WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

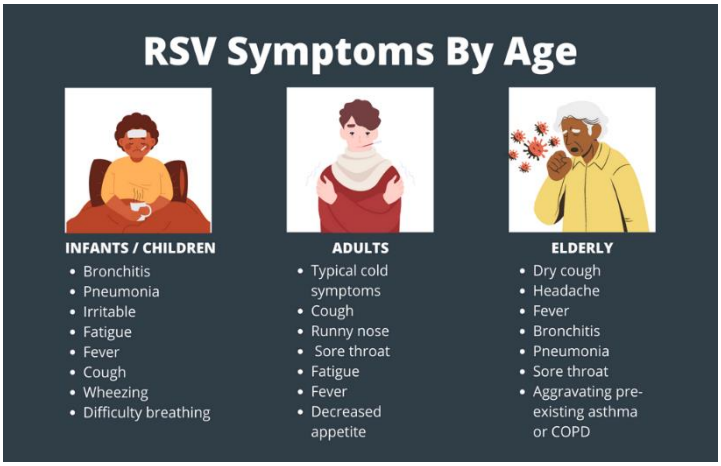
Respiratory syncytial virus (RSV)

Key Facts

- Respiratory syncytial virus (RSV) is one of the most common causes of acute lower respiratory infections in children globally, as well as causing substantial burden of severe respiratory disease among elderly persons.
- Each year RSV causes over 3.6 million hospitalizations and about 100 000 deaths in children under 5 years of age. Most paediatric RSV deaths (97%) occur in low- and middle-income countries where there is limited access to supportive medical care.
- There are three licensed immunization products for prevention of RSV disease in young infants: two long-acting monoclonal antibodies administered to infants soon after birth and a maternal vaccine given to pregnant women and persons in the latter part of pregnancy.
- Three vaccines are licensed to prevent severe RSV disease in elderly persons and adults with certain underlying illnesses, like lung and heart disease.

Overview

Respiratory syncytial virus (RSV) is an RNA virus that belongs to the Pneumoviridae family along with the human metapneumovirus and consists in two genotypes (A and B) (1). RSV is specific and pathogenic for humans and infects cells along the human respiratory tract, from the nose to the lungs. RSV causes a wide spectrum of respiratory disease, from mild upper respiratory tract infections (in most cases) to life threatening lower respiratory tract infections (2). Infants, especially those under six months of age, are at highest risk of severe RSV disease and death. RSV can also cause severe disease among elderly people and those with underlying illnesses. Until recently, there was no vaccine available to protect infants and elderly people from RSV disease. In the last few years, several vaccines and a long-acting monoclonal antibody have been licensed and are starting to be used to prevent severe RSV disease in these high-risk populations.



Transmission

RSV is transmitted via infectious respiratory particles through the air from an infected person to another one. The virus is also thought to be transmitted by direct contact with infected persons or through support contaminated with the virus. Almost all babies are infected by RSV by their second birthday. Most have mild illness, but some can get very sick. Older children and adults are often re-infected with RSV, but usually have mild illness, except for elderly persons and those with significant underlying illnesses who can have severe illness and even die.

Severe lung disease can result in low oxygen levels in the body, respiratory muscle fatigue and can sometimes result in death. RSV-LRTI in early life may lead to long-term respiratory consequences, including repeat hospitalizations for respiratory illness during infancy, recurrent wheeze and/or asthma, and impaired lung health beyond infancy *(2)*.

RSV infection in elderly adults can exacerbate chronic underlying illnesses, such as lung and heart disease *(4)*.

Treatment and prevention

There is no specific treatment for RSV. Management of severe RSV disease involves supportive care, such as nasal suction of secretions, intravenous fluids for hydration, and most importantly supplemental oxygen to help breathing *(2)*.

Several immunization products are currently available to prevent severe RSV disease in infants and elderly adults *(7)*. To protect infants, there is a vaccine given to pregnant women and persons late in pregnancy (WHO recommends third trimester vaccination, defined from 28 weeks gestational age in most settings). Maternal immunization allows transfer of antibodies against RSV through the placenta to the unborn baby, who is then protected for approximately 6 months after birth.

Another immunization product to protect babies is a long-acting monoclonal antibody that targets the RSV virus. It is given as an intramuscular injection to protect against severe RSV lower respiratory tract infection lung disease during RSV infection. This product can be administered to all neonates and infants entering their first RSV season. In addition, countries could consider administering monoclonal antibody to young children (up to 24 months) with high risk of severe RSV disease (e.g. chronic lung disease, congenital heart disease, immunocompromised) entering their second RSV season.

Article:. https://www.who.int/news-room/fact-sheets/detail/respiratory-syncytial-virus-(rsv)
Image: https://cdn.shopify.com/s/files/1/0488/2877/6600/files/RSV_symptoms_by_age_1024x1024.png?v=1669999236

EPI WEEK 35



Syndromic Surveillance

Accidents

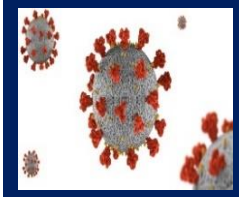
Violence

Pages 2-4



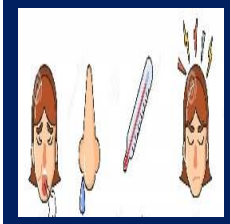
Class 1 Notifiable Events

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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.

