NATIONAL HIV · STI · TB PROGRAMME

ANNUAL REPORTS 2012-2015

Ministry of Health

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This document presents the National HIV/STI Programme report covering the period of January 2012 – December 2015. It reflects implementation of the National HIV Strategic Plan 2012 – 2017 and the National Integrated Strategic Plan 2014 – 2019 through the outstanding coordination of the National HIV/STI/TB Unit in collaboration with the National Family Planning Board, other government agencies, civil society organisations and the private sector.

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Special recognition to the Government of Jamaica, whose dedication and commitment to ending AIDS is an exemplar to other Caribbean Countries.

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DISCLAIMER

Unless otherwise stated, the appearance of individuals or groups in this publication gives no indication of HIV status, sexual orientation or gender identity.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARV	Anti-Retroviral
CDC	Centres for Disease Control
CHAI	Clinton Health Access Initiative
CSO	Civil Society Organization
EEHR	Enabling Environment and Human Rights
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GoJ	Government of Jamaica
HATS	HIV/AIDS Tracking System
HIV	Human Immuno-deficiency Syndrome
JaQIC	Jamaica Quality Improvement Collaborative
JN+	Jamaican Network of Seropositives
MAJ	Medical Association of Jamaica
M&E	Monitoring and Evaluation
MLSS	Ministry of Labour and Social Security
MOH	Ministry of Health
NERHA	North East Regional Health Authority
NFPB	National Family Planning Board
NHF	Nation Health Fund
NHP	National HIV/STI Programme
NPHL	National Public Health Laboratory
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PHDP	Positive Health Dignity and Prevention
PLHIV	Persons Living with HIV
PR	Principal recipient
SERHA	South East Regional Health Authority
SRHA	Southern Regional Health Authority
SOP	Standard Operating Procedure
SMO	Senior Medical Officer
SR	Sub-recipient

TCS	Treatment Care and Support
TFM	Transitional Funding Mechanism
TPDCo	Tourism Development Company
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
UWI-CHART	Caribbean HIV/AIDS Regional Training Network
VCT	Voluntary Counselling and Testing
WB	World Bank
WRHA	Western Regional Health Authority

MESSAGE

Minister of Health
Dr. Christopher Tufton

Jamaica has much to be proud of with respect to the work that has taken place over the last three decades under the leadership of the National HIV/STI/TB Unit. Significant strides have been made and the last decade of the epidemic has seen a shift in the HIV burden to a manageable disease.

Over the last three years, the Ministry of Health has remained committed towards reversing the epidemic and providing support to those affected. Medications to persons living with HIV are provided free of charge, prevention of mother to child transmission is a success story and people on treatment are living longer and their quality of life has improved with less AIDS-related illnesses.

Among the most significant achievement between 2012 and 2015 is the country's success in HIV testing. Of the estimated 29,000 persons living with HIV infection in Jamaica, 85% have been diagnosed. This represents a major success in the testing capacity of the country and an early indication that Jamaica is poised to meet at least the testing target of the UNAIDS 90-90-90 targets for 2020 aimed at ending the AIDS epidemic by 2030. These targets include 90% of people living with HIV being aware of their HIV infection, 90% of those receiving antiretroviral treatment, and 90% of people on antiretroviral therapy (ART) having no detectable virus in their blood. The magnitude of the success in testing can be seen within the context that in 2012, only 50% of persons estimated to be infected were diagnosed.

Jamaica is also on track to meet the regional elimination goal of less than 2% mother to child transmission of HIV. HIV prevalence among antenatal women has also declined over the last decade, with the 2015 prevalence rate at 1%. In 2015, for every one thousand pregnant women attending public antenatal clinics, approximately 10 were HIV infected. The AIDS mortality rate continues to trend down with just over 9 deaths/100,000 population in 2015. This represents a 64% decline since 2004.

During 2014, significant progress was made towards the goal of one national coordinating platform with the integration of the National HIV/STI Programme into the National Family Planning Board (NFPB) in 2013 to form one executive agency with responsibility for sexual and reproductive health. A National Integrated Strategic Plan for HIV and Sexual and Reproductive Health (2015-2019) was completed in 2015. The plan is being used to guide the implementation of the national response to HIV and AIDS and Family Planning in Jamaica.

In 2015, Jamaica joined countries globally under the UNAIDS-led 'All In to End the AIDS Epidemic among Adolescents (ages 10-19) by 2030' to initiate actions towards improving the situation of adolescents in the context of HIV and AIDS. The main aim of 'All In' is to accelerate reductions in AIDS-related deaths and new HIV infections among adolescents by 2020 as part of the global push to end the AIDS epidemic for all by 2030.

Based on the above-mentioned achievements, it is evident that Jamaica's HIV response is on solid ground. However, as we embark on achieving the 2030 target of ending AIDS, we must pause to reflect on some persisting challenges. Among the most persistent is stigma and discrimination.

National surveys indicate that one out of every three men who have sex with men (MSM) are HIV-infected, 2.9% of female sex workers are HIV-infected, 3.3% of inmates are HIV positive and 4% of homeless drug users. Some 63% of reported HIV cases in 2015 were from the parishes of Kingston and St. Andrew, St. Catherine and St. James. Further, despite the excellent results in testing, linking and retention in treatment and care has been inadequate.

These issues must be addressed, as the Ministry of Health remains committed to ending the AIDS epidemic. To reach this goal, we need to strengthen our efforts to retain people living with HIV into care, and develop new strategies to ensure that there is effective follow up. We need to reduce stigma and discrimination towards those seeking HIV services. We need to reinforce the combination of prevention activities with treatment, care and support for people infected and affected by HIV to meet the needs of the communities involved. The initiatives of civil society in prevention and care are viable strategies in empowering those most affected through involvement and participation. These approaches are to be encouraged and supported. We need to scale up linkage and retention efforts by addressing a range of issues including confidentiality, stigma related to services and quality improvement.

Ending AIDS by 2030 will require strong leadership and the engagement of people living with HIV, civil society in partnership as well the private sector to offer a more coordinated HIV response.

MESSAGE

Permanent Secretary
Dr Kevin Harvey

For more than 30 years, the success of Jamaica's HIV response is largely a result of a multi-sectoral partnership between Ministries, Departments and Agencies, nongovernment organisations (NGOs), academic institutions, key population groups, people living with HIV and health professionals. The last three years has again demonstrated the effectiveness of this collaborative approach, which has been strengthened when compared to previous years. This support to the HIV response in the country is encouraging.

The Ministry of Health is deeply grateful for the continued commitment from the National HIV/STI/TB Unit and also the continued support from donor agencies. This support has benefitted the HIV response in the country in its various components including prevention, enabling environment and human rights, treatment, care and support programs implemented by government agencies and our other key partners especially the NGO sector.

An important milestone in the year 2014 was undoubtedly the integration of the National HIV/STI Programme into the National Family Planning Board (NFPB) to form one executive agency with responsibility for Sexual and Reproductive Health (SRH). The integration represents Jamaica's commitment towards the goal of one national coordinating platform for HIV and SRH.

Another significant milestone was the approval of funding of US$14.9 million for 2016-2018 by Global Fund. This funding is expected to significantly address the situation of key populations at high risk of contracting HIV as well as those who are already infected through the provision of treatment, care, and support services.

Jamaica was also able to launch its first National Integrated Strategic Plan for HIV and Sexual and Reproductive Health 2015 – 2019 in 2015.

Throughout 2012 to 2015, we continued our commitment to improving the quality of those living with and affected by HIV. As you peruse this report, you will learn of the many successes that we have had with the HIV response particularly in the last three years. We are now able to state that with the significant achievements within the last three years, ending AIDS by 2030 appear a realistic goal.

Data indicates that men who have sex with men and their female partners accounted for almost 40 per cent of new infections in 2012. Further, MSM who reported being involved in sex work reported an HIV prevalence of 41 per cent, transgender women 45 per cent, and transgender populations in sex work reaching as high as 56 per cent.

The road to ending AIDS by 2030 is however paved with a myriad of challenges, and as a country, we should not underestimate them. The high prevalence among MSM (32.9%) and other key population calls for a concerted effort by all key partners – government, CSOs,

academia and private sectors - to improve access to sexual and reproductive health services for all. Stigma and discrimination against PLHIV and key populations remains an obstacle that must be addressed to strengthen the progress of our HIV response. The increasing number of women being newly infected is also cause for concern. Data indicates that of the 29,000 individuals estimated to be living with HIV infection, 85% have been diagnosed. However, of those diagnosed, 14% have never been linked to care. A total of 55% of those ever linked to care have been seen at a treatment site in the past 12 months. These troubling data indicates that retention in care is one of the major challenges faced by the country and which must be addressed if Jamaica is to achieve the goal of ending AIDS by 2030.

Efforts to sustain and diversify our resources for the HIV response must be intensified. There is need to collaborate more effectively with our partners, donors and other key stakeholders in mobilizing resources to address the epidemic.An assessment of our achievements and lessons learnt over the last three years indicate that with continued commitment at all levels to the HIV response, Jamaica is up to facing the challenges outlined.

Allow me to take this opportunity to thank all our partners from government sector, civil society, donor agencies for your unwavering support and contribution. Your invaluable support is appreciated. Sincere thanks also for the commitment of the staff of the National HIV/.STI/TB Unit and the National Family Planning Board in paving a strategic way forward to the HIV response.

I look forward to another successful year and also to the significant role that the agencies will continue to play as we head towards the target of ending AIDS by 2030.

MESSAGE

Director, HIV/STI/Tb Unit
Dr. Nicola Skyers

The achievements noted in this report would not have been possible without the hard work and dedication of all partners in the National HIV Response. The significant increase in HIV testing and the scale of the number of persons living with HIV accessing antiretroviral therapy over the period has resulted in an estimated 75% of PLHIV being aware of their status and more than half of the persons living with HIV in care accessing antiretroviral therapy.

HIV testing in settings such as STI Clinics as well as adult hospital admissions has reaped success as the majority of persons living with HIV diagnosed, were identified in these settings. Success is also noted in the decreasing trend in the number and proportion of late diagnoses. Continued efforts are required to ensure that persons who seeking health care services are offered to HIV testing in order to reduce the number of persons living with HIV who are unaware of their status. Of note, risk reduction counselling must remain a hallmark in the engagement process for those who test HIV negative in the health care setting.

An increasing number of persons living with HIV are accessing antiretroviral therapy with subsequent improvement in their life course through reduced morbidity and mortality. The scale up of antiretroviral therapy has been complemented with psychosocial support from an expanded HIV care team. However, persons living with HIV continue facing challenges which limit their ability to adhere to antiretroviral therapy. Psychosocial issues and economic are pervasive and disclosure continues as a significant challenge. This has resulted in less than half of persons living with HIV on antiretroviral therapy attaining viral suppression. Continued efforts are required to ensure that there is a consistent supply of antiretroviral drugs and monitoring reagents as well as continuous review of the persons living with HIV as a whole in order to provide the requisite support by ensuring that the persons living with HIV are fully engaged in the management and decision-making processes relating to his/her own health. Peer support is a strategy which needs to be developed and expanded in order to improve adherence and viral suppression.

Over the period under review, there has been significant scaling up of training with health care workers to improve the quality of care offered to persons living with HIV ranging from building clinical skills to reducing stigma and discrimination. Treatment guidelines have also been updated periodically to mirror international trends in HIV Care.

Our strategic information systems have also been strengthened in order to improve the quality of data for decision-making. Its continued evolution is essential for not only measuring the impact of programming as well as the providing the evidence base for programmatic changes.

As Jamaica's HIV epidemic evolves, the mandate and commitment of the HIV/STI/Tb Unit

remains that of supporting the provision of quality services to those at risk of, infected with, and affected by, HIV.

MESSAGE

Executive Director
National Family Planning Board – Sexual and Reproductive Health Agency

Between the years 2012 and 2015, the National HIV/STI programme continued to make significant progress in Jamaica's national HIV response. In 2012, Jamaica maintained a generalised HIV/ AIDS epidemic with a high prevalence among the key population groups including men who have sex with men (MSM), female sex workers (FSW), homeless drug users and inmates. The HIV prevalence rate was 1.7 percent with 19 cases of mother-to-child transmission (MTCT). Since then, we have been able to reduce the HIV prevalence rate to 1.6 percent in 2015 and eliminate MTCT all together.

In 2013, aspects of the former National HIV/STI programme – specifically Prevention; Enabling Environment and Human Rights; Treatment, Care and Support – were integrated into the National Family Planning Board (NFPB) to form one executive agency responsible for all aspects of sexual and reproductive health. The new integrated entity, now known as the National Family Planning Board - Sexual and Reproductive Health Agency (NFPB-SRHA), is guided by the National Integrated Strategic Plan for Sexual and Reproductive Health & HIV (2014-2019) which has five priority areas including: Prevention and Sexual and Reproductive Health (SRH) Outreach; Universal Access to Treatment, Care and Support and SRH Services; Enabling Environment and Human Rights; Monitoring and Evaluation of HIV, Family Planning and Sexual Health Response; and Sustainability, Governance and Leadership. The execution of this plan will play an important role in Jamaica's National Development Plan – Vision 2030 Jamaica, into which HIV and Population Planning have been integrated reflecting the Three Ones principle.

During the period under review, the achievements were:

- A reduction in the number of cases of advanced HIV from 1,888 in 2012 to 196 in 2015;
- A reduction in the number of AIDS-related deaths from 260 in 2012 to 61 in 2015;
- A reduction of the HIV prevalence rate from 1.7 to 1.6 percent;
- A reduction in the number of persons living with HIV (PLHIV) who are unaware of their status from approximately 50 percent in 2012 to 19 percent in 2015;
- An increase in the number of MSMs reached from 4,902 in 2012 to 6,502 in 2015 with 33% of them tested that year;
- An increase in the number of FSWs reached from 10,959 in 2012 to 17,607 in 2015 with 27% of them tested that year.

The approaches used to reach these key populations include peer support, counselling, risk reduction conversations, empowerment and capacity building workshops and other community outreach programmes. With the scaling up of the Reach and Test, counselling and Link to Care activities and interventions within the Programme, Jamaica is now positioned to

meet the UNAIDS 90-90-90 goal by 2020. We have already increased our Link to Care figures as in 2013, 25 percent of persons diagnosed with HIV were never linked to care; this figure has been reduced to 14 percent in 2015.

The NFPB-SRHA continues to work with non-government organisations (NGOs), civil society organisations (CSOs), international donor agencies, and health care providers to strengthen the prevention efforts through treatment, education and advocacy.

FOREWORD

The progress that Jamaica through the HIV/STI/Tb Unit and the National Family Planning Board – Sexual Health Authority continues to make in the HIV response has been significant. This has been possible through the continuous support, commitment and dedication from all key partners in the response to HIV and AIDS and SRH. Looking back on the last three years, the notion of ending AIDS by 2030 appears to be more and more realistic than before.

Between 2012 and 2015, the number of new HIV infections in the country declined from 1551 new cases in 2012 to 1,222 cases in 2015. The number of newly reported HIV cases has declined by 25% in the last 10 years. HIV prevalence for 2015 stands at 1.6% down from 1.7% in 2012. This is a result of significant investments in testing by the Ministry of Health. There has also been an increase in the coverage of community based HIV interventions particularly to key populations in both urban and rural areas and also in communities that are not easily accessible.

The HIV response in Jamaica is led by four technical components: Prevention and SRH; Treatment, Care and Support (TCS), Enabling Environment and Human Rights and Monitoring and Evaluation (M&E). Over the last three years a number of new initiatives were undertaken to improve the HIV response. A few of these are highlighted below and are further elucidated in the annual reports.

A number of research studies/ projects were finalised in 2012, many of which formed the evidence from which ensuing work over the last three years rested. They include:

- MSM and CSW Behavioural and Serological Survey (MEASURE)
- Co-occurring Psychiatric Disorders among HIV/STI Patients Attending Public HIV/STI Clinics in Jamaica (World Bank funded)
- Modes of Transmission Study (UNAIDS funded)
- Knowledge, Attitude, Behaviour and Practices (KAPB) Survey (Global Fund)
- National AIDS Spending Assessment (UNAIDS funded)

The KABP is a cross-sectional, household-based survey that was conducted among a randomly selected sample of 1800 persons island-wide. The results of the 2012 KABP survey indicate mixed programme results in a number of areas:

Multiple partnerships rank among the leading risk factors in Jamaica registered a 2% increase overall between 2008 and 2012, with a significant increase among the 15 – 24 year age group. Overall condom use at last sex remained constant at 63% over the period for persons with multiple partners. Persons engaged in more risky behaviours (i.e. non-users of condoms in multiple partnerships) tested for HIV more frequently than their counterparts and at a slightly increased rate over 2008 (50.9% vs. 50%). Transactional sex recorded a concerning increase among all groups in 2012, but was higher among males, younger persons and person in short term (< 1 year) relationships. Casual relationships increased overall, but were more pronounced among females and younger persons. Overall, HIV prevention knowledge decreased by 7 – 10% among males and females.

SEX WORKER SURVEY

The survey indicated that HIV prevalence ranged from 4.7% among female workers at venues to 0.5% among male venue patrons. The prevalence among female sex workers was similar to the prevalence among all women working at venues (4.7% versus 4.1%).

MSM SURVEY

The prevalence of HIV was 32.9%. Results also showed that 8.5% had a positive rapid test for syphilis, indicating that they had ever been infected with syphilis. The prevalence of gonorrhoea was 2% and chlamydia, 8.9%.

MODES OF TRANSMISSION STUDY

A Modes of Transmission Analysis was completed in 2012 and indicated that whilst new HIV infections in Jamaica have declined by 25% in the last decade, 2,500 new HIV infections were expected to occur in 2012. The new infections were anticipated to be greatest among MSM, accounting for 32%. Female partners of MSM were also at significant risk with an estimated 7% of new infections. It further indicated that female sex workers, their clients and the partners of sex worker clients were expected to contribute approximately 11% of incident infections. The general population engaging in casual heterosexual intercourse was expected to contribute 22% of new HIV infections and mother-to-child transmission of HIV was estimated at 1.9% in 2012.

Also happening in 2012, there was an Amendment to the Public Health (Notifiable Diseases) Order and its regulations which were approved by Cabinet on March 28. The amendment safeguards persons living with HIV certain rights such as access to education and employment opportunities in the tourism sector and the food industry.

The National Workplace Policy on HIV and AIDS was also approved as a Green Paper by the Human Resources Committee of Cabinet (HRC) on July 26, 2012.

HIV CARE CONTINUUM

Due to high levels of loss to follow up among PLHIV on HAART, the national programme moved in 2013 to track the country's efforts to improve the care continuum for persons living with HIV to sustain their health from diagnosis to linkage and retention in care. The goals of the HIV care continuum are for all persons with HIV to be diagnosed, linked to treatment and care and achieve viral load suppression. Viral suppression ensures a strong immune system and healthier outcomes for persons living with HIV. In 2013, the following was the situation:

- 75% of estimated persons living with HIV diagnosed and reported
- 25% have never been seen at a treatment site (linked to care)
- 56.5% of PLHIV retained in care
- Just over 50% of PLHIV retained in care are currently on ART
- 42.8% of PLHIV retained in care have achieved viral suppression

INTEGRATION OF HIV AND SRH

During 2014, significant progress was made towards the goal of one national coordinating

platform with the integration of the National HIV/STI Programme into the National Family Planning Board (NFPB) to form one executive agency with responsibility for sexual and reproductive health. The National Family Planning Board, empowered by the National Family Planning Act (1970), is the Government agency responsible for preparing, implementing, coordinating, and promoting sexual and reproductive health services in Jamaica.

NATIONAL INTEGRATED STRATEGIC PLAN FOR SEXUAL AND REPRODUCTIVE HEALTH AND HIV 2014 – 2019

A National Integrated Strategic Plan (2015-2019) was started in 2014. The plan was completed in 2015 and will be used to guide the implementation of the national response to HIV/AIDS and Sexual and reproductive health.

In 2015, Jamaica joined countries globally to initiated actions towards improving the situation of adolescents in the context of HIV and AIDS. Dubbed the 'All In to End the AIDS Epidemic among Adolescents (ages 10-19) by 2030' platform for action, it is anticipated that countries will put in place strategies to drastically improve the situation of adolescents through critical changes in programmes and policy.

This 2012 to 2015 report contains information on the HIV response over a four year period. It includes overviews of programmatic activities geared at reducing new infections, HIV-related stigma and discrimination, actions at policy and legislative reform, and summaries of findings from analyses of programme data from January 1, 2012 through to December 31, 2015.

The last decade of the epidemic has seen a shift in the HIV burden to a manageable disease. This report reflects that transition by describing trends, survival and retention in care.

EXECUTIVE SUMMARY

The Government of Jamaica began its national response to HIV and AIDS in 1986 with the start-up of a comprehensive National HIV/STI Programme (NHP). Today, the response is guided by the National HIV/STI/TB Unit.

OVE RVIEW

The majority of persons diagnosed with HIV since 1982 are still alive. Between 2002 and 2012, the number of newly reported HIV cases declined by 25% while the number of persons linked to care following diagnosis, gradually increased during that ten-year period. Ministry of Health records show that between 2012 and 2015, the number of newly diagnosed and reported HIV cases declined by 21. 2%.

Jamaica has features of both a generalized and concentrated HIV epidemic. Between 2012 and 2015, the estimates of the HIV prevalence in the general population ranged from between 1.6% and 4%. Survey data points to higher HIV prevalence among some key populations. These key populations are deemed as high risk and they include men who have sex with men (MSM) for example. This group represents 4.4% of the adult male population in Jamaica; however a 2012 survey showed that approximately 1 out of every 3 MSM was HIV infected. Available survey data from the Ministry of Health show that, prevalence among the key groups is as follows:

- Men who have sex (MSM): 31.8% in 2012
- Female sex workers (SW): 4.1%, 2012; 2.9%, 2015
- Homeless drug users (HDU): 12%, 2012; 4% 2015
- Prison inmates: 3.3%, 2006

The key features of the epidemiological profile for 2012-2015 are that:

- AIDS mortality rate continues to trend down. Since the inception of universal access to ARVs in 2004 the AIDS mortality rate has dropped by 64%; there were 25 deaths/100,000 persons in 2004 and 9-deaths/100,000 population in 2015. The decline in AIDS deaths is attributed to universal access to ARVs, the scaled up national VCT programme and the use of rapid test kits allowing for earlier diagnosis, the availability of prophylaxis and improved laboratory capacity to conduct investigations such as CD4 counts, viral load and PCR tests.
- The number of females living with AIDS increased in 2012. Although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually. Between 2007- 2012, there was a 40% increase in the number of reported cases among women, moving from 339 (2007) to 563 (2012). Young females aged 10 – 29 years old typically account for the larger share of the reported cases.
- The majority of people living with HIV and AIDS reside in three parishes. Since 1982, the majority of reported AIDS cases (approximately 63%) were reported in the three parishes that account for 50% of the nation's population, Kingston & St. Andrew, St. James, and St. Catherine. Between 2011 and 2015, the parishes accounted from anywhere between one-half to two-thirds of number of reported cases. The data shows 57% in 2011, 59% in 2012, 61% in 2013, 52% in 2014 and 63% in 2015.
- Heterosexual transmission remained the highest self-reported risk for acquiring HIV infection. In Jamaica, HIV is primarily transmitted through sexual intercourse. Among all reported adult HIV cases for which n data about sexual practices are available (77% of cases), heterosexual practice is reported by 95% of persons.
- The STI burden remained high. In 2015, there were 41,703 cases reported in the public health system according to data from the Jamaica STI Monthly Summary Report and the STI Epi Update 2013 – 2015; this shows a 4% increase when compared to 2014. STIs increase the risk of HIV infection as well as transmission as activated CD4 cells are more easily infected with the virus and viral load in vaginal and seminal fluids increase during an STI. Surveillance data from STI clinic attendees indicates that, between 2013 and 2015, for every 1,000 persons with a sexually transmitted infection, on average, approximately 24 were infected with HIV.

The National HIV/STI/TB Programme's approach to addressing the epidemic acknowledges that changes in epidemiological profile hinges on the stakeholders' ability to make sustainable gains in the following areas.

I. Diagnosing all persons infected with HIV

II. Retaining people in care

III. Increasing the proportion of persons with sustained viral load suppression.

IV. Addressing health disparities that remain a significant feature of the epidemic.

The success of the National HIV/STI/TB Programme is in part, dependent on the extent to which the national response takes poverty into account, as one of the key drivers of the epidemic. Poverty is closely related to high levels of unemployment, low academic achievement, early sexual debut, multiple partnerships, and transactional and commercial sex.

STRATEGIC INVESTMENTS IN THE FIGHT AGAINST HIV AND AIDS

Jamaica's approach to tackling the HIV epidemic is a multi-sectoral effort that engages persons living with HIV and stakeholders from the Government, non-governmental organizations, civil society, private sector groups, and international development partners. Since 1988, Jamaica has had a national plan to guide the response to HIV and a well-established National HIV/STI Programme. The Plans that provided the road map for the implementation of the national response for the period under review (2012-2015) are:

I. National Strategic Plan on HIV and AIDS 2012 – 2017 (NSP 2012-2017). The Plan outlines six priority areas: Prevention, Treatment, Care and Support, Enabling Environment and Human Rights, Empowerment and Governance, Monitoring & Evaluation, and Sustainability.

II. Gender Responsive National Integrated HIV&AIDS Strategy (2012-2017).

III. The National Integrated Strategic Plan (NISP 2014-2019) for Sexual and Reproductive Health and HIV.

The vision of the National Strategic Plan on HIV and AIDS 2012 – 2017 was:

> *"To protect the rights of all Jamaicans including those infected with and affected by HIV and AIDS and to create an enabling environment free of stigma and discrimination while providing access to prevention knowledge and skills; treatment care and support; and other services".*

The stakeholders' collaborative efforts focused on reducing the transmission of new HIV infections while mitigating the impact of HIV/AIDS on the people of Jamaica within a sustained, effective multi-sectoral infrastructure and soliciting the necessary commitment to support the national response to HIV (NSP 2012-2017, Goal Statement). The NSP 2012-2017 overarching strategic outcomes reflect the critical areas in which the stakeholders intended to achieve success; they are:

I. Effective prevention interventions and additional interventions

II. Effective interventions for comprehensive care and support and additional interventions

III. Effective interventions for impact mitigation and additional interventions developed;

IV. Effective leadership by government and non-government sectors for implementation of the response to HIV/AIDS, at central and local levels;

V. A supportive legal and public policy environment for the HIV/AIDS response;

VI. Availability of information for policy makers and programme planners through monitoring, evaluation and research and,

VII. Sustainable and equitable allocation of resources to the national response.

During 2012 and 2015, the national response benefited from the support of donor agencies such as Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and United States Agency for International Development (USAID). The calendar year 2013 budget allocation for the NHP was J$M 1,006.66; in the following year the budget declined to J$M838.19. By 2015, the budget increased and surpassed the 2012 allocation, to round out at J$M 1084.60

The NHP secured two new funding agreements in 2015: 1) Three-year funding from, the Global Fund for US$15.24M (January 2016-December 2018) and 2) A five-year funding agreement (starting September 2015) from USAID for US$2.6M.

STRENGTHENING THE APPROACH TO FIGHTING HIV AND AIDS

In response to the high levels of loss to follow up among PLHIV on HAART, the National Programme in 2013, adopted the Continuum of Care approach and started to track the country's efforts in improving the care continuum for persons living with HIV. The approach s was introduced to ensure that all persons with HIV are diagnosed, linked to treatment and care and achieve viral load suppression. Viral load suppression is a marker of a person's strong immune system and overall health.

In 2013, the National HIV/STI Programme was integrated into the National Family Planning Board (NFPB) to create one executive agency with responsibility for sexual and reproductive health. The National Family Planning Board, empowered by the National Family Planning Act (1970), is the Government agency responsible for preparing, implementing, coordinating, and promoting sexual and reproductive health services in Jamaica.

In 2014, the stakeholders embarked on the implementation of the National Integrated Strategic Plan for Sexual and Reproductive Health and HIV (2014 – 2019). The plan serves as stakeholders' guide to the implementation of the national response to HIV/AIDS and Family Planning in Jamaica. The Plan is outlines five priority areas: 1) Prevention and SRH Outreach; 2) Universal Access to Treatment, Care and Support and SRH Services; 3) Enabling Environment and Human Rights; 4) Monitoring and Evaluation of HIV, Family Planning and Sexual Health Response and 5) Sustainability, Governance and Leadership. Key targets include:

- Reduce by half, the number of new HIV infections by 2019
- Reduce the number of HIV related deaths by 25% by 2019
- Increase coverage of ARV treatment for PLHIV to 65% by 2019
- Increase to 90% the proportion of PLHIV on ART one year after initiating therapy

In 2014, the NHP reintroduced the Provider Initiated Testing and Counselling (PITC) Programme in sixteen hospitals across the island. The service is available for persons who would not have

actively sought healthcare services, but who, through their interaction with the emergency care services at the hospital, are given the opportunity to know their HIV status. Between 2014 and 2015, an average, 25.7% of persons admitted to health care facilities across the six RHAs were tested.

In 2015, the NHP started its efforts to decentralize CD4 testing. Nine sites received PIMA training. By year-end, more than half of the sites trained had submitted their parallel studies for analysis. The CDC contributed to the NHPs efforts to further expand point of care CD4 testing by donating six FACS Presto machines.The teams at the sites that received the machines received the requisite technical training sessions. At the time of this report, sites were conducting parallel testing for certification before routine usage.

In 2015, the NHP expanded the scope of the STI Prevalence and Drug Resistance Study. The 2015 version of the study was the first Sexually Transmitted Infections (STI) prevalence study in Jamaica to : 1) cover parishes outside of Kingston and St. Andrew (KSA), 2) examine an asymptomatic population (i.e. ANC attendees) and 3) to assess the prevalence of Mycoplasma.

The national response was expanded to include the ALL IN TO END ADOLESCENT AIDS Initiative. The initiative's global 2020 targets include accelerating reductions in AIDS related deaths by 65% and new HIV infections in adolescents by 75%. This initiative, which targets ages 10 to 19 years is part of the global push to end the AIDS epidemic for all by 2030. For the Jamaican context All In's approach takes into account that the various challenges affecting adolescents in Jamaica are interlinked and therefore increases their risk of contracting HIV and amplifies challenges faced by those who are infected. As a result, All In takes an integrated approach –incorporating sexual and reproductive health in HIV programmes, strengthening social protection for youth, addressing mental health and drug use among adolescents, working to eliminate gender inequalities and discrimination and addressing gender based violence including child sexual abuse.

In 2013, the Ministry of Health, I-TECH, UWI CHART and ERTU CHART Jamaica, established the Jamaica Quality Improvement Collaborative (JaQIC!). Through this collaborative, quality improvement teams (health care providers) from each site learn to develop and test change strategies using Plan-Do-Study-Act (PDSA) cycles. PDSA is a rapid-cycle, continuous quality improvement (CQI) approach in which teams test a change for improvement on a small scale, observe the results, and based upon their findings, adjust the strategy. The programme's key performance indicators are: 1) Viral suppression <1000 copies/ml; 2) On time pick up of prescriptions; 3) Prescription practices (no mono or dual therapy); 4) VL turnaround time of 15 days and 5) CD turnaround time of 15 days.

KEY ACHIEVEMENTS IN THE FIGHT AGAINST HIV AND AIDS

Decrease in infection rate among female commercial sex workers. Results of the 2014 Sex Work Survey show an infection rate of approximately 2.9%, a 41% reduction when compared to the rate in 2011, (4.1%). The reduction is linked to expanded efforts to target and implement interventions with sex workers. During the reporting period for example, the Programme prioritized its outreach programme aimed at identifying new sex workers. During 2015 in particular, the sex workers benefited from interventions that addressed both sexual health needs and social welfare; they were referred to social agencies such as the Programme of Advancement Through Health and Education (PATH), a conditional cash transfer programme,

the National Insurance Scheme (NIS), a social insurance contributory scheme and the Registrar General Department (RGD) for birth registrations.

Jamaica is on track to meeting the regional mother-to-child transmission (MTCT) elimination goal of ≤2% by 2015. The HIV prevalence among antenatal women has declined over the last 15 years, with the 2013 and 2014 prevalence rates remaining at 1% and below. The success has been attributed to the implementation of the Prevention of mother-to-child transmission (MTCT) HIV programme. Upon completion of the pre-validation mission in December 2015, by a team of PAHO consultants, the decision has been made to institutionalize the EMTCT initiative. The focus of the initiative for 2016 and beyond would include: 1) introduction of dual testing kits for HIV and syphilis; 2) ensuring 100% compliance with DNA PCR testing in HIV exposed babies; 3) Improved data capture and analysis and 4) increasing PLHIV's uptake of antenatal care earlier in the pregnancies.

In 2015, the Treatment Care and Support arm of the NHP accomplished no stock out of testing and monitoring reagents and supplies. This success can be attributed to the strengthening of procurement processes and a closer working relationship between the Unit and the NPHL. Operationally practices such as monthly and quarterly audits for example, have resulted in the team being better able to verify the available stocks at the central warehouse and lab and subsequently make more accurate projections.

On June 1, 2015, Cabinet approved the Revised National HIV/AIDS Policy. The Steering Committee's recommendations on the policy provision process were to: 1) conduct broad stakeholder consultations and partnering with agencies such as the Social Development Commission to mobilize consultations; 2) engage in public discourse on issues such as the buggery law and discrimination on the basis of sexual orientation as the anticipated that these issues would have an impact on policy implementation and 3) engage in deliberation on whether or not the revised Policy would be proposing amendments to the Sexual Offences Act (SOA) and the Charter of Fundamental Rights and Freedoms.

On March 28, 2012, the Cabinet approved the amendment to the Public Health (Notifiable Diseases) Order and its regulations. The amendment safeguards the rights persons living with HIV by securing their access to education and employment opportunities in the tourism sector and the food industry.

On July 26, 2012, Human Resources Committee of Cabinet (HRC) approved the Green Paper for the National Workplace Policy on HIV and AIDS. This was a key policy win as it is a milestone towards the advancement of HIV-related regulations; the Policy will inform regulations to be appended to the proposed Occupational Safety and Health (OSH) Bill. Five Government of Jamaica ministries (and their departments and agencies) updated and finalized their Draft HIV Workplace Policies. The policies were launched on November 30, 2012 in commemoration of World AIDS Day (WAD).

The eight-module Positive Health Dignity and Prevention (PHDP) Curriculum was developed in 2012 by PLHIV for use by leaders in the PLHIV community. The PHDP Curriculum's learning objective is to increase PLHIV awareness and understanding of critical areas such as: sexual and reproductive health and rights, human rights, gender equality and health promotion. A workshop series, using the PHDP Curriculum was implemented with financial and technical support from the Health Policy Project (HPP).

CONCLUSION

During the reporting period the NHP made important strides in addressing the HIV/AIDS epidemic in Jamaica. Accomplishments such as the approval of policies and regulations served to strengthening the enabling environment for the stakeholders' collaborative efforts to have an impact on the lives of people living with HIV. Additionally, institutional and operational changes with the NHP and its units, were critical for strengthening the management framework in which the NHP operates. The benefits of those changes are expected to include better coordination of stakeholders efforts, optimizing limited resources and better service delivery.

Key interventions and initiatives that were pursued prior to 2012, yielded key shifts in the epidemiological profile of HIV and AIDS in Jamaica. More specifically, the eMTCT Initative has been identified as the key intervention that has led to Jamaica's being on track to meeting the regional mother-to-child transmission (MTCT) elimination goal of ≤2% by 2015.

The work of the NHP continues in the face of challenges in reaching key populations. The socio-economic vulnerabilities such as poverty, unemployment and homelessness are underlying factors for HIV transmission about the transgender population. For the MSM population, those socio-economic vulnerabilities are barriers to them buying in and committing to pursuing the opportunities that the NHP interventions provide. The transience of key populations such as commercial sex workers increases the risks that implementers face in making long-term investments to serve the population.

In large part, the NHP has relied on the strength of its collaborative, multi-stakeholder approach to overcome the challenges in facing in addressing the HIV and AIDS epidemic in Jamaica.

NATIONAL HIV · STI · TB PROGRAMME

ANNUALREPORT

2012

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
EEHR	Enabling Environment and Human Rights
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immuno-deficiency Syndrome
GoJ	Government of Jamaica
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MLSS	Ministry of Labour and Social Security
NFPB	National Family Planning Board
NHP	National HIV/STI/TB Programme
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PHDP	Positive Health Dignity and Prevention
PLHIV	Persons Living with HIV
PR	Principal recipient
SR	Sub-recipient
TCS	Treatment Care and Support
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WB	World Bank

INTRODUCTION

This Annual HIV and AIDS Report confirms that Jamaica maintains a generalised HIV and AIDS epidemic with concentrated pockets among some high risk groups including men who have sex with men (MSM), female sex workers (FSW), homeless drug users and inmates. There is evidence that the National HIV/STI Programme (NHP) continues to make some progress in combatting the epidemic. The number of newly reported HIV cases has declined by 25% in the last 10 years and there has been a gradual increase in the number of persons linked to care following diagnosis.

Jamaica's national response to the HIV epidemic is multi-sectoral and is guided by stakeholders from the Government, non-governmental organizations, civil society, private sector groups, international development partners and persons living with HIV. The Government of Jamaica began its national response to HIV and AIDS in 1986 with the start-up of a comprehensive National HIV/STI Programme (NHP). The HIV response in 2012 is guided by the National Strategic Plan on HIV and AIDs 2012 – 2017 developed around six priority areas: Prevention, Treatment, Care and Support, Enabling Environment and Human Rights, Empowerment and Governance, Monitoring & Evaluation, and Sustainability.

The following outlines the vision of the national response:

"To protvect the rights of all Jamaicans including those infected with and affected by HIV

and AIDS and to create an enabling environment free of stigma and discrimination while providing access to prevention knowledge and skills; treatment care and support; and other services".

The above statement guides the national response, the National HIV/AIDS Policy and the National Strategic Plan.

The goal of the NSP 2012 – 2017 is "to reduce the transmission of new HIV infections while mitigating the impact of HIV/AIDS on the people of Jamaica within a sustained, effective multi-sectoral infrastructure and soliciting the necessary commitment to support the national response to HIV and AIDS."

The overarching strategic outcomes of the National Strategic Plan are:

- Increased coverage of effective prevention interventions and additional interventions developed;
- Increased coverage of effective interventions for comprehensive care and support and additional interventions developed;
- Increased coverage of effective interventions for impact mitigation and additional interventions developed;
- Effective leadership by government and non-government sectors for implementation of the response to HIV/AIDS, at central and local levels;
- A supportive legal and public policy environment for the HIV/AIDS response;
- Increased availability of information for policy makers and programme planners through monitoring, evaluation and research
- Increased, sustainable and equitably allocated resources for the national response

As indicated in this report, the country still has significantly more to accomplish towards achieving its goals of diagnosing all persons infected with HIV, retaining people in care, and increasing the proportion of persons with sustained viral load suppression. Health disparities remain a significant feature of the epidemic. In particular, key populations and vulnerable groups especially men who have sex with (MSM), homeless drug users, prison inmates, sex workers and adolescent girls are disproportionately impacted by HIV.

EPIDEMIOLOGICAL SUMMARY

Key points in this report in 2012 include:

- 34,000 persons are estimated to be living with HIV or 1.7% of the population
- Some key populations are disproportionately affected by HIV with some having rates above the national average. National surveys indicate that one out of every three men who have sex with men (MSM) is HIV-infected, 4.1% of female sex workers are HIV-infected, 3.3% of inmates are HIV positive and 12% of homeless drug users.
- The number of newly diagnosed HIV cases in Jamaica declined by 25% in the last decade
- There were 1551 cases of HIV and 1,888 persons with advanced HIV reported in 2012
- In 2012, there were 260 reported AIDS deaths (156 males and 104 females)

- There were 19 babies born with HIV in 2012 and seven deaths reported.
- The majority of persons diagnosed with HIV since 1982 are still alive
- The main drivers of the HIV epidemic are closely tied to poverty and include high levels of unemployment, low academic achievement, early sexual debut, multiple partnerships, transactional and commercial sex.

SCALING UP SUCCESS

The NHP and key stakeholders continued work at scaling up programmes to reduce the new HIV infections and deaths.

The following are some of the key achievements in 2012.

- A total of 248,311 HIV tests were conducted including more than 4000 (4113) STI clinic attendees, 1059 MSMs and 2,418 female sex workers
- Surveillance data for 2012 reveal the number of AIDS deaths declined by 61% since the introduction of Universal Access to ARVs in 2004.
- 18,919 persons living with HIV (PLHIV) were linked to treatment with 38.5% (7267) receiving lifesaving ARVs
- There was a 3.5% increase in pregnant mothers who received ARVs to prevent mother-to-child transmission of HIV
- 98% of HIV-exposed babies received drugs to prevent mother to child transmission of HIV.

CHAPTER 1: EPIDEMIOLOGY OF HIV IN JAMAICA

SUMMARY

Jamaica has features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.7%; however surveys show higher HIV prevalence among some key populations and high-risk groups. As at December 31, 2012, an estimated 34,000 persons were living with HIV and AIDS, with as many as 50% being unaware that they are living with the virus.

Surveillance data indicates that in 2012 for every one thousand persons with a sexually transmitted infection (STI) that visited an STI clinic, approximately 26 were infected with HIV. Surveys conducted in 2012 also show higher HIV prevalence in some populations such as among men who have sex with men (MSM) (32.8%), female sex workers (SW) (4.1%), and homeless drug users (12%) (Ministry of Health, 2012).

The main drivers of the HIV epidemic are closely tied to poverty and other related development issues, including the slow rate of economic growth, high levels of unemployment, low academic achievement, early sexual debut, multiple partnerships, and transactional and commercial sex.

In 2012, a total of 1,888 persons with advanced HIV were reported compared to 1,250 in 2011. HIV remains a leading cause of death among adults 15-49 years, with over 393 reported deaths due to AIDS in 2012.

INCIDENCE AND PREVALENCE OF HIV AND AIDS IN JAMAICA

In 2012, 1551 HIV cases were reported to the National HIV/STI Programme; this represents a 13.68% decline over 2011. Over the same period, 1,888 persons with advanced HIV were reported compared to 1,250 in 2011.

All 14 parishes are affected by the HIV epidemic with HIV cases ranging from a low of 523.2 per 100,000 to a high of 2195.9 per 100,000 population.

The number of females living with AIDS increased in 2012

Although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually. Since 2007, there has been a 40% increase in the number of reported cases among women, moving from 339 to 563 in 2012.

The cumulative male to female ratio for persons reported with AIDS in 2012 is 1.31:1. The cumulative AIDS case rates are also higher among males (27.8 cases per 100,000) compared to females (21.6 cases per 100,000 females). Despite this, there is some variation in the gender distribution of reported AIDS cases that indicates the need for targeting among certain females. Young females aged 10 – 29 years old account for the larger share of cases. In the age group 15 to 19 years old, four times more young women have been reported with AIDS than young men. Similarly, young women aged 20 – 24 years old are one and a half times more likely to be infected than males in the same age group. However, adult males account for a larger proportion (61%) of the cases reported in the 30 to 79 years age group.

In 2012, for every one thousand pregnant women attending public antenatal clinics, at least 9 were HIV infected. Between 1989 and 1996 the HIV prevalence among antenatal clinic attendees increased from 0.14% to 1.96%. The prevalence has declined over the last 15 years, with the 2011 and 2012 rates remaining at 1% and below. This overall decline likely reflects the success of Behaviour Change strategies among the general population.

DISTRIBUTION OF HIV AND AIDS IN JAMAICA BY PARISH AND AGE

The majority of people living with HIV and AIDS are from three parishes

The parishes of Kingston & St. Andrew, St. James, and St. Catherine, which is home to 50% of the Jamaican population, account for 63% of all reported HIV cases since 1982. Further, 59% of reported AIDS cases in 2012 were also from KSA, St. Catherine, and St. James. This proportion shows a slight increase over 2011 (57 %).

The two most urbanized parishes have the highest cumulative number of reported HIV cases: Kingston & St. Andrew (KSA) - 1656.2 cases per 100,000 persons, and St. James – 2195.9. HIV cases per 100,000 persons. In fact, KSA and St. James have cumulative case rates that exceed the national case rate (670.5 cases/100,000 population.

In addition to the urbanized parishes, parishes with significant tourism-based economies have the next highest level of cumulative number of reported HIV cases since the start of the epidemic: 1257.9 cases per 100,000 persons in St. Ann, 1124.9 cases per 100,000 persons in Westmoreland, 1090.5 cases per 100,000 persons in Hanover, 1053.5 cases per 100,000 persons in Trelawny. Of note, all parishes in the Western Region are counted among those with the highest cumulative number of HIV cases.

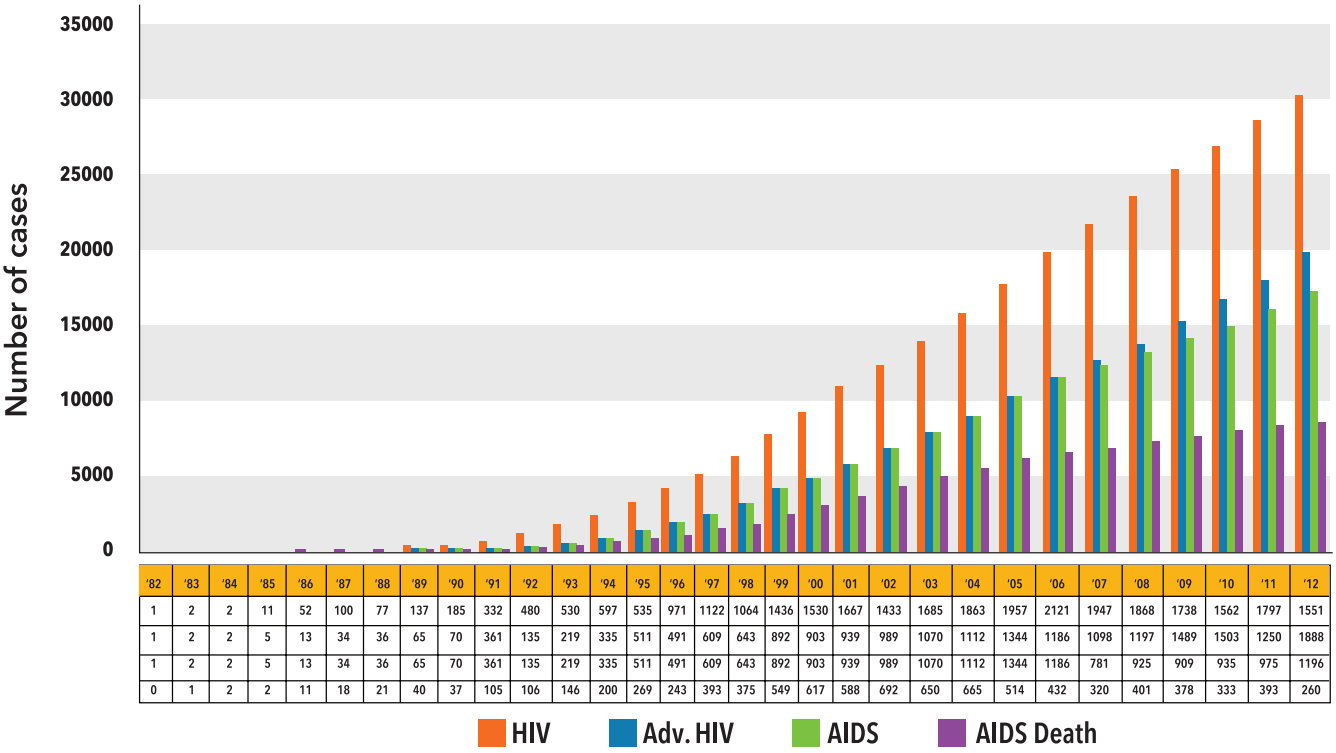
AGE

Approximately 74% of all AIDS cases reported 1982 - 2012 are in the 20-49 year old age group and 86% of all AIDS cases reported 1982 - 2012 are between 20 and 59 years old. Cumulatively, the number of AIDS cases reported among 20-24 year olds (1,056 cases) is 4.5 times the number of cases reported among 15-19 year olds (233 cases).

HIV MORTALITY

The majority of people diagnosed with HIV in the 30 years since the first person was diagnosed in Jamaica are still alive. Between 1982 and 2012, 30,620 persons were diagnosed with HIV and AIDS, of whom 21,862 people (71.39%) are still living. The total number of reported AIDS-related deaths in Jamaica between January 1982 and December 2012 was 8,758.Catio,

Figure 1: Cumulative number of reported HIV/AIDS cases and deaths, 1982 to 2012



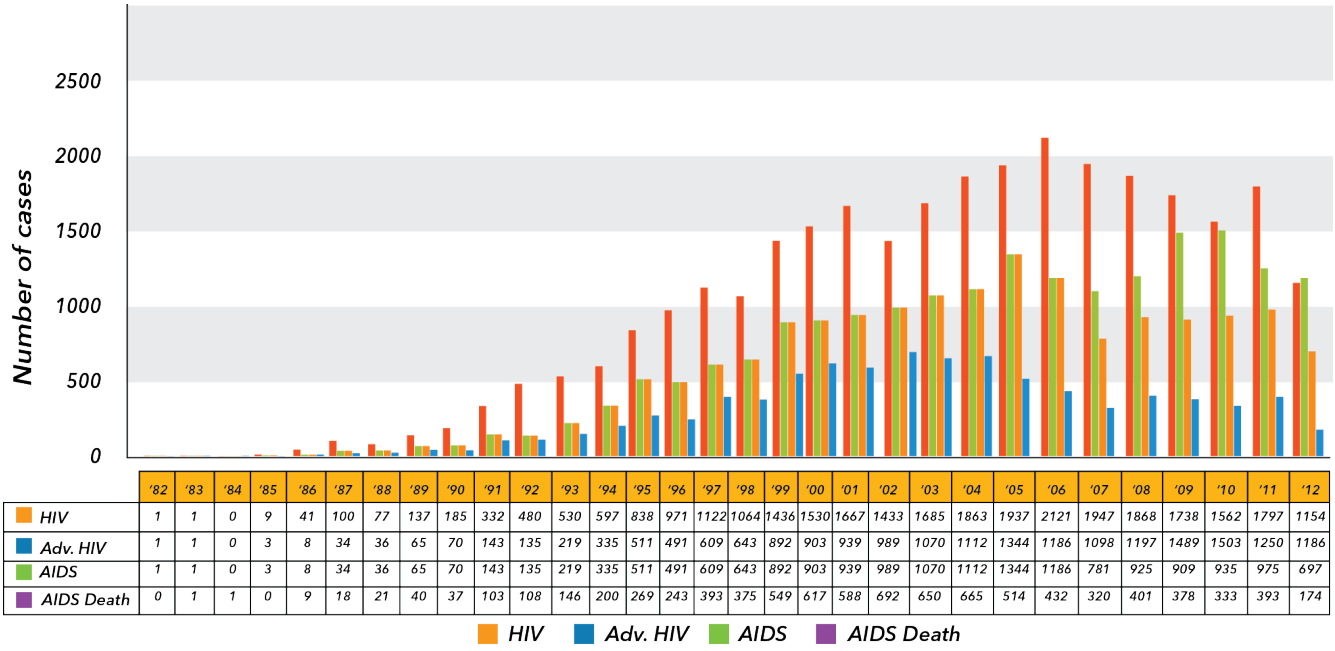
'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12
1	2	2	11	52	100	77	137	185	332	480	530	597	535	971	1122	1064	1436	1530	1667	1433	1685	1863	1957	2121	1947	1868	1738	1562	1797	1551
1	2	2	5	13	34	36	65	70	361	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	1098	1197	1489	1503	1250	1888
1	2	2	5	13	34	36	65	70	361	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	781	925	909	935	975	1196
0	1	2	2	11	18	21	40	37	105	106	146	200	269	243	393	375	549	617	588	692	650	665	514	432	320	401	378	333	393	260

Since 1982, AIDS-related deaths rapidly increased on a yearly basis peaking at 692 in 2002. With the introduction of public access to anti-retrovirals (ARVs), AIDS-related deaths have been declining steadily. In 2012, 260 AIDS-related deaths were reported compared to 692 in

2002 and 665 in 2004. This represents a 61% decline since the inception of Universal Access to ARVs in 2004, and a 62% decline when compared to 2002 (692 AIDS deaths).

Approximately 60% of deaths in 2012 occurred among men compared to women.

Figure 2: Reported cases and deaths annually in Jamaica, 1982 -2012



	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12
HIV	1	1	0	9	41	100	77	137	185	332	480	530	597	838	971	1122	1064	1436	1530	1667	1433	1685	1863	1937	2121	1947	1868	1738	1562	1797	1154
Adv. HIV	1	1	0	3	8	34	36	65	70	143	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	1098	1197	1489	1503	1250	1186
AIDS	1	1	0	3	8	34	36	65	70	143	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	781	925	909	935	975	697
AIDS Death	0	1	1	0	9	18	21	40	37	103	108	146	200	269	243	393	375	549	617	588	692	650	665	514	432	320	401	378	333	393	174

HIV Adv. HIV AIDS AIDS Death

MODES OF TRANSMISSION

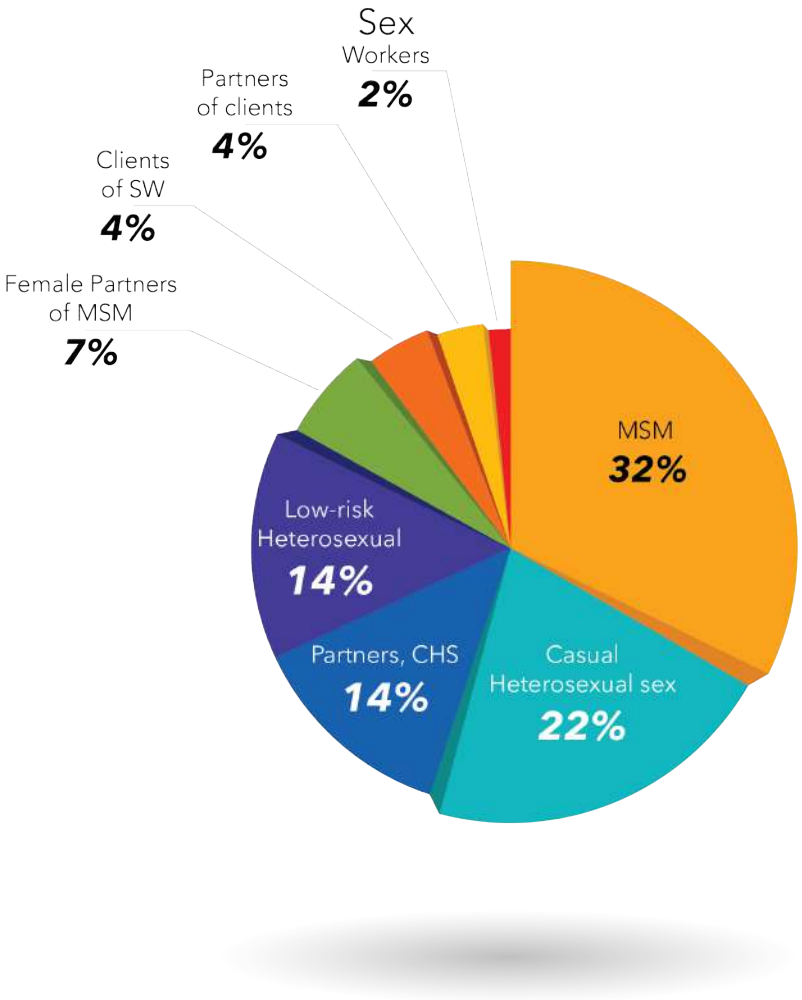
A Modes of Transmission Analysis completed in 2012 indicated that whilst new HIV infections in Jamaica have declined by 25% in the last decade, 2,500 new HIV infections were expected to occur in 2012. The new infections are anticipated to be greatest among MSM, accounting for 32%. Female partners of MSM are also at significant risk with an estimated 7% of new infections. It further indicated that female sex workers, their clients and the partners of sex worker clients were expected to contribute approximately 11% of incident infections.

The general population engaging in casual heterosexual intercourse was expected to contribute 22% of new HIV infections and mother-to-child transmission of HIV was estimated at 1.9% in 2012.

Heterosexual transmission remained the highest self-reported risk for acquiring HIV infection in Jamaica, HIV is primarily transmitted through sexual intercourse. Among all reported adult HIV cases on whom data about sexual practices are available (77% of cases), heterosexual practice is reported by 95% of persons.

In 2012, the sexual practice of 44% of men reported with HIV (and 41% of men reported with AIDS) was unknown. This is due to inadequate investigation and reporting of cases as well as unwillingness among men who engage in sex with other men to disclose their sexual practices. Of the total number of men reported with HIV, 4% (626) were identified as bisexual and 3.6% (544) identified as homosexual.

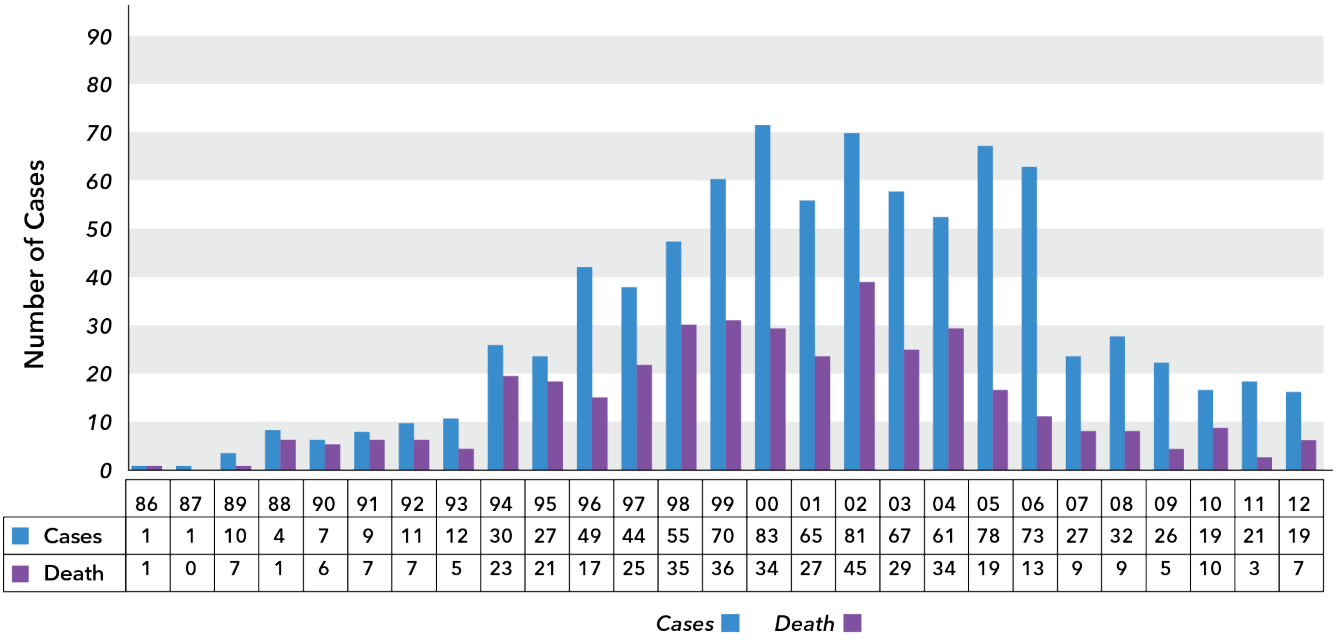
Figure 3: Estimated distribution of incident HIV cases in 2012



PERINATAL HIV CASES

Perinatal HIV cases are defined as those in which transmission occurs during pregnancy, labour and delivery, or breastfeeding. Since the introduction of recommendations to provide anti-retrovirals to women during pregnancy, during labour and delivery, and to the infant in the neonatal period, there has been a significant reduction in mother-to-child transmission of HIV nationally. Transmission rates among those who receive recommended treatment during pregnancy, at labour and delivery, and new-born period is estimated at approximately 2.0% in 2012, compared to 25% in 2002 (prior to the introduction of antiretroviral medication for prevention of mother-to-child transmission (pMTCT)). There were 19 perinatal HIV cases diagnosed in 2012 compared to 78 in 2005. This significant decline reflects the success of the pMTCT programme in reaching HIV-infected women.

Figure 4: Number of Paediatric AIDS Cases and Deaths reported annually, 1982 - 2012



	86	87	89	88	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09	10	11	12
Cases	1	1	10	4	7	9	11	12	30	27	49	44	55	70	83	65	81	67	61	78	73	27	32	26	19	21	19
Death	1	0	7	1	6	7	7	5	23	21	17	25	35	36	34	27	45	29	34	19	13	9	9	5	10	3	7

FACTORS FUELLING THE HIV EPIDEMIC

Among reported HIV cases on whom risk data are available, the main risk factors are multiple sex partners, history of STIs, crack/cocaine use, and sex with sex workers. 'No high risk behaviour' was reported for a notable proportion of HIV cases and this may represent persons who have one sex partner who was HIV infected by another partner.

Table 1: Reported risk behaviours among adults with HIV *(1982 – Dec 2012 cumulative)*

N = 27200

RISK	No. of Persons
Sex with Sex workers	4040 (15.0%)
Crack, Cocaine use	1250 (4.6%)
STI History	9705 (35.6%)
IV Drug use	171 (3.2%)
Multiple Sexual Partners/contacts	Estimated > 80%
No High-Risk Behavior	5321 (19.6%)

Surveillance of STI clinic attendees in 2012, indicate that for every one thousand persons with a sexually transmitted infection, approximately 26 were infected with HIV. Data shows that 70% of STI clinic attendees tested in the sentinel surveillance were females. This reflects the gender distribution seen in over 10,000-recorded STI clinic visits and is an indication of the less than satisfactory health seeking behaviours of Jamaican men. A total of 2.08% of females tested positive for HIV compared to 4.00% of male STI attendees. The positive test among males is almost twice as many as that of the females although the number of females attending the clinics is more than twice that of males.

Table 2: HIV status of STI clinic attendees by parish 2012*, Jamaica

Parish	Total Tested	Total Positive	Percent Positive (95% C.I.)
Kingston & St. Andrew	1486	37	2.51 (1.77 - 3.44)
Manchester	424	2	0.47 (0.06 - 1.69)
St. Ann	383	16	4.18 (2.41 - 6.70)
St. Catherine	1102	31	2.81 (1.92 - 3.97)
St. James	407	12	2.95 (1.53 - 5.09)
Westmoreland	321	11	3.43 (1.72 - 6.05)
Total	4,113	109	2.65 (2.18 - 3.19)

**Survey conducted between April and September 2012* *Source: MOH/NHP Jamaica HIV/AIDS Epidemic Update 2012*

Further, a 2012 survey of sex workers found that 4.1% of female sex workers were HIV infected. In 2011, a survey of 453 men who have sex with men (MSM) found that approximately 1 out of every 3 MSM was HIV infected. Additionally, a 2006 survey of prison inmates indicated that approximately 3.3% of inmates are HIV positive.

