has physical, psychological, social and economic impacts, not only for people living with dementia, but also for their carers, families and society at large. There is often a lack of awareness and understanding of dementia, resulting in stigmatization and barriers to diagnosis and care.

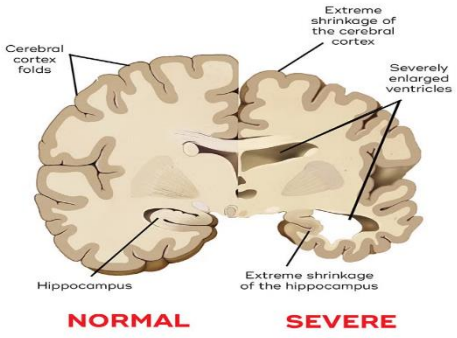
Risk factors and prevention

Although age is the strongest known risk factor for dementia, dementia can also affect younger people, and young-onset dementia – in which symptoms begin before the age of 65 – accounts for up to 9% of cases.

Evidence suggests that people can reduce the risk of cognitive decline and dementia by adopting healthy behaviours and lifestyles, managing health conditions that are known to increase the risk for dementia, and reducing environmental risk factors.

Important actions include:

- being physically active
- not smoking
- avoiding harmful alcohol use
- eating a healthy, balanced diet
- staying socially and cognitively active
- maintaining a healthy weight
- managing blood pressure, cholesterol and blood sugar levels
- using hearing aids where needed
- reducing exposure to air pollution.



Dementia risk accumulates across the life course, and some risk factors may have a greater impact at particular stages of life.

Social factors such as poverty, limited education and unequal access to employment and health care can also influence the risk of dementia. Reducing risk therefore requires not only individual action, but also supportive systems and policies that shape people's everyday lives.

The WHO guidelines on risk reduction of cognitive decline and dementia, second edition, provide comprehensive, practical recommendations to support countries, health systems and communities in integrating dementia risk reduction into policies and programmes.

Article:.https://www.who.int/news-room/fact-sheets/detail/dementia
Image 1:.https://acendahealth.org/blog/how-to-recognize-treat-and-live-with-dementia/
Image 2: https://qbi.uq.edu.au/dementia/dementia-causes-and-treatment

EPI WEEK 32



Syndromic Surveillance

Accidents

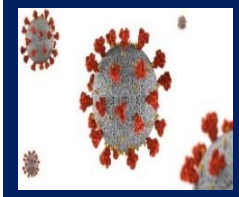
Violence

Pages 2-4



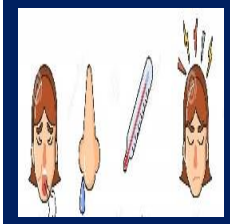
Class 1 Notifiable Events

Page 5



COVID-19 Surveillance

Page 6



Influenza Surveillance

Page 7



Dengue Surveillance

Page 8



Research Abstract

Page 9

ISSN 0799-3927

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.

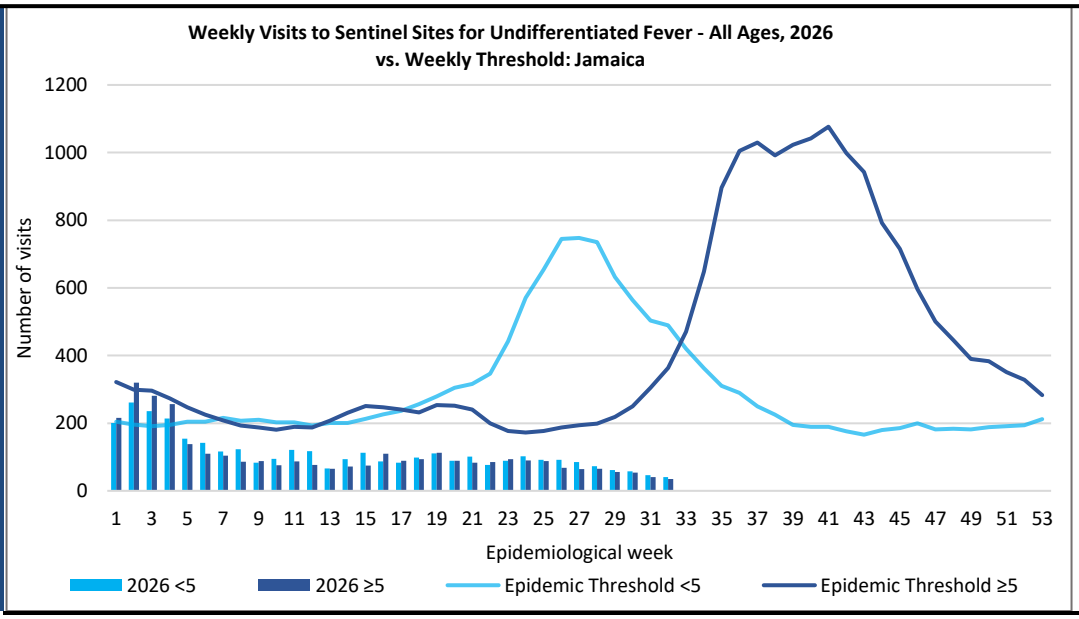
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
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
31	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
32	On Time	On Time	On Time	On Time	On Time	On Time	On Time	Late (W)	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