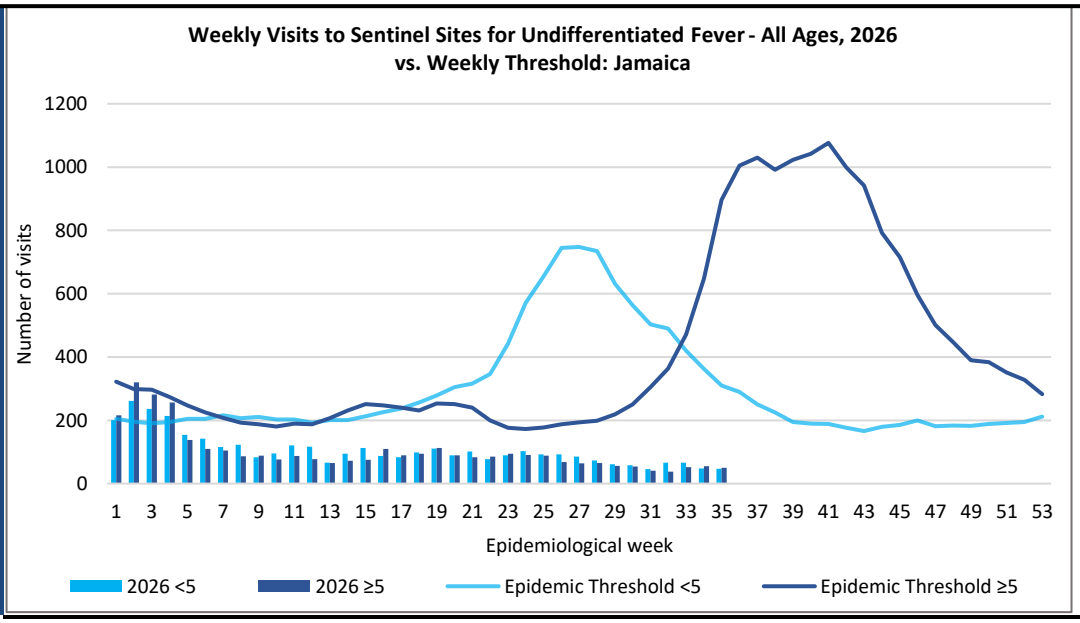
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
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
33	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
34	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
35	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

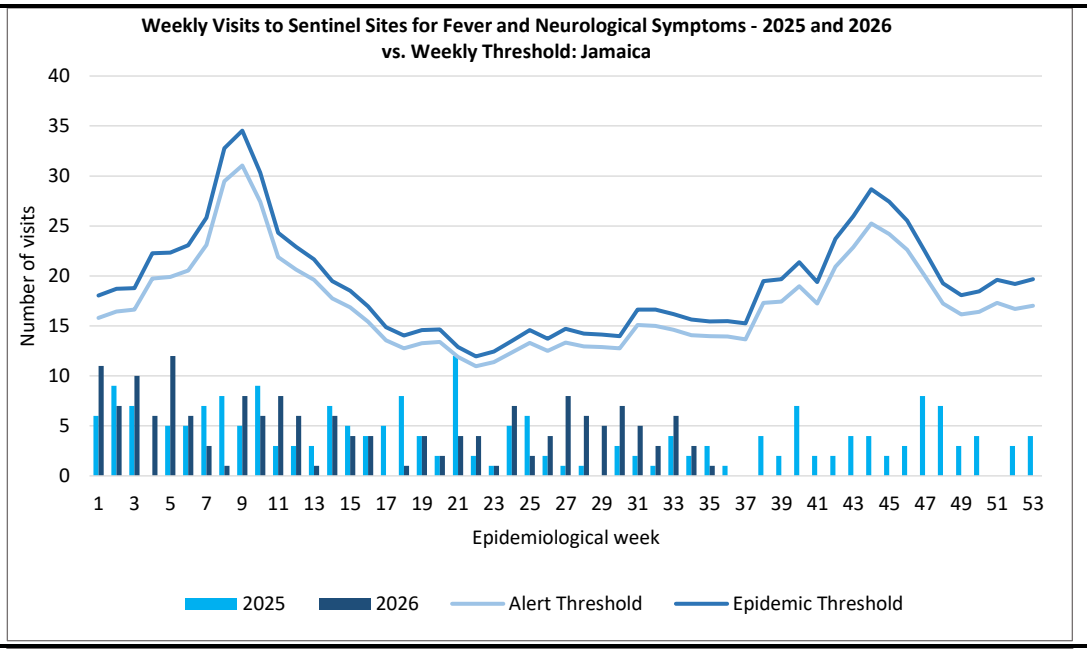
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