CHAPTER 2: PREVENTION AND SEXUAL AND REPRODUCTIVE HEALTH

INTRODUCTION

The National Programme's goal as stated in its Strategic Plan on HIV and AIDS 2007-2012 is to: "Reduce the transmission of new HIV infections while mitigating the impact of HIV/AIDS on the people of Jamaica within a sustained, effective multi-sectoral infrastructure and soliciting the necessary commitment to support National response to HIV/AIDS.

The National Programme's work targets the following key populations:

- Men who have Sex with Men
- Sex Workers
- Out of School Youths
- In-school youths or In-school Adolescents
- Homeless drug users
- Prison inmates

The prevalence of HIV/AIDS is highest amongst the MSM sub-population, at 32%; this is

approximately six times higher than the prevalence amongst sex workers, which is 5%.

In 2012, the Behaviour Change and Communication (BCC) team focused its efforts on delivering a range of interventions to the most vulnerable sub-populations as well as to the general population. The objective of the BCC programme is to reduce the transmission of new HIV infections through universal access to prevention and support services, focusing on the most at-risk populations (MARPs) in the region, using a variety of strategies.

These interventions included HIV testing and outreach and community-based interventions. These efforts were aimed at on improving awareness regarding STI/HIV transmission and their prevention; engaging persons in individual (sexual) risk assessment and risk reduction planning, promotion of abstinence, and the promotion of condom use through condom distribution & condom demonstrations and condom negotiation skills building.

HIV TESTING AND OUTREACH AMONG KEY POPULATIONS

The key populations which are targeted in Jamaica's HIV response include men who have sex with men (MSM), sex workers (SW), adolescents, youth, inmates, homeless men and women, drug users, persons reporting a previous STI and people living with HIV (PLHIV).

Low self-esteem and lack of self-efficacy have been identified as important underlying factors that result in risky behaviours in these groups. As a result, prevention efforts include building self-efficacy as it allows individuals to adopt and maintain healthy lifestyles. Such lifestyle changes allow the individual to recognize and exercise their responsibility to protect themselves and others from HIV/STI.

MEN WHO HAVE SEX WITH MEN (MSM)

MSM are estimated to represent 4.4% of the adult male population in Jamaica and account for approximately 30% of new HIV infections. HIV prevalence among MSM is 32.9%. This data indicates the urgent need for effective, scaled-up prevention interventions in this group.

HIV prevention activities among MSM consist of empowerment workshops, voluntary counselling and testing (VCT) and peer education (including community and site based interventions peer educators).

In 2012, the BCC team targeted MSM at PLACE (Prioritized Local AIDS Control Efforts) sites across the island. These sites included popular restaurants, plazas/malls, at private homes and in churches. These visits facilitated HIV prevention activities such as risk assessment and risk reduction conversations and discussions, condom skills building, as well as distribution of condoms and lubes to the population.

Across the four regions 3,844 MSMs benefited from HIV testing and outreach services. The Western and North Eastern regions' efforts accounted for approximately 75% of MSMs reached in 2012. However, it was the Southeast and Southern regions that had the highest testing rates at 31.2% and 30.6 % respectively.

Table 3: Summary of HIV Testing and Outreach Activities for MSMs, 2012

Regional Health Authority	Number of MSMs reached	Number of MSMs tested	Condoms Distributed	Lubes Distributed
Western	1354	81	18147	2193
North East	1518	191	38916	418
South East	551	172	11274	1991
Southern	421	129	9592	663
Total	3844	573	77929	5265

The BCC team's attempts to deliver services to the MSM sub population were met with challenges. These challenges include denial about HIV status, their sexuality and their sexual behaviour and practices. It was also observed that MSMs also faced difficulties in providing for their basic needs such as shelter and food. In some instances also, limited financial resources impacted their ability to participate in programme activities such as workshops.

In SERHA, the following were the main challenges highlighted:

- The number of MSM tested in comparison to those reached although slightly higher than last year (31%) is still too low
- Stigma and discrimination (S&D) still contributes to non-disclosure of orientation, reluctance to take condoms lubes and poor treatment seeking behaviour
- Resignation of MSM CPEs toward the last quarter of 2012 in both STC and KSA
- Reaching MSMs outside of workshops

WAY FORWARD

- Intensify site based and party interventions across the regions by creating a regional MSM team that would provide prevention services at these sites where sex is likely to occur
- Conduct follow up sessions with workshop graduates
- Focus on the number of MSM specific sessions conducted, in addition to number of MSMs reached - these should be general sessions conducted at PLACE sites where MSMs frequented, with MSM specific messages (MSMs who do not disclose will still benefit from the interventions directly and the sessions done by the CPE would be counted and used as an indicator for work done with this group)

COMMERCIAL SEX WORKERS

HIV prevalence among female sex workers (SW) declined from 9% in 2005 to 4.9% in 2008 and 4.1% in 2012 (Ministry of Health 2009, Ministry of Health, 2012). The declining trend is attributable to prevention interventions such as risk reduction conversations, condom and lubricant distribution, voluntary counselling and testing (VCT), empowerment workshops and initiatives to reduce social vulnerability.

The BCC team conducted its weekly site-based interventions across the island. The sites covered include night clubs, massage parlours and streets where sex is sold. The table below summarizes the outreach activities conducted in each region.

Table 4: Summary of HIV Testing and Outreach Activities for Commercial Sex Workers, 2012

Regional Health Authority	Number of CSWs reached	Number of CSWs tested	Condoms Distributed	Lubes Distributed
Western	4226	197	98849	2694
North East	526	15	4410	695
South East	1742	455	49827	3132
[1]Southern	2490	477	58283	-
Total	8984	1144	211369	6521

In 2012, the Western and Southern regions reached greater numbers of CSWs when compared to the Northeast and Southeast regions. The southern region registered the highest test rate, 19.2%

The BCC team in St. Thomas faced a particular challenge in its outreach efforts in that the CSWs didn't operate from nightclubs or obvious street sites in the parish. However, the team was able to ascertain home based CSW sites and develop its profile of CSWs using information from secondary sources.

Information indicated that the harsh economic reality that exists facilitated a kind of underground CSW network in the parish that needed further exploration. It was discovered that:

- Personal dwellings were used as sex spots within the communities especially around the rural area (reducing the motel cost and developing a secured clientele given the demand of cash from the females is more than the supply existing)
- Sex on credit was allowed to facilitate consistency of the client base.
- Most of the females who are involved in this practice live alone in order to accommodate this lifestyle and it is a means of earning to maintain children and daily living expenses
- The competition is so high that the cost for sex is very low
- This is ideal for a lot of the men involved since they do not have a lot of money
- In other sites in the South Eastern region, the programme team experienced difficulty in conducting interventions with CSWs who work in massage parlours.

HIV TESTING AND OUTREACH AMONG GENERAL POPULATION

The RHA's continued their HIV testing outreach work during signature days and weeks such as Regional Testing Day, World AIDS Week and Safer Sex Week. These commemorative events feature HIV/AIDS information, condom demonstrations, risk reduction conversations,

1 Inadequate reporting especially at sites where both CSWs and patrons are tested is one of the main reasons for the low numbers in St. Catherine (part of the Southern region)

empowerment opportunities, entertainment and voluntary counselling and testing. The table below summarizes the outreach conducted during Safer Sex Week 2012 and World AIDS Day 2012.

Regional Health Authority	Number of Persons tested					
	Safer Sex Week			World Aids Week		
	Female	Male	Total	Female	Male	Total
Western	-	-	-	-	-	2206
North eastern	892	513	1405	747	695	1442
South eastern	-	-	739	493	445	938
Southern	103	52	155	337	220	557
Total	995	565	2299	1577	1360	5143

The testing and outreach efforts during World AIDS week resulted almost twice as many tests being conducted than were done during Safer Sex Week, with 5143 tests compared to 2299 tests. The majority of tests during World AIDS week were conducted in the Western region.

The National Event for Safer Sex Week was held at Skate land Plaza, Linstead, St. Catherine on Tuesday, February 14, 2012 under the theme Tek Charge – Condom (check), HIV Test (check), Less Partners (check).

Regional Testing Day is commemorated on June 22, 2012.

COMMUNITY INTERVENTIONS

In 2012, the BCC team continued to deliver interventions at the community level as one of its strategic approaches for reducing the transmission of new HIV infections while mitigating the impact of HIV and AIDS on the Jamaican population. The interventions ranged from establishing condom distribution outlets to using peer-to-peer interactions

CONDOM DISTRIBUTION OUTLETS

The Western region had the largest number of condom outlets when compared to the other Regional Health Authorities (RHAs). The Western region established between five and six times as many condom outlets established when compared to the other RHAs. In 2012, persons in the Southeast region had access to almost 100% more condom distribution outlets than they did in 2011, with an increase from 31 to 61.

Regional Health Authorith	Number of outlets established	Number of outlets maintained	Reported number of condoms (male) sold
Western	313	-	388,351
North Eastern	54	155	-
Southern	68	-	6306
South eastern	61	127	-
Total	496	282	

Table 8: New Communities targeted

Kingston and St. Andrew (KSA)	St. Catherine (STC)
Tivoli Gardens	Newlands
Majesty Gardens	Homestead
Jones Town	Red Ground
Allman Town	Orange field

The figure below shows the number of persons reached and tested and condoms distributed in TCIs by parish in SERHA.

Figure 5: Targeted Community Interventions in SERHA, 2012

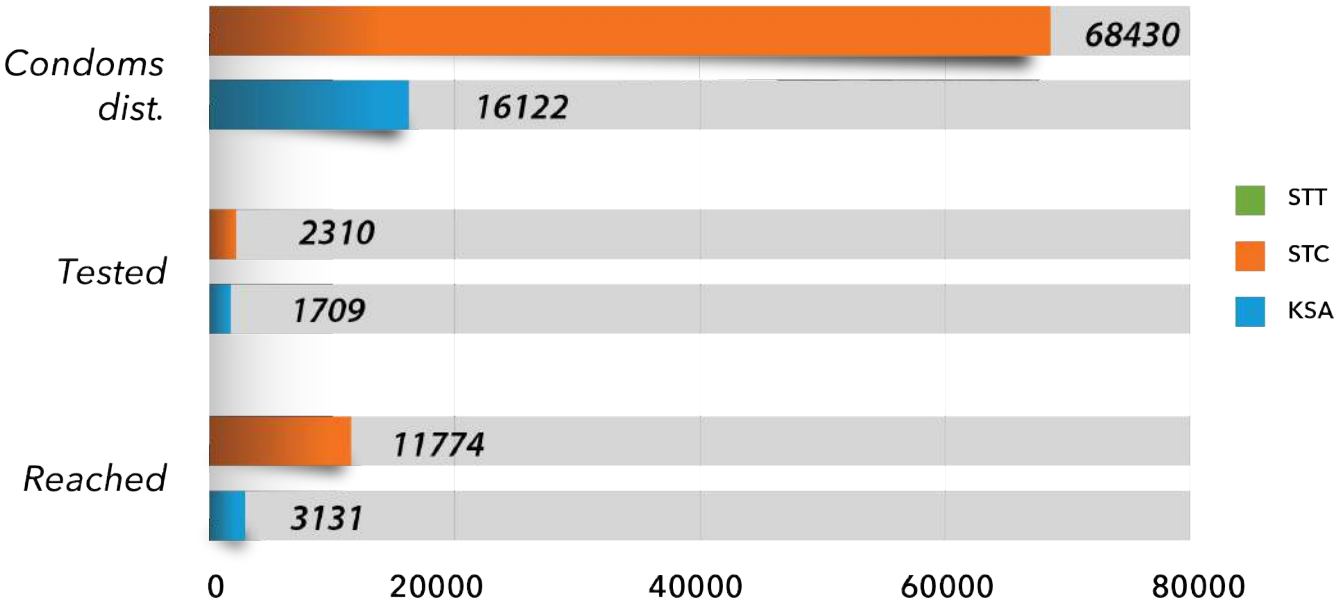
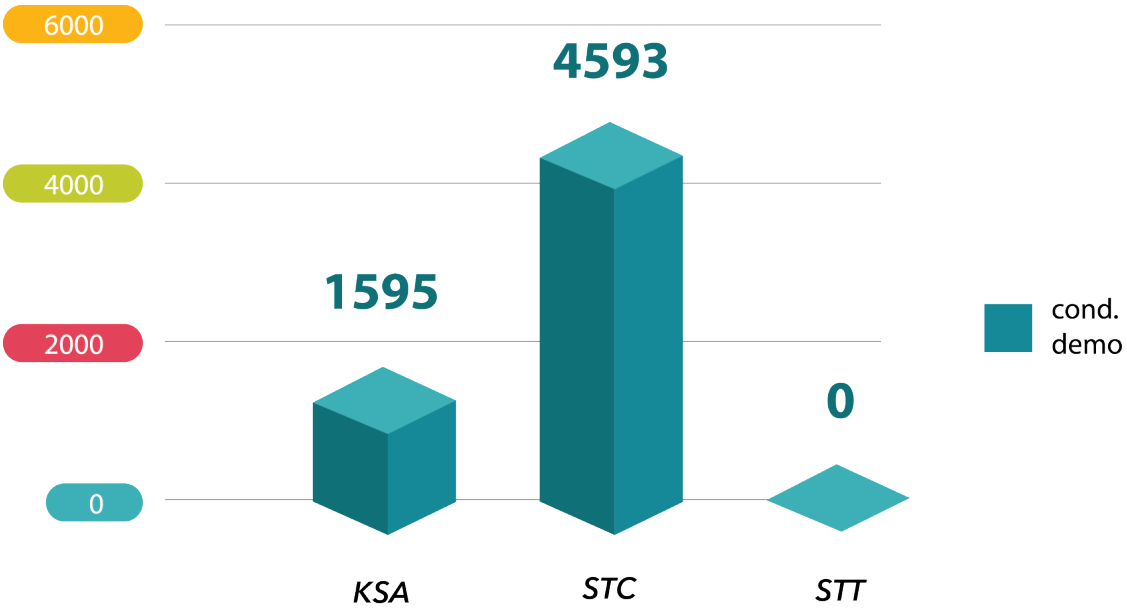


Figure 6: Number of condom demonstrations done in TCIs by parish



PARENTING WORKSHOPS

Four (4) parenting workshops were conducted in four communities with 97 participants. Focus was on gender-sensitive parenting, especially for parents of adolescent children. The main objective of the workshops was to empower parents with regards to proper parenting and sexual and reproductive health, who would in turn be better able to communicate same to their children.

ROLE PLAY – GENDER SENSITIVE PARENTING

Father and son

Mother and daughter

Participation in role plays and group work were two important techniques used in engaging the participants in the behaviour change process.

THREE-MONTH SKILLS BUILDING PROGRAMMES

Two skills building programmes were conducted in Majesty Gardens (KSA) and Homestead (St. Catherine). The objective was to address challenges identified by the OSYs building technical and social skills, increasing employability and fostering entrepreneurship. Fifty six OSYs were trained in electrical installation, tiling, building construction, barbering, cosmetology, nail technology, music, numeracy, literacy as well as a series of life skills sessions.

OSYs practicing nail technology (left)

OSY Participants at graduation

CHALLENGES

- The main challenge was managing a plethora of new and old TCIs with a reduction in our staff compliment
- The time allotted for each session and tardiness of students in attending the sessions in the ISI made it very difficult to complete activities of the programmePoor reporting of OSYs reached is a challenge – they are usually recorded as part of the general population

WAY FORWARD

- Reduce the number of new TCIs and structure interventions in old TCIs make it more manageable (conduct quarterly instead of monthly visits to old TCIs)
- Increase interventions targeting males 19-39 and OSYs and improve reporting of same

Table 9: Taxi Peer Counsellors

	Number of persons reached by taxi peer counsellors			Number of Male Condoms distributed
Regional Health Authority	Femalea	Males	Total	
North East				
South West	1,369	1,658	3,027	9,255

PREVENTION PROGRAMMES

HOLD ON, HOLD OFF

The Hold On, Hold Off intervention is an in-school intervention (ISI) that is aimed at empowering students to make healthy lifestyle choices by increases knowledge and skills of issues relating to their sexual and reproductive health and personal growth and development. The students are reached through interactive classroom sessions, peer education training and off-campus activities such as educational field trips.

YOUTH MENTORSHIP

The objective of the mentorship programme is to reduce social and economic vulnerability of out-of-school youth that was linked to increased risk of HIV transmission. The programme continued its work in 2012, with seventeen (17) mentors and thirty-six (36) mentees. The mentees were selected from a targeted community interventions being conducted in the communities of Water House and August Town.

Mentors assisted their mentees in compiling actions plans; the plans presented specific goals and outlined the requirements, resources and practical steps needed to achieve them these goals, within a specified timeline. During the reporting year, ten (10) mentees were enrolled in CXC and Practical Nursing courses at School of Excellence. Four (4) mentees who were already enrolled in school were assisted with the tuition and transportation costs.

MEDIA CAMPAIGNS

During the reporting period the BCCC programme utilized several media platforms and partnership to deliver its prevention message.

The Prevention Unit placed a number of media campaigns during high visibility periods on location television and radio stations. These campaigns include:

- Take Your Meds- Promoting adherence to medication for chronic illnesses including HIV
- Real Big Man Nuh Ride Widout Condom- Promoting condom use among men
- Get Tested for HIV: Ah Nuh Nutten- Encouraging HIV testing
- Pinch, Leave an Inch and Roll- To build skills on correct and consistent condom use
- Paradise fi Real- Docudrama targeting the tourism sector

The National HIV/STI Programme sponsored the Mission Catwalk Programme that was aired on Television Jamaica. The sponsorship gave the National Programme one episode to deliver its key message. During that episode, the Programme that presented the competing designers with a challenge to incorporate the World AIDS Day Ribbon in their designs to make a fashion statement.

Additionally during the reporting period, the National Programme collaborated with the National Council on Drug Abuse to launch a media campaign on Alcohol Abuse and HIV. The campaigned was designed to highlight the risks associated with alcohol use and sexual decision-making and to promote the protective behaviours in decision making skills, self-control and delayed gratification in the use of alcohol in youth 12 – 18.

- During the reporting period, the National Programme conducted two media recall surveys: ***Smart Women Always Buy, Carry and Use Condoms.*** The results show that those who saw it obtained the campaign messages and that the campaign was successful in influencing behavioural and attitude change among those who were exposed to its message.

- ***Get Tested: Ah Nuh Nutten.*** Approximately 93% of the respondents (448) recalled seeing messages about getting tested for HIV on local television since 2010 without being prompted to remember any specific campaign. When asked if they saw any messages about getting tested for HIV on a poster since 2010, 52 % of the respondents (245) said yes without being prompted to remember any specific campaign. An overwhelming majority (353 respondents or 75.8%) of the respondents recalled hearing messages about getting tested for HIV on radio since 2010 without being prompted to remember any particular campaign.

OUT OF SCHOOL YOUTH (OSY)

Out-of-school youth (OSY) refers to young boys and girls aged 15 – 24 years who have prematurely dropped out of school or those who have finished school but are without skills. This key population is targeted by Regional Health Authorities and NGOs.

The prevention interventions for OSY address underlying economic and social vulnerabilities that lead to risky sexual practices. They include HIV testing, risk reduction conversations, values clarification, condom demonstrations and negotiations, skills building exercises and interactions to build self-efficacy.

In 2012, 4,824 contacts were made with OSY with 1,467 tested for HIV and 25,136 condoms distributed in the South East Regional Health Authority. The table below shows the number of OSYs reached and tested and condoms distributed by parish in the region.

Table 7: OSYs reached and tested and condoms distributed by parish

Parish	Reached	Tested	Condoms Distributed
KSA	1950	610	8,685
STC	2812	857	16,051
STT	62	0	400
Total	4,824	1,467	25,136

INTERVENTIONS WITH MALES 19-39 YEARS

Behavioural surveys, qualitative studies and local BCC (Behaviour Change Communication) specialists indicate that multiple partnerships, concurrency and inadequate condom use are practiced most prominent among young men aged 19-39 years old.

Despite, the higher AIDS case rates among men compared to women, uptake of HIV prevention activities among women have exceeded uptake by men due to the health seeking behaviour of women and availability of services such as PMTCT. Consequently, special interventions have been designed to reach this group of men.

In 2012, 1942 males 19-39 were reached, 763 condom demonstrations were conducted and 11,219 condoms were distributed in KSA and St. Catherine. The target population was reached in the TCIs, night clubs and other PLACE sites in both parishes. While more intervention specifically targeting this group need to be conducted some of the challenges

that were encountered included poor reporting and difficulty separating members of this age cohort from the regular age cohorts (15-24, and 25-49) under which the data is usually collected in the field.

Table 10: Number of males aged 19-39 years reached, condoms distributed and demonstrations done by parish

	KSA	STC	STT	Total
Reached	1011	931		1942
Condoms distributed	6675	4544		11219
Condom demo done	554	209		763

CHALLENGES

- Target group continued to shy away from condom demonstrations
- Males are reluctant to test and continue to encourage their partners to get tested as a means of determining their own status based on the partners results

OUTREACH VOLUNTARY COUNSELLING AND TESTING (VCT)

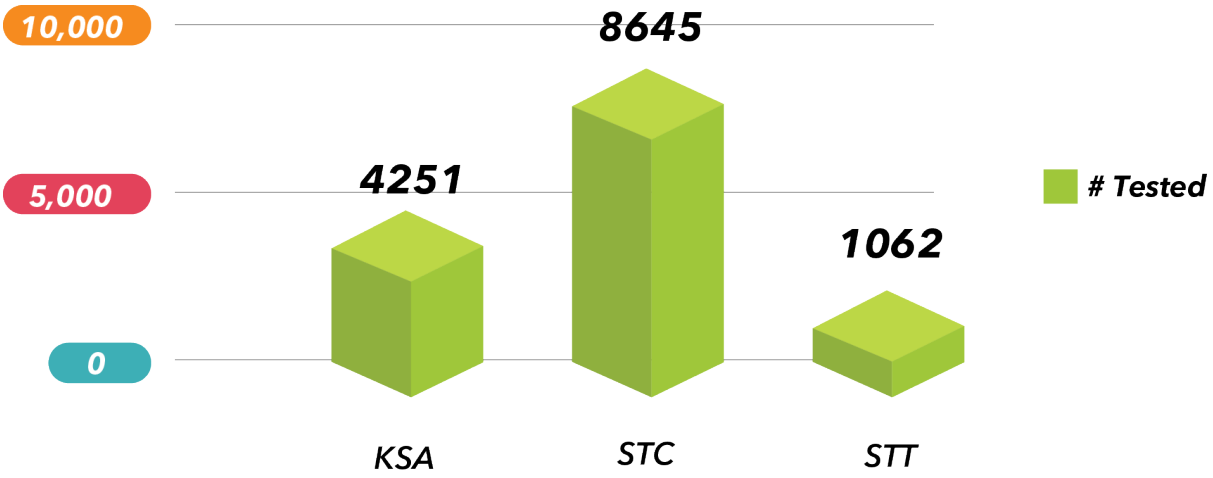
HIV and STI testing is an important aspect of prevention activities in Jamaica. HIV counselling and testing (HCT) is an important part of a continuum of HIV prevention and treatment services. It is one of the primary entry points into prevention and other services. Knowing one's HIV status - whether HIV- or HIV+ - is key to preventing the spread of HIV and accessing counselling and medical care.

In SERHA, outreach testing continued to be well supported by the general public and among the main target groups across the region. Testing is usually conducted at a variety of locations upon requests from stakeholders and others initiated by the team. The locations include PLACE sites, popular events, communities and drop-in testing sites, using the mobile lab and other accommodations at the sites where the bus is not available (see the table below for the total number of persons tested in the region).

Table 11: Total Number of Persons Tested by Age, Gender and Parish

	Males			Females		
	KSA	STC	STT	KSA	STC	STT
Over 50	148	242	39	161	360	53
25 - 49	644	1548	218	1394	3567	364
15 - 24	839	903	151	1065	2025	237
Total	1631	2693	408	2620	5952	654

Figure 7: Total number of persons tested by parish



THE MOBILE LAB

The mobile lab continued to play a critical role in the delivery of VCT services across the region. In addition to enabling the reach of clients more consistently in areas that were previously inaccessible for various reasons, the bus also has a pull factor that attracts clients to get tested.

Table 12: Total number of persons who were tested at mobile lab by age, sex and parish

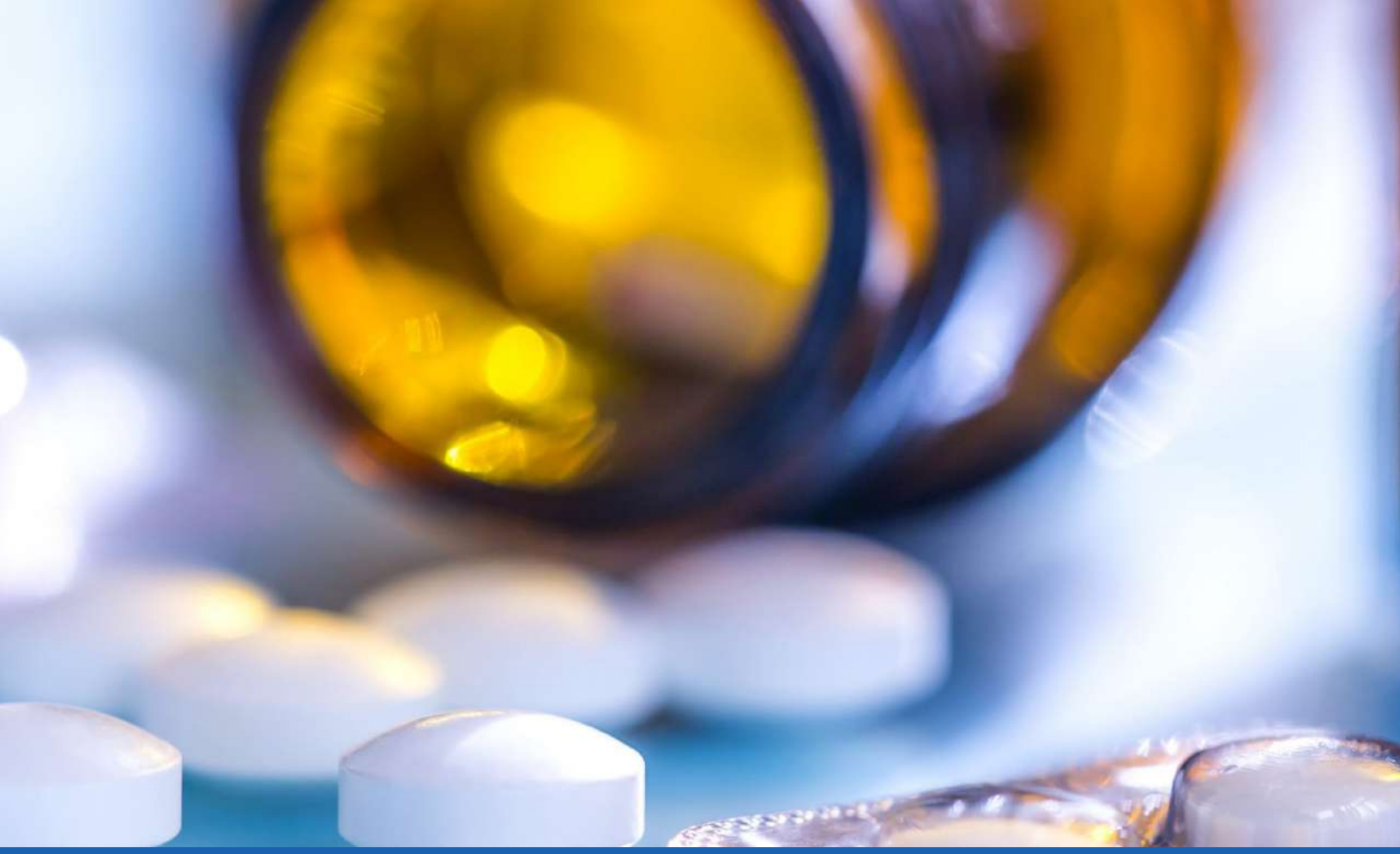
	Males			Females		
	KSA	STC	STT	KSA	STC	STT
Over 50	42	166	50	42	305	65
25 - 49	325	1034	112	523	2111	278
15 - 24	267	571	80	465	1308	237
Total	634	1771	242	1030	3724	580

DROP-IN TESTING SITES

Walk in testing continued in KSA at Windward Road and Olympic Gardens health Centres. In STC the sites are St. Jago Park, Greater Portmore and Linstead Health Centres. In addition, three other sites were established at town centres (Portmore Mall, Juici Patties, Old Harbour and Rose Duncan Park, Linstead). Testing is conducted at these sites at the same time and day each month.

Table 13: Total number of persons tested at Drop-in testing sites by age, sex and parish

	Males		Females	
	KSA	STC	KSA	STC
Over 50	34	102	82	200
25 - 49	155	617	540	1573
15 - 24	107	331	559	937
Total	286	1050	1181	2710



CHAPTER 3: TREATMENT, CARE AND SUPPORT

INTRODUCTION

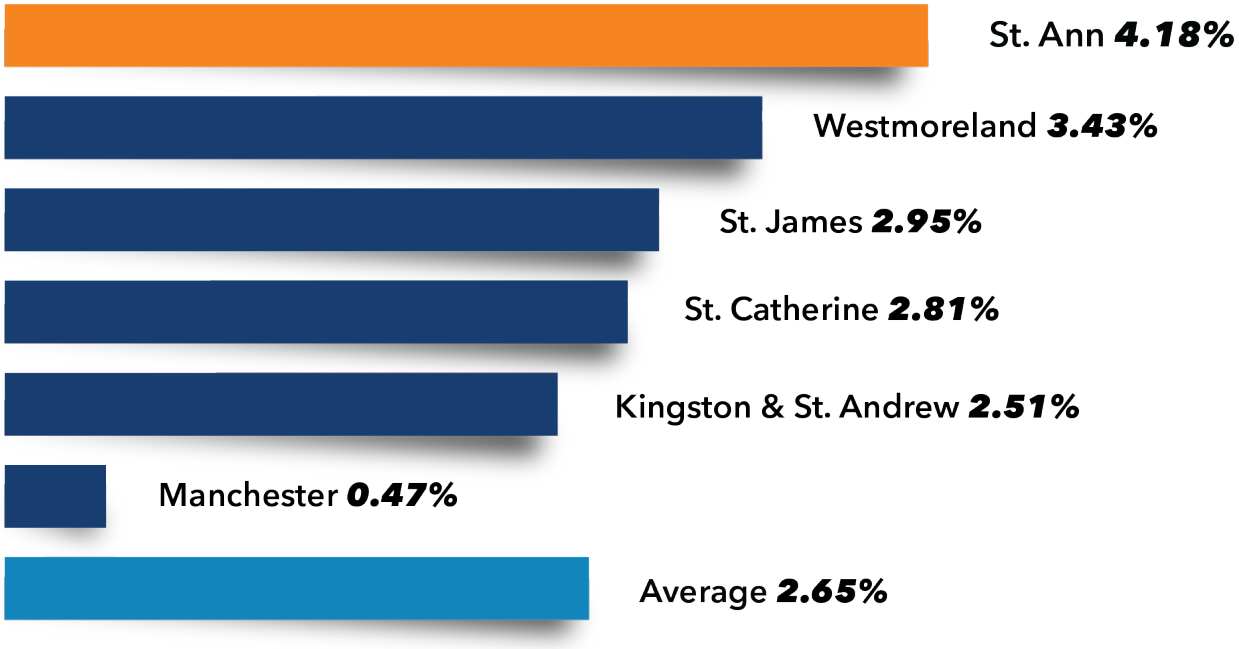
The Treatment, Care and Support (TCS) component is mandated to ensure that PLHIV have access to comprehensive care as per national and international guidelines. For 2012, J$593.90M or 40.1% of the budget for the national response to HIV was allocated to the TCS component of the National HIV/STI Programme (NHP). The funding for the TCS component supports the procurement of antiretroviral drugs, infant formula, viral load, CD4 and PCR reagents. In 2012, J$470.07M, 79% of the J$593.90M budgeted for the period was spent.

HIV TESTING AND PITC UPTAKE

The number of HIV tests done annually has more than doubled from less than 100,000 tests per year prior to 2004 to 248,311 in 2012[2]. The results of a 2012 survey of 4,113 STI clinic attendees across six parishes show that, on average, 2.65% of clinic attendees were HIV positive. The parishes of St. Ann and Westmoreland had the highest proportion of HIV positive STI clinic attendees.

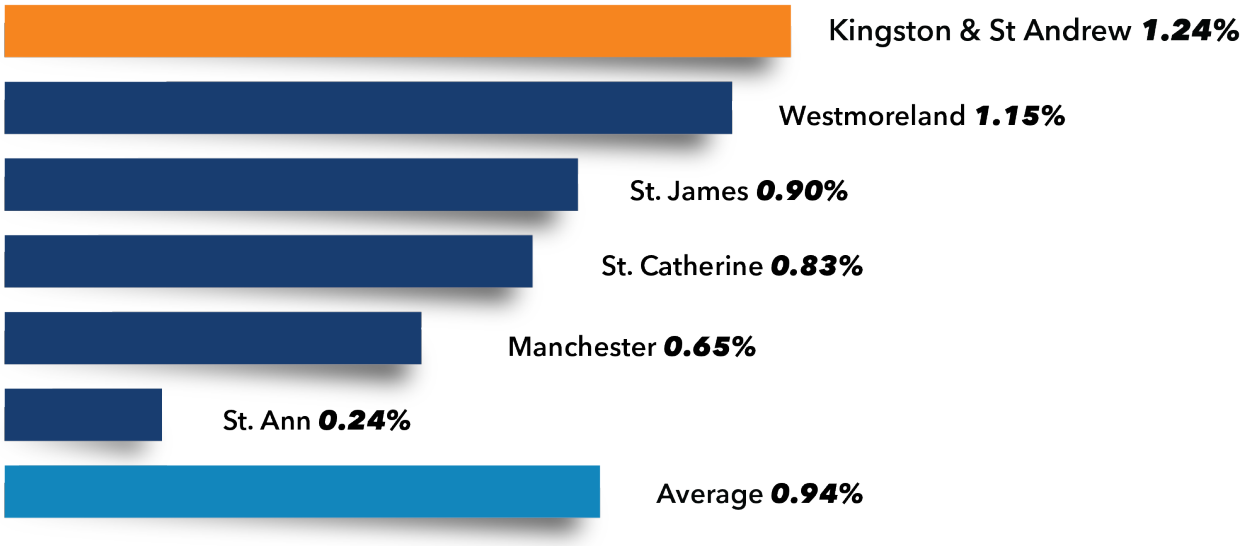
[2] *The survey was conducted between April and September 2012*

Chart 1: HIV Positive Rates amongst Surveyed STI Clinic Attendees in Six Parishes, April to September 2012



Amongst the 4,477 Antenatal clinic (ANC) attendees who were surveyed in the same six parishes in 2012, on average, for every 1000 attendees, 94 were HIV positive. Kingston and St Andrew and Westmoreland had the highest proportion of HIV positive ANC clinic attendees.

Chart 2: HIV Positive Rates amongst Surveyed ANC Clinic Attendees in Six Parishes



TREATMENT SERVICES

CONTINUUM OF CARE AND ART ACCESS

In 2012, 18,919 persons living with HIV were linked to the treatment care options provided by the public health system. Of that total, 38.5% (or 7,267 PLHIV) received ART from 18 treatment sites across the island.

Table 14: Provision of ART across Treatment Sites in 2012

	Treatment type	
Site	First line	Second line
Black River	116	9
CHARES	516	46
Comprehensive clinic	873	31
CRH	462	41
KPH	421	34
Linstead	82	6
Mandeville Health	254	5
Mandeville Hospital	126	29
Maxfield Park	33	3
May Pen	288	18
Montego Bay Type 5	504	11
NCH	89	5
Port Antonio	123	7
Port Maria	201	18
Sav-La-Mar	357	7
St. Ann's Bay	417	25
St. Jago Health Centre	554	22
Windward Road	55	8
Total	5011	325

SOURCE: Treatment Site database

CD4/ VIRAL LOAD/DNA-PCR TESTING

Services such as CD4/ Viral Load/DNA-PCR testing are critical components for ensuring that PLHIV, those who are exposed to HIV and their care providers are able to manage their health.

The results of CD4 and Viral Load tests are used to determine the efficacy of ART on adult patients. A 2010 WHO guideline recommendation is that a patient should receive two CD4 tests and two viral load tests annually.

At the time of this report, there were 7,287 PLHIV being treated with ART (HATS Database) who would have been eligible for twice-yearly testing. For 2012, 10,742[3] CD4 and 8,443[4] viral load tests were processed. Therefore, the test rate for Jamaica fell below the WHO standard with testing rate of 1.4 and 1.15 per patient for CD4 and viral loads respectively.

Table 15: Summary of Types of Treatment Monitoring Testing Conducted 2012

Description	HIV Positive Adults		HIV Exposed Infants
	CD4	Viral Load	DNA PCR
Received	11,276	9,476	793
Rejected	534	513	21
Processed	10,742	8,443	772[5]
Testing rate per WHO 20101 guideline	1.47	1.16	n/a

SOURCE: Treatment Site database

SUPPORT SERVICES

COUNSELLING INTERACTIONS

In 2012, there were a total of 17,291 counselling interactions between PLHIV and adherence counsellors. Females accounted for 52% of the interactions and the remainder, 48% of counselling interactions were with males.

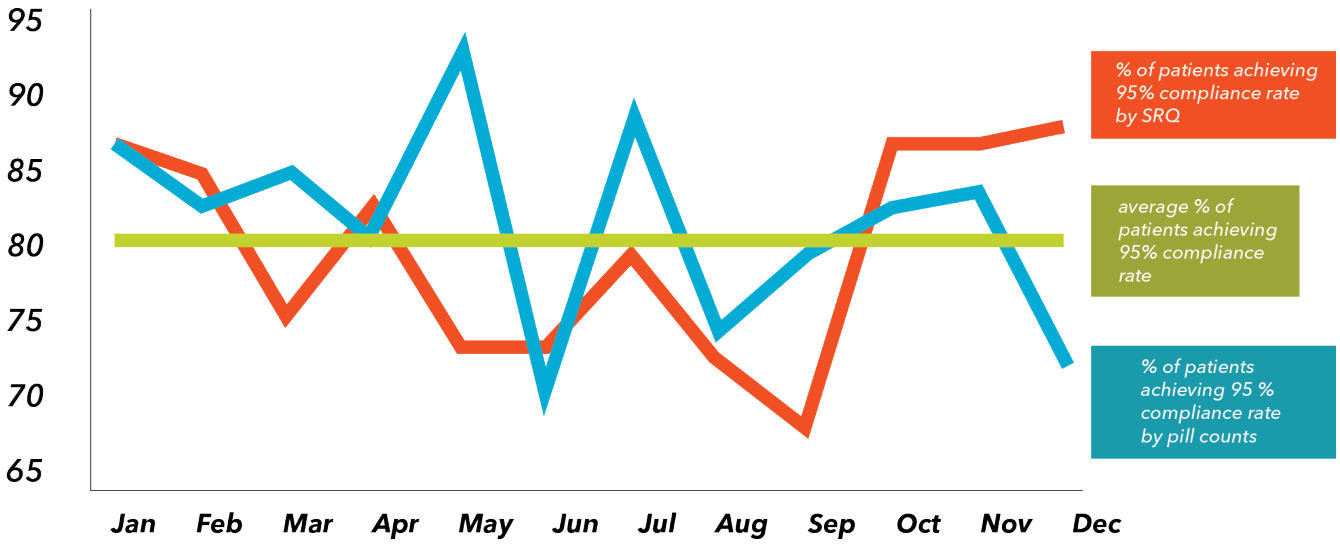
The results of a questionnaire administered to determine the number of patients achieving a 95% compliance rate with treatment show that on average, 81% of patients achieved the targeted level of compliance by SRQ and 79% by Pill Counts.

[3] *95.3 % of samples received for testing; samples were rejected due to poor collection and handling techniques*

[4] *97.4 % of all samples received for testing; samples were rejected due to poor collection and handling techniques*

[5] *For HIV exposed infants, 772 DNA PCR test samples were processed to confirm HIV infection.*

Figure 8: Percentage of Persons Living with HIV achieving 95% compliance rate with SRQ and Pill Counts



The proportion of patients achieving 95% compliance for both SRQ and Pill Counts was above the average for the first two months of 2012. Starting in March however there was a decline in the proportion of patients who were compliant with SRQ.

The summer months were the period in which the proportion of patients who were complaint with SRQ was at its lowest. Greater numbers of patients were compliant with SRQ from September on to the end of the year.

The proportion of patients achieving 95% compliance for Pill Counts spiked in May, fell drastically at summer and fluctuated until the end of the year.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

Data from PMTCT HIV Clinics showed that in 2012, nine of out of every one thousand pregnant women attending public antenatal clinics were HIV positive. (Source: Jamaica HIV/AIDS Epidemic Update 2012).

The target for the elimination of MTCT of HIV is ≤0.3 per 1000 live births. In 2012, the incidence of MTCT of HIV was 0.2 per 1000 live births. The 2012 incidence of MTCT of HIV was 28.5% lower than in 2011 (0.28 per 1000 live births) and 37.5% lower than the average incidence of MTCT of HIV from 2009 and 2011 (0.32 per 1000 live births).

In 2012, 445 HIV positive women (or 1.3% of ANC attendees) delivered babies. Of that number HIV positive mothers, 88% or 391 women received ARVs. In 2012, a slightly greater proportion of the HIV positive mothers (3.5%) received ARVs than those who received in 2011.

Table 16: PMTCT Data for 2009 -2012

	2009	2010*	2011	2012
Live Births	42,372	39,804	39,673	39,348
Antenatal Clinic Attendees	30,076	26,697	27,985	33378
HIV positive women delivered	440	432	417	445
Women getting ARVs	369 (84%)	375 (87%)	354 (85%)	391 (88%)
HIV exposed infants	439	419	413	432
Infants receiving PMTCT interventions	430 (98%)	408 (97%)	413 (100%)	422 (98%)
HIV positive infants	12	19	10	8
HIV positive infants born to mothers who tested HIV negative in pregnancy	1	2	0	2
Transmission Rate [≤ 2%]	2.7%	4.6%	2.4%	1.9%
Incidence of MTCT of HIV/1000 live births in Population[6]	0.26	0.48	0.28	0.20

[6] *Target for the elimination of MTCT of HIV/100 is ≤0.3 per 1000 live births*

Among the 445 HIV positive women who attended the ANC in 2012, there were 432 HIV-exposed infants. Of the 432 infants, 98% (422) received PMTCT interventions. This coverage rate for HIV exposed infants is consistent with the rates in recent years; between 2009 and 2011, on average, 98% of HIV exposed infants received PMTCT interventions.

OTHER SEXUALLY TRANSMITTED INFECTIONS

This section provides an overview of the incidence and trends of sexually transmitted diseases –chlamydia, gonorrhoea, and primary and secondary syphilis –in Jamaica. Sexually transmitted infections (STIs) continue to have a major impact on the HIV epidemic as indicated in the positive tests at STI clinics. Data indicates that STI is a major risk factor for HIV transmission in Jamaica and more than a third of those diagnosed with HIV in 2012 also had a history of STIs.

STI SURVEILLANCE FINDINGS

Generally, there has been a steady increase in the total number of patients visiting STI clinics every year since 2007. This is primarily due to increases in the number of revisits as the number of new cases has not shown a similar trend. However, the number of new patients decreased from 26,382 in 2011 to 24,732 in 2012 (Figure 9). Men represented approximately 28% of the total number of new clients attending STI clinics in 2012 (See Figure 10 below). The parish of Clarendon reported approximately a quarter (23%, 5736) of the new patients that visited STI clinics.

Figure 9: Number of new patients visiting STI clinics by year 2010-2012

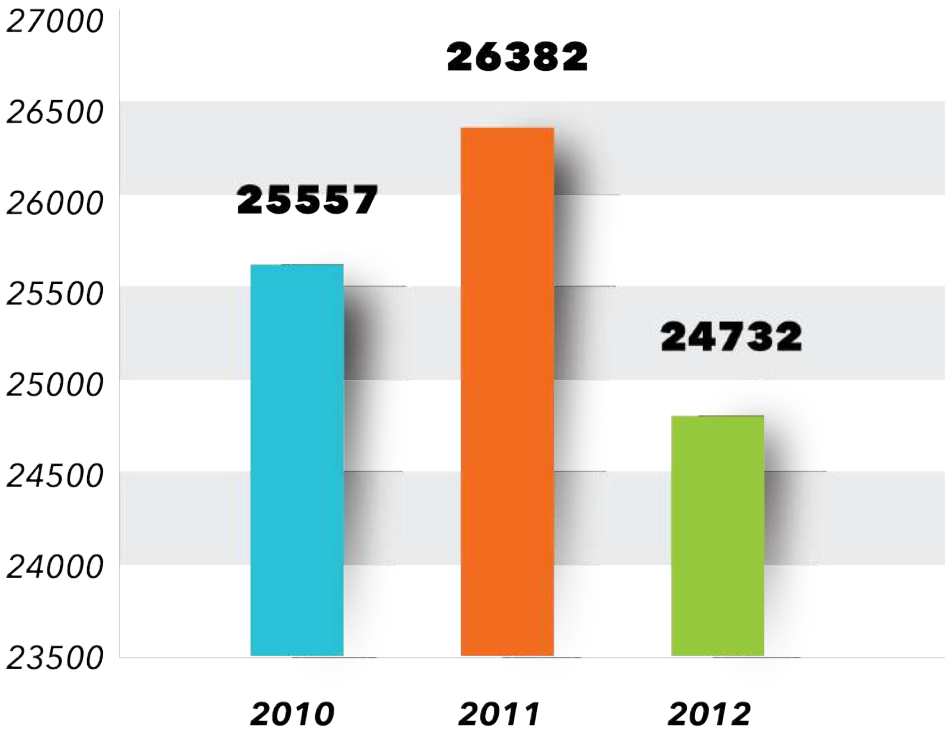


Figure 10: New Clients visiting STI clinics by Gender 2012

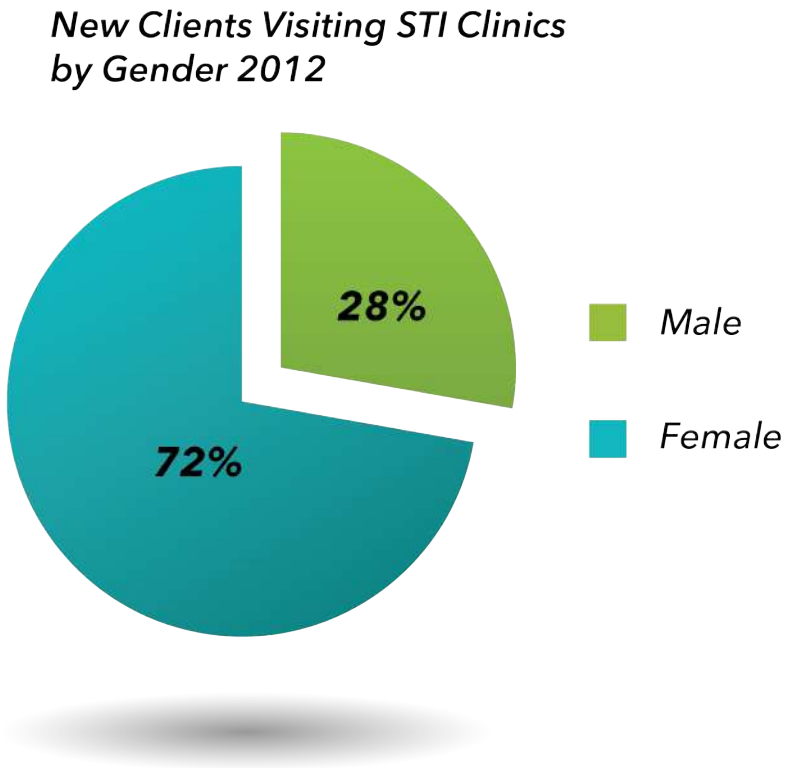
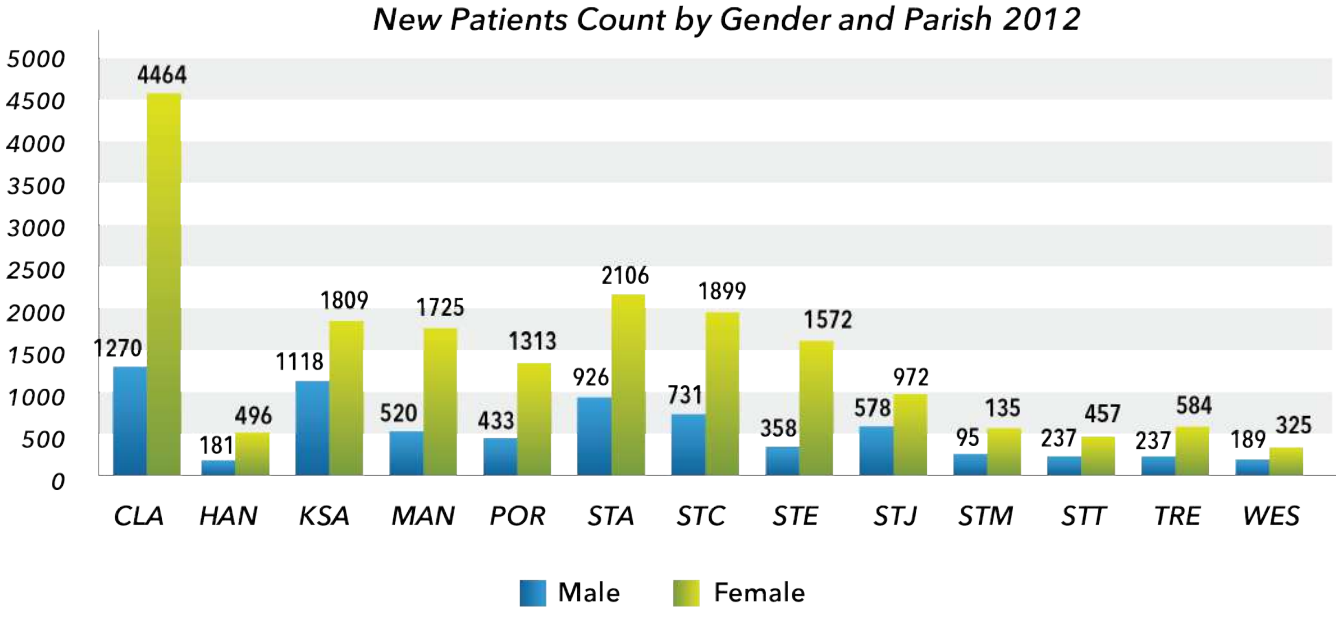


Figure 11: New Patients Count by Sex and Parish 2012

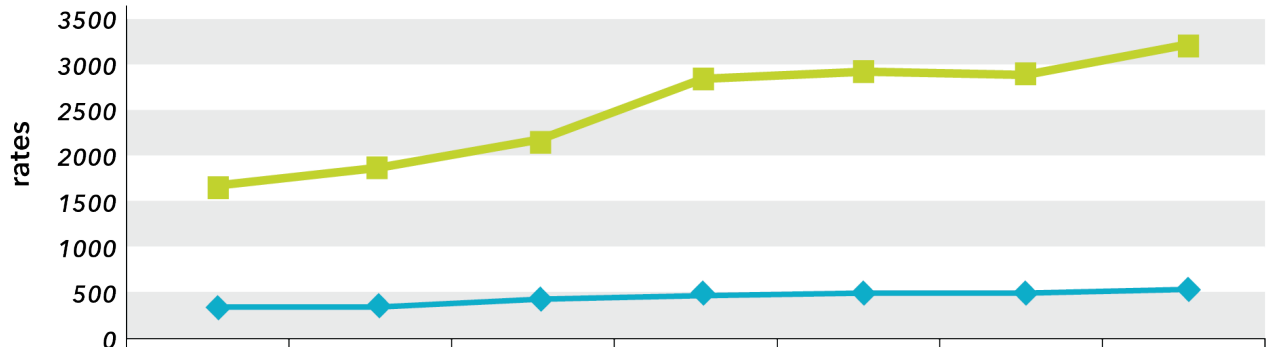


GENITAL DISCHARGE SYNDROME (GDS)

Genital Discharge Syndrome was the most common syndrome diagnosed among STI clinic attendees, with 33,969 cases of GDS being reported in 2011 compared to 43,764 in 2012. As per the **World Health Organization (WHO)**, Jamaica classifies GDS as urethral discharge in men with or without dysuria (most commonly caused by Neisseria gonorrhoea and Chlamydia trachomatis) or abnormal vaginal discharge (amount, colour, and odour) with or without lower abdominal pain or specific symptoms or specific risk factors.

Overall, the rate and number of reported cases of GDS have trended upwards between 2006 and 2012; women experienced the greatest increase in cases which accounted for 3 to 5 times as many cases of GDS when compared to men (Figure 12). This disparity may be due to a combination of factors including greater susceptibility of women to STI, sex differences in health seeking behaviours and detection bias among women with regard to discharge syndromes. Women are more likely to present to a clinic for care and are more likely to accurately report genital discharge symptoms than men.

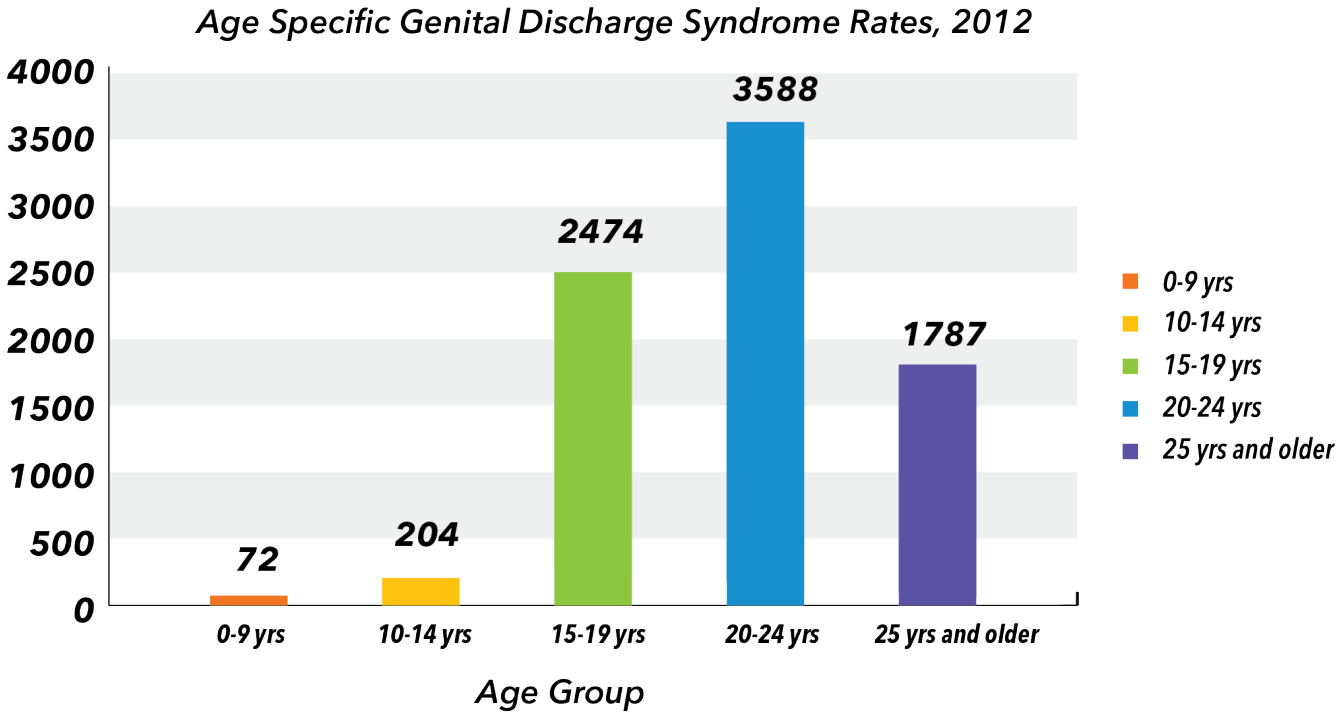
Figure 12: Genital Discharge Syndrome rates by Gender 2013



	2006	2007	2008	2009	2010	2011	2012
Female	1216.6	1432.2	1678.7	2372.6	2429.2	2395	2702.3
Male	379	392.5	465.8	528.2	540.2	561	588.7

Figure 12 Illustrates Genital Discharge syndrome rates per year by gender, 2006 to 2012.
Note population by sex 2012 STATIN demographic report was used as denominator for rates 2012

Figure 13 Illustrates Age Specific Genital Discharge (GDS) per 100000 populations 2010-2012



Note: Total population from STATIN 2013 demographic report was used as denominator for calculation of rates 2012.

When disaggregated by age, the number of GDS cases reported at STI clinics in 2012 increased in all age groups. Genital discharge syndromes occurred more frequently in the 20-24 year old age group followed by the 15-19 year old group (Figure 13). In 2012, the GDS rate peaked at 3588 per 100,000 populations in the 20-24 age groups. Candidiasis continued to be the most frequently reported condition among GDS cases in 2012, accounting for 14532 (41%) of all cases (Figure 15). Gonorrhoea and Chlamydia (represented by cervicitis/Erosion) accounted for approximately 9% of cases in 2012 while Trichomoniasis decreased from 8,075 (24%) in 2011 to 7539 (21%) in 2012.

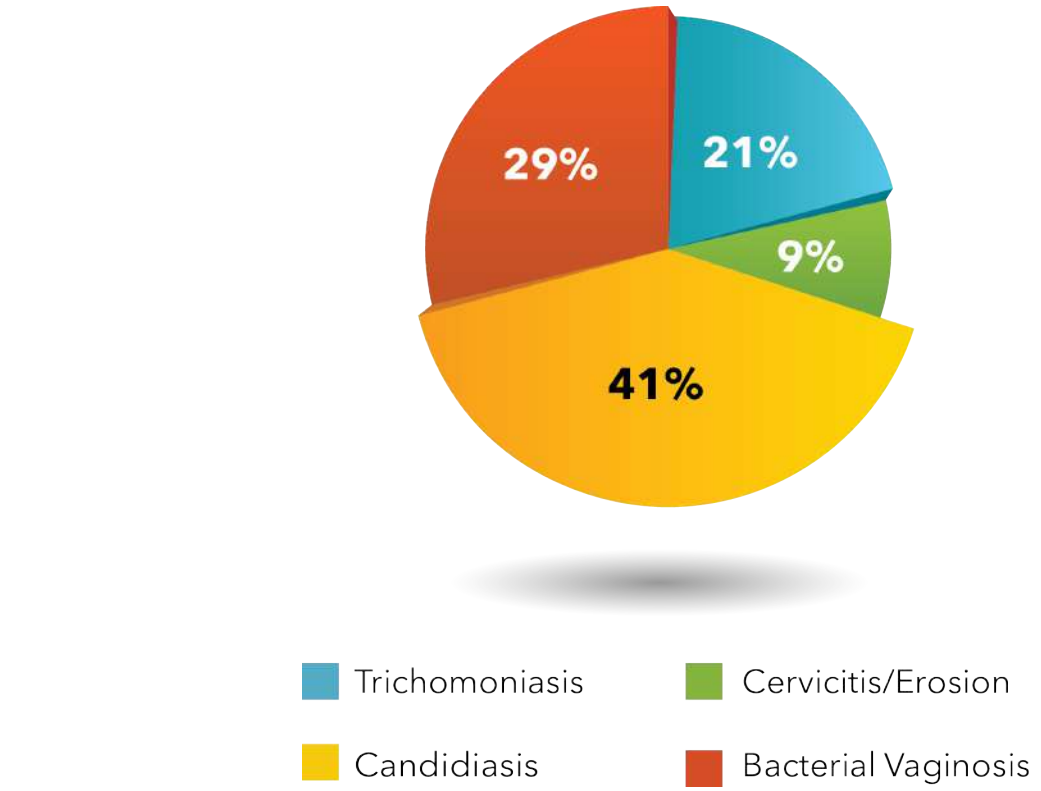


Figure 14 illustrates the distribution of the causes of genital discharge syndrome (GDS), 2012.

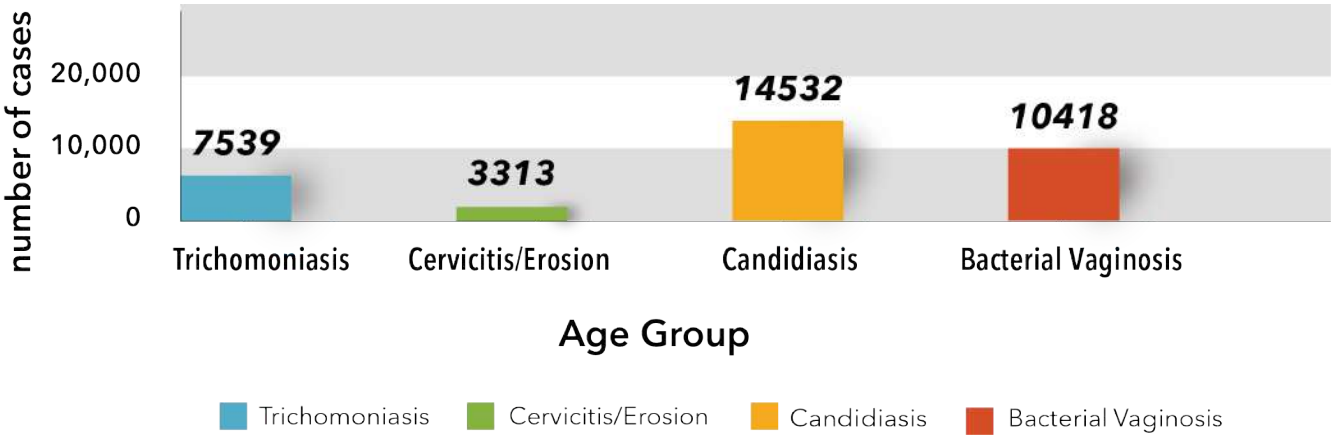


Figure 15 illustrates the number of cases per subgroup condition of Genital discharge syndrome 2012.

Table 17: Genital Discharge Syndrome Rates By Gender 2011-2012

PARISH	2011				2012			
	Female	Male	Total	Rate	Female	Male	Total	Rate
CLA	5174	1061	6235	2513	4633	1080	5713	2319
HAN	342	121	463	658	337	90	427	611
KSA	6141	1977	8118	1212	9303	2560	11863	1781
MAN	2169	409	2578	1342	2622	402	3024	1585
POR	2785	305	3090	3733	3736	411	4147	5046
STA	2945	1220	4165	2386	2983	891	3874	2236
STC	3953	836	4789	955	3428	766	4194	809
STE	2014	188	2202	1448	2289	243	2532	1677
STJ	1598	201	1799	969	1299	138	1437	778
STM	2311	528	2839	2467	2199	430	2629	2302
STT	1998	599	2597	2738	1867	546	2413	2556
TRE	960	165	1125	1478	813	102	915	1211
WES	535	95	630	432	525	71	596	412
TOTAL	32925	7705	40630	1500	36034	7730	43764	1614

GENITAL ULCER DISEASE SYNDROME (GUD)

Genital ulcer diseases (GUD) "according to the practical case management of common STI syndrome published by the Ministry of Health (MOH) " are conditions of the anogenital region (with or without lymphadenopathy) which cause a break or dissolution of the epithelial lining of the skin or mucous membrane in this area". These include syphilis, chancroid, herpes simplex virus (HSV), granuloma inguinale (GL), lymphogranuloma venereum (LGV).

