APPENDIX A: SUMMARY OF LOGICAL FRAMEWORK - NSP 2007-2012

Narrative	Prevention	Treatment Care & Support	Enabling Environment & Human Rights	Empowerment & Governance
GOAL	To reduce the transmission of new HIV infections Indicators HIV prevalence in 15-19 y.o. HIV prevalence in MSM HIV prevalence in CSW	To mitigate the impact of HIV/AIDS on the people of Jamaica Indicator % Adults/Children on ART alive 12 months after initiation of ARV	To provide an enabling infrastructure for the protection of the rights of all Jamaicans including PLWHA and other vulnerable groups Indicator % People expressing accepting attitudes to PLWHA and affected	To achieve a sustained, effective multisectoral infrastructure and commitment to support the national response to HIV and AIDS Indicator Amount of national funds disbursed by government for HIV
PURPOSE	To improve access to prevention services, specifically to most at-risk populations Indicator Number Persons trained to provide prevention services to most-at-risk Number Individuals reached through community outreach and TCI # Persons reached by target group (MSM, CSW, Tourism, Inmates)	To achieve universal access to high quality comprehensive treatment, care and support in an environment that is non discriminatory and supports adherence. Indicators % MSM, CSW & youth who received HIV testing in the last months and know the results % Women/Men/Children with advanced HIV infection receiving antiretroviral combination therapy	To decrease stigma and discrimination towards PLWHA and affected Indicators % People expressing accepting attitudes to PLWHA and affected	To achieve a sustained effective multisectoral response to the HIV epidemic Indicator Number government-funded social development programmes that have an HIV/AIDS component

APPENDIX A: SUMMARY OF LOGICAL FRAMEWORK (CONT'D) - NSP 2007-2012

Narrative	Prevention	Treatment Care & Support	Enabling Environment & Human Rights	Empowerment & Governance
OBJECTIVES	P1. Increased quality of prevention services P2. Increased public awareness of HIV prevention, sex and sexuality P3. Identification of communities and populations most at-risk P4. Increased access to targeted, age-appropriate HIV prevention services for youth P5. Strengthened prevention efforts for SWs and others engaging in transactional sex P6. Strengthened prevention efforts for MSM P7. Strengthened prevention efforts for tourism workers	T1.To increase access to HIV testing among priority populations T2. To prevent Mother to Child Transmission of HIV. T3. To improve *access* to and quality of ARV treatment. T4. To increased adherence to treatment and care T5. To improve care and support for Orphans & Vulnerable Children (OVC)	E1. Systematic identification and reporting of acts of discrimination E2. Improved public awareness of HIV/AIDS E3. Strengthened community advocacy against stigma and discrimination E4. Reduced stigma and discrimination in all sectors E5. Reduced stigma and discrimination in the health sector E6. Empowerment of youth to address stigma and discrimination	G1. Capacity and commitment of the health sector to recognize their role and provide high quality services for all G2. Capacity and commitment of non-health sector G3. Development of one M&E Framework G4. Improved procurement and financial management systems G5. Development of a sustainability plan
		T6. To improve access and use of Home Based Care T7. To improve infection control and access to Post Exposure Prophylaxis for accidentally exposed Health Care Workers. T8. To strengthen prevention efforts for PLWHA. T9. To improve the management of Tuberculosis especially in the HIV infected. T10. To strengthen the management of Sexually Transmitted Infections including Syphilis. T11. To improve the diagnostic capacity of the laboratory services. T12. To strengthen and institutionalize the training programme.	E7. Empowerment of PLWHA re stigma and discrimination reduction and seeking treatment & care E8. Advocacy for legislation protecting human rights and supporting the national response to HIV/AIDS E9. Advocacy and public education among insurance executives, management and employees	G6. Assurance of a multi-sectoral commitment to the National Strategic Plan G7. Assurance of strong governance and accountability

APPENDIX A: SUMMARY OF LOGICAL FRAMEWORK - NSP 2007-2012

Narrative	Prevention	Treatment Care & Support	Enabling Environment & Human Rights	Empowerment & Governance
INDICATORS	- % Youth (15-24) or at risk groups who correctly identify ways of preventing sexual transmission of - HIV and reject major misconceptions - Median age at first sex for men and women - % CSWs reporting condom use the last time they had sex with a client - % MSM reporting using a condom at last sex act - % Young men & women (15-24) reporting condom use the last time they had sex with a non-regular partner	- % MSM, CSW & youth who received HIV testing in the last year and know the results - % HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT - Number of HIV-infected infants born to HIV-infected mothers PLWHA on ARV reporting 100% adherence over last 3 months -% Women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy -Ratio of current school attendance among orphans to non-orphans aged 10-14	- Number and % of cases of discrimination receiving redress - % Large companies with policies & programmes that address HIV	% Routine reports completed on time (i.e. AHTS, MIS) - Number of persons trained/sensitised by client/area and service/programme area

