WEEKLY EPIDEMIOLOGY BULLETIN

NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

HIV and AIDS (Part 2)

Transmission



HIV can be transmitted via the exchange of body fluids from people living with HIV, including blood, breast milk, semen, and vaginal secretions. HIV can also be transmitted to a child during pregnancy and delivery. People cannot become infected with HIV through ordinary day-to-day contact such as kissing, hugging, shaking hands, or sharing personal objects, food or water.People living with HIV who are taking ART and have an undetectable viral load will not transmit HIV to their sexual partners. Early access to ART and support to remain on treatment is therefore critical not only to improve the health of people living with HIV but also to prevent HIV transmission.

Risk factors

Behaviours and conditions that put people at greater risk of contracting HIV include:

- having anal or vaginal sex without a condom;
- having another sexually transmitted infection (STI) such as syphilis, herpes, chlamydia, gonorrhoea and bacterial vaginosis;
- harmful use of alcohol or drugs in the context of sexual behaviour;
- sharing contaminated needles, syringes and other injecting equipment, or drug solutions when injecting drugs;
- receiving unsafe injections, blood transfusions, or tissue transplantation; and
- medical procedures that involve unsterile cutting or piercing; or accidental needle stick injuries, including among health workers.

Diagnosis

HIV can be diagnosed through rapid diagnostic tests that provide same-day results. This greatly facilitates early diagnosis and linkage with treatment and prevention. People can also use HIV self-tests to test themselves. However, no single test can provide a full HIV positive diagnosis; confirmatory testing is required, conducted by a qualified and trained health worker or community worker. HIV infection can be detected with great accuracy using WHO prequalified tests within a nationally approved testing strategy and algorithm.

Article:.https://www.who.int/news-room/fact-sheets/detail/hiv-aids
Image: https://dbclinic.com.sg/hiv-test-vs-std-test/

EPI WEEK 37



Syndromic Surveillance

Accidents

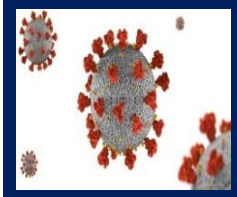
Violence

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

Page 9

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.

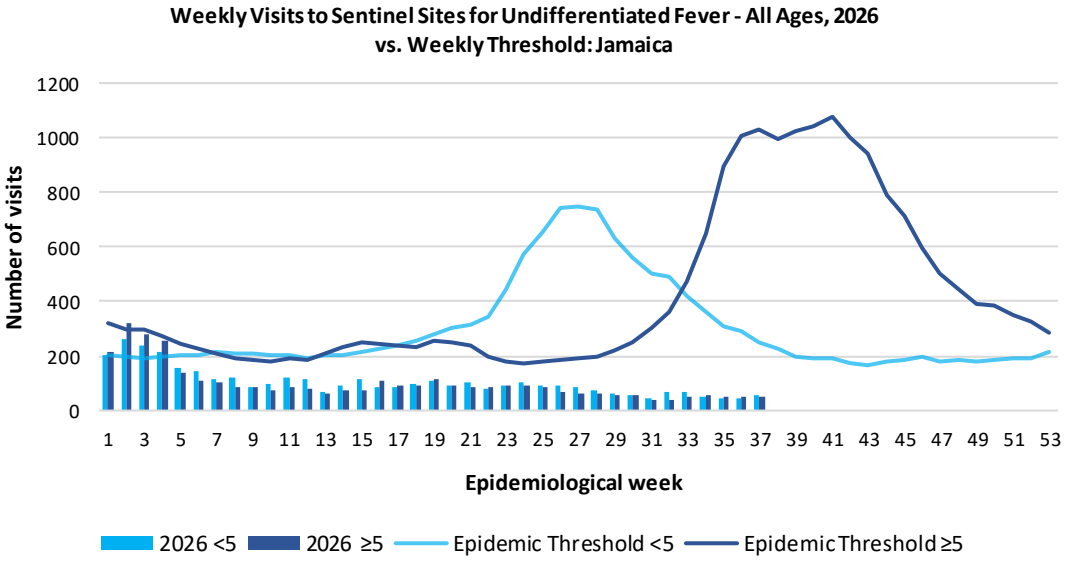
KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

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													
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
36	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
37	Late (W)	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time

SYNDROMIC SURVEILLANCE

FEVER
UNDIFFERENTIATED FEVER

Temperature of $>38^0C$ $/100.4^0F$ (or recent history of fever) with or without an obvious diagnosis or focus of infection.



NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

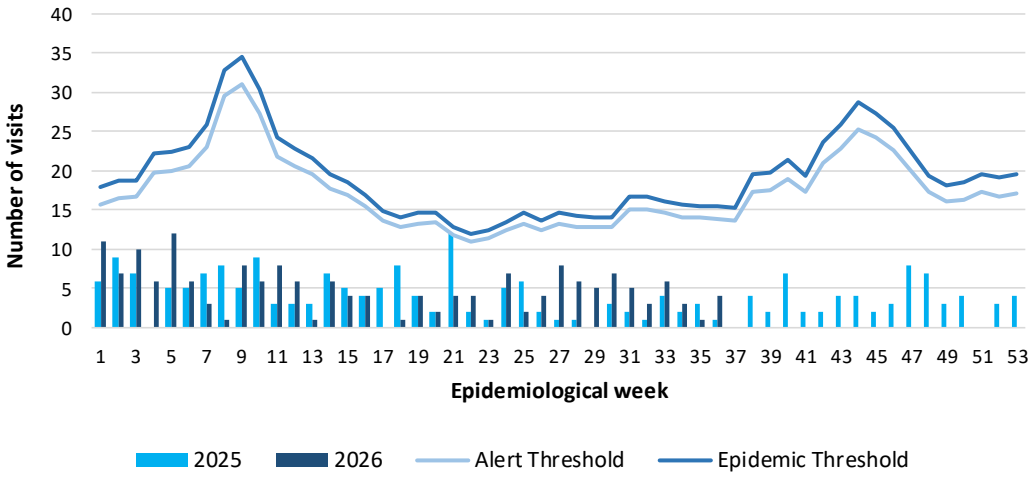
HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

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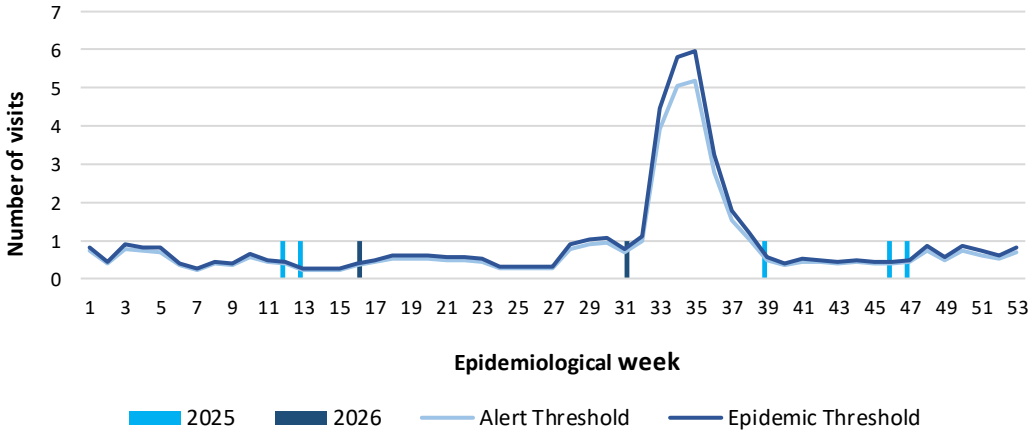
FEVER AND NEUROLOGICAL

Temperature of >38^{0}C /100.4^{0}F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).



FEVER AND HAEMORRHAGIC

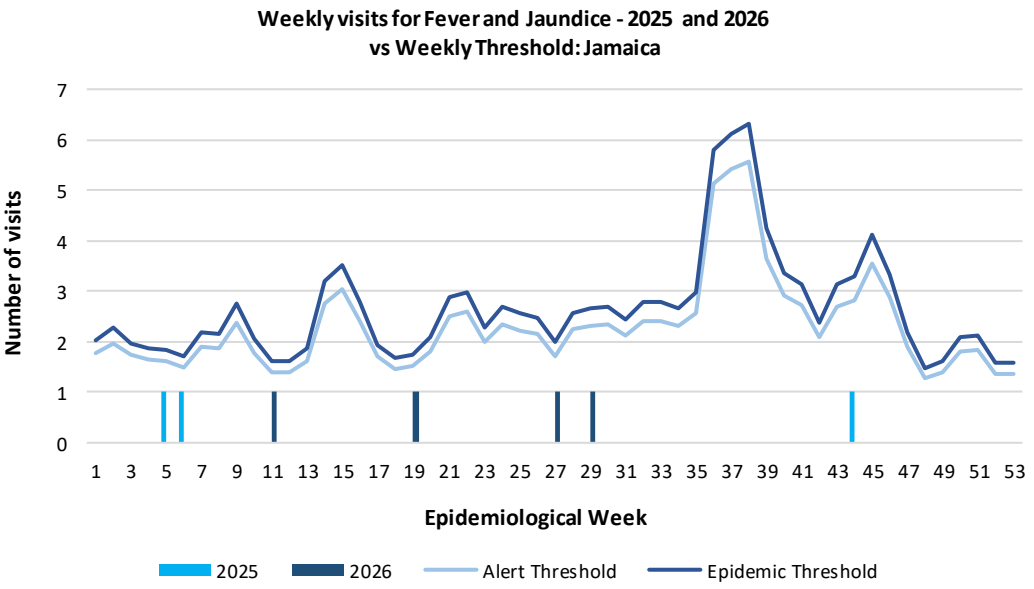
Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