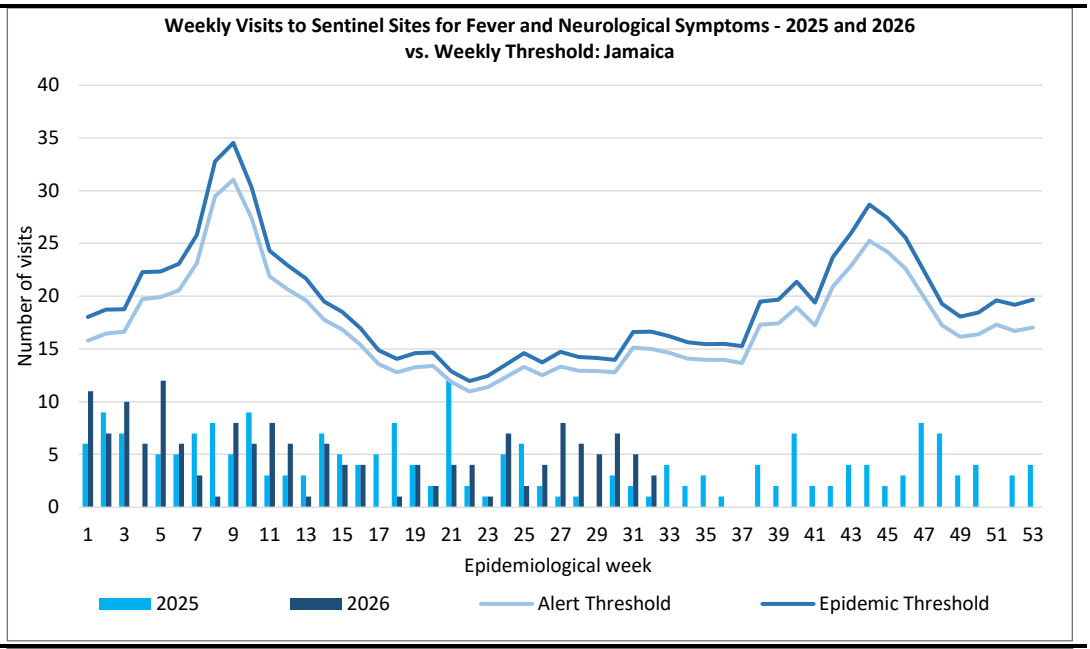
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