Between 2007 -2012, the number of cases of GUD continued to fluctuate over the six year period, but notably rates decreased in 2012 in comparison to 2011.

Table 18: Genital Ulcer Disease rates per 100000 population by sex

Year		Female	Male	Total
2007	Number	521	414	935
	Rate	38.3	31.3	69.6
2008	Number	496	399	895
	Rate	36.3	30.1	66.4
2009	Number	781	537	1318
	Rate	57.2	40.5	97.7
2010	Number	626	553	1179
	Rate	45.8	41.7	87.5
2011	Number	636	632	1268
	Rate	46	47	93
2012	Number	599	540	1139
	Rate	45	39	84.

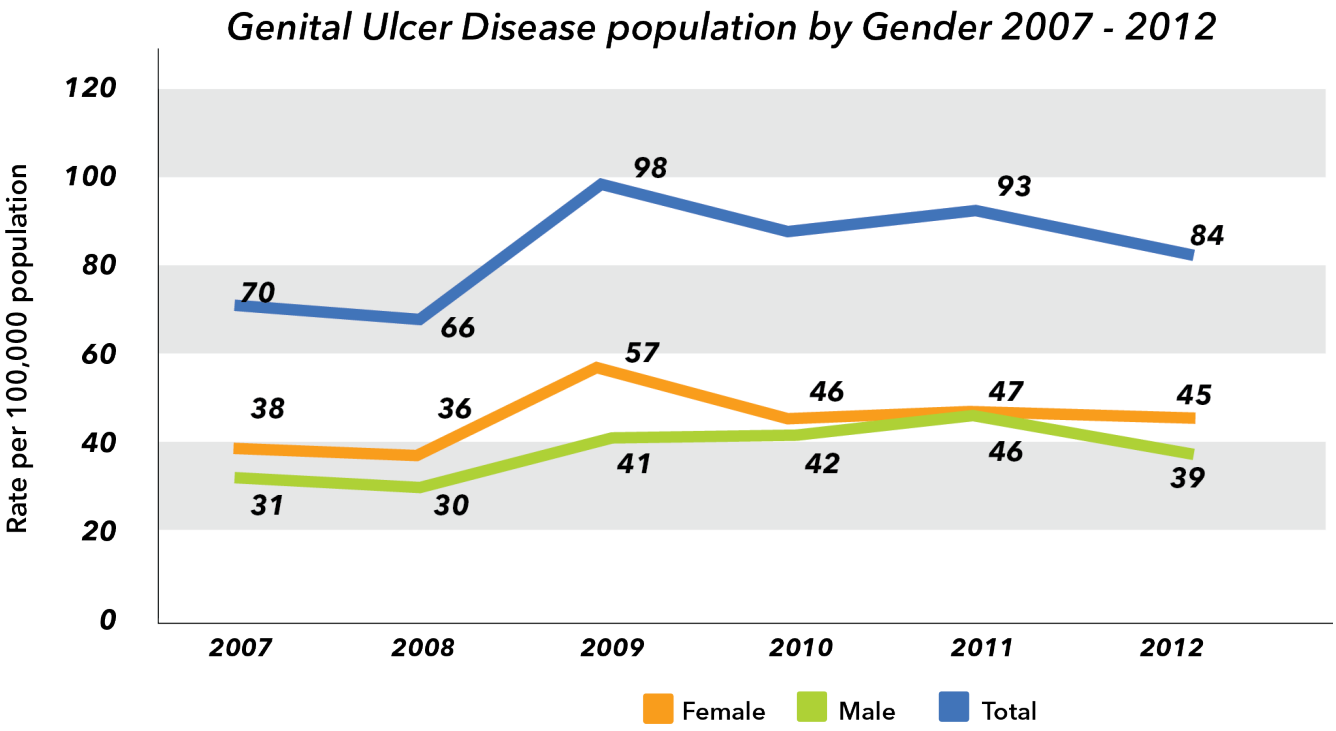


Figure 16 illustrates Genital Ulcer Disease per100, 000 population by Gender 2007-2012

The highest rates of infection were recorded in the 20-24 age cohorts, as expected low rates of GUD were recorded in the 0-9 age group for the six year period. In 2011 the number of cases of GUD in the 10-14 age group showed a slight increase (9 cases), with the numbers further increasing in 2012 (11 cases). A 6% increase in GUD rates were recorded for the 15-19 age group between 2011 and 2012 (Table 19).

Herpes, which represents the largest portion of reported GUD, increased from 775 cases in 2011 to 852(72%) cases in 2012, while chancroid remained constant at 59 (5%) cases for 2011 and 2012. Twenty four (24%) cases of granulomainguinale/lymphogranuloma venereum (Gl/LV) were recorded in 2012 with no greatly significant changes since 2007. However the number of cases of syphilis trended upward between 2007 and 2011 but decreased by 44% in 2012 when compared to 2011. (Table 19).

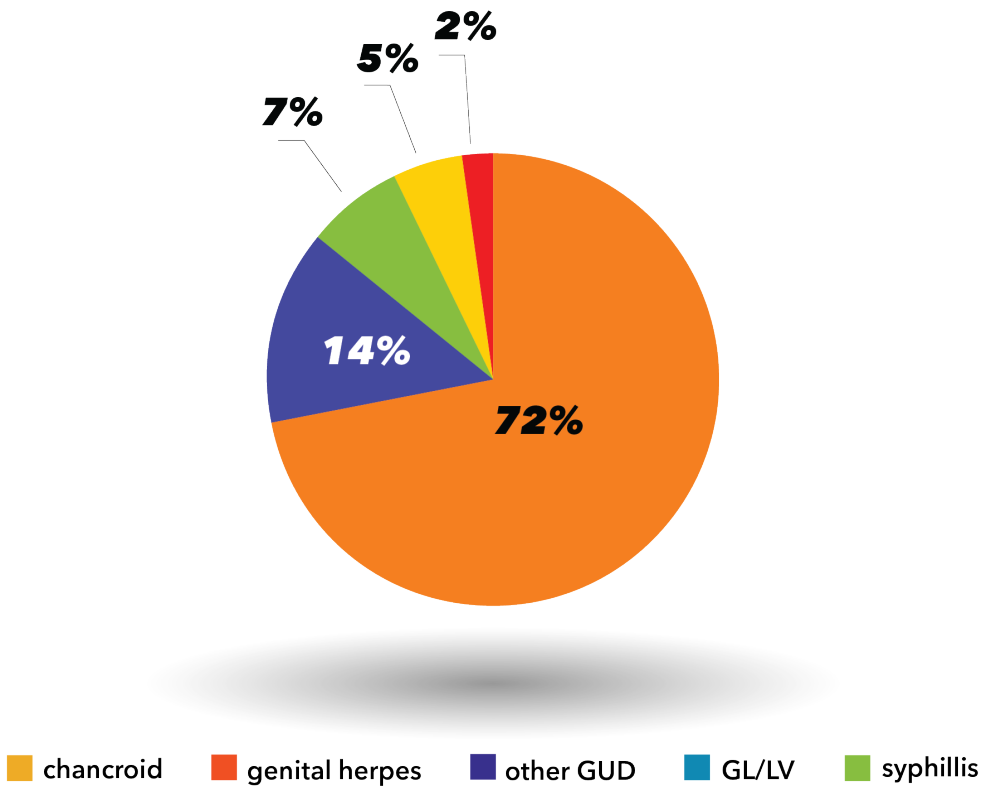


Figure 17 illustrates distribution of the causes of Genital Ulcer disease 2012

Herpes and syphilis accounted for 79 % or 931 cases of reported GUD in 2012 while unspecified ulcerative diseases made up 14% of cases, also chancroid and GL/GLV) represented 5% and 2% GUD cases respectively (Figure 10).

Table 19: Age Adjusted Genital Ulcer Disease Rates (GUD) Per 100,000 Population, 2007 To 2012

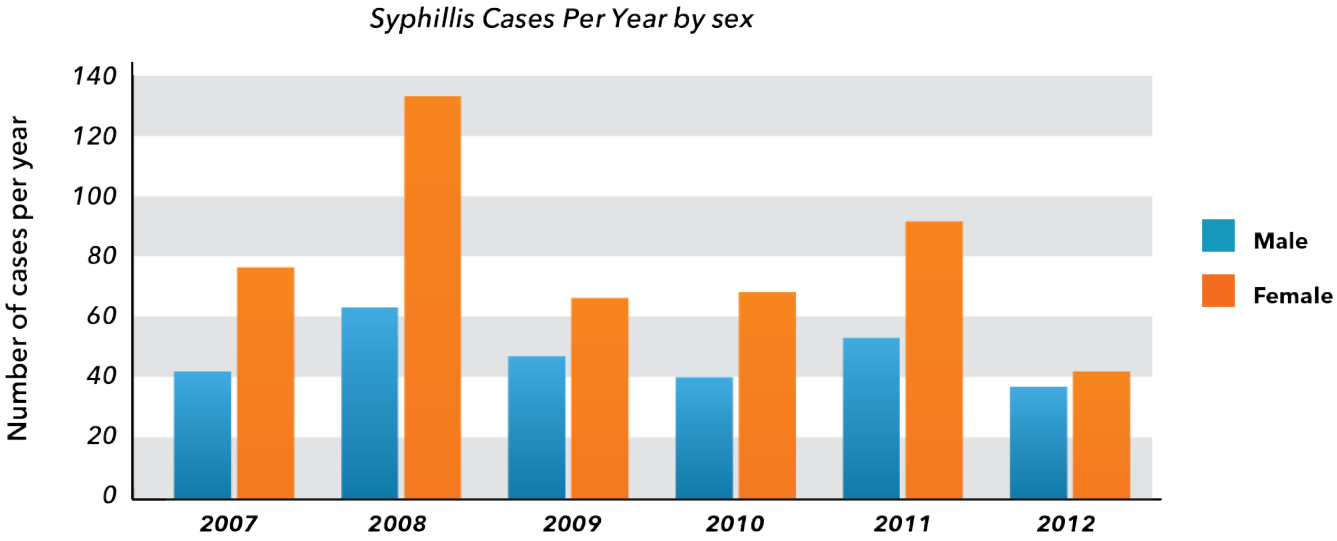
Age groups	2007	Year rate	2008	Year rate	2009	Year rate	2010	Year rate	2011	Year rate	2012	Year rate
	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
0-9 years	1	0	1	0	1	0	0	0	3	1	1	0
10-14 years	17	6	12	4	10	4	5	2	9	3	11	4
15-19 years	146	59	100	40	150	60	153	61	147	59	158	63
20-24 years	229	110	186	90	233	112	225	108	276	131	259	130
25 or older	542	37	596	40	924	62	799	54	799	53	747	50

Among the parishes Kingston & St Andrew (KSA), St Thomas and St Ann recorded the highest number of GUD cases for 2011 and 2012. However St Thomas and KSA had the highest rate of GUD per 100,000 populations (194 and 67 respectively) Westmoreland had the lowest rate at 8 per 100000 populations with 11 GUD cases per 100,000 (Table 20).

Table 20 .GENITAL ULCER DISEASE SYNDROME 2011-2012

PARISH	2011				2012				Rate difference
	Female	Male	Total	Rate	Female	Male	Total	Rate	
CLA	63	36	99	40	34	52	86	35	4.991553
HAN	16	15	31	44	13	15	28	40	3.81861
KSA	236	256	492	73	249	196	445	67	6.00584
MAN	24	12	36	19	9	13	22	12	7.439003
POR	8	4	12	14	24	27	51	62	-48.2255
STA	75	172	247	142	50	64	114	66	76.01365
STC	33	35	68	14	32	29	61	12	2.199814
STE	34	17	51	34	17	16	33	22	12.08532
STJ	24	15	39	21	29	24	53	29	-7.77901
STM	7	6	13	11	4	19	23	20	-9.18996
STT	100	45	145	153	59	124	183	194	-41.3624
TRE	9	8	17	22	12	17	29	16	6.252995
WES	7	11	18	12	8	3	11	8	4.38359
TOTAL	636	632	1268	47	540	599	1139	42	4.879291

Figure 18 illustrates the age specific genital ulcer disease rates for 2012.



Overall more women were diagnosed with syphilis than men over the 2007-2012 period. This is partly due to detection bias as women have increased access to tests for syphilis through antenatal clinics.

Table 21: GUD Cases by Year and Disease Category 2007-2012

Infection	2007	2008	2009	2010	2011	2012
Chancroid	75	82	95	35	59	59
GL/LV	25	33	30	30	30	24
Other GUD	189	93	123	178	139	167
Herpes	433	591	972	900	775	852
Syphilis	57	53	58	66	141	79

In addition, the greater health seeking behaviour of women allows more timely diagnosis. However, it is important to note that the female to male ratio for infectious syphilis (primary and secondary syphilis) is 2.1:1 while the female to male ratio for STI clinic attendance is 4:1 this implies that infectious syphilis is more prevalent among male STI clinic attendees compared to female STI clinic attendees.

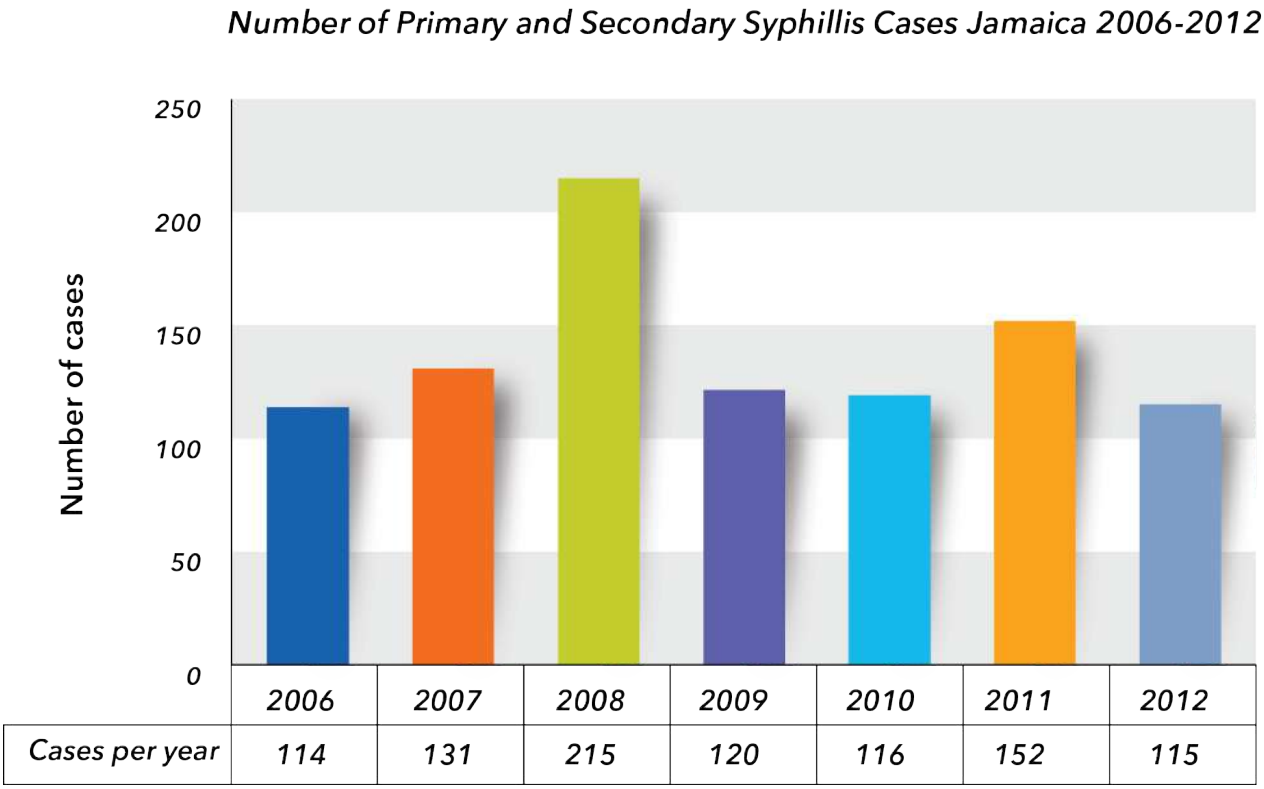


Figure 20: Number of cases of Primary and Secondary Syphilis, 2006-2012

CHAPTER 4: ENABLING ENVIRONMENT & HUMAN RIGHTS

INTRODUCTION

The mandate of the Enabling Environment & Human Rights (EEHR) Component within the context of the Strategic Plan is "the pursuit of a just, equitable society with strengthened policies and rules for sexual and reproductive health and HIV prevention, treatment and care services for all; emphasis on the right to health for all, which includes reducing stigma, as well as pursuing the removal of legal barriers to access health care, and the provision of health services in a non-discriminatory manner."

In 2012, the broad programme of work under the Enabling Environment and Human Rights (EEHR) component spanned across three main institutions; they were:

1. The HIV Unit in the Ministry of Labour and Social Security (MLSS)
2. The Jamaican Network for Seropisitives (JN+)
3. Jamaica Business Council on HIV and AIDS (JaBCHA) National Foundation

More specifically, the component's work set out to make impacts in the following key areas:

- Assessments and Reviews of the Government Response

- Legal Reform
- Greater Involvement of Persons Living with HIV and AIDS in National Response
- Stigma and discrimination

ASSESSMENTS AND REVIEWS

The information and knowledge generated from the assessments proved useful in improving the interventions under the Enabling Environment and Human Rights (EEHR) Component. The three assessments undertaken in 2012 were:

Situation Analysis for Patient Confidentiality in the Public Health Care Sector: The results from the assessment is expected to unearth those features of the current legislative and policy framework that support and or hinder patients' access to confidentiality when they interface with the public health care sector. The implementation of the assessment will continue into 2013.

Review of the National HIV-related Discrimination Reporting and Redress System (NHDRRS). The review will highlight the gaps in the system through a comprehensive review examining the NHDRRS and provide recommendations on how to improve its visibility and effectiveness. The review which commenced in 2012 will be continued in 2013.

LEGAL REFORM

The National Programme achieved a number of milestones with respect to legal reform. These are listed below:

The Amendment to the Public Health (Notifiable Diseases) Order and its regulations was approved by Cabinet on March 28, 2012. The amendment safeguards persons living with HIV certain rights such as access to education and employment opportunities in the tourism sector and the food industry.

The National Workplace Policy on HIV and AIDS was approved as a Green Paper by the Human Resources Committee of Cabinet (HRC) on July 26, 2012. This marked a significant milestone towards the advancement of HIV-related regulations as the Policy will inform regulations to be appended to the proposed Occupational Safety and Health (OSH) Bill.

The Draft HIV Workplace Policies for Ministries and Agencies were updated, finalised and launched in the following Ministries, Departments and Agencies of Governments:

- Foreign Affairs & Foreign Trade
- Justice
- Industry, Investment and Commerce
- Local Government and Science
- Technology, Energy and Mining

The Policies were launched during the Component's High-Level Leadership Breakfast held on November 30, 2012 in commemoration of World AIDS Day (WAD).

Senator the Hon. Mark Golding, Minister of Justice, hands over copy of the MOJ HIV Policy to a representative of the Attorney General's Department

From left: Mrs. Geraldine Miles (MFA&FT), Mrs. Kathy Chambers-Adman (MSTEM) and Mr. Reginal Budhan-Permanent Secretary, MIIC-holds up copies of their respective HIV Policies during the Joint Policy Launch Function held on November 30, 2012

GREATER INVOLVEMENT OF PERSONS LIVING WITH HIV AND AIDS (GIPA)

In its commitment towards the participation of persons living with HIV in the design, implementation and monitoring and evaluation of the HIV response, the NHP undertook various initiatives guided by the GIPA principle. There were two key activities for 2012.

DEPLOYMENT OF COMMUNITY FACILITATORS (CFS)

Five of the 30 PLHIVs who participated in capacity building training workshops in 2011 were deployed as Community Facilitators (CFs) in 2012. The CFs were placed in public and private sector organizations they were placed in.

During their three month engagement (March and June 2012), two (2) CFs were deployed to the MLSS's HIV Unit. They participated in workshops and Steering Committee Meetings while based at the Jamaica Business Council on HIV/AIDS (JaBCHA). Overall, the GIPA Coordinator and CFs participated in more than 52 workplace sensitisation and training sessions.

The CFs' involvement at the policy and planning levels in public and private sector organisations

continued the push towards the creation of supportive political, legal, social and [enabling] environments. The CFs' deployment was integral to the realisation of the GIPA principle.

DEVELOPMENT OF THE POSITIVE HEALTH DIGNITY AND PREVENTION (PHDP) CURRICULUM

The development and implementation of the eight-module (PHDP) curriculum advanced the capacity building element of GIPA. The curriculum was developed by PLHIV for use by leaders in the PLHIV community to develop various cohorts of CFs. The learning objective was to increase PLHIVs awareness and understanding of critical areas such as:

a. sexual and reproductive health and rights
b. human rights
c. gender equality
d. empowerment
e. social and economic support
f. health promotion
g. increasing access.
h. impact measurement
i. CFs role in preventing new infections

A workshop series was implemented with financial and technical support from the Health Policy Project (HPP) throughout the year. The PHDP Framework serves as an advocacy strategy for PLHIVs as well as an empowerment tool showing PLHIVs how to take responsibility for improving the dignity, quality, and length of their lives.

SUPPORT TO THE JAMAICA NETWORK OF SEROPOSITIVES (JN+)

With regards to the work that the National Programme does with JN+, the focus for 2012 was on streamlining the network's core activities. The following activities were identified as ways to accomplish a more focused programme of work for JN+:

a. Development of an Advocacy Plan
b. Revitalization of the National HIV-Related Discrimination Reporting and Redress System (NHDRRS)
c. Establishment of a baseline of the trends of stigma and discrimination using the People Living with HIV and AIDS Stigma Index

THE NATIONAL HIV-RELATED DISCRIMINATION REPORTING AND REDRESS SYSTEM (NHDRRS)

In September 2012 the Advisory Board's Interim Investigative Team for the National HIV-related Discrimination Reporting and Redress System reviewed 16 cases of alleged discriminatory

acts. Of these cases, the team recommended three (3) for legal support. An ad hoc legal team was assembled to advocate for redress. However, no consensus was reached amongst members of the Advisory Board.

Efforts to achieve redress for thethree cases ended in the involvement of an ad hoc legal team as a provisional measure. Similarly, efforts to engage the Advisory Board to gain consensus on the way forward was not successful due to the unavailability of the members.

In the last quarter of the year, HPP provided financial support for a comprehensive review of the NHDRRS - looking particularly at the partnership with redress, the investigation process, the advisory board, the data collection, protection and analysis, the human resource needs and its functionality and visibility.

PLHIV STIGMA INDEX SURVEY

The People Living with HIV (PLHIV) Stigma Index is used globally to measure and detect changing trends regarding stigma and discrimination as experienced by people living with HIV. Administered by PLHIVs who are also the interviewees, the Index is intended to shape programmatic interventions and policy change.

In 2011, the Jamaica Network of seropositives (JN+) used the stigma index tool to find out the trends in relation to stigma and discrimination as per the experience of PLHIVs. The final report was submitted in February 2012. The final report was, however, deemed incomplete, inaccurate and unacceptable by the Project's Steering Committee. In light of this, the Steering Committee put forward several remedial steps as likely solutions to strengthen the methodology section of the report. One of the recommended solutions was conducting a focus group discussion with persons involved in the research which was held on August 30, 2012, However, the implementation of only one of the recommended solutions still did not remove all the challenges with its reliability and validity, the Stigma Index was not disseminated.

WORKPLACE PROGRAMME

The HIV Unit of the Ministry of Labour and Social Security (MLSS) continued the implementation of a series of activities under the Workplace Programme intervention. The programme, which was launched in 2006, was designed to provide on-going technical support for both private and public sector employers and employees on the development and implementation of their HIV Workplace Policy and Programme.

ACHIEVEMENTS

During 2012, the Unit realized three major achievements

1. The launch of the HIV Workplace Education Media Campaign to create public awareness and an understanding of the importance of having HIV workplace policies and programmes in private sector companies. The campaign comprised of one 30 second radio and one 30 second television advertisement. Representatives from the private sector, the PLHIV community, government officials, USAID and other development partners were in attendance at the launch of the Media Campaign.

Caption: Mission Director of USAID/Jamaica, Ms. Denise A. Herbol (left) is seen here in discussion with the Minister of Labour & Social Security the Hon. Derrick Kellier, Mrs. Rosemarie Stone (second left and Mr. Ainsley Reid (far right) at the National HIV/AIDS Workplace Policy Media Launch on July 3, 2012, at the Mona's Visitors' Lodge.

2. The approval of the Green Paper on National Workplace Policy on HIV and AIDS was secured on July 26, 2012. The National Programme furthered its efforts to advance the policy by engaging in policy dialogues with relevant stakeholders such as the Labour Advisory Council (LAC). The LAC is drawn from members of MLSS, representing the Government, the Jamaica Employers Federation (JEF) and the Jamaica Confederation of Trade Unions (JCTU), representing workers. The policy dialogue amongst the members of the LAC was aimed at the members determining a way forward to get the policy to a White Paper.
3. The number of trained Voluntary Compliance Programme (VCP) Auditors increased from 7 to 20 during 2012. Two VCP awareness workshops were implemented to train the new batch of VCP Auditors for private sector companies. Additionally, through the Unit's collaborative efforts with other partners, 91 private and public sector employees benefited from training workshops to improve their HIV workplace peer education skills.

   The Voluntary Compliance Programme (VCP) Auditors Awards Ceremony recognized the efforts of employers and employees in developing and implementing a workplace policy and programme. For the 2012 staging of the event, which was held in December, employers and employees from over 12 companies were honoured.

From Left: Mr. Robert Chung, Dr. Jennifer Knight-Johnson and Mrs. Audi Brevett in conversation at the VCP Awards function, December 20, 2012

DEPLOYMENT OF WORKPLACE TECHNICAL OFFICERS

Workplace Technical Officers were deployed to work in private sector umbrella organizations and Government of Jamaica Ministries. In 2012, one workplace technical officer was deployed to the Jamaica Business Council on HIV/AIDS (JaBCHA) and another to the Jamaica Employers' Federation (JEF). Three (3) workplace technical officers worked across the following five Ministries: Finance, National Security, Foreign Affairs & Foreign Trade, Science Technology Energy & Mining, Justice and Health.

The collaborative efforts between the organizations and the Workplace Technical Officers yielded the following results:

- Draft HIV Workplace Policies for five (5) Ministries were updated, finalised and launched through a mix of 1-3 hour, half-day and one day HIV Sensitization Workshops , some 2,922 employees reached.
- Ninety-one (91) employees from five organizations were trained as Peer Educators. The majority (36 employees) were from the JaBCHA.
- Over 1,000 persons were tested for HIV
- Condoms were distributed, 41,802 male condoms and 268 female condoms

Figure 21: No. of persons sensitised within public and private sector entities in 2012

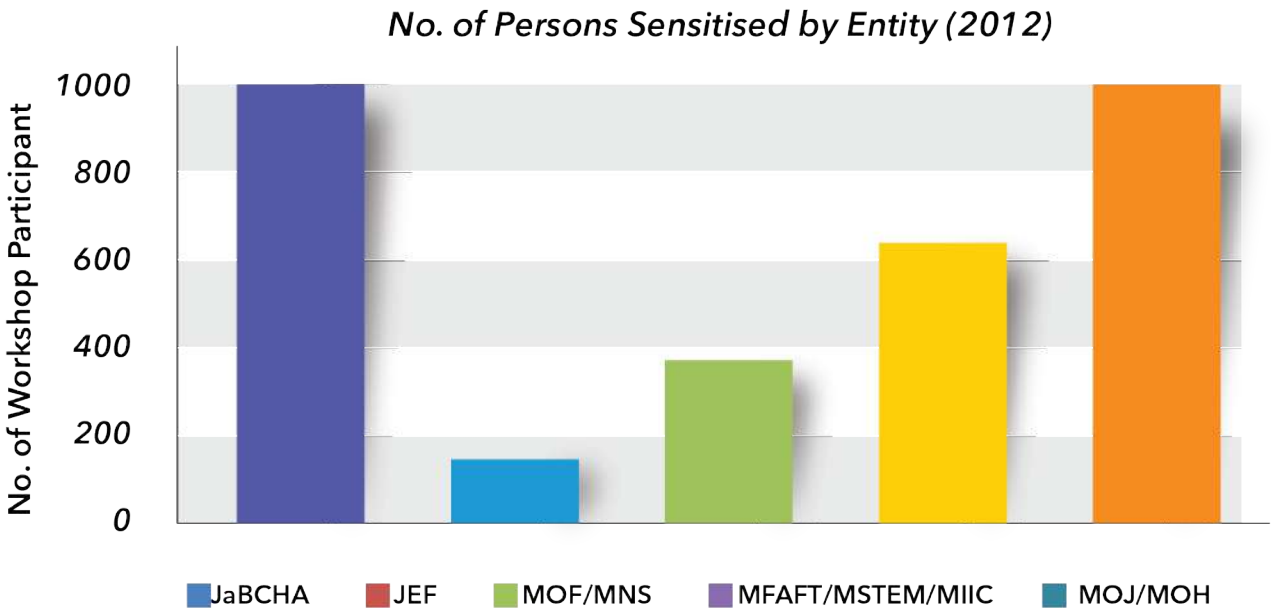
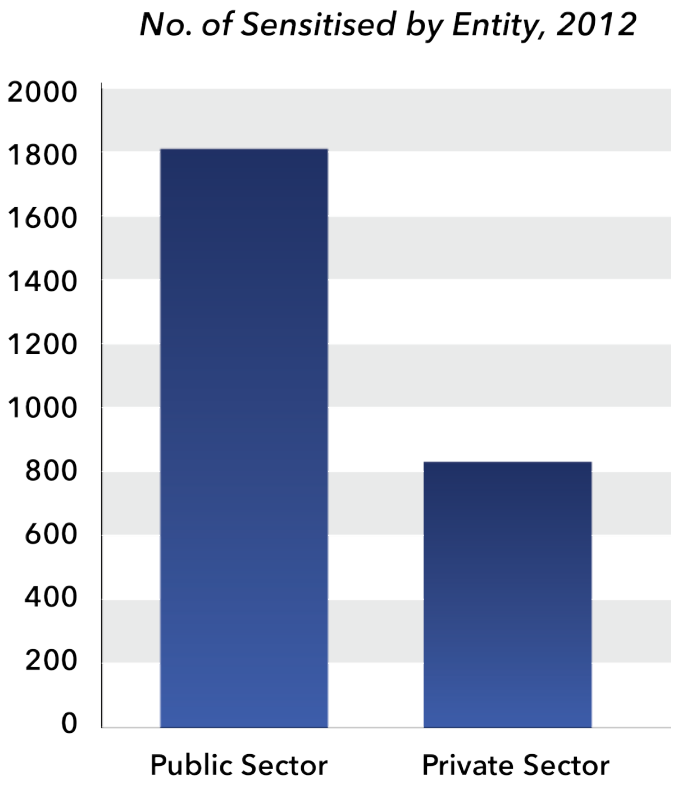


Figure 22: No. of persons sensitised by sector in 2012



SECURING PROGRAMME SUSTAINABILITY

The Workplace Programme is a public-private sector partnership. However, the National Programme has acknowledged that the sustainability of the Workplace Programme rests in the MLSS HIV Unit ability to establish itself as the coordination body all workplace activities relating to HIV and AIDS.

Throughout the reporting year, sensitizations sessions were an opportunity to deliver the messages about the MLSS plays in ensuring the management of HIV in the workplaces. The messages included that:

- The MLSS is charged with ensuring that there is compliance to international standards on the management of HIV in the workplace
- The MLSS' Voluntary Compliance Programme is available to assisting employers from various companies, ministries and agencies to identify, and train suitably qualified employees to volunteer as Peer Educators and VCP Auditors.

SPECIAL EVENTS

The observance of World AIDS Day (WAD) and Safer Sex Week (SSW) continues to be part of the mainstay of special events for both the public and private sector entities in the Workplace Programme. The interventions that marked both World AIDS Day and Safer Sex Week were designed to increase employers' and employees' awareness of HIV-related issues in order to safeguard against complacency in response to HIV.

Over 1,000 employees were tested for HIV during 2012; the majority of those were tested during Safer Sex Week. The World AIDS Day celebrations were used as an opportunity to launch and re-launch the government Ministries' HIV workplace policies.

SAFER SEX WEEK 2012

Young people getting information about HIV at sex week event 2012

Safer Sex Week 2012 was observed between February 13 and 17 under the theme, "Tek Charge". During the week public and private sector entities facilitated voluntary HIV counselling and testing for employers and employees.

Additionally, a four (4) condom negotiation skills workshops was conducted with the staff of MFA&FT, MSTEM and MIIC. The workshop objective was to strengthen participants' ability to negotiate condom use.

WORLD AIDS DAY

TGP - World AIDS Day Breakfast-2012

World AIDS Day 2012 was commemorated under the theme "On a Mission to Zero New HIV Infections". The Annual High-Level Leadership Breakfast was held on November 30 under the theme "HIV Leadership through Commitment and Accountability". US Ambassador to Jamaica Pamela Bridgewater in her keynote address emphasised the need for country ownership of the HIV response where efforts are led and paid for by government, communities, civil society and private sector playing an important role in efforts to expand funding sources for the HIV response.

Additionally, several public and private sector organizations received support from the Programme to deliver their own WAD activities.

Display mounted by Cari-Med during joint Policy Launch Function on November 30, 2012

STIGMA AND DISCRIMINATION REDUCTION INTERVENTIONS

FAITH-BASED ORGANISATIONS (FBOS) INTERVENTION

In 2012, the component placed emphasis on developing a framework for the re-engagement of the FBO community in the national HIV response through collaboration and consensus-building, a process which began in 2011. At the forefront of this approach was the ahosting of a harmonisation meeting providing partners (NHP, UNAIDS, HPP and UNFPA) with the opportunity to discuss and agree on methodologies for the execution of portfolio responsibilities in order to prevent duplication of efforts.

Ms. Terri Myrie, former Discrimination Reduction Technical Coordinator (DRTC) during S&D presentation at Northern Caribbean University (NCU)

Achievements toward sustainability and replication of the FBO approach were attained by the implementation of training workshops as well as the development of training materials and a curriculum. These include:

- three (3) five-minute docu-dramas - highlighting discriminatory actions against PLHIV, MSM and Sex Worker with the church setting
- a facilitator's guide
- an adapted I-TECH monitoring tool to assess the knowledge and skills-set of persons trained as FBO change agents
- 492 congregants from various denominations participated in training and sensitisation workshops.
- A FBO forum held on March 29, 2012, in collaboration with the HPP where a proposal for the development of a generic inter-faith HIV policy through island-wide consultations was put forward

Despite the traction gained, the execution of this portfolio was beset by several challenges. Chief among them was the abandonment of the proposal to develop an ecumenical (inter-faith) policy on HIV and AIDS amid concerns expressed by the United Theological College (UTC) about working with more than one collaborating/donor agency. As a result, UTC accepted support from UNIAIDS where they conducted a study on the attitude of faith-based leaders toward PLHIV and key populations.

PANCAP REGIONAL STIGMA & DISCRIMINATION UNIT (RSDU) PROJECT

The PANCAP Regional Stigma & Discrimination Unit (RSDU) Project was conceptualised to bring about a reduction of S&D towards people living with HIV, their families and other vulnerable groups throughout the Caribbean. This Project was implemented in several countries across the Caribbean including Jamaica, Guyana, St. Lucia, Belize, Dominica and Grenada.

The Project's main achievements included the production of information, educational and communication (IEC) materials and a human rights campaign which entailed appearances in February and June a representative from the component on News Talk 93 FM and Hot 102 FM talk shows respectively, advocating the right of PLHIV to work. Despite funding from the UK's Department for International Development (DFID) and well-intentioned objectives, the Jamaican-based Project ended in August 2012. The Project was considered a missed opportunity because it lacked effective management as well as targets and consistent project deliverables.

JAMAICA BUSINESS COUNCIL ON HIV/AIDS (JABCHA) NATIONAL FOUNDATION

The Jamaica Business Council on HIV/AIDS (JaBCHA), continued its efforts to support the financial sustainability of the national HIV response through increased private sector investment. Its support was in keeping with its proposal to take two years (2010 and 2012) to lay the foundation for raising one billion Jamaican dollars.

The fund-raising efforts of the Jamaica Business Council on HIV/AIDS, represented by Earl Moore (left), yielded the donation from the LIME Jamaica Foundation, represented by Errol Miller (right). Kerreen Wilson (centre) is delighted (Source: The Sunday Gleaner, February 5, 2012;

Despite innovative proposals and increased media exposure, however, this proposal was not realised. In a newspaper article on June 3, 2012, the Executive Director lamented that the JaBCHA National Foundation was having a hard time getting buy-in from corporate Jamaica. Up to the end of the Executive Director's tenure in October 2012, the Foundation raised six million from six corporate sponsors, each donating 1 million dollars, while two others offered in-kind donations.

Notwithstanding, there was no shortage of innovative proposals aimed at putting the Foundation on a firm footing including a number of fundraising ventures. These proposals are documented below:

- The "live, love, donate" campaign in which a website will be developed to facilitate donations from persons across the world. The advantages of this technologically driven effort is that it should provide anonymity and a wider target audience from which to raise funds
- The JaBCHA "getting to zero" car raffle which would raise J$350,000 for the financial sustainability of JaBCHA and the employment of persons living with HIV (PLHIV) while promoting the "getting to zero" drive of the National HIV/STI Programme
- Partnering with the GRATA Foundation to stage the "Red Ribbon Run" with proceeds shared between both entities and a selected charity
- Launching a Media campaign to sensitise the public to the objectives of the Foundation
- Soliciting sponsorship from corporate entities to off-set operational expenses

The activities that were implemented included:

- A "getting to zero" jingle was developed and shared with key stakeholders.
- The Red Ribbon Run was held on November 25 at Kings House with 200 participants. A profit of $52,750.65 was realised of which the JaBCHA National Foundation received $21,100.26 after the money was shared among the three beneficiaries. The fund

Achievements toward sustainability and replication of the FBO approach were attained by the implementation of training workshops as well as the development of training materials and a curriculum. These include:

- three (3) five-minute docu-dramas - highlighting discriminatory actions against PLHIV, MSM and Sex Worker with the church setting
- a facilitator's guide
- an adapted I-TECH monitoring tool to assess the knowledge and skills-set of persons trained as FBO change agents
- 492 congregants from various denominations participated in training and sensitisation workshops.
- A FBO forum held on March 29, 2012, in collaboration with the HPP where a proposal for the development of a generic inter-faith HIV policy through island-wide consultations was put forward

Despite the traction gained, the execution of this portfolio was beset by several challenges. Chief among them was the abandonment of the proposal to develop an ecumenical (inter-faith) policy on HIV and AIDS amid concerns expressed by the United Theological College (UTC) about working with more than one collaborating/donor agency. As a result, UTC accepted support from UNIAIDS where they conducted a study on the attitude of faith-based leaders toward PLHIV and key populations.

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- The contracts of JaBCHA Executive Director and the project assistant which ended in October and November, 2012 respectively were not renewed. They were responsible for managing and executing the daily activities of the Jamaica Business Council on HIV/AIDS (JaBCHA) and the JaBCHA National Foundation. In December 2012, the workplace technical officer deployed to JaBCHA was relocated to the Ministry of Health in the section housing the National HIV Programme (NHP).

CHALLENGES

Overall, there is limited financial support to implement the interventions under the component. Additionally, the gaps in the M&E mechanism made it difficult to document and track the implementation of all interventions under the component.

The HIV Unit of MLSS intervention had its own unique challenges. They include: securing auditors to conduct audits; lack of adequate staffing limits small businesses' level of commitment to HIV interventions and the timing of interventions are often incongruent with companies' schedules.

The Workplace Programme Intervention experienced a wane in the level of interest from the large and medium private sector companies. Additionally some companies reported that they were awaiting the approval of the Occupational Safety and Health (OSH) Bill before embarking on developing and implementing a HIV policy and programme.

In terms of internal operations for the Workplace Programme Intervention, it was noted that the maintenance of an HIV workplace programme was not documented in employees' job descriptions

Regarding the faith-based organizations, the UTC raised concerns about partnering with more than one funding agency for the development of the generic inter-faith HIV policy. In 2012, the implementation of faith-based organizations training workshops considerably affected by competing events and a general lack of support from church leadership. Despite an expression of interest by the Rastafarian communities of the Twelve Tribe and Nyahbinghi, a training programme was not finalised owing to scheduling difficulties

The PANCAP Regional Stigma & Discrimination Unit (RSDU) Project's challenges included:

- Lack of a Memorandum of Understanding between CVC and the RSDU as well as a functional Community Advisory Board
- The concerns were raised about the effectiveness of the human rights campaign and empowerment training. These concerns also extended to the administration, communication, monitoring and impact of the project activities.

CHAPTER 5: MONITORING & EVALUATION

OVERVIEW/SUMMARY

During 2012,the Monitoring and Evaluation Unit continued to build on the foundation that was established since 2004. The Unit facilitated a number of national surveys, evaluations, and data quality improvement interventions during the period. The Unit continues to grow, develop and refine its contribution to eliminating new HIV infections, discrimination and AIDS related deaths.

DATA MANAGEMENT AND ANALYSIS

M&E DATABASE

The Unit continues to use the M&E database that was developed to capture all stakeholders' reports. The database facilitates the generation of reports at the national level. Over the period, several important updates were made to the M&E database. These changes addressed gaps in the reports being captured by the system and will eliminate the need for dual data entry process for donor reports.

ARV TREATMENT SITE DATABASE

During 2012 the M&E UNit continued to work with Clinton Health Access Initiative (CHAI) on strengthening the ARV treatment database and pharmacy monitoring systems. Some key

actions were identified by the team and are being addressed. These include procurement of computers for sites with "outdated" or insufficient hardware to support the treatment database.

ARV DATABASE SWEEP

The database sweep activity was initiated in collaboration with CHAI as an intervention to address gaps noted in the data quality (completeness, accuracy) at the treatment sites. The database sweep commenced at 91% of adult treatment sites island wide. A number of issues were noted after data entry commenced that suggested that if left unattended, theywill not only compromise the integrity of the data being entered but also will hinder the completion of the database sweep activities at the site. Due to budgetary constraints, this activity needs to be completed by the end of January 2013. The following are key issues hindering the progress of the activity:

1. Limited number of persons entering data at the sites. Most sites have assigned 1 or 2 persons to enter data during the sweep (all of whom have their regular work duties to fulfil). This minimizes the speed at which data can be entered thus negatively impacting sites' ability to meet the January 2013 deadline. In light of this, the Regional HIV/STI Coordinators (particularly those facing this problem within their region) were engaged and asked to assist the process by identifying additional persons to help the process. In instances however where such persons cannot be identified, the CHAI team expressed its willingness to train an independent contractor to visit the sites and assist the data entry process as a collaborative effort with the current data entry team at the sites.
2. Cooperation of Staff Another major issue arose among Medical Records staff at several site who were unsatisfied with the incentive that was offered. Similarly, supervisors reported dissatisfaction with the incentive offered to review dockets. The supervisors indicated that their efforts to ensure the sweep activities are moving smoothly will be drastically reduced and they will only accommodate sweep activities when they find the time to do so.

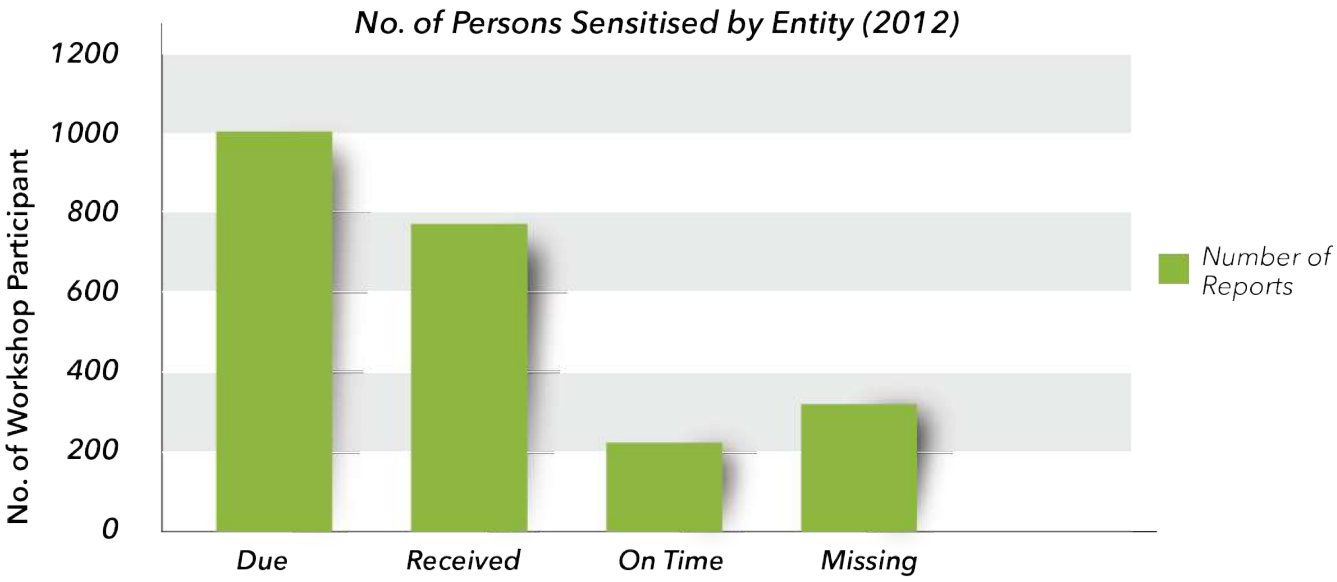
These issues were presented to the Director, NHP, who provided support in facilitating discussions with various Regional Technical Directors and well as the Medical Officers of Health in order to have the activity flow smoothly and with a greater sense of urgency within these sites.

DATA MANAGEMENT

The Monitoring and Evaluation Unit continues to work with the parish staff and SRs towards improving data quality. This involves detailed examination of all reports received for completeness and inconsistencies and giving feedback to all stakeholders involved. The following activities were carried out as part of the data management protocol.

Reporting by stakeholders between January and December 2011 are summarized in the chart below. This graph represents the number of monthly reports received against the number of reports that were expected from 84 organizations

Figure 24: Status of reports expected by the M&E Unit, Jan –December 2012



RESEARCH AND EVALUATION

RESEARCH STUDIES AND PROJECTS FOR 2012

The M&E Unit worked collaboratively with the other priority areas (Prevention, Treatment, care and Support and Human Rights and Enabling Environment) of the National HIV/STI Programme to guide and support the inclusion of accepted protocols and procedures of analysis that were implemented across all studies. A number of research studies/ projects were finalised during this period. They include:

- MSM and CSW Behavioural and Serological Survey (MEASURE)
- Co-occurring Psychiatric Disorders among HIV/STI Patients Attending Public HIV/STI Clinics in Jamaica (World Bank funded)
- Modes of Transmission Protocol (UNAIDS funded)
- National Knowledge, Attitude, Behaviour and Practices survey (Global Fund)
- National AIDS Spending Assessment (NASA)

The following provides an update on the research studies and projects for 2012:

Knowledge, Attitude, Practices and Behaviours Study (KABP) – The KABP is a cross-sectional, household-based survey that was conducted among a randomly selected sample of 1800 persons island-wide. Respondents represented persons aged 15-49 years with the younger group, 15-24 years, over-sampled to facilitate a more robust sample of sexually active persons in this age cohort.

The results of the 2012 KABP survey indicate mixed programme results in a number of areas:

Multiple partnerships, which has continued to rank among the leading risk factors in Jamaica registered a 2% increase overall between 2008 and 2012, with a significant increase among

the 15 – 24 year age group. The prevailing harsh economic climate has continued to impact the HIV epidemic, making the young increasingly vulnerable to high risk practices.

Overall condom use at last sex remained constant at 63% over the period, 2008-2011, for persons with multiple partners. Persons engaged in more risky behaviours (i.e. non-users of condoms in multiple partnerships) tested for HIV more frequently than their counterparts and at a slightly increased rate over 2008 (50.9% vs. 50%). Another encouraging signal was the decline in coercive sex, whether as a victim or aggressor.

Transactional sex recorded a concerning increase among all groups in 2012, but was higher among males, younger persons and person in short term (< 1 year) relationships. Casual relationships increased overall, but were more pronounced among females and younger persons. However, with sensitization to the importance of protective sex, condom use in such situations increased just over 2% in 2012.

Reported lifetime incidence of STIs showed a significant decrease, particularly among older males 25-49 years. STI incidence also declined among all risk groups, but particularly so among persons involved in transactional sex (16% decline) and those with multiple partners (14.8% decline).

Overall, HIV prevention knowledge decreased by 7 – 10% among males and females. Knowledge of condom use and having one faithful uninfected partner each declined by 4 – 5%, while abstinence knowledge increased by 4%. Of noteworthy importance is the decline in endorsement of inappropriate methods of HIV transmission (i.e. mosquito bites, sharing food with HIV positive person, etc.).

Accepting attitudes towards Persons living with AIDS (PLWWAs) increased among females in 2012, but declined among younger males. Targeted human rights interventions should be developed to address what appears to be an increase in stigma and discrimination among males.

Psychiatric Prevalence Study: Data analysis was completed for this study. The study was conducted to determine prevalence of psychiatric illnesses among PLHIV assessing care in the public sector. A total of 155 patients participated in the study in 5 treatment sites in SERHA and NERHA. The data was entered and analysed. Dissemination of findings will include: abstracts prepared from this study were accepted for poster presentation at the International AIDS conference held in Washington DC, July 2012. The abstracts examined the mental health needs of HIV and STI Patients and the impact of mental health of ART adherence. The titles of these abstracts were:

1. Quantitative Assessment of Mental Health Care Needs Among HIV/STI Patients Attending Public Clinics in Jamaica (and)
2. Traumatic Life Events (TLE), Symptoms of Post-Traumatic Stress Disorder (PTSD) and their impact on ART Adherence in Patients Attending HIV Treatment sites in Jamaica.

MSM and CSW Behavioural and Serological Surveys: Data collection for both studies were completed in 2011 and data entry and data analysis were completed in 2012. A series of debriefing meetings were held January 26 – January 30 to discuss key indicators coming out of these studies and to debrief on issues of implementation as the NHP prepares to lead the implementation of subsequent surveys.

PLACE WORKER AND PATRON SURVEYS

A total of 463 female workers, 263 female site and event patrons, and 278 male patrons were interviewed. Of the 729 women interviewed, 373 reported exchanging sex for money in the past 3 months. HIV prevalence ranged from 4.7% among female workers at venues to 0.5% among male venue patrons. The prevalence among female sex workers was similar to the prevalence among all women working at venues (4.7% versus 4.1%). The proportion who had evidence of a current or previous syphilis infection was approximately 9% among female workers and sex workers. The most common STI was chlamydia. Proximate determinants of the heterosexual epidemic include high numbers of sexual partners, lack of condom use and untreated STI. None of these factors was uncommon among female venue workers, female sex workers, female patrons of venues or male patrons of venues. Almost one fourth of women socializing at a venue reported having more than one partner in the past four weeks. Condom use with regular partners was low, especially among female patrons of venues. Underlying determinants of the epidemic include young age, unemployment, history of jail or prison, low education and low socio-economic status.

MSM SURVEY

The prevalence of STI was high among MSM. The prevalence of HIV was 32.9%. Results show that 8.5% had a positive rapid test for syphilis, indicating that they had ever been infected with syphilis. The prevalence of gonorrhoea was 2% and chlamydia ,8.9%. The estimates for the prevalence of gonorrhoea and chlamydia are underestimates because the test used did not uncover cases of rectal gonorrhoea or chlamydia. Instead, MSM provided a urine specimen and not a rectal specimen. The results cannot be generalized to MSM in Jamaica. Most of the MSM in these surveys were poor, unemployed and socially vulnerable. Transactional andcommercial sex was more common in this population than expected in a random sample of MSM. HIV infection was associated with receptive anal intercourse, engaging in both receptive and insertive sex (known as "versed"), ever having a STD, commercial sex, and five or more one night stands. HIV was also associated with being a victim of physical violence, lower socio-economic status, and a history of rape.

DATA USE AND RECOMMENDATIONS

PLACE findings were reviewed and reported in meetings with the MOH and in public meetings. Preliminary findings were described and discussed with the MOH BCC team in January 2012. During that discussion, some suggestions were made about simplifying the protocol so that it could institutionalized by the MOH. During another session with the MOH in June, small groups were convened to further discuss operationalizing the method. In addition to operationalizing PLACE, there were other opportunities to use the PLACE and MSM findings:

- For reporting to the Global Fund

- For informing the Modes of Transmission Analysis
- For giving context to other interventions on the island
- For contributing to regional discussions at scientific meetings and at global meetings.

Modes of Transmission (MOT): With financial and technical support from UNAIDS, the NHP contracted a local consultant to complete the MOT study. Several meetings were held to review the available data and the local consultant prepared the final report.. The UNAIDS MOT model was applied to assess the HIV epidemic in Jamaica allowing policy makers to gain an understanding of the short-term risk of HIV infection in various risk groups and guide the national response to HIV.

GIS mapping: The MOH partnered with Mona GIS Unit to map all reported HIV and AIDS cases. However Mona GIS informed the MOH that the data that was entered was corrupted and all files were lost. They were unable to recover or redo data entry and as a result brought an end to the MOU. No deliverables were received from this agreement. The project was subsequently reformulated and the M&E Officer with responsibility for GIS supervised a team of GIS staff who completed data entry. This allowed the M&E Unit to produce maps of the all reported HIV and AIDS cases.

National AIDS Spending Assessment for Jamaica (NASA). The M&E Unit supported the implementation of the National AIDS Spending Assessment for Jamaica for the fiscal years 2009/10- 2010/11. The NASA methodology involves several stages. These include data collection, data entry and data analysis and the final report. The Jamaican NASA was conducted in two phases. Phase 1 was conducted between October and November 2011. It was believed that the data received from the stakeholders was insufficient to make a valid approximation of expenditure. Therefore, another phase took place between April and June 2012.The results depict a very close approximation of what was actually spent on HIV and AIDS in the national response.

It is hoped that the results of this assessment will assist in the planning and execution of the Jamaican HIV response in years to come, especially, as funding shifts from HIV, which requires the country's response to be more self-sustaining.

PANCAP STI SURVEILLANCE

The M&E Unit supported the PANCAP-funded evaluation of STI Surveillance in Jamaica. The overarching objective of the surveillance component is to design and implement mechanisms to strengthen surveillance and monitor and evaluate the STI burden in Jamaica. During The first phase of the project the team assessed the epidemiological surveillance system for sexually transmitted infection in Jamaica.

The consultants held teleconferences and briefing meetings with the senior Ministry of Health officials including the members of the National HIV/AIDS Programme and Surveillance Department. In addition, discussions were also held with the Chairperson of Health Information and Technologies, Director of Health Record Services, Medical Director of the Caribbean HIV/AIDS Regional Training Network. Representatives in each of the four Regional Health Authorities (RHAs) were also engaged. A convenience sampling method was used to select the study sites at health facilities in Jamaica but included representatives from each Regional Health Authority of the country.

Based on the findings of the assessment, recommendations were proposed in the key areas; the areas of priority include:

- The standardization of data collection tools and reporting protocols to encompass all STIs.
- Appropriate training and capacity building in Monitoring and Evaluation, Data Quality and Management, update on syndromic and case based surveillance and Coordination and Feedback mechanisms.
- The establishment of a computer based STI data management at the level of the MOH and health records departments in each parish, supported by paper based surveillance.
- Bolstering of the human resources involved in surveillance and laboratory testing.
- Identification and mobilization of resources to enable STI laboratory testing.
- Revision and updating the technical guidelines, legal framework and protocols on case based epidemiological disease surveillance of STIs.
- Support the implementation of an electronic national health management system to accommodate STI case data.
- Establishing STI reporting from private laboratories and physicians.
- Resource mobilization of personnel in various levels of surveillance at the Ministry of Health, Regional Health Authorities and parishes to ensure appropriate STI surveillance management.

CAPACITY BUILDING IN M&E

The M&E Unit convened a number of capacity building interventions during the period January to December 2012. The area of capacity building remains a M&E priority for key stakeholders. The focus was primarily around strengthening skills set of partners involved in the monitoring and evaluation process of the National HIV/STI Programme. Some interventions are detailed in the following table:

Table 22: M&E Capacity building

	Summary
Effectively using the Treatment Database NERHA	The workshop reviewed the ART Programme, Early Warning Indicators, understanding of data entry fields, running reports, etc.
Effectively using the Treatment Database - SRHA	The workshop reviewed the ART Programme, Early Warning Indicators, understanding of data entry fields, running reports, etc.
Onsite Treatment Database training -	Onsite training was provided in: data entry, understanding data entry fields, search the database and generating reports
Annual STI conference for Contact Investigators – M&E & CHART	The conference focused on the presentation of STI data for 2011, updates on the HIV response, the elimination initiative, findings of the STI prevalence study, and TB/HIV co-infection.
STI Data Quality & Management	PANCAP consultants facilitated the Data Quality and Management Workshop with HIV, STI and surveillance staff of the various regional health authorities of Ministry of Health. The workshop combined plenary presentations and practical working-group sessions that aided the standardisation of STI surveillance forms in the public health system. The focus of the workshop included reminding the surveillance staff (contact investigators, nurses, STI physician HIV/STI physician, epidemiologists, surveillance officers, M&E officers, medical officers of health, laboratory personnel) of the responsibilities and the needs of national surveillance of STIs in terms of data quality. Following from June 2012 workshop, comments on STI forms have been incorporated and amendments made. The draft final STI Forms have been forwarded to MoH Surveillance Unit for their review and finalisation.
Monitoring, Evaluation and Introduction to Research Techniques	The M&E Unit of the National HIV/STI Programme in the Ministry of Health conducted a two day workshop. The workshop was a direct outcome of the Caribbean Health Research Council training in Advanced Monitoring and Evaluation Workshop that was attended by two M&E Staff, Ms Zahra Miller and Ms Suzanne Robinson Davis. The workshop was organized and facilitated in-part by the M&E Unit with direct assistance from M&E practitioners who also attended the CHRC training. They are Ms Terry-Ann Lewis Pearcy, Ms Uki Atkinson and Dr Oneil Watson. The purpose of the M&E training workshop series was to support and encourage data utilization and research within the regional teams and the wider HIV response by building the capacity of key staff while supporting organization-specific programmes that will be developed within as well as outside of the training workshops. This workshop was the first in the three-part series of workshops intended to be rolled out in 2013.

	Summary
Leadership in Data Dissemination & Use	The M&E Unit collaborated with MEASURE Evaluation to faciltate a workshop on Leadership in Data Dissemination & Use at Hilton, Rose Hall, Montego Bay February 6-8. The workshop aimed to: Define the role of leadership in promoting sustainable data use Raise awareness of the importance of data in decision making Apply leadership practices in building individual and team capacity to apply data demand and use concepts, approaches, and tools; and promote and sustain them through strong leadership. Develop and implement specific plans to use data in decision making and overcome barriers to data use. Strengthen demand for and use of data at national and sub-national levels. Participants included key persons responsible for data use in RHAs and civil society. Overall the workshop was successful as 32 of 37 participants stated that their expectations were met, two said their expectations were partially met while three did not respond to the question.

In addition to the workshops listed above, the M&E staff participated in a several workshops and made a series of presentations. The follow activities capture the involvement of the staff.

- Member of the CHRC Mission to Belize and Suriname to evaluate the National AIDS Programme NSP.
- Presented at the ARV management workshops held for the 4 health regions. Presentations included _ "The Jamaica HIVDR surveillance Strategy" and "Mental health and HIV".
- Caribbean Health Research Council training in Advanced Monitoring and Evaluation Workshop.
- Presented the EpiProfile at national C-Change Dissemination meeting.

MAJOR ACHIEVEMENTS

The M&E team worked hard in spite of the various challenges to produce timely reports and to provide technical assistance to the wider NHP. The following highlights the major achievements of the Unit during 2011:

- 2012 Global AIDS Response Progress Report was completed on behalf of Jamaica. This report comprised the National Commitments and Policy Index.
- 2011 ANC/STI Sentinel Surveillance Report was completed
- The report for the 2012 Mode of Transmission (MOT) Study was completed and disseminated. And M&E supported the Evaluation of STI Surveillance in Jamaica
- The 2011 Epi Update was completed and placed on the NHP website
- The HIV case based reporting form was revised
- GF PUDR for period 9 & 10 were completed
- National AIDS Spending Assessment for Jamaica for the fiscal years 2009/10- 2010/11.
- Completed the 2012 Knowledge, Attitude, Behaviour and Practices survey

MAJOR CHALLENGES

As the M&E Unit celebrates its achievements, it is important that the challenges are highlighted to engender discussions and action for the upcoming period. The challenges are discussed below.

1. Despite significant improvement of monitoring systems, little data exists on effectiveness of interventions and stakeholders have limited capacity to conduct impact evaluation. Consequently, many interventions continue to be implemented based on anecdotal evidence and without outcome monitoring or evaluation. While the capacity to conduct or monitor impact studies have increased, staff turnover and limited resources are barriers to implementing rigorous evaluations.
2. An M&E priority is to strengthen the electronic information systems. Numerous databases have been designed with varying stages of implementation including a rapid test database in keeping with the scaled-up testing programme, a treatment database, revised HATS and an M&E database. Full implementation of databases has been hampered by stakeholder commitment to use newer systems which require more time initially, lack of IT support at the field level which results in inconsistency in electronic systems (crashed computers, lack of antiviral software etc.) and inadequate human resources to perform required data entry functions. At the national level, the inconsistency of internet and intranet services also affected functioning of the unit, in particular the maintenance of the HATS database.
3. HIV surveillance continued to be hampered by under-reporting in public and private sectors. Widespread sensitization of health care workers on HIV surveillance is necessary to improve reporting. Changes in the surveillance system have also been identified to improve data capture such as web-based systems and cross matching cases in different databases such as CD4 testing, laboratory databases and HATS. The significant number of late and missing reports for the period limits the Unit's ability to definitively say if it has made adequate progress towards meeting targets. The unit continues to urge key stakeholders (SRs, RHAs) be vigilant in the quality of the reports that are fed through the system.

M&E STAFF

The M&E Unit experienced a number of staff changes during 2012. The team welcomed a new member - HIV/STI Information Officer. We hope that his time with the Unit will be fulfilling and an enriching one. The contract for one of the data entry clerks, Ms Tricia Manning, ended during this period. The Director, M&E, also resigned from her post in December 2012.