ISSN 0799-3927

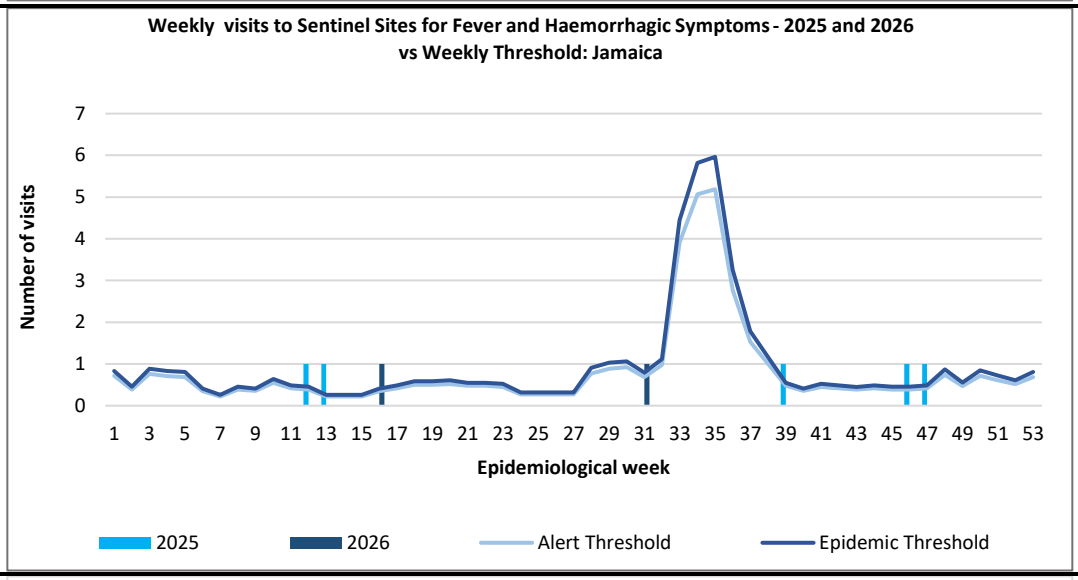
FEVER AND NEUROLOGICAL

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

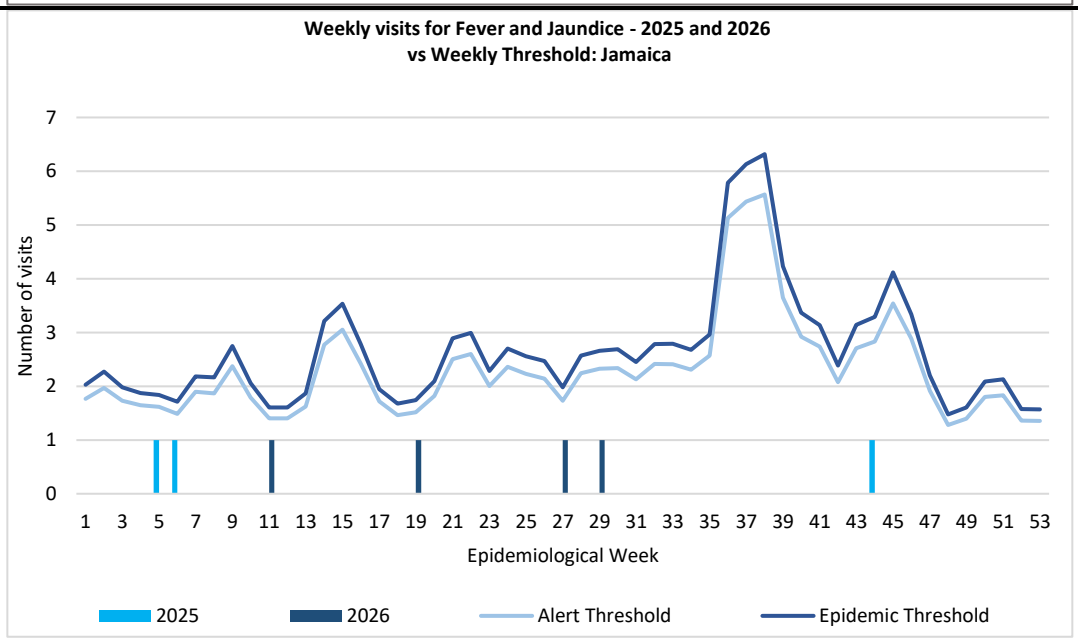
Temperature of >38^0*C* /100.4^0*F* (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



