### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Clinic</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
</tr>
<tr>
<td>CARICOM</td>
<td>Caribbean Community</td>
</tr>
<tr>
<td>CI</td>
<td>Contact Investigator</td>
</tr>
<tr>
<td>CIMT</td>
<td>Caribbean Indicators and Measurement Tools</td>
</tr>
<tr>
<td>CRIS</td>
<td>Country Response Information System</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial Sex Worker</td>
</tr>
<tr>
<td>ERTU</td>
<td>Epidemiology Research and Training Unit</td>
</tr>
<tr>
<td>GoJ</td>
<td>Government of Jamaica</td>
</tr>
<tr>
<td>HATS</td>
<td>HIV/AIDS Tracking System</td>
</tr>
<tr>
<td>HFLE</td>
<td>Health and Family Life Education</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>JN+</td>
<td>Jamaica Network of Seropositive</td>
</tr>
<tr>
<td>KABP</td>
<td>Knowledge, Attitudes, Behaviour and Practices</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring &amp; Evaluation</td>
</tr>
<tr>
<td>MESST</td>
<td>Monitoring and Evaluation Systems Strengthening Tool</td>
</tr>
<tr>
<td>MERG</td>
<td>Monitoring and Evaluation Reference Group</td>
</tr>
<tr>
<td>MCSR</td>
<td>Monthly Clinic Summary Report</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother to Child Transmission</td>
</tr>
<tr>
<td>NERHA</td>
<td>North East Regional Health Authority</td>
</tr>
<tr>
<td>NHP</td>
<td>National HIV/STI Programme</td>
</tr>
<tr>
<td>NPHL</td>
<td>National Public Health Laboratory</td>
</tr>
<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organization</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>----------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>PLACE</td>
<td>Priority for Local AIDS Control Efforts</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living With HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>RHAs</td>
<td>Regional Health Authorities</td>
</tr>
<tr>
<td>SERHA</td>
<td>South East Regional Health Authority</td>
</tr>
<tr>
<td>SRHA</td>
<td>Southern Regional Health Authority</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WRHA</td>
<td>Western Regional Health Authority</td>
</tr>
</tbody>
</table>
Acknowledgements

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SUMMARY OF HIV CASES DIAGNOSED BY YEAR AND SEX, 1982 TO 2017
SUMMARY OF AIDS DEATHS IN JAMAICA, 1982 – DEC 2017
SUMMARY OF AIDS DEATH BY PARISH IN JAMAICA, 1982 – DEC 2017
Background

In Jamaica, HIV/AIDS is a class 1 notifiable disease according to the Public Health (Class 1 Notifiable Disease) Order, 2003 (section 2). The order states, where a medical practitioner suspects that a person has contracted Human Immunodeficiency Virus (HIV), the medical practitioner shall forthwith or not later than twenty-four hours after the case is discovered, make a report to-

   a) the Public Health Department for the parish in which the suspected case has been found; or
   b) the Surveillance Unit of the Ministry responsible for Health.

A report under subparagraph (1) may be made—

   a) in writing, on a Class 1 Notification Form; or
   b) by any other appropriate means, if the circumstances so require.¹

Jamaica has a well-established web-based HIV Case-Based Reporting system that facilitates real-time reporting and allows for the efficient management and analysis of data.

Data emanating from the Case-Based Surveillance system and estimates generated from surveillance models indicates that as of December 2017, there were 34,000 persons living with HIV in Jamaica, of whom 22% (approximately 7,480) of the persons living with HIV were unaware of their status. The data indicates an estimated HIV prevalence of 1.8% in the general population. During the period of 1982 – 2017, a total of 35,563 diagnosed cases of HIV infections were reported, of which, 28% (10, 127) are known to be deceased.

The data showed an increase of 33.5% (230) in the number of reported cases that were classified at the advanced HIV stage, from 686 cases (2015) to 916 cases (522 males/ 394 females; 2016). Advanced HIV refers to persons with a CD4 count ranging between 201-350.

The AIDS mortality rate declined from 25 deaths/100,000 population in 2004 to 13 deaths/100,000 population in 2016 which represents a 48% decrease since the inception of Universal Access to ARVs in 2004. The reduction in reported AIDS deaths, was confirmed by ___________________
the Spectrum modelling estimates, noting the limitation that deaths are under reported. The main contributors to this decline include scaling up of the national VCT programme through the use of rapid test kits – allowing for earlier and more timely diagnoses, greater public access to antiretroviral treatment, the availability of prophylaxis and improved laboratory capacity to conduct investigations such as CD4 counts, viral load and PCR tests. Additional strategies that contributed to this decline include the advances in diagnoses, the wider availability of treatment and routine clinical monitoring of PLHIV.

However, despite these advances, suboptimal retention in care and poor adherence to treatment pose a significant challenge to reduction of AIDS morbidity and mortality efforts.
Purpose

The 2017 Annual HIV/AIDS Epidemiological Report is to provide evidence for the National HIV/STI/Tb Programme’s strategic direction, priority strategies and activities. This report is intended for public health professionals, policymakers and all other partners in the national HIV response for use in planning and evaluation of the strategies and activities implemented to address epidemic control and to guide patient and programme management.

It is anticipated that this report will provide a clearer understanding of the HIV epidemic in Jamaica and the various risk-factors associated with transmission. It is also expected that this report would lead to greater awareness of the magnitude of HIV/AIDS and contribute to safer-sex practices in the population if widely disseminated, used to inform decision making and influence the relevant policy changes to achieve epidemic control.
Methodology

In Jamaica, each person diagnosed with HIV or suspected to be HIV-positive including babies born to HIV positive mothers is reported using the Class 1 Reporting Form. Notifications are made even if individuals are asymptomatic or found to be presumptively positive after a rapid test. The Class 1 Reporting Form is then submitted to the Health Department and/or the Ministry of Health to ensure that persons who have not received a confirmatory HIV test are contacted for follow-up and confirmation.

An HIV diagnosis is based on a positive HIV antibody testing (whether rapid or laboratory-based enzyme immunoassay) for adults and children 18 months or older. This is then confirmed with a second and a third HIV antibody test (whether rapid or laboratory-based enzyme immunoassay) relying on different antigens or on different operating characteristics and/or; positive virological test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by a second virological test obtained from a separate determination.

Regarding children younger than 18 months, HIV infection is diagnosed based on a positive virological test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) and then confirmed by a second virological test obtained from a separate determination taken at least five weeks after birth. An HIV antibody test is not recommended for confirmatory HIV infections until 18 months of age.