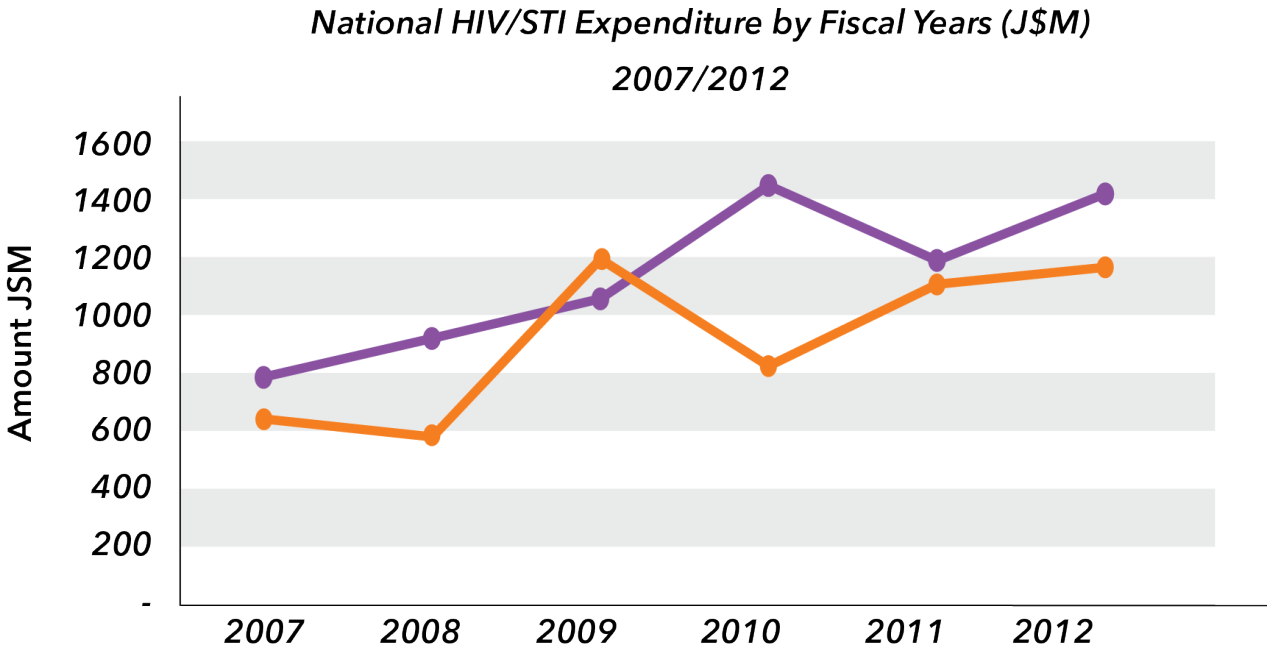
CHAPTER 6: FINANCE & ADMINISTRATION

INTRODUCTION

The Jamaica National HIV/STI Programme is financed from a variety of sources: loans, grants, funds and Government of Jamaica cash and in-kind contributions. Donor funds account for the largest share of Programme's funding resources; these include support from the Global Fund to fight AIDS, Tuberculosis and Malaria (GF), the World Bank (WB) and The United States Agency for International Development (USAID).

The National Programme's budget steadily increased from 2007 to 2010. The value of the 2011 budget fell by 17.3% of the 2010 budget. The budget allocation rebounded in 2012, close to 2010 budget values. The year 2009, was the only year between 2007 and 2012 that expenditure exceeded budget allocations as Figure 12 shows.

Figure 25: Summary of National HIV/STI Programme Budget and Expenditure, 2007-2012



FINANCIAL PERFORMANCE [7] , JANUARY - DECEMBER 2012

Of the J$1.42b budgeted during the year for the Programme, approximately 82% (J$1.17b) was spent. Spending at the Principal Recipient (PR) level, totalled J$913.55M and spending at the Sub-recipient (SR) level was J$258.68M. Therefore for every dollar spent by the PR, 30 cents was spent by the Programme's SRs.

The Programme's 2012 budget was allocated to the following priority areas:

i. Prevention
ii. Treatment, Care and Support
iii. Policy (or Enabling Environment)
iv. Monitoring and Evaluation
v. Administration and Capacity Building
vi. Health Sector

PROGRAMME COMPONENTS

TREATMENT, CARE AND SUPPORT (TCS)

One of the mandates of the National Programme is to ensure that those who are affected are linked to care and receive treatment. The funding for TCS component supported the

[7] *Analysis is done using calendar year figures in keeping with the requirements of the Annual Report, thus January 2012 - December 2012. The cash basis of accounting is also applied in the Programme.*

procurement of antiretroviral drugs, infant formulas, viral load, CD4 and PCR reagents and test kits that were used island-wide. The component was allocated 40.1% of the Programme's 2012 budget.

In 2012, the cumulative expenditure for the component was J$470.07M, 79% of the J$593.90M budgeted for the period. The unspent portion was due the lengthy procurement of ARVs that resulted in the delivery and payment being made in the 2013 reporting period, though the Programme had procured them in 2012.

Table 23: Summary Budget and Actual Spending by Component, 2010-2012

Components	Calendar year 2010		Calendar year 2011		Calendar year 2012	
	Budget J$M	Actual J$M	Budget J$M	Actual J$M	Budget J$M	Actual J$M
Cash Basics						
Prevention	334.96	381.75	280.81	290.59	405.76	366.85
Treatment Care & Support	686.14	175.75	455.78	455.78	593.90	470.07
Monitoring & Evaluation	53.78	46.86	51.04	35.21	45.56	25.33
Enabling Environment/ Policy	68.92	55.21	45.06	39.42	33.70	65.08
Capacity Building & Admin	234.15	175.07	278.78	255.07	278.80	180.32
Health Sector	15.70	6.52	28.68	38.83	66.15	64.57
HADDS	55.56	-	57.62	0.05		
Sub total	1,449.21	841.16	1,197	1,114.95	1,422.89	1,172.22
In-kind Contribution		14.95	-	14.47	-	16.23
Grand Total	1,449.21	856.11	1,197.45		1,422.89	1,188.45

PREVENTION

The expenditure under the Prevention component is as a result of work done to identify, develop and implement strategies to reach the most at risk population, implement mass media initiatives and procure rapid test kits and condoms.

The 2012 budget for the Prevention component was J$405.76M, 44.5% more than the 2011 budget allocation. In 2012, 90% of the budgeted amount, J$366.85M, was spent.

The majority of the activities funded under this component were implemented at the field-level and therefore Programme partners are sub-recipients (SRs) of Prevention budget funds. The SRs work plans are closely monitored so as to increase the likelihood of the allocated funds being used fully and efficiently.

MONITORING AND EVALUATION (M&E)

In 2012, the M&E Component was allotted J$45.56M budget to advance its initiatives. Of the amount that was allocated, 55.6 % (J$25.33M) was spent.

Two of the priorities that were outlined in the 2007-2012 Monitoring & Evaluation (M&E) Plan were to strengthen the M&E capacity at the regional level and to give support the National HIV M&E Team that had been mobilized to provide M&E support at the national level.

The M&E component delivered several research products; these include: The Knowledge Attitude Practice and Behaviour (KAPB) 2012 Survey, the Second Generation Sex Workers and Men Having Sex with Men studies, the National AIDS Spending Assessment (NASA) Study and the Modes of Transmission Study.

ENABLING ENVIRONMENT (EE)

In 2012, several initiatives were undertaken over the period to advance the Programme's work in fostering an enabling environment for PLHIVs. The National HIV Related Discrimination Reporting and Redress System (NHDRRS) for example, became operational in 2012. In addition, there was an increase in the number of private companies signing on to implement the HIV Workplace Policy.

The 2012, total expenditure, J$65.08, surpassed the budgeted amount, J$31.38M by 51.7 %. The gaps in expenditure were facilitated from savings that were realized from other components.

HEALTH SECTOR (HS)

The budget for the Health Sector is directly funded by a World Bank loan. For the reporting period, close to 100% of the budgeted amount was spent–J$64.57M in expenditures when compared to the allocation of was J$65.17M. The upgrading of the South East Medical Waste Management Treatment Facility and the expansion of the Portland Health Department accounted for the majority of the expenditure.

CAPACITY BUILDING AND ADMINISTRATION (CBA)

The funding allocated to the Capacity Building and Administration component supports the work of all the other components. Funds are allocated to areas such as payment of staff salaries, capacity building activities for staff, service cost for the storage and distribution of ARV drugs.

For 2012, the component was allocated J$278.80M and 65% (J$180.32M) was spent.

FUNDING SOURCES

The Global Fund remained the largest funding source for the National Programme in 2012, though the overall funding support was less than the support provided in 2011. The value of the GF support for 2012 was J$692.93M, 48.8% of the overall budget.

For every dollar that was provided by the GF in 2012, the World Bank contributed 53 cents, USAID contributed 25 cents, and the GoJ contributed 13 cents.

Table 24: Summary of Budget Allocation and Expenditure by funding Source, 2012

	Performance			Illustrative Components Funded					
Sources	Allocation ($JMillion)	Expenditure ($J Million)	Burn Rate (%)	PR	TCS	EE	HS	M&E	CBA
Global Fund Grant	692.93	785.08	88	•	•			•	•
World Bank	369.17	274.41	74	•			•		
USAID	172.17	150.12	87	•		•			•
GoJ(cash)	93.32	51.62	55						•
GoJ(kind)	16.23	n/a	n/a						•
UNAIDS	3.15	3.15	100						•

GLOBAL FUND

GF resources were directed to support the procurement of ARVs, reagents, test kits, condoms and lubricants; develop mass media activities; support the activities targeted at the most at risk populations; support surveys and research initiatives that were managed by the through the M&E Department; support salaries and to pay for service cost for the warehousing and distribution of ARVs.

WORLD BANK

The year 2012 was the penultimate year for the programme of work tied to the second World Bank loan. In 2012, the World Bank loan supported the procurement of infant formula, financed staffs cost, supported the Principal Recipient (PR) component activities through the development mass media outreach and supported outreach activities targeting the key populations. Of the J$369.17M budgeted J$274.41M (74%) was spent.

USAID

For the reporting period, USAID funds were allocated to the PR and twelve (12) SRs. The resources were committed to, among other things, finalizing the National HIV Policy, modernizing the National Public Health Lab and supporting capacity building exercises for the Ministry of Health and other stakeholders.

GOVERNMENT OF JAMAICA

The GoJ contributed J$93.32M in cash and J$16.23M in-kind to the budget of the National Programme in 2012. Approximately 55.3% (J$51.62M) of the cash support was spent within the period. Human resource costs accounted for the majority of the spending of the GoJ cash support, at 85%. The in-kind contribution was allocated to the payment of salaries, security cost and office rental and maintenance costs.

UNAIDS

The Programme expended 100% of the J$3.15M grant received from UNAIDS.

CHALLENGES

The challenges that the Programme experienced during the reporting year include:

- Delays in the disbursement of funds from USAID
- Lengthy procurement processes for ARV drugs
- Preparations for integrating the National Programme with the NFPB
- Protracted negotiations with donors
- Delays in the execution of work plans as a result of protracted negotiations with donors

Additionally the National Programme was faced with the challenge of sustaining its funding given that the support from the largest funder, the GF, will end in less than two years. In response to the likely impact that this lack of funding will have on the national response, the Programme prepared a comprehensive Sustainability Framework and Implementation Plan, with the support from UNAIDS to identify options for addressing the financial and capacity gaps.

In addition to supporting the development of the Sustainability Framework and Implementation Plan, UNAIDS supported a study commissioned by the GoJ to investigate innovative financing for sustainability of the Programme. More specifically, this study sought to identify the specific financial needs for the Programme over the next five years.

NATIONAL HIV · STI · TB PROGRAMME

ANNUALREPORT

2013

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CSO	Civil Society Organization
EEHR	Enabling Environment and Human Rights
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GoJ	Government of Jamaica
HIV	Human Immuno-deficiency Syndrome
JN+	Jamaican Network of Seropositives
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NERHA	North Easton Regional Health Authority
NFPB	National Family Planning Board
NHP	National HIV/STI/TB Programme
NPHL	National Public Health Laboratory
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PHDP	Positive Health Dignity and Prevention
PLHIV	Persons Living with HIV
PR	Principal recipient
SERHA	South Eastern Regional Health Authority
SRHA	Southern Regional Health Authority
SR	Sub-recipient
TCS	Treatment Care and Support
TPDCo	Tourism Development Company
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WRHA	Western Regional Health Authority

INTRODUCTION

The success of the HIV response in Jamaica for the last 27 years is a result of a multi-sector partnership between government agencies; nongovernment organisations (NGOs), communities based organizations (CBOs), academic institutions, people living with HIV, international development partners and health professionals. This year again demonstrates the effectiveness of this partnership approach which also strengthened as compared to previous years.

The Government of Jamaica began its national response to HIV and AIDS in 1986 with the start-up of a comprehensive National HIV/STI Programme (NHP). The HIV response in 2013 is guided by the National Strategic Plan on HIV and AIDs 2012 – 2017 developed around six priority areas: Prevention, Treatment, Care and Support, Enabling Environment and Human Rights, Empowerment and Governance, Monitoring & Evaluation, and Sustainability.

The following outlines the vision of the national response: "To protect the rights of all Jamaicans including those infected with and affected by HIV and AIDS and to create an enabling environment free of stigma and discrimination while providing access to prevention knowledge and skills; treatment care and support; and other services".

The above statement guides the national response, the National HIV/AIDS Policy and the National Strategic Plan.

The goal of the NSP 2012 – 2017 is "to reduce the transmission of new HIV infections while mitigating the impact of HIV/AIDS on the people of Jamaica within a sustained, effective multi-sectoral infrastructure and soliciting the necessary commitment to support the national response to HIV and AIDS."

The overarching strategic outcomes of the National Strategic Plan are:

- Increased coverage of effective prevention interventions and additional interventions developed;
- Increased coverage of effective interventions for comprehensive care and support and additional interventions developed;
- Increased coverage of effective interventions for impact mitigation and additional interventions developed;
- Effective leadership by government and non-government sectors for implementation of the response to HIV/AIDS, at central and local levels;
- A supportive legal and public policy environment for the HIV/AIDS response;
- Increased availability of information for policy makers and programme planners through monitoring, evaluation and research
- Increased, sustainable and equitably allocated resources for the national response

Throughout 2013, the NHP continued its commitment to improving the quality of life of those living with and affected by HIV. There were many highlights.

There continues to be a downward trajectory in the number of persons diagnosed with advanced HIV with a decline of 59% in 2013 over 2012. AIDS mortality rate continues to trend down with just over 6 deaths/100,000 population in 2013 - a 76% decrease since the inception of universal access to ARVs in 2004. This reduction is attributed to the introduction of public access to antiretroviral treatment in 2004, scaling up of the national VCT programme and the use of rapid test kits allowing for earlier diagnosis, availability of prophylaxis against opportunistic infections and improved laboratory capacity to conduct CD4 counts, viral load and PCR tests.

With so much progress in stemming the tide of the HIV transmission and AIDS related death, there still exists some major gaps which will require increasing investments and commitment to ensure that the response is sustained and also has a high impact. Most significantly, although the country has been highly successful in increasing access to treatment and care services, data indicates serious challenges in retention in care with increasing loss-to-follow-up among patients on HAART.

NEW IN THIS REPORT

HIV CARE CONTINUUM

Due to high levels of loss to follow up among PLHIV on HAART, the NHP moved in 2013 to track the country's efforts to improve the care continuum for persons living with HIV to sustain their health from diagnosis to linkage and retention in care. The goals of the HIV care continuum are for all persons with HIV to be diagnosed, connected to treatment and care and achieve viral load suppression. Viral suppression ensures a strong immune system and healthier outcomes for persons living with HIV. In 2013, the following was the situation:

- 75% of estimated persons living with HIV diagnosed and reported
- 25% have never been seen at a treatment site (linked to care)
- 56.5% of PLHIV retained in care
- Just over 50% of PLHIV retained in care are currently on ART
- 42.8% of PLHIV retained in care have achieved viral suppression

EPIDEMIOLOGICAL SUMMARY

Key points in this report in 2013 include:

- 30,313 persons are estimated to be living with HIV or 1.8% of the population. Approximately 28% are unaware of their status.
- Between January 1982 and December 2013, 31,898 cases of HIV were reported to the Ministry of Health.
- Of the 31,898 persons, 9,056 (28.4%) are known to have died
- Some key populations are disproportionately affected by HIV with some having rates above the national average. National surveys indicate that one out of every three men who have sex with men (MSM) is HIV-infected, 4.1% of female sex workers is HIV-infected, 3.3% of inmates are HIV positive and 12% of homeless drug users.
- Sixty-one percent (61%) of reported AIDS cases in 2013 were from the most urbanized parishes (KSA, St. Catherine, and St. James).
- Approximately 75% of all AIDS cases reported 1982 - 2013 are in the 20-49 year old age group and 85% of all AIDS cases reported 1982 - 2013 are between 20 and 59 years old.
- Young females account for the larger share of cases in the 10 – 29 age range
- Surveillance data from STI clinic attendees in 2013 indicated that for every 1,000 persons with a sexually transmitted infection, approximately 24 were infected with HIV.
- There were 10 babies born with HIV in 2013 down from 19 in 2012 and three deaths

reported down from seven in 2012.

SCALING UP SUCCESS

The NHP and key stakeholders continued work at scaling up programmes to reduce the new HIV infections and deaths. The following are some of the key achievements in 2013.

- A total of 248,311 HIV tests were carried including more than 4000 (4113) STI clinic attendees, 1059 MSMs and 2,418 female sex workers
- Surveillance data for 2012 reveal the number of AIDS death declined by 61% since the introduction of Universal Access to ARVs in 2004.
- 18,919 persons living with HIV (PLHIV) were linked to treatment with 38.5% (7267) receiving lifesaving ARVs
- There was a 3.5% increase in pregnant mothers who received ARVs to prevent mother-to-child transmission of HIV
- 98% of HIV-exposed babies received drugs to prevent mother to child transmission of HIV.

CHAPTER 1: EPIDEMIOLOGY OF HIV

SUMMARY

Jamaica has features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.8%; however surveys show higher HIV prevalence in some key populations and at risk groups. 2012 surveys of sex workers and men who have sex with men found that 4.1% of female sex workers and 31.8% of MSM were HIV infected. A 2006 survey of prison inmates indicated that approximately 3.3% of inmates are HIV positive.

As at December 31, 2013, an estimated 30,313 persons were living with HIV and AIDS, with as many as 25% being unaware of that they have the virus.

Surveillance data indicates that in 2013 for every 1000 persons with a sexually transmitted infection (STI) that visited an STI clinic, approximately 24 were infected with HIV. Seventy one per cent of STI clinic attendees tested in the sentinel surveillance were females and 2.07% of these females tested positive for HIV compared to 3.1 % of male STI attendees.

The main drivers of the HIV epidemic continue to be closely tied to poverty and other related development issues, including the slow rate of economic growth, high levels of unemployment, low academic achievement, early sexual debut, multiple partnerships, and transactional and commercial sex.

In 2013, seven hundred and eighty (780) persons with advanced HIV (423 males and 357

females) were reported compared to 1,888 in 2012.HIV remains a leading cause of death among adults 15-49 years, with over 393 reported deaths due to AIDS in 2012.

INCIDENCE AND PREVALENCE OF HIV AND AIDS IN JAMAICA

In 2013, 1278 HIV cases were reported to the National HIV/STI Programme, a 17.6% decline over 2012. Over the same period, there was a steep decline in reported advanced HIV cases, moving from 1,888 persons in 2012 to 780 in 2013.

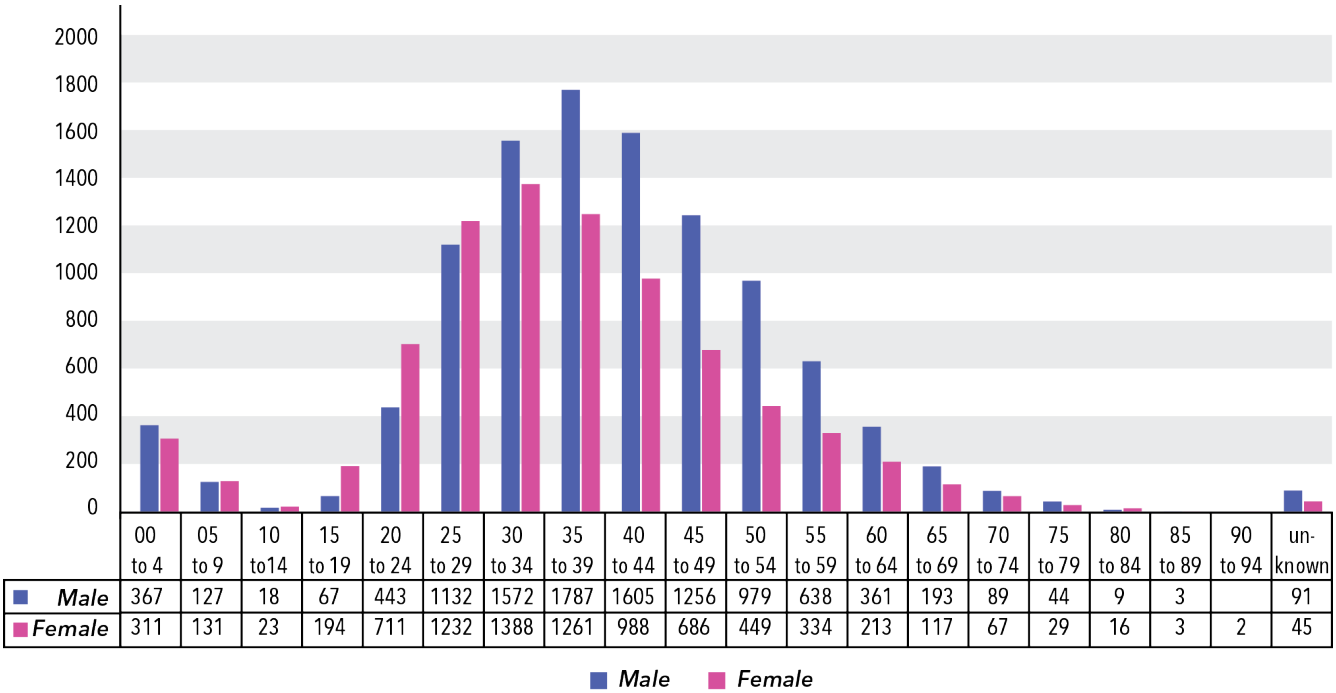
All 14 parishes are affected by the HIV epidemic with HIV cases ranging from a low of 47.21 per 100,000 to a high of 2785.71 per 100,000 population.

The number of females living with AIDS increased in 2013

Although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually. Since 2007, there has been a 40% increase in the number of reported cases among women, moving from 339 to 563 in 2012.

The cumulative male: female ratio for persons reported with AIDS in 2013 is 1.31:1 and the ratio of men: women in 2013 is 1.28:1. The cumulative AIDS case rates are also higher among males (27.8 cases per 100,000) compared to females (21.6 cases per 100,000 females). There continues to be a significant variation in the gender distribution of reported AIDS cases which indicates the need for targeting among certain females. Young females aged 10 – 29 years old account for the larger share of cases. In the age group 15 to 19 years old, four times more young women have been reported with AIDS than young men.

Figure 1: Cumulative AIDS Cases Reported by Age Group and Sex



	00 to 4	05 to 9	10 to14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 to 94	un-known
Male	367	127	18	67	443	1132	1572	1787	1605	1256	979	638	361	193	89	44	9	3		91
Female	311	131	23	194	711	1232	1388	1261	988	686	449	334	213	117	67	29	16	3	2	45

Similarly, young women aged 20 – 24 years old are one and a half times more likely to be infected than males in the same age group. However, adult males account for a larger proportion of the cases reported in the 30 to 79 age group.

In 2013, for every one thousand pregnant women attending public antenatal clinics, at least 9 were HIV infected. Between 1989 and 1996 the HIV prevalence among antenatal women increased from 0.14% to 1.96%. The prevalence has declined over the last 15 years, with the 2012 and 2013 rates remaining at 1% and below. This overall decline likely reflects the success of Behaviour Change strategies among the general population.

DISTRIBUTION OF HIV AND AIDS IN JAMAICA BY PARISH, AGE

The majority of people living with HIV and AIDS are from three parishes

The parishes of Kingston & St. Andrew, St. James, and St. Catherine which is home to 50% of the Jamaican population, account for 61% of all reported HIV cases since 1982. This proportion shows a slight decline from 2012 (63 %).

The two most urbanized parishes have the highest cumulative number of reported HIV cases: Kingston & St. Andrew (KSA) - 998.9 cases per 100,000 persons, and St. James – 1,435.2 HIV cases per 100,000 persons. These parishes - KSA and St. James have cumulative case rates that exceed the national case rate (670.5 cases/100,000 population).

In addition to the urbanized parishes, parishes with significant Tourism based economies have the next highest level of cumulative number of reported HIV cases since the start of the epidemic 711.0 cases per 100,000 persons in Westmoreland, 660.6 cases per 100,000 persons in Trelawny, 656.4 cases per 100,000 persons in St. Ann, and 623.3 cases per 100,000 persons in Hanover.

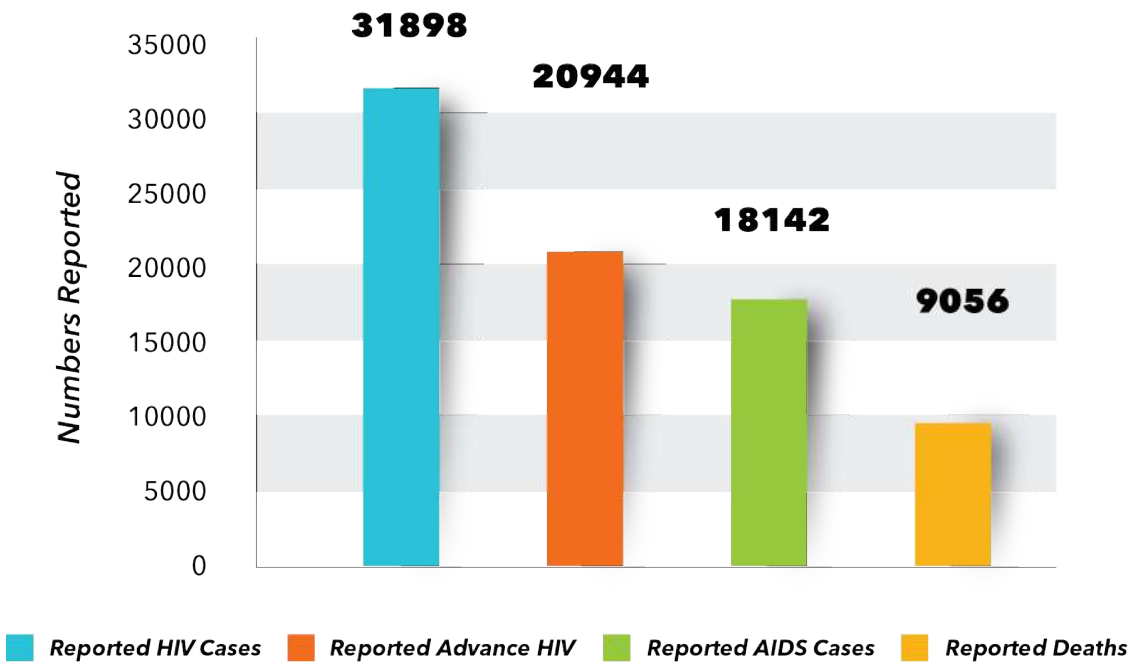
AGE

Approximately 75% of all AIDS cases reported 1982 - 2012 are in the 20-49 year old age group and 85% of all AIDS cases reported 1982 - 2012 are between 20 and 59 years old. There has been a steep incline in the number of AIDS cases from 10 – 24 years old for decades. The number of AIDS cases reported among 20-24 year olds (1,109) cases is 4 times the number of cases reported among 15-19 year olds (250 cases).

AIDS MORTALITY

The majority of people diagnosed with HIV in the 30 years since the first person was diagnosed in Jamaica are still alive. Between 1982 and 2013, 31,898 persons were diagnosed with HIV and AIDS, of whom 21,862 people (71.6%) are still living. The total number of reported AIDS deaths in Jamaica between January 1982 and December 2013 was 9,056 (28.4%).

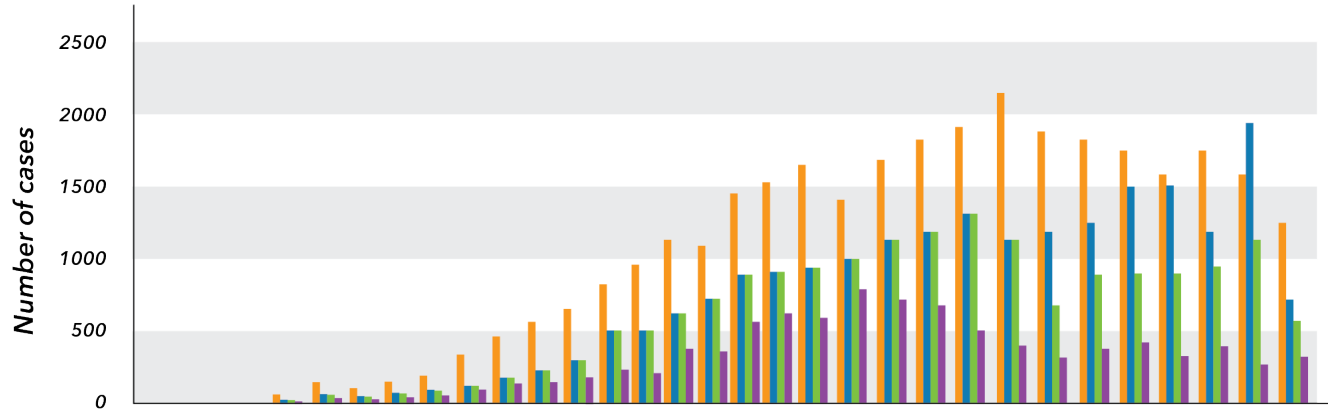
Figure 2: Total Number of HIV, AIDS and Deaths Reported, 1982 – 2013



Source: National HIV/STI Programme HIV/AIDS Epidemic Update - January to December 2013

Since 1982, AIDS-related deaths rapidly increased on a yearly basis peaking at 692 in 2002. With the introduction of public access to anti-retrovirals (ARVs), AIDS deaths have been declining steadily. In 2013, there were 298 deaths up from 260 reported in 2012. Since 2004, there has been reductions in the number of deaths to below 50% of AIDS cases.

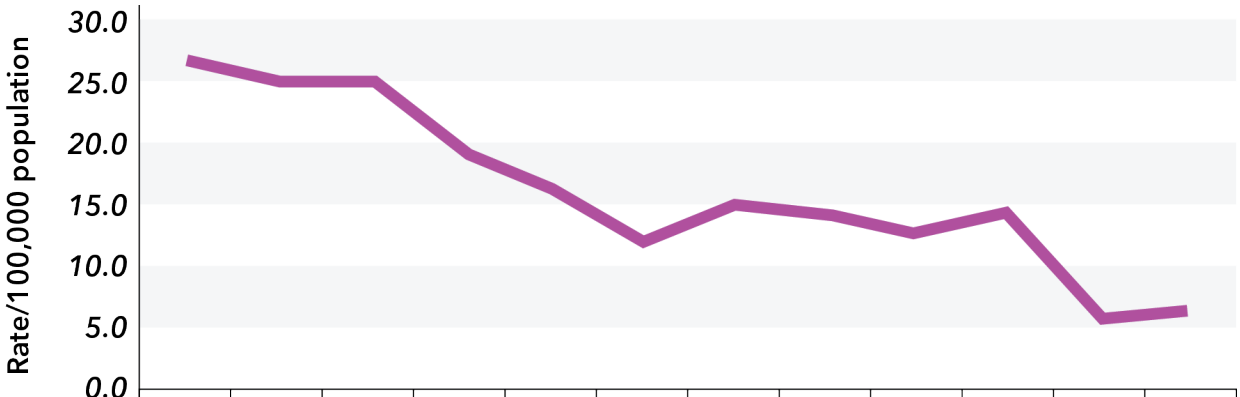
Figure 3: Reported cases of HIV, AIDS and deaths annually in Jamaica, 1982 -2013



	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13
HIV	1	1	0	9	41	100	77	137	185	332	480	530	597	535	971	1122	1064	1436	1530	1667	1433	1685	1863	1957	2121	1947	1868	1738	1562	1797	1551	1278
Adv. HIV	1	1	0	3	8	34	36	65	70	361	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	1098	1197	1489	1503	1250	1888	780
AIDS	1	1	0	3	8	34	36	65	70	361	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	781	925	909	935	975	1196	682
AIDS Death	0	1	1	0	9	18	21	40	37	105	106	146	200	269	243	393	375	549	617	588	692	650	665	514	432	320	401	378	333	393	260	298

HIV Adv. HIV AIDS AIDS Death

Figure 4: AIDS Mortality Rate/100,000 Population, Jamaica 2002 – 2013



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Rate/100,000 pop.	26.5	24.8	25.2	19.4	16.3	12.0	15.0	14.1	12.4	14.6	5.8	6.2

MODES OF TRANSMISSION

Heterosexual transmission remains the highest self-reported risk for acquiring HIV infection in Jamaica, HIV is primarily transmitted through sexual intercourse. Among all reported adult HIV cases on whom data about sexual practices are available (77% of cases), heterosexual practice is reported by 95% of persons.

In 2013, the sexual practice of 44% of men reported with HIV (and 41% of men reported with AIDS) was unknown. This is due to inadequate investigation and reporting of cases as well as unwillingness among men who engage in sex with other men to disclose their sexual practices. Of the total number of men reported with HIV, 4% (647) were identified as bisexual and 3.6% (592) identified as homosexual.

FACTORS FUELLING THE HIV EPIDEMIC

The main risk factors for contracting HIV in Jamaica are history of STIs (35.6%), sex with sex workers (13.4%), multiple sex partners (11.5%) and crack/cocaine use (4.08%). Between 1982 and 2013, 180 (0.57%) persons reported IV drug use as a vehicle for HIV transmission. Of the 180 cases of IV Drug use reported since 1982, the NHP indicates that 73 (43%) of these were reported during the period 2008 - 2013. The unit posits that this significant increase in IDU reflects increased coverage among homeless drug users or is an indication of an important shift in the modes of transmission of HIV in Jamaica.

'No high risk behaviour' was reported for 19.6% of HIV cases reported. The NHP indicates that this may represent persons who have one sex partner who was HIV infected by another partner.

Table 1: Reported risk behaviours among adults with HIV (1982 – Dec 2013 cumulative)

Risk	No. of Persons (%)
Sex with Sex workers	4,279 (13.4%)
Crack, Cocaine Use	1,301 (4.08%)
STI History	10,183 (35.6%)
IV Drug Use	180 (0.57%)
Multiple Sexual Partners/Contacts	3,665 (11.5%)
No high risk behavior	5,2321 (19.6%)

Source: HIV Epidemiology Profile 2013

Surveillance of STI clinic attendees in 2013, indicate that for every one thousand persons with a sexually transmitted infection, approximately 24 were infected with HIV. A significant trend is that 71% of STI clinic attendees tested in the sentinel surveillance were females. This reflects the gender distribution seen in over 10,000-recorded STI clinic visits and is an indication of the less than satisfactory health seeking behaviours of Jamaican men. A total of 2.07% of females tested positive for HIV compared to 3.1% of male STI attendees. The positive test among males shows an important improvement over 2012 where 4% were tested positive. The data however still shows that almost twice as many males as females are testing positive despite the disproportionately high number of females attending the clinics compared to males.

Table 2: HIV status of STI clinic attendees by parish 2013*, Jamaica

Parish	Total Tested	Total Positive	% Positive	(95% CI) exact
Kingston & St. Andrew	1,425	43	3.02	2.18 - 3.92
Manchester	396	4	1.01	0.39 - 2.54
St. Ann	356	5	1.40	0.59 - 3.20
St. Catherine	1,069	28	2.62	1.77 - 3.66
St. James	396	6	1.52	0.69 - 3.22
Westmoreland	317	8	2.52	1.25 - 4.78
TOTAL	3,959	94	2.37	1.9 - 2.83

Source: HIV Epidemiology Profile 2013

PERINATAL HIV CASES

Since the introduction of recommendations to provide anti-retrovirals to women during pregnancy, during labour and delivery, and to the infant in the neonatal period, there has been a significant reduction in mother-to-child transmission of HIV nationally. In 2013, for every one thousand pregnant women attending public antenatal clinics, at least 9 were HIV infected.

Table 3: HIV Seroprevalence Rate Among ANC Attenders By Parish 2013

Parish	Total Tested	Total Positive	% Positive	(95% CI) exact
Kingston & St. Andrew	1,594	16	1.0	0.61 - 1.61
Manchester	1,077	6	0.6	0.25 - 1.20
St. Ann	997	4	0.4	0.16 - 1.02
St. Catherine	328	4	1.2	0.47 - 3.06
St. James	750	15	2.0	1.19 - 3.21
Westmoreland	1,089	10	0.9	0.49
TOTAL	5,835	55	0.94	0.72 - 1.21

Source: Sentinel Surveilance, 2013

Transmission rates among those who receive recommended treatment during pregnancy, at labour and delivery, and new-born period is estimated at 2.5% in 2013, compared to 25% in 2002 (prior to the introduction of antiretroviral medication for prevention of mother-to-child transmission (pMTCT)).

There were 10 perinatal HIV cases diagnosed in 2013 compared to 78 in 2005. Utilising an opt-out HIV testing protocol for pregnant women in both public and private health sectors, national surveys show that 91% women who were pregnant 2010 to 2011 were tested and received counselling (KABP, 2012).

The significant decline in perinatal transmission reflects the success of the pMTCT programme in reaching HIV-infected women. Jamaica is on track to meeting the regional elimination goal of ≤2% by 2015. The country currently has in place the required policies, guidelines, and an integrated service delivery system to ensure access to the necessary range of services, including sexual and reproductive health care, antenatal care (ANC), as well as HIV and syphilis testing, treatment, and care.

The implementation of the pMTCT programme in 2004 included routine opt-out testing of antenatal clinic attendees, provision of antiretroviral (ARV) and access to alternate infant feeding for HIV-infected women. More than 95% of pregnant women have been tested through this protocol and ARV treatment or prophylaxis provided for 92% of HIV infected mothers in the public sector in 2013. More than 98% of infants born to HIV infected women in public health sector received ARV for pMTCT.

Table 4: Progress Towards Elimination of Mother to Child Transmission of HIV in Jamaica (2006 - 2013)

	2006	2007	2008	2009	2010	2011	2012	2013
No. of ANC attendees tested	28,446 (95%)	22,478 (95%)	29,119 (>95%)	30,076 (>95%)	26,697 (>95%)	27,985 (>95%)	33,378 (>95%)	35,479* (107%)
No. of HIV positive women delivered	442	358	623	440	432	417	445	446
% of women getting ARVs	84%	84%	83.1%	84%	86.3%	85%	88%	92%
No. of HIV exposed infants	433	362	620	439	419	413	432	443
No. of infants getting PMTCT	403 (93%)	350 (97%)	608 (98%)	430 (98%)	408 (97%)	413 (100%)	422 (98%)	436 (98%)
# HIV Positive infants	40	17	25	12	19	10	10	10
(MTCT) Transmission rate	<10%	<5%	<5%	2.76%	4.6%	2.4%	2.4%	2.5%

** Some women are tested more than once during their pregnancy*

In 2013, three paediatric AIDS deaths were reported. This figure, when compared to 34 in 2004 represents a 91% decrease in the number of paediatric AIDS deaths over this period.

CHAPTER 2: PREVENTION INTRODUCTION

The prevention of HIV and AIDS is one of the National HIV/STI Programme's priority areas and the Behaviour Change and Communication component is one aspect of the Prevention portfolio. The main objective of the BCC component is to reduce the transmission of new HIV infections through universal access to prevention and support services, focusing primarily on the most at-risk populations (MARPs).

In addition to outreach to the general population, the BCCC targets MARPs at three levels: individual, group and community. The interventions strategies include: risk reduction conversation; empowerment/capacity building workshops; psycho-educational sessions; evidence based interventions and voluntary counselling and testing (VCT).

Through their interventions the Prevention component delivered key messages such as:

- Promoting abstinence
- Delaying debut of sexual activity
- Reduction of multiple sex partners
- Mutual monogamy
- Promotion of rapid HIV and syphilis testing

- Promotion of appropriate treatment seeking behavior
- Promotion of consistent and correct condom use and condom negotiation

In 2013, efforts were focused on delivering a range of interventions designed to meet the needs of the most vulnerable sub-populations as well as to the general population. These interventions included HIV testing and outreach and community-based interventions. Efforts were aimed at improving awareness regarding STI/HIV transmission and their prevention; engaging persons in individual (sexual) risk assessment and risk reduction planning, promotion of abstinence, and the promotion of condom use through condom distribution & condom demonstrations and condom negotiation skills building.

This Prevention component's efforts in 2013 were bolstered by partnerships with other entities such as Government Ministries, Departments and Agencies, private financial Institutions and community-based organizations (CBOs). The partnerships were valuable in addressing some of the social, economic, political and cultural challenges that would have impacted implementation and ultimately, the achievement of programme targets.

The current HIV prevalence rate for the general population is 1.7%. The sub-populations that are considered most risk are:

- Men who have Sex with Men (MSM)
- Commercial Sex Workers (CSWs)
- Out of School Youths (OSYs)
- Residents in vulnerable communities
- Prison Inmates
- Wards of the state

It is estimated that the prevalence rate for MSMs is 32% and approximately 5% for CSWs.

PREVENTION PROGRAMMES

MEN WHO HAVE SEX WITH MEN (MSM)

In 2013, 3,297 MSMs were reached across the four regions. Approximately 46% of those reached were new contacts. On average, about 10.9 % of those who were reached received testing services. The number of MSMs reached in 2013 is approximately 16.6 % less than those reached in the previous year (3,844 MSMs).

Table 5: Summary of HIV Testing and Outreach Activities for MSMs, 2013

Regional Health Authority	Number of MSMs reached	Number of MSMs tested	Condoms distributed	Lubes distributed
Western	1878	80	13892	1184
North East	289	9	3036	226
South East	709	139	-	-
Southern	421	129	9592	663
Total	3,297	357	26,520	2,073

The testing rate for 2013 also fell, standing at 10.9% when compared to 14.9% in 2012. The Western and North East regions recorded the lowest testing rates, with 4.3% and 3.1% respectively. This is considerably lower when compared to the South East at 19.6% and the Southern region at 30.6%

Overall, challenges in delivering prevention services to MSMs included non-disclosure of orientation, which is perhaps related to stigma and discrimination; peer-to-peer aggression and violence, reluctance to take the condoms and lubes that are made available to them. Additionally the programme was challenged with reaching MSMs outside of the workshop setting. The MSMs themselves were faced with personal setbacks such homelessness and difficulties meeting basic food needs.

The solutions for strengthening prevention efforts with MSMs at the regional levels include: deploying a regional (South eastern) MSM team to intensify site-based and party interventions; delivering MSM specific messages at sessions conducted at PLACE sites that are frequented by MSMs; conducting follow up sessions with workshop graduates.

COMMERCIAL SEX WORKERS

The Prevention programme conducted regular weekly site-based interventions across the island. The sites covered include night clubs, massage parlours and the street sites where sex workers operate. The table below summarizes the outreach activities conducted in each region.

The number of CSWs reached in 2013 increased by approximately 42% when compared to the 2012 (8,984) figure. The Western region accounted for the highest number of CSWs reached. It reached more than twice that of the South East and more than three times as the number reached in the North East region. The testing rate for CSWs in 2013 was 13.1%, a slight decrease from the 2012 rate of 12.7% and higher than the testing rate for MSMs, 10.9%.

Table 6: Summary of HIV Testing and Outreach Activities for Commercial Sex Workers, 2013

Regional Health Authority	Number of CSWs reached	Number of CSWs tested	Condoms distributed	Lubes distributed
Western	5,669	148	108,552	2,533
North East	1,570	183	47,157	-
South East[1]	2,490	477	58,283	3,132
Southern	3,034	875	62,498	1,112
Total	12,763	1,683	276,490	6,777

1 The figure for Kingston and St. Andrew includes repeat contacts

During 2013, CSWs benefited from empowerment workshops in which they were exposed to condom use and negotiation skills, HIV/STI basic facts, parenting, money management and female sexual and reproductive health.

TARGETED COMMUNITY INTERVENTIONS

In 2013, Prevention teams continued to deliver yearlong prevention intervention services in communities that were identified as being at risk. These communities were largely, low income, had high HIV/STI prevalence and were faced with other social issues such as poverty, high teenage pregnancy, transactional sex and commercial sex work.

Some of the activities included VCT sessions, outreach at community events, house-to-house visits, the establishment of condom distribution outlets and in some instance, in-school interventions at schools were students in the TCI programme are enrolled.

In 2013 targeted community interventions were implemented in the South Eastern and Southern regions. In the Southern region, 16,276 residents from 47 communities were reached, while in the southern region 6240 persons from 9 communities benefitted from the programme.

PREVENTION PROGRAMMES

HOLD ON, HOLD OFF

The Hold On, Hold Off is an in-school intervention (ISI) that is aimed at empowering students to make healthy lifestyle choices by increased knowledge and skills of issues relating to their sexual and reproductive health and personal growth and development. The discussion on topics covered included: abstinence, HIV/STI prevention, risk assessment and self-esteem and career development.

In 2013, 1234 students aged 10 to 19 years from 20 schools benefited from the programme. The schools spanned three regions: Northeast, Southeast and Western. In the Southeast region the programme was impacted by funding, as a result in-school interventions were not conducted in Kingston and St. Andrew and St. Thomas. Instead, the students at Eltham High School in St. Catherine were the lone beneficiaries for the region. The summer camp and the field trip component of the programme for the Eltham High students however, were abandoned due to limited financial resources.

In the parish of Trelawny, in the Western region, the programme was implemented as a peer-to-peer educator training. In 2013, 35 grades 7 – 9 students were trained as peer educators. In St James, 18 teachers from one high school, St. James High School benefited from an STI/HIV workshop that was implemented by the Hold On, Hold Off Programme

MEDIA CAMPAIGN

Dual Method Use (DMU): With the integration of the HIV Prevention unit into the National Family Planning Board, and the establishment of the Board as the National Sexual Authority, a new campaign focusing on Dual Method Use was developed in 2013. The campaign aimed to create awareness on the importance of dual protection for STI/HIV prevention as well as unintended pregnancies. The DMU campaign also seeks to empower adolescents and youth to take responsibility and reduce sexual risk taking behaviour.

CHAPTER 3: TREATMENT, CARE AND SUPPORT

INTRODUCTION

In 2013, the activities of the Treatment, Care and Support (TCS) component of the Programme were directed by the Treatment, Care and Support Unit. The Unit is mandated to:

- Manage procurement and monitoring of HIV testing and ART supplies
- Coordinate the care and psychosocial support services that are available at the various treatment sites across the country
- Build the capacity of staff to deliver treatment care and support to PLHIV.
- The TCS component received the largest share of the Programme's budget in 2013, 32% or J$329.21M. The expenditure for the TCS component during the calendar was J$433.64M; it exceeded the budgeted amount by approximately 31.7%.

The key TCS activities for 2013 were: procurement of ARVs drugs, test kits, reagents and provision of nutritional options for new-borns of HIV infected mothers.

The work of the Unit in 2013 would have been estimated to support some 17251 persons who were linked to care (or 79% of PLHIV). In 2013, the retention rate for clients receiving care was approximately 57% (UNAIDS estimates, HATS and treatment site database).

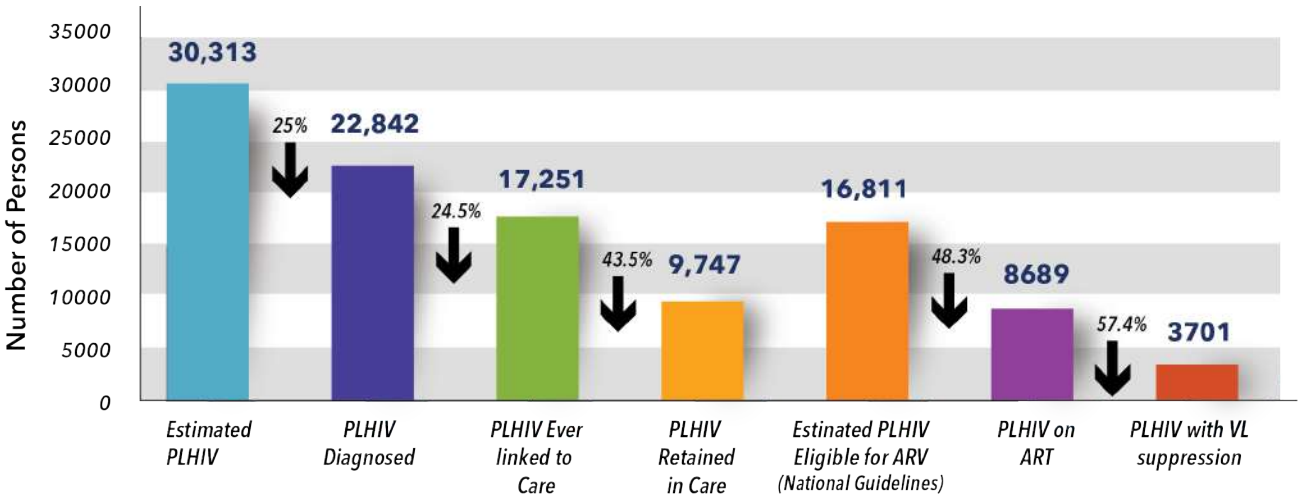
HIV CARE CONTINUUM

With the advances and effectiveness of care and treatment, globally, HIV has transitioned to a chronic condition that can be managed successfully for persons living with HIV to maintain healthy outcomes and live longer. The HIV Care Continuum is a relatively new approach of diagnosing persons with HIV, linking them into care and treatment, retaining them in continuous care and achieving viral load suppression, which is the marker of good health. In addition to the goal for healthy outcomes for persons living with HIV, viral suppression helps decrease new transmissions by vastly decreasing the amount of HIV circulating in the body and reduces the chances of infection. Analysing HIV care is therefore an essential step in understanding the strengths of the HIV response in Jamaica. It also provides the opportunity to identify and resolve gaps in the care continuum.

In 2013, significant input was made to improve the care of persons living with HIV in Jamaica. The NHP in partnership with civil society organisations and international development partners began prioritizing early diagnosis and rapid connection to care and introduced new innovations to support and retain persons in HIV care and treatment. In the HIV care continuum, there are persons who drop out of care. The NHP partnered with civil society reach those persons and re-engage them into care and treatment.

There still persist some significant gaps along the care continuum and there is indication of fall off at each critical point along the continuum.

Figure 5: Jamaica's Treatment Cascade, 2013



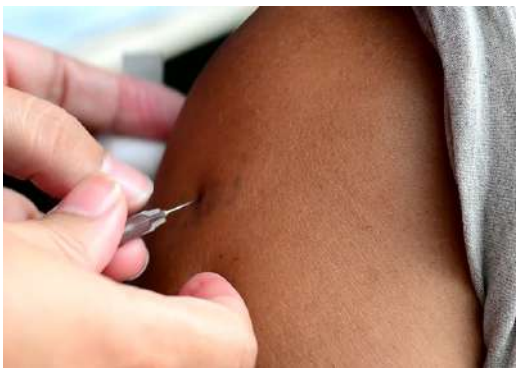
Sources of Data: Spectrum Output 2013, HIV/AIDS Tracking System and the Treatment Site Databases The estimated number of PLHIV and the estimated number of PLHIV eligible for treatment according to national guidelines are determined from the Spectrum model output. All other programme data, except for the number of PLHIV diagnosed (which is taken from HATS), are taken from the treatment site databases

The figure above indicates that in 2013 of the 30,313 persons estimated to be living with HIV infection in Jamaica, 75% have been diagnosed and reported. Some 25% of persons are unaware of their status and therefore testing through outreach will need to improve to reach these individuals.

Of those persons diagnosed, 25% have never been seen at a treatment site (linked to care); and only a little over half of those ever linked to care (56.5%) were seen in the last 12 months. The figure indicates that the numbers of PLHIV retained in care (4th column) and the numbers of PLHIV on ART (6th column) show very little gap which suggests that the persons who are retained in care are primarily the PLHIV who are on ART.

Although it is clear that persons retained in care are to a large extent those who are on HAART, the number of PLHIV estimated to be in need of ART, based on national guidelines (5th column) (CD4<350) exceeds the number of persons who were retained in care. This means that a significant number of persons who are in need of ART but not retained in care have not yet been diagnosed. It also indicates that some persons who initiated HAART have since defaulted from the clinic.

Of those estimated to be in need of ART, just over 50% are currently on ART, of which only 42.8% have achieved viral suppression. These highlight the challenges that are being faced across the continuum of care in Jamaica, but particularly with retention in care and also adherence to treatment once placed on ART.



HIV TESTING AND PITC UPTAKE

UNAIDS Spectrum Estimates show that 30,313 persons in Jamaica are living with HIV; however, only about 72% of them are aware of their status (UNAIDS estimates, HATS and treatment site database). It is also estimated two out of every ten persons (about 21%) who diagnosed, are not linked to care.

Testing was conducted based on the algorithm developed by the NPHL through public and private laboratories as well as outreach activities carried out by VCT trained personnel.

In 2013, 146,816 HIV tests [2] were conducted at the four public regional health authorities. On average 2.14 % of those tested was HIV positive. The positive test rate in the South Eastern region (3.14%) was the highest; it was 47.6% above the national average.

[2] *For the WRHA, tests were conducted up to October 2013. For the other regions the tests were conducted up to November 2013*

Table 9: Summary of HIV Testing done at through the Public Health System, January to November 2013

Regional Health Authority	HIV Tests Done[3]	HIV Positive Test Results[4]	% Positive
1. Western	25,932	299	1.15
2. North Eastern	15,319	132	0.86
3. Southern	30,905	326	1.05
4. South Eastern	74,660	2,346	3.14
Total	146,816	3,103	2.14

Source: MoH Surveillance Data

Table 10: Summary of HIV Testing done at Private Laboratories, 2013[5]

Laboratory	HIV Tests Done	HIV Positive Test Results	% Positive
1. Central Medical	6,004	Data not rec'd	-
2. Bio-Medical	7,441	38	0.51
3. Microlab	6,822	44	0.64
4. Consolidated	831	5	0.60
5. Hargreaves	342	2	0.58
6. Andrews Memorial	423	2	0.47
7. Medical Associates	549	1	0.18
8. Eagles Medical	407[6]	0	-
9. Blood Bank	23,975	44	0.18
10. UHWI	3,144	93	2.96
Total	49,938	229	0.46

Source: MoH Surveillance Data

TREATMENT SERVICES

ART PROVISION

UNAIDS Spectrum estimates indicate that of those in need of ART, just over 50% are on it. Of those numbers who area on ART about 42.8% achieved viral suppression (UNAIDS estimates, HATS and treatment site database). Persons living with HIV have access to 24 treatment sites across the island. Antiretroviral drugs are distributed free of cost through public pharmacies and for a nominal fee through few private pharmacies.

[3] *Tests done are up to November 2013 for all regions except WRHA which is up to October 2013*
[4] *Positive test result is between March to November 2013 for all regions except WRHA which is from March to October 2013*
[5] *January to October*
[6] *August and September 2013 data missing*

In 2013, 10,982 persons were started on ART, representing approximately 50.2 % of persons ever diagnosed with HIV in Jamaica (Source: GARP Report 2014).

By year-end, 84% (or 5,878 patients) received first line drugs and the remaining 16% (or 1,147 patients) received second line drugs as shown in the table 11 below.

Table 11: ART Provision by Treatment Site, 2013

Site	Type of Treatment	
	First line	Second Line
May Pen Health Centre	278	20
Black River Health Centre	110	12
CHARES	590	51
Mandeville Hospital	257	19
National Chest Hospital	87	6
Port Antonio Hospital	140	6
St. Ann's Bay Health Centre	420	26
Port Maria Hospital	201	21
Sav-La-Mar Hospital	302	16
Linstead Hospital	71	5
St. Jago Health Centre	619	813
Cornwall Regional Hospital	535	35
Kingston Public Hospital	389	31
Maxfield Park Health Centre	44	3
Montego Bay Type 5	569	15
Windward Road Health Centre	70	9
Comprehensive Centre	939	40
Mandeville Health Centre	257	19
Total	5,878	1,147

CARE SERVICES

CD4/VIRAL LOAD TESTING/DNA PCR TESTING

Services such as CD4/ Viral Load/DNA-PCR testing are critical components of ensuring that PLHIV, those who are exposed to HIV and their care providers are able to manage their health.

The CD4 and viral load tests in particular, are used as markers to monitor the stage of HIV disease of the PHLIV and the level of immune system impairment; the result are used therefore to determine the efficacy of ART on adult patients. A 2010 WHO guideline recommendation is that a patient should receive two CD4 tests and two viral load tests annually.

In 2013 there were 8287 patients being treated with ART (HATS Database); they who would

have been eligible for twice-yearly testing. For 2013, 10,234[7] CD4 and 6,969[8] viral load tests were processed. Therefore, the test rate for Jamaica fell below the WHO standard with testing rate of 1.23 and 1.16 per patient for CD4 and viral loads respectively.

Table 12: Summary of Types of Treatment Monitoring Testing Conducted 2013

	HIV positive adults		HIV-exposed Infants
Description	CD4	Viral Load	DNA PCR
Received	10,813	10,407	778
Rejected	423	433	45
Processed	10,234	6,969	733
Testing rate per WHO 2010 guideline	1.23	1.16	n/a

The testing rate for viral load tests was similar to the 2012 rate of 1.15. The rate for the CD4, however fell by approximately 20% when compared to the 2012 of 1.47.

For 2013, 778[9] DNA PCR test samples were processed for HIV-exposed infants, to confirm HIV infection.

SUPPORT SERVICES

COUNSELLING

The National Programme provides support for PLHIV through a team of adherence counsellors, social workers and psychologists. The team conducts counselling, psychosocial analysis and mental health assessments. The unit is expected to expand in 2014 with the addition of psychologists, social workers, eight regional officers.

The role of adherence counsellors in monitoring treatment is critical element in the management of HIV and treatment outcomes. The counsellors pill counts and self-reporting questionnaires to determine adherence levels for PLHIV.

In 2013, 16,517 counselling sessions with PLHIV were carried out and 10, 435 received adherence counselling. The list of PLHIV receiving adherence counselling had 569 new PLHIV.

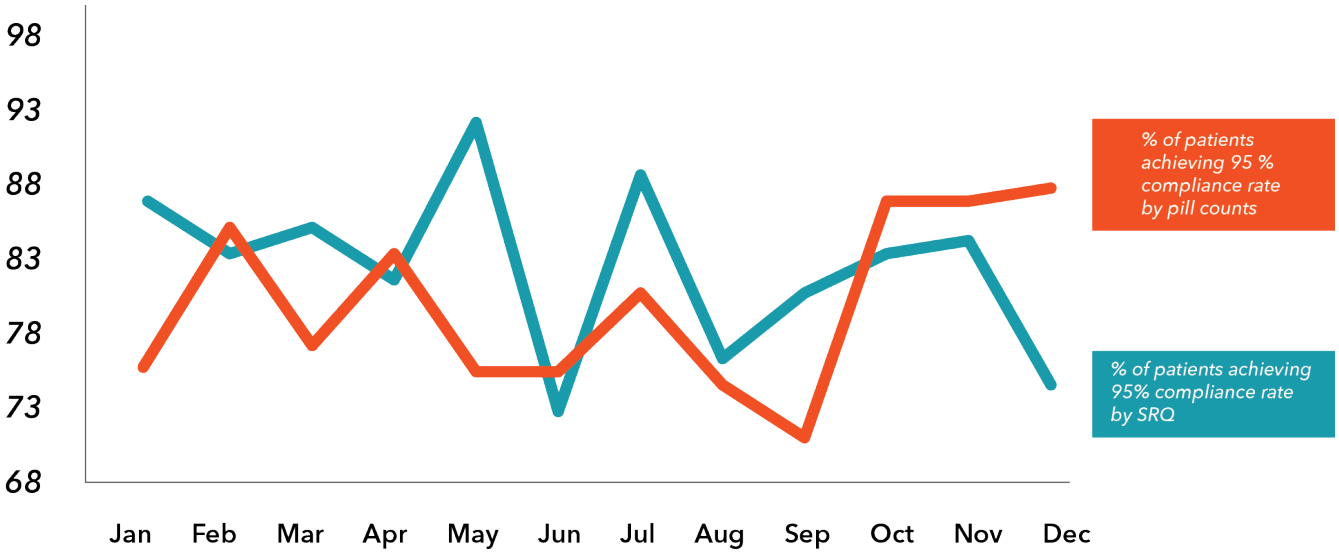
Data show that 82% of PLHIV achieved a 95% compliance rate by SRQs and by Pill Counts.

[7] *3.9 % of samples received for testing were rejected due to poor collection and or poor handling techniques*

[8] *4.2 % of samples received for testing were rejected due to poor collection and or poor handling techniques*

[9] *5.8 % of samples received for testing were rejected due to poor collection and or poor handling techniques*

Chart 1: Percentage of Persons Living with HIV achieving 95% compliance rate by SRQ and by Pill Counts, 2013



PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

The target for the elimination of MTCT of HIV is ≤0.3 per 1000 live births. The incidence of MTCT of HIV for 2013 was 0.25 per 1000 live births; this represents a 25% increase when compared to 2012 (.20 per 1000 live births).

In 2013, 446 HIV positive women (or 1.3% of ANC attendees) delivered babies. Of the number HIV positive mothers, 92% or 410 women received ARVs. A slightly greater proportion of HIV positive mothers (4.5% more) receiving ARV in 2013 than did in 2012.