APPENDIX A: LOGFRAME WORK PLAN – PRIORITY AREAS

1. PREVENTION

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
To reduce the transmission of new HIV infections	• Percentage of MSM who are HIV infected	MSM second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years. Success is dependent on trust with community.
	• Percentage of CSW who are HIV infected	CSW second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years.
	• HIV prevalence in men & women aged 15-24 who are HIV infected	ANC/STI Surveillance	Collected every two years
PURPOSE			
To achieve universal access to prevention services, focusing on most at-risk populations	• Number of BCC/TCIs with most at risk sub-populations	Reported to M&E unit by MOH BCC unit on an annual basis	There are challenges associated with defining sub-populations and with double-counting
OBJECTIVES			
Narrative	**Verifiable Indicators**		**Means of Verification**
P1. To increase quality of prevention services	Number of condoms distributed annually by public/private sectors		
P2. To increase accurate information of ways to prevent HIV and dispel myths.	% Young people (15-24) or at risk groups who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions		KABP survey
P3. To identify communities and populations most at-risk			
P4. To increase access to targeted, age-appropriate HIV prevention services for youth	% Young men and women who have had sex before age 15		KABP survey
P5. To strengthen prevention efforts for CSWs and others engaging in transactional sex	% CSWs reporting condom use the last time they had sex with a client		CSW second generation surveillance (PLACE-like methodology)
P6. To strengthen prevention efforts for MSM	% MSM reporting using a condom at last sex act		MSM second generation surveillance (PLACE-like methodology)
P7. To strengthen prevention efforts for tourism workers	% Young men & women (15-24) reporting condom use the last time they had sex with a non-regular partner		KABP survey

Narrative	Verifiable Indicators	Means of Verification
Objectives (continued)		
P8. To strengthen prevention efforts for inmates in correctional facilities	% Young men & women (15-24) reporting condom use the last time they had sex with a non-regular partner	KABP survey
P9. To increase prevention interventions in the labour sector directed at reducing stigma and discrimination	% Young men & women (15-24) reporting condom use the last time they had sex with a non-regular partner	KABP survey
P.10 To strengthen prevention efforts for persons within the uniformed services	% Young men & women (15-24) reporting condom use the last time they had sex with a non-regular partner	KABP survey
P11. To strengthen HFLE program in the education sector (early childhood to tertiary).	% Young men and women who have had sex before age 15 % of young people who correctly identify ways of preventing sexual transmission of HIV and reject major myths	KABP survey
P 12. To strengthen the capacity of the sectors in the national response to conduct prevention interventions		
P13. To reduce transmission from PLWHA to their partners and secondary infections		
P14. To improve prevention interventions for drug abusers		
P 15. To increase the use of the mass media in prevention efforts	% Young men & women (15-24) reporting condom use the last time they had sex with a non-regular partner % Young men and women who have had sex before age 15	KABP survey
P16. To identify cultural influential who can positively shift existing risky cultural norms	% Young men & women (15-24) reporting condom use the last time they had sex with a non-regular partner % Young men and women who have had sex before age 15	KABP survey
P17.To strengthen prevention efforts for vulnerable adolescents	% Young men & women (15-24) reporting condom use the last time they had sex with a non-regular partner	KABP survey

ACTIVITIES
P1. To increase quality of prevention services
1.1 Develop guidelines, standards and a training curriculum in quality of care (respect, confidentiality, communication style, etc.) with specific focus on meeting the needs of youth, PLWHA, MSM, CSW, people with disabilities, and recognizing gender differences
1.1a Build youth-friendly services using Youth. Now model
1.2 Train workers in quality of care across sectors including linkages to accreditation processes, e.g.: • Health sector BCC specialists, outreach workers, etc. • Guidance Counsellors • Effective/popular school teachers & coaches • Correctional facility resident nurses and pharmacists • Pharmacists
1.3 Conduct quality control monitoring of prevention service delivery
P2. To increase public awareness of HIV prevention, sex and sexuality
2.1 Implement public campaigns involving the general population e.g. schools, clubs, churches, etc.
ACTIVITIES
2.2 Recruit influential men (e.g. men on the corners) to lead, design and participate in interventions
P3. To identify communities and populations most at risk
3.1 Map locations of target populations using PLACE data
3.2 Assess current coverage of prevention services related to targeted populations & set coverage targets
3.3 Develop workgroup to regularly review surveillance data for targeted community efforts.
P4. To increase access to targeted, age-appropriate HIV prevention services for youth
4.1 Facilitate stakeholder consultation (administration, youth, parents, service providers, legal community) on adolescents accessing SRH information & services towards developing evidenced-based programmes and/or policy position.
4.2 Update/develop policy and legislation to improve access to services and treatment (inclusive of VCT, contraception and disclosure etc.) without parental consent
4.3 Identify best-practice holistic peer education strategies through formative research and program evaluation.
4.4 Develop and implement a best-practice structured youth outreach, peer education and support programme. Consider partnering with existing non-HIV peer youth services.
4.5 Expand out-of-clinic youth services (and ensure governance by service provision policy)
4.6 Define and develop “Youth Safe Spaces” with age- , sexual orientation- and gender- specific activities
4.7 Tailor messages and outreach for youth with disabilities
4.8 Expand targeted interventions for youth in the Tourism Industry
4. 9 Include HIV prevention as part of the Mandatory Community Placement Programme for tertiary students