When the class 1 and confidential reporting forms enter the National Surveillance Unit at the Ministry of Health they are classified as HIV, advanced HIV or AIDS depending on the client’s CD4 count, or AIDS Related Death. The forms are then entered into the HIV/AIDS tracking system (HATS), where identifiers, such as name(s), mother’s name, date of birth and others are used to reduce duplication of cases. An export of HATS is completed at the end of each year and the data was used to provide the epidemiological profile of the country.

The date of test is used as the date of diagnosis for the client. In lieu of the date of test, the date the class 1 form was reported is used as the date of diagnosis. It is important to note that
the date the class 1 is reported may be delayed for up to a year after the person is tested; therefore, this date is not the preferred indication of incidence but is used as a proxy.

The HIV cases documented in this report are based on the aforementioned HIV notification system and the confidential reporting forms that were received by the National Surveillance Unit, Ministry of Health Jamaica as at May 1, 2018.

While this system is routinely monitored and audited it must be noted that there are potential data limitations. Specifically, some notifications received are incomplete and as such, not included in this report. Furthermore, late reporting – that is, HIV related cases or events being reported after the mandated timeframe; incomplete reports – forms missing date of births, addresses, telephone contacts and other critical information; client aliases leading to duplications in the database; and under-reporting because some providers are not reporting HIV positive cases, particularly in the private sector may pose challenges to the quality of the data reported. However, while acknowledging the limitations, efforts were made to ensure that the data reported is as sound as possible.
Key Facts

- There were 1,197 new HIV infections in 2017.
- The Parishes of Kingston and St. Andrew had the majority of new HIV infections and Manchester the least number of new HIV infections in 2017.
- Overall males accounted for the higher proportion of new HIV infections in 2017 (Males: 621, Females: 576)
- In 2017, new HIV cases diagnosed declined by 41% from 2016.
- There were approximately 8% fewer late diagnoses (Advanced HIV, AIDS, and AIDS Deaths) than the previous year (2016)
- In 2017, there was a 10% decrease in AIDS deaths from 2016.
- The majority of deaths amongst PLHIV occurred between the ages 40 years to 49 years for males and 30 years to 39 years for females in 2017.
**Sociodemographic Factors**

Jamaica is the third largest of the Caribbean islands, and the largest English-speaking island in the Caribbean Sea. Situated 90 miles south of Cuba, and 100 miles south-west of Haiti, Jamaica is approximately 146 miles long, 51 miles wide, and has an area of 4,411 square miles (United Nations, 2018). The capital, Kingston, is the largest city and is located in the south-eastern part of the island. The estimated population of the country is 2.7 million (STATIN, 2018).

There have been no major shifts in the population distribution by parishes from the mid-year to end-of-year tallies. The parish with the greatest population is Kingston & St Andrew, followed by St Catherine and Clarendon (Table 1).

**Table 1: Jamaica’s population distribution by parish, 2017 (using table below)**

<table>
<thead>
<tr>
<th>Parish</th>
<th>End of year</th>
<th>Mid-year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston &amp; St Andrew</td>
<td>670,312</td>
<td>670,325</td>
</tr>
<tr>
<td>St Thomas</td>
<td>95,015</td>
<td>95,017</td>
</tr>
<tr>
<td>Portland</td>
<td>82,710</td>
<td>82,712</td>
</tr>
<tr>
<td>St Mary</td>
<td>114,959</td>
<td>114,962</td>
</tr>
<tr>
<td>St Ann</td>
<td>174,343</td>
<td>174,346</td>
</tr>
<tr>
<td>Trelawny</td>
<td>76,043</td>
<td>76,044</td>
</tr>
<tr>
<td>St James</td>
<td>185,846</td>
<td>185,850</td>
</tr>
<tr>
<td>Hanover</td>
<td>70,322</td>
<td>70,324</td>
</tr>
<tr>
<td>Westmoreland</td>
<td>145,746</td>
<td>145,749</td>
</tr>
<tr>
<td>St Elizabeth</td>
<td>151,961</td>
<td>151,964</td>
</tr>
<tr>
<td>Manchester</td>
<td>192,036</td>
<td>192,039</td>
</tr>
<tr>
<td>Clarendon</td>
<td>247,902</td>
<td>247,906</td>
</tr>
<tr>
<td>St Catherine</td>
<td>521,669</td>
<td>521,679</td>
</tr>
</tbody>
</table>

Source: STATIN, 2017
The proportion of the population in the younger age groups (0-4 and 5-14) have been falling and the older age groups (45-64 and 65 over) have been increasing since the 1970 population census (STATIN, 2018). The change in the distribution of the population by age is reflected in the increasing median age when the 2011 (27.9) census is compared to that of 1970 (16.8) (STATIN, 2018). This change in the median age is evidence of the ageing population (STATIN, 2018) (Figure 1).

An examination of the Jamaican population shows that since 1980 the population has been growing at less than one per cent per annum (STATIN, 2018). Although the decade of 2010 has not yet ended, the decline in the growth of the population of Jamaica is evident, as over the past seven years the population has grown by 0.20% (STATIN, 2018). The low rate of increase of the population can be attributed to the decline in fertility and the increased outward migration. At the end of 2017, the population of Jamaica was estimated at 2,728,864 of which 1,351,392 were males and 1,377,472 were females (STATIN, 2018).

Figure 1: Population Distribution by Age Group and Sex, Jamaica, 2017

Source: STATIN, Jamaica
People living with HIV

Modelled estimates and case based surveillance data estimate that there are 34,000 (Spectrum, UNAIDS, 2017) persons living with HIV in Jamaica of whom, 22% are unaware of their status. In Jamaica’s general population, HIV prevalence is estimated to be 1.8%. Since January of 1982 to December of 2017, the Ministry of Health has received reports of 36,553 diagnosed cases of HIV infection of which, 10,127 (27.7%) are known to be deceased.

Since the beginning of the HIV epidemic in 1982, there was a steady increase in the number of persons living with HIV and AIDS with its peak around 2006 and 2008. The numbers have been on the decline with some troughs. In the past two years (2016 and 2017) there has been a noticeable increase in HIV (non-AIDS), advanced HIV and AIDS. Since 2004, the number of direct or indirect AIDS deaths have also been on the decline but rose slightly in 2016 (Figure 2). Despite advances in antiretroviral therapy, retention in care and poor adherence to treatment are ongoing challenges hampering the reduction of AIDS morbidity and mortality.