FEVER AND JAUNDICE

Temperature of >38^0C /100.4^0F (or recent history of fever) in a previously healthy person presenting with jaundice.

The epidemic threshold is used to confirm the emergence of an epidemic in order to implement control measures. It is calculated using the mean reported cases per week plus 2 standard deviations.



3 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

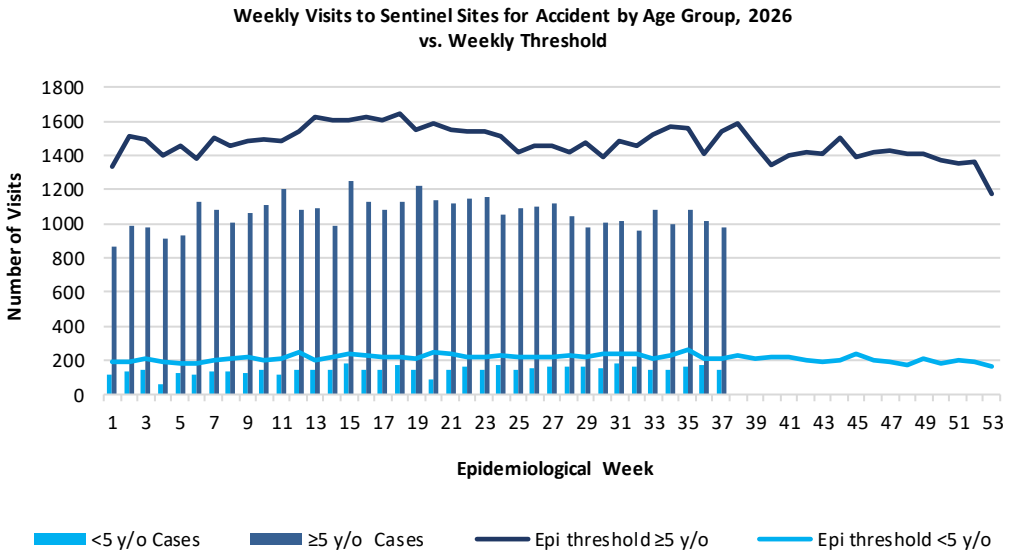
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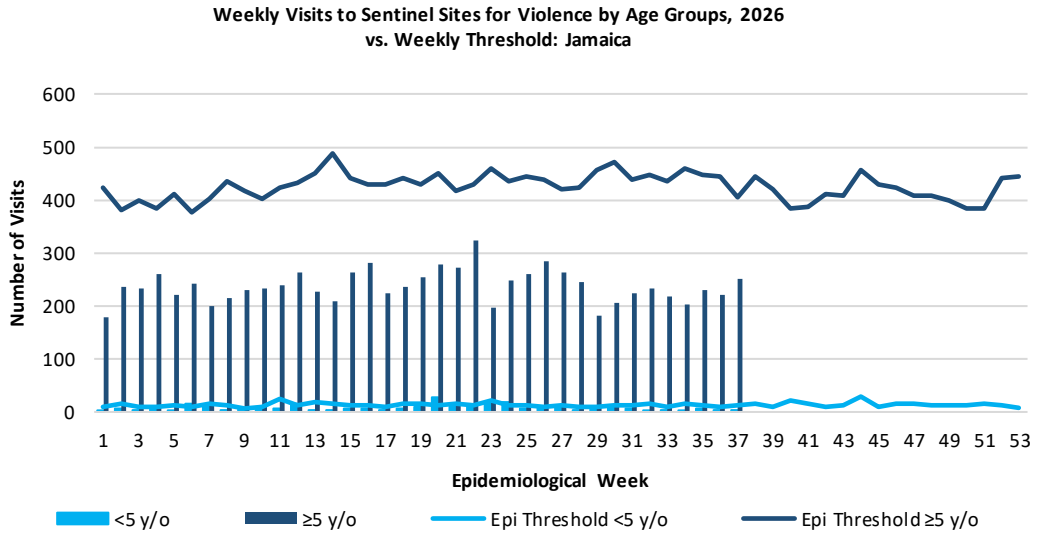
ACCIDENTS