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

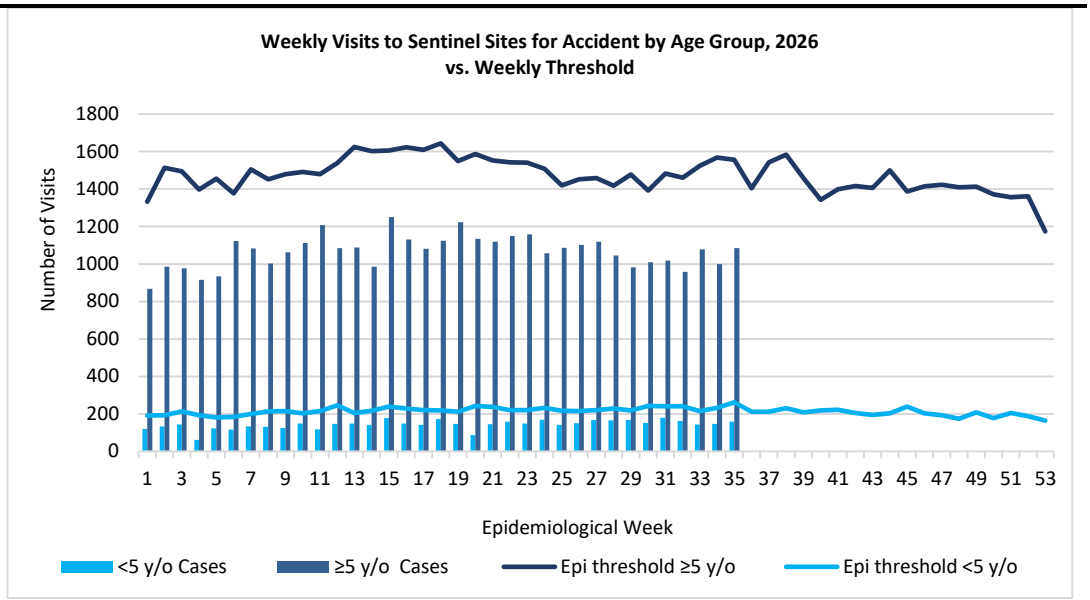
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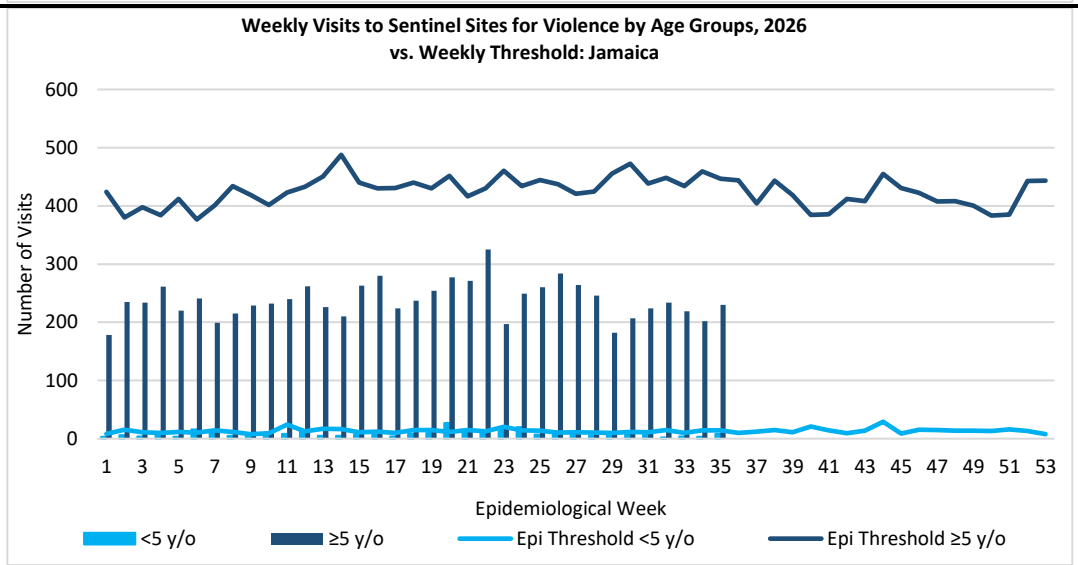
ACCIDENTS

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



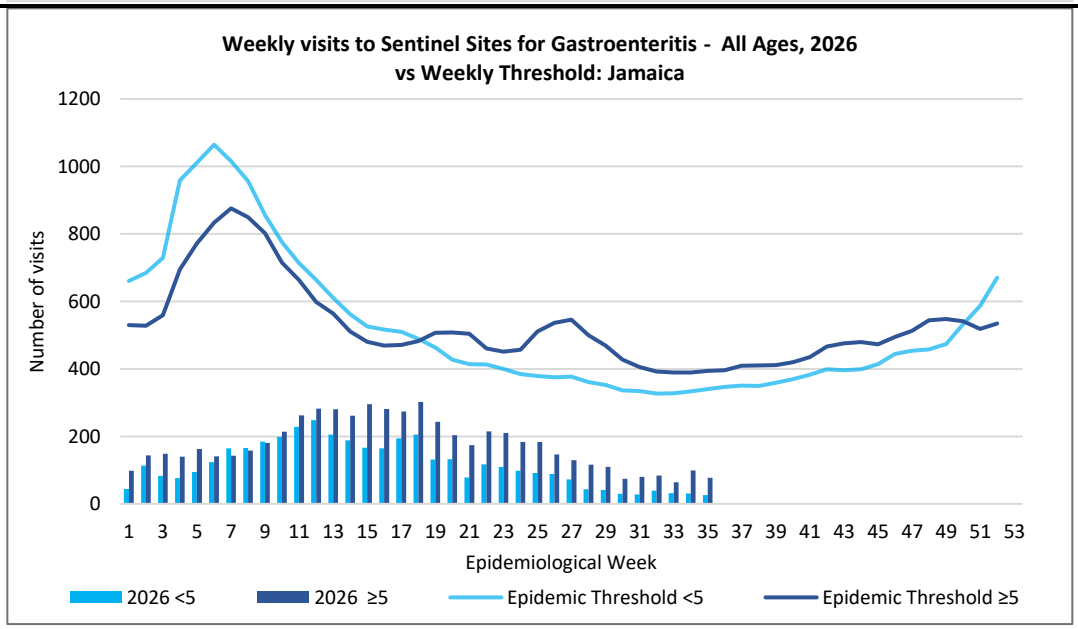
VIOLENCE

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

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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		59[β]	144[β]
	Cholera		0	0
	Severe Dengue[γ]		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		34	286
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		10	11
	Hepatitis C		0	2
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis		6	14
	Mpox		1	1
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 (notified pregnanacy related deaths) [δ]		35	42
	Ophthalmia Neonatorum		55	68
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		1	3
	Tuberculosis		56	51
	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