ACTIVITIES
P5. To strengthen prevention efforts for sex workers (SW) and others engaging in transactional sex
5.1 Conduct Formative Research to better understand: (1) Sexual behaviour of entertainment workers - (e.g. masseurs, water sports operators) (2) Transactional sex practices
5.2 Develop and implement interventions that focus on the gender issues that inform sex work to empower sex workers – male and female to make healthy choices
5.3 Develop and implement interventions targeting entertainment workers through PLACE
5.4 Identify best practice for peer education and scale up
5.5 Improve skills to negotiate condom use with main partner.
P6. To strengthen prevention efforts for Men who Have Sex with Men
6.1 Conduct participatory community-based research on social norms and access to social support within this population
6.2 Review international best practices related to prevention, treatment, and care among MSM and make recommendations for adaptations in Jamaica
6.3 Use/adapt existing interventions (e.g. PLACE) to reach MSM
6.4 identify influential that can provide access to other MSM networks
6.5 Increase access to prevention services
P7. To strengthen prevention efforts for Tourism Workers
7.1 Conduct participatory community-based research on social norms and access to social support within this population
7.2 Replicate successful models (e.g. Sandals) in other hotels
7.3 Recruit "champions" in the hotel industry to address HIV/AIDS
P8. To strengthen prevention efforts for Inmates in Correctional Facilities
8.1 Review results and lessons learned of pilot project in Tower Street for implementation in other correctional facilities
8.2 Develop integration and sustainability plan for efforts in correctional facilities
8.3 Develop guidelines and reorientation training for persons employed in prisons
8.4 Strengthen the functions of the Department of Corrections resident nurse to reach staff through risk assessment and counselling
P9. To increase prevention interventions in the labour sector
9. 1 Identify leaders and other influential to mobilize the sector to own and address HIV/AIDS issues at the workplace.
9.2 Equip sector with skills to establish sector wide prevention programmes for workers
P.10 To strengthen prevention efforts for persons within the uniformed services
10.1 Establish condom outlets at sites where uniformed services are posted
10.2 Develop peer education program at sites for persons in uniformed services
10.3 Create supportive environment to reinforce practice of safer sex behaviours in this population

ACTVITIES
P11. To strengthen HFLE program in the education sector (early childhood to tertiary).
11.1 Complete revision of HFLE curriculum at all levels and implement comprehensive sector wide program
11.2 Revise and implement the national HFLE policy (and HIV/AIDS policy), inclusive of materials development, mandated time-tabling etc.)
11.3 Enforce the code of conduct of Guidance Counselors (teaching professionals) especially regarding breach of confidentiality.
11.4 Implementation of whole institution approach to teaching of HFLE
P 12. To strengthen the capacity of the sectors in the national response to conduct prevention interventions
12.1 Introduction/ expansion of courses at the tertiary level to equip a cadre of trained personnel to conduct prevention interventions in all sectors involved in the national response
12.2 Documentation of in-service training conducted within sectors to be used to informed curriculum for professional courses
P. 13. To reduce transmission from PLWHA to their partners and secondary infections
13.1 Train health workers in age and gender-specific motivational interviewing techniques for positive prevention
13.2 Develop common messages for Positive Prevention including risks of secondary prevention
13.3Create and implement support groups for PLWHA
13.4 Mobilize the community to provide leadership on this issues
P14. To improve prevention interventions for drug abusers
14.1 Develop and implement policy for most at risk drug abusers involved in sex work
14.2 Improve access to prevention services rehab process
P 15. To increase the use of the mass media in prevention efforts
15.1 Expand media alliance with media managers
15.2 Develop and air media campaigns messages aimed at risk reduction and stigma reduction
P16. To identify cultural influential who can positively shift existing risky cultural norms
16.1 identify influential in music, media, formal and informal community leaders and sports
16.2 Develop strategy to assist in shifting adult entertainment from mainstream media
P17.To strengthen prevention efforts for vulnerable adolescents
17.1 Assess size of population of vulnerable groups of adolescents e.g. disabled, street children, adolescent sex workers etc.
17.2 Develop contextual and age appropriate intervention to reach population
17.2 Improve access to prevention services

LOGFRAME WORKPLAN PRIORITY AREAS (CONT'D)

2. TREATMENT, CARE & SUPPORT

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
PURPOSE			
To achieve universal access to high quality comprehensive treatment, care and support in an environment that is non-discriminatory and supports adherence.	% MSM, SW & youth who received HIV testing in the last year and know the results	MSM & SW second generation surveillance (PLACE-like methodology) & Healthy Lifestyles Survey	MSM, SW surveys done in 2006/2007 will be repeated every two years. Regions are clear on definitions and instructions on completion of monthly reporting forms. MICS done in 2005-2006 will be repeated every five years. STATIN does the analysis. MOH is a partner in the working group
	% Women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy	Monthly treatment site reports to the regional surveillance officers	
OBJECTIVES			
Narrative	**Verifiable Indicators**	**Means of Verification**	
T1. To increase *access* to HIV testing among priority populations	% MSM, SW & youth who received HIV testing in the last year and know the results	MSM & SW second generation surveillance (PLACE-like methodology) & Healthy Lifestyles Survey	
	% Hospital Admissions, Family Planning Clients, Outpatients who received HIV testing in the last year (and know the results)	Quarterly NPHL HIV Testing report.	
T2. To prevent Mother to Child Transmission of HIV	% HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	Regional HIV/AIDS Summary Report Form – Monthly	
	% HIV exposed infants receiving a complete course of ARV prophylaxis to reduce risk of MTCT	Regional HIV/AIDS Summary Report Form – Monthly	
T3. To improve *access* to and quality of ARV treatment	% Women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy	Monthly treatment site reports to the regional surveillance officers	
T4. To increase adherence to treatment and care	% PLWH on ARVs reporting at least 95% adherence	NHF, Adherence Counsellors/ Social Workers reports	