ISSN 0799-3927

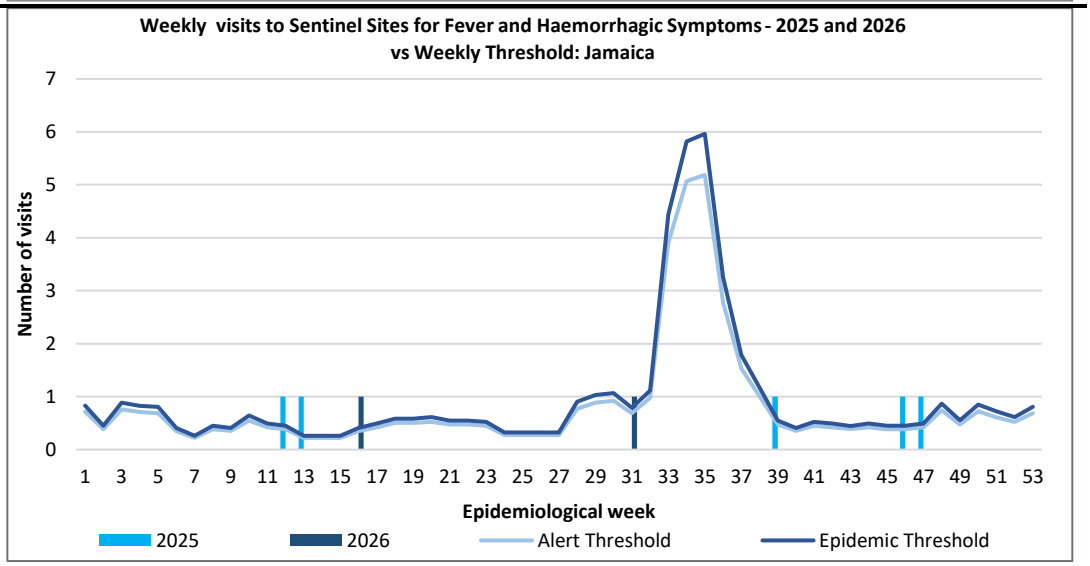
FEVER AND NEUROLOGICAL

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

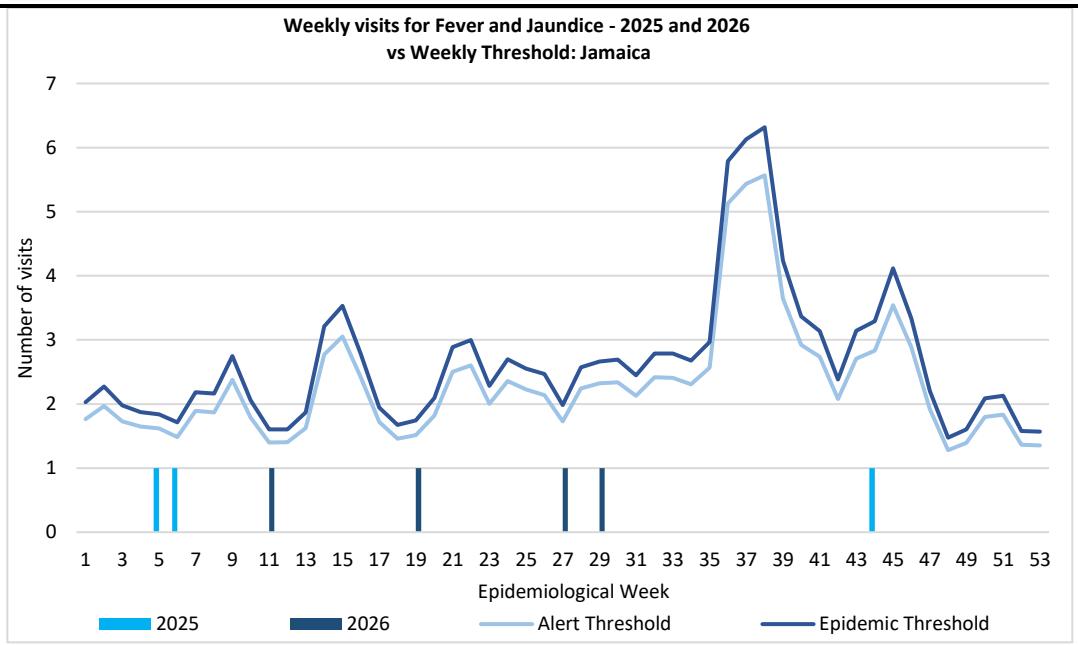
Temperature of >38^0*C* /100.4^0*F* (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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

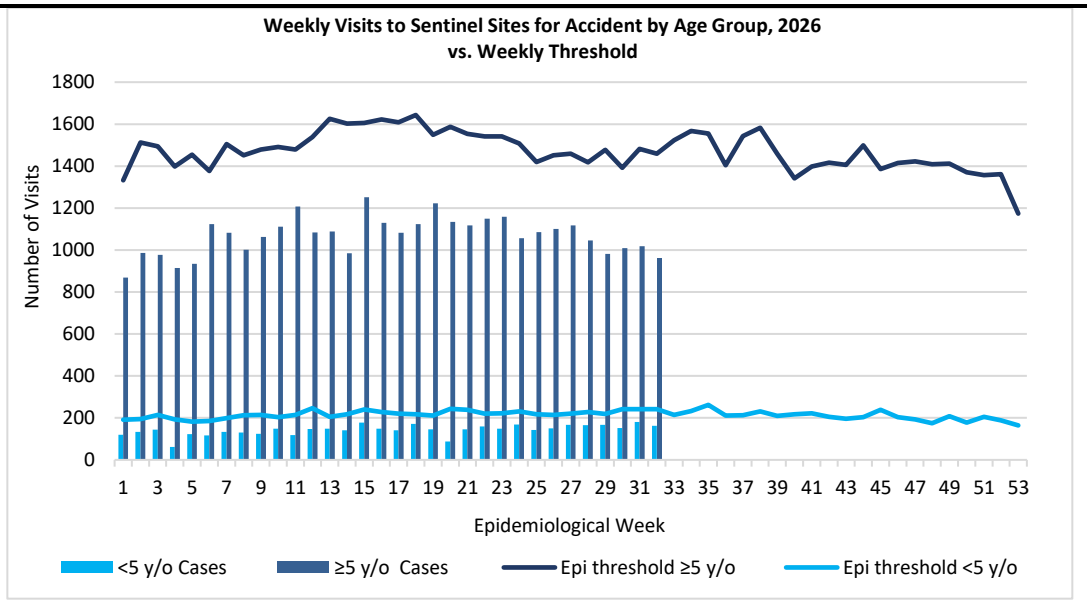
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