Figure 2: Persons Living with HIV (non-AIDS), Advanced HIV and AIDS and Deaths, Jamaica, 1982-2017

Source: HIV/STI/Tb Unit, Ministry of Health

Using the population estimates from STATIN for the years between and including 1982-2017 the rates of HIV (non-AIDS), advanced HIV, AIDS and AIDS deaths (direct and indirect) were
calculated. The year with the highest rate of HIV (not AIDS) was 2005. The year with the highest rate of advanced HIV was 2009. The year with the highest rate of AIDS was 2006. The year with the highest rate of AIDS deaths (direct and indirect) was 2004 (Table 2).

Table 2: Persons Reported with HIV and AIDS and Deaths in Jamaica, 1982-2017

Source: HIV/STI/Tb Unit, Ministry of Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Persons reported with HIV (not AIDS)</th>
<th>Persons reported with Advanced HIV</th>
<th>Persons reported with AIDS</th>
<th>HIV/AIDS related deaths</th>
<th>All persons reported with HIV/AIDS (including Advanced HIV)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Rate (per 100,000)</td>
<td>N</td>
<td>Rate (per 100,000)</td>
<td>N</td>
</tr>
<tr>
<td>1982-1989</td>
<td>233</td>
<td>9.873</td>
<td>1</td>
<td>0.042</td>
<td>103</td>
</tr>
<tr>
<td>1990-1994</td>
<td>1286</td>
<td>52.005</td>
<td>1</td>
<td>0.040</td>
<td>482</td>
</tr>
<tr>
<td>1995-1999</td>
<td>2936</td>
<td>113.72</td>
<td>10</td>
<td>0.387</td>
<td>1504</td>
</tr>
<tr>
<td>2000</td>
<td>822</td>
<td>31.651</td>
<td>11</td>
<td>0.424</td>
<td>472</td>
</tr>
<tr>
<td>2001</td>
<td>848</td>
<td>32.520</td>
<td>6</td>
<td>0.230</td>
<td>454</td>
</tr>
<tr>
<td>2002</td>
<td>631</td>
<td>24.089</td>
<td>7</td>
<td>0.267</td>
<td>446</td>
</tr>
<tr>
<td>2003</td>
<td>839</td>
<td>31.908</td>
<td>7</td>
<td>0.266</td>
<td>503</td>
</tr>
<tr>
<td>2004</td>
<td>931</td>
<td>35.280</td>
<td>16</td>
<td>0.606</td>
<td>605</td>
</tr>
<tr>
<td>2006</td>
<td>1085</td>
<td>40.824</td>
<td>65</td>
<td>2.446</td>
<td>630</td>
</tr>
<tr>
<td>2008</td>
<td>1098</td>
<td>41.021</td>
<td>223</td>
<td>8.331</td>
<td>470</td>
</tr>
<tr>
<td>2009</td>
<td>613</td>
<td>22.821</td>
<td>440</td>
<td>16.381</td>
<td>466</td>
</tr>
<tr>
<td>2010</td>
<td>681</td>
<td>25.264</td>
<td>345</td>
<td>12.799</td>
<td>467</td>
</tr>
<tr>
<td>2012</td>
<td>742</td>
<td>27.365</td>
<td>271</td>
<td>9.995</td>
<td>499</td>
</tr>
<tr>
<td>2013</td>
<td>741</td>
<td>27.264</td>
<td>155</td>
<td>5.703</td>
<td>293</td>
</tr>
<tr>
<td>2014</td>
<td>706</td>
<td>25.925</td>
<td>183</td>
<td>6.720</td>
<td>215</td>
</tr>
<tr>
<td>2016</td>
<td>754</td>
<td>27.629</td>
<td>92</td>
<td>3.371</td>
<td>314</td>
</tr>
<tr>
<td>2017</td>
<td>748</td>
<td>27.411</td>
<td>131</td>
<td>4.801</td>
<td>236</td>
</tr>
</tbody>
</table>

Table 3 and figure 3 present the rate of persons living with HIV/AIDS in Jamaica by parish of residence from 1982 – 2017. The parish of St James had the highest PLHIV per 100,000 population rate (1709.5), this rate means that approximately 2 in every 100 persons residing in St James is living with HIV. St Elizabeth had the lowest PLHIV per 100,000 population rate (448.8), which can also be interpreted as approximately 4 in every 1000 persons residing in.
St Elizabeth are living with HIV. The five highest PLHIV rates are among parishes that are considered to be urban or tourism-centric: St James, Kingston & St Andrew, St Ann, Westmoreland and Trelawny.

The death rate of PLHIV was highest in St James (0.34) for the 1982-2017 period, followed by Hanover (0.33), Westmoreland (0.32) and Trelawny (0.31) as seen in table 3. Of note, the parishes among the highest fatality rate are all those in the western region. The lowest case fatality rate was in Clarendon (0.15) which is followed by St Ann with a 0.18 rate.

Table 3: Rate of persons living with HIV/AIDS by Parish of Residence, Jamaica, (2017 and cumulative)
Source: HIV/STI/Tb Unit, Ministry of Health