OBJECTIVES (CONT'D)		
Narrative	**Verifiable Indicators**	**Means of Verification**
T5. To improve care and support for Orphans and Vulnerable Children (OVC)	Ratio of current school attendance among orphans to non-orphans, aged 10-14 % OVC (boy/girl) under 18 living in households whose households have received a basic external support package	MICS – conducted every 5 years by UNICEF.
T6. To improve access and use of Home Based Care	Number of PLWHA receiving home-based care within the last 12 months	Quarterly regional technical reports by the Regional HIV Coordinators
T7. To improve infection control and access to Post Exposure Prophylaxis for accidentally exposed Health Care Workers.	% Exposed HCW receiving PEP as per protocol.	Quarterly regional technical reports by the Regional HIV Coordinators Quarterly Regional Surveillance Officers' reports
T8. To strengthen prevention efforts for PLWH.	Number of Positive Prevention Workshops done	Quarterly regional technical reports by the Regional HIV Coordinator
OBJECTIVES		
T9. To improve the management of Tuberculosis especially in the HIV infected.	HIV/ TB Coinfection rates % TB infected receiving full course of treatment # Cases of MDRTB	Quarterly Regional Surveillance Officers' reports Quarterly NPHL Report
T10. To strengthen the management of Sexually Transmitted Infections including Syphilis.	Prevalence rates of congenital syphilis Prevalence rates of syphilis in antenatal population Prevalence rates of syphilis in STI Clinic Attendees % Persons with STIs managed appropriately as per Syndromic Management protocol	Quarterly Regional Surveillance Officers' reports Medical/ Docket audit
T11. To improve the diagnostic capacity of the laboratory services.	# Patients having CD4 tests done # Patients having VL tests done # Patients having PCR tests done # Patients having resistance testing for TB and HIV	NPHL reports
T12. To strengthen and institutionalize the training programme.	# Persons trained by service area and programme	Quarterly regional technical reports by the Regional HIV Coordinator Reports from CHART

ACTIVITIES
T1. To increase *access* to HIV testing among priority populations
1.1 Scale up PITC to all users of primary, secondary and tertiary services (especially for person between the ages 10 to 60 years).
1.2 Test all persons who are being treated for STIs
1.3 Test all persons who are being treated for TB
1.4 Assure quality counselling and referrals and provide training in PITC
1.5 Conduct Formative Research to better understand the real and perceived barriers to testing and perception of risk
1.6 Conduct Media Campaign to increase awareness regarding the importance of testing and perception of risk
1.7 Build capacity in NGOs to capably address barriers to HIV testing.
1.8 Reach Vulnerable Populations through peer approaches and their networks and events
1.9 Conduct targeted outreach of male youths by partnering with male-focused organizations, and going to heavily populated male events, use champions and role model men
1.10 Conduct VCT at sites where young spend time (e.g. Sports venue, Bashy Bus, Adolescents centre where young people do school work, etc)
1.11 Increase number of confidential areas at testing sites to facilitate counselling and privacy.
T.2 To prevent Mother to Child Transmission of HIV
2.1 Retrain Public Health Nurses and Midwives in updated protocol PMTCT+ on an annual basis
2.2 Screen all HIV positive pregnant women with CD4 Counts.
2.3 Ensure all women testing positive receive appropriate antiretroviral therapy for prevention of mother to child transmission in accordance with revised PMTCT+ guidelines
2.4 Identify mechanisms to reach at-home births (e.g. midwife training)
2.5 Ensure rapid testing for women arriving at maternity ward with unknown status
2.6 Conduct appropriate follow-up of mother-baby pairs
2.7 Ensure all points of service delivery must have starter packs of ARVs
2.8 Increase the number of sites offering the HIV testing service
2.9 Use Child Protection Act to assure testing and treatment of mother
2.10 Engage fathers in the delivery of the PMTCT programme by offering testing and providing HIV related information
2.11 Provide universal access to long term Family Planning Methods
2.12 Improve information sharing (M&E) between primary, secondary and national levels

ACTIVITIES
T3. To improve *access* to and quality of ARV treatment
3.1 Increase the number of sites at which treatment is available by involving all Primary Care Staff in Treatment and maintaining the current Treatment Centres as Specialist referral sites.
3.2 Retrain Clinic Staff in updated HIV Management Protocol on an annual basis
3.3 Improve access to CD4 & viral load
3.4 Conduct resistance testing
3.5 Conduct appropriate follow-up of patients
3.6 Make existing and new sites 'Youth friendly' by hiring younger people, or involving them as volunteers, and providing holistic, non-judgmental support.
3.7 Identify best practices for engaging men in treatment. (E.g. Examine the male health seeking behaviour and address the findings)
3.8 Review "User Fee Policies" to ensure that patients' fees are set appropriately and that treatment is not denied. Assess how User Fee Policies affect access to treatment.
3.9 Conduct quality assurance audits at all levels of service.
3.10 Develop and implement an information tracking system that facilitates effective management of appointments and medication.
3.11 Develop mechanism to integrate pharmacy outlets for ARVs with treatment centres
3.12 Improve supply management structure for ARVs
T4. To increase adherence to treatment and care
4.1 Enrolling persons on antiretrovirals with NHF, will allow them a further discounted access to medication
4.2 Review TOR of adherence counselors to include counselling for HIV testing as well as adherence counselling on a wider scale, in the hospitals, etc.
4.3 Development of a structured adherence protocol for pre ARV treatment
4.4 Strengthen adherence programme by involvement of all members of the Treatment Team
4.5 Ensure provision of nutritional advice and support by all members of treatment team
4.6 Provide training in adherence to all members of Treatment Team
4.7 Development of treatment support groups.
4.8 Simplify regime by increased availability of fixed combination drugs
4.9 Collaborate with NGOs and other relevant agencies that can provide financial and social support (for meals, transportation, school fees) and income generating assistance to PLWH
4.10 Develop linkages and referral mechanisms to community support
4.11 Utilize non-traditional health care workers to ensure follow-up with known PLWHs
4.12 Develop and distribute user-friendly material for PLWH that describes treatment (medication, nutrition), and adherence