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



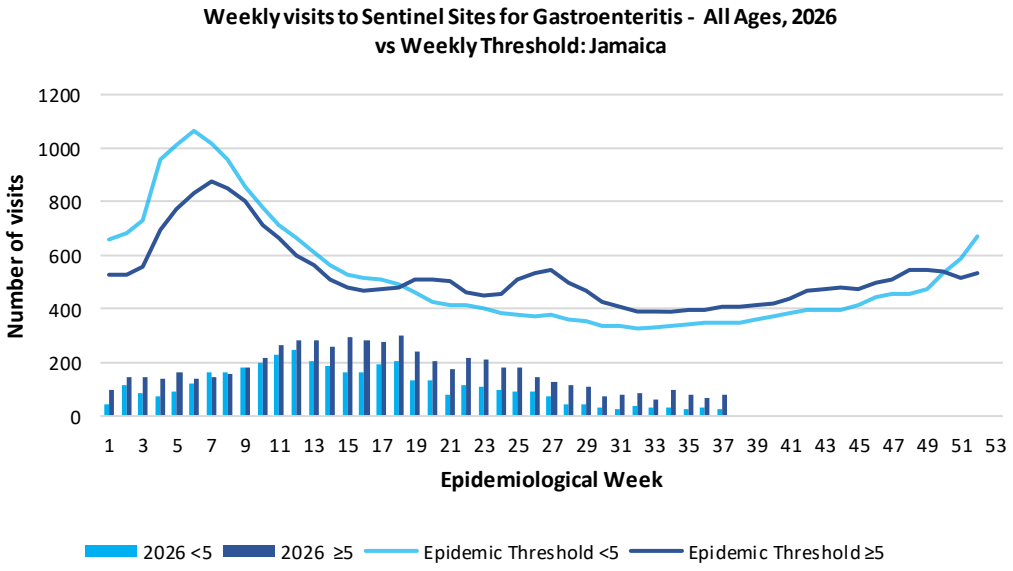
VIOLENCE

Any injury for which the cause is intentional, e.g. gunshot wounds, stab wounds, etc.



GASTROENTERITIS

Inflammation of the stomach and intestines, typically resulting from bacterial toxins or viral infection and causing vomiting and diarrhoea.



4 NOTIFICATIONS- All clinical sites

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CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS	Confirmed YTD[α] CURRENT YEAR 2026	Confirmed YTD[α] PREVIOUS YEAR 2025
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning	59[β]	151[β]
	Cholera	0	0
	Severe Dengue[γ]	See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)	40	296
	Hansen's Disease (Leprosy)	0	0
	Hepatitis B	12	12
	Hepatitis C	0	2
	HIV/AIDS	NA	NA
	Malaria (Imported)	0	1
	Meningitis	9	15
	Mpox	1	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
	Fever and Rash – Rubella	0	0
	Maternal Deaths (notified pregnanacy related deaths) [δ]	39	43
	Ophthalmia Neonatorum	55	71
	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

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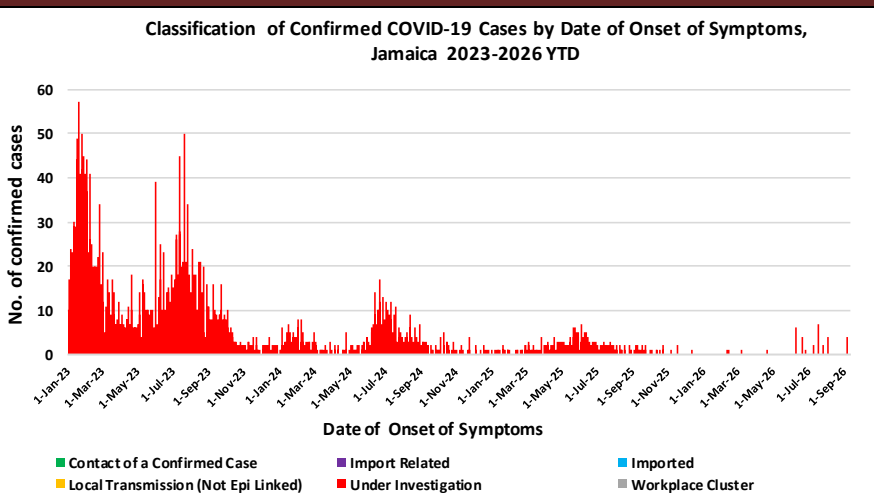
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COVID-19 SURVEILLANCE

CASES	EW 37	Total
Confirmed	6	157,790
Females	3	90902
Males	3	66885
Age Range	55 days old to 66 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.