<table>
<thead>
<tr>
<th>Parish</th>
<th>Total HIV/AIDS cases</th>
<th>Deaths among PLHIV 1982-2017</th>
<th>Total PLHIV 1982-2017</th>
<th>Parish Pop.</th>
<th>HIV RATE PER 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982 - 2017 N Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kingston &amp; St Andrew</td>
<td>13056</td>
<td>3850</td>
<td>0.29</td>
<td>9206</td>
<td>670312</td>
</tr>
<tr>
<td>St Thomas</td>
<td>614</td>
<td>124</td>
<td>0.20</td>
<td>490</td>
<td>95015</td>
</tr>
<tr>
<td>Portland</td>
<td>804</td>
<td>215</td>
<td>0.27</td>
<td>589</td>
<td>82710</td>
</tr>
<tr>
<td>St Mary</td>
<td>1203</td>
<td>375</td>
<td>0.31</td>
<td>828</td>
<td>114959</td>
</tr>
<tr>
<td>St Ann</td>
<td>2533</td>
<td>449</td>
<td>0.18</td>
<td>2084</td>
<td>174343</td>
</tr>
<tr>
<td>Trelawny</td>
<td>1007</td>
<td>310</td>
<td>0.31</td>
<td>697</td>
<td>76043</td>
</tr>
<tr>
<td>St James</td>
<td>4799</td>
<td>1622</td>
<td>0.34</td>
<td>3177</td>
<td>185846</td>
</tr>
<tr>
<td>Hanover</td>
<td>937</td>
<td>307</td>
<td>0.33</td>
<td>630</td>
<td>70322</td>
</tr>
<tr>
<td>Westmoreland</td>
<td>2081</td>
<td>673</td>
<td>0.32</td>
<td>1408</td>
<td>145746</td>
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<tr>
<td>St Elizabeth</td>
<td>968</td>
<td>286</td>
<td>0.30</td>
<td>682</td>
<td>151961</td>
</tr>
<tr>
<td>Manchester</td>
<td>1269</td>
<td>341</td>
<td>0.27</td>
<td>928</td>
<td>192036</td>
</tr>
<tr>
<td>Clarendon</td>
<td>1912</td>
<td>284</td>
<td>0.15</td>
<td>1628</td>
<td>247902</td>
</tr>
<tr>
<td>St Catherine</td>
<td>5018</td>
<td>1265</td>
<td>0.25</td>
<td>3753</td>
<td>521669</td>
</tr>
<tr>
<td>Parish Unknown</td>
<td>319</td>
<td>19</td>
<td>NA</td>
<td>300</td>
<td>N/A</td>
</tr>
<tr>
<td>Overseas address</td>
<td>33</td>
<td>7</td>
<td>NA</td>
<td>26</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>36553</td>
<td>10127</td>
<td>0.28</td>
<td>26426</td>
<td>2728864</td>
</tr>
</tbody>
</table>
Among the 26426 PLHIV in Jamaica for the year 2017, the male: female ratio was 1:1.02. The cumulative HIV/AIDS case rates for females is (968 cases per 100,000) and this is slightly higher when compared to the male rate of (965 cases per 100,000). More males are diagnosed with HIV/AIDS and still more also die whether directly or indirectly related to the disease, therefore more women are living with the disease than men (see Figure 4 below).

People between the ages of 20 to 39 years have the highest number of people currently living with HIV/AIDS among all age groups and both sexes. Among females, the 20 to 29 year olds dominate that group and among male PLHIVs, the 30-39 year olds dominate the group. The 0-4 age group accounts for 3% and the 5-9 age group account for less than 1% of the total number over the 35-year period. For PLHIV reported to the MOH, there were 15 unknown gender in the 0-4 year’s age group and 37 unknown gender in the unknown age group as well.
The total HIV seroprevalence among antenatal clinic (ANC) participants increased from 0.8% in 2016 to 0.9% in 2017. When HIV sero-prevalence for individual parishes were compared between 2016 and 2017, increases were observed in the parishes of KSA, St. Catherine, and St. James, while decreases were observed in St. Ann, Clarendon, and Westmoreland (Table 4). Increases in HIV seropositive prevalence were also observed in most age groups in 2017 when compared with 2016 (Table 11).
Table 4: Seroprevalence of HIV by parish among ANC attendees who participated in the 2017 sentinel survey
Source: National Epidemiology Unit, Ministry of Health

<table>
<thead>
<tr>
<th>PARISH</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Tested</td>
<td>Total Positive</td>
</tr>
<tr>
<td>Kingston &amp; St Andrew</td>
<td>1,547</td>
<td>12</td>
</tr>
<tr>
<td>St Catherine</td>
<td>1,161</td>
<td>8</td>
</tr>
<tr>
<td>St Ann</td>
<td>569</td>
<td>5</td>
</tr>
<tr>
<td>Clarendon</td>
<td>781</td>
<td>6</td>
</tr>
<tr>
<td>St James</td>
<td>464</td>
<td>4</td>
</tr>
<tr>
<td>Westmoreland</td>
<td>695</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,217</td>
<td>39</td>
</tr>
</tbody>
</table>

Figure 5 illustrates the HIV seropositive prevalence trends among the antenatal clinic attendees for the period 1989 -2017.

From the graph below it can be noted that the HIV seropositive prevalence among Antenatal Clinic attendees peaked in 1996. There have been a number of fluctuations in the HIV seropositive prevalence over the years, with an overall decline since 2009. There was an almost steady decline observed between 2011 and 2014. In 2015 however, the HIV seropositive prevalence increased almost to what it was in 2011. The HIV seropositive prevalence for 2016 fell below those of the prior seven years. In 2017 the seroprevalence rate increased (compared to 2016) and was similar to rates seen in in 2010, 2012 and 2013 (Figure 2).
Of the total 36,553 cases reported since 1982, 10,127 of those cases have died, whether directly or indirectly from the disease. Males account for the greater number of PLHIV deaths across most age groups except notable differences in 10-19 and 20-29 year-old females as illustrated in Figure 4. Since the diagnosis of HIV/AIDS in 1982, the highest number of deaths have occurred among 30 to 39 year-olds for both males and females, 32% of the overall reported HIV/AIDS deaths.
Tables 5 shows the HIV risk history among PLHIV disaggregated by sex. HIV is primarily transmitted through sexual intercourse in Jamaica. From the first diagnosed case of HIV in 1982, the cumulative predominant risk history associated with PLHIV males is having a history of STI and likewise for females. This is followed by sex with CSW for males and multiple partners for females. Approximately 11% of both men and women reported multiple sex partners as a risk behaviour. Almost four percent of men reported “ever in prison” as a risk history. Crack cocaine use was reported more in males (3.2%) than females (2.0%) and blood transfusions was more reported in females (3.6%) than in males (1.9%). The lowest reported risk history categories (less than 1%) for both males and females were: intravenous drug use, unprotected anal sex, victim of assault, sex with known PLHIV, transactional sex and perinatal exposure.
Table 5: HIV Risk History by Sex (1982-2017)  
Source: HIV/STI/Tb Unit, Ministry of Health

<table>
<thead>
<tr>
<th>Risk History</th>
<th>Male (%)</th>
<th>Female (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood transfusion</td>
<td>541 (1.9%)</td>
<td>825 (3.6%)</td>
</tr>
<tr>
<td>Crack/cocaine use</td>
<td>941 (3.2%)</td>
<td>459 (2.0%)</td>
</tr>
<tr>
<td>Intravenous drug use</td>
<td>128 (0.4%)</td>
<td>83 (0.4%)</td>
</tr>
<tr>
<td>Sex Transmitted Infection</td>
<td>10095 (34.7%)</td>
<td>9749 (43.0%)</td>
</tr>
<tr>
<td>Genital Ulcers/sores</td>
<td>3033 (10.4%)</td>
<td>2055 (9.1%)</td>
</tr>
<tr>
<td>Sex with CSW</td>
<td>4497 (15.5%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>CSW</td>
<td>152 (0.5%)</td>
<td>680 (3.0%)</td>
</tr>
<tr>
<td>Unprotected anal sex</td>
<td>19 (0.1%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Multiple partners</td>
<td>3193 (11.0%)</td>
<td>2425 (10.7%)</td>
</tr>
<tr>
<td>Ever in prison</td>
<td>1066 (3.7%)</td>
<td>225 (1.0%)</td>
</tr>
<tr>
<td>Victim of assault</td>
<td>72 (0.2%)</td>
<td>213 (0.9%)</td>
</tr>
<tr>
<td>Sex with known PLHIV</td>
<td>13 (0.0%)</td>
<td>196 (0.9%)</td>
</tr>
<tr>
<td>Transactional sex</td>
<td>264 (0.9%)</td>
<td>193 (0.9%)</td>
</tr>
<tr>
<td>Perinatal exposure</td>
<td>0 (0.0%)</td>
<td>1 (0.0%)</td>
</tr>
</tbody>
</table>