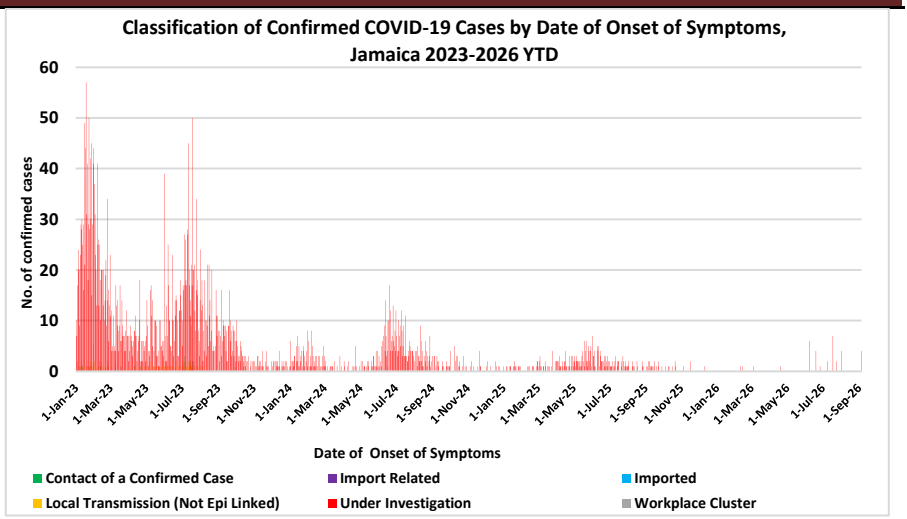
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

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COVID-19 SURVEILLANCE

CASES	EW 35	Total
Confirmed	0	157,784
Females	0	90,899
Males	0	66,882
Age Range	5 months to 50 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.

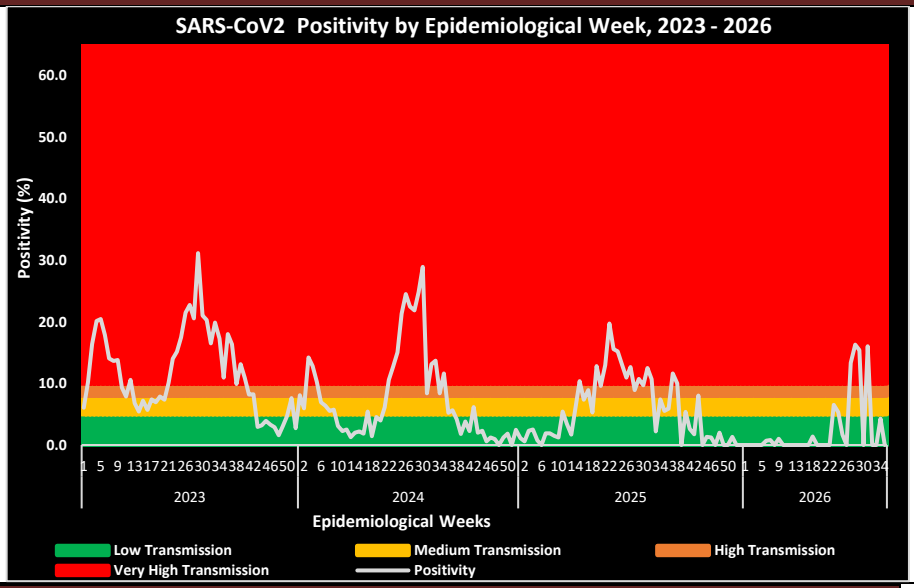


COVID-19 Outcomes

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

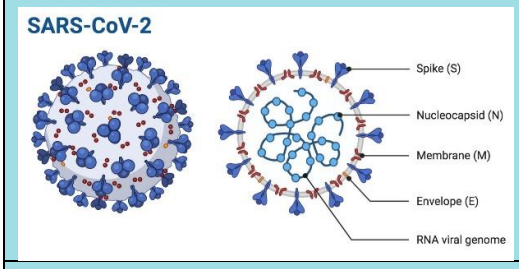
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	34	157,784
Deaths	621	116	24	13	0	3,921