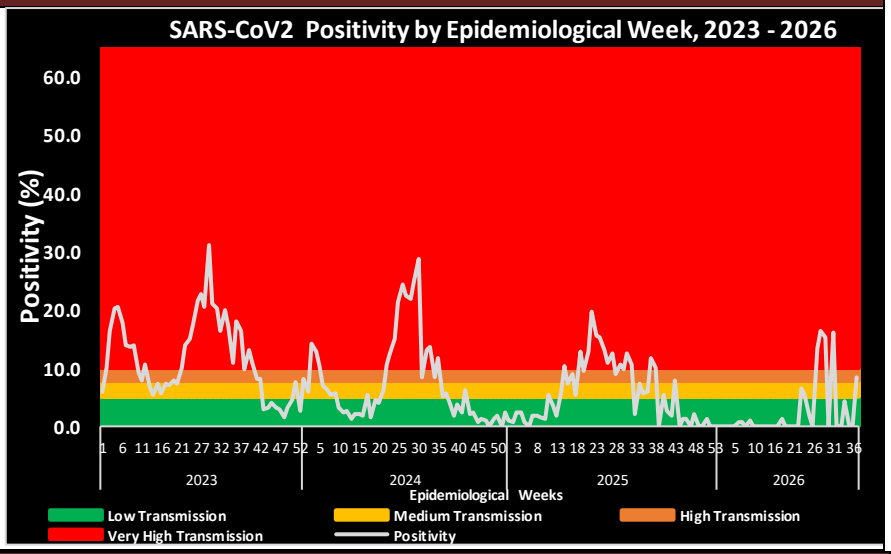


COVID-19 Outcomes

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

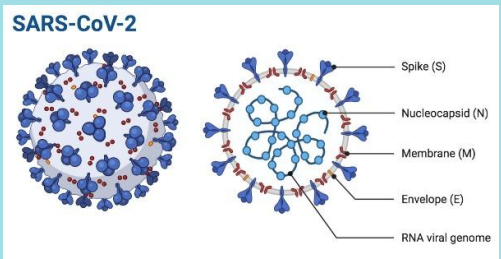
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	40	157,790
Deaths	621	116	24	13	0	3,921

- Current positivity rate: 8.5%
- Positivity = (positive samples/total samples tested)
- Low transmission for infection



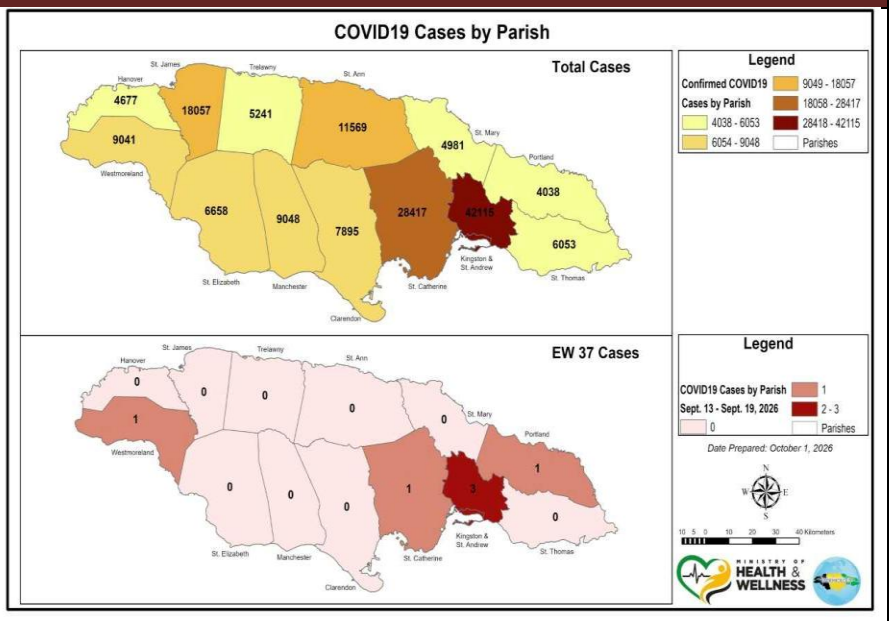
COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID-19 WHO Global Statistics Epi Week 34-37, 2026