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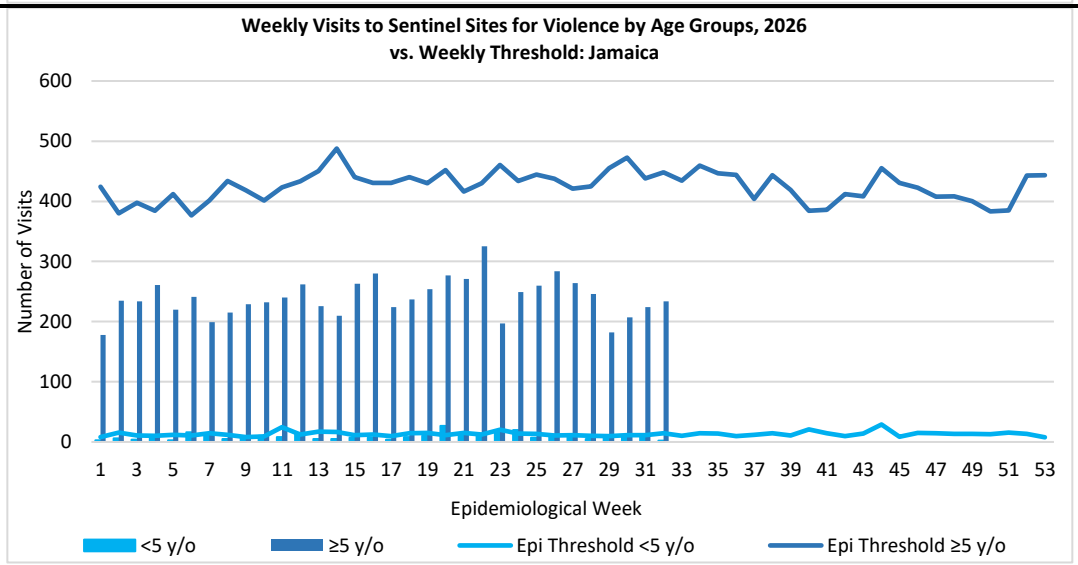
ACCIDENTS

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



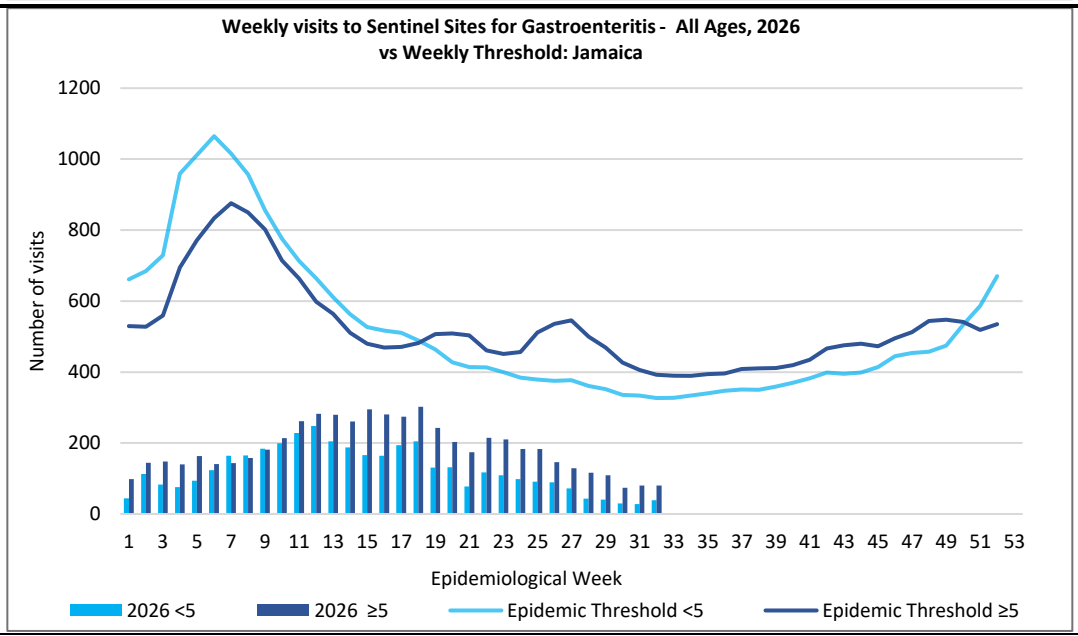
VIOLENCE

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

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ISSN 0799-3927

CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS		Confirmed YTD[α] CURRENT YEAR 2026	Confirmed YTD[α] PREVIOUS YEAR 2025
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		54[β]	134[β]
	Cholera		0	0
	Severe Dengue[γ]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		30	276
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		8	10
	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]		32	38
	Ophthalmia Neonatorum		22	55
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		1	2
	Tuberculosis		46	46
	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