Table 6 tabulates the behavioural practices of PLHIV disaggregated by sex. During the period 1982-2017, of the total number of males reported with HIV, 5% (836) were identified as men who have sex with men and 4% (798) identified as bisexual. Almost all PLHIV women are heterosexual and less than 1% identified as bisexual.
**Table 6:** Behavioural practices of people living with HIV/AIDS in Jamaica by gender (1982-2017)

*Source:* HIV/STI/Tb Unit, Ministry of Health

<table>
<thead>
<tr>
<th>Behavioural Practices</th>
<th>Male (%)</th>
<th>Female (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>9392 (51.54)</td>
<td>16595 (99.93)</td>
</tr>
<tr>
<td>Homosexual</td>
<td>863 (4.74)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>798 (4.38)</td>
<td>2 (0.01)</td>
</tr>
<tr>
<td>Not stated</td>
<td>7170 (39.35)</td>
<td>10 (0.06)</td>
</tr>
</tbody>
</table>
**New HIV Diagnoses in 2017**

There were 1197 new cases in 2017. The scope of testing has improved since 2016, where of the 1197 newly diagnosed in 2017 only 82 (6.8%) were notified to the National Epidemiology Unit for the first time as deaths.

Approximately eleven percent (or 131) of these had a CD4 between 200 and 350. This may be attributed to the scaled-up HIV testing and counselling through Provider Initiated Testing and Counselling (PITC), in order to facilitate early diagnosis. The scope of testing needs to be widened since of these new cases, 236 (20%) were notified to the National Epidemiology Unit for the first time as AIDS (Figure 7).

*Figure 7: Number of New HIV diagnosis (not AIDS), AIDS diagnosis and AIDS deaths, Jamaica, 2017*

The national HIV/AIDS case rate for 2017 is 43.9 cases per 100,000 population. Table 7 and figure 8 present the rate of new HIV/AIDS cases in 2017 in Jamaica by parish of residence. The highest HIV/AIDS rates were among the most urbanized parishes: Kingston & St. Andrew –73 cases per 100,000 persons, and St. James –70 cases per 100,000 persons followed by
the rural parishes Westmoreland (50.8/100,000) and Trelawny (50.0/100,000). In comparison to the national rate, these parishes have higher HIV/AIDS case rates per population. Manchester had the lowest rate (13.0/100,000) for the year (Table 7 and Figure 8).

The death rate of PLHIV in 2017 was highest in Kingston and St Andrew (27.3), followed by St Catherine (8.6) and Trelawny (7.9) as seen in table 7. Portland and Clarendon both have the lowest death rate among PLHIV for 2017, which was 2.4 per 100,000 population.

Table 7: Persons newly diagnosed with HIV/AIDS by Parish of residence, Jamaica, 2017

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Rate*</td>
<td>N</td>
</tr>
<tr>
<td>Kingston &amp; St Andrew</td>
<td>670312</td>
<td>489</td>
<td>73.0</td>
</tr>
<tr>
<td>St Thomas</td>
<td>95015</td>
<td>32</td>
<td>33.7</td>
</tr>
<tr>
<td>Portland</td>
<td>82710</td>
<td>25</td>
<td>30.2</td>
</tr>
<tr>
<td>St Mary</td>
<td>114959</td>
<td>37</td>
<td>32.2</td>
</tr>
<tr>
<td>St Ann</td>
<td>174343</td>
<td>24</td>
<td>13.8</td>
</tr>
<tr>
<td>Trelawny</td>
<td>76043</td>
<td>38</td>
<td>50.0</td>
</tr>
<tr>
<td>St James</td>
<td>185846</td>
<td>130</td>
<td>70.0</td>
</tr>
<tr>
<td>Hanover</td>
<td>70322</td>
<td>28</td>
<td>39.8</td>
</tr>
<tr>
<td>Westmoreland</td>
<td>145746</td>
<td>74</td>
<td>50.8</td>
</tr>
<tr>
<td>St Elizabeth</td>
<td>151961</td>
<td>35</td>
<td>23.0</td>
</tr>
<tr>
<td>Manchester</td>
<td>192036</td>
<td>25</td>
<td>13.0</td>
</tr>
<tr>
<td>Clarendon</td>
<td>247902</td>
<td>57</td>
<td>23.0</td>
</tr>
<tr>
<td>St Catherine</td>
<td>521669</td>
<td>183</td>
<td>35.1</td>
</tr>
<tr>
<td>Parish Unknown</td>
<td>20</td>
<td>5</td>
<td>43.9</td>
</tr>
</tbody>
</table>

Source: HIV/STI/Tb Unit, Ministry of Health; *Rate per 100,000 population Please note that of the 1197 – some of these cases were diagnosed at the stage of death (82 in 2017).
Figure 8: Rate of persons newly diagnosed with HIV/AIDS in Jamaica by Parish of residence, 2017

Figure 9 indicates, the number of new HIV, Advanced HIV and AIDS diagnosed for 2017 by sex and current age group. Of these, there were more males diagnosed across all age groups except 10 -19 year-olds. The age group 20 to 29 year olds represents the highest diagnosed cases for both male and female, 160 and 149 cases respectively. The decrease in condom use among persons in the 15-24 and 25-49 age groups as noted in the 2017 knowledge attitudes and behaviour survey may have contributed to the high level of diagnosed cases in the 20-29 age group.

Source: National Epidemiology Unit, Ministry of Health
In spite of the highest number of diagnoses at ages 20-29 years old for both males and females, the most deaths (direct and indirect) occurred at ages 40-49 for males and 30-39 years for females. Deaths at 20-29 years are about the same for both sexes (Figure 10).