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



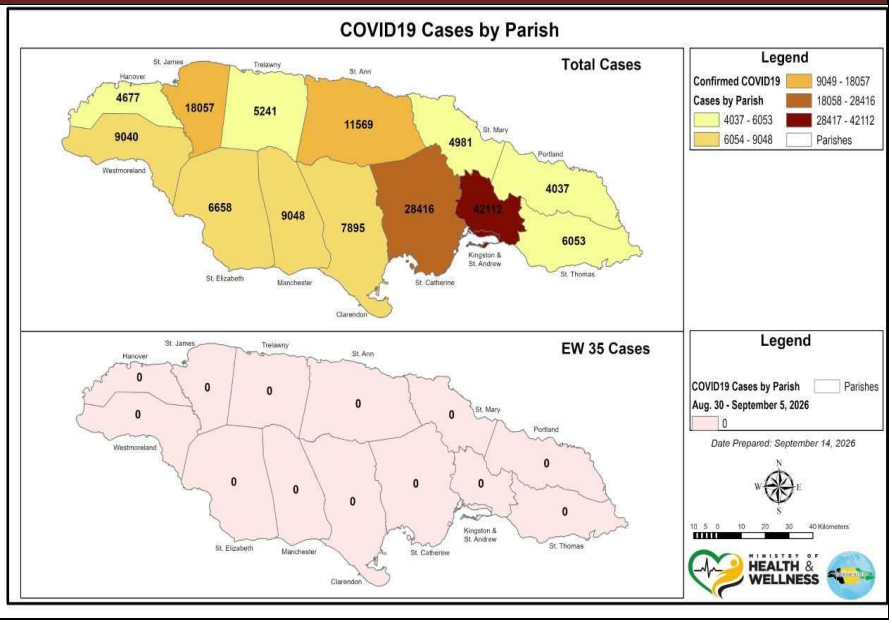
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics Epi Week 32-35, 2026

Epi Week	Confirmed Cases	Deaths
32	13,900	65
33	15,400	69
34	15,600	75
35	17,900	70
Total (4weeks)	62,800	279



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

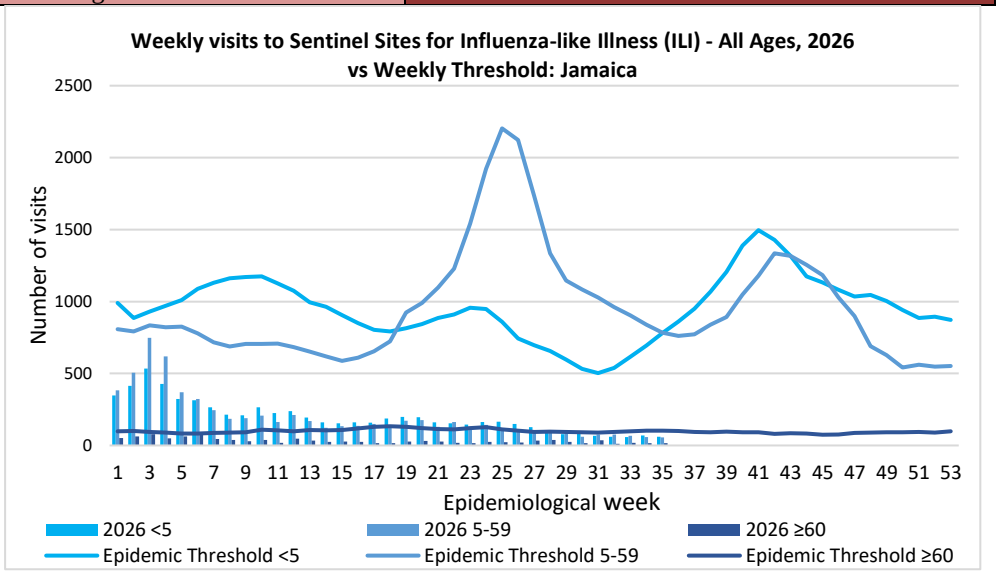
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INFLUENZA SURVEILLANCE

EW 35

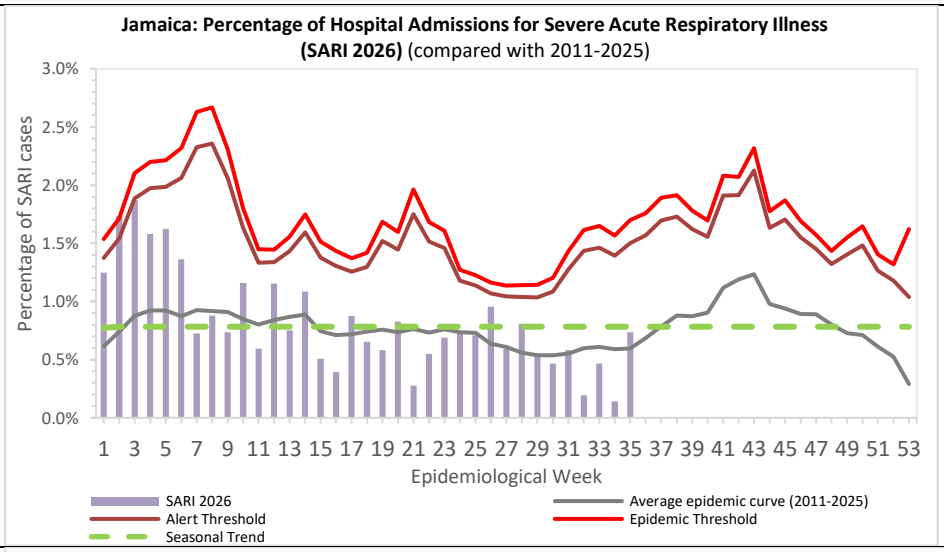
August 30, 2026 – September 05, 2026 Epidemiological Week 35