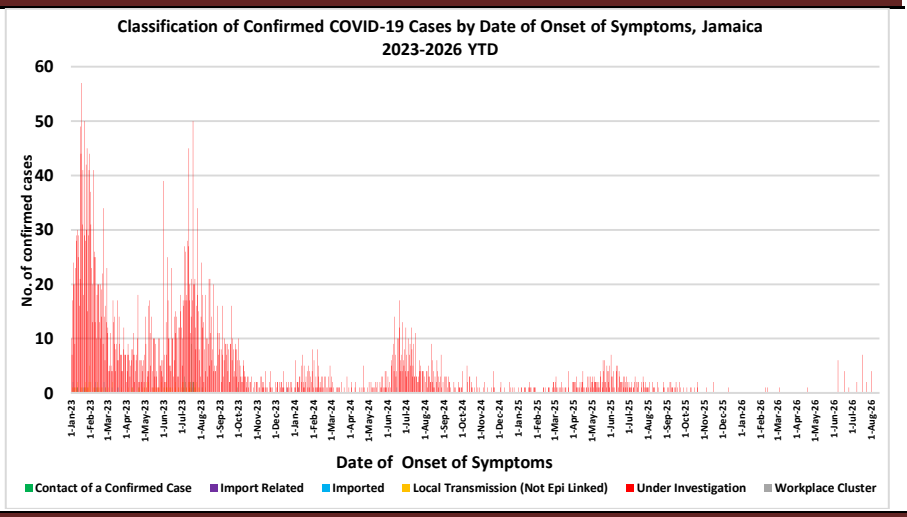
SENTINEL REPORT- 78 sites. Automatic reporting

ISSN 0799-3927

COVID-19 SURVEILLANCE

CASES	EW 32	Total
Confirmed	0	157,780
Females	0	90,897
Males	0	66,880
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.

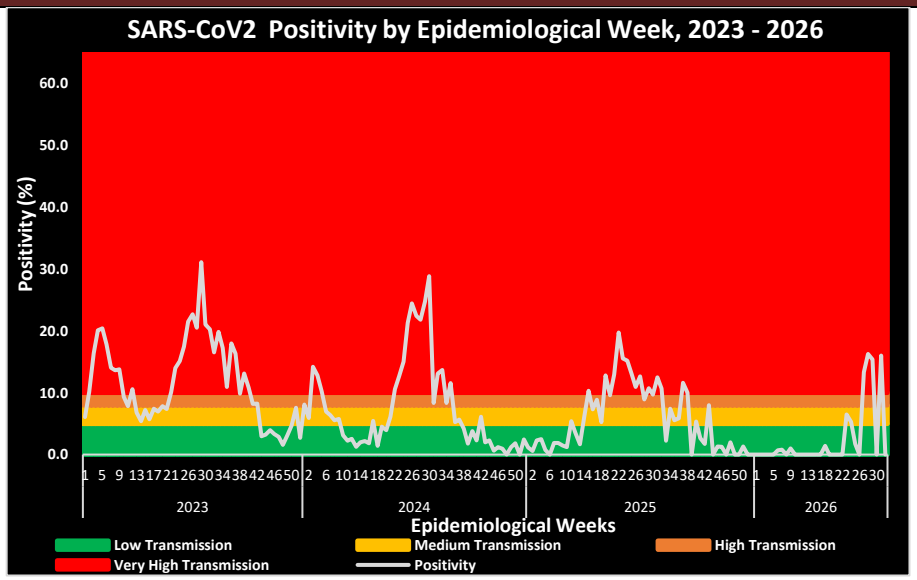


COVID-19 Outcomes

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

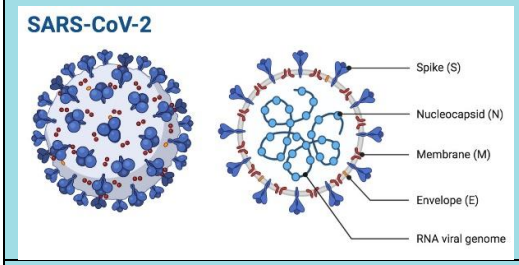
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	30	157,780
Deaths	621	116	24	13	0	3,921

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



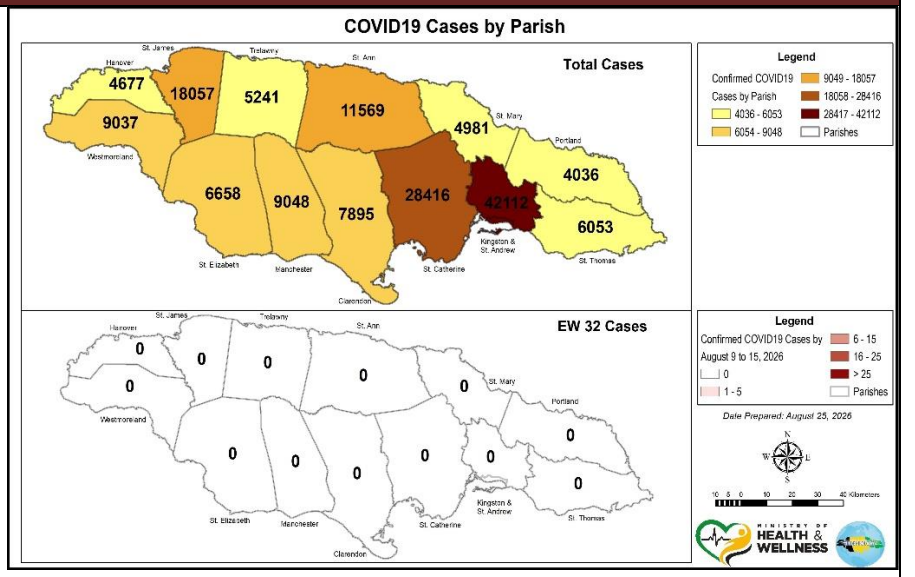
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics Epi Week 29-32, 2026