**Figure 10: HIV/AIDS deaths (direct and indirect) by Sex and Current Age Group, Jamaica, 2017**

Source: HIV/STI/Tb Unit, Ministry of Health
Table 8 shows the HIV risk history of new HIV diagnoses in 2017. The highest risk history among males was multiple partners and among females it was sexually transmitted infection. The top three risk history among males was, multiple partners (26.8%), STI (21.5%) and sex with CSW (15.8%). The three highest risk history among females are, STI (41.2%), multiple partners (22.9%) and victim of assault (7.2%). Similar to the cumulative risk history profile, intravenous drug use and perinatal exposure remain below one percent for both males and females.

In 2017, the sexual practice trend is similar to the cumulative 1982-2017 pattern with the top sexual practice being heterosexuality, then homosexuality and bisexuality (Table 9). However, in 2017 the data shows that reporting of homosexual practice among men increased. This may be attributed to improved data collection and quality including collection of risk factor information.

**Table 8: Risk behaviour of newly diagnosed HIV cases in Jamaica by gender, 2017**

*Source: HIV/STI/Tb Unit, Ministry of Health*

<table>
<thead>
<tr>
<th>Risk Behaviour</th>
<th>Male (%)</th>
<th>Female (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood transfusion</td>
<td>2 (0.9%)</td>
<td>5 (3.3%)</td>
</tr>
<tr>
<td>Crack/cocaine use</td>
<td>3 (1.3%)</td>
<td>1 (0.7%)</td>
</tr>
<tr>
<td>Intravenous drug use</td>
<td>2 (0.9%)</td>
<td>1 (0.7%)</td>
</tr>
<tr>
<td>Sex Transmitted Infection</td>
<td>49 (21.5%)</td>
<td>63 (41.2%)</td>
</tr>
<tr>
<td>Genital Ulcers/sores</td>
<td>7 (3.1%)</td>
<td>7 (4.6%)</td>
</tr>
<tr>
<td>Sex with CSW</td>
<td>36 (15.8%)</td>
<td>1 (0.7%)</td>
</tr>
<tr>
<td>CSW</td>
<td>2 (0.9%)</td>
<td>6 (3.9%)</td>
</tr>
<tr>
<td>Unprotected anal sex</td>
<td>16 (7.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Multiple partners</td>
<td>61 (26.8%)</td>
<td>35 (22.9%)</td>
</tr>
<tr>
<td>Ever in prison</td>
<td>10 (4.4%)</td>
<td>2 (1.3%)</td>
</tr>
<tr>
<td>Victim of assault</td>
<td>7 (3.1%)</td>
<td>11 (7.2%)</td>
</tr>
<tr>
<td>Sex with known PLHIV</td>
<td>13 (5.7%)</td>
<td>10 (6.5%)</td>
</tr>
<tr>
<td>Transactional sex</td>
<td>17 (7.5%)</td>
<td>9 (5.9%)</td>
</tr>
<tr>
<td>Perinatal exposure</td>
<td>0 (0.0%)</td>
<td>1 (0.7%)</td>
</tr>
</tbody>
</table>
Table 9: Sexual practices of newly diagnosed HIV cases in Jamaica by gender, 2017

<table>
<thead>
<tr>
<th>Sexual Practices</th>
<th>Male (%)</th>
<th>Female (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>335 (54.29)</td>
<td>565 (98.09)</td>
</tr>
<tr>
<td>Homosexual</td>
<td>82 (13.29)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>38 (6.16)</td>
<td>1 (0.17)</td>
</tr>
</tbody>
</table>

Figure 11 represents a trend for new HIV diagnoses by disease stage for a 5-year period. There has not been a remarkable decrease in diagnosis at the advanced HIV stage from the base year 2013 to 2017. There have been slow, steady fluctuations in the diagnosis at death. Of note, 2015 had the lowest percentage of new diagnoses classified as AIDS and AIDS deaths. The year 2016 had the highest percentage of new diagnoses classified as AIDS. Compared to previous years, 2017 had one of the more cases diagnosed at the HIV stage, however the year also saw seven percent of cases newly classified at death.

Figure 11: New HIV diagnoses by Disease Stage, Jamaica, 2013–2017
HIV in Key and Vulnerable Populations

Jamaica has features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.8%, however surveys (MSM, 2011 [33%] and FSW, 2017 [2%]) show higher HIV prevalence in at-risk groups. The main risk groups that have been identified in Jamaica are men who have sex with men, female sex worker, transgender people, adolescents, prisoners, persons with disabilities, women and STI clinic attendees.

Key Population
Men who have sex with men (MSM) accounted for the highest proportion of a diagnosis of HIV among the key populations (95% of KP). This KP also accounts for the highest percentage of new advanced HIV and new AIDS diagnoses (Table 10).

Table 10: Key population newly diagnosed with HIV (not AIDS), AIDS, and living with HIV and/or AIDS

<p>| Source: HIV/STI/Tb Unit, Ministry of Health |</p>
<table>
<thead>
<tr>
<th>Key Populations and Vulnerable Groups</th>
<th>New HIV diagnoses (not AIDS)</th>
<th>New Advanced HIV diagnoses</th>
<th>New AIDS diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM/Bisexual men</td>
<td>84</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Female Sex Worker</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Prisoners</td>
<td>Twelve (12) diagnosed classification is currently unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td>Five (5) diagnosed classification is currently unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>None reported for 2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tables 11 and 12 characterise new HIV and AIDS diagnoses among key populations for 2017. The young MSM population account for the highest HIV diagnosis (15-24 years =58 and 25-29 years = 29). The MSM population had the youngest age group of all the key populations. Female sex workers, prisoners, and transgender persons had no 15-24 year olds diagnosed for the year 2017. Data related to the homeless population were unavailable.
Table 11: Key populations newly diagnosed with HIV and AIDS by age, 2017  
Source: HIV/STI/Tb Unit, Ministry of Health

<table>
<thead>
<tr>
<th>Key populations and vulnerable groups</th>
<th>15-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45+</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM/Bisexual men</td>
<td>58</td>
<td>29</td>
<td>16</td>
<td>8</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Female Sex Worker</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Prisoners</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Transgender</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Homeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None reported for 2017</td>
<td></td>
</tr>
</tbody>
</table>

Kingston & St. Andrew (KSA) have the highest number of newly diagnosed HIV and AIDS among key populations recorded for the year 2017. This could be related to the fact that KSA has the largest population in the island (Table 12).