Table 13: PMTCT Data, 2009 -2013

	2009	2010*	2011	2012	2013
Live Births	42,372	39,804	39,673	39,348	39,500
Antenatal clinic attendees	30,076	26,697	27,985	33378	35479
HIV positive women delivered	440	432	417	445	446
Women getting ARVs	369 (84%)	375 (87%)	354 (85%)	391 (88%)	410 (92%)
HIV exposed infants	439	419	413	432	443
Infants receiving PMTCT interventions	430 (98%)	408 (97%)	413 (100%)	422 (98%)	436 (98%)
HIV positive infants	12	19	10	8	10
HIV positive infants born to mothers who tested HIV negative in pregnancy	1	2	0	2	2
Transmission rate [10]	2.7%	4.6%	2.4%	1.9%	2.3%
Incidence of MTCT of HIV/1000 live births in Population[11]	0.26	0.48	0.28	0.20	0.25

Source: MoH, STATIN, JAPPAIDS

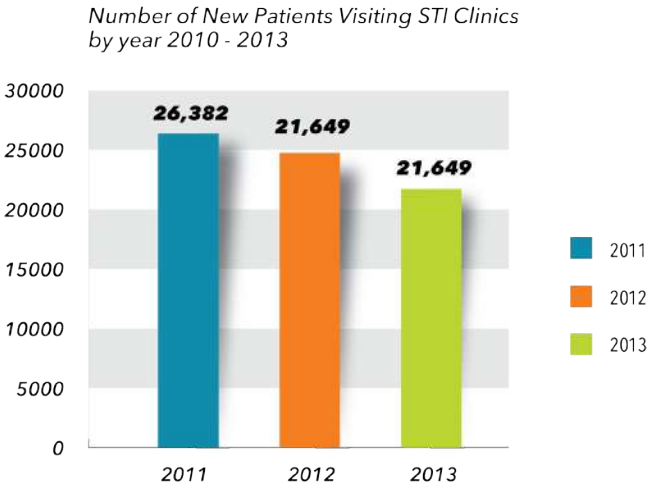
[10] *The target for the transmission rate is ≤ 2%*
[11] *Target for the elimination of MTCT of HIV/100 is ≤0.3 per 1000 live births*

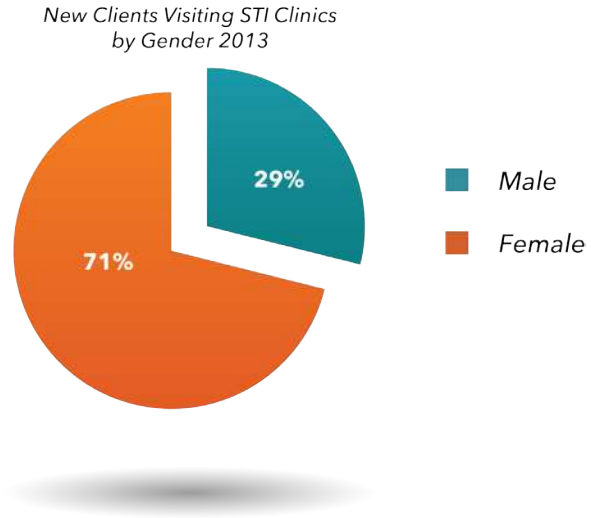
Among the 446 HIV positive women who attended the ANC in 2013, there were 443 HIV exposed infants. Of the 443 infants, 98% (436) received PMTCT interventions. The 2013 coverage rate for HIV exposed infants is consistent with the recent rates; between 2009 and 2012, on average, 98% of HIV exposed infants received PMTCT interventions.

OTHER SEXUALLY TRANSMITTED INFECTIONS

SUMMARY

This section provides an overview of the incidence and trends of sexually transmitted diseases –chlamydia, gonorrhoea, and primary and secondary syphilis in Jamaica. Sexually transmitted infections (STIs) continue to have a major impact on the HIV epidemic as indicated in the positive tests at STI clinics. Data indicates that STI is a major risk factor for HIV transmission in Jamaica and more than a third of those diagnosed with HIV in 2012 also had a history of STIs.





(Left) Figure 6 Illustrates Number of new patients visiting STI clinics by year 2010-2013

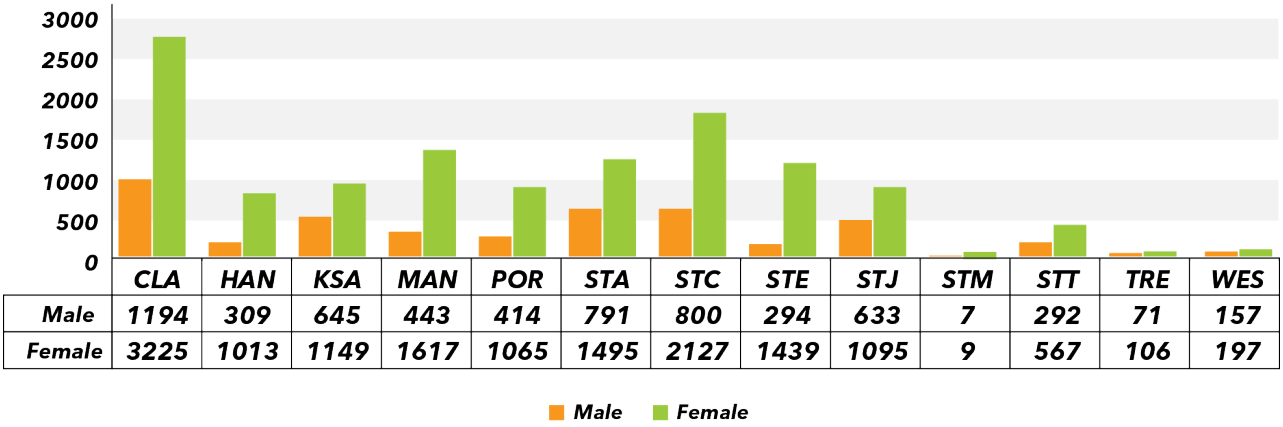
(Right) Figure 7 Illustrates New Clients visiting STI clinics by Gender 2013.

STI SURVEILLANCE FINDINGS

Since 2007, there has been a steady increase in the total number of patients visiting STI clinics every year. This is primarily due to increases in the number of revisits as the number of new cases has decreased from 26,382 in 2012 to 21,649 in 2013 (Figure 6)

Men represented 29% of the total number of new clients attending STI clinics in 2013 and Clarendon reported the highest number of new cases with approximately a 20% (4419) of the new patients that visited STI clinics (Figure 7).

Figure 8: New Patients Count by gender and Parish 2013



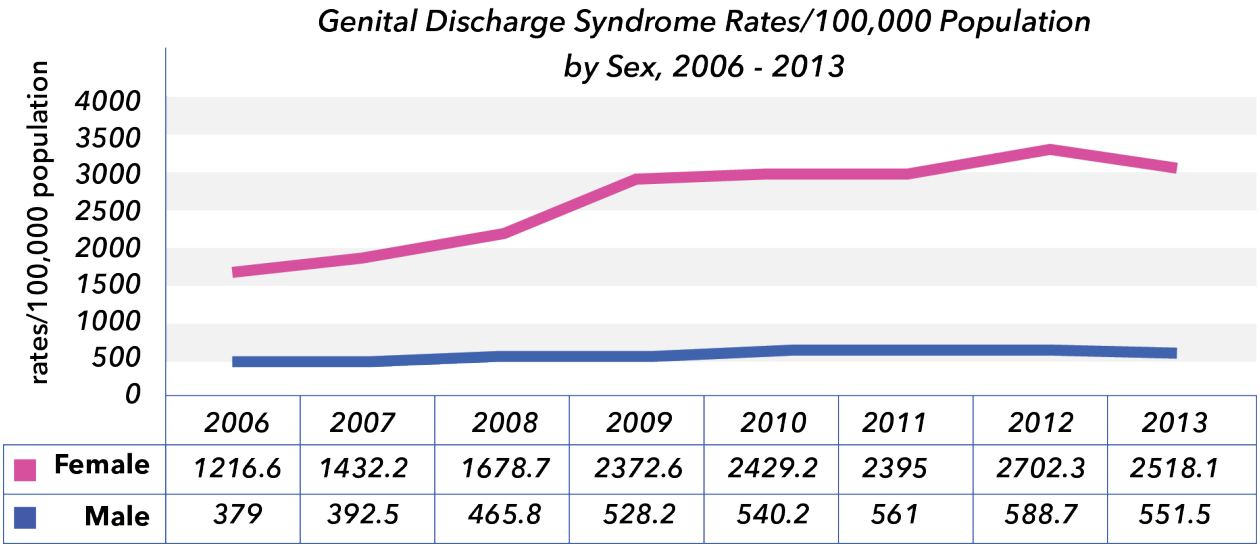
	CLA	HAN	KSA	MAN	POR	STA	STC	STE	STJ	STM	STT	TRE	WES
Male	1194	309	645	443	414	791	800	294	633	7	292	71	157
Female	3225	1013	1149	1617	1065	1495	2127	1439	1095	9	567	106	197

GENITAL DISCHARGE SYNDROME (GDS)

Genital Discharge Syndrome (GDS) includes "urethral discharge in men with or without dysuria (most commonly caused by Neisseria gonorrhoea and Chlamydia trachomatis); or abnormal vaginal discharge (amount, colour, and odour) with or without lower abdominal pain or specific symptoms or specific risk factors. Genital Discharge Syndrome was the most common syndrome diagnosed among STI clinic attendees.

Overall, the rate of reported cases of GDS has trended upwards between 2006 and 2013. Women continue to record the greatest number of cases which account for 3 to 5 times as many cases of GDS when compared to men (Figure 4). This disparity may be due to a combination of factors including greater susceptibility of women to STI, sex differences in health seeking behaviours and detection bias among women with regard to discharge syndromes. Women are more likely to present to a clinic for care and are more likely to accurately report genital discharge symptoms than men.

Figure 9: Genital Discharge syndrome rates per year by gender, 2006 to 2013



	2006	2007	2008	2009	2010	2011	2012	2013
Female	1216.6	1432.2	1678.7	2372.6	2429.2	2395	2702.3	2518.1
Male	379	392.5	465.8	528.2	540.2	561	588.7	551.5

Genital discharge syndromes were more frequently reported in the 20-24 year old age group followed by the 15-19 year old group (Figure5). Candidiasis continued to be the most frequently reported condition among GDS cases in 2013, accounting for 13237 (32%) of all cases. Gonorrhoea and Chlamydia (represented by cervicitis/erosion) accounted for approximately 13% of cases in 2013; while Trichomoniasis cases decreased from 7,539 (21%) in 2012 to 6,922 in 2013, but still represented 21% of all reported cases.

Figure 10: Age Specific Genital Discharge Syndrome (GDS) per 100000 populations 2010-2013

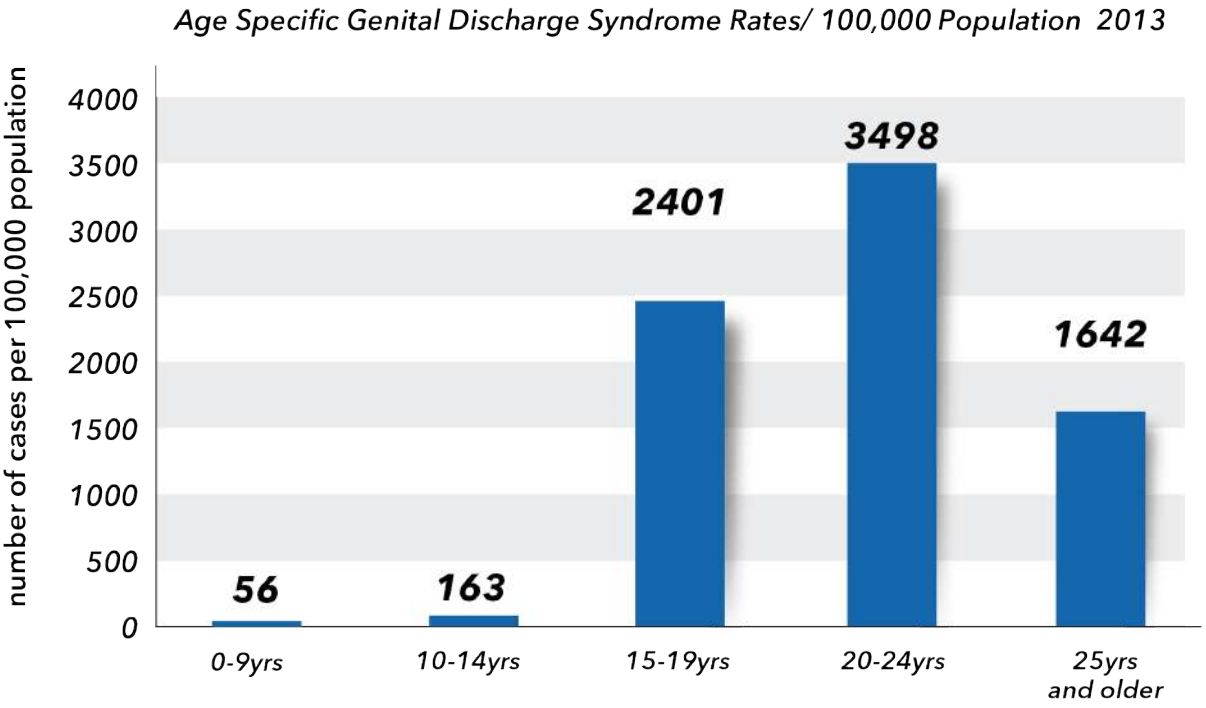
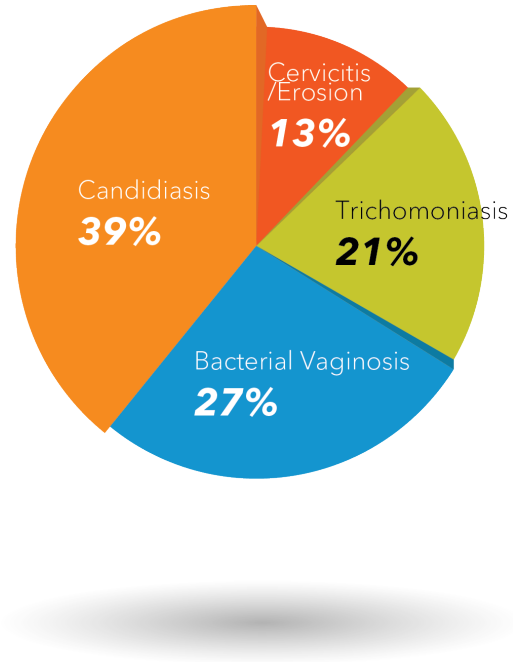


Figure 11: Distribution of the causes of genital discharge syndrome (GDS), 2013.

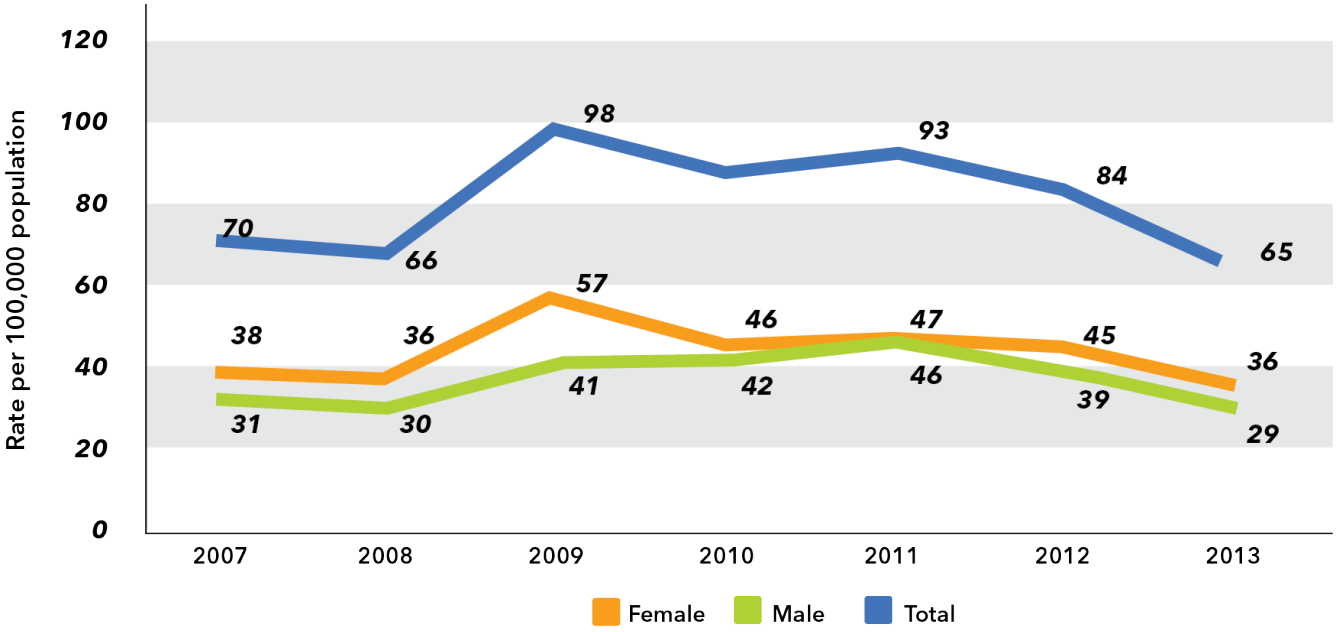


GENITAL ULCER DISEASE SYNDROME (GUD)

A genital ulcer disease (GUD) is defined by the guidelines for practical case management of common STI syndromes published by the Ministry of Health (MOH) as "conditions of the anogenital region (with or without lymphadenopathy) which cause a break or dissolution of the epithelial lining of the skin or mucous membrane in this area". These include syphilis, chancroid, herpes simplex virus (HSV), granuloma inguinale (GL), and lymphogranuloma venereum (LGV).

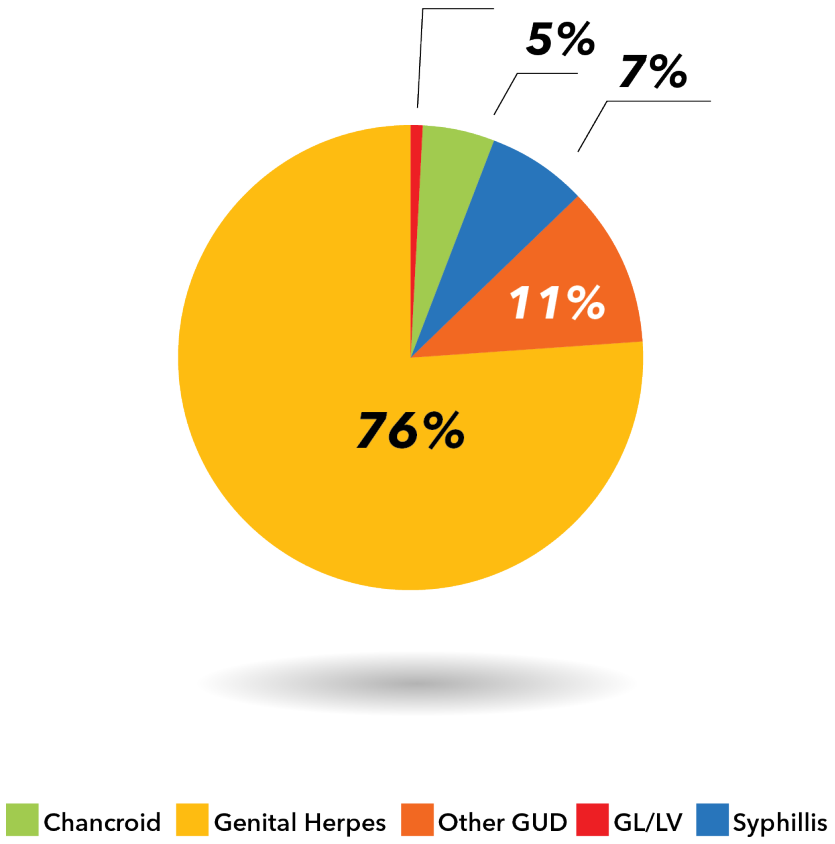
Between 2007 -2013 the rate of cases of GUD showed a lot of fluctuation with a decrease noted most recently in 2013 in comparison to 2012 (Figure 12).

Figure 12: Genital Ulcer Disease Rates/100,000 Populaion by Sex 2007 - 2013



Disaggregation by age showed that, similarly to genital discharge syndrome, the highest rates of infection were recorded in the 20-24 age group, followed by the 15 – 19 year olds. Herpes and syphilis accounted for 83% or 761 cases of reported GUD in 2013, unspecified ulcerative diseases made up 11% of cases and chancroid and GL/GLV) represented 5% and 1% of GUD cases respectively (Figure 13).

Figure 13 Distribution of the causes of Genital Ulcer disease 2013



St Thomas, Kingston & St Andrew (KSA), and St Ann recorded the top three highest rates of GUD cases for 2012 and 2013 , while Westmoreland had the lowest rate (Table below). Overall more women were diagnosed with syphilis than men over the 2007-2013 periods (figure 10). This is partly due to detection bias as women have increased access to tests for syphilis through antenatal clinics. In addition, the greater health seeking behaviour of women allows more timely diagnosis. However, it is important to note that the female to male ratio for infectious syphilis (primary and secondary syphilis) is 1.4:1 while the female to male ratio for STI clinic attendance is 4:1. This implies that infectious syphilis is more prevalent among male STI clinic attendees compared to female STI clinic attendees.

Table 14. Age-Specific GUD Rates/ 100,000 Population, 2007 - 2013

Age groups	2007		2008		2009		2010		2011		2012		2013	
	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
0-9 years	1	0	1	0	1	0	0	0	3	1	1	0	2	1
10-14 years	17	6	12	4	10	4	5	2	9	3	11	4	6	2
15-19 years	146	59	100	40	150	60	153	61	147	59	158	63	161	65
20-24 years	229	110	186	90	233	112	225	108	276	131	259	130	176	88
25 or older	542	37	596	40	924	62	799	54	799	53	747	50	580	39

Table 15. Genital ulcer disease syndrome by parish and sex, 2012-2013

PARISH	2012				2013				Rate difference
	Female	Male	Total	Rate	Female	Male	Total	Rate	
KSA	249	196	445	67	165	199	364	55	-12
STC	32	29	61	12	34	31	65	13	1
STT	59	124	183	194	64	92	156	166	-29
POR	24	27	51	62	6	13	19	23	-39
STM	4	19	23	20	4	6	10	9	-11
STA	50	64	114	66	28	19	47	27	-39
TRE	12	17	29	16	6	1	7	4	-12
STJ	29	24	53	29	26	37	63	34	5
HAN	13	15	28	40	20	24	44	63	23
WES	8	3	11	8	4	3	7	5	-3
STE	17	16	33	22	10	17	27	18	-4
MAN	9	13	22	12	12	10	22	12	0
CLA	34	52	86	35	22	33	55	35	0

Figure 14: Age Specific GUD's Rates/100,000 Population, 2013

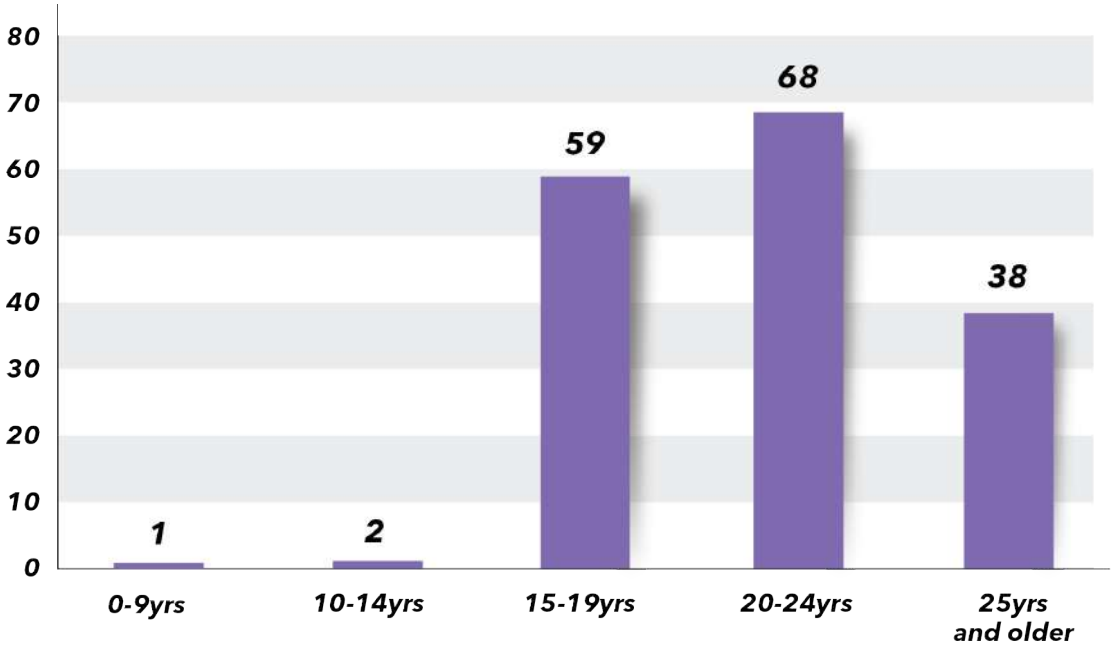


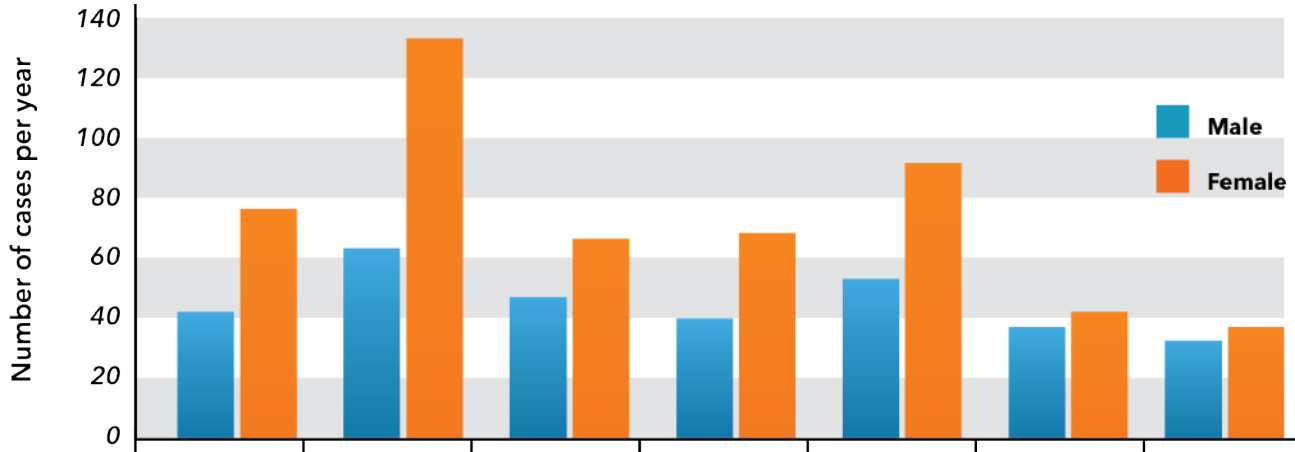
Table 16. GUD Cases by Year and Disease Category; 2007-2013

Infection	2007	2008	2009	2010	2011	2012	2013
Chancroid	75	82	95	35	59	59	46
GL/LV	25	33	30	30	30	24	12
Other GUD	189	93	123	178	139	167	96
Herpes	433	591	972	900	775	852	694
Syphilis	57	53	58	66	141	79	67

SYPHILIS

The number of cases of infectious syphilis declined by 4% among men and by 29% among women between 2012 and 2013. Three age groups recorded slight reductions in reported infectious syphilis cases for 2012, namely categories 20 through to 30-34 years (Table 17). The highest rates of primary and secondary syphilis occurred in the 20-24 age group in 2012. (Figure 15 below)

Figure 15: Syphillis Cases Per Year by Sex

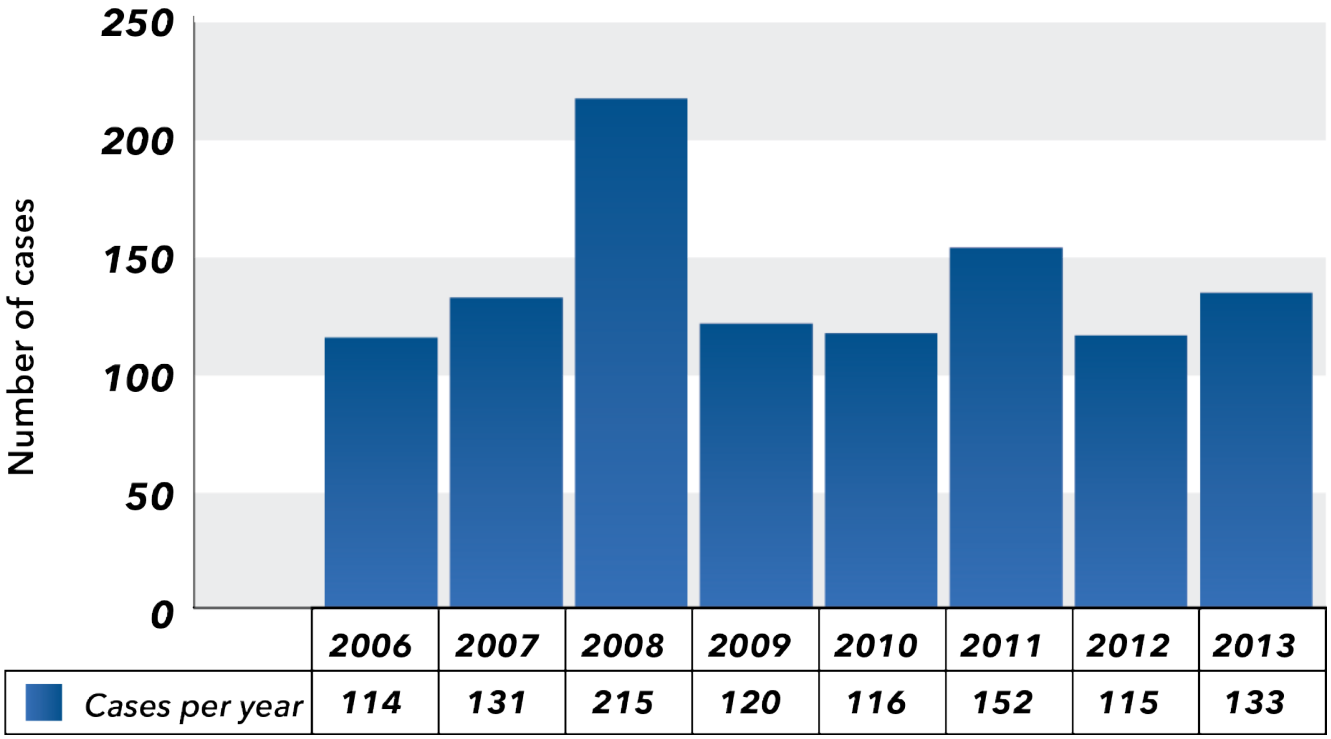


	2007	2008	2009	2010	2011	2012	2013
Male	42	63	47	40	53	37	31
Female	76	132	66	68	91	42	36

Table 17 Infectious Syphilis (primary and secondary) by Sex and Age Group, 2012 -2013

Year	2012			2013			Total difference
Sex	Female	Male	Total	Female	Male	Total	
Age groups							
0-9 yrs	0	0	0	0	0	0	0
10-14 yrs	2	0	2	0	2	2	0
15-19 yrs	18	7	25	13	8	21	-4
20-24 yrs	13	8	21	16	12	28	7
25-29 yrs	15	2	17	13	9	22	5
30-34	8	5	13	10	3	13	0
35-39 yrs	10	4	14	7	8	15	1
40-44 yrs	6	3	9	6	6	12	3
45yrs and over	6	8	14	10	10	20	6
Total	78	37	115	75	58	133	18

Figure 16: Reported number of Primary and Secondary Syphillis cases, 2006 - 2013



CAPACITY BUILDING

In 2013, The TCS Unit secured a capacity building opportunity for Adherence Counsellors to enrol in an Introductory counselling course slated to start the first quarter in 2014. The course is offered at open campuses of the University of the West Indies across the island. The course's objectives are: 1) to examine the general principles, goals, nature and process of counselling with individuals and groups and 2) to practice fundamental communication and counselling skills.

CHAPTER 4: ENABLING ENVIRONMENT & HUMAN RIGHTS

INTRODUCTION

For the year 2013, The Enabling Environment and Human Rights (EEHR) Component of the National Programme continued its work that was started in 2012, in the following areas:

Assessments
Governance Reform
Stigma and Discrimination
Greater Involvement of Persons Living with HIV and AIDS in National Response

In addition, the Enabling Environment and Human Rights Unit invested in restructuring its operations. The programme of work under the Enabling Environment and Human Rights (EEHR) Component was done through partnerships with:

a. HIV Unit in the Ministry of Labour and Social Security (MLSS)
b. Public and private sector organizations in the Workplace Programme
c. Jamaican Network for Seropositive (JN+)
d. JaBCHA National Foundation

RESTRUCTURING OF THE EEHR UNIT

The Unit embarked on making changes to its leadership, focus and funding. Through a series of stakeholder consultations and capacity building workshops, the Unit gathered information needed to define its priority areas of work to guide the restructuring.

The stakeholder consultative exercises were geared at defining and describing existing partnerships and examining the framework for involvement of the EEHR Unit with Civil Society Organisations (CSOs), Faith-Based Organisations (FBOs) and other components within the National HIV/STI Programme (NHP). The wide cross section of stakeholders who were consulted included: Jamaica Youth Advocacy Network (JYAN), Eve for Life, Caribbean Vulnerable Communities (CVC), Jamaica AIDS Support for Life (JASL), Centre for the Investigation of Sexual Offences and Child Abuse (CISOCA), JFLAG, JN+ and the Bureau of Women's Affairs (BWA).

The capacity building exercises in particular introduced relevant skills such as: conflict resolution, advocacy skills and work plan development which assisted with developing areas of focus.

At year-end, the National Programme had achieved the following:

- Adopted, as of April 1, the cabinet's approval to integrate the National HIV/STI Programme and the National Family Planning Board. As a result, the Unit's office was relocated to the office of the National Family Planning Board in June.
- Secured support for the expansion of the Unit's role in national response to HIV and AIDS
- Secured additional financial support for the Unit, including an expansion of the EEHR budget
- Increased its visibility among CSOs, government ministries including PIOJ, and International Development Partners
- Restructured the portfolio and staffing of the Unit

ASSESSMENTS AND REVIEWS

In 2013, the National Programme continued to undertake assessments and reviews that will be used to improve the Unit's work and by extension, the impact of the National Programme. During the reporting period the following assessments were conducted:

SITUATIONAL ANALYSIS FOR PATIENT CONFIDENTIALITY IN THE PUBLIC HEALTH CARE SECTOR – PHASE ONE AND TWO

The first phase of the assessment examined the adequacy of the existing legislative and policy framework with respect to patient confidentiality, particularly within the public health care sector. The assessment started in 2012 and was completed In February 2013.

The second phase of the assessment began in August 2013. This phase examined procedures and practices with respect to patient confidentiality, particularly in the public health care sector.

The findings and recommendations were shared and discussed with the Directors of the

Ministry of Health.

REVIEW OF THE NATIONAL HIV-RELATED DISCRIMINATION REPORTING AND REDRESS SYSTEM (NHDRRS)

The results of the review highlighted the gaps in the system and presented recommendations on how to improve its visibility and effectiveness.

The review, which was funded by Health Policy Project (HPP), commenced in 2012 and was completed in 2013. The findings and recommendations were disseminated with key stakeholders.

ASSESSMENT OF HIV-AIDS RELATED DOMESTIC LEGISLATION

The findings of the assessment brought to the fore the gaps in compliance with international human rights instruments.

A steering committee comprised of legal officers from at least four (4) government ministries provided oversight for the UNDP-funded consultancy assignment.

The study was completed in November 2013 and presentation of the preliminary findings was shared with key stakeholders.

GOVERNANCE REFORM

POLICY DEVELOPMENT

Following the approval of the National Workplace Policy on HIV and AIDS as a Green Paper in July 2012, both Houses of Parliament approved the White Paper in February 2013. The White Paper is the highest level that can be attained for Government policies. Prior to the approval of the White Paper, a series of stakeholder consultations to support the production of policy documents were conducted and two thousand (2000) copies of the document were printed.

The National Workplace Policy on HIV and AIDS and the Occupational Safety and Health (OSH) Profile of Jamaica were launched on December 16, 2013 at a cocktail reception held at the Jamaica Pegasus Hotel. Both documents are crucial to the development of the decent work agenda under the International Labour Organisation (ILO) to which Jamaica is a signatory. The launch was an avenue to begin the dialogue for the preparation for the pending passage of the OSH Act.

Among the 150 attendees were members of Parliament, Ministers of government, and representatives of key stakeholders such as international funding agencies, unions, private sector associations and companies. The keynote address was delivered by the Hon. Derrick Kellier, CD, MP, Minister of Labour and Social Security.

DEVELOPMENT OF HIV REGULATIONS TO BE APPENDED TO THE OCCUPATIONAL SAFETY AND HEALTH ACT

The consultancy to develop the HIV regulations to be appended to the OSH Act was commenced in the reporting year. At the time of this report, the drafting of the regulations had commenced, following the recommendations for the approaches to the regulations that were presented by the consultant

GREATER INVOLVEMENT OF PERSONS LIVING WITH HIV AND AIDS (GIPA)

The eight-module Positive Health and Dignity Prevention (PHDP) Curriculum that was developed in 2012 with the financial and technical assistance from Health Policy Project (HPP) is one of the key elements of the GIPA Capacity Building Programme.

The curriculum, which covers topics such as Stigma and Discrimination, Sexual and Reproductive Rights, Sexuality, Gender, Sexual Diversity and the PHDP Framework is designed to increase the participants' understanding of the training modules and improve their presentation and facilitation skills so that they are able to effectively deliver the curriculum's key messages effectively. For the reporting period, the curriculum was used to a new cohort of people living with HIV.

Between July and November 2013, 53 community leaders, some of whom were participants in cohort one and two of the PHDP trainings, participated in process to develop additional curriculum modules.

POSITIVE HEALTH AND DIGNITY PREVENTION (PHDP) CURRICULUM

The second cohort of persons living with HIV (26) individuals) to receive training with the Positive, Health and Dignity Prevention (PHDP) Curriculum participated in a series of fourteen (14) sensitization and training workshop. This training of the second cohort of individuals was accomplished in collaboration with the Jamaican Network of Seropositives (JN+) and served to contribute to the strengthening the capacity of JN+.

Three new modules were added to PHDP Curriculum: 1) Continuum of Care, 2) Positive Health with a focus on Self Care and 3) Combination Prevention and Advocacy.

PWHA INVOLVEMENT

During the reporting year PLHIVs continued their efforts to engage with their public and private sector stakeholders through their facilitated sessions. Through their 52 sessions, the PLHIV facilitators delivered on topics such as HIV Basic Facts, Positive Health and Dignity Prevention--Living with HIV, Ministering to PLHIV, Dealing with Stigma and Discrimination.

Table 18: Summary PWHA Stakeholder Outreach 2013

Groups Targeted	Number of PLHIV facilitators	Number of sessions facilitated
Public Sector	4	9
Private Sector	4	1
Community Service Organizations	1	42

WORKPLACE PROGRAMME

For 2013, the HIV Unit of the Ministry of Labour and Social Security (MLSS) focused on improving its Voluntary Compliance Programme (VCP) in the private sector by launching new strategies and conducting a series of audits and workshops.

HIGH LEVEL CONSULTATIONS WITH PRIVATE SECTOR LEADERS

On October 16, 2013 the unit engaged 40 food service industry CEOs who are part of Jamaica Manufacturers' Association in a discussion titled, "The Role of Hazard Analysis Critical Control Points (HACCP) in Occupational Safety and Health (OSH)". The objectives of the session were to:

a. Increase the participants' awareness of the Ministry's Voluntary Compliance Programme
b. Increase the participants' awareness high levels of HIV-related stigma and discrimination that is experienced in the food industry.
c. Increase the participants' awareness of the ways in which stigma and discrimination is a breach of the National Workplace Policy on HIV and AIDS (White Paper, February 2013).

The discussions also focused on the types of interventions and strategies that would be most appropriate to meet the objectives of the Policy and the concerns of the CEOs.

At the end of the consultation, eight (8) of the CEOs indicated their willingness to participate in the workplace interventions being implemented by the MLSS.

REVIEW OF MLSS POLICIES AND PROGRAMMES REGARDING SOCIAL PROTECTION

In October 2013 a consultant conducted a desk review of the policies, programmes and initiatives administered by the MLSS as part of the National Social Protection System. The results of the review showed that there are gaps in the National Social Protection System with regards to HIV. The results further revealed that stereotypes, self-stigma and fear of disclosure and discrimination were amongst the most significant barriers to accessing the provisions of the social safety net.

Though the policies, programmes and initiatives administered by the MLSS are not HIV-sensitive, they do not exclude persons on the basis on HIV status, with the exception of the Overseas Employment Programme (OEP).

The consultancy findings' recommendations included:

- Development policies and strategies that could be used to make the Social Security System more HIV sensitive.
- Collaboration between MLSS and the Planning Institute of Jamaica (PIOJ) to develop a new Social Security Framework.

- The Overseas Employment Programme (OEP) should be guided by the principles of the National Workplace Policy on HIV and AIDS and as such, not exclude on the basis of HIV status.

SMALL BUSINESS WORKPLACE INTERVENTION

Over a three month period, a consultant assisted the ministry in enrolling a minimum of 15 small businesses (with 49 or fewer employees) in the Ministry's Voluntary Compliance Programme (VCP). The companies received technical support to develop policies and implement programmes on HIV and AIDS in their workplaces in compliance with the pending OSHA. Each participating company was engaged in one VCP awareness workshop, in which participants were exposed to the requirements of the programmes and recommendations for implementing same based on the size and nature of their businesses. They were also engaged in a 3-hour policy development session.

VCP AWARENESS WORKSHOP FOR ENROLLED COMPANIES

The pending Occupational Safety and Health Act (OSHA) requires that all workplaces implement an appropriate response to protecting the health and safety of workers using a rights-based approach. This response should include not only occupational safety and health but also HIV. It is against this background that the structure of the Voluntary Compliance Programme (VCP) was revised. Participating companies are no longer able to choose to implement an OSH programme or an HIV programme. Once enrolled, they are expected to implement an integrated programme with an HIV component and an OSH component. The audit process was also revised to reflect one audit to assess the status of both components. The manual used to guide companies was therefore revised to reflect this change. Five Hundred (500) copies of the revised manual were printed.

In addition, 81 companies were newly enrolled. The VCP currently has a total of 268 companies enrolled. The newly enrolled companies were reached through three awareness workshops. Despite the number of companies enrolled during this period, the majority of companies approached for baseline assessments and audits declined the invitation for various reasons. Two of which were that they were not prepared for an audit and/or they will wait for the passing of the pending OSHA.

THE ILO FOOD PROCLAMATION INTERVENTION

The project involves the development of an HIV Proclamation using a rights based approach to employment irrespective of real or perceived HIV status as well as HIV prevention education for participating private sector companies with a focus on employers, employees, patrons associated with participating food restaurants/enterprises. Throughout the period several

capacity building plans were set inclusive of:

A three day Training of Trainer workshop with the following objectives:

a. To reduce HIV-related stigma & discrimination in the food sector

b. To improve understanding of HIV & AIDS related issues in the workplace

c. To equip participants with basic techniques to train workers on HACCP and OSHA in the HIV response

d. To increase accepting attitudes towards PWHIV and risk reduction practices among participants

Feedback from participants indicate that the workshop achieved its objectives; there was an improved understanding of matters pertaining to HIV and the vulnerabilities within the food industry as well as training and action plans were drafted to guide the way forward.

STIGMA AND DISCRIMINATION REDUCTION INTERVENTIONS

Addressing stigma and discrimination is a key aspect of the national response to HIV and AIDS. During the reporting year, the National Programme advanced its work through the Justice For All Initiative, which it does in partnership with the Pan Caribbean Partnership against HIV and AIDS (PANCAP) and through engaging in dialogue about an anti-discrimination tribunal.

JUSTICE FOR ALL (JFA) CONSULTATION WITH PARLIAMENTARIANS

The Justice for All initiative, which is part of the Pan Caribbean Partnership against HIV and AIDS (PANCAP), aims to, by 2015:

a. Eliminate stigma and discrimination against people living with HIV

b. Uphold human rights and dignity of all.

The Unit coordinates Jamaica's involvement in the Justice for All initiative.

Following consultations with parliamentarians that were led by Hon Dr. Fenton Ferguson Minister of Health in December 2013, there was agreement that there was a need to review antiquated laws that hindered the National HIV response.

The parliamentarians also recommended that cluster consultations be continued in 2014 with

stakeholders from private sector organisations, community services organizations, youth-based organizations and the faith-based community. These consultations would be aimed at identifying actionable recommendations for a national declaration to reduce stigma and discrimination.

ANTI-DISCRIMINATION TRIBUNAL

The National Programme embarked on efforts to build leadership commitment and support for the establishment of an anti-discrimination tribunal by hosting meetings with Minister of Justice, the Permanent Secretary in the Ministry of Justice and the Attorney General's Office.

Options for the establishment of the tribunal were put forward at those meetings for further investigation. However, no progress was made on advancing the assessment of those options.

The Unit continued to build awareness and support from stakeholders regarding the establishment of an Anti-Discrimination Tribunal as way of ensuring that there is equality of access to non-discriminatory information, goods and services.

OTHER STIGMA AND DISCRIMINATION REDUCTION INTERVENTIONS

FAITH-BASED AND COMMUNITY-BASED INITIATIVES

One of the highlights of the year was a three-day training-of-trainer workshop held with sixteen (16) church leaders. The leaders were trained in facilitation skills geared at reducing stigma and discrimination using trigger scenarios and docu-dramas developed for use among faith groups. Participating denominations included Anglicans, Methodist, Moravians, the Salvation Army, the United Church, Pentecostal and a community church - Restoration Outreach Ministry. The participants were encouraged to conduct and report on sessions with their respective congregations. During this reporting period, 5 trainees representing the United Church, Seventh Day Adventist, and Pentecostal group, reported using the FBO docudrama to sensitise their congregations on how to reduce stigma and discrimination against PLHIV, sex worker and men who have sex with men.

HANNAH TOWN AND GREENWICH TOWN INTERVENTIONS

The unit designed targeted interventions for the churches situated in the Hannah Town and Greenwich communities. These interventions were designed to complement the prevention Unit's intervention with out-of- school youth and men on the corners in these communities. As a result of the partnership with the St. Anne's Roman Catholic Church located in Hannah Town, community members received care packages from the church. Through the church's outreach ministry, two sensitization sessions focusing on HIV basics; gender norms and sexuality and stigma & discrimination were held with a total of seventy (70) community members in attendance. In Greenwich Town Community, church leaders and members of the community participated in a sensitization session on stigma and discrimination. The attempted at having a coordinated effort by the churches in the area, however, not many church leaders/members gave their support and it ended up being predominantly member of the community that participated in the session.

JAMAICA SOCIAL INVESTMENT FUND (JSIF)

Through a partnership with JSIF, persons from communities from three parishes (St. Thomas,

Trelawny and St. Mary) participated in sensitization sessions on how to reduce stigma and discrimination in the community. A total of 43 persons were reached in three one-day sensitization sessions on HIV Basics, Gender norms and Sexuality. Based on the issues experienced and shared by the families, two -day weekend sessions were conducted to involve the teenagers with in the targeted families. During these sessions emphasis was placed on adolescent risky behaviours, rights of the child, parenting styles, talking about sexuality and building healthy relationships. A total of 60 persons participated in these sessions.

TOURISM DEVELOPMENT COMPANY (TPDCO) AND THE MINISTRY OF TOURISM

Efforts were made to re-engage with the Tourism Development Company (TPDCo) and the Ministry of Tourism. The entities however indicated that participation in driving tourism sector-based HIV response is limited due to lack of adequate human and financial resources. Nevertheless, a costed five-year work plan was developed in collaboration with representatives from the TPDCo for submission to the Tourism Enhancement Fund (TEF).

Fourteen (14) small hotels in Negril participated in discussions regarding HIV and the tourism sector. They were engaged in two Small Business Fora at which they were sensitized to the nuances of HIV in the context of the workplace and how it affects the tourism sector as well as policy development. The participants were also apprised of the requirements of the pending OSH Act and its implications for small operators and measures to address concerns regarding HIV-related stigma and discrimination and food preparation. Each of the companies had developed a draft workplace policy on HIV.

ADOLESCENT POLICY WORKING GROUP

The Adolescent Policy Working Group which is coordinated by the Ministry of Health's Adolescent Health Unit developed key messages for use with high level leaders as well as for public consultation regarding the provision of sexual and reproductive health services to minors in need of such services. Some of the key messages developed are below:

a. Sexually active youth under 16 to be able to access Voluntary Confidential Counselling and Testing services

b. Need to amend existing legislation to allow HCWs to provide SRH services to minors without fear of prosecution

c. Need to address potential for minors to be unfairly prosecuted in absence of a nuanced approach to interpretation and application of the law

CHAPTER 5: MONITORING & EVALUATION

OVERVIEW/SUMMARY

In 2004, the NHP established an M&E Unit to track the progress of the National Strategic Plan and hence, Jamaica's HIV response. Guided by the M&E Plan, the M&E system has been implemented and has supported the national response.

In April 2013, the integration of the National HIV/STI Programme (NHP) into the National Family Planning Board (NFPB) to form one executive Sexual Health Agency was formalized. Although the MoH retained its monitoring and responsibility of Treatment, Care & Support of PLHIV, this Sexual Health Agency has responsibility for sexual and reproductive health and will support the sustainability of the HIV Prevention and the Enabling Environment and Human Rights components.

In December 2013, joint stakeholders from the Ministry of Health, the Sexual Health Agency, various line ministries and civil society met at the 1st Annual Review of the Sexual Health Agency and worked in assigned small groups to contribute to the development of the integrated strategic plan. Each group identified strategies to improve on the strengths and address the gaps and weaknesses that were identified. A committee was established to continue the revision.

DATA MANAGEMENT

Substantial work was done with the staff involved in management of the HIV treatment database at the adult treatment sites in 2013. This led to improvements in the usefulness and accuracy of the data making it easier to collect and analyse.

The M&E Unit gradually strengthened the level of supportive supervision to treatment sites through multiple field visits throughout 2013. These visits were geared at engendering the systematic processing of data in order to improve the timeliness of database entries, and improve the understanding of inputs and outputs of the database to guide patient management. Additionally, through the support of the Clinton Health Access Initiative (CHAI), a "Database Sweep" was done across all the adult treatment sites, ensuring all critical data points (for every clinic visit since diagnosis) were up to date for each patient seen at the treatment site since 2010 through 2012.

In response to stakeholder requests, new modules and reports were added to the treatment site database to support the use of the electronic ARV registry and strengthen the tracking of indicators for the treatment cascade which had been introduced as an important monitoring framework for treatment interventions following national performance from diagnosis of PLHIV, through to linkage and retention in care to viral load suppression.

RESEARCH AND EVALUATIONS

The M&E Unit collaborated with the Caribbean Region Public Health Agency (CARPHA) to conduct assessments of different components of the National HIV Programme. In July, CARPHA, alongside a team from MEASURE Evaluation (University of North Carolina), conducted a pilot of Country Ownership of M&E system tool in Jamaica. This tool looked at a status assessment of the people, partnerships and planning elements of a fully functioning M&E system; and the assessment of country ownership of the M&E system.

Country ownership was defined by the dimensions of 1) power, legitimacy and respect; 2) commitment and responsibility, 3) capacity and 4) accountability. The methodology for this assessment was key informant interviews with selected stakeholders followed by a joint consultative workshop.

Findings from this tool identified that although there was strong ownership of the M&E system in Jamaica; the main areas identified for improvement were capacity and accountability at sub-national levels.

Capacity considered existing and planned human capacity, existing physical capacity and leadership and management of capacity while accountability considered data management systems around established guidelines, data capture, storage and information flow and feedback. Very few stakeholders had a committed M&E position, and even fewer had developed M&E plans for their programmes.

Additionally, the other evaluation was an end of term evaluation to assess the progress made by the National HIV/STI Programme with the support of its stakeholders in achieving the objectives of the Prevention and Enabling Environment and Human Rights (EEHR) Components of the HIV/AIDS National Strategic Plan 2007 to 2012. This evaluation, led by CARPHA, incorporated a Utilization-Focused Theory within a Results Based Monitoring and Evaluation

(M&E) Framework, and used an External Evaluation Team who worked in partnership with a Local Evaluation Team to develop a realistic evaluation of achievements during the strategic plan implementation period. In addition to providing strategic information to guide the restructure of programmes going forward, the team was also focused on helping build evaluation capacity.

MID-TERM REVIEW OF PROGRESS ON ACHIEVING THE 10 POLITICAL DECLARATION TARGETS

The 2011 United Nations General Assembly Political Declaration on HIV/AIDS set ambitious targets to be achieved by 2015. A framework of ten core indicators was developed to reflect the new targets and elimination commitments. Jamaica committed to reporting on all of the targets except targets two and nine which were not applicable to the country; and to monitor and report on progress and challenges encountered in the national AIDS responses.

In light of the upcoming United Nations General Assembly on the Millennium Development Goals (MDG) in 2013; Jamaica undertook a mid-term review of the targets aimed at assessing the status of achievement to identify barriers and opportunities. The review assessed the need for re-prioritization and/or accelerated action towards achieving the Political Declaration targets. This mid-term review followed a participatory and inclusive approach and used a mix of qualitative and quantitative methods, namely a document review and analysis, key informant interviews, and focus group discussions. The findings from these formed the bases for the analysis of data which took into consideration the key review questions highlighted in the 10 Targets Tracking Tool and the national baselines, targets outlined in the draft Jamaica Monitoring and Evaluation Plan and achievements up to 2013. From the analysis, a set of findings and recommendations were developed and drafted into a comprehensive report. The findings of the MTR were presented at a national stakeholders consultation and consensus reached on the key achievements, challenges and recommendations for achieving or surpassing the 2015 targets.

KEY TRAININGS TO IMPROVE M&E CAPACITY

Training is a key strategy of the M&E unit to build capacity at the sub-national level. One of the key trainings conducted by M&E unit in 2013 was on Monitoring and Evaluation techniques targeting government and civil society partners. This training took the format of a 2-day workshop that covered various topics including log frame development, data collection methods for M&E, data quality assessments, and a hands-on practical introduction to Epi Info for data entry and analysis using an existing data collection tool and real parish data.

Another major training conducted was on the content of the HIV Case-Based surveillance manual. The HIV Case-Based Surveillance Manual was completed in 2012 with support from USAID and disseminated to stakeholders involved in the diagnosis and reporting of HIV cases. The training therefore served to further sensitize field personnel on the content of the manual in order to ensure understanding of current case definitions and protocol for diagnosis, notification and investigation of positive HIV cases.

CHALLENGES

The integration of the HIV Prevention and EEHR components into the National Family Planning Board Sexual Health Agency will require the guidance of a revised national strategic and monitoring plan that incorporates the priorities of the HIV response within a broader national sexual and reproductive health agenda. Similarly, the terms of reference for the MERG, which had been recently revised at the end of the National Strategic Plan in 2012 will have to be revised again to also reflect this broader sexual and reproductive health agenda.

Another major challenge is that the treatment site databases are not networked to each other across the different sites. This means the potential for duplication is highly possible if patients visit more than one site.

The lack of a networked database also limits the ability to identify if persons lost to follow-up are accessing care at other sites and thus national coverage figures for treatment indicators may not be as precise as required.

Additionally, disaggregated data on indicators by key population status are still unavailable, limiting the understanding of access to services by key populations. The unit has allocated funds towards developing a unique identifier system for key populations, and collecting bio-behavioural data for key populations, including adolescents and youth. Strategies to address the policy barrier to testing youth are also being explored.

CHAPTER 6: FINANCE & ADMINISTRATION

INTRODUCTION

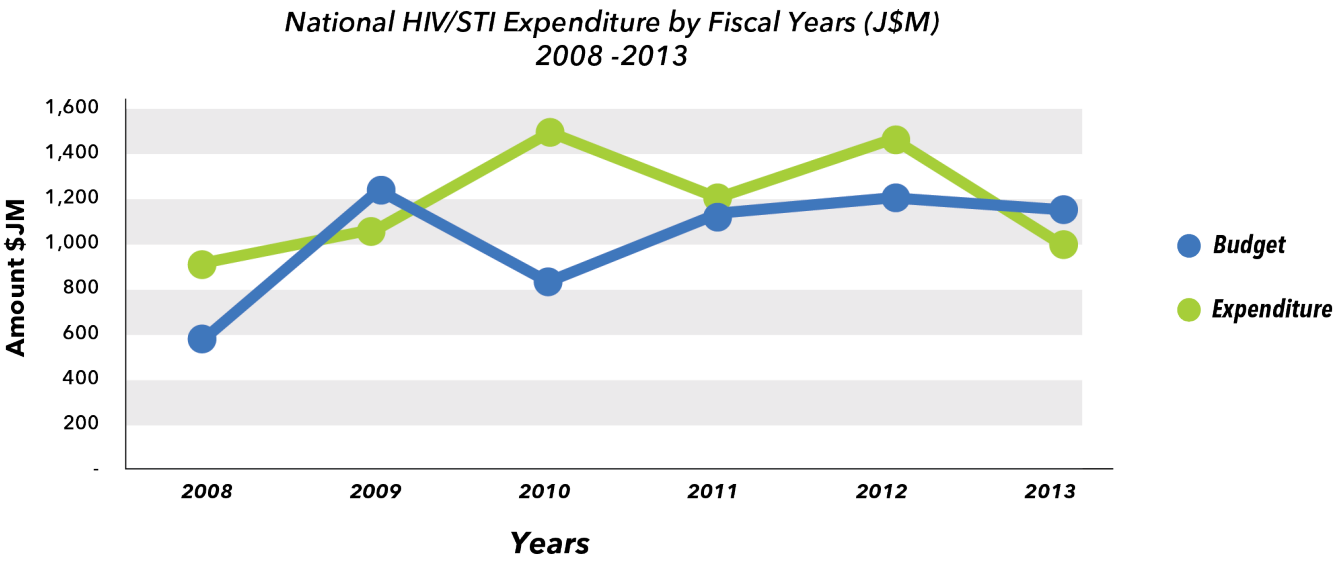
For the year 2013, the National HIV Strategic Plan guided the national HIV/AIDS response. The development of a National HIV Strategic Plan was one component of the process of integrating the National HIV Programme with the National Family Planning Board.

The funding sources for the 2013 programme of work were: The Global Fund to fight AIDS, Tuberculosis and Malaria (GF), the United States Agency for International Development (USAID), a World Bank loan and cash and in-kind support from the Government of Jamaica (GoJ).

The national programme anticipated that the support from international partners would reduce starting in 2013 given Jamaica's recently assigned classification as an upper middle-income country. As a middle-income country, Jamaica eligibility profile for donor funding resources would change and therefore affect the value of the financial support available for the National Programme.

The Programme's, budget for 2013 was J$1.02B; it was approximately 28% less than the budget allocation for 2012 (J$1.42B). The total expenditure for 2013 was J$1.14B.

Figure 17: Summary of National HIV/STI Programme Budget and Expenditure, 2008-2013



The availability of funding for the Programme through the World Bank loan and the Global Fund Round 7 projects came to an end within this year. Reduction of resources to the Programme from these donors was offset by the introduction of Government contribution to the Global Fund Transitional Funding Mechanism (TFM) project and the TFM Project itself from the Global Fund.

FINANCIAL PERFORMANCE12 , JANUARY - DECEMBER 2013

The Programme's, budget for 2013 was J$1.02b. The 2013 budget allocation was 28% less than the allocation for 2012 (J$1.42b). The expenditure for 2012 was J$1.14b; this exceeded the budget amount by 11.7%.

Of the J$1.14b spent in 2012, approximately 65% (J$743.21M) was spent by the Principal Recipient and the remainder, 35% (J$393.74M) was spent at the field level by the Sub-recipients (SRs).

The budget allocations were directed to the following Programme Components:

i. Prevention
ii. Treatment, Care and Support
iii. Policy (or Enabling Environment)
iv. Monitoring and Evaluation
v. Administration and Capacity Building
vi. Health Sector

[12] *Analysis is done using calendar year figures in keeping with the requirements of the Annual Report, thus January 2013 - December 2013. The cash basis of accounting is also applied in the Programme.*

PROGRAMME COMPONENTS

TREATMENT, CARE AND SUPPORT (TCS)

This component focuses on ensuring that the target populations have access to a comprehensive system of care. The key TCR activities for 2013 were: procurement of ARVs drugs, test kits, reagents and provision of nutritional options for new-borns of HIV infected mothers.

The TCS component accounted for the largest share of the Programme's butdget in 2013, at 32% or J$329.21M. The expenditure during the 2013 calendar was J$433.64M; it exceeded the budgeted amount by approximately 31.7%.

PREVENTION

The activities implemented in the PR component are aimed at reducing the spread of HIV. The interventions were targeted that the general population and the most at-risk populations; they were implemented by the Ministry of Health, the Regional Health Authorities and non-government organizations.

For 2013 the PR component received a budget of J$301.64M; however J$440.69M[13] was spent in the calendar year.

The interventions implemented in 2013 included mass media campaigns, targeted interventions for Most-at-risk-Populations (MARPs) including Men Having Sex with Men (MSM) and Commercial Sex Workers (CSWs); peer education; procurement of condoms, and training and capacity building for Civil Society Organizations (CSOs) to implement prevention activities.

[13] *The over-expenditure on the Prevention component existed in the calendar year. The Programme's budget and audit reporting is customarily aligned to fiscal period; therefore this will correct itself in fiscal reporting.*

Table 19: Summary Budget and Actual Spending by Component, 2011-2013

Comparative Summary of component expenditures 2011 -2013						
	Calendar Year 2011		Calendar Year 2012		Calendar Year 2013	
Components	**Budget J$M**	**Actual J$M**	**Budget J$M**	**Actual J$M**	**Budget J$M**	**Actual J$M**
Cash Basis						
Prevention	280.81	290.59	405.76	366.85	301.64	440.69
Treatment Care & Support	455.46	455.78	593.90	470.07	329.21	433.64
Monitoring & Evaluation	51.04	35.21	45.56	25.33	14.19	9.50
Enabling Environment/ Policy	45.06	39.42	33.70	65.08	50.24	57.24
Capacity Building/ Administration	278.78	255.07	278.80	180.32	268.72	187.72
Health Sector	28.68	38.83	65.17	64.57	42.66	8.14
HADDS	57.62	0.05				
Sub total	1,197.45	1,114.95	1,422.89	1,172.22	1006.66	1,136.94
In Kind Contribution		14.47		16.23		67.54
Grand Total	1,197.45	1,129.42	1,422.89	1,188.45	1006.66	1,204.48

Source: National HIV/STI Programme Financial Statements

ENABLING ENVIRONMENT/POLICY

The work under this component is aimed at safeguarding the rights of the target population and empowering the beneficiaries of HIV policies to understand their rights and to seek redress in instances where their rights are violated.

The achievements for the reporting period included: the completion of the Person Living with HIV Stigma Index Survey report and the launch of the National Workplace Policy on HIV/ AIDS

The expenditure for work EEAP component exceeded budget by approximately 13.9%, with J$50.24M being budgeted and J$57.24M being spent.

MONITORING AND EVALUATION (M&E)

For 2013, the M&E component had about half of the budget that it had for previous year. For 2013, the M&E budget allocation was J$14.19M and for 2012, it was J$28.07M.

During the reporting period, a series of training workshops were implemented with the Regional Health Authorities and with SRs. Additionally M&E Components funds were used to support the efforts to strengthen the data and information systems by merging all three NHP databases and ensure that they new system includes linkages with the databases at the

27 treatment sites throughout the country.

Of the J$14.19M budget allocated to M&E for 2013, approximately two-thirds (66.9%) was spent.

HEALTH SECTOR (HS)

CAPACITY BUILDING AND ADMINISTRATION (CBA)

The CBA component's funding for 2013 was J$268.72; of that figure J$187.72 (69.8%) was spent. The work under this component ensures that the Programme's resources are managed efficiently and that the targets of the respective donor are achieved through the employment of suitable and qualified staff.

The 2013 budget resources were allocated to staff cost, service fees for the distribution of ARVs, stationery, support with tuition fees for staff and workshops accounts for some of the major activities under the component.