	EW 35	*YTD*
SARI cases	6	443
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

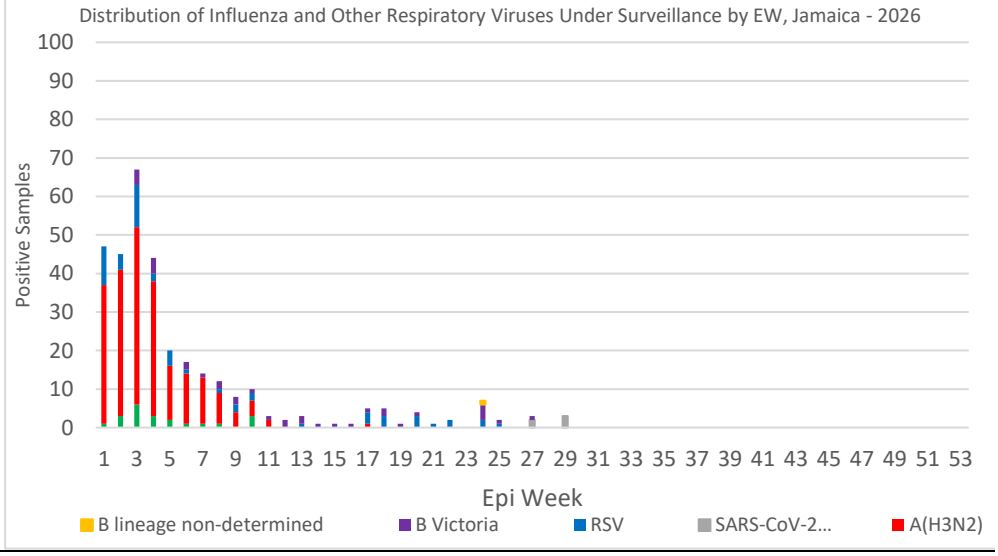
During Epi Week 35, six(6) SARI admissions were reported.



Caribbean Update Epi Week 35

Caribbean: Influenza activity has shown a downward trend in recent weeks, with a regional positivity rate of 1% in EW34, with influenza B/Victoria predominating (47.1%). The circulation of SARS-CoV-2 has shown an upward trend over the past four weeks reaching a positivity rate of 13.9% in EW34

*Update as of Epi Week 34
(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

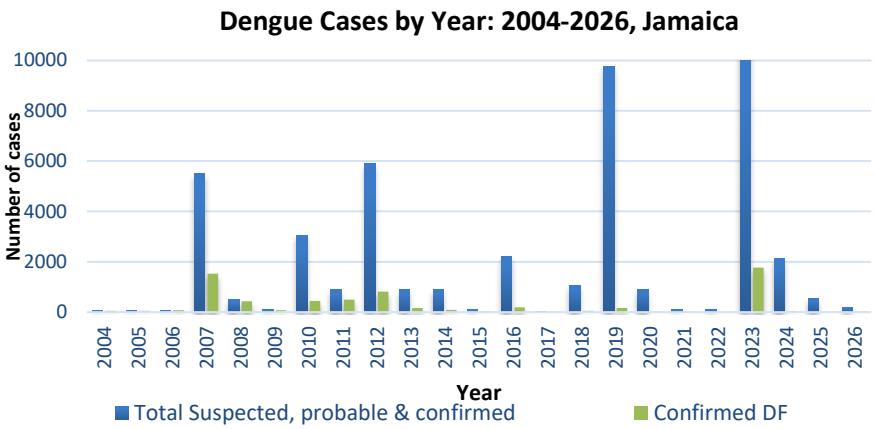
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

DENGUE SURVEILLANCE

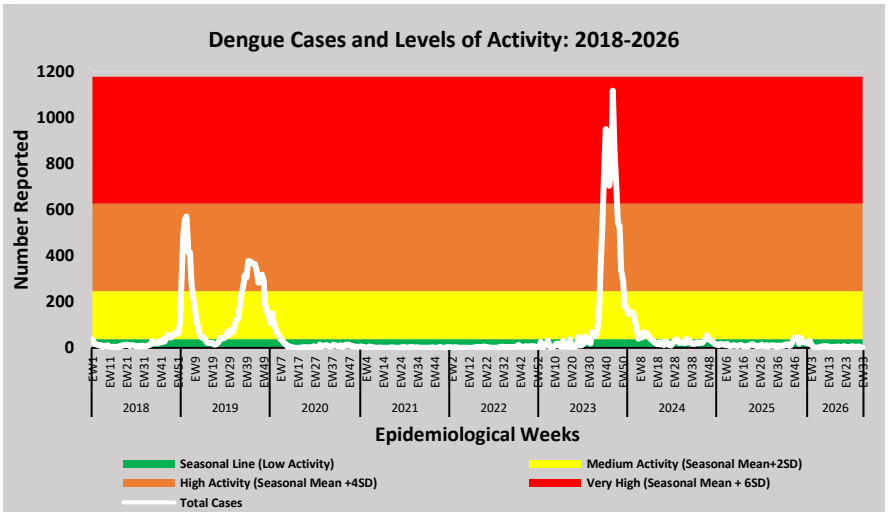
August 30, 2026 – September 05, 2026 Epidemiological Week 35 | Epidemiological Week 35