Table 12: Key populations newly diagnosed with HIV and AIDS by parish, 2017  
Source: HIV/STI/Tb Unit, Ministry of Health

<table>
<thead>
<tr>
<th>Key population</th>
<th>KSA</th>
<th>STT</th>
<th>POR</th>
<th>STM</th>
<th>STA</th>
<th>TRE</th>
<th>STJ</th>
<th>HAN</th>
<th>WES</th>
<th>STE</th>
<th>MAN</th>
<th>CLA</th>
<th>STC</th>
<th>UNK</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM/Bisexual men</td>
<td>59</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>27</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Female Sex Worker</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Prisoners</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>None reported for 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vulnerable Population

Table 13 show the age categories and parish of residence, respectively, for new HIV and AIDS diagnoses among vulnerable populations for 2017. Women 45 years and over account for the highest number of newly diagnosed with HIV and AIDS for 2017 (n=177) followed by the adolescents (15-24 age group).
Table 13: Vulnerable populations newly diagnosed with HIV and AIDS by age, 2017
Source: HIV/STI/Tb Unit, Ministry of Health

<table>
<thead>
<tr>
<th>Key populations and vulnerable groups</th>
<th>15-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
<th>40-44</th>
<th>45+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents (15-24 years)</td>
<td>67</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Persons with disabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>130</td>
<td>66</td>
<td>76</td>
<td>61</td>
<td>59</td>
<td>177</td>
</tr>
<tr>
<td>STI clinic attendees</td>
<td>15</td>
<td>10</td>
<td>11</td>
<td>9</td>
<td>11</td>
<td>23</td>
</tr>
</tbody>
</table>

Kingston & St. Andrew (KSA) have the highest number of newly diagnosed HIV and AIDS among vulnerable populations recorded for the year 2017 (Table 14). The four parishes that constitute the Western Region have the next highest number of vulnerable population, these parishes are tourism heavy spots and this might contribute to the high burden of vulnerable population acquiring HIV in 2017.

Table 14: Vulnerable populations newly diagnosed with HIV and AIDS by parish, 2017
Source: HIV/STI/Tb Unit, Ministry of Health

<table>
<thead>
<tr>
<th>Key populations and vulnerable groups</th>
<th>KSA</th>
<th>STT</th>
<th>POR</th>
<th>STM</th>
<th>STA</th>
<th>TRE</th>
<th>STJ</th>
<th>HAN</th>
<th>WES</th>
<th>STE</th>
<th>MAN</th>
<th>CLA</th>
<th>STC</th>
<th>UNK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents (15-24 years)</td>
<td>22</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Persons with disabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>223</td>
<td>16</td>
<td>11</td>
<td>21</td>
<td>13</td>
<td>19</td>
<td>67</td>
<td>14</td>
<td>30</td>
<td>15</td>
<td>15</td>
<td>34</td>
<td>90</td>
<td>8</td>
</tr>
<tr>
<td>STI clinic attendees</td>
<td>23</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>15</td>
<td>11</td>
<td>0</td>
</tr>
</tbody>
</table>

Data from surveillance of STI clinic attendees in 2017 indicated that for every 1,000 persons with a sexually transmitted infection, approximately 46 were infected with HIV (Table 15). Further, 62% of STI attendees tested in the sentinel surveillance were females – 3.0% of these females tested positive for HIV compared to 7.3% of male STI attendees.
Table 15: HIV prevalence among STI clinic attendees who participated in the 2017 sentinel survey
Source: National Epidemiology Unit, Ministry of Health

<table>
<thead>
<tr>
<th>PARISH</th>
<th>Total Tested</th>
<th>Total Positive</th>
<th>% Positive</th>
<th>(95% CI) Exact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston &amp; St Andrew</td>
<td>1,224</td>
<td>76</td>
<td>6.21</td>
<td>4.92 – 7.71</td>
</tr>
<tr>
<td>St Catherine</td>
<td>307</td>
<td>8</td>
<td>2.61</td>
<td>1.13 – 5.07</td>
</tr>
<tr>
<td>St Ann</td>
<td>181</td>
<td>3</td>
<td>1.66</td>
<td>0.34 – 4.77</td>
</tr>
<tr>
<td>Clarendon</td>
<td>82</td>
<td>1</td>
<td>1.22</td>
<td>0.03 – 6.61</td>
</tr>
<tr>
<td>St James</td>
<td>275</td>
<td>7</td>
<td>2.55</td>
<td>1.03 – 5.17</td>
</tr>
<tr>
<td>Westmoreland</td>
<td>34</td>
<td>2</td>
<td>5.88</td>
<td>0.72-19.68</td>
</tr>
<tr>
<td>Total</td>
<td>2,103</td>
<td>97</td>
<td>4.61</td>
<td>3.76 – 5.60</td>
</tr>
</tbody>
</table>

Figure 12 illustrates trends in HIV seropositive prevalence in STI Clinic attendees over the past 29 years. From the graph below it can be noted that the HIV seropositive prevalence in STI clinic attendees trended downwards down-wards from 2001 to 2014. In the past three years, however, the HIV sero-prevalence in this group has been trending up (Figure 12).

Figure 12: HIV seroprevalence in STI Clinic attendees

Source: National Epidemiology Unit, Ministry of Health
Public Health Conclusions

The changing epidemiology of HIV infections observed over the last decade suggests that some progress has been achieved, particularly with regard to reducing infections. However, these epidemiological trends also indicate that it is crucial to sustain, and in some places strengthen evidence-based HIV prevention interventions tailored to the local epidemiological context and targeting those most at risk, including more frequent testing for those at-risk of HIV infection, immediate offer of antiretroviral therapy for those found positive. The scope of HIV testing has improved, diagnoses will be more widespread, allowing for greater impact with the test and treat initiative which commenced in January 2017. Greater access to ART can also be a major contributor to overall viral suppression if followed along the HIV continuum of care.