Epi Week	Confirmed Cases	Deaths
29	9,900	57
30	11,700	54
31	11,000	64
32	12,800	47
Total (4weeks)	45,400	222



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

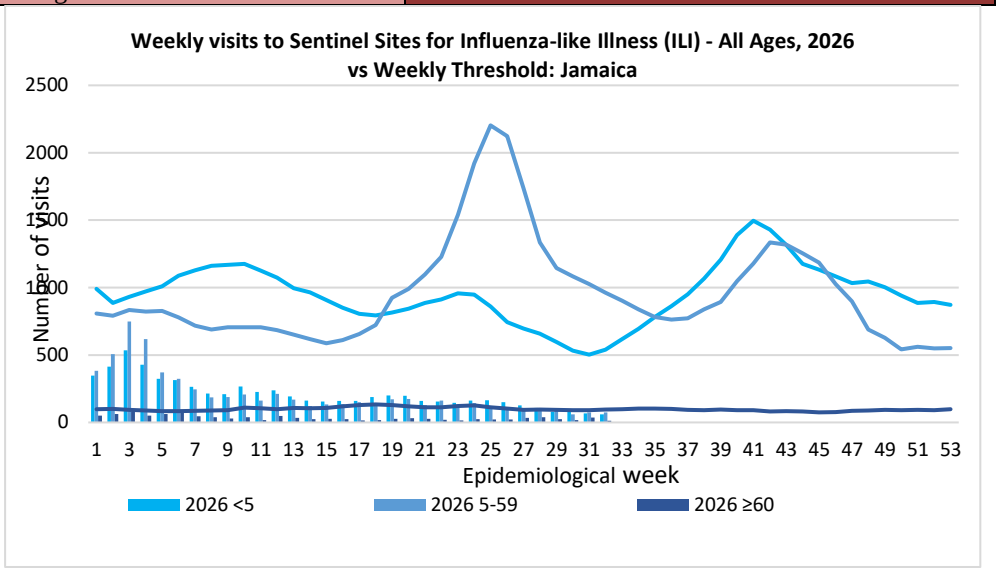
August 28, 2026 ISSN 0799-3927

INFLUENZA SURVEILLANCE

EW 32

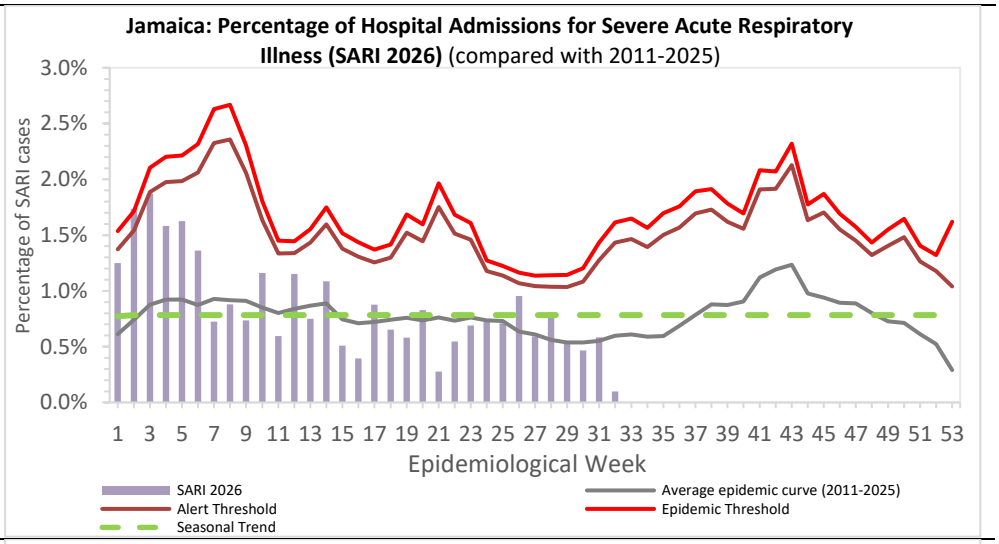
August 09, 2026 – August 15, 2026 Epidemiological Week 32