Epi Week	Confirmed Cases	Deaths
34	15,800	84
35	18,900	90
36	19,300	75
37	Data not available	Data not available
Total (4weeks)	54,000	249



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

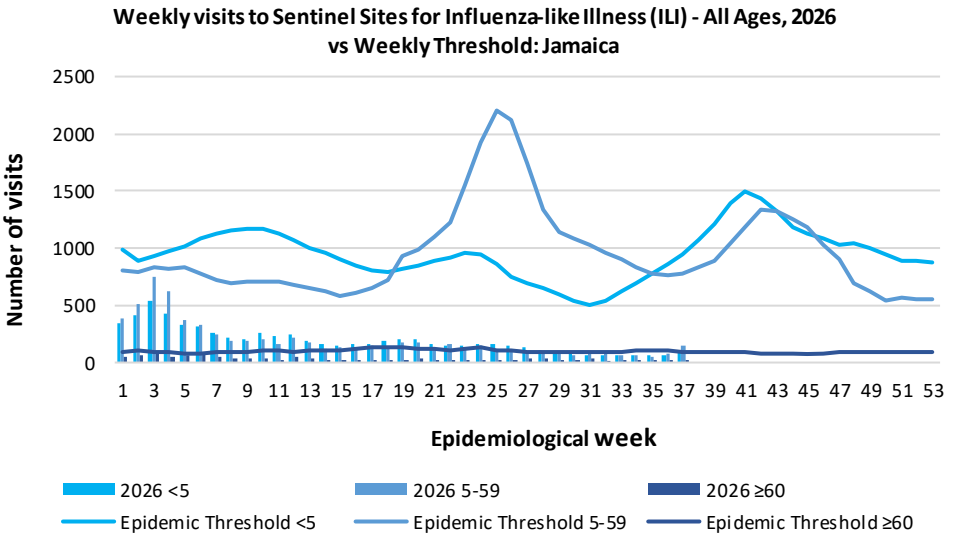
October 02, 2026 ISSN 0799-3927

INFLUENZA SURVEILLANCE

EW 37

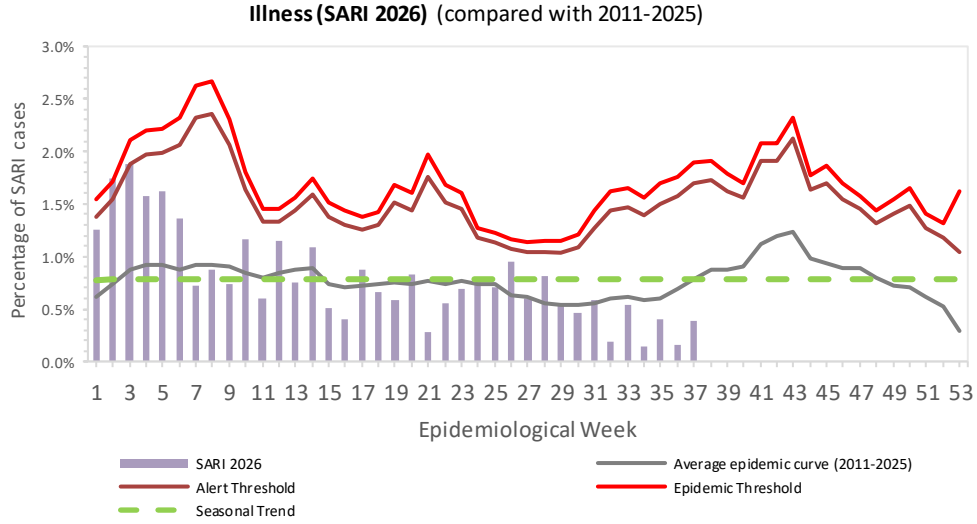
September 13, 2026 – September 19, 2026 Epidemiological Week 37

	EW 37	YTD
SARI cases	4	450
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	57