One of the priorities for the CBA Component for 2013 was to prepare a sustainability plan for the staffing for the Programme considering that a significant portion of the costs for Regional and Prevention staffing is funded under the World Bank Project that was slated to end in 2013.

FUNDING SOURCES

Almost half of the National Programme's budget in 2013 was from The Global Fund. The GF's contributions were valued at J$478.38M (48%) of the overall budget of J$1.42B. The USAID's contribution for 2013, $223.21, accounted for 22 % of the budget; this represented an increase in the level of financial commitment when compared to 2012, when the USAID support accounted for 8% of the Programme's budget.

The World Bank's support was valued at J$109.71M. The Government of Jamaica (GoJ), committed cash and in-kind support to the programme, valued at J$246.51M. The programme also received contribution from small grants from UNAIDS, valued at J$0.21M.

GLOBAL FUND

The GF's support for the Programme, which began in 2008, ended during this reporting year. Between 2008 and 2013, the GF would have committed some US$39.90M to the Programme. The cumulative expenditure as at July 2013 was US$39.47M.

In 2013, the GF agreed to a Transitional Funding Mechanism (TFM) phase, effective August 2013, that would extend the Grant # JAM-708-GO2-H project until December 2015. The TFM valued at US$7.69M (a revision of the initial commitment of US$7.95M).

The total commitment from the GF for 2013 was $478.38M. The GF's resources for 2013 were primarily used for the procuring of ARVs, testing supplies, scaling up of prevention and advocacy activities. The expenditure for the year, which straddled both the Round 7 and TFM agreements, was J$612.17M. The expenditure therefore exceeded the budget allocation by about 27.9%. The over expenditure was primarily due to the implementation of the GF Round

7 activities and also the delayed activities and payments from previous years' work that were finalized in 2013.

WORLD BANK

The WB's support to the programme began in June 2008 with the signing of three-year loan agreement. The funding agreement was later extended to another two years.

In 2013, the WB project supported activities such as procurement of HIV testing supplies and infrastructural works at a new treatment site in the parish of Portland, a clinic for the incarcerated population and the Biomedical Waste Management Plant in the Western Region.

Expenditure for the World Bank project in 2013 was J$93.37M from a budget of J$109.70 for the reporting period.

USAID

For 2013, the PEPFAR Project spent $312.24M on the national response. The objectives of the project are: 1) to reduce sexual transmission of HIV, 2) improve the use of strategic information for evidence-based policies and 3) reduce stigma and discrimination.

GOVERNMENT OF JAMAICA

With the reduction funding available for 2013 from international sources, the GoJ increased its level of cash and in-kind contribution to the Programme. The year 2013 therefore marked the first funding year for which the GoJ provided counterpart funding for the GF Project. The GoJ support to the GF project was valued at J$14.58M; approximately one-third of the funds (J$4.79M) was spent.

An additional J$148.59M was committed from the GoJ recurrent budget, double of what was committed in 2012 (J$71.37M). Of the J$148.59M, J$82.36M was spent.

The GoJ's counterpart funding to the USAID PEPFAR project was valued at J$31.99M; of that total, J$31.81M (99.4%) was spent.

The in-kind contribution of J$51.34M for 2013, represents an increase of 68.4% when compared to the J$16.23M contribution of the previous year. The funds allocated in 2013 were used to fund salaries, office space rental and maintenance, security and janitorial costs.

Table 20: Summary of Budget Allocation and Expenditure by funding Source, 2013

	Performance			Illustrative Components Funded					
Sources	Allocation ($J Million)	Expenditure ($J Million)	Burn Rate (%)	PR	TCS	EE	HS	M&E	CBA
Global Fund Grant	478.38	612.17	128	•	•			•	•
World Bank	109.70	93.37M	85	•			•		
USAID	223.21	312.24	160	•		•			•
GoJ (cash)	195.17	118.96	61	•	•	•		•	•
GoJ (kind)	51.34	n/a	n/a						•
UNAIDS	0.21	n/a	n/a						

CHALLENGES

The challenges that the Programme experienced during the reporting year include:

- Reduced funding support as a result of the closeout of the World Bank project and the Global Fund Round 7 projects.
- Delays in warrant allocation to the different projects
- Co-mingling of funds from Grant and Counterpart sources that resulted from the failure to establish a separate bank account for the GF counterpart resources.
- Late submission of monthly financial reports by field implementers
- Long-term sustainability of the Programme

APPRAISALS

The funding agency-mandated closeout audits were conducted for the Global Fund (financial year ended in August 2013) and The World Bank (financial year ended in June 2013). The audit firm KMPG provided the audit services. The audit for reporting period for USAID PEPFAR for the period Feb 2013 – Feb 2014was conducted by BDO Jamaica.

NATIONAL HIV · STI · TB PROGRAMME

ANNUALREPORT

2014

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
CHAI	Clinton Health Access Initiative
CSO	Civil Society Organization
EEHR	Enabling Environment and Human Rights
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GoJ	Government of Jamaica
HIV	Human Immuno-deficiency Syndrome
JaQIC	Jamaica Quality Improvement Collaborative
JN+	Jamaican Network of Seropositives
MAJ	Medical Association of Jamaica
M&E	Monitoring and Evaluation
MLSS	Ministry of Labour and Social Security
MOH	Ministry of Health
NERHA	North Easton Regional Health Authority
NFPB	National Family Planning Board
NHF	Nation Health Fund
NHP	National HIV/STI/TB Programme
NPHL	National Public Health Laboratory
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PHDP	Positive Health Dignity and Prevention
PLHIV	Persons Living with HIV
PR	Principal recipient
SERHA	South Eastern Regional Health Authority
SRHA	Southern Regional Health Authority
SR	Sub-recipient
TCS	Treatment Care and Support
TFM	Transitional Funding Mechanism
TPDCo	Tourism Development Company
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WRHA	Western Regional Health Authority

INTRODUCTION

The success of the HIV response in Jamaica for the last 27 years is a result of a multi-sector partnership between government agencies; nongovernment organisations (NGOs), community-based organizations (CBOs), academic institutions, people living with HIV, international development partners and health professionals. This year again demonstrates the effectiveness of this partnership approach which also strengthened as compared to previous years.

The Government of Jamaica began its national response to HIV and AIDS in 1986 with the start-up of a comprehensive National HIV/STI Programme (NHP). The HIV response in 2014 is guided by the National Strategic Plan on HIV and AIDs 2012 – 2017 developed around six priority areas: Prevention, Treatment, Care and Support, Enabling Environment and Human Rights, Empowerment and Governance, Monitoring & Evaluation, and Sustainability.

The following outlines the vision of the national response: "To protect the rights of all Jamaicans including those infected with and affected by HIV and AIDS and to create an enabling environment free of stigma and discrimination while providing access to prevention knowledge and skills; treatment care and support; and other services".

The above statement guides the national response, the National HIV/AIDS Policy and the National Strategic Plan.

The goal of the NSP 2012 – 2017 is "to reduce the transmission of new HIV infections while mitigating the impact of HIV/AIDS on the people of Jamaica within a sustained, effective multi-sectoral infrastructure and soliciting the necessary commitment to support the national response to HIV and AIDS."

The overarching strategic outcomes of the National Strategic Plan are:

- Increased coverage of effective prevention interventions and additional interventions developed;
- Increased coverage of effective interventions for comprehensive care and support and additional interventions developed;
- Increased coverage of effective interventions for impact mitigation and additional interventions developed;
- Effective leadership by government and non-government sectors for implementation of the response to HIV/AIDS, at central and local levels;
- A supportive legal and public policy environment for the HIV/AIDS response;
- Increased availability of information for policy makers and programme planners through monitoring, evaluation and research
- Increased, sustainable and equitably allocated resources for the national response

Throughout 2014, the NHP continued its commitment to improving the quality of life of those living with and affected by HIV. There have been many highlights.

AIDS mortality rate continues to trend down with just over 8.2 deaths/100,000 population in 2014. This reduction is attributed to the introduction of public access to antiretroviral treatment in 2004, scaling up of the national VCT programme and the use of rapid test kits allowing for earlier diagnosis, availability of prophylaxis against opportunistic infections and improved laboratory capacity to conduct CD4 counts, viral load and PCR tests.

HIV prevalence among antenatal women has declined over the last 15 years, with the 2013 and 2014 prevalence rates remaining at 1% and below. The Prevention of mother-to-child transmission (MTCT) of HIV programme in Jamaica has been highly successful and Jamaica is on track to meeting the regional elimination goal of ≤2% by 2015.

NEW IN THIS REPORT

DISAGGREGATION OF NEW HIV CASES BY GENDER, AGE CD4

There were 1295 newly diagnosed cases of HIV in 2014. Data collected for newly diagnosed HIV cases by NHP were further disaggregated by gender and showed that males (657) accounted for slightly more newly diagnosed cases than females (638). The age group 20 - 29-year-olds accounted for the largest proportion of newly diagnosed cases.

Approximately two thirds of newly diagnosed PLHIV in 2014 were first diagnosed with CD4 ≥350. This is posited to be a reflection of scaled-up HIV testing and counselling efforts, particularly with Provider Initiated Testing and Counselling (PITC), in order to facilitate early diagnosis. There is still need for wider testing as 69 (5%) cases were still notified to the National Epidemiology Unit for the first time as deaths.

INTEGRATION OF HIV AND SRH

During 2014, significant progress was made towards the goal of one national coordinating platform with the integration of the National HIV/STI Programme into the National Family Planning Board (NFPB) in 2013 to form one executive agency with responsibility for sexual and reproductive health. The National Family Planning Board, empowered by the National Family Planning Act (1970), is the Government agency responsible for preparing, implementing, coordinating, and promoting sexual and reproductive health services in Jamaica.

NATIONAL INTEGRATED STRATEGIC PLAN FOR SEXUAL AND REPRODUCTIVE HEALTH AND HIV 2014 – 2019

A National Integrated Strategic Plan (2015-2019) was started in 2014. The plan will be used to guide the implementation of the national response to HIV/AIDS and Family Planning in Jamaica. The Plan is consolidated around five priority areas:

1. Prevention and SRH Outreach
2. Universal Access to Treatment, Care and Support and SRH Services
3. Enabling Environment and Human Rights
4. Monitoring and Evaluation of HIV, Family Planning and Sexual Health Response
5. Sustainability, Governance and Leadership

A number of targets are expected to be achieved over the five year period. The key targets are:

1. Reduce by 10% the number of unplanned pregnancies by 2019
2. Reduce the unmet need for contraceptive among all women 15-44 years to 5.7% by 2019
3. Increase contraceptive prevalence rate to 76% by 2019
4. Increased dual method contraceptive use by 20% by 2019
5. Reduce by half, the number of new HIV infections by 2019
6. Increase coverage of ARV treatment for PLHIV to 65% by 2019
7. Increase to 90% the proportion of PLHIV on ART one year after initiating therapy
8. Reduce the number of HIV related deaths by 25% by 2019
9. Eliminate vertical transmission of HIV and syphilis by 2015

EPIDEMIOLOGICAL SUMMARY

Key points in this report in 2014 include:

- 29,690 persons are estimated to be living with HIV or 1.6% of the population. Approximately 19% are unaware of their status.
- Between January 1982 and December 2014, 33,193 cases of HIV were reported to the Ministry of Health. Of this 9,278 (28.0%) are known to have died.

- Some key populations are disproportionately affected by HIV with some having rates above the national average. National surveys indicate that one out of every three men who have sex with men (MSM) is HIV-infected, 4.1% of female sex workers is HIV-infected, 3.3% of inmates are HIV positive and 12% of homeless drug users.
- Fifty-two percent (52%) of reported AIDS cases in 2014 were from the most urbanized parishes (KSA, St. Catherine, and St. James).
- Approximately 75% of all AIDS cases reported 1982 - 2014 are in the 20-49 year old age group and 85% of all AIDS cases reported 1982 - 2014 are between 20 and 59 years old.
- HIV prevalence among young adolescent girls and boys aged 10-14 is equal and is estimated to be 0.1% predominantly the result of mother-to-child transmission of HIV (UNAIDS, 2014).
- Surveillance data from STI clinic attendees in 2014 indicated that for every 1,000 persons with a sexually transmitted infection, approximately 20 were infected with HIV.
- There were 10 babies born with HIV in 2014 down from 19 in 2012 and eight deaths reported up from three in 2013.

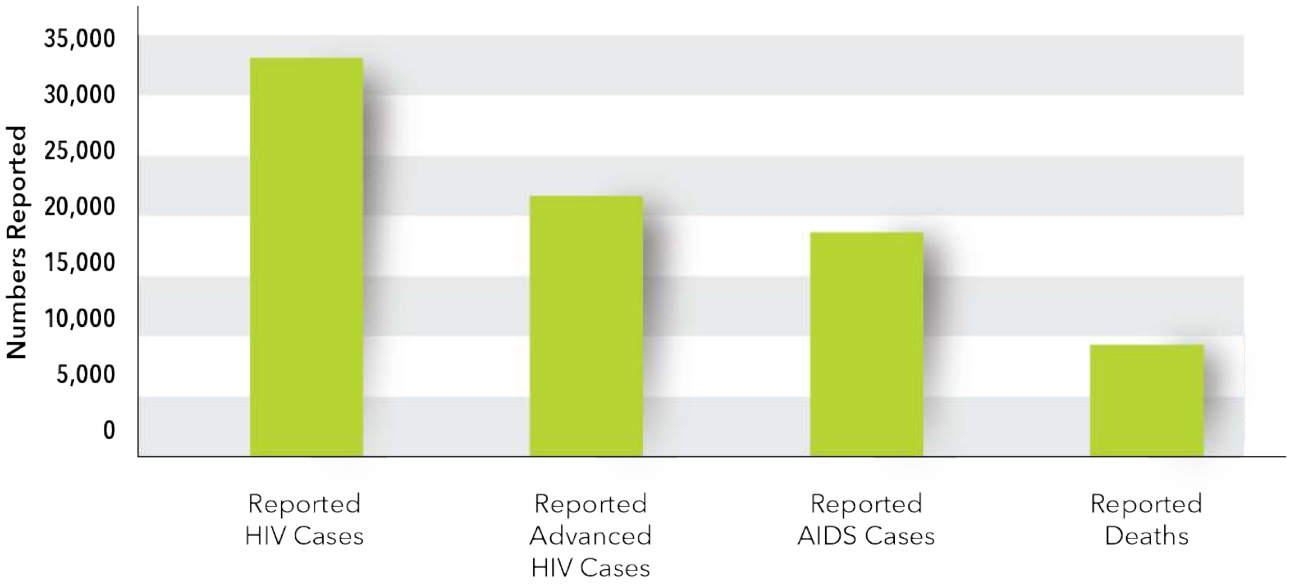
CHAPTER 1: EPIDEMIOLOGY OF HIV

INCIDENCE AND PREVALENCE OF HIV IN JAMAICA

The Ministry's 2014 HIV Epidemiological Profile indicates that "Based on modelled estimates and the case-based surveillance data, it is estimated that 29,690 persons are currently living with HIV in Jamaica" but approximately 19% are unaware of their status. Between January 1982 and December 2014, 33,193 cases of HIV were reported to the Ministry of Health. Of these, 9,278 (28.0%) are known to be deceased.

There were 1,295 newly diagnosed cases in 2014, a slight increase over the 1278 reported in 2013 but a more significant decrease from the 1551 newly diagnosed cases in 2012. In 2014, 764 persons with advanced HIV (423 males and 357 females) were reported compared to 780 in 2013. The National HIV/STI Programme began monitoring cases of advanced HIV in July 2005 to reflect the need for treatment at an earlier stage of disease. Persons with advanced HIV include persons with CD4 count <350.

Figure 1: Total Number of HIV, Advanced HIV Cases, AIDS and Deaths Reported, 1982 – 2014



Source: HATS Database, 2014

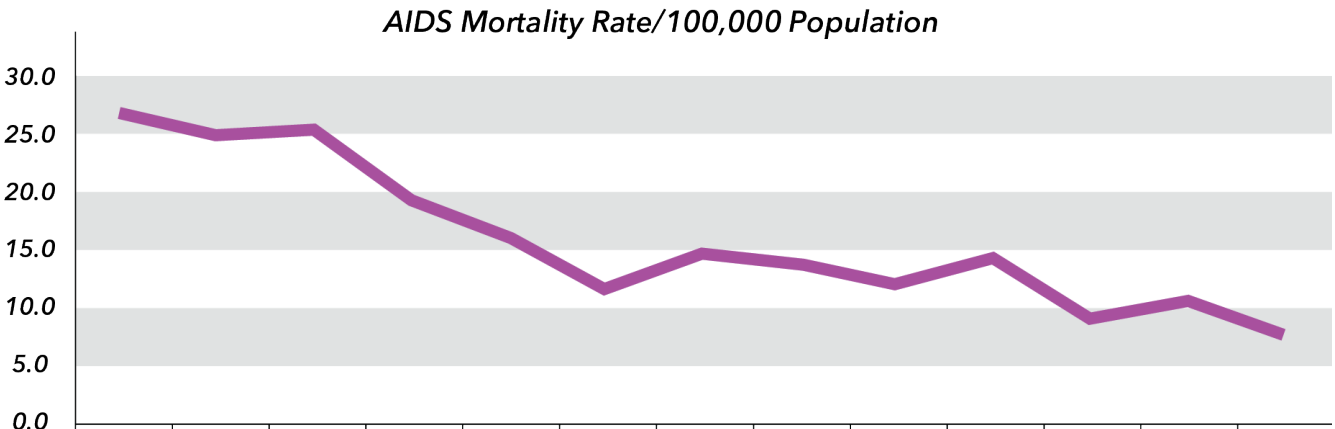
AIDS MORTALITY

Jamaica continues to produce good results in terms of deaths averted as a result of AIDS-related illnesses. Of the 33,193 reported HIV cases between 1982 and 2014, an estimated 72.04% (23,915) are estimated to be alive. In 2014, there were 222 AIDS deaths compared to 298 the previous year. This represents a 25.5% decline.

In 2014, the AIDS mortality rate declined from 25 deaths/100,000 population in 2004 to just over 8 deaths/100,000 population. This represents a 67% decline since the inception of universal access to ARVs in 2004. Additionally, Spectrum modelling estimates also confirm this declining trajectory of AIDS deaths, but suggests that there may be several deaths that are not being reported as reported deaths are only approximately 20% of the estimated number of deaths.

The decline in AIDS deaths is attributed to the increasing public access antiretroviral treatment since 2004, scaled up national VCT programme and the use of rapid test kits allowing for earlier diagnosis, availability of prophylaxis against opportunistic infections and improved laboratory capacity to conduct investigations such as CD4 counts, viral load and PCR tests are believed to have contributed to the decrease in deaths.

Figure 2: AIDS Mortality Rate/100,000 Population, Jamaica 2002 - 2014



2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
26.5	24.8	25.2	19.4	16.3	12.0	15.0	14.1	12.4	14.6	9.6	11.0	8.2

Source: HATS Database, 2014; STATIN Mid-year Populations 2002 -2013

Although Jamaica has successfully increased access to treatment and care services; analysis of data related to retention in care has shown increased loss-to-follow-up among patients on HAART. Failure to adhere to treatment and care could impact efforts at reducing AIDS morbidity and mortality.

DISTRIBUTION OF HIV IN JAMAICA

GENDER

Males (657) accounted for slightly more newly diagnosed cases than females (638) in 2014.

The cumulative male: female ratio for persons reported with AIDS is 1.32:1, and the ratio of men: women reported in 2014 are 1.37:1. The cumulative AIDS case rates are higher among males (27.8 cases per 100,000) compared to females (21.6 cases per 100,000 females). Although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually compared to the beginning of the outbreak.

There is variation in the gender distribution of reported AIDS cases across the lifespan. Young females account for the larger share of reported cases in the 10 – 29 age range. In the age group 15 to 19 years old, four times more young women have been reported with AIDS than young men. Similarly, young women aged 20 – 24 years old are one and a half times more likely to be infected than males in the same age group. Adult males account for a larger proportion of the cases reported in the 30 to 79 age group.

However, the HIV prevalence among young adolescent girls and boys aged 10-14 years is equal and is estimated to be 0.1% predominantly the result of mother-to-child transmission of HIV (UNAIDS, 2014). In later adolescence (15 – 19 years), there is an estimated increase in HIV prevalence, consistent with the onset of sexual behaviour; and by the age of 24, there

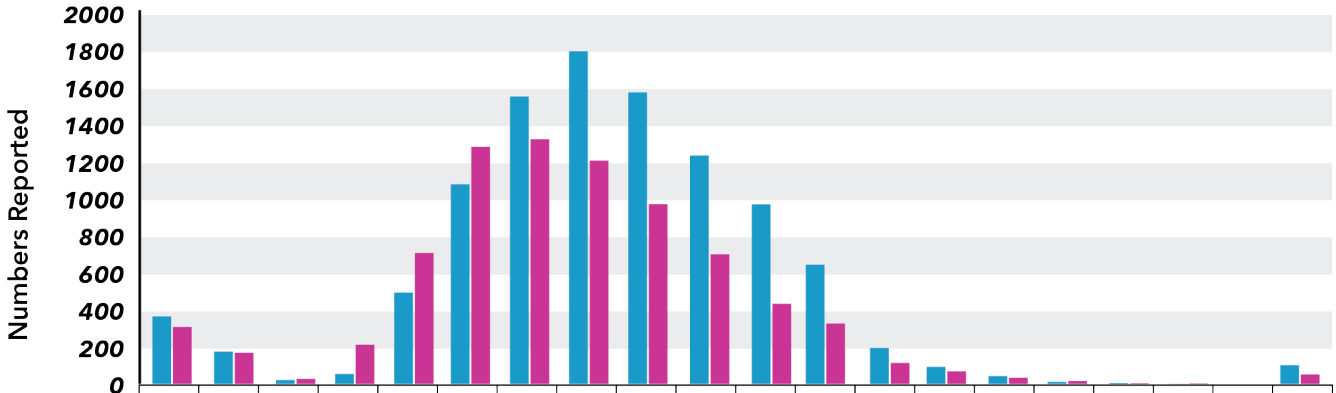
is a further increase in HIV prevalence consistent with increased sexual behaviour as well as survival and transition of HIV infected adolescents into the early adult years. Consequently, the estimated HIV prevalence rises to 1% in young women aged 20 – 24 and to 1.4% in young men in the same the group.

Data also indicates that the HIV prevalence among gay and bisexual adolescent boys is estimated to be 14% while HIV prevalence in transgender adolescents is estimated to be 27% (National HIV/STI Programme, 2014). The NHP notes that the figure represents underlining extreme vulnerability and the urgent need for sustained HIV prevention, treatment, care and support response for these adolescents.

AGE

Approximately 75% of all AIDS cases reported between 1982 and 2014 are in the 20-49 year old age group and 85% of all AIDS cases reported 1982 - 2014 are between 20 and 59 years old. Cumulatively, there is a steep incline in the number of AIDS cases from 10 – 24 years. The number of AIDS cases reported among 20-24 year olds (1,109) is over 4 times the number of cases reported among 15-19 year olds (250 cases).

Figure 3: Cumulative AIDS Cases Reported by Age Group and Sex, 1982 - 2014



	0 to 4	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	50 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 to 94	UNK
Male	360	172	20	52	488	1067	1537	1779	1559	1221	960	637	367	191	90	41	10	4	0	99
Female	304	166	26	209	700	1268	1308	1195	961	693	428	322	322	111	66	32	14	3	2	50

GEOGRAPHICAL AREA

The proportion of reported cases from the most urbanized parishes has decreased in recent years. Fifty-two percent (52%) of reported AIDS cases in 2014 were from the most urbanized parishes (KSA, St. Catherine, and St. James). This is a decline from sixty-one (61%) percent of reported AIDS cases in 2013 coming from the most urbanized parishes (KSA, St. Catherine, and St. James) and from 59% in 2012. These figures are a notable decrease from 70% of cases in 2008.

However, despite the recent decrease in proportion of reported cases, the most urbanized parishes still have the highest cumulative number of reported HIV cases: Kingston & St.

Andrew – 1,017.9 cases per 100,000 persons, and St. James – 1,498.9 HIV cases per 100,000 persons. The parishes - KSA and St. James - have cumulative case rates that exceed the national case rate (690.5 cases/100,000 population).

In addition to the urbanized parishes, parishes with significant tourism-based economies have the next highest level of cumulative number of reported HIV cases since the start of the epidemic: 754.9.0 cases per 100,000 persons in Westmoreland, 684.2 cases per 100,000 persons in Trelawny, 677.6 cases per 100,000 persons in St. Ann, and 647.4 cases per 100,000 persons in Hanover. Of note, all parishes in the Western Region are counted among those with the highest cumulative number of HIV cases.

HIV TRANSMISSION CATEGORIES

In Jamaica, HIV is primarily transmitted through sexual intercourse. Among all reported adult HIV cases on whom data about sexual practices are available (77% of cases), heterosexual practice is reported by 95% of persons.

In 2014, the sexual practice of 44% of men reported with HIV (and 41% of men reported with AIDS) was unknown (figures which remain unchanged from 2012 and 2013). This is due to inadequate investigation and reporting of cases as well as unwillingness among men who engage in sex with other men to disclose their sexual practices. Of the total number of men reported with HIV, 4% (669) were identified as bisexual and 4% (618) identified as homosexual.

PERINATAL HIV

In 2014, a total of 10 paediatric AIDS cases (children 0 to 9 years old) were reported compared to 78 paediatric AIDS cases in 2005. In 2012 a total of 19 cases were reported and in 2013 a total of 10 cases were reported. This significant decrease reflects the success of the Prevention of Mother-To-Child Transmission (pMTCT) programme in reaching HIV-infected women.

The pMTCT programme in Jamaica has been highly successful and Jamaica is on track to meeting the regional elimination goal of below 2%. The country currently has in place the required policies, guidelines, and an integrated service delivery system to ensure access to the necessary range of services, including sexual and reproductive health care, antenatal care (ANC), as well as HIV and syphilis testing, treatment, and care.

The success of the programme is reflected in the low mother to child transmission rate of 1.1% (2014). The number of reported paediatric AIDS cases (0 - 9 years old) declined from 61 cases in 2004 to 10 in 2014. Utilising an opt-out HIV testing protocol for pregnant women in both public and private health sectors, national surveys show that 91% of women who were pregnant 2010 to 2011 were tested and received counselling (KABP, 2012). Additionally, in 2013, most HIV infected pregnant women and HIV-exposed infants within the public sector received ARV medication in order to prevent mother to child transmission.

RISK BEHAVIOURS AND OTHER FACTORS FUELLING THE EPIDEMIC IN JAMAICA

Persons with a history of STI represent the highest category of risk behaviours that led to HIV in 2014. This has been the trend for decades and in 2014 accounted for 33.9% of reported cases. This is closely followed by persons who report having sex with sex workers (14.2%), multiple sexual contacts (13.5%), crack/cocaine use (4.2%) and IV drug use at (0.61%).

'No high risk behaviour' (16.9%) was reported for a notable proportion of HIV cases and this may represent persons who have one sex partner who was HIV infected by another partner.

Of the 192 cases of IV Drug use reported since 1982, 85 (44%) were reported in the period 2008 - 2014. This significant increase in IDU in the last couple of years might reflect increased coverage among homeless drug users; as well it could indicate an important shift in the modes of transmission of HIV in Jamaica.

Table 1: Risk factors influencing HIV epidemic in Jamaica

Risk	No. of Persons (%)
Sex with sex workers	4,487 (14.2%)
Crack, Cocaine use	1,337 (4.2%)
STI History	10,690 (33.9%)
IV Drug Use	192 (0.61%)
Multiple Sexual Partners/contacts	4,256 (13.5%)
No high risk behavior	5,321 (16.9%)

Jamaica continues to exhibit features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.6%, however surveys show higher HIV prevalence in some population groups.

Data from surveillance of STI clinic attendees in 2014 indicated that for every 1,000 persons with a sexually transmitted infection, approximately 20 were infected with HIV. In 2013 approximately 24 in 1000 STI attendees were HIV positive and in 2012 the figure stood at 26 indicating a steady decline over the three year period.

Further, 67% of STI clinic attendees tested in the sentinel surveillance were females - 1.87% of these females tested positive for HIV compared to 2.15% of male STI attendees in 2014.

Table 2: HIV Seroprevalence rate among STI Clinic attendees by parish, 2014

Parish	Total Tested	Total Positive	%Positive	(95%CI) exact
Kingston & St. Andrew	1448	35	2.42	1.74 - 3.34
Manchester	415	0	0.00	0.00 - 0.92
St. Ann	377	4	1.06	0.41 - 2.70
St. Catherine	1126	24	2.13	1.44 - 3.15
St. James	401	5	1.25	0.53 - 2.89
Westmoreland	315	12	3.81	2.19 - 2.43
TOTAL	4082	80	1.96	1.57 - 2.43

**Survey conducted between Apriland September 2014*

The main drivers of the HIV epidemic are closely tied to poverty and related development issues, including the slow rate of economic growth, high levels of unemployment, low academic achievement, early sexual debut, multiple partnerships, and transactional and commercial sex.

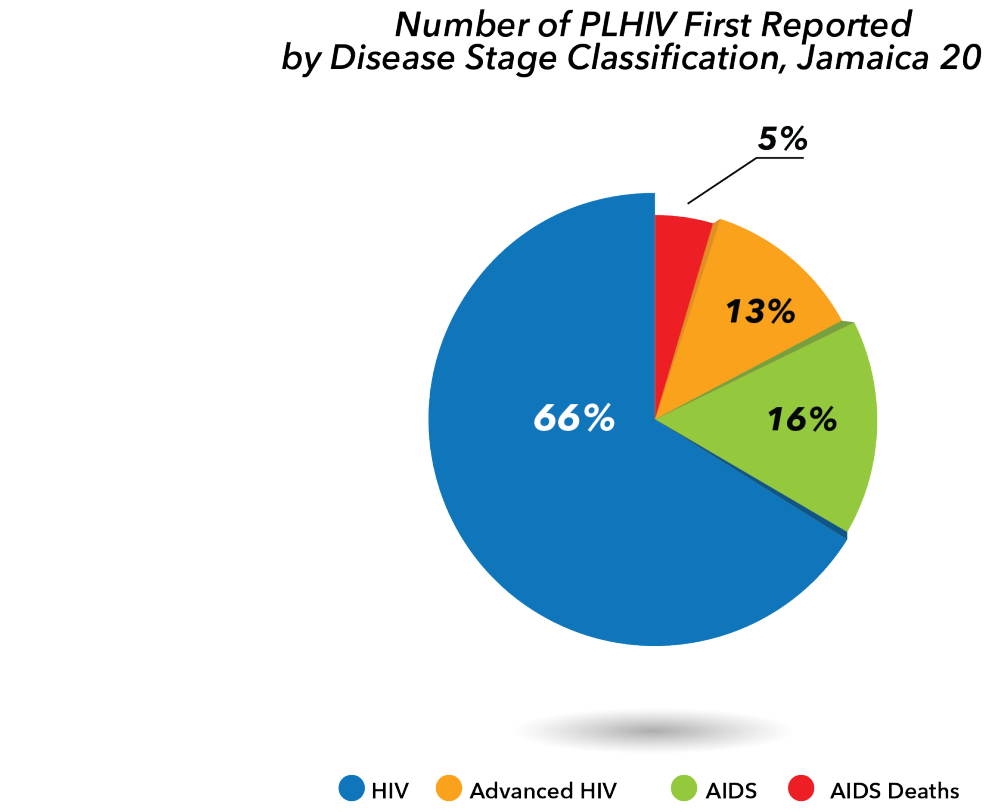
TRENDS IN HIV AND AIDS

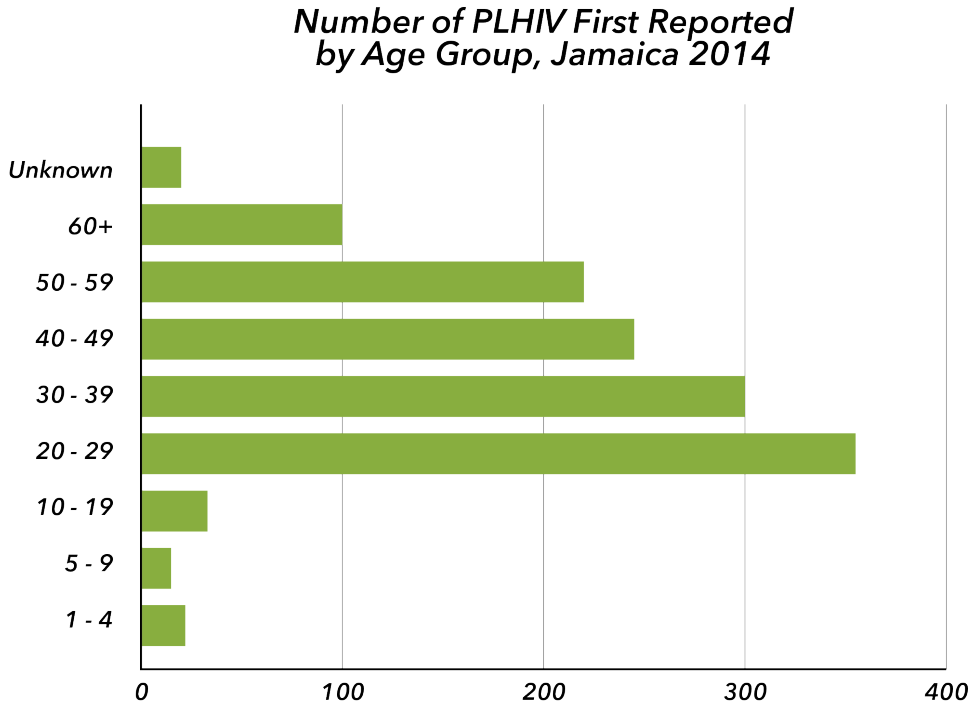
Jamaica's latest country report to the UNGASS indicates that while the burden of non-communicable diseases is declining in the island, "HIV continues to play a significant role in morbidity and mortality level of the population and carries great financial and human resource cost to the health sector." (Source: 2014 UNGASS Report)

There were 1,295 newly diagnosed cases in 2014. Approximately two thirds of these newly diagnosed PLHIV were diagnosed with CD4 >/=350 which likely is a reflection of scaled-up HIV testing and counselling efforts, particularly with Provider Initiated Testing and Counselling, in order to facilitate early diagnosis. However, there is still need for wider testing as 69 (5%) of these cases were still notified to the National Epidemiology Unit for the first time as deaths.

Males (657) accounted for slightly more newly diagnosed cases than females (638). The age group 20 – 29 years accounted for the largest proportion of newly diagnosed cases followed closely by those in the 30 – 39 age range.

Figure 4: Newly diagnosed by stage of disease and age





ORPHANS AND CHILDREN MADE VULNERABLE BY HIV

It is estimated that Jamaica has about 13,000 Orphans and Children made vulnerable by HIV (OVC). Generally speaking, the policy and legislative framework for the protection of children in Jamaica does not directly address the issues of children with HIV. In 2012 -2013 there was limited strategic effort around orphans and children made vulnerable by HIV/AIDS. The national treatment programme has significantly reduced AIDS deaths and the pMTCT programme has significantly reduced vertical transmission of HIV, however efforts to address the needs of the aging OVC population have not kept pace. There is a lack of data and understanding of the current situation of OVC and a recently conducted study (World Learning, 2013) presents a dismal picture of their social condition (Source: 2014 UNGASS Report).

CHAPTER 2: PREVENTION [1]

INTRODUCTION

The 2012 Knowledge Attitude Practice and Behaviour Survey confirms that the main factors driving the epidemic in Jamaica are multiple partnerships, early sexual debut, high levels of transactional and casual sex and inadequate condom use. Prevention strategies of the National HIV/STI Programme (NHP) aim at influencing underlying factors that contribute to these behaviours.

Further, the HIV landscape in Jamaica is characterised by concentrated HIV sub-epidemics within a generalized epidemic. Empirical data indicates higher prevalence rates are evident in key populations such as MSM, sex workers, homeless drug users and prison inmates. As a result, there remains a clear rationale for increased targeted prevention efforts on these sub-epidemics to supplement measures aimed at the general population in 2014. The main sub-populations that are targeted through the Prevention component were:

- Men who have Sex with Men (MSM)
- Commercial Sex Workers (CSWs)

[1] *The complete data for the Prevention Component for 2014 was not available.*

- Out of School Youths (OSYs)
- Residents in vulnerable communities
- Prison Inmates
- Wards of the state

Ms Kitty engaging the clients waiting to be tested at safer sex week 2014

The Behaviour Change and Communication Component is the key vehicle for prevention interventions. The main objective of BCC is to reduce the transmission of new HIV infections through universal access to prevention and support services, focusing primarily on key populations. The approaches adapted to reach these key populations included the use of peer support for hard to reach KPs, HIV and Syphilis testing in outreach settings, empowerment workshops and the procurement of lubricants to promote condom use.

In addition BCC teams targeted key populations at three levels: individual, group and community. The interventions strategies include: risk reduction conversation; empowerment/ capacity building workshops; psycho-educational sessions; evidence based interventions and voluntary counselling and testing (VCT). Through their interventions the BCC team delivered key messages such as:

- Promoting abstinence
- Delaying debut of sexual activity
- Reduction of multiple sex partners
- Mutual monogamy
- Promotion of rapid HIV and syphilis testing
- Promotion of appropriate treatment seeking behaviour
- Promotion of consistent and correct condom use and condom negotiation

In 2014, the focus of the Prevention programme was on delivering a range of interventions to the most vulnerable sub-populations as well as to the general population. These interventions included HIV testing and outreach and community-based interventions. These efforts were aimed at improving awareness regarding STI/HIV transmission and their prevention; engaging persons in individual (sexual) risk assessment and risk reduction planning, promotion of abstinence, and the promotion of condom use through condom distribution, condom demonstrations and condom negotiation skills building.

HIV TESTING AND OUTREACH AMONG KEY POPULATIONS

Table 3: Key Populations Reached and Tested in 2014

Entity	MSM Reached	MSM Tested	FSW Reached	FSW Tested	OYS Reached	OYS Tested
NFPB	223	63	531	132	2094	686
NERHA	218	31	1710	438	2820	1187
SERHA	813	198	3957	550	4797	4339
SRHA	314	87	2064	518		1957
WRHA	1779	119	5848	158	5434	2029
ASHE	658	347	0	0	669	578
Children First	376	174	0	0	4412	1377
Hope Worldwide	0	0	0	0	1246	531
JASL	1400	508	1610	1211	0	0
Jamaica Red Cross	259	66	414	91	4386	925
RISE	48	47		42	510	95
TOTAL	6088	1640	16134	3140	26368	13704

The table above indicates the total number of key population reached and tested in 2014.

COMMERCIAL SEX WORKERS

There was a significant reduction in the rate of infection among female sex workers moving from 4.1% in 2011 to 2.9% in 2014, based on the 2014 Sex Work Survey. The reduction is linked to significant expansion, geo-targeting and intensification of interventions with the sex workers, as well as the discovery of sex worker sites. Frequent site visits continued to be a high priority strategy in order to identify new sex workers. There was a further expansion of HIV prevention programme into massage parlours over the reporting period.

TARGETED COMMUNITY INTERVENTIONS

Targeted community interventions were implemented in high-risk communities island-wide in 2014. The objectives of these interventions included:

- The promotion of mutual monogamy
- Promotion of appropriate STI health-seeking behaviour
- Promotion of consistent and correct condom use
- Promoting condom negotiation skills
- Promoting appropriate risk assessment skills

CHAPTER 3: TREATMENT, CARE AND SUPPORT

INTRODUCTION

The activities of the Treatment, Care and Support (TCS) component of the Programme are directed by the Treatment, Care and Support Unit.

The Unit is mandated to:

Manage procurement and monitoring of testing and ART supplies

Coordinate the care and psychosocial support services that are available at the various treatment sites across the country

Build the capacity of staff to deliver treatment care and support to PLHIV.

The TCS budget for 2014 was J$175.00M. In recent years, the TCS component had typically received the largest proportion of Programme funding. However, in 2014, TCS component received 21% of the Programmes 2014 budget; this compares to 32% in 2013, 40.1% in 2012. The 2014 expenditure for the TCS Component ($189.41M) exceeded the budgeted amount by 8.2%.

The work of the Unit in 2014 would have been estimated to support some 22,398 PLHIV who were linked to care (or 74% of PLHIV).

In 2014, the retention rate for clients receiving care was approximately 51% (or 11,487 PLHIV) (UNAIDS estimates, HATS and treatment site database). Close to half of the PLHIV on ARV in 2014 achieved viral suppression.

HIV TREATMENT CASCADE

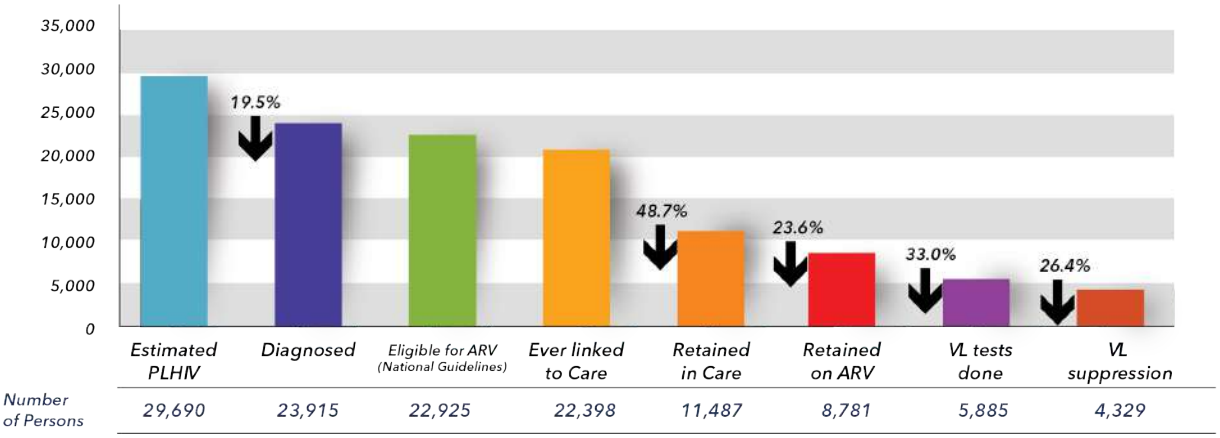
The HIV treatment cascade (Table below) presents available data on several key points for monitoring progress towards successful engagement of persons living with HIV in treatment and care in order to improve the quality of life for all PLHIV and reduce transmission.

The percentages shown indicate the coverage gap or subsequent fall off at each critical point along this continuum. Of the 29,690 individuals estimated to be living with HIV infection in Jamaica, 80.5% have been diagnosed, reported and assumed to be still alive. Testing needs to improve to reach the 20% who are still unaware of their HIV infection.

Additionally, of those persons diagnosed, at least 6% have never been seen at a treatment site (i.e. linked to care); and only a little over half of those ever linked to care (51.3%) have been seen in the last 12 months (i.e. retained in care).

'Despite consistently increasing access, the proportion of persons retained on care has been declining.' (Source: 2014 Report to UNGASS)

Figure 6: Treatment Cascade



Comparison of the numbers of PLHIV retained in care (5th column) and the numbers of PLHIV on ART (6th column) show very little gap which suggests that the persons who are retained in care are primarily the PLHIV who are on ART.

Even though the numbers who are retained in care are primarily those who are on ART, the number of PLHIV estimated to be in need of ART according to national guidelines (3rd column) (i.e. CD4<350) exceeds the number of persons who are currently retained in care. The persons who are in need of ART but not retained in care will include persons who have not yet been diagnosed; but also persons who initiated but have since defaulted from the clinic. Of those estimated to be in need of ART, just over 50% are currently on ART, of which just under half (49%) have achieved viral suppression. It is noted though that uptake of VL tests done needs to be improved as 33% of persons retained on ARV did not have a viral load test date recorded in the past 12 months.

Persons living with HIV received care at 23 public treatment sites island-wide during this period. All public sites are located at facilities that provide other health services, making care for PLHIV available within an integrated service setting. In addition, a total of 75 NHP/MOH certified practitioners offered service to PLHIV in the private sector. Care and support services were enhanced by the addition of four regional psychologists, who provided counselling to over 1,300 persons in 2012-2013. (Source: 2014 UNGASS Report)

HIV TESTING, SUPPORT AND PITC UPTAKE

HIV TESTING

The results of a 2012 Knowledge Attitudes, Behaviour and Perception survey revealed that 59.1% of men and women aged 15-49 years had received an HIV test in the past 12 months and were aware of their results. More recent estimates (using past treatment database figures) show that some 30,313 persons in Jamaica are living with HIV; however, only about 75% of them are aware of their status (UNAIDS estimates, HATS and treatment site database).

Given the high prevalence of HIV amongst MSMs and CSWs, the HIV outreach testing activities for 2014, were targeted those sub-populations. This effort was made possible through the work of CSOs, NGOs and the RHAs and the unit's support in procuring and disseminating rapid test kits.

On average, an estimated 12,990 tests were done per month; approximately 155,884 were conducted for the year– 6.2% more than 2013 (146,816). Approximately 2.14 percent of those tested received positive test results.

Table 4: Summary of HIV Testing done through the Public Health System, 2014

Month	HIV Tests Done	HIV Positive Test Results	% Positive
January	13,065	289	2.21
February	16,182	181	1.12
March	12,158	122	1.00
April	24,772	430	1.74
May	12,613	277	2.20
June	9,912[2]	213	2.15
July	13,840	708	5.12
August	12,276[3]	240	1.96
September	15,952	174	1.09
October	10,186	326	3.20
November	2,488[4]	102	4.10
December	12,440	277	2.23
Total	155,884[5]	3,339	2.14

[2] *Data incomplete*
[3] *Data incomplete*
[4] *Data incomplete*
[5] *Data incomplete*

COUNSELLING

The National Programme provides support for PLHIV through a team of adherence counsellors, social workers and psychologists. The team conducts counselling, psychosocial analysis and mental health assessments. Liaison officers are assigned to each region to help support these and the contact investigators' activities.

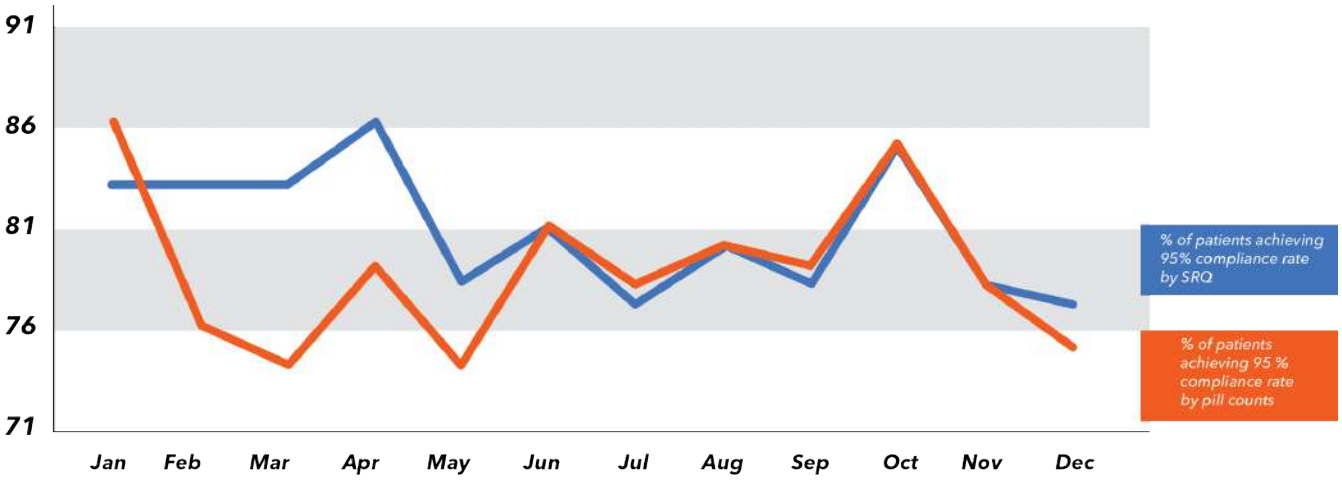
The role of adherence counsellors in monitoring treatment is a critical element in the management of HIV and treatment outcomes. The counsellors use pill counts and self-reporting questionnaires to determine adherence levels for PLHIV.

In 2014, adherence counsellors engaged with 1960 PLHIV; 6.8% (133) were newly diagnosed with HIV. During the year, social workers had 12570 interactions with PLHIV, conducted 1365 homes visits and conducted 1823 social investigations.

Table 5: Staff perspectives on factors affecting adherence in 2014

Adherence Counsellors	Psychologists	Social Workers
Adherence Issues	Anxiety	Unwillingness to disclose status
Participant in pill count	Adherence issues	Unwillingness to join support groups
Denial	Suicidal ideation	Financial constraints
Financial constraints	Adjustment issues	Adherence issues
Missed adherence counselling appointments	Marital/relationship conflicts	Inadequate social agencies to meet clients' needs

Chart 1: Percentage of Persons Living with HIV achieving 95% compliance rate by SRQ and by Pill Counts, 2014



POVIDER INITIATED TESTING AND COUNSELLING (PITC) PROGRAMME

The PITC was reintroduced in sixteen hospitals across the island. The initiative aims to provide persons who do not actively seek healthcare with an opportunity to know their HIV status as they access emergency care.

Of the 87,175 admissions at the facilities across the four RHAs, 26.8% were tested. The Southern and Southeast Regional Health Authorities recorded the highest share of tests conducted.

Table 6: PITC Uptake in Hospitals March to December 2014

Regional Health Authority	Number of Admissions[6]	Number of Admissions Tested for HIV	Uptake (%)
1. Western	17847	3106	17.4
2. North Eastern	18604	3342	17.9
3. South Eastern	29588	9969	33.7
4. Southern	21136	6946	32.9
Total	87175	23363	26.8

On average, 4% of samples tested through this initiative in 2014, returned HIV positive results.

PITC WORKSHOPS

The TCS Unit in conjunction with the CHAI team and ERTU-CHART conducted sensitization and training sessions for frontline staff in emergency departments where the thrust for PITC was being initiated. After discussions with teams from the two Type A Hospitals, KPH and CRH, best practices for PITC were developed. These include:

- The placement of HIV testing signage and other HIV related information at the critical points of entry (e.g. Accident and Emergency Department).This will assist in driving the demand for testing rather than relying solely on doctors or nurses to offer the test.
- The use of educational DVD on HIV testing to be played frequently in the waiting areas to increase awareness of patients about PITC.
- Proper completion of lab request forms is required for the timely processing of samples.
- Results ideally should be placed in patients' dockets within 24 hours. HIV test results are to be delivered several times daily to Medical Records Department and enclosed in the patients' dockets (both positive and negative results) or to the wards to which the patients have been admitted.

These guidelines were disseminated to other hospitals during the training sessions.

The counselling component of PITC (this includes consent and the choice to opt out of testing) remains a challenge in the busy setting of the emergency departments. The SMOs

[6] excluding Obstetrics

of several hospitals and the RTD in one region are considering training of the interns in VCT during their orientation period as a solution to this problem. Training of PITC trainers will be rolled out in 2015.

Local stock-outs of test kits remain the greatest challenge to efficient HIV testing and improved stock projections for 2015 should help to prevent same.

TREATMENT SERVICES

ART PROVISION

Persons living with HIV have access to 27 treatment sites across the island. Antiretroviral drugs are distributed free of cost through public pharmacies and for a nominal fee through few private pharmacies.

Of the total number of ARV dispensed for 2014, over 73% of unique patients were served with first line drugs, 24% with second line drugs and less than 1% with third line, as outlined in the table below.

Table 7: Regimen dispensed and patient served by Line of Drug, 2014

Type of Treatment			
	First line	Second Line	Third Line
Number of unique patients served	43803	13985	97
Number of months dispensed	44786	14399	97

ACCESS TO TREATMENT: TRAINING FOR PRIVATE PHARMACIES

Long waiting times at public pharmacies is a barrier to accessing treatment especially for those you have difficulty getting time off from work. Incorporation of dispensation of ARVs by private pharmacies has helped to alleviate this issue.

ERTU-CHART in conjunction with the TCS Unit and CHAI embarked on training of several private pharmacists across the island. Site visits were initially conducted to determine whether or not the pharmacies met the programme standards:

- ease of accessibility,
- confidential counselling facilities and,
- Convenient opening hours.

Following the site visits, Pharmacy Management and ARV Workshop was held in October. At the workshops, participants were updated on the national treatment guidelines for HIV, pharmacology of ART, forecasting. Additionally they discussed issues such as confidentiality, stigma and discrimination and adherence. Participants then completed a preceptorship with a pharmacy already dispensing ARVs.

Subsequent to the training, the TCS Unit acted as liaison between NHF and these newly

trained pharmacies to ensure that all requirements were met and the first ARV procurement process was a smooth one.

Follow-up visits were made to the sites after training; they provide monthly reports on their dispensing activities. The table below lists the five new pharmacies to join the Programme.

Table 8: List of new private pharmacies joining the national response, 2014

Pharmacy	Location
Royale Pharmacy	Savanna La Mar
Krysdave Pharmacy	Kingston
J&J Pharmacy	Montego Bay
Fontana Pharmacy	Montego Bay
Fontana Pharmacy	Ocho Rios

CARE SERVICES

CD4/VIRAL LOAD TESTING/DNA PCR TESTING

Services such as CD4/ Viral Load/DNA-PCR testing are critical components of ensuring that PLHIV, those who are exposed to HIV and their care providers are able to manage their health.

The CD4 and viral load tests in particular, are used as markers to monitor the stage of HIV disease of the PHLIV and the level of immune system impairment; the result are used therefore to determine the efficacy of ART on adult patients. A 2010 WHO guideline recommendation is that a patient should receive two CD4 tests and two viral load tests annually.

In 2014, 12,598 CD4 and 10,097 viral load tests were processed. Therefore, the test rate for Jamaica fell below the WHO standard with testing rate of 1.23 and 1.16 per patient for CD4 and viral loads respectively.

For 2014, 1045 DNA PCR test samples were processed for HIV-exposed infants, to confirm HIV.

Table 9: Summary of Types of Treatment Monitoring Testing Conducted 2012- 2014

HIV positive adults							HIV-exposed Infants		
Description	CD4			Viral Load			DNA PCR		
	2012	2013	2014	2012	2013	2014	2012	2013	2014
Received	11276	10813	13038	9476	10407	11490	793	765	1045
Rejected	534	423	440	513	433	506	45	21	76
Processed	10742	10234	12598	8443	6969	10097	772	719	891
Testing rate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

JAMAICA QUALITY IMPROVEMENT COLLABORATIVE (JAQIC!)

The Programme initiated the initial phase of the Jamaica Quality Improvement Collaborative (JaQIC!), from October 2013 to May 2014. The collaborative is designed to provide support to clinical care teams to learn and apply improvement methods to achieve the following goals:

I. Improve reliable ordering and completion of CD4 and viral load tests (according to national guidelines).

II. Build knowledge, skills, and experience among frontline care delivery teams in quality improvement methods and the use of data for decision-making at the local level.

Improved patient monitoring bolstered through these activities to ensure timely collection of samples at treatment sites and subsequent processing at regional laboratories and NPHL has resulted in this increased testing as shown in the table above. Rejection rates continue to fluctuate and are being reviewed to determine the root cause. Plans are in place to increase the level of CD4 decentralized testing using PIMA machines distributed in all regions in 2015. One of the greatest challenge to these testing modalities remain the rejection rate of samples. The Immunology Unit at the NPHL is planning to re-sensitize staff regarding the importance of timing sample collection to meet necessary deadlines.

REFERRAL & LINKAGE PROTOCOL FOR HIV

The Referral and Linkage Protocol for HIV was developed in conjunction with Clinton Health Access Initiative (CHAI) to streamline activities associated with accessing care at HIV treatment sites across the RHAs. An assessment of the processes of referral and linkage for patients who were newly diagnosed with HIV was initially conducted.

The protocol subsequently developed outlines these processes, the roles and responsibilities of the linkage team members, standards of care and indicators that may be used to measure the linkage process. It was disseminated through a series of meetings held in October and November 2014.

The dissemination meetings were held in the four health regions across Jamaica. Representatives from the linkage teams participated in these meetings including doctors, nurses, social workers, liaison officers, contact investigators, lab technologists and adherence counsellors. Members of CSOs such as Jamaica AIDS Support for Life (JASL) and Eve for Life were also present. Staff from the M&E Unit provided guidance on the indicators developed to assess the linkage process.

The new indicators have been incorporated into treatment site databases for evaluation and reporting purposes. Most sites anticipated that the reporting process would be easily facilitated with access to the information from the databases. While there was concern that the timeliness of appointments would result in poor reflection of efforts made to link patients to care, both the M&E Unit and the TCS Unit sought to allay these fears. The new indicators will be used to improve efficiency at each unique site rather than a measure of comparison between sites and regions. In time, each region will be expected to develop additional indicators to monitor their linkage to care process.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV AND CONGENITAL SYPHILIS

In 2014, the Programme continued its efforts to progress towards the elimination of the vertical transmission of HIV & Syphilis. The Programme partnered with the Pan American Health Organization to engage with all private health facilities in the island that offer maternal and obstetric services to sensitize them about their role in the Elimination initiative. The facilities were:

- Andrews Memorial Hospital, Kingston & St. Andrew
- Nuttall Memorial Hospital, Kingston & St. Andrew
- Hargreaves Memorial Hospital, Manchester
- Montego Bay Hospital & Urology Centre, St. James
- Royale Medical Centre, Westmoreland

The target for the elimination of MTCT of HIV is ≤0.3 per 1000 live births. The Programme continued to deliver ARV interventions to HIV-positive attendees at the ANC. In 2014, 424 HIV positive women (or 1.7% of ANC attendees) delivered babies. Of the number HIV positive mothers, 92% or 388 women received ARVs.The share of HIV positive mothers receiving ARVs in 2014, increased by 9.5% when compared to 2009.

The incidence of MTCT of HIV for 2014 was 0.15 per 1000 live births; this represents a 40% decrease when compared to 2013 (.25 per 1000 live births) and 50% decrease when compared to the average incidence of MTCT of HIV from 2009 to 2013 (0.29 per 1000 live births.

Among the 424 HIV positive women who attended the ANC in 2014, there were 417 HIV exposed infants. Of the 417 infants, 97% (406) received PMTCT interventions. The 2014 coverage rate for HIV exposed infants is consistent with the recent rates where between 2009 and 2013, on average, 98% of HIV exposed infants received PMTCT interventions.

Table 10: PMTCT Data, 2009 -2014

2008	2009	2010 *	2011	2012	2013	2014
Live Births	42372	39804	39673	39348	39500	34441
Antenatal clinic attendees	30076	26697	27985	33378	35479	24669
HIV positive women delivered	440	432	417	445	446	424
Women getting ARVs	369 (84%)	375 (87%)	354 (85%)	391 (88%)	410 (92%)	388 (92%)
HIV exposed infants	439	419	413	432	443	417

[7]

[8] *From PMTCT report not STATIN*

2008	2009	2010 *	2011	2012	2013	2014
Infants receiving PMTCT interventions	430 (98%)	408 (97%)	413 (100%)	422 (98%)	436 (98%)	406 (97%)
HIV positive infants	12	19	10	8	10	5
HIV positive infants born to mothers who tested HIV negative in pregnancy	1	2	0	2	2	0
Transmission rate	2.7%	4.6%	2.4%	1.9%	2.3%	1.2
Incidence of MTCT of HIV/1000 live births in Population	0.26	0.48	0.28	0.20	0.25	0.15

Source: MoH, JAPPAIDS

The following factors impact the efficacy of the ARV interventions to pregnant women who are HIV positive:

- The HIV status of the pregnant woman may not be known at the time of delivery.
- The timeliness of HIV antenatal screens is impacted the when the pregnant woman accesses care. Results of these screens may not be available at the time of delivery. Default from high-risk clinic is an issue and patient recovery protocol may be delayed beyond the time of delivery.
- Adequacy and adherence to ART for both pregnant mother and infant
- Lack of information about a mother's HIV status at the time of initiation of breastfeeding is a hindrance to her making an informed choice regarding feeding her infant.

Through sensitization of frontline staff to increase awareness of these issues, there have been strides towards narrowing these gaps in 2014. There was dissemination of an algorithm for bedside rapid testing for labour wards at the public hospitals to ensure that the HIV status of each woman delivered was known. Private physicians and hospitals have also been engaged through workshops detailing the eMTCT initiative and the need for reporting HIV exposed infants at the national level. The TCS Unit through the MAJ physician database also disseminated a memorandum on the eMTCT HIV/Congenital syphilis initiative on World AIDS Day 2014.

[9] *The target for the transmission rate is ≤ 2%*

The data for Congenital Syphilis has not kept up with the HIV data and the figures do not reflect the success that the health service has had over the past several years in reducing the incidence of congenital syphilis. In spite of the knowledge of health care providers of eMTCT, there is much less data available for syphilis than HIV. Steps are to be taken in 2015 to identify some of the gaps in the system, resulting in poor data flow.

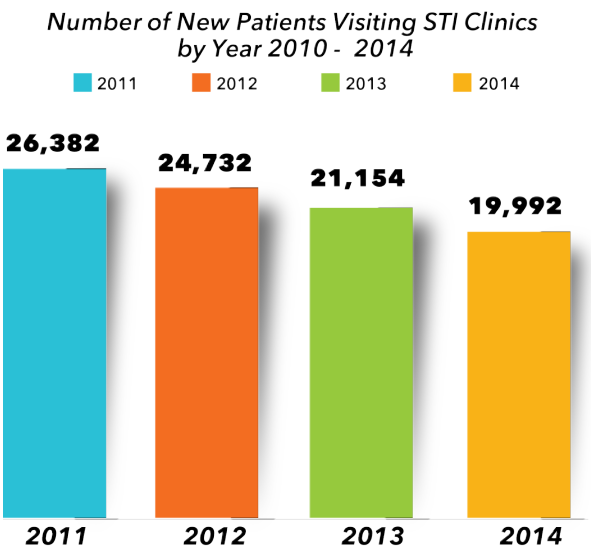
OTHER SEXUALLY TRANSMITTED INFECTIONS

In Jamaica public sector clinics are distributed across the four Regional Health Authorities (RHAs). The RHAs manage clients with sexually transmitted infections (STI) according to international standards for STI surveillance based on the syndromic surveillance model.

STI SURVEILLANCE FINDINGS

Generally, there has been a steady increase in the total number of patients visiting STI clinics every year since 2007. This is primarily due to increases in the number of revisits as the number of new cases has declined from 21649 in 2013 to 19992 in 2014 (Figure 7.)

Men represented 30% of the total number of new clients attending STI clinics in 2014 and Clarendon reported the highest number of new cases with approximately a fifth (19%, 3711) of the new patients that visited STI clinics (Figure 7).