ACTIVITIES
T5. To improve care and support for Orphans and Vulnerable Children (OVC)
5.1 Identify a specific agency (eg. CDA) to be charged with assuring that the needs of OVC are met
5.2 Employ a Children's Officer to work from the Ministry of Health to liaise with relevant agencies, develop and implement mechanisms to ensure the follow-up of OVC.
5.3 Address issues of vulnerability taking into consideration the following special groups: Orphans in Homes; Street Children; Young girls who head households; Boys who have to hustle; Children with disabilities
T6. To improve access and use of Home Based Care
6.1 Develop a registry of home based caregivers and agencies to provide these services and disseminate this information
6.2 Provide training to care givers in Home Based Care
6.3 Involve family members and other support groups e.g. Churches etc in the training of home based care
T7. To improve infection control and access to Post Exposure Prophylaxis for accidentally exposed Health Care Workers.
7.1 Implementation of an alternative technology for medical waste (including sharps) management
7.2 Update and reprint the infection control manual and distribute widely
7.3 Training of all levels of health care workers in the management of post exposure prophylaxis.

ACTIVITIES
T8. To strengthen prevention efforts for PLWH.
8.1 Integrate expected roles and responsibilities of PLWH into existing HIV/AIDS Policy
8.2 Develop standardized messages geared towards encouraging responsible sexual behaviour among PLWH
8.3 Develop and strengthen support groups and provide intervention counselling for PLWH attending treatment sites
8.4 Train available adherence counselors in Positive Prevention Methodologies.
8.5 Conduct trainings in Positive prevention for PLWH
T9. To improve the management of Tuberculosis especially in the HIV infected
9.1 Strengthen linkages between TB and HIV programmes.
9.2 Screen all HIV infected persons for TB as well as ensure the availability of facilities for early diagnosis.
9.3 Ensure the availability of anti-TB drugs
9.4 Conduct training for HCW in the management of TB and TB/HIV
9.5 Improve the follow-up of TB patients to ensure completion of course of medication
9.6 Improve the capacity of the laboratory to conduct diagnostic tests for TB and resistance testing.
T10. To strengthen the management of Sexually Transmitted Infections including Syphilis.
10.1 Conduct trainings in the management of STIs including Syphilis
10.2 Improve the capacity of the laboratory to conduct testing to determine aetiological agents
T11. To improve the diagnostic capacity of the laboratory services.
11.1 Expand the capacity of the laboratory services to deal with the increased numbers of persons being tested
11.2 Improve the management structure of the NPHL
11.3 Improve the capacity of the laboratories (in the regions also) to diagnose TB, STIs and opportunistic infections.
11.4 Expand the lab capacity to include resistance testing for Anti TB and HIV drugs.
11.5 Improve the capacity of the laboratory to carry out CD4, Viral Loads and other supportive investigation
T12. To strengthen and institutionalize the training programme.
12.1 In collaboration with CHART to develop standard short courses for HIV case managements, PMTCT, Adherence, Infection Control and Counselling for HCW.
12.2 Conduct trainings for HCW
12.3 Regions to duplicate trainings to ensure dissemination of information to all relevant staff
12.4 Conduct audits to ensure standard and quality of care.

LOGFRAME WORKPLAN PRIORITY AREAS (CONT'D)

3. ENABLING ENVIRONMENT & HUMAN RIGHTS

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
To protect fundamental human rights and empower the Jamaican people to make health choices			
PURPOSE			
To decrease stigma and discrimination toward people with HIV/AIDS	Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/ generalizability at the general population level.
OBJECTIVES			
Narrative	**Verifiable Indicators**		**Means of Verification**
E.1 To systematically identify and report acts of discrimination	Number of cases of discrimination reported by setting		JN+ stigma database collects this information and reports in quarterly to the NAC
E.2 To improve public awareness of HIV and AIDS			
E.3 To strengthen Community Advocacy against Stigma and Discrimination			
E.4 To reduce stigma in all sectors	Number of large (>100 employees) private organizations not requiring pre-employment HIV tests		Ministry of Labour conducts a workplace survey every 2-3 years. Last one was in 2005
E.5 To reduce stigma and discrimination in the health sector			
E.6 To empower youth to address stigma and discrimination			
E.7 To empower PLWHA in the context of reducing stigma and discrimination and seeking treatment and care			Stakeholder & regional technical reports sent monthly to the NAP M&E unit
E.8 To advocate for legislation that protects human rights			PEPFAR indicators reported annually by stakeholders to NAP M&E unit
E.9 To advocate for non discrimination among management and employees of the Insurance sub sector			

ACTIVITIES
E1. To systematically identify and report acts of discrimination
1.1 Assemble a multi-sector working group to define 'Discrimination' &identify specific examples including unequal access for people with disabilities.
1.2 Develop a common Discrimination Reporting tool for civil society and all sectors to report discrimination
1.3 Develop & maintain a system of data collection, data maintenance (database) and analysis of reports of stigma, discrimination and response
1.4 Establish a system with office of Public Defenders to act upon data on behalf of persons who have been discriminated against
1.5 Develop and implement a dissemination strategy/information campaign to civil society and all sectors so they utilize the Discrimination Reporting mechanism
E.2 To improve public awareness of HIV and AIDS
2.1 Develop and implement anti stigma mass media campaign with supporting public relations campaign with gender-specific, geographic-specific and target-group-specific messages
2.2 Develop messages that reinforce that HIV is important to address because of the economic impact, potential to spread and for protection of human rights.
2.3 Use cell phones as avenues to reach young people in terms of HIV messages
2.4 Use drama and other cultural approaches to create awareness of gender specific issues
E3. To strengthen Community Advocacy against Stigma and Discrimination
3.1 Conduct community-specific research to identify the extent that PLWH and families can challenge community level S&D
3.2 Facilitate community consultations in urban and rural parishes for development of support mechanisms for PLWH and their families. Include a broad array of organizations including churches.
E4. To reduce stigma in all sectors
4.1 Expand development and implementation of workplace policies and programmes including action for breaches.
4.2 Implement disciplinary measures when Policy is violated
4.3 Promote existing Education Policy and Child Care Act in private schools and monitor activities which support or contravene principles enshrined in the Act.
E5. To reduce stigma and discrimination in the health sector
5.1 Develop and implement a health care policy to ensure adherence to a strict protocol for caregivers and other HCW when working with PLHIV, including privacy and confidentiality and a mechanism for recourse and sanctions for breaches of policy.
5.2 Develop a comprehensive S & D programme which incorporates training for quality of care for health workers.