Epi Week Summary

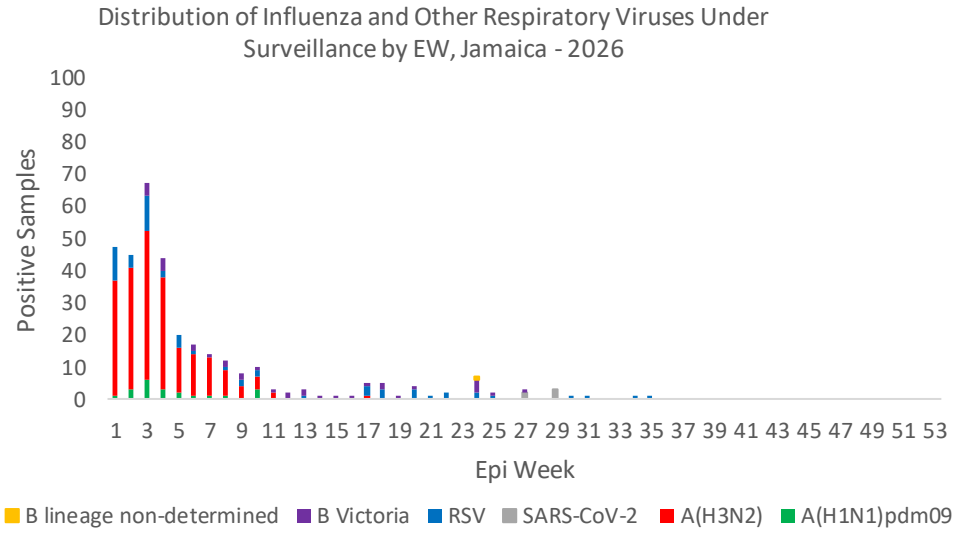
During Epi Week 37, four (4) SARI admissions were reported.



Caribbean Update Epi Week 37

Caribbean: Influenza circulation is relatively stable over the last 3 EWs, with positivity at 6.8% and cocirculation of influenza B (65%) and A(H1N1)pdm09. RSV activity remains low and stable , with positivity at 2.6%, while SARS-CoV-2 circulation decreased compared continues elevated ,with a positivity of 15.6%.

*Update as of Epi Week 36
(Source: PAHO Respiratory viruses weekly report)
https://www.paho.org/en/influenza-situation-report



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HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

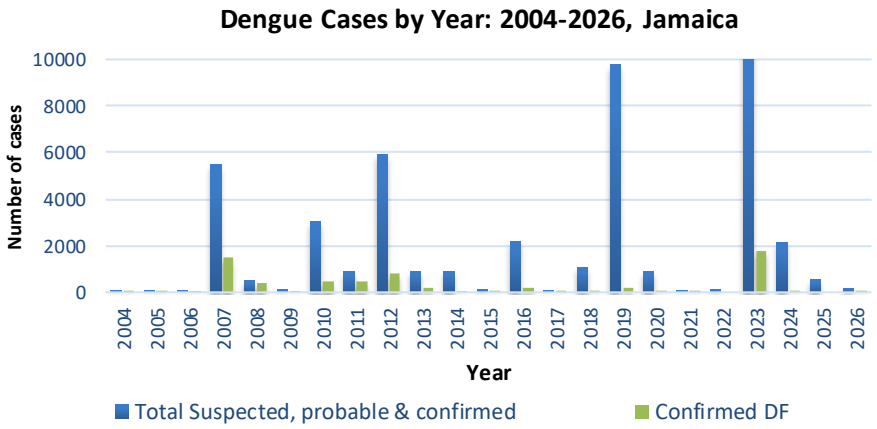
SENTINEL REPORT- 78 sites. Automatic reporting

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DENGUE SURVEILLANCE

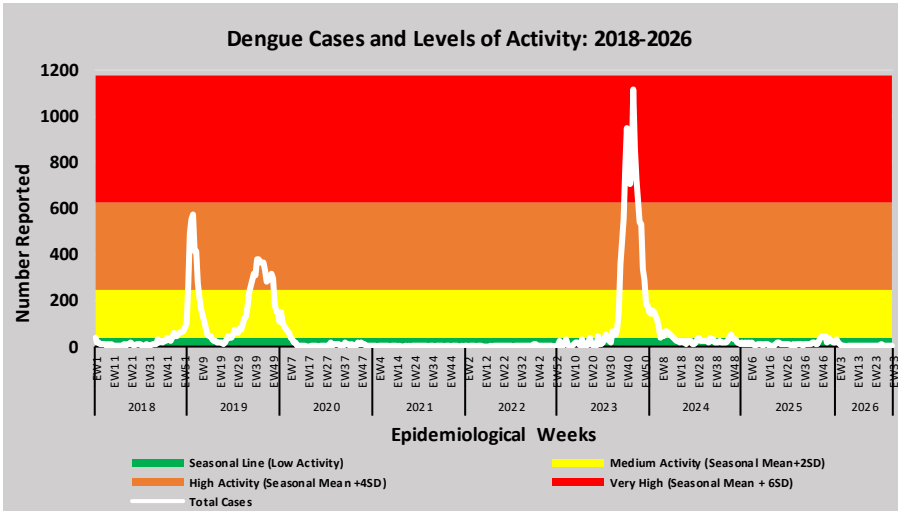
September 13, 2026 – September 19, 2026 Epidemiological Week 37 | Epidemiological Week 37