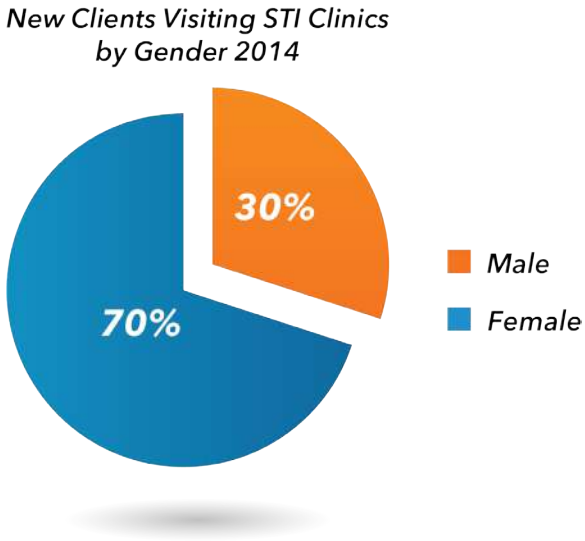
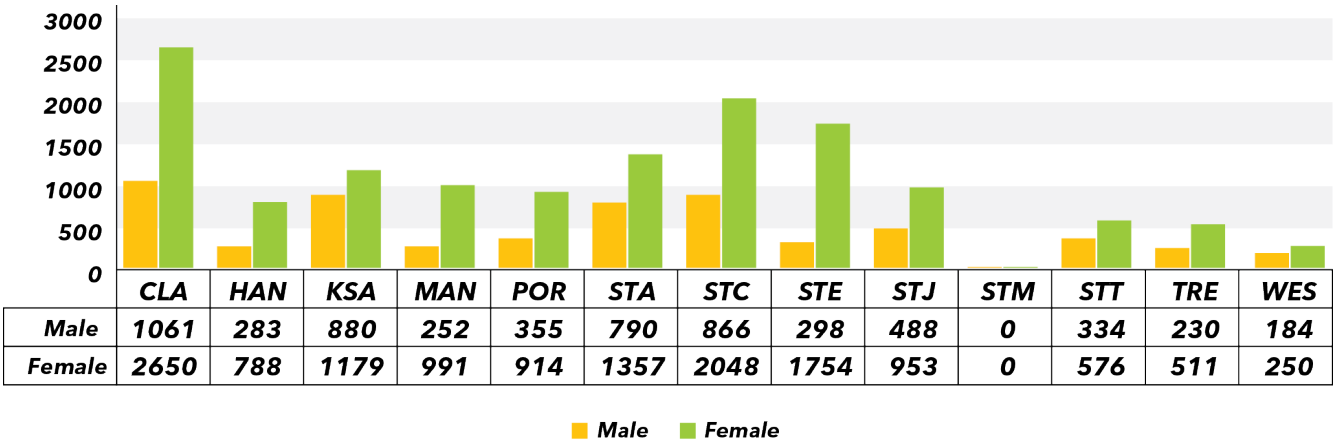


Figure 7: Number of new patients visiting STI clinics by year 2010-2013

Figure 8: New Clients visiting STI clinics by Gender 2013

Figure 9: New Patients by Sex and Parish, 2014



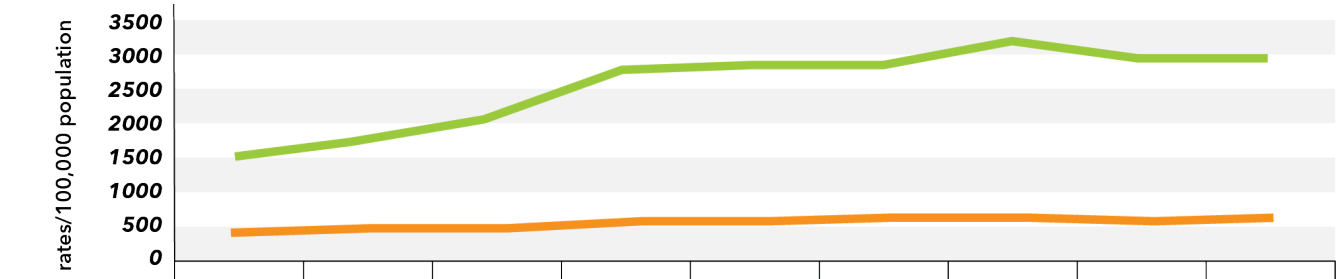
	CLA	HAN	KSA	MAN	POR	STA	STC	STE	STJ	STM	STT	TRE	WES
Male	1061	283	880	252	355	790	866	298	488	0	334	230	184
Female	2650	788	1179	991	914	1357	2048	1754	953	0	576	511	250

GENITAL DISCHARGE SYNDROME (GDS)

Genital Discharge Syndrome (GDS) includes "urethral discharge in men with or without dysuria (most commonly caused by Neisseria gonorrhoea and Chlamydia trachomatis); or abnormal vaginal discharge (amount, colour, and odour) with or without lower abdominal pain or specific symptoms or specific risk factors.

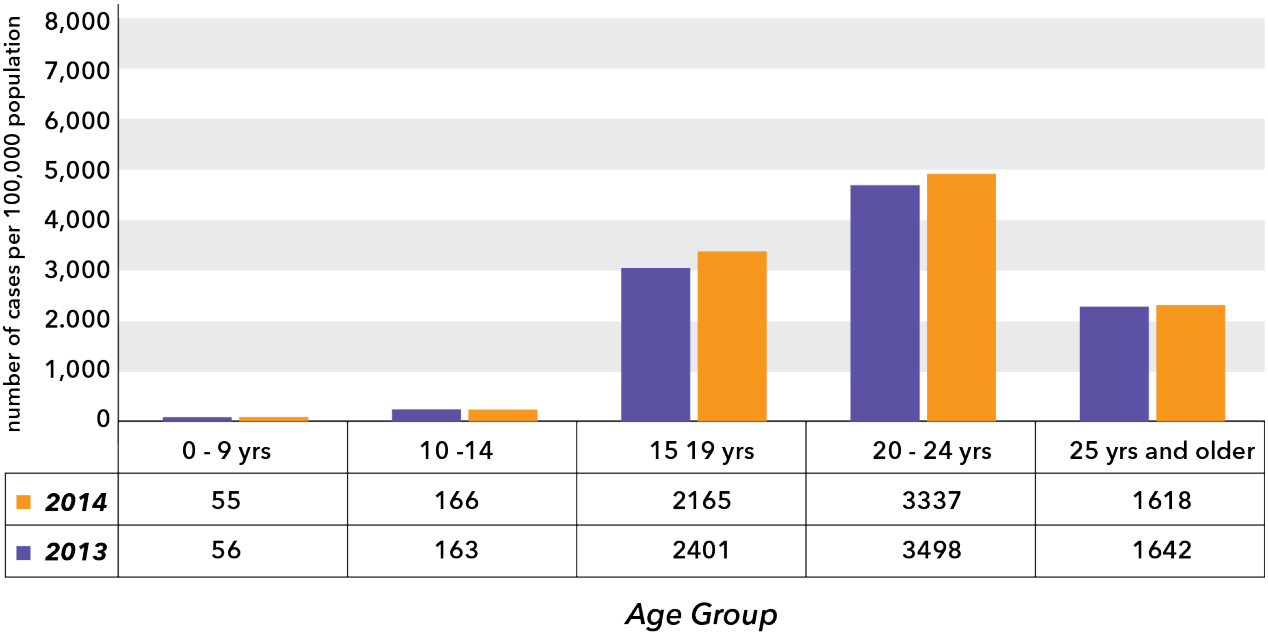
Genital Discharge Syndrome was the most common syndrome diagnosed among STI clinic attendees. Overall, the rate of reported cases of GDS has trended upwards between 2006 and 2014. Women continue to record the greatest number of cases which account for 3 to 5 times as many cases of GDS when compared to men (Figure 10). This disparity may be due to a combination of factors including greater susceptibility of women to STI, sex differences in health seeking behaviours and detection bias among women with regard to discharge syndromes. Women are more likely to present to a clinic for care and are more likely to accurately report genital discharge symptoms than men.

Figure 10: Genital Discharge Syndrome Rates/100,00 Population by Sex, 2006 - 2014



	2006	2007	2008	2009	2010	2011	2012	2013	2014
Female	1216.6	1432.2	1678.7	2372.6	2429.2	2395	2702.3	2518.1	2378.9
Male	379	392.5	465.8	528.2	540.2	561	588.7	551.5	591.4

Figure 11: Age Specific Genital Discharge Syndrome Rates/100,000 Population, 2014

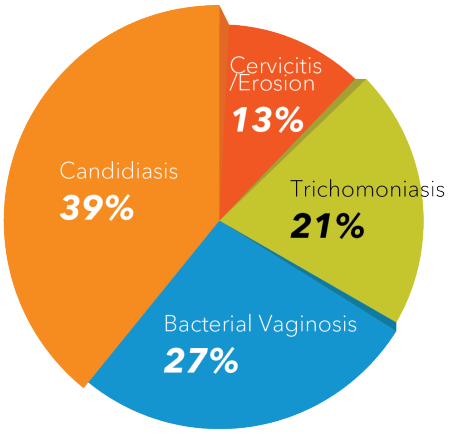


	0 - 9 yrs	10 -14	15 19 yrs	20 - 24 yrs	25 yrs and older
2014	55	166	2165	3337	1618
2013	56	163	2401	3498	1642

Age Group

Note: Total population from STATIN 2013 demographic report was used as denominator for calculation of rates 2013.
Figure 11 Age Specific Genital Discharge Syndrome (GDS) per 100000 populations 2010-2013

Genital discharge syndromes were more frequently reported in the 20-24-year-old age group followed by the 15-19-year-old age group (Figure 11). Candidiasis continued to be the most frequently reported condition among GDS cases in 2014, accounting for 12,948 (32%) of all cases (Figure 11). Gonorrhoea and Chlamydia (represented by cervicitis/erosion) accounted for approximately 11% of cases in 2013; while Trichamoniasis cases increased from to 6922 (21%) in 2013 to 7230 in 2014, and represented 18% of all reported cases.



GENITAL ULCER DISEASE SYNDROME (GUD)

Between 2007 -2014 the rate of cases of GUD showed a lot of fluctuation with a decrease noted most recently in 2014 in comparison to 2013 (Table 11).

Table 11. Genital Discharge syndrome rates/100000 Population by sex , 2012-2014

Parish	2013				2014			
	Female	Male	Total	Rate	Female	Male	Total	Rate
CLA	4991	1417	6408	2601	4436	1352	5788	2350
HAN	666	111	777	1112	517	116	633	906
KSA	5842	1851	7693	1155	5314	1894	7208	1082
MAN	3566	441	4007	2100	2524	327	2851	1494
POR	3023	364	3387	4121	2562	327	2889	3515
STA	3294	1224	4518	2608	3198	1311	4509	2603
STC	3963	810	4773	921	3991	1093	5084	981
STE	2576	244	2820	1868	2558	266	2824	1870
STJ	1305	182	1487	805	1186	149	1335	723
STM	2123	276	2399	2100	2767	375	3142	2751
STT	1883	518	2401	2543	1936	663	2599	2753
TRE	201	21	222	294	638	109	747	989
WES	303	86	389	269	244	109	353	244
TOTAL	33736	7575	41281	1522	31871	8091	39962	1474

Note: Population DATA was taken from STATIN 2012 parish population demographic report and used as denominator for calculation of rates.

Figure 12: Genital Ulcer Disease Rates/100,000 Population by Sex, 2007 - 2014

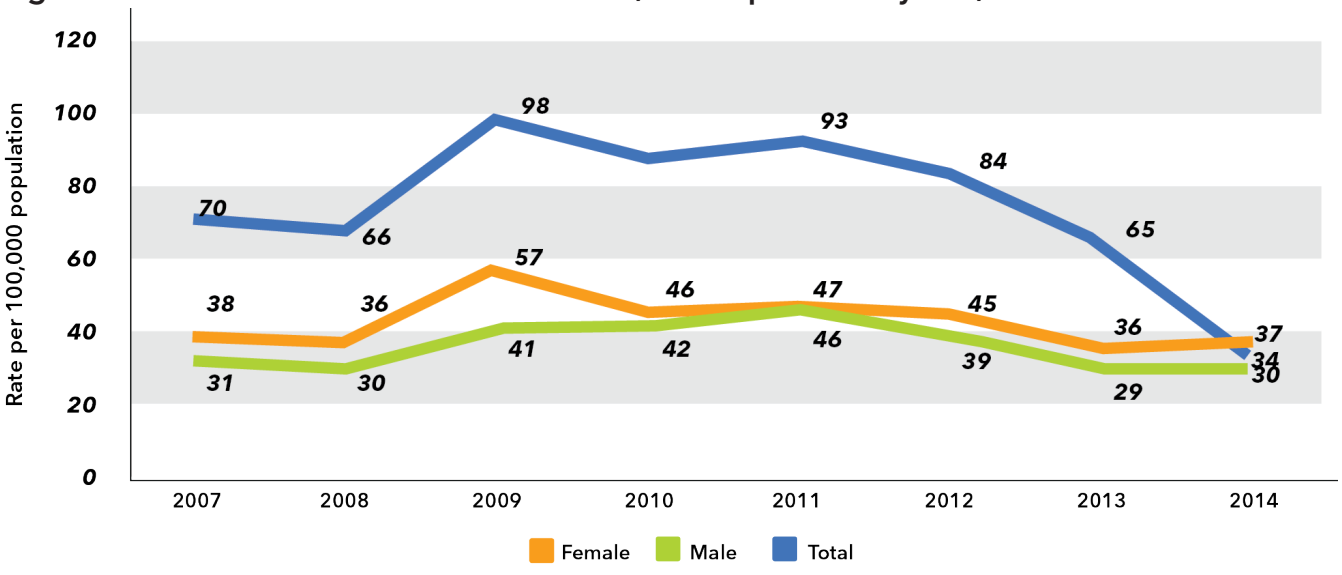


Figure 12 illustrates Genital Ulcer Disease per100, 000 populations by gender 2007-2014, and the end of year population for Jamaica 2013 was used to calculate 2014 rates.

Disaggregation by age showed that, similarly to genital discharge syndrome, the highest rates of infection were recorded in the 20-24 age group, followed by the 15 – 19 year olds. Herpes and syphilis accounted for 75% or 689 cases of reported GUD in 2014 while unspecified ulcerative diseases made up 37% of cases, also chancroid and GL/GLV) represented 1% and 1% GUD cases respectively (Figure X).

Figure 13 Distribution of the causes of Genital Ulcer disease 2014

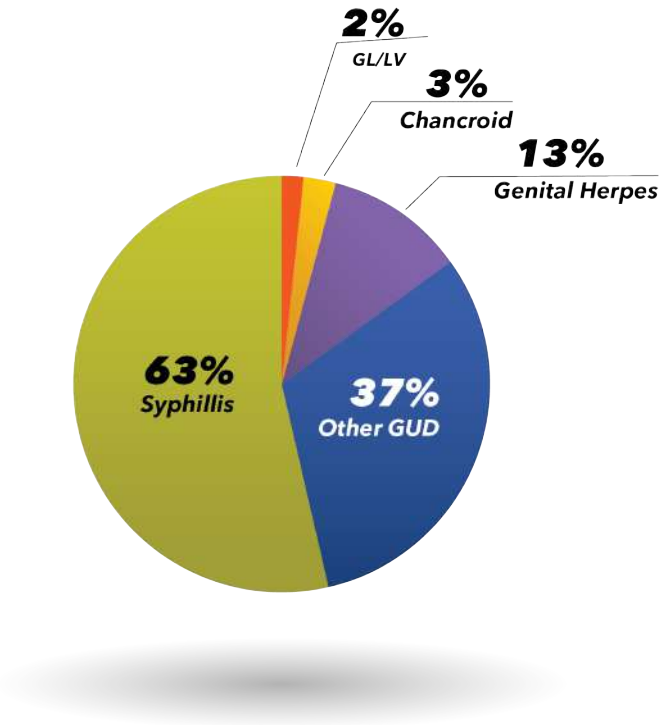


Table 12. Age-Specific GUD Rates/ 100,000 Population, 2007 - 2014

Age groups	2007		2008		2009		2010		2011		2012		2013		2014	
	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
0-9 years	1	0	1	0	1	0	0	0	3	1	1	0	2	1	1	0
10-14 years	17	6	12	4	10	4	5	2	9	3	11	4	6	2	10	4
15-19 years	146	59	100	40	150	60	153	61	147	59	158	63	161	65	157	57
20-24 years	229	110	186	90	233	112	225	108	276	131	259	130	176	88	204	79
25 or older	542	37	596	40	924	62	799	54	799	53	747	50	580	39	555	16

St Thomas, Kingston & St Andrew (KSA), and St James recorded the top three highest rates of GUD cases for 2013 and 2014 while Manchester had the lowest rate (Table below). Overall more women were diagnosed with syphilis than men over the 2007-2014 periods (figure 10). This is partly due to detection bias as women have increased access to tests for syphilis through antenatal clinics. In addition, the greater health seeking behaviour of women allows more timely diagnosis. However, it is important to note that the female to male ratio for infectious syphilis (primary and secondary syphilis) is 1.4:1 while the female to male ratio for STI clinic attendance is 4:1. This implies that infectious syphilis is more prevalent among male STI clinic attendees compared to female STI clinic attendees.

Parish	2013				2014				Rate difference
	Female	Male	Total	Rate	Female	Male	Total	Rate	
KSA	165	199	364	55	167	164	331	50	-5
STC	34	31	65	13	36	37	73	14	1
STT	64	92	156	166	96	39	135	143	-23
POR	6	13	19	23	6	9	15	18	-5
STM	4	6	10	9	23	5	28	25	16
STA	28	19	47	27	30	26	56	32	5
TRE	6	1	7	4	6	14	20	26	22
STJ	26	37	63	34	95	57	152	82	48
HAN	20	24	44	63	11	11	22	31	-32
WES	4	3	7	5	5	6	11	8	3
STE	10	17	27	18	10	10	20	13	-5
MAN	12	10	22	12	4	5	9	5	-7
CLA	22	33	55	35	20	23	43	17	-18

Figure 14: Age Specific GUD's Rates/100,000 Population, 2013 -2014

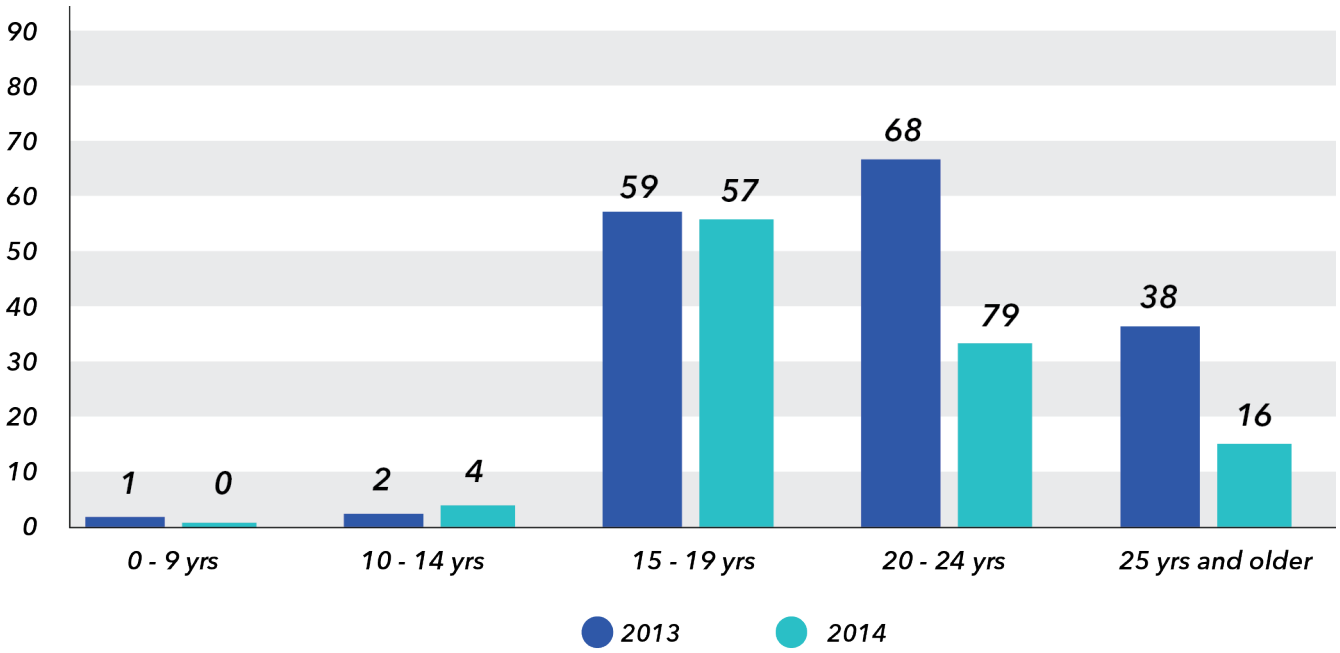
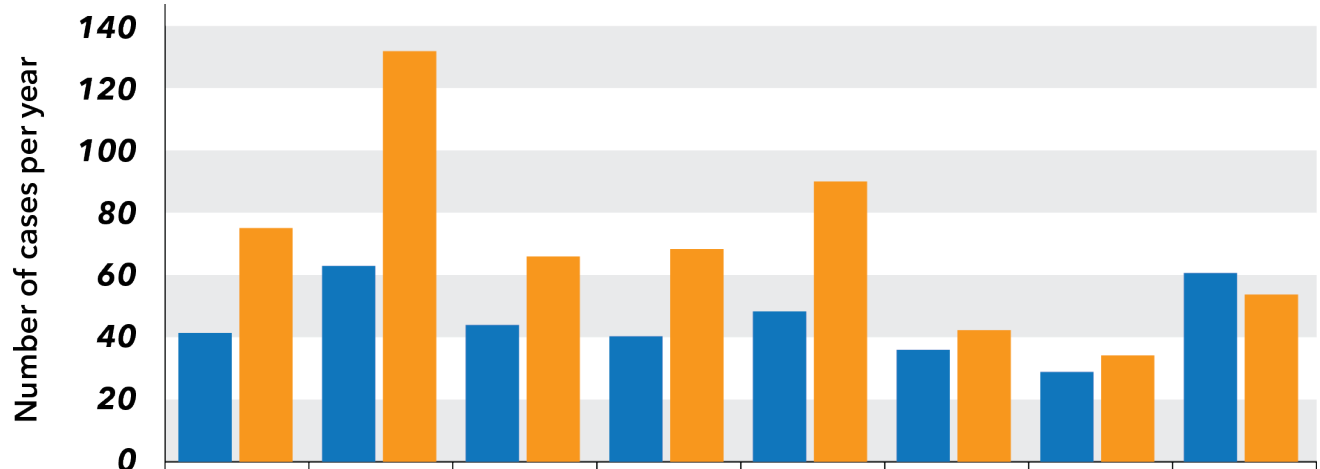


Figure 14 illustrates the age specific genital ulcer disease rates for 2014. Note STATIN2013 age specific population used to calculate rates.

Table 14. GUD Cases by year and disease category; 2007-2014

Infection	2007	2008	2009	2010	2011	2012	2013	2014
Chancroid	75	82	95	35	59	59	46	26
GL/LV	25	33	30	30	30	24	12	15
Other GUD	189	93	123	178	139	167	96	336
Herpes	433	591	972	900	775	852	694	572
Syphilis	57	53	58	66	141	79	67	117

Figure 15: Number of Syphillis cases reported by Sex, 2007 - 2014



	2007	2008	2009	2010	2011	2012	2013	2014
Male	42	63	47	40	53	37	31	61
Female	76	132	66	68	91	42	36	56

The number of cases of infectious syphilis increased by 49% among men and by 36% among women between 2013and 2014.

All age groups recorded decreases in reported infectious syphilis cases for 2014, namely categories 15-19 years through to 20-24 years (Table 5). The highest rates of primary and secondary syphilis occurred in the 20-24 age group in 2012. (Table 15)

Table 15 Infectious Syphilis cases (primary and secondary) by Sex and Age Group, 2012 -2014

Year	2013			2014			2014 difference
Sex	Male	Female	Total	Female	Male	Total	
Age groups							
0-9 yrs.	0	0	0	0w	0	0	0
10-14 yrs.	0	2	2	0	1	1	1
15-19 yrs.	13	8	21	2	8	10	11
20-24 yrs.	16	12	28	7	11	18	10
25-29 yrs.	13	9	22	16	7	23	-1
30-34	10	3	13	11	4	15	-2
35-39 yrs	7	8	15	6	8	14	1
40-44 yrs	6	6	12	5	5	10	2
45yrs and over	10	10	20	10	10	20	0
Total	75	58	133	57	54	111	22

CAPACITY BUILDING

INTRODUCTION TO COUNSELLING COURSE

In 2013, the TCS Unit secured a capacity building opportunity for the Adherence Counsellors to enrol in an Introductory to counselling course. The Adherence Counsellors (including those at JASL) were enrolled in 2014 at open campuses of the University of the West Indies. The objective of the course was to examine the general principles, goals, nature and process of counselling with individuals and groups. Participants were exposed to principles of self-awareness, the family, counselling techniques, communications skills, the counselling process and practicum exercise.

The course lasted 10 weeks, with a maximum of 30 contact hours. Most participants were successful in completing the course; four were unsuccessful, one due to medical illness.

PAHO TREATMENT 2.0 MISSION

The Joint Technical Mission for the Expansion and Sustainability of HIV care under the Treatment 2.0 Initiative in Jamaica was held in September 2014. This treatment initiative is the WHO/UNAIDS response (adapted by PAHO in LAC countries) to the financial and technical challenges which seek that hamper universal ART access.

The purpose of the mission was to discuss expansion and sustainability of HIV care with local and global authorities and other key partners as well as to determine the next steps in achieving these goals. Five areas of work (pillars) were identified under this initiative and these were comprehensively addressed during the mission. The five pillars include:

i. Updated and improved ART regimens
ii. Accessibility to diagnosis and monitoring for HIV at point of care
iii. Rational and efficient use of financial resources
iv. Appropriate and accessible HIV services
v. Community participation in the development of the initiative.

The PAHO Treatment 2.0 /Tb mission was an opportunity to evaluate the expansion and sustainability of the national HIV response.

The mission was composed of:

- Presentations from various stakeholders in the MOH and
- Site visits to the NHF, the NPHL, the NCH (Joint HIV/Tb mission) and a local treatment site.

The national working group along with the international technical team prepared the missions' findings and recommendations which they presented to Dr Kevin Harvey and Dr Marion Bullock-Ducasse, MOH at the closing session. The findings and recommendations of the mission are in Annex XX

The second phase of the joint mission will focus on the development of work plans based on the adopted recommendations. Overall the joint technical mission successfully achieved all its objectives. The near-term changes include the oversight of the national tuberculosis programme being subsumed by the NHP in 2015 with plans for revision of the national guidelines that were formulated in 2007.

CHAPTER 4: ENABLING ENVIRONMENT & HUMAN RIGHTS

INTRODUCTION

Partnerships for Action was the guiding principle for the work that was implemented by the EEHR Unit in 2014. Through partnerships the unit set out to improve the effectiveness of its operations, maximize the use of resources amongst partners and improve its impact in reducing stigma and discrimination

ESTABLISHMENT OF AN ENABLING ENVIRONMENT AND HUMAN RIGHTS TECHNICAL WORKING GROUP (TWG)

The Technical Working Group for the Enabling Environment and Human Rights Component of the national programme was established in January 2014. The group's mandate is to coordinate and strengthen the collaboration between the agencies and organizations that are advocating for a supportive environment for the national response to HIV and AIDS. The TWG is a multi-sector partnership comprised of representatives of key populations, the government, non-governmental organizations and international development partners.

The TWG was a platform for partners to collaborate on key matters such as the National Integrated Strategic Plan 2014-2019, the Global Fund Concept Note: 2015-2018, the Jamaica

Post-2015 Development Agenda, the revision of the National HIV/AIDS Policy (2005) and the indicators for the EEHR national response.

Through their participation in the TWG, the members have the opportunity to increase their understanding of each other's respective mandates and thereby providing an opportunity for possible partnerships.

GOVERNANCE AND REFORM

COALITION FOR THE REVIEW OF THE SEXUAL OFFENCES ACT

Voices for Equal Rights and Justice (VERJ), a coalition of civil society organisations was established to promote greater protection from sexual abuse in response to Parliaments' invitation for public submissions on the review of the Sexual Offences Act. The coalitions' joint submission of recommendations for changes to the Sexual Offences Act, focused on the peculiar vulnerabilities that exist amongst various marginalized populations and emphasized that there rights ought to be protected and fulfilled.

POLICY MONITORING PILOT PROJECT

A multi-sector steering committee comprising of the NFPB as the government representative, the Caribbean Vulnerable Communities Coalition as the civil society representatives, the Health Policy Project as international development partner representative and the University of the West indies HIV/AIDS Response Programme representing academia, implemented a one-year Policy Monitoring Pilot Project.

The purpose of the project was to develop a curriculum that would:

- build capacities and systems for Civil Society Organisations and representatives of key populations to monitor the development and implementation of policies and programme , and
- increase evidence-based advocacy.

The project's components included a three-day training exercise followed by two practicum exercises.

During 2014, seven (7) training workshops and meetings were held benefiting an average of 21 participants. A graduation ceremony was held in December 2014.

By the end of the project, a draft curriculum was developed and participants shared that they had a better understanding of the policy development, implementation and monitoring processes.

GREATER INVOLVEMENT OF PERSONS LIVING WITH HIV AND AIDS (GIPA)

The GIPA Capacity Building Programme is designed as an approach to target a cohort of 30 participants for six month to a year in sensitisation and training to further strengthen their abilities for community participation through self-determination and actualisation of their greater involvement based on the international GIPA principle. The efforts of GIPA serve to drive demands for effective leadership and participation of people living with HIV (PLHIV) as critical core elements in the development of an effective HIV response. It also has evolved to responding to the changing needs of stakeholders and funding priorities.

During this reporting period, the capacity building programme was coordinated through the GIPA Coordinator under the purview of the Enabling Environment and Human Rights Unit and in collaboration with the Jamaican Network of Seropositives (JN+). The main tennets of this programme are the development of a PHDP curriculum, the training of PLHIV using the curriculum, deployment of successful participants from the programme and assessment of the programme's effectiveness.

THE JAMAICAN NETWORK OF SEROPOSITIVES (JN+)

During this reporting period, the Jamaican Network of Seropositives increased its visibility through forging partnerships and increasing its interaction with its members across the island. JN+ with technical support from the GIPA capacity building programme completed a preliminary assessment of its support group system and the leaders. JN+ efforts to achieve redress for its members (who have reported experiencing stigma and discrimination) was endorsed with the Ministry of Health and the Office of the Public Defender formally agreeing to investigate their cases.

PHDP CURRICULUM

In March 2014, one of the participants of the 1st cohort of PHDP trainee was deployed to the NFPB to work with the GIPA coordinator. By the end of 2014, the journey in the development of the 15 modules of the PHDP Curriculum for PLHIV community leaders was completed with support from the USAID/PEPFAR-funded Health Policy Project and NFPB/NHP through partnerships with JN+. In December 2014, JN+ in collaboration with CRN+ launched the PHDP curriculum in Jamaica.

DEPLOYMENT OF PHDP TRAINEES – COMMUNITY FACILITATORS

During this reporting period, 23 participants were trained using the PHDP curriculum. Of the 23, four (4) were successfully deployed to health facilities of the South-East and Western Regional Health Authorities as Community Facilitator. In their capacity, they worked with healthcare workers such as the psychologist and social worker in their support group sessions and in the behaviour change communication interventions targeting and reaching

key affected populations such as sex workers and out of school youth. The deployment process continued into 2015.

The deployment of the trainees into the health sector was strategic as it supports the dialogue on treatment as prevention. This experience will be used to guide the GIPA capacity building programmes strategy in using PHDP training sessions to prepare PLHIV leaders to improve their health roles and increase their involvement in the national response achieving UNAIDS ambitious goals of 90-90-90.

Two of the elected PLHIV representatives on the Jamaica Country Coordinating Mechanism (JCCM) were trained in Cohort 1. Although the main beneficiaries of the programme are PLHIV, and Community Leaders, other key populations group such as MSM and CSW have also benefitted from sensitization sessions using modules form the curriculum.

WORKPLACE PROGRAMME

MINISTRY OF LABOUR AND SOCIAL SECURITY STEERING COMMITTEE

In an effort to increase its capacity to improve the HIV Workplace response, the MLSS established a steering committee that comprised of Directors and Senior Managers from across the Ministry, its departments and agencies. The committee's mandate was to manage and support the integration of an HIV response in the Ministry's operations and plans within the different departments and agencies. The work of the committee yielded the following results:

- Capacity building initiatives benefiting 499 members of staff at all levels across the island implemented
- Capacity building initiatives for union delegates in the areas of advocacy and policy monitoring implemented
- Assessment of Workplace Peer Education and HIV Voluntary and Compliance Programmes conducted
- Consultation to gather feedback on the draft Occupational Safety and Health Bill held and 70 stakeholders convened to participate in the final review the Occupational Safety and Health (OSH) Bill[10].
- Managing HIV in the Workplace activities implemented in partnership with the Jamaica Information Service (JIS); these include a radio feature with placement, a document feature the HIV in the world of work and a think tank session

ENGAGING THE UNIONS IN THE WORKPLACE HIV RESPONSE

The MLSS and Jamaica Confederation of Trade Unions (JCTU) partnered to design a three-phased pilot project on Policy Monitoring and Advocacy for Union Delegates. In this reporting period two of the three phases were implemented.

The first phase was a high-level breakfast meeting with leaders of the JCTU in November,

[10] *The OSH Bill was not tabled during this reporting period*

hosted by the MLSS. At the meeting the Minister of Labour and Social Security, Honourable Derrick Kellier, C.D, M.P discussed the union's role in monitoring the implementation of the National Workplace Policy on HIV and AIDS.

The second phase of the implementation of the pilot project was two-day capacity building workshop led by the MLSS where delegates at the management level of the Union were trained in policy monitoring and advocacy. A monitoring toolkit as well as a work plan for implementing the toolkit was developed during this second phase.

STIGMA AND DISCRIMINATION REDUCTION INTERVENTIONS

REGIONAL PARTNERSHIPS FOR THE ELIMINATION OF STIGMA AND DISCRIMINATION

A multi-sector committee was convened to conduct four (4) consultations with civil society organizations, faith-based organizations, private sector organizations and youth, in an effort to build awareness and support for the PANCAP Justice for All Initiative and The Human Rights Agenda.

The information gathered from these consultations was used to better understand the issues that perpetuate stigma and discrimination and possible solutions to eliminate them. A report on the local consultations, which included recommended areas of focus for each sector, for the Jamaican Justice For All initiative was compiled and disseminated amongst the participants of the consultations and PANCAP.

In April 2014, PANCAP in collaboration with the Ministry of Health and University of the West Indies hosted a three-day regional consultation on advancing the Human Rights Agenda in the Caribbean. PANCAP prepared a Declaration with actionable recommendations for consideration and approval of the Caribbean Community Heads of Government meeting to be held in July 2014. The Declaration was shared and Caribbean Community Heads of Government meeting, however it was not approved.

LOCAL PARTNERSHIP FOR ACTION TO REDUCE STIGMA AND DISCRIMINATION

A concept paper regarding the revision and updating of the National HIV/AIDS Policy was submitted to the Cabinet Human Resources Committee for approval.

Efforts to address confidentiality issues in the public health facilities, increasing clients' knowledge and understanding of available services at treatment sites and applying a human rights approach to delivering health services were some of the interventions implemented.

PARTNER-LED INITIATIVES

TRAINING OF HEALTH CARE WORKERS

JFLAG through its partnership with the Ministry of Health and the National Family Planning Board established a partnership with the four (4) Regional Health Authorities to train

healthcare providers on how to:

- Effectively provide health care services to gay and bisexual men
- Improve their Client Complaint Systems
- Improve the quality of care they deliver by monitoring the implementation of policies, guidelines and protocols.

Since the establishment of the partnership, JFLAG has reported improvements in the delivery of health care to the vulnerable groups.

WE ARE JAMAICANS

During the reporting year, twelve (12) new videos of LGBT Jamaicans and allies their local and international allies, were added to the We are Jamaicans Campaign. There are now over fifty videos with 221,733 lifetime views. In 2014, there were 78,934 views representing a 43.15% decrease in the total number of views when compared to 2013 when the campaign was launched.

THE JAMAICAN NETWORK OF SEROPOSITIVES (JN+)

During this reporting period, JN+ with technical support from the GIPA capacity building programme completed a preliminary assessment of its support group system and the leaders. JN+ efforts to achieve redress for its members (who have reported experiencing stigma and discrimination) was endorsed with the Ministry of Health and the Office of the Public Defender formally agreeing to investigate their cases.

EVE FOR LIFE

Nuh Guh Deh! Campaign

On October 11, 2014, EVE for Life officially launched the "Nuh Guh Deh!" National Campaign to End Sex with the Girl Child'. It is the organisation's response to try to curb the number of pregnant and HIV positive girls as young as thirteen years, who are referred to their programmes. The overarching goal is to contribute to reducing the incidents of sexual abuse of the girl child in Jamaica. The key outcomes sought by the campaign are:

a. Increased awareness about the long term physical, emotional, health, financial and social consequences of sexual abuse of young girls and the links to HIV.
b. Jamaicans mobilised to report acts of sexual violence against the girl child
c. Jamaicans are using the phrase "Nuh Guh Deh!" to challenge current behaviours of men who sexually exploit the girl child.

EVE for Life utilised an approach to campaign management that maximized the participation and ownership by girls and young women who are survivors of sexual abuse in the planning, development, and implementation of the initiative. It is their stories around which the campaign revolves. The stories highlight serious issues facing young girls in communities across Jamaica. Incest, rape, physical violence, silence of parents around sexual abuse, lack of parenting skills, lack of life skills, HIV and stigma and discrimination are highlighted.

CAPACITY BUILDING EFFORTS

ADDRESSING ISSUES WITH CONFIDENTIALITY

During the reporting year, The Ministry of Health and the National Family Planning Board partnered to advance efforts in addressing issues of confidentiality faced by persons with HIV and AIDS. The partnership yielded the following results:

- Draft poster illustrating the Ministry of Health's Access to Information Policy Manual was developed and distributed to the four (4) regional health authorities.
- Draft Privacy Regulations/Codes of Practice Policy Provisions for the health sector was prepared
- Revision of staff Orientation Plan of the Western Regional Health Authority to include training on confidentiality and reducing conflict between staff and clients.

The Ministry of Labour and Social Security, The National Family Planning Board and the Ministry of Labour and Social Security partnered to deliver a series of sensitization sessions targeted at key populations, PLHIV, health care workers and civil society organizations. The session was designed to increase awareness and knowledge of delivering services to key populations and PLHIV. The sessions covered topics such as the availability and accessibility of social protection mechanisms, the minimum package of services for PLHIV, and their role in monitoring and assessing the quality care.

CHAPTER 5: MONITORING & EVALUATION

OVERVIEW/SUMMARY

In 2004, the NHP established an M&E Unit to track the progress of the National Strategic Plan and hence, Jamaica's HIV response. Guided by the M&E Plan, the M&E system has been implemented and has supported the national response. In April 2013, the integration of the National HIV/STI Programme (NHP) into the National Family Planning Board (NFPB) to form one executive Sexual Health Agency was formalized.

Although the MoH retained its monitoring and responsibility of Treatment, Care & Support of PLHIV, this Sexual Health Agency has responsibility for sexual and reproductive health and will support the sustainability of the HIV Prevention and the Enabling Environment and Human Rights components.

The M&E unit's function is cross-cutting across the other components of the national HIV response and therefore, M&E often provides a supporting role in several other initiatives led by other components. In 2014, such collaborations included:

- The roll-out of the Referral and Linkage protocol that streamlines activities associated with accessing care at HIV treatment sites; and is intended to increase the number of PLHIV that are linked to care, and the timeliness with which this linkage occurs;
- The Jamaica Quality Improvement Collaboration with TCS, CHART and ITECH which was

initiated in late 2013 but continued throughout 2014 that sought to increase quality of care to PLHIV attending treatment sites through several strategies including increased data review and utilization and

- The Treatment 2.0 Mission that sought to engage the local country team and funding partners to identify opportunities to expand HIV care in a sustainable and strategic manner.

ROUTINE PROGRAMME MONITORING AND SURVEILLANCE ACTIVITIES

Throughout the year, the M&E Unit utilized the treatment cascade to monitor clinical performance through the development and launch of several new automated database reports in the treatment site database. These reports should include such information as:

- Number of PLHIV registered at the site
- Number of PLHIV seen in the last year
- Number currently on treatment and
- Numbers with undetectable viral load

The data are further disaggregated by facility, parish (where more than one site exists), region and national. The cascades once completed were shared at the annual review in 2014 and training conducted with staff at the sites around generation and interpretation of the new reports.

Surveillance data from case investigation reports and an annual sentinel sero-survey among antenatal and STI clinic attendees was also collated in an annual epidemiological update and published on the National HIV Programme's website as well as being presented to a wide stakeholder group at the Annual HIV Review in December 2014. Data was utilized to input into the Spectrum/EPP software to update the estimates of HIV trends in adults and children which are used to guide programme planning and service delivery. Spatial data entry and mapping exercises for the HIV/AIDS down to the STATIN community level were also completed and will be used to monitor hotspots.

An annual epidemiological update for 2013 data was prepared and published on the website (*www.nhpjamaica.org*) and data presented in various fora including the annual review. Semi-annual programme reporting to Global Fund and USAID, the two major donors of the HIV response in Jamaica, were completed; as well as the annual Global AIDS Response Progress Report (GARPR) to the UN General Assembly to show national progress towards reaching the '10 Political Declaration Targets'. The National Composite Policy Index component of the GARPR that shows where the strengths and gaps in terms of policy environment existed, which is done every other year, was also completed and submitted. Data reported through these channels were first validated by national stakeholders through the MERG meetings and also specific meetings convened for stakeholder validation of the GARPR report. The greatest challenge M&E faced was the timely and complete submissions of reports to the unit.

RESEARCH AND EVALUATIONS

Jamaica began work towards completing the fourth round of bio-behavioural serological surveys (BBSS) among key populations. The protocols for both studies were submitted and approved in 2014.

Data collection for female sex workers was completed in the latter part of 2014; and preparations for the formative assessment for the MSM study conducted. Several meetings were also held with programme personnel that deal with 'out-of-school youth' (OSY) from the HIV Outreach Team, SERHA, and Hope Worldwide to develop a better understanding of work being carried out with OSYs by the prevention unit at the NFPB-SHA, with the view to inform a BBSS protocol for OSYs.

An annual sentinel sero-survey was also completed among antenatal and STI clinic attendees in six sentinel sites. HIV sero-surveys on STI and Antenatal sentinel groups have been conducted in Jamaica since 1990. Throughout the years testing expanded from the original parishes of KSA (Kingston and St Andrew), St. Catherine and St. James to include other parishes and selected groups as deemed necessary, based on epidemiological evidence of STI/HIV risks. Since 2002, testing has been in six (6) parishes - three (3) urban parishes (KSA, St. Catherine and St James) and three (3) rural parishes (Manchester, Westmoreland and St Ann).

Also in 2014, the NFPB-SHA staged its second Sexual and Reproductive Health Conference during the period November 28-30, 2014 at the Jamaica Conference Centre in Kingston.

The conference opening ceremony was presided over by a distinguished panel including:

- Dr. Arun Kashyap, United Nations Resident Coordinator and Resident representative
- Dr. Kevin Harvey, Permanent Secretary, MOH
- Dr. Sandra Knight, Chairman, NFPB
- The Honourable Dr. Fenton Ferguson, MOH
- Dr. Edward Greene, UN Secretary General Special Envoy for AIDS in the Caribbean and
- Dr. Denise Chevannes-Vogel, Executive Director, NFPB

Plenaries focused on making the link between SRH programmes and national development, and the impact of SRH policies on adolescents, PLHIV and key populations. The conference also consisted of workshops throughout the day with topics such as 'Integrating family planning and HIV, are we ahead of the game?', 'Long acting reversible contraceptive technologies: guidelines for use and monitoring safety', and 'breakthroughs in fertility management: Jamaica leading the way' and urgent SRH issues among adolescents along with several research presentations. A conference magazine was also prepared and disseminated to conference attendees.

Other research activities conducted include the National AIDS Spending Assessment for the financial years April 2011/Mar 2012 and April 2012/ March 2013.

KEY TRAININGS TO IMPROVE M&E CAPACITY

The M&E Unit organized training workshops for Senior Public Health Nurses and Regional Nursing Supervisors in the areas of Monitoring and Evaluation and Record keeping. The main topics covered were Monitoring and Evaluation, Data Sources and Data Collection and Data Quality and Monthly Clinic Summary Report (MCSR).

Presentations on Record Keeping, the Contraceptive Logistics Management System (CLMS) and data use in decision making were also made. Other trainings included GIS mapping of the BCC teams to enable the diagrammatic mapping of PLACE sites; and also regional trainings in data quality and data management that highlighted the principles of good data quality and emphasized common challenges experienced in obtaining data of high standards and mechanisms to address them.

At a national level, a HIV Drug Resistance Workshop in Trinidad and Tobago June was attended by the Research Officer. The objectives of this workshop was to introduce participants to the updated WHO HIV/DR surveillance strategies utilizing a public health approach, to support countries in the development of harmonized protocols for surveillance of HIV pre-treatment resistance and acquired drug resistance in accordance with the recommendations of the PAHO/WHO and to share challenges and strategies among countries for the adaptation of protocols and implementation logistics for the surveillance of the pre-treatment and acquired drug resistance.

SUPPORTIVE SUPERVISION

One-on-one site-level training with various staff members that had responsibility for data entry and overall data management at the treatment sites were conducted with the roll-out of the updated database. Database audits were also conducted to assess the quality of inputs into the database and highlight the greatest areas of weakness at each site.

Additionally, a formative assessment of the quality of care within 12 public sector family planning clinics island-wide was performed. The assessment comprised 23 interviews with family planning clients, 12 interviews with nurses at these clinics and interviews with regional nursing supervisors. The aims of the assessment were to:

- Determine guidelines for programme accountability and
- Establish criteria for best practice in the provision and management of family planning information and service.

Among other factors, the assessment explored issues surrounding the unmet need for family planning, dual method use, marital status, contraceptive method satisfaction, HIV testing and conditions of the facility.

CHAPTER 6: FINANCE & ADMINISTRATION

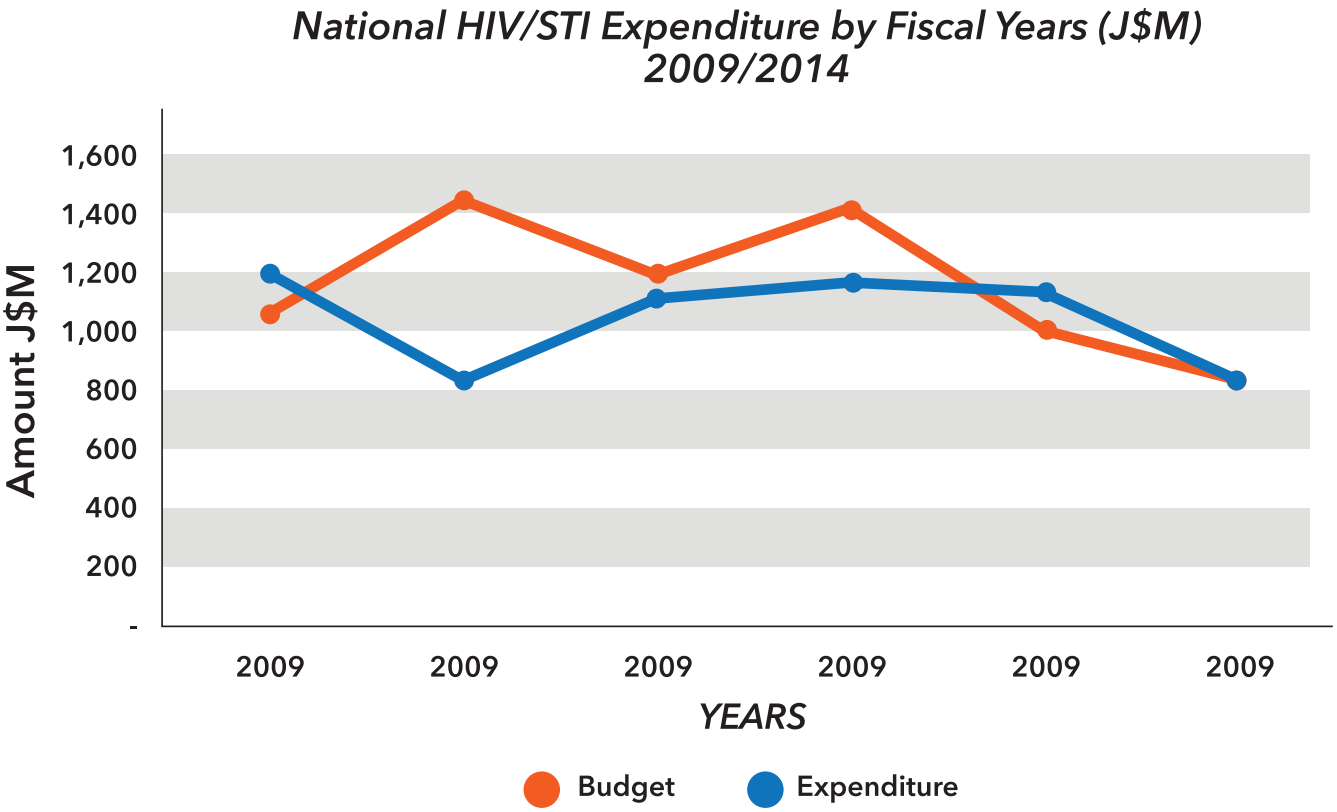
INTRODUCTION

The National Programme's work for 2014 remained guided by the National HIV Strategic Plan. The development of a National HIV Strategic Plan was one components of the process of integrating the National HIV Programme with the National Family Planning Board.

For the year 2014, the National Programme received support from a variety of sources, including the Global Fund to fight AIDS, Tuberculosis and Malaria (GF), United States Agency for International Development (USAID). Given the decrease in funding from international donor institutions, the GoJ significantly increased its support to the National Programme through its cash and in-kind contributions. Although the GoJ positioned itself as being of the largest sources of funding to the Programme, the GoJ support was not sufficient to close the gaps in previous levels of funding.

The Programme's, budget for 2014 was J$838.17M, a 17% decrease from the 2013 budget of J$1.02b. In 2013, the World Bank loan support ended. Additionally, the classification of Jamaica as an upper middle-income country fund has impacted its eligibility for previously available sources of funding.

The 2014 budget allocations returned the Programme's financial resources to below 2009 levels.



The change in the funding landscape resulted in donor agencies investing resources in the key populations that have contracted or are at greatest risk of contracting HIV. Therefore, this resulted in the GoJ efforts being strategically invested towards serving the general population.

FINANCIAL PERFORMANCE , JANUARY - DECEMBER 2014

The Programme spent 100% of its budget allocation of J$838.17. Expenditure at the Principal Recipient level was J$498.33M and J$339.99M at the Sub-recipient (SR) level. Therefore for every dollar that was spent by the PR, 68 cents was invested in the work being done by partners on the ground.

The four Regional Health Authorities, three other GoJ agencies and seven non-governmental organizations collaborated to implement the approved programme of work for 2014.

The budget allocations were directed to the following Programme Components:

i. Prevention

ii. Treatment, Care and Support

iii. Enabling Environment and Human Rights

iv. Monitoring and Evaluation

v. Administration and Capacity Building

PROGRAMME COMPONENTS

PREVENTION

The activities implemented in the PR component are aimed at reducing the spread of HIV. Despite a decrease in financial resources, the PR component was able to scale up its interventions. The National Family Planning Board is the technical lead for the PR component.

The PR component's budget for 2014 was $329.17M; of that amount, J$311.15M (94.5%) was expended.

TREATMENT, CARE AND SUPPORT (TCS)

The TCS component continued to make its contribution to the national response by providing ARVs, test kits and other medicinal supplies.

The TCS budget for 2014 was J$175.00M. In recent years, the TCS component had typically received the largest proportion of Programme funding. However, in 2014, TCS component received 21% of the Programmes 2014 budget; this compares to 32% in 2013, 40.1% in 2012. The factors that resulted in the decrease in the budget allocation include that:

- The procurement of infant formulas was one of the activities funded under the TCS component, with the support of the WB loan. With the close out of the WB loan in 2013, a GoJ funding source, independent of Programme resources, was used to procure the infant formulas in 2014.
- The resources allocated to procure ARVs (funded through the Global Fund TFM) were significantly less when compared to previous years. In 2014, the funds available for the procurement of ARVs (US$0.80M) were approximately two-thirds less of the funds available for ARV procurement in 2013 (US$2.49M). The stock of ARVs that were procured at the closing of the previous GF grant in 2013, were drawn upon to meet the Programme needs in the face of reduced funding to procure large amounts of ARVs in 2014.

The 2014 expenditure for the TCS Component ($189.41M) exceeded the budgeted amount by 8.2%.

ENABLING ENVIRONMENT & HUMAN RIGHTS (EEHR)

The NFPB was the technical lead for the EE&HR/Advocacy and Policy Component. One of component's priorities in 2014 was to advance its efforts to reduce stigma and discrimination. Through continued stakeholder engagement and sensitization, the component directed its efforts to advocating for enactment and amendment of laws and policies.

The majority of the funds for this component were committed from USAID. Of the J$44.03M spent in 2014, J$37.57M (85%) was from the USAID project.

A budget of J$62.95M was allocated to the EEHR Component; of that total, 70% (the J$44.03M) was expended.

[11] *Analysis is done using calendar year figures in keeping with the requirements of the Annual Report, thus January 2013 - December 2013. The cash basis of accounting is also applied in the Programme.*

[12] *Previously, Policy/Enabling Environment*

Table 16: Summary Budget and Actual Spending by Component, 2012-2014

Comparative Summary of component expenditures 2011 -2013						
	Calendar Year 2012		Calendar Year 2013		Calendar Year 2013	
Components	Budget J$M	Actual J$M	Budget J$M	Actual J$M	Budget J$M	Actual J$M
Cash Basis						
Prevention	405.76	366.85	301.64	440.69	329.17	311.15
Treatment Care & Support	593.90	470.07	329.21	433.64	175.00	189.41
Monitoring & Evaluation	45.56	25.33	14.19	9.50	23.68	30.56
Enabling Environment/ Policy	33.70	65.08	50.24	57.24	247.38	236.16
Capacity Building/ Administration	278.80	180.32	268.72	187.72	62.95	44.03
Health Sector	65.17	64.57	42.66	8.14	-	-
Sub total	1,422.89	1,172.22	1006.66	1,136.94	838.19	838.32
In Kind Contribution		16.23	-	67.54	-	73.35
Grand Total	1,422.89	1,188.45	1006.66	1,204.48	838.19	911.67

MONITORING AND EVALUATION (M&E)

For 2014, J$23.68M was budgeted and J$30.56M was spent. The component is tasked with tracking the National HIV response. The work of the component includes collecting, collating and analyzing all the data in support of targets and indicators for the Programme and conducting surveys and research.

One of the major achievements during the year was the submission of the Global AIDS Response Progress report to UNAIDS

CAPACITY BUILDING AND ADMINISTRATION (CBA)

This component was allotted J$247.38M, 30% of the 2014 budget. The expenditure for the year was J$263.16M; the expenditure exceeded the 2014 budget allocation by 106.4%[13].

FUNDING SOURCES

GLOBAL FUND

The TFM was used to deliver support from the GF for 2014. The approved budget for 2014 was J$307.74 and J$397.01[14] was expended. The funds supported work with regards to the

[13] *The over expenditure is due to the fact that this report covers two fiscal periods.*

[14] *The expenditure spanned two financial years of April 2013 – March 2014 and April 2014 – March 2015.*

key population and treatment care and support. The key activities undertaken were the procurement of condoms, ARVs, test kits, reagents and the supporting staff costs.

USAID

The PEPFAR project's expenditure for 2014 was J$192.98M[15] or 72% the budget allocation of J$267.22M. The resources of the project wereused to achieve the following objectives:

- Increase Safer Sex Practices
- Reduce stigma & Discrimination
- Finalize National Workplace Policy
- Provide institutional support for HIV policy making

GOVERNMENT OF JAMAICA

The GoJ's funding of J$258.04M accounted for 30% of the Programmes budget for 2014; of that amount, J$238.14M or 92% was spent. A significant portion of GoJ commitment to the Programme in 2014 was used to cover staff cost (86.4% or J$205.95M).

The in-kind contributions from the GoJ in 2014 wereapproximately J$73.35M; the funds were used to support salaries and the costs of office rental, janitorial services and security services.

Table 17: Summary of Budget Allocation and Expenditure by funding Source, 2014

Performance				Illustrative Components Funded				
Sources	Allocation ($J Million)	Expenditure ($J Million)	Burn Rate (%)	PR	TCS	EEHR	M&E	CBA
Global Fund Grant	307.74	397.01	129	•	•			
USAID	267.22	192.98	72	•		•		
GoJ (cash)	258.04	238.14	92					•
GoJ (kind)	73.35	n/a	n/a					•

[15] *The USAID financial year runs from October to September. The budget and expenditure figures are for USAID's Year 3 and Year 4 of implementation; the resources therefore span two financial years*

CHALLENGES

The challenges that the Programme experienced during the reporting year include:

- Slow disbursement of cash warrants to the Project.
- Late receipt of the initial cash disbursement from the Global Fund delayed August 2014 timeline for the Programme implementation schedule.
- Timeliness in the submission of report from field implementers
- Delays in submissions of the audited financial statements to the Global Fund.
- Increased efforts to strengthen of the internal control of the finance units both at the PR and the SRs levels.
- Co-mingling of resources for the Global Fund projects

APPRAISALS

The audits for USAID and the Global Fund Projects were conducted as per the terms of the project agreements. The audit for Global Fund reporting year was conducted by KPMG for the period Aug 2013 to Mar 2014 and by the firm of Mair Russell for the period Apr 2014 to Mar 2015.

The audit for the USAID Project for Feb 2013 – Feb 2014 and Mar 2014 – Mar 2015 was conducted by BDO.

CHAPTER 7: GOVERNANCE

HIV is recognized as a development issue and requires a multi-sectoral response. Government ministries, civil society organisations (CSOs) and International Development Partners (IDP) continued to play an important role in implementing the priorities of Jamaica's HIV response under the national strategic plan. In particular, the following ministries and civil society organisations conducted activities in collaboration with the NHP:

1. Ministry of Labour and Social Security
2. Ministry of Industry and Tourism
3. Ministry of Education
4. Ministry of Youth and Culture
5. Ministry of Local Government
6. Ministry of Justice
7. Ministry of National Security
8. Jamaica Red Cross
9. Jamaica AIDS Support for Life (JASL)
10. Children First

11. Jamaica Network of Seropositives (JN+)
12. Jamaica Community of Positive Women (JCW+)
13. ASHE Performing Arts Ensemble
14. Jamaica Forum for Lesbians All-Sexuals and Gays (JFLAG)
15. EVE for Life
16. Hope Worldwide

INTEGRATION OF HIV AND SRH

In 2014, significant effort was made towards achieving one national coordinating platform started with the integration of the National HIV/STI Programme into the National Family Planning Board (NFPB) in 2013. The NFPB is now recognised as the one executive agency with responsibility for sexual and reproductive health in Jamaica. The NFPB, empowered by the National Family Planning Act (1970), is the Government agency responsible for preparing, implementing, coordinating, and promoting sexual and reproductive health services in Jamaica. In 2013 the Jamaican Government gave approval for the integration of certain components of the National HIV/STI Programme into the NFPB. The components that were integrated were:

- Support to Treatment and Care Services
- Prevention and SRH
- Enabling Environment and Human Rights
- Monitoring and Evaluation

The overall direction and leadership of the response currently lies with the Sexual Health Authority. It has the legal status and mandate to autonomously manage and coordinate the national response with formal reporting relationships to government authorities at ministerial and administrative levels.

While coordination of the response lies with the Sexual Health Authority, the four regional health authorities have responsibility for implementing programmes and services at the regional level. Further, other ministries Ministry of Labour and Social Security; the Ministry of Industry and Tourism; the Ministry of Education; the Ministry of Youth and Culture; the Ministry of Local Government; Ministry of Justice and the Ministry of National Security - also continue to implement HIV response programmes.

The central Ministry of Health retains those aspects of the former National HIV/STI Programme - now known as the HIV/STI/Tb Unit in the Ministry of Health - that currently focus on Policy, Treatment and Surveillance, Quality and Standard Setting.

NATIONAL INTEGRATED STRATEGIC PLAN FOR SEXUAL AND REPRODUCTIVE HEALTH AND HIV 2014 – 2019

Since 1988, Jamaica has had a national plan to guide the response to HIV and a well-established National HIV/STI Programme. Revision of this strategic plan, began in 2014 and will be finalized in 2015. The new plan is expected to reflect a new integrated approach for sexual health services and should guide the joint delivery of family planning and HIV

programmes in Jamaica.

Sexual and reproductive health and rights – as part of inalienable human rights, forms the core emphasis of this National Integrated Strategic Plan for Sexual and Reproductive Health and HIV (2014-2019). The plan provides a blue print for achieving the vision of an integrated programme while supporting the achievement of the Millennium Development Goals (MDGs) and the emerging themes in the2030 sustainable development goals Agenda. Furthermore, the plan responds to the Government of Jamaica's thrust to rationalize the public sector through the creation of a single sexual health authority.

The NISP was developed through a highly consultative process involving input and representation from government, the private sector; civil society organizations including faith based organizations; youth; PLHIV and organizations representing those living with HIV and AIDS, and international development partners. The goals, priorities and key actions were derived from the situational analysis, SWOT analysis, the NFPB and National HIV/STI Strategic Plans and international best practice.

The development process is expected to last for just over one year and already some key consultation meetings in various sectors and a comprehe nsive review of the then existing strategic plan on HIV.

The Plan is consolidated around five priority areas:

1. Prevention and SRH Outreach
2. Universal Access to Treatment, Care and Support and SRH Services
3. Enabling Environment and Human Rights
4. Monitoring and Evaluation of HIV, Family Planning and Sexual Health Response
5. Sustainability, Governance and Leadership

A number of targets are expected to be achieved over the five year period. The key targets are:

1. Reduce by 10% the number of unplanned pregnancies by 2019
2. Reduce the unmet need for contraceptive among all women 15-44 years to 5.7% by 2019
3. Increase contraceptive prevalence rate to 76% by 2019
4. Increased dual method contraceptive use by 20% by 2019
5. Reduce by half, the number of new HIV infections by 2019
6. Increase coverage of ARV treatment for PLHIV to 65% by 2019
7. Increase to 90% the proportion of PLHIV on ART one year after initiating therapy
8. Reduce the number of HIV related deaths by 25% by 2019
9. Eliminate vertical transmission of HIV and syphilis by 2015

CHAPTER 8: ANNEXES

ANNEX 1: OTHER RESOURCES

FINDINGS AND RECOMMENDATIONS OF THE JOINT PAHO TREATMENT 2.0 AND TUBERCULOSIS MISSION JAMAICA 2014

Mission findings emphasized the use of local data to drive activities delineated under the work pillars. Hence, one recommendation was to monitor the trends in late diagnosis by region and parishes, as well as the epidemiological profile of cases with late diagnosis. This will in turn inform strategies to promote retesting for earlier diagnosis in key populations, pregnant women in third trimester and people with risk exposure, another recommendation presented. Another major recommendation was to update ART initiation criteria based on WHO 2013 consolidated guidelines. These guidelines include initiation of ART in adults and adolescents with CD4 counts less than 500 and in children less than 5 years old and serodiscordant couples regardless of CD4 count. They also include adoption of Option B+ for PLHIV who become pregnant.