ACTIVITIES
E6. To empower Youth to address Stigma and Discrimination
6.1 Use Sphere of influence Model (reference to JASTYLE)
6.2 Infuse S&D messages into school curriculum such as the Safe Schools Programme
6.3 Utilize NYS Health Promotion Facilitators trained by MOH to undertake targeted interventions in the communities.
6.4 Develop programmes for young persons to interact with and show care and support for PLWH e.g. Junior PAAs
E7. To empower PLWHA in the context of reducing stigma and discrimination and seeking treatment and care
7.1 Conduct research to understand social and economic needs of PLWH and how best to engage them in services
7.2 Provide PLWH with training and support in: (1) Life and communication skills (2) Positive prevention (3) anti stigma and discrimination interventions (4) work place implementation and treatment compliance and adherence (5) Skills to achieve economic independence (6) Psycho-social support to address perceived or internal stigma and to enhance self-esteem
7.3 Provide shelter and other facilities for persons who are negatively treated when they disclose their status e.g. Safe House
7.4 Adapt protocol and training for Contact Investigators to: (1) Address and support issues of disclosure to PLWH partners (2) Refer PLWH to the existing support and advisory boards and encourage their participation
E8. To advocate for Legislation that protects human rights
8.1 Submit recommendation to Cabinet for support of anti discrimination laws to reduce human rights violations
8.2 Provide legal assistance to PLWH (*pro bono*)
8.3 Develop and Implement safeguards against sexual violence and exploitation of girls
8.4 Identify leaders/change champion for law reform including repeal of the buggery law (re human rights) and conduct education & dialogue on the issue
8.5 Assess/examine policy/legislative options regarding regulations of CSW.
8.6 Amend education act to change HIV as a communicable disease and include private institutions
8.7 Enhance lobbying and advocacy for OVCs due to HIV and AIDS in institutions: social integration etc.
E.9 To advocate for non discrimination among management and employees of the Insurance sub sector
9.1 To establish and implement interventions targeted to management and employees in the Insurance sub sector focused on negotiations, advocacy, public education and training in regards to the 10 workplace principles

LOGFRAME WORKPLAN PRIORITY AREAS (CONT'D)

4. EMPOWERMENT & GOVERNANCE

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
To achieve a sustained, effective multisectoral infrastructure and commitment to support the national response to HIV and AIDS	Amount of national funds disbursed by government for HIV		
PURPOSE			
Integration of HIV programs into existing human and social development programmes	# Human and Social Development Programmes that have integrated HIV.	Reports from stakeholders	These indicators were required by some donor agencies
OBJECTIVES			
Narrative	**Verifiable Indicators**	**Means of Verification**	
G.1.To build capacity and commitment of health sector to recognize their role and provide high-quality services for all people			
G.2. To build capacity and commitment of other sectors to recognize their role	Management Information System developed for routine reporting (M&E Unit in MOH and RHAs)	NAP progress reports	
G. 3. To develop one monitoring and evaluation framework	Number of local organizations provided with technical assistance for strategic information activities	Reports by stakeholders to M&E unit annually for PEPFAR report	
G.4. To improve procurement and financial management systems			
G.5.To implement a sustainability plan			
G.6. To assure multi-sectoral commitment to National Strategic Plan			
G.7. To assure strong governance and accountability			
ACTIVITIES			
G1. To build capacity and commitment of health sector to recognize their role and provide high-quality services for all people			
1.1 Assess Human Resource needs as part of a sustainability plan and implement chosen recommendations			
1.2 Strengthen staff knowledge and skills through Pre-service Training, CHART and other sensitisation and training			
1.3 Develop a clinic-based information system			
1.4 Implement a Laboratory Information System			
1.5 Ensure participation of health care workers in the review of health data and decision-making processes			
G2. To build capacity and commitment of other sectors to recognize their role in the response			
2.1 Strengthen partner knowledge and skills through CHART and other sensitisation and training			
2.2 Address barriers and improve implementation of a family life education in schools that adequately addresses sex, sexuality and health			
2.3 Provide individualized technical assistance to selected NGOs (e.g., NAC, JN+, etc,) to build their capacity in accountability, quality control, M & E			
2.4 Develop an NGO forum			