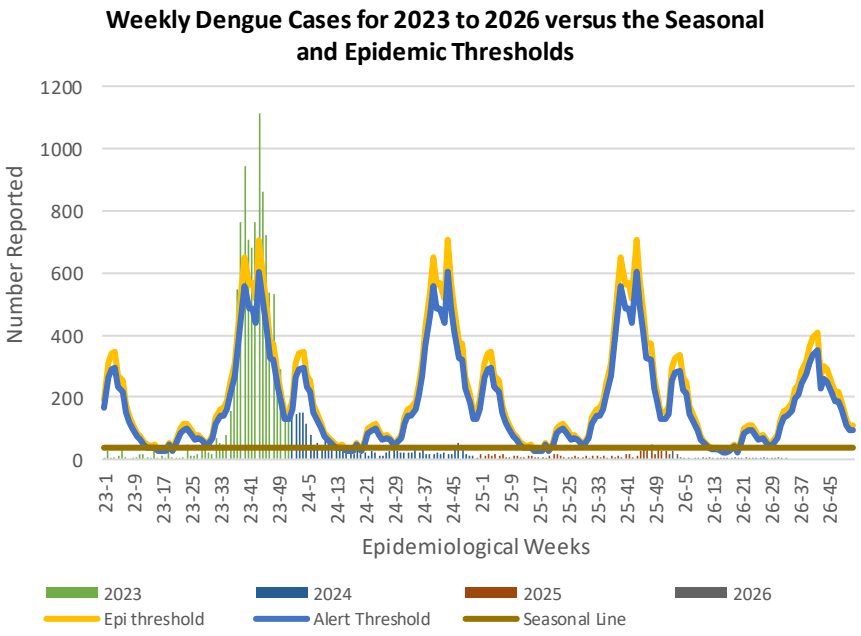
Reported suspected, probable and confirmed dengue with symptom onset in week 37 of 2026

	2026*	
	Epi Week 37	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	184
Lab Confirmed Dengue cases	0	1
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- **Dengue deaths are reported based on date of death.**
- **Only PCR positive dengue cases are reported as confirmed.**
- **IgM positive cases are classified as probable dengue.**



8 NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

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SENTINEL REPORT- 78 sites. Automatic reporting

RESEARCH ABSTRACT

Abstract

NHRC-25-O-

Retention in Care Among PLHIV Accessing Care at Public Treatment Sites in Jamaica

Lewis, S[1], Khan-Francis, R[1], Skyers, N[1], Whitehead, A[1], Brissett, S[1], Williams, A[1]

[1]*HIV/STI/TB Unit, Ministry of Health and Wellness, Kingston, Jamaica*

Objectives: To characterize Jamaica's HIV population based on retention status, identify factors associated with retention in care, and develop recommendations to improve retention.

Methods: A retrospective analysis was conducted using data from the Treatment Site Information System (TSIS). A total of 40,272 PLHIV were identified, with exclusions for duplicates, transfers, non-regional health authority attendees, and deaths, leaving 12,542 for analysis. Retention was defined as active HIV care engagement without missed appointments >90 days, while loss to follow-up (LTFU) was >90 days without a clinic visit. Retention status was compared across demographic, socioeconomic, and clinical variables using descriptive statistics and logistic regression to identify factors significantly associated with retention.

Results: Overall, 83% (n=10,466) were retained and 17% (n=2,076) were LTFU. Retention was significantly higher among females (84% vs. 82%, p=0.003) and married individuals (OR=2.0, p<0.001). Retention was lowest in PLHIV aged 20–44 years compared to those ≥50 (p<0.001). PLHIV receiving care outside their parish of residence were less likely to be retained (OR=0.7, p<0.001). Receiving SMS reminders was strongly associated with retention (OR=20.1, p<0.001). Clinical factors associated with higher retention included first CD4 <200 (OR=1.9, p<0.001) and viral load suppression, with undetectable VL increasing retention fivefold (OR=5.4, p<0.001).

Conclusion: Retention in HIV care at public sites in Jamaica is generally high but suboptimal among younger age groups, males, and those accessing care outside their parish. Strengthening SMS reminder systems, targeted interventions for vulnerable groups, and expanded service access are recommended to improve retention.

Keywords: HIV, retention in care, Jamaica, PLHIV, lost to follow-up

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