	EW 32	*YTD*
SARI cases	1	418
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

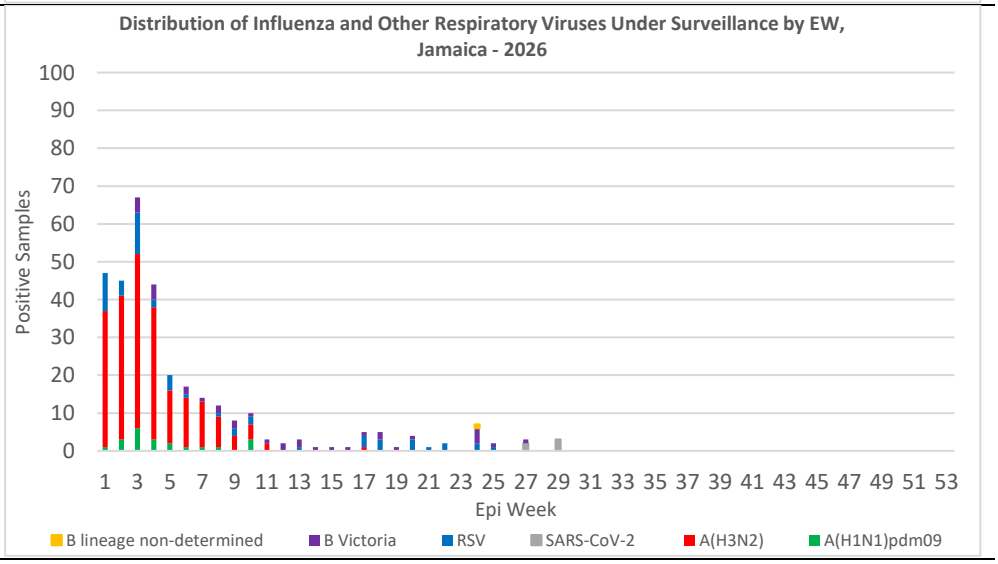
During Epi Week 32, one (1) SARI admissions were reported.



Caribbean Update Epi Week 32

Influenza circulation decreased for a second consecutive EW, reaching a positivity of 8.6%, with cocirculation of influenza B and A(H3N2). RSV activity remains stable at a positivity of 5.2%, while SARS-CoV-2 circulation increased over the past two EWs, reaching a positivity of 8.5%.

*Update as of Epi Week 31
(Source: 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

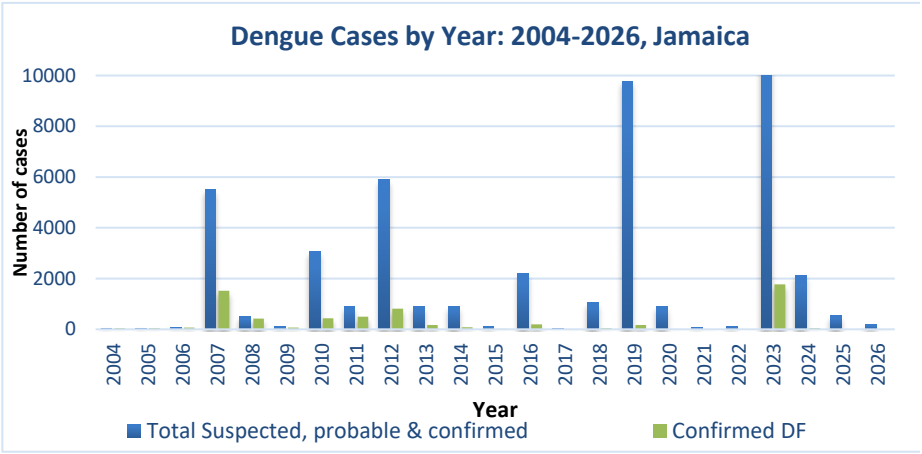
SENTINEL REPORT- 78 sites. Automatic reporting

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DENGUE SURVEILLANCE

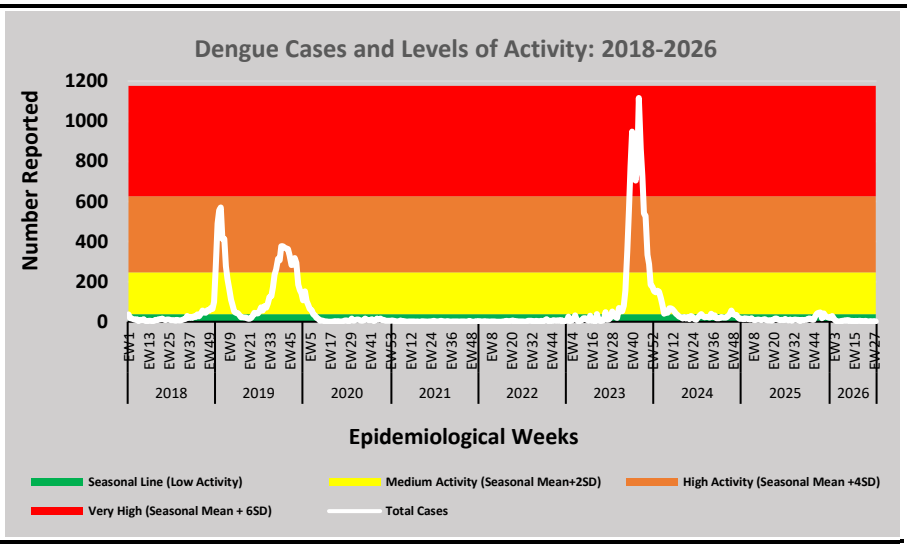
August 09, 2026 – August 15, 2026 Epidemiological Week 32 | Epidemiological Week 32