ACTIVITIES
2.5 Conduct outreach and training to civil society to understand policy processes, advocacy, and their role
2.6 Institutionalize mechanisms for participation of civil society (MSM, CSW, PLWHA) in programme design, monitoring and evaluation
2.7 Develop a youth-board for input on planning, implementation and evaluation
2.8 Train young PLWHA as peer educators and outreach officers in schools, etc.
2.9 Provide capacity building training workshops for community youth and youth organizations in life & leadership skills
G3. To develop one monitoring and evaluation framework
3.1 Identify priority indicators and sources for use by all sectors
3.2 Assist key partners in development and implementation of their M & E systems
3.3 Train stakeholders in data collection and surveillance methods for programme monitoring
3.4 Implement the HIV/AIDS Tracking System (HATS)
3.5 Monitor and Evaluate the National Strategic Plan
G4. To improve procurement and financial management systems
4.1 Align the GOJ procurement process to that of the International Donor Agencies
4.2 Allow for special provisions in the procurement process for the HIV/AIDS Programme
G5. To implement a sustainability plan
5.1 Institutionalize the positions of the National HIV/AIDS programme posts in the present government cadre
5.2 Include as a separate budget line item for HIV/AIDS in the recurrent budget
5.3 Provide capacity building, training, and development of systems and guidelines across partners
5.4 Develop systems to strengthen integrity/transparency of resource allocation between intervention alternatives
5.5 Develop incentive scheme for ongoing service delivery after training
5.6 Include PLWHAs and other vulnerable populations in the implementation of the plan
G6. To assure multi-sectoral commitment to National Strategic Plan
6.1 Establish mechanisms for communication, coordination, implementation and operation at the national and regional levels
6.2 Identify specific roles and responsibilities for each sector
6.3 Develop sector-specific work plans
6.4 Develop an NGO forum to share best-practices/lessons learned and to coordinate activities
G7. To assure strong governance and accountability
7.1 Establish a multi-sectoral working group to consider structure for One Authority (mechanism for coordination and accountability across all sectors)
7.2 Move forward on creation of One Authority once roadmap is agreed upon
7.3 Establish mechanisms for communication and coordination across sectors to minimize duplication of efforts
7.4 Implement the One Authority entity based on the selected structure/ format
7.5 Monitor and evaluate the performance of the One Authority entity

Appendix C. Additional Epidemiological Profile Tables

Table 1. Summary of AIDS Cases in Jamaica

PERIOD	TOTAL	MALE (%)	FEMALE (%)
Cumulative 1982–2006	**11739**	**6783 (57.8)**	**4956 (42.2)**
Jan–Dec 2000	903	515 (57.0)	388 (43.0)
Jan–Dec 2001	939	511 (54.4)	428 (45.6)
Jan–Dec 2002	989	580 (58.6)	409 (41.4)
Jan–Dec 2003	1070	611 (57.0)	459 (43.0)
Jan–Dec 2004	1112	603 (54.2)	509 (45.8)
Jan–Dec 2005	1344	696 (51.8)	648 (48.2)
Jan-Dec 2006	1186	659 (55.6)	527 (44.4)

Table 2. Summary of AIDS Cases by Parish in Jamaica (by date of reporting)

PARISH	JAN – DEC 2006	1982 – DEC 2006 CUMULATIVE TOTAL	RATE PER 100,000 POPULATION
Kingston & St. Andrew	400	4616	697.7
St. Thomas	20	213	228.6
Portland	17	238	291.4
St. Mary	33	335	295.1
St. Ann	75	711	413.4
Trelawny	41	298	396.8
St. James	178	1817	992.1
Hanover	40	283	407.5
Westmoreland	91	591	410.4
St. Elizabeth	31	260	173.2
Manchester	38	298	157.2
Clarendon	50	440	179.7
St. Catherine	171	1606	324.8
Parish Not Known	0	22	0
Overseas Address	1	11	0
Total	1186	11739	439.0

Table 3. Summary of AIDS Deaths, Jamaica

PERIOD	TOTAL	MALE (%)	FEMALE (%)
1983–Dec 2006	**6673**	**4015 (60.2)**	**2658 (39.8)**
Jan–Dec. 2001	588	329 (56.0)	259 (44.0)
Jan–Dec. 2002	692	406 (58.7)	286 (41.3)
Jan–Dec 2003	650	381 (58.6)	269 (41.4)
Jan–Dec 2004	665	377 (56.6)	288 (43.3)
Jan–Dec 2005	514	310 (60.3)	204 (39.7)
Jan–Dec 2006	432	262 (60.6)	170 (39.4)

Table 4. Summary of AIDS Death by Parish in Jamaica (By date of reporting)

PARISH	JANUARY – DEC 2006	1982 – DEC 2006 CUMULATIVE TOTAL
Kingston & St. Andrew	152	2626
St. Thomas	2	95
Portland	5	136
St. Mary	14	237
St. Ann	17	311
Trelawny	19	205
St. James	78	1084
Hanover	13	191
Westmoreland	26	373
St. Elizabeth	14	173
Manchester	13	193
Clarendon	15	194
St. Catherine	64	836
Parish Not Known	0	5
Overseas Address	0	14
Total	**432**	**6673**

Table 5. Summary of Paediatric AIDS Cases (Age 0 - 9 Years)

PERIOD	TOTAL	MALE (%)	FEMALE (%)
1986–Dec 2006	**838**	**440 (52.5)**	**398 (47.5)**
Jan–Dec. 2001	65	39 (45.7)	26 (54.3)
Jan–Dec. 2002	81	37 (65.4)	44 (34.5)
Jan–Dec 2003	67	36 (53.7)	31 (46.3)
Jan–Dec 2004	61	29 (47.5)	32 (42.5)
Jan–Dec 2005	78	42 (53.8)	36 (46.2)
Jan – Dec 2006	73	37 (50.7)	36 (49.3)

Table 6. Summary of Paediatrics AIDS Cases by Parish in Jamaica (by date of reporting), 1986 – Dec 2006