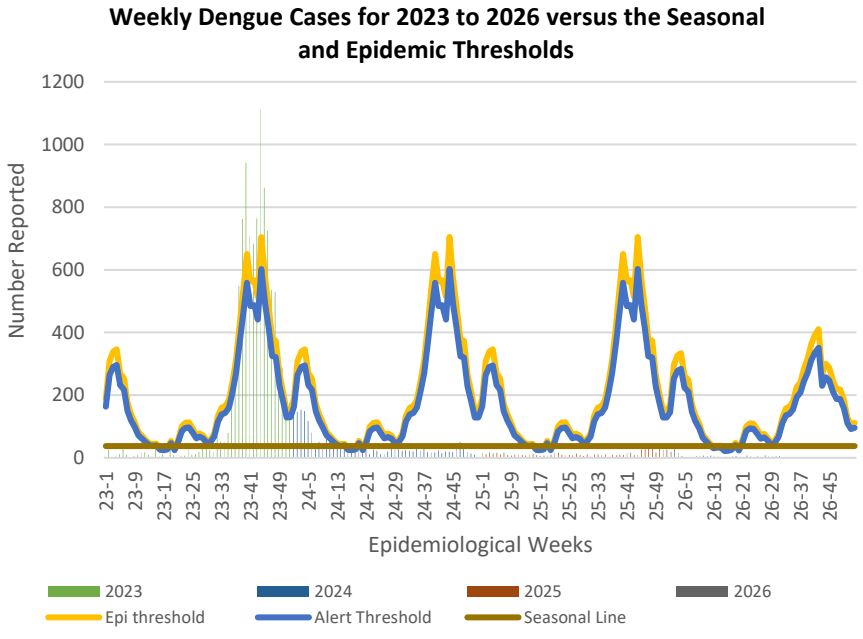
Reported suspected, probable and confirmed dengue with symptom onset in week 35 of 2026

	2026*	
	Epi Week 35	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	183
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

Knowledge, attitudes and practices of salt consumption among Jamaican adults, and its relationship with socioeconomic status and prevalent hypertension and diabetes mellitus

Watson, K[1], Younger-Coleman, N[1], McNeil ST[1], Bennett, NR[1], Webster-Kerr, K[2], Tulloch-Reid, MK[1], Davidson, T[2], Grant, A[2], Soares-Wynter, S[3], McKenzie, J[1], Walker, E[1], Blake, A[4], Anderson, SG[5], Spence, S[2], Ferguson, TS[1]

[1]Epidemiology Research Unit, Caribbean Institute for Health Research, The University of the West Indies, Mona, Kingston 7, Jamaica.
[2]Ministry of Health and Wellness, Kingston 5, Jamaica.
[3]Tropical Metabolism Research Unit, Caribbean Institute for Health Research, The University of the West Indies, Mona, Kingston 7, Jamaica.
[4]School of Clinical Medicine and Research, The Faculty of Medical Sciences, The University of the West Indies, Nassau, The Bahamas.
[5]George Alleyne Chronic Disease Research Centre, Caribbean Institute for Health Research, The University of the West Indies, Cave Hill, Bridgetown, St. Michael. BB11115, Barbados.

Objective: To assess knowledge, attitudes, and practices (KAP) on salt consumption among Jamaican adults, and examine associations with socioeconomic and clinical characteristics.

Methods: We conducted a cross-sectional analysis of a nationally representative sample of Jamaican ≥18 years. Structured questionnaires assessed knowledge of salt-related health risks, attitudes, and practices. Composite knowledge and practice scores were created by summing item responses, and attitudes classified into ordinal categories toward salt intake (low, neutral, or high favourability). KAP characteristics were summarized using weighted means or proportions. Weighted linear and logistic regression models examined associations between salt KAP and socio-demographic or health-related variables. Multivariable models were adjusted for age, sex, smoking, physical activity, self-reported hypertension, and self-reported diabetes.

Results: Among 961 participants, (mean [±SD] age 50.0 [±18.4] years; 39% male), the mean knowledge score (max 36) was 26.1 (95%CI 25.8-26.5) and greater in those with more than high school (HS) education ($p<0.001$). In the adjusted models, education attainment was significantly associated with higher knowledge (β, +3.7, 95%CI 3.2-4.2, $p<0.001$ [>HS vs <HS]) and salt-avoidance practice scores (β, +1.8, 95%CI 0.8-2.9, $p<0.001$). HS education was associated with more favourable attitudes among men. Hypertensive participants reported greater adoption of salt-limiting practices, but relationships with hypertension and diabetes were not significant in adjusted models. Older age and greater physical activity were associated with more favourable practices, whereas current tobacco use predicted poorer KAP.

Conclusion: Educational attainment was significantly associated with salt-related KAP. Tailored public health strategies targeting less educated, younger populations are critical to Jamaica's salt reduction efforts.

Keywords: 'knowledge, attitudes, practices', salt consumption, Jamaica, socioeconomic status