Programmes on the prevention and control of HIV infection adapted to key populations and youth are of utmost importance. It is critical that services for prevention and HIV testing, are combined with policies that facilitate, promote and ensure linkage and access to care throughout the island.
References


### Addtional Facts and Figures

**Summary of HIV Cases diagnosed by Year and Sex, Jamaica, 1982 - 2017**

<table>
<thead>
<tr>
<th>Year</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Unknown (%)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982-1996</td>
<td>2770 62.7%</td>
<td>1613 36.5%</td>
<td>37 0.8%</td>
<td>4420</td>
</tr>
<tr>
<td>1997</td>
<td>698 60.9%</td>
<td>447 39.0%</td>
<td>2 0.2%</td>
<td>1147</td>
</tr>
<tr>
<td>1998</td>
<td>652 58.6%</td>
<td>460 41.3%</td>
<td>1 0.1%</td>
<td>1113</td>
</tr>
<tr>
<td>1999</td>
<td>831 56.0%</td>
<td>651 43.9%</td>
<td>2 0.1%</td>
<td>1484</td>
</tr>
<tr>
<td>2000</td>
<td>853 54.4%</td>
<td>714 45.6%</td>
<td>0 0.0%</td>
<td>1567</td>
</tr>
<tr>
<td>2001</td>
<td>795 50.0%</td>
<td>791 49.7%</td>
<td>5 0.3%</td>
<td>1591</td>
</tr>
<tr>
<td>2002</td>
<td>729 51.7%</td>
<td>681 48.3%</td>
<td>1 0.1%</td>
<td>1411</td>
</tr>
<tr>
<td>2003</td>
<td>844 50.1%</td>
<td>838 49.8%</td>
<td>1 0.1%</td>
<td>1683</td>
</tr>
<tr>
<td>2004</td>
<td>865 45.8%</td>
<td>1023 54.2%</td>
<td>0 0.0%</td>
<td>1888</td>
</tr>
<tr>
<td>2005</td>
<td>896 45.7%</td>
<td>1063 54.3%</td>
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<td>1959</td>
</tr>
<tr>
<td>2006</td>
<td>994 48.3%</td>
<td>1063 51.7%</td>
<td>1 0.0%</td>
<td>2058</td>
</tr>
<tr>
<td>2007</td>
<td>823 48.4%</td>
<td>879 51.6%</td>
<td>0 0.0%</td>
<td>1702</td>
</tr>
<tr>
<td>2008</td>
<td>944 47.5%</td>
<td>1040 52.4%</td>
<td>2 0.1%</td>
<td>1986</td>
</tr>
<tr>
<td>2009</td>
<td>798 48.2%</td>
<td>859 51.8%</td>
<td>0 0.0%</td>
<td>1657</td>
</tr>
<tr>
<td>2010</td>
<td>849 52.1%</td>
<td>782 47.9%</td>
<td>0 0.0%</td>
<td>1631</td>
</tr>
<tr>
<td>2011</td>
<td>823 49.2%</td>
<td>850 50.8%</td>
<td>0 0.0%</td>
<td>1673</td>
</tr>
<tr>
<td>2012</td>
<td>835 51.3%</td>
<td>793 48.7%</td>
<td>0 0.0%</td>
<td>1628</td>
</tr>
<tr>
<td>2013</td>
<td>680 53.7%</td>
<td>586 46.3%</td>
<td>0 0.0%</td>
<td>1266</td>
</tr>
<tr>
<td>2014</td>
<td>585 49.2%</td>
<td>604 50.8%</td>
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<td>1189</td>
</tr>
<tr>
<td>2015</td>
<td>543 51.1%</td>
<td>519 48.9%</td>
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<td>1062</td>
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<tr>
<td>2016</td>
<td>661 53.3%</td>
<td>580 46.7%</td>
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<td>1241</td>
</tr>
<tr>
<td>2017</td>
<td>621 51.9%</td>
<td>576 48.1%</td>
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<td>1197</td>
</tr>
<tr>
<td>Total</td>
<td>19089 52.2%</td>
<td>17412 47.6%</td>
<td>52 0.1%</td>
<td>36553</td>
</tr>
</tbody>
</table>

**Source:** HIV/STI/Tb Unit, Ministry of Health
Summary of AIDS Deaths, Jamaica, 1982 – 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982-1996</td>
<td>768</td>
<td>428</td>
<td>1288</td>
</tr>
<tr>
<td>1997</td>
<td>248</td>
<td>145</td>
<td>375</td>
</tr>
<tr>
<td>1998</td>
<td>233</td>
<td>142</td>
<td>442</td>
</tr>
<tr>
<td>1999</td>
<td>341</td>
<td>207</td>
<td>538</td>
</tr>
<tr>
<td>2000</td>
<td>359</td>
<td>257</td>
<td>557</td>
</tr>
<tr>
<td>2001</td>
<td>329</td>
<td>258</td>
<td>616</td>
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<tr>
<td>2002</td>
<td>402</td>
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<td>696</td>
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<tr>
<td>2003</td>
<td>380</td>
<td>269</td>
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<tr>
<td>2004</td>
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<td>700</td>
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<td>2005</td>
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<tr>
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<td>2010</td>
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<td>2011</td>
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<td>169</td>
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<td>159</td>
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<tr>
<td>2014</td>
<td>121</td>
<td>96</td>
<td>196</td>
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<tr>
<td>2015</td>
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<td>136</td>
</tr>
<tr>
<td>2016</td>
<td>185</td>
<td>133</td>
<td>260</td>
</tr>
<tr>
<td>2017</td>
<td>170</td>
<td>139</td>
<td>293</td>
</tr>
<tr>
<td>Total</td>
<td>6047</td>
<td>4080</td>
<td>10127</td>
</tr>
</tbody>
</table>

Source: HIV/STI/Tb Unit, Ministry of Health
## Summary of AIDS Death by Parish, Jamaica, 1982 – 2017

<table>
<thead>
<tr>
<th>Parish</th>
<th>2017</th>
<th>1982 - 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston &amp; St Andrew</td>
<td>183</td>
<td>3850</td>
</tr>
<tr>
<td>St Thomas</td>
<td>3</td>
<td>124</td>
</tr>
<tr>
<td>Portland</td>
<td>2</td>
<td>215</td>
</tr>
<tr>
<td>St Mary</td>
<td>4</td>
<td>375</td>
</tr>
<tr>
<td>St Ann</td>
<td>9</td>
<td>449</td>
</tr>
<tr>
<td>Trelawny</td>
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<td>310</td>
</tr>
<tr>
<td>St James</td>
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<td>1622</td>
</tr>
<tr>
<td>Hanover</td>
<td>3</td>
<td>307</td>
</tr>
<tr>
<td>Westmoreland</td>
<td>7</td>
<td>673</td>
</tr>
<tr>
<td>St Elizabeth</td>
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<td>Manchester</td>
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<tr>
<td>Clarendon</td>
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<td>284</td>
</tr>
<tr>
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<td>1265</td>
</tr>
<tr>
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<td>19</td>
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<tr>
<td>Overseas address</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>293</td>
<td>10127</td>
</tr>
</tbody>
</table>

*Source: HIV/STI/Tb Unit, Ministry of Health*