PARISH	CUMULATIVE TOTAL	RATE PER 100,000 POPULATION (2003 EST. STATIN 0 – 9 AGE GROUP)
Kingston & St. Andrew	349	275.4
St. Thomas	25	123.0
Portland	14	81.3
St. Mary	27	112.3
St. Ann	32	88.7
Trelawny	13	83.1
St. James	111	292.4
Hanover	17	119.6
Westmoreland	27	89.1
St. Elizabeth	17	57.4
Manchester	25	64.9
Clarendon	50	91.7
St. Catherine	128	127.1
Parish Not Known	2	0
Overseas Address	1	0
Total	838	153.5

Table 7. Summary of Paediatric AIDS Death

PERIOD	TOTAL	MALE (%)	FEMALE (%)
1986 - Dec 2006	393	199 (50.8)	193 (49.2)
Jan - Dec. 2001	27	14 (51.9)	13 (48.1)
Jan - Dec. 2002	45	22 (48.9)	23 (51.1)
Jan - Dec 2003	29	17 (58.6)	12 (41.4)
Jan - Dec 2004	34	17 (50.0)	17 (50.0)
Jan – Dec 2005	19	12 (63.2)	7 (36.8)
Jan – Dec 2006	**13**	**11 (84.6)**	**2 (15.4)**

Table 8. Summary of AIDS Cases by 5-Year Age Groups 1986 – Dec 2006, Jamaica

AGE GROUP	MALE	FEMALE	TOTAL
00 to 4	306	267	573
05 to 9	134	131	265
10 to 14	16	13	29
15 to 19	28	110	138
20 to 24	269	395	664
25 to 29	704	784	1488
30 to 34	1108	863	1971
35 to 39	1176	769	1945
40 to 44	964	573	1537
45 to 49	725	392	1117
50 to 54	540	239	779
55 to 59	364	160	524
60 to 64	218	112	330
65 to 69	87	62	149
70 to 74	49	25	74
75 to 79	14	10	24
80 to 84	2	6	8
85 to 89	3	2	5
Unknown	76	42	118
Total	6783	4956	11739

Table 9. AIDS Cases by Sexual Practice (1982–Dec '06 Cumulative)[1]

SEXUAL PRACTICE CATEGORY	MALE	FEMALE	TOTAL (%)
Bisexual Male	300	N/A	300 (2.8)
Heterosexual	3242	4558	7800 (71.5)
Homosexual	222	N/A	222 (2.0)
Unknown*	2579	N/A	2579 (23.7)
Total[1]	**6343**	**4558**	**10,901**

N/A – not available/not applicable

** Response not obtained*

[1] *Children <10 years old excluded from the total (N= 10,901)*

Table 10. Reported Risk Behaviour (1982 – Dec 2006 cumulative) Total (8,597 reported)

RISK	NO. OF PERSONS (%)
Sex with Sex workers	2104 (24.5)
Crack , Cocaine Use	715(8.3)
STD History	3966 (46.1)
IV Drug Use	92 (1.1)
Multiple Sexual Partners/contacts	~ 80%
No Known high risk behaviour	~ 20%

Table 11. HIV Seroprevalence rates in pregnant women by parish Jan – Dec 2005, Jamaica

PARISH	TOTAL TESTED	HIV POSITIVE	PERCENT (%)
Kingston & St. Andrew	1128	16	1.42
Manchester	322	6	1.86
St. Ann	290	5	1.72
St. Catherine	835	9	1.07
St. James	303	6	1.98
Westmoreland	240	5	2.08
Jamaica	3118	47	1.51

**Survey conducted between April and September 2005*

Table 12. HIV Seroprevalence rates in STI Clinic attendees, by parish Jan – Dec 2005, Jamaica

PARISH	TOTAL TESTED	HIV POSITIVE	PERCENT (%)
Kingston & St. Andrew	1361	74	5.44
Manchester	221	6	2.70
St. Ann	419	17	4.07
St. Catherine	600	22	3.66
St. James	520	30	5.77
Westmoreland	113	1	0.88
Jamaica	3234	150	4.64

**Survey conducted between April and September 2005*

Appendix D.

Ten ILO Principles on HIV/AIDS and the World of Work

1. **Recognition of HIV/AIDS as a workplace issue.** HIV/AIDS is a workplace issue, and should be treated like any other serious illness/condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, being part of the local community, has a role to play in the wider struggle to limit the spread and effects of the epidemic.
2. **Non-discrimination.** In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatisation of people living with HIV/AIDS inhibits efforts aimed at promoting HIV/AIDS prevention.
3. **Gender equality.** The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men due to biological, socio-cultural and economic reasons. The greater the gender discrimination in societies and the lower the position of women, the more negatively they are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.
4. **Healthy work environment.** The work environment should be healthy and safe, so far as is practicable, for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention, 1981 (No. 155). A healthy work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.
5. **Social dialogue.** The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government, where appropriate, with the active involvement of workers infected and affected by HIV/AIDS.
6. **Non-screening for purposes of exclusion from employment or work.** HIV/AIDS screening should not be required of job applicants or persons in employment.
7. **Confidentiality.** There is no justification for asking job applicants or workers to disclose HIV related personal information. Nor should co-workers be obliged to reveal such personal information about fellow workers. Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with the ILO's code of practice on the protection of workers' personal data, 1997.
8. **Continuation of employment relationship,** HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work.
9. **Prevention.** HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive. Prevention can be furthered through

changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment. The social partners are in a unique position to promote prevention efforts particularly in relation to changing attitudes and behaviours through the provision of information and education, and in addressing socio-economic factors.

10. **Care and support.** Solidarity, care and support should guide the response to HIV/AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependants in access to and receipt of benefits from statutory social security programmes and occupational schemes.