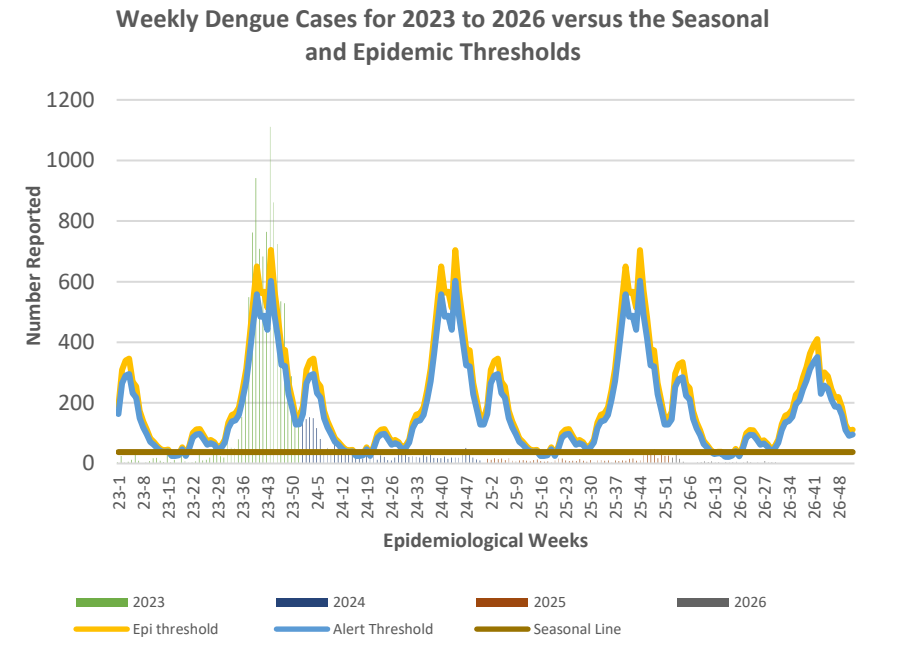
Reported suspected, probable and confirmed dengue with symptom onset in week 32 of 2026

	2026*	
	Epi Week 32	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	174
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

HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

RESEARCH ABSTRACT

Abstract

NHRC-25-O

Acceptability of online hypertension health education with student-led interventions

Howard J[1], Bennett S[1], Jones D[1], O'Connor K[1], Seymour R[1], Muir S.A[1]

[1]*University of Technology, Papine, Jamaica*

Objectives: The study investigated whether clinicians, hypertension (HTN) patients and their student relatives would be willing to use an innovative online hypertension health education (OHHE) for improving hypertension control and management.

Methods: We performed an online survey of 74 university students and 69 HTN patient relatives from 2 Jamaican universities about their receptivity towards OHHE using the Unified Theory of Acceptance and Use of Technology (UTAUT2) and Health Belief Model frameworks. These were complemented by semi-structured interviews of 5 clinicians. The data was analysed using correlation and thematic analysis. The pilot OHHE intervention is a Learning Management System about hypertension management, with data security features.

Results: Over 80% of student respondents (ages 18-29) reported intention to use OHHE to assist hypertensive family members. However, only about one-third of patient relatives reported willingness to participate, with one-third uncertain, and the remaining third unwilling. All clinicians were positive but emphasised the need for simple, culturally relevant designs and sustained support. Key predictors of OHHE use among patients and students included behavioural expectation and performance expectancy; barriers included limited digital literacy and technology access. Correlation analysis revealed significant relationships between Behavioural Intention of patients and Behavioural Expectations ($r = 0.689$, $p= 0.01$) and Mobile Literacy ($r = 0.684$, $p= 0.01$).

Conclusion: High acceptance of OHHE by students, patients and clinicians suggests that targeting student relatives of HTN patients may be a promising avenue for enhancing HTN control and management. Additional effort may be needed to engage HTN patients to maximise the potential impact.

Keywords: digital health interventions, hypertension, technology acceptance, student-led interventions, UTAUT2