Recalibration of the World Bank sustainability study formed another key recommendation in order to identify feasible resources to cover the financial gaps in the HIV response. The latter speaks directly to the sustainability of the programme and forms an important part of considerations of the adoption of the 2013 WHO guidelines.

initiative. Key recommendations included a co-ordinated response from CSOs to facilitate further engagement in the HIV response such as documenting performance indicators and addressing policy barriers to enable CSO participation in HIV care. Recommendations were also tabled for strategic information such that epidemiological analysis would be utilised to inform the direction of the national response and for stigma and discrimination regarding legal reforms and sensitization of workers in the public healthcare system.

HIV/TB RECOMMENDATIONS

The objectives of the Tb Mission were to address the national response to TB-HIV co-infection and implementation of WHO Tb guidelines regarding DOT and FDC drugs. The agenda included meetings with National Tuberculosis Programme manager and team and site visits to the National Chest Hospital and the National Public Health Lab (reference lab for Tb) and a primary health care facility. Dr Rafael Lopez Olarte, PAHO Regional Tb Advisor presented his findings and recommendations to the Permanent Secretary, Dr Kevin Harvey and Chief Medical Officer, Dr Marion Bullock-Ducasse during the mission debriefing session. Key recommendations proposed include:

- Updating the Tb National Strategic Plan to address high TB risk populations in Jamaica and development of national Tb and Tb/HIV clinical guidelines per latest WHO recommendations.
- Implementation of DOT in accessible health facilities using a Tb patient centered approach (with the aim of discarding the practice of isolation of pts for two months in hospital).
- Development of an effective Tb training program for health professionals and students.
- Urgently address the issues that will reinitiate TB culture in the national reference laboratory while strengthening and expanding the quality assurance program and developing a formal mechanism for performing drug susceptibility testing (DST) in a Tb supranational laboratory.
- Establish a Tb/HIV coordinating body at national level for planning, surveillance and monitoring.
- Ensure availability of Tb drugs and rapid HIV tests for Tb patients in the National Chest hospital and other treatment health facilities.

NATIONAL HIV · STI · TB PROGRAMME

ANNUALREPORT

2015

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARV	Anti-Retroviral
CDC	Centres for Disease Control
CHAI	Clinton Health Access Initiative
CSO	Civil Society Organization
EEHR	Enabling Environment and Human Rights
GF	Global Fund to fight AIDS, Tuberculosis and Malaria
GoJ	Government of Jamaica
HADS	HIV/AIDS Tracking System
HIV	Human Immuno-deficiency Syndrome
JaQIC	Jamaica Quality Improvement Collaborative
JN+	Jamaican Network of Seropositives
MAJ	Medical Association of Jamaica
M&E	Monitoring and Evaluation
MLSS	Ministry of Labour and Social Security
MOH	Ministry of Health
NERHA	North Easton Regional Health Authority
NFPB	National Family Planning Board
NHF	Nation Health Fund
NHP	National HIV/STI/TB Programme
NPHL	National Public Health Laboratory
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PHDP	Positive Health Dignity and Prevention
PLHIV	Persons Living with HIV
PR	Principal recipient
SERHA	South Eastern Regional Health Authority
SRHA	Southern Regional Health Authority
SOP	Standard Operating Procedure
SMO	Senior Medical Officer
SR	Sub-recipient
TCS	Treatment Care and Support
TFM	Transitional Funding Mechanism
TPDCo	Tourism Development Company
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
UWI-CHART	Caribbean HIV/AIDS Regional Training Network
VCT	Voluntary Counselling and Testing
WB	World Bank
WRHA	Western Regional Health Authority

INTRODUCTION

This report presents information on the type, level, quality, and cost-effectiveness of services to prevent and treat Human Immunodeficiency Virus (HIV). The report also includes overviews of programmatic activities geared at reducing HIV-related stigma and discrimination, actions at policy and legislative reform, and summaries of findings from analyses of programme data from January 1, 2015 through December 31, 2015.

It highlights a range of important aspects of the response. The last decade of the epidemic has seen a shift in the HIV burden to a manageable disease. This report reflects that transition by describing trends, survival and retention in care.

Throughout 2015, the NHP continued its commitment to improving the quality of life of those living with and affected by HIV. There have been many highlights.

By the end of 2015, there were 29,000 Jamaicans known to be living with HIV and AIDS. Approximately 15% of Jamaicans are unaware of their status. Between January 1982 and December 2015, a total of 34,125cases of HIV were reported to the Ministry of Health (MOH). The majority of persons diagnosed (72%) are still living.

Of the estimated 29,000 persons living with HIV infection in Jamaica, 85% (24,650) have been diagnosed. This represents a major success in the testing capacity of the country and an early indication that Jamaica is poised to meet at least the testing target of the UNAIDS 90-90-90 targets for 2020 aimed at ending the AIDS epidemic by 2030. These targets include 90% of

people living with HIV being aware of their HIV infection, 90% of those receiving antiretroviral treatment, and 90% of people on antiretroviral therapy (ART) having no detectable virus in their blood.

The estimated HIV prevalence based on 2015 data indicates a rate of 1.6% of the adult population.

AIDS mortality rate continues to trend down with just over 9 deaths/100,000 population in 2015. This represents a 64% decline since 2004 when the rate stood at 25 deaths/100,000 population. The reduction is attributed to the introduction of public access to antiretroviral treatment in 2004, scaling up of the national VCT programme and the use of rapid test kits allowing for earlier diagnosis, availability of prophylaxis against opportunistic infections and improved laboratory capacity to conduct CD4 counts, viral load and PCR tests.

HIV prevalence among antenatal women has also declined over the last 15 years, with 2015 prevalence rate at 1%. In 2015, for every one thousand pregnant women attending public antenatal clinics, approximately 10 were HIV infected. The Prevention of mother-to-child transmission (MTCT) of HIV programme in Jamaica has been highly successful and Jamaica is on track to meeting the regional elimination goal of ≤2%.

NATIONAL INTEGRATED STRATEGIC PLAN FOR SEXUAL AND REPRODUCTIVE HEALTH AND HIV 2014 – 2019

A National Integrated Strategic Plan (2015-2019) was completed in 2015. The plan will be used to guide the implementation of the national response to HIV/AIDS and Family Planning in Jamaica. The Plan is consolidated around five priority areas:

1. Prevention and SRH Outreach
2. Universal Access to Treatment, Care and Support and SRH Services
3. Enabling Environment and Human Rights
4. Monitoring and Evaluation of HIV, Family Planning and Sexual Health Response
5. Sustainability, Governance and Leadership

A number of targets are expected to be achieved over the five year period. The key targets are:

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5. Reduce by half, the number of new HIV infections by 2019
6. Increase coverage of ARV treatment for PLHIV to 65% by 2019
7. Increase to 90% the proportion of PLHIV on ART one year after initiating therapy
8. Reduce the number of HIV related deaths by 25% by 2019

9. Eliminate vertical transmission of HIV and syphilis by 2015

ALL IN #ENDADOLESCENTAIDS

All In to End the AIDS Epidemic among Adolescents (ages 10-19) by 2030 is a platform for action and collaboration to drastically improve the situation of adolescents through critical changes in programmes and policy. Jamaica was among countries globally that initiated actions towards improving the situation of adolescents in the context of HIV and AIDS. The main aim of All In is to accelerate reductions in AIDS-related deaths and new HIV infections among adolescents by 2020 as part of the global push to end the AIDS epidemic for all by 2030.

The overall global targets for All In are a reduction by 75% the number of new infections and 65% reduction in AIDS-related deaths among adolescents. All In is seen as an opportunity for Jamaica to improve data collection, analysis and utilization for programme planning for adolescents generally.

EPIDEMIOLOGICAL SUMMARY

The Epidemiology Report for 2015 indicates that Jamaica continues to maintain significantepidemics of HIV and other sexually transmitted infections despite progress made in the last decade. The following are some of the major highlights.

As at the end of 2015, 29,000 persons were estimated to be living with HIV or 1.6% of the population. Of this, approximately 15% are unaware of their status.

There were 1,222 HIV cases diagnosed and reported to the Ministry of Health in 2015. The number of newly diagnosed HIV cases declined last year, from 1295 cases in 2014 to 1,222 and represents a 5.63% decline.

Data indicated that 67% of those diagnosed in 2015 were at stage 1 – HIV; 16% advanced HIV and 12% with AIDS. Importantly, 5% of newly diagnosed cases were deaths. This means the persons were only diagnosed in death. There was a decline in the percentage of persons diagnosed with AIDS in 2015 over 2014 when 16% were first diagnosed as AIDS. There were increases in both new HIV and advanced HIV cases in 2015 over 2014. In 2014, new HIV cases diagnosed was 66% and 13% for advanced HIV cases.

Approximately 26% of all new AIDS cases occurred in the age group 20-29 and 70% among those aged 20-49. The distribution of the new epidemic for 2015 has shown an increasing number of infections among women and in 2015, the male female ratio was 1:1. More than two-thirds of these cases (63.0%) were from three parishes – Kingston and St. Andrew (KSA), St. Catherine (STC) and St. James (STJ).

As has been the case for decades, the leading modes of transmission among newly diagnosed cases in 2015 were persons with a history of sexually transmitted infections (STI) at 2.84% and multiple sexual partnerships. Further, among males, 9% of newly diagnosed

cases were among MSM and among females, 3% were among FSW. Mode of transmission was not identified in 40% of newly diagnosed HIV cases among males.

Between January 1982 and December 2015, 34,125 cases of HIV were reported to the Ministry of Health. Of this 9,517 (27.9%) are known to have died.

Some key populations are disproportionately affected by HIV with some having rates above the national average. National surveys indicate that one out of every three men who have sex with men (MSM) is HIV-infected, 2.9% of female sex workers is HIV-infected, 3.3% of inmates are HIV positive and 4% of homeless drug users.

Sixty-three percent (63%) of reported HIV cases in 2015 were from the most urbanized parishes (KSA, St. Catherine, and St. James).

The most urbanized parishes have the highest cumulative AIDS case rates: Kingston & St. Andrew – 1,033.4 cases per 100,000 persons, and St. James – 1,515.2 HIV cases per 100,000 persons.

HIV prevalence among young adolescent girls and boys aged 10-14 is equal and is estimated to be 0.1% predominantly the result of mother-to-child transmission of HIV (UNAIDS, 2014).

Surveillance data from STI clinic attendees in 2015 indicated that for every 1,000 persons with a sexually transmitted infection, approximately 20 were infected with HIV.

There were 8 babies born with HIV in 2015 down from 10 in 2014 and eight deaths reported up from three in 2014.

PREVENTION SUMMARY

Reducing new HIV infections in Jamaica depends to a large extent on coordinated multi-sector efforts to increase awareness of HIV and to provide behavioural prevention services especially to those groups and individuals considered to be at high-risk of contracting HIV. Public awareness and prevention efforts serve to reduce the number of persons with undiagnosed HIV infection, and increase the number of persons living with HIV retained on treatment and who have suppressed viral load. The government of Jamaica, through the National HIV/STI/TB Unit and the National Family Planning Board (NFBP), works with non-government organisations and other state agencies and health care providers to strengthen prevention and ensure that gaps in treatment are filled.

During the 2015 reporting period, the national response reached a total of 6,502 men who have sex with men (MSM) and tested 2,148 (33%). In the sex worker category, the response reached 17,607 and tested 4,704 (26.7%). Also in 2015, the cumulative number of out of school youth reached was 26,747 and 15,925 (59.5%) tested. These key populations were reached and tested through outreach

activities, empowerment workshops and peer educators.

There has been a remarkable reduction in the rate of infection among female sex workers moving from 4.1% in 2011 to 2.9% based on the 2014 Sex Work survey. The reduction is linked to significant expansion, geo-targeting and intensification of interventions with the sex workers, as well as the discovery of new sex worker sites. Frequent site visits continued as a high priority area in order to identify new sex workers. There was a further expansion of HIV prevention programme into massage parlours over the period.

During the year, 1,519 prison inmates were reached and tested for HIV and Syphilis and 25 linked to care. Among homeless drug users (HDU), HIV prevalence stood at 4% in 2015. Gonorrhoea was also prevalent among this at risk population group. The National Council on Drug Abuse (NCDA) in collaboration with the National HIV/STI/TB Unit continues to provide support to homeless persons and drug users. The NCDA reached 1,277 persons for testing, feeding and substance abuse services in 2015.

TREATMENT SUMMARY

Persons living with HIV who stay in treatment live longer, healthier lives and are less likely to transmit HIV. The National HIV/STI/TB Unit is mandated to manage HIV treatment care and support. The Unit through coordinated and sustained actions combining prevention and treatment services has successfully contributed to reducing HIV. These actions can be described as a cascade. The goal of amalgamating prevention and treatment is viral suppression. To achieve this, persons once diagnosed with HIV must be linked to care, placed on effective treatment, and given the supportive care and services to help them adhere to treatments. Following are some of the treatment care and support highlights for 2015.

HIV Testing: In 2015, 85% of the estimated 29,000 persons living with HIV were diagnosed. Approximately 171,245 HIV tests were conducted across facilities in the public health system; the results of 4024 (or 2.35%) were HIV positive.

Treatment Access: There were 9,370 patients on treatment in 2015. A total of 76% of PLHIV are on first line ARV drugs, 24% on second line and <1% on third line drugs.

Linkage and Retention in Care: The Treatment cascade indicated that of the 24,650 people diagnosed with HIV, 14% were never linked to care. That is, they were never enrolled at a site for pre-ART care. Further along the cascade, of the 21,174 persons linked to care, only 11,713 or 48% received care in 2015. This indicates that some 9,461 (45%) PLHIV who were linked into care are being lost to follow up even before a decision is made on eligibility for ART.

Elimination of Mother to Child Transmission of HIV and congenital Syphilis: The mother to child transmission rate of HIV decreased to 1% in 2015 from 2% in the previous year with 0.13 new paediatric HIV infections per 1000 live births compared to 0.23 infections in 2014. Some

554 women tested positive for syphilis in 2015 at a rate of 1.65% and 31 babies were born with congenital syphilis. Incidence of congenital syphilis is 0.80 per 1000 live births, a slight increase over the previous year when the rate was 0.77. Incidence of congenital syphilis did not meet the target of <0.5 per 1000 live births for 2015.

Sexually Transmitted Infections (STIs): Data from the Jamaica STI Monthly Summary Report and the STI Epi Update 2013 - 2015 indicates that the STI burden remained high in 2015 with 41,703 cases reported in the public health system. This is an increase of 4% over the preceding year.

ENABLING ENVIRONMENT SUMMARY

Below are some key achievements for the Enabling Environment Component:

National Data Protection Act and the Health Information Protection Regulations/Codes of Practice Policy: During the reporting year the National Family Planning Board (NFPB) and the MOH commissioned an assessment of existing provisions related to the protection of personal health information within the health sector.

Cabinet Approval of the Revised National HIV/AIDS Policy: On June 1, 2015, Cabinet approved the revision of the National HIV/AIDS Policy. The approval was secured subsequent to the MOH's Minister and Permanent Secretary presentation of a concept paper outlining the rationale for the revision to the Human Resource Committee.

Service Delivery Audit: In 2015, the MOH and NFPB commissioned an assessment of the Western Regional Health Authority's service delivery mechanisms and its Complaint Management System. The findings of the assessment highlighted the need to revise the WRHA orientation programme in order to ensure that all staff are sensitized on the importance of delivering their care services to key populations with confidentiality and sensitivity.

Redress Directory of Services: The NFPB developed a Redress Directory of Services. It is a compilation organizations that offer service support to individuals and communities whose SRH rights are threatened or violated. The directory is a key output of a workshop that was implemented in 2015 to strengthen the redress framework; it was developed through the NFPB's collaborative efforts with redress partners.

MONITORING AND EVALUATION

STI prevalence and drug resistance study: An STI prevalence and drug resistance study examining the prevalence of the four main Sexually Transmitted Infections (STIs) in patients attending the ANC and STI clinics at six sentinel sites across the island was conducted in 2015. This study represents the first STI prevalence study in Jamaica to include parishes outside of Kingston and St. Andrew (KSA), an asymptomatic population (i.e. ANC attendees) and also to assess the prevalence of Mycoplasma.

To improve efficiency in the national response, Population Service International (PSI) was engaged by the Ministry of Health to provide guidance on the national roll-out of a unique identification code (UIC).

NATIONAL INTEGRATED STRATEGIC PLAN

The M&E unit was involved in the detailed review of programme and local survey data for

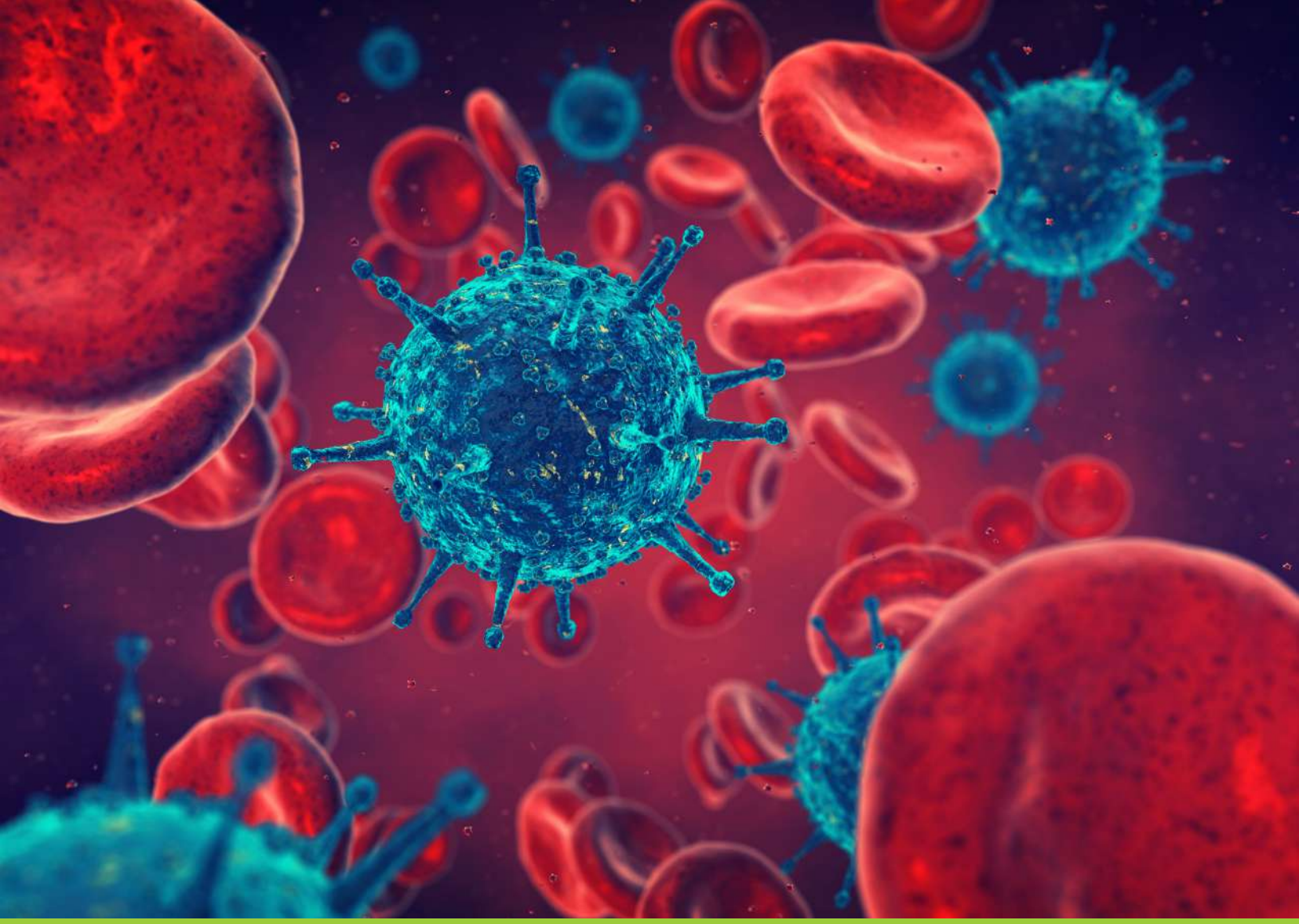
the finalization of the 2014 - 2019 National Integrated Strategic Plan (NISP) for Sexual and Reproductive Health and HIV. Key changes for M&E that have been made in the NISP include M&E is now treated as a separate priority area within the NISP rather than a cross-cutting element of the other priority areas.

FINANCE AND ADMINISTRATION

During 2015, the national HIV and AIDS response was supported through external grant agreements between the Government of Jamaica (GoJ) and donor agencies such as Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and the United States Agency for International Development (USAID). The Government of Jamaica (GoJ) also contributed significantly to the response through in-kind contributions and cash.

There was an increase in the amount of resources available to the response during the 2015 calendar year of approximately 29% or J$246.41M over that of 2014. The largest increase was through the Global Fund resources of 42%, while GoJ contribution in cash increased by 40%. The Transitional Funding Mechanism agreement under the Global Fund grant came to an end in December 2015 this is after the extension from the original end date of July 2015. The Transitional funding under the USAID Project had an original end date of September 2015, however approval was given to extend the project end date to June 2016.

Two new agreements were negotiated during the year, the Global Fund approved US$15.24M in funding for the National HIV/STI Programme for three years, commencing January 2016 through to December 2018. Under the USAID, the Year 5 agreement was also signed in the amount of US$2.6M. The funds will be used to provide support geared at reaching the most at risk populations (those most at risk of becoming HIV infected and those who are already infected) through the provision of treatment, care and support services.



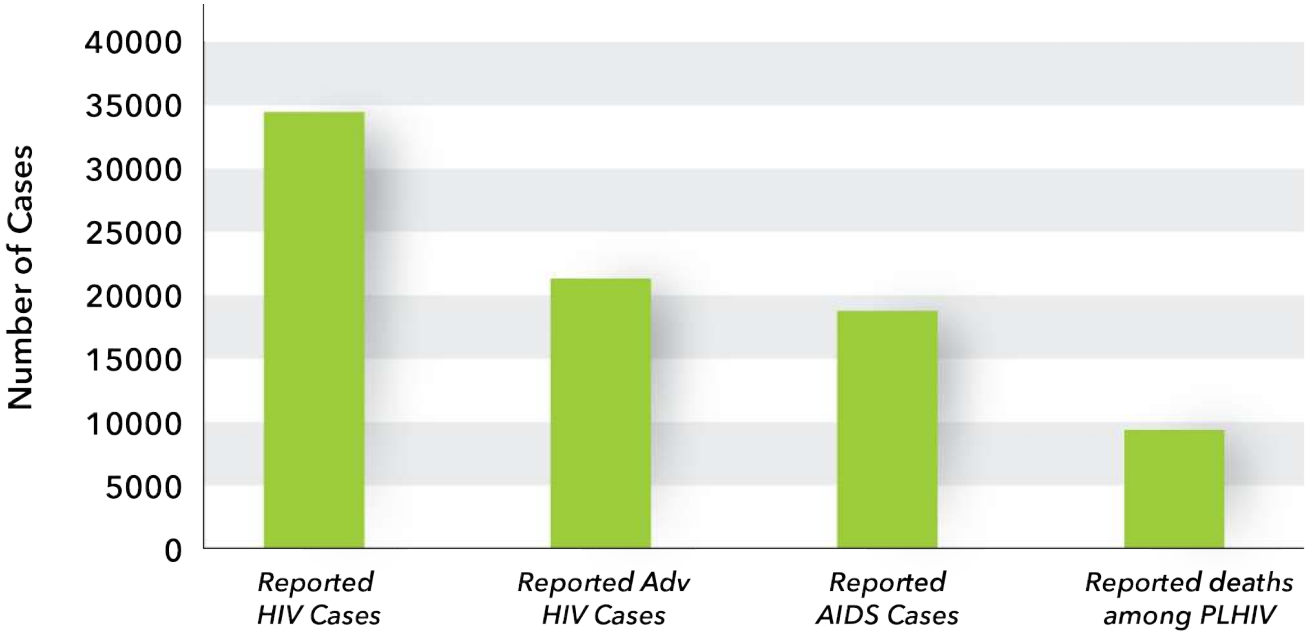
CHAPTER 1: EPIDEMIOLOGY OF HIV

INCIDENCE AND PREVALENCE OF HIV IN JAMAICA

The Ministry's 2015 HIV Epidemiological Profile indicates that an estimated 29,000 persons are currently living with HIV in Jamaica, but approximately 16% are unaware of their status. Between January 1982 and December 2014, 34,125 cases of HIV were reported to the Ministry of Health. Of these, 9,517 (27.9%) are known to be deceased.

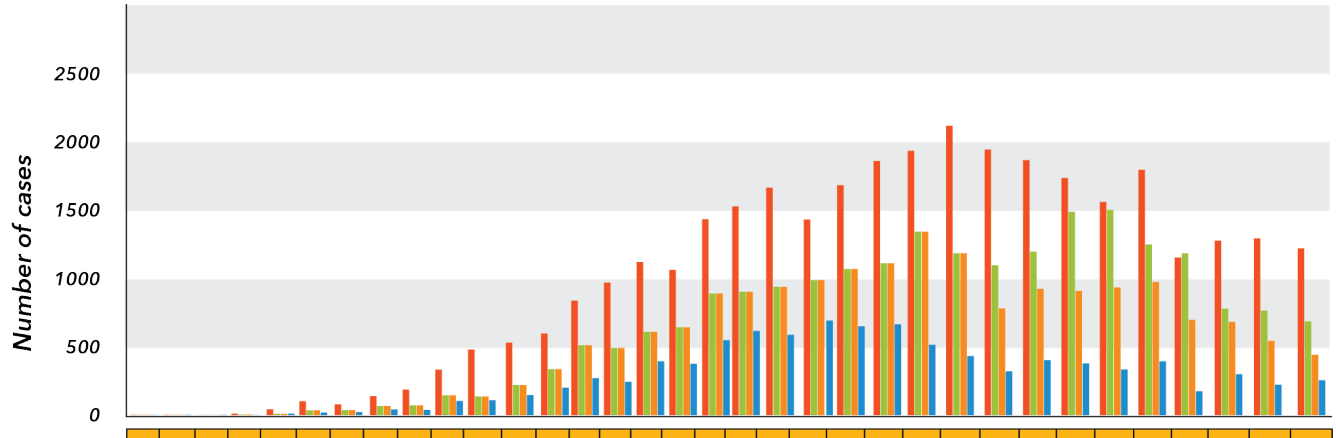
There were 1,222 newly diagnosed cases in 2015, a slight decline from the 1,295 reported in 2014. In 2015, six hundred and eighty-six (686) persons with advanced HIV (349 males and 337 females) were reported compared to 764 in 2014. The National HIV/STI Programme began monitoring cases of advanced HIV in July 2005 to reflect the need for treatment at an earlier stage of disease. Persons with advanced HIV include persons with CD4 count <350.

Figure 1: Total Number of HIV, Advanced HIV Cases, AIDS and Deaths Reported, 1982 – 2015



Source: HATS Database, 2015

Figure 2: Annual reported cases of HIV, Advanced HIV, AIDS and AIDS Deaths



	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15
HIV	1	1	0	9	41	100	77	137	185	332	480	530	597	838	971	1122	1064	1436	1530	1667	1433	1685	1863	1937	2121	1947	1868	1738	1562	1797	1154	1278	1295	1222
Adv. HIV	1	1	0	3	8	34	36	65	70	143	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	1098	1197	1489	1503	1250	1186	780	765	686
AIDS	1	1	0	3	8	34	36	65	70	143	135	219	335	511	491	609	643	892	903	939	989	1070	1112	1344	1186	781	925	909	935	975	697	682	543	441
AIDS Death	0	1	1	0	9	18	21	40	37	103	108	146	200	269	243	393	375	549	617	588	692	650	665	514	432	320	401	378	333	393	174	298	222	254

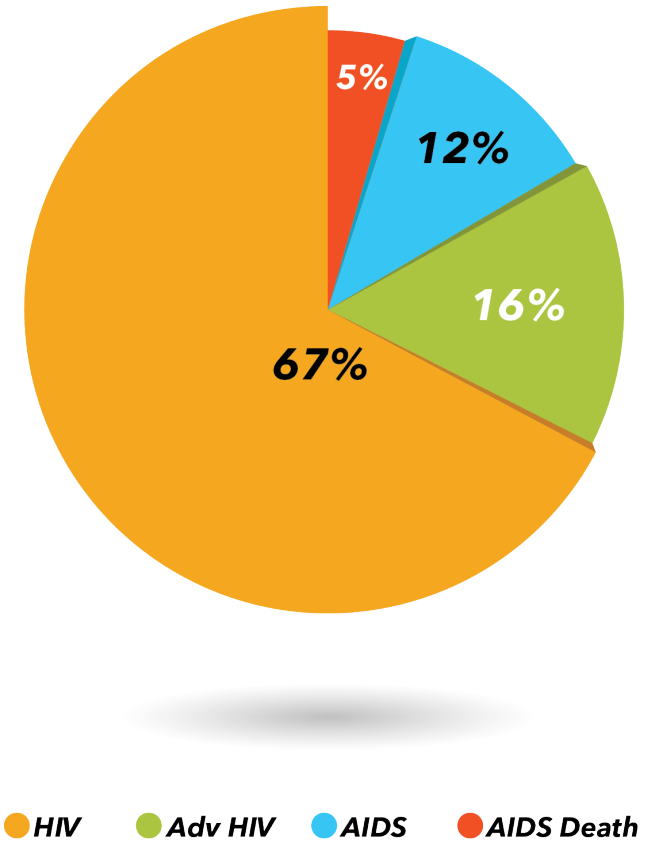
HIV Adv. HIV AIDS AIDS Death

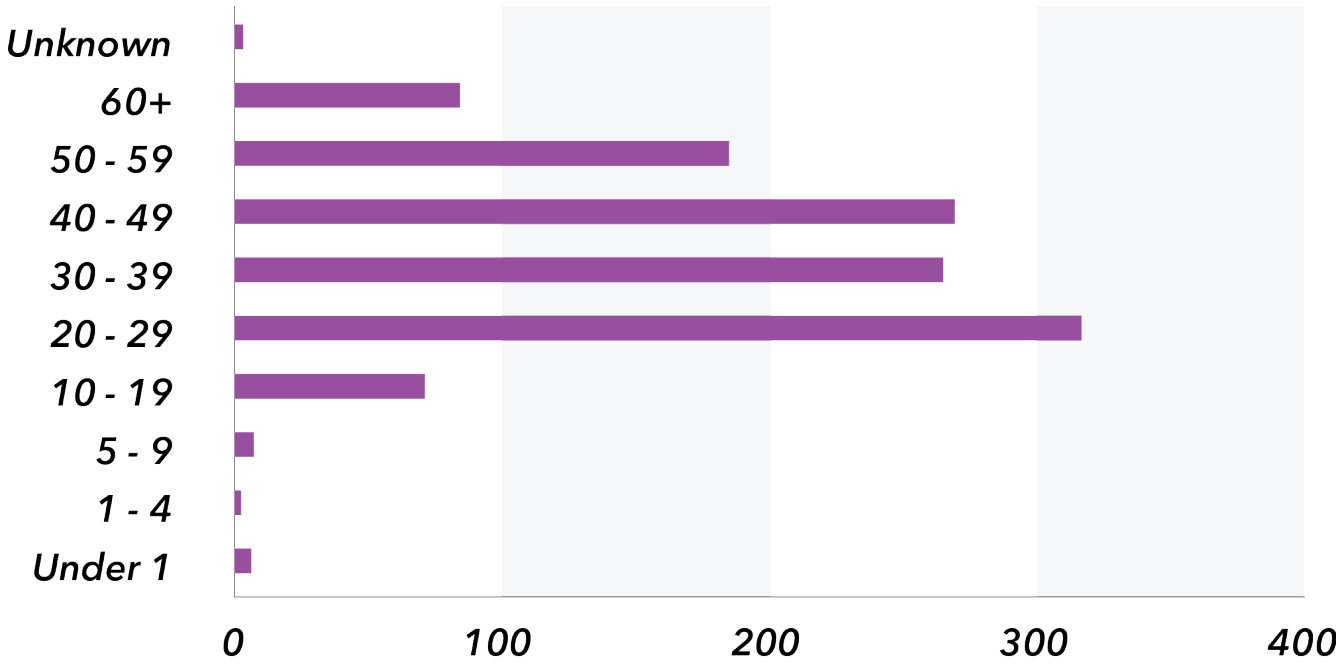
Source: HATS Database, 2015

NEWLY DIAGNOSED CASES

In 2015, 1,222 newly diagnosed cases were reported to the MoH. Of these newly diagnosed PLHIV, approximately two thirds (67%) were diagnosed with CD4 ≥350 which likely is a reflection of scaled-up HIV testing and counselling efforts. However, there is still need for wider testing as 58 (5%) of these cases were still notified to the National Epidemiology Unit for the first time as deaths.

The proportion of newly diagnosed males and females were roughly equal with the males (609) accounting for slightly less (49.8%) newly diagnosed cases than females (613; 50.2%); with the age group 20 – 29 year-olds accounting for the largest proportion (26%) of newly diagnosed cases.

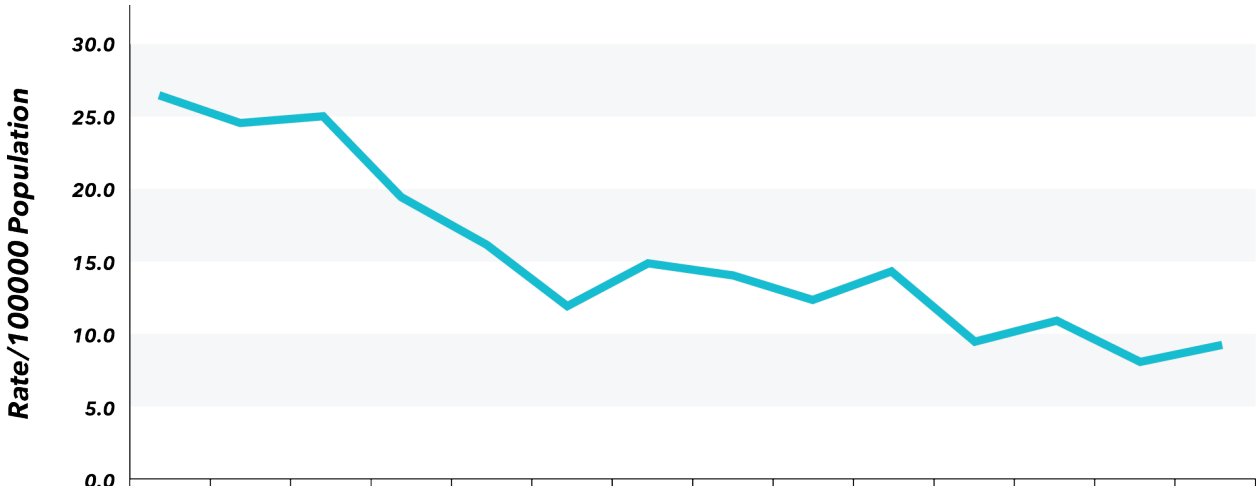




AIDS MORTALITY

Jamaica continues to produce good results in terms of deaths averted as a result of AIDS-related illnesses. The AIDS mortality rate has declined from 25 deaths/100,000 population in 2004 to just over 9 deaths/100,000 population in 2015 which represents a 64% decrease since the inception of universal access to ARVs in 2004. The reduction in deaths can be traced to the introduction of public access to antiretroviral treatment in 2004, scaling up of the national VCT programme and use of rapid test kits allowing for earlier diagnosis, availability of prophylaxis against opportunistic infections and improved laboratory capacity to conduct investigations such as CD4 counts, viral load and PCR tests.

Figure 5: AIDS Mortality Rate/100,000 Population, Jamaica 2002 – 2015



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Rate/100,000 Pop.	26.5	24.8	25.2	19.4	16.3	12.0	15.0	14.1	12.4	14.6	9.6	11.0	8.2	9.4

Although Jamaica has successfully increased access to treatment and care services; analysis of data related to retention in care has shown increased loss-to-follow-up among patients on HAART. Failure to adhere to treatment and care could impact efforts at reducing AIDS morbidity and mortality.

DISTRIBUTION OF HIV IN JAMAICA

GENDER

Females (613; 50.2%) accounted for slightly more newly diagnosed cases than males (609; 49.8%) in 2015. However, the cumulative male: female ratio for persons reported with AIDS in 2015 was 1.31:1, very similar to the ratio of men: women reported in 2014 (1.32:1). The cumulative AIDS case rates are higher among males (27.8 cases per 100,000) compared to females (21.6 cases per 100,000 females). Thus, although the epidemic affects more men than women, over time females are accounting for an increased proportion of the AIDS cases that are reported annually compared to the beginning of the outbreak.

There is also variation in the gender distribution of reported AIDS cases across the lifespan. Young females account for the larger share of reported cases in the 10 – 29 age range. In the age group 15 to 19 years old, four times more young women have been reported with AIDS than young men. Similarly, young women aged 20 – 24 years old are one and a half times more likely to be infected than males in the same age group. Adult males account for a larger proportion of the cases reported in the 30 to 79 age group.

However, recent data indicates that the HIV prevalence among young adolescent girls and boys aged 10-14 is equal and is estimated to be 0.1% predominantly the result of mother-to-child transmission of HIV (UNAIDS, 2014). In later adolescence (15 – 19 years), there is an estimated increase in HIV prevalence, consistent with the onset of sexual behaviour. By the age of 24, there is a further increase in HIV prevalence consistent with increased sexual

behaviour as well as survival and transition of HIV-infected adolescents into the early adult years. Consequently, the estimated HIV prevalence rises to 1% in young women aged 20 – 24 and to 1.4% in young men in the same the group.

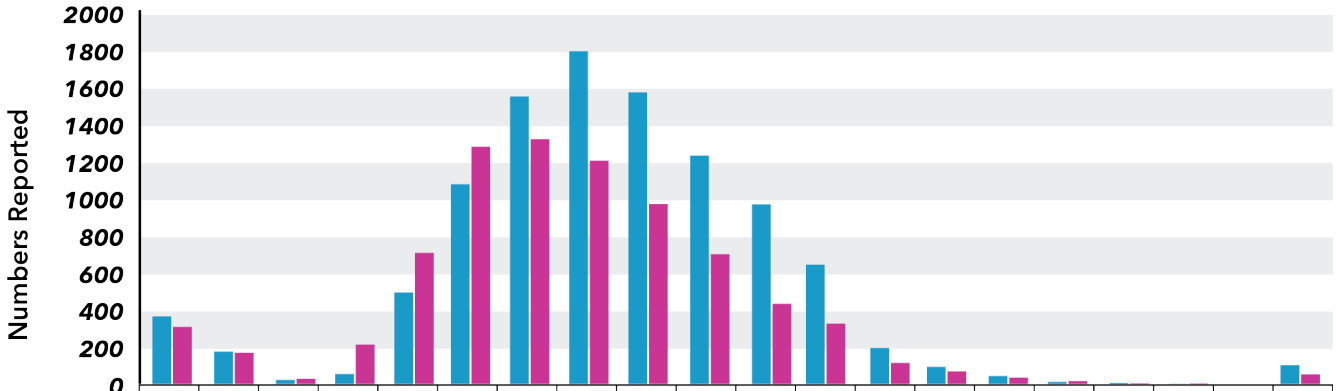
In contrast with the estimated HIV prevalence of 0.4 and 0.5 reported in adolescent girls and boys aged 15 – 19 at the national level, some populations within the adolescent group are more affected. The HIV prevalence among gay and bisexual adolescent boys is estimated to be 14% while HIV prevalence in transgender adolescents is estimated to be 27% (National HIV/STI Programme, 2014) underlining the extreme vulnerability and urgent need for sustained HIV prevention, treatment, care and support response for these adolescents.

AGE

Three quarters (75%) of Jamaicans living with HIV are aged 20 – 49 years old. At the same time, about 26% of the HIV diagnoses made in 2015 were in Jamaicans between the ages of 20 and 29 years old.

Cumulatively, there is a steep incline in the number of AIDS cases from 10 – 24 years. The number of AIDS cases reported among 20-24 year olds (1,154) is over 4 times the number of cases reported among 15-19 year olds (261 cases) which may possibly be due to testing access.

Figure 6: Cumulative AIDS Cases Reported by Age Group and Sex, 1982 - 2015



	0 to 4	5 to 9	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	50 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 to 94	UNK
Male	367	127	18	67	443	1132	1572	1787	1605	1256	979	638	361	193	89	44	9	3	0	91
Female	311	131	23	194	711	1232	1388	1261	988	686	449	334	213	117	67	29	16	3	2	45

GEOGRAPHICAL AREA

More than half (63%) of the Jamaicans living with HIV currently reside in the most urbanized parishes (KSA, St. Catherine, and St. James). This proportion is slightly higher than it was in 2014, but has decreased from 70% of cases in 2008.

The most urbanised parishes also have the highest cumulative AIDS case rates: Kingston and St. Andrew – 1,033.4 cases per 100,000 persons, and St. James – 1,5155.2 HIV cases per 100,000 persons. Both Kingston and St. Andrew and St. James have cumulative case rates that exceed the national case rate (698.2 cases/100,000 population).

Parishes with significant tourism-based economies have the next highest level of cumulative number of reported AIDS cases since the start of the epidemic: 776.0 cases per 100,000 persons in Westmoreland, 695.6 cases per 100,000 persons in Trelawny, 683.7 cases per 100,000 persons in St. Ann, and 679.7 cases per 100,000 persons in Hanover. Notably, all parishes in the Western Region are among those with the highest cumulative number of HIV cases.

HIV TRANSMISSION CATEGORIES

In Jamaica, HIV is primarily transmitted through sexual intercourse. Among all reported adult HIV cases on whom data about sexual practices are available (78% of cases), heterosexual practice is reported by 95% of persons.

As has been the case for decades, in 2015, the sexual practice of 41% of men ever reported with HIV (and 45% of men reported with AIDS) was unknown. This is due to inadequate investigation and reporting of cases as well as unwillingness among men who engage in sex with other men to disclose their sexual practices.

Of the total number of men reported with HIV in 2015, 5.7% (35) were identified as homosexual and 3.2% (20) identified as bisexual. In 2015, a total of 28 PLHIV (2.2%) reported being a sex worker, with the sex breakdown among them showing 64% (18) females to 36% (10) males.

PERINATAL HIV

In 2015, for every one thousand pregnant women attending public antenatal clinics, approximately 10 were HIV infected. Between 1989 and 1996 the HIV prevalence among antenatal women increased from 0.14% to 1.96%. The prevalence has declined over the last 15 years, with the 2013 and 2014 prevalence rates remaining at 1% and below. This overall decline likely reflects the success of Behaviour Change strategies among the general population.

In 2015, a total of six paediatric AIDS cases (children 0 to 9 years old) were reported compared to 76 paediatric AIDS cases in 2005. This significant decline reflects the success of the pMTCT programme in reaching HIV-positive women.

Table 1: HIV Seroprevalence Rate among ANC Attendees By Parish 2015

PARISH	Total Tested	Total Positive	% Positive	(95% CI) exact
Kingston & St Andrew	1,421	20	1.4	0.86 – 2.17
Manchester	588	3	0.5	0.11 – 1.48
St Ann	524	2	0.4	0.05 – 1.37
St Catherine	1,028	7	0.7	0.27 – 1.40
St James	418	12	2.9	1.49 – 4.96
Westmoreland	412	1	0.2	0.01 – 1.34
TOTAL	4,391	45	1.0	0.75 – 1.37

Source: Sentinel Surveillance, 2015

Three paediatric AIDS deaths were reported in 2015, compared to 34 in 2004. This represents a 90% decrease in the number of paediatric AIDS deaths over this period.

RISK BEHAVIOURS AND OTHER FACTORS FUELLING THE EPIDEMIC IN JAMAICA

Jamaica continues to exhibit features of both a generalized and concentrated HIV epidemic. The prevalence in the general population is estimated at 1.6%, however surveys show higher HIV prevalence in at-risk groups.

The main risk factors fuelling the epidemic in Jamaica include multiple sex partners, history of STIs, crack/cocaine use, and sex with sex workers. 'No high risk behaviour' was reported for a significant proportion (12%) of HIV cases and this may represent persons who have one sex partner who was HIV infected by another partner.

Table 2: Annual Reported risk behaviours among adults with HIV (1982 – Dec 2015 cumulative)

RISK	No. of Persons (%) -2015	No. of Persons (%) 1982 - 2015
Sex with Sex workers	114 (9.3%)	4,667 (13.7%)
Crack , Cocaine Use	17 (1.4%)	1,357 (4.0%)
STI History	300 (24.6%)	11,167 (31.3%)
IV Drug Use	2 (0.2%)	196 (0.57%)
Multiple Sexual Partners/contacts	341 (28%)	4,841 (14.2%)
No high risk behaviour	146 (12%)	5,321 (15.6%)

Data from surveillance of STI clinic attendees in 2015 indicated that for every 1,000 persons with a sexually transmitted infection, approximately 28 were infected with HIV. Further, 68% of STI attendees tested in the sentinel surveillance were females – 2.03% of these females tested positive for HIV compared to 4.6% of male STI attendees.

Table 3: HIV Seroprevalence Rate Among STI Clinic Attendees by Parish 2015

PARISH	Total Tested	Total Positive	% Positive	(95% CI) exact
Kingston & St Andrew	1,241	49	3.95	2.94 – 5.19
Manchester	419	1	0.24	0.01 – 1.32
St Ann	626	8	1.28	0.55 – 2.50
St Catherine	974	32	3.29	2.26 – 4.61
St James	380	14	3.68	2.03 – 6.10
Westmoreland	381	10	2.62	1.27 – 4.77
TOTAL	4,021	114	2.84	2.34 – 3.40

Survey conducted between April and September 2015

ALL IN TO END ADOLESCENT AIDS

All In is a response to the inequity in progress towards the global goals of the AIDS response. It is a collaborative platform aimed at driving better results for adolescents through critical changes in programmes and policy. All In seeks to engage adolescents and unite stakeholders to accelerate reductions in AIDS related deaths by 65% and new infections in adolescents by 75% by 2020.

The initiative is led by the UN joint team on AIDS and the Ministry of Health and focuses on four key areas:

1. Engage, mobilize and support adolescents as leaders and agents of social change.
2. Sharpen adolescent elements of national AIDS programmes through improving data collection, analysis and utilization to drive programming and results.
3. Foster innovation in approaches to improve reach to adolescents and increase impact of prevention, treatment and care programmes.
4. Mobilize global, regional and country-level advocacy to firmly position adolescent AIDS on the agenda, communicate needs and successes effectively, and mobilize and direct resources towards effective and efficient programmes for and with those adolescents most in need.

All In is seen as an opportunity for Jamaica to improve data collection, analysis and utilization for programme planning for adolescents generally. As such, a key component is on linkages. Various challenges affecting adolescents in Jamaica are interlinked and serve to put them at greater risk of contracting HIV or further exacerbating challenges faced by those perinatally and or behaviourally infected. Thus, it is important to link adolescent HIV strategies and programmes to other national initiatives on adolescent health and development. This

includes integrating sexual and reproductive health into HIV programmes, eliminating gender inequalities and discrimination, strengthening social protection for youth, addressing gender based violence including child sexual abuse; and addressing mental health and drug use among adolescents.

KEY FINDINGS FROM ALL IN

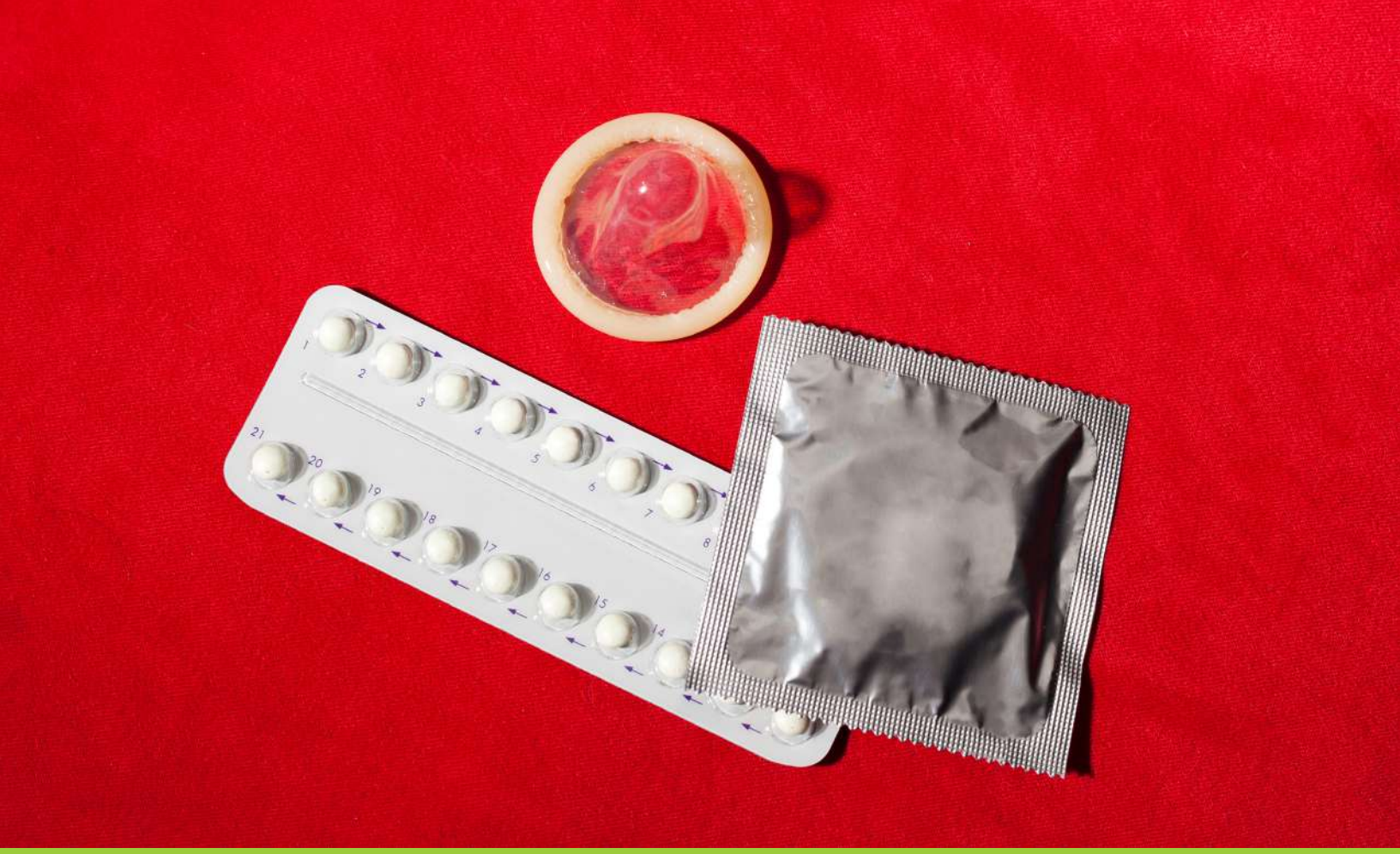
The following are some key findings from a national assessment done in 2015:

1. HIV prevalence among young adolescent girls and boys aged 10-14 is equal and is estimated to be 0.1%
2. The estimated HIV prevalence in young women aged 20 – 24 is 1% and 1.4% in young men in the same the group.
3. The number of adolescents and youth living with HIV was estimated at 685 adolescent girls (aged 10 – 19) and 825 adolescent boys
4. HIV prevalence among gay and bisexual adolescent boys is estimated to be 14% and 27% among transgender adolescents

LESSONS LEARNT

The following represents the key lessons learnt in 2015:

- There is need for urgent implementation of better strategies to identify and link behaviourally infected adolescents to HIV testing and treatment and care services as well as the critical complementary protection, care and support services.
- Coverage of HIV testing and counselling among sexually active adolescents needs to be scaled up. Only 30% of sexually active adolescent girls aged 15 – 19 years and 18% of adolescent boys have tested for HIV, which is well below the target of 75%.
- The current legislation regarding the age of consent for service delivery for adolescents, in particular HIV testing and counselling as well as sexual and reproductive health services including contraceptives presents a barrier for effective interventions.
- Cash transfers have been found to have significant influence on preventive behaviour, lowering transactional and age disparate sex among adolescent girls in vulnerable households receiving them.
- There is a need for strengthening and sustaining of comprehensive protection, care and support interventions and programmes for adolescents.



CHAPTER 2: PREVENTION AND SEXUAL AND REPRODUCTIVE HEALTH

SUMMARY

The HIV epidemic in Jamaica is characterised by concentrated HIV sub-epidemics within a generalized epidemic. This is supported by empirical data which indicates higher prevalence rates in key populations such as MSM, sex workers, homeless drug users and prison inmates. Based on this, HIV prevention efforts in 2015 were specifically geared towards these sub-epidemics.

Prevention programmes use a variety of evidence-based approaches to provide the knowledge, skills, and support that persons in these key populations need to reduce their vulnerability to HIV. The approaches adapted to reach these key populations include the use of peer support for hard to reach KPs, HIV and Syphilis testing in outreach settings, empowerment workshops and the procurement of lubricants to promote condom use. The goals of these interventions are to increase understanding of HIV risk, to teach participants to practice risk-reduction skills, and to encourage attitudes and behaviours that reduce risk for becoming infected or passing on HIV. Each of the approaches used plays a part in fulfilling the public health goal of reducing the spread of HIV infection in Jamaica.

PREVENTION APPROACHES

HIV TESTING AND OUTREACH AMONG KEY POPULATIONS

The overall strategy to scale up HIV testing and outreach for key populations resulted in the following key outputs:

- MSM Strategy
- SW Strategy
- OSY Strategy
- Prison Inmates Strategy

All of the abovementioned strategies, with the exception of the Prison Inmates Strategy, were structured around improving the delivery of a comprehensive package of behaviour change communication based prevention intervention.

During the 2015 reporting period, the national response reached a total of 6,502 MSM and tested, 2,148 (33%) as captured in Table 4 below. In the sex worker category, the response reached 17,607 and tested 4,704 (26.7%). Finally, in relation to out of school youth, the cumulative number tested was 26,747 and 15,925 (59.5%) reached. These key populations were reached and tested through outreach activities, empowerment workshops and peer educators.

Table 4: Total Number of Most at Risk Population Reached and Tested by entity in 2015

Total Number of Most at Risk Poulation Reached and Tested in 2015						
Entity	**MSM Reached**	**MSM Tested**	**SW Reached**	**SW Tested**	**OSY Reached**	**OSY Tested**
NFPB	324	94	635	132	1045	463
NERHA	176	51	2042	656	274	1737
SERHA	934	235	4150	595	4460	5159
SRHA	296	95	2506	910	2058	1942
WRHA	1676	208	5604	642	5724	2367
ASHE	795	397	n/a	n/a	784	624
Children First	474	304	99	86	5161	1825
Children of Faith	94	37	206	82	111	14
Hope Worldwide	n/a	n/a	406	284	318	112
JASL	1259	591	1258	758	n/a	n/a
Jamaica Red Cross	281	60	584	474	5912	1575
RISE	193	76	117	85	900	107
Total	6502	2148	17607	4704	26747	15925

As indicated in the table above, testing among key populations is low when compared to the number reached.

Table 5: Key Population Reached and Tested 2012 - 2015

Year	2012	2013	2014	2015
MSM (Reached)	4902	5480	6088	6502
MSM (Tested)	352 (April-Dec)	972	1640	2148
FSW (Reached)	10959	11954	16152	17607
FSW (Tested)	1182 (April-Dec)	1445	3104	4704
Inmates (Reached)	***	1752	1682	1518
Inmates (Tested)	1491	1749	1608	1518
OSY (Reached)	48355	42848	27967	26713
OSY (Tested)	***	5931	13628	15953
Homeless (Reached)	***	216 (Oct – Dec)	860	396 (Jan – Jul)
Homeless (Tested)	***	216 (Oct – Dec)	603	392 (Jan – Jul)

Source: Family Planning Board

MEN WHO HAVE SEX WITH MEN

There was a concentrated effort at coverage of the MSM population through the peer link strategy to access hard to reach MSM, increase the uptake of HIV testing and to provide the necessary linkage to care. There was an increase in the numbers reached in 2015 through the strategy. In 2015 6,502 MSM were reached compared to 6,088 MSM in 2014. The number of MSM tested in 2015 (2,148) was however slightly lower than those tested in 2014 (2,172).

Men's Health workshops provided empowerment and linkage to social inclusion programmes for MSM. Support was provided for eligible participants to pursue various certificate courses and skills training, such as catering and customer service from reputable local educational institutions. Of the 25 participants who started the courses, 17 completed same and earned certification, while 14 of the 17 became gainfully employed. Other strategies included increasing access to condoms, lubricants, and access to treatment and care to HIV positive MSM.

CHALLENGES AND LESSONS LEARNT

Violence: Threats of violence compounds community interventions among the MSM population and also compromises the safety of staff. As a result, staff is encouraged to work in groups and maintain their presence in high visibility areas.

Duplication of efforts: Various agencies are reaching the same persons

Low buy-in from MSM population of empowerment sessions: The MSM population in general were more concerned about satisfying their immediate needs for survival such as shelter and food. They were not readily open to other life skills and livelihood opportunities such as educational opportunities.

WAY FORWARD

There is the need to implement more creative strategies to encourage acceptance of skills-building opportunity as well as closer collaboration with social agencies to address adverse life events.

TRANSGENDER POPULATION

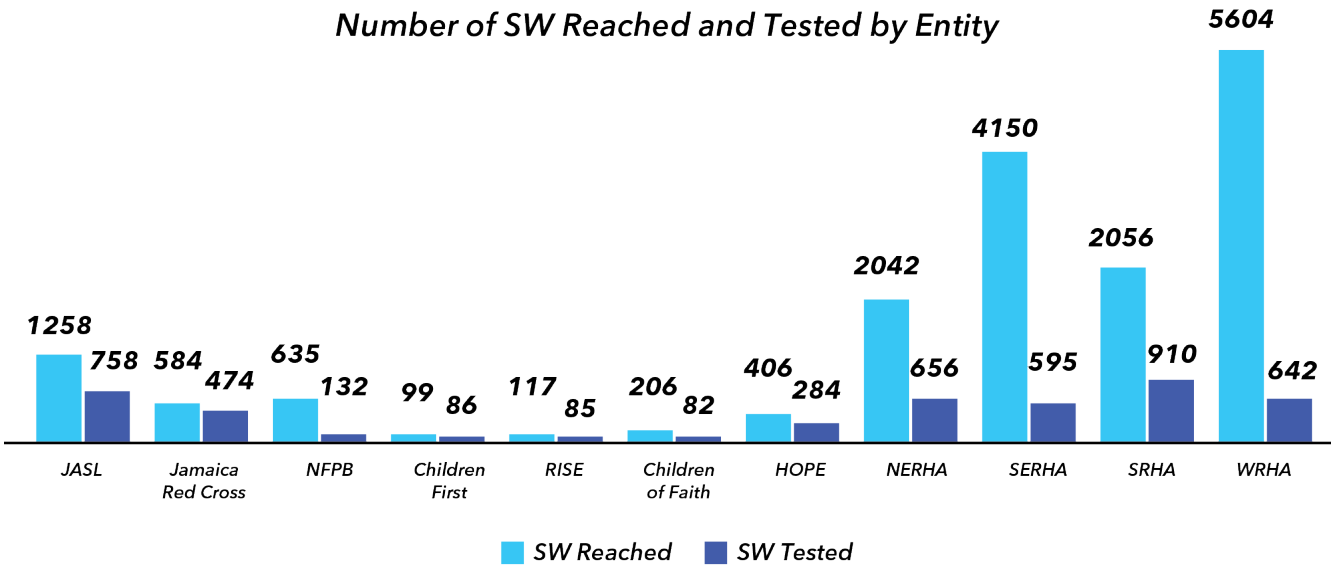
The major underlying factors for HIV transmission among the transgender population are high levels of unemployment, homelessness and poverty. Strategies undertaken in 2015 were geared at addressing these social vulnerability issues through partnership with civil society partners.

The Colour Pink Group is one organization that works specifically with the TG population. It implemented a **Trans HealthCare project**, which aimed at empowering the population of the homeless/sofa surfing transgender woman. Some 35 transgender women benefitted from two regional training workshops as well as vocational training in various skills.

FEMALE SEX WORKERS

There has been a remarkable reduction in the rate of infection among female sex workers moving from 4.1% in 2011 to 2.9% based on the 2014 Sex Work survey. The reduction is linked to significant expansion, geo-targeting and intensification of interventions with the sex workers, as well as the discovery of new sex worker sites. Frequent site visits continued as a high priority area in order to identify new sex workers. There was a further expansion of HIV prevention programme into massage parlours over the period.

Figure 7: Sex Workers reached and tested in 2015



Interventions among sex workers included addressing sexual health needs as well as social welfare. Linkages to social inclusion programmes were strengthened with referrals to social agencies including the Programme of Advancement Through Health and Education (PATH), National Insurance Scheme (NIS) and the Registrar General Department (RGD) for birth registrations.

Site-based empowerment workshops were also conducted usually over a period of three days. A nurse was contracted in the South East Region to conduct Pap smears and syndromic STI management. Her duties also included conducting sensitization sessions at the workshops.

A total of 96 empowerment workshops were conducted across the four Regional Health Authorities reaching 519 persons. Site-based interventions continue in bars, clubs, street sites and massage parlours. A total of 7,751 interactions were done with members of the population, of which 2,450 were with new persons. A total of 2009 HIV and Syphilis screening was conducted. Fourteen (14) female sex workers completed certification in housekeeping and food preparation at Level 1.

CHALLENGES AND LESSONS LEARNED

This population is highly mobile which makes long-term interventions difficult. A key strategy employed is to provide a menu of services to the SW during a single intervention. This could include the provision of check-ups, pap smears and HIV testing in one single visit. At some facilities, health care providers facilitated a fast track system whereby if the women were accompanied by a Peer Educator they would by facilitated quickly. The length of time spent at the health facilities is a major deterrent to SW accessing health care.

INMATES

Prevention interventions took place in the following five adult institutions during the reporting period:

- Tower Street Adult Correctional Centre (TSACC),
- St. Catherine Adult Correctional Centre (ST. CACC),
- Fort Augusta Adult Correctional Centre (FAACC),
- Tamarind Farm Adult Correctional Centre (TFACC) and
- Horizon Adult Correctional Centre (HACC).

During the period, 1,519 inmates were reached and tested for HIV and Syphilis and 25 linked to care. The inmates who needed adherence counselling were engaged in continuous discussions. Inmates slated to leave the institutions were engaged in special Risk Assessment, Condom Skills, and HIV Basic Facts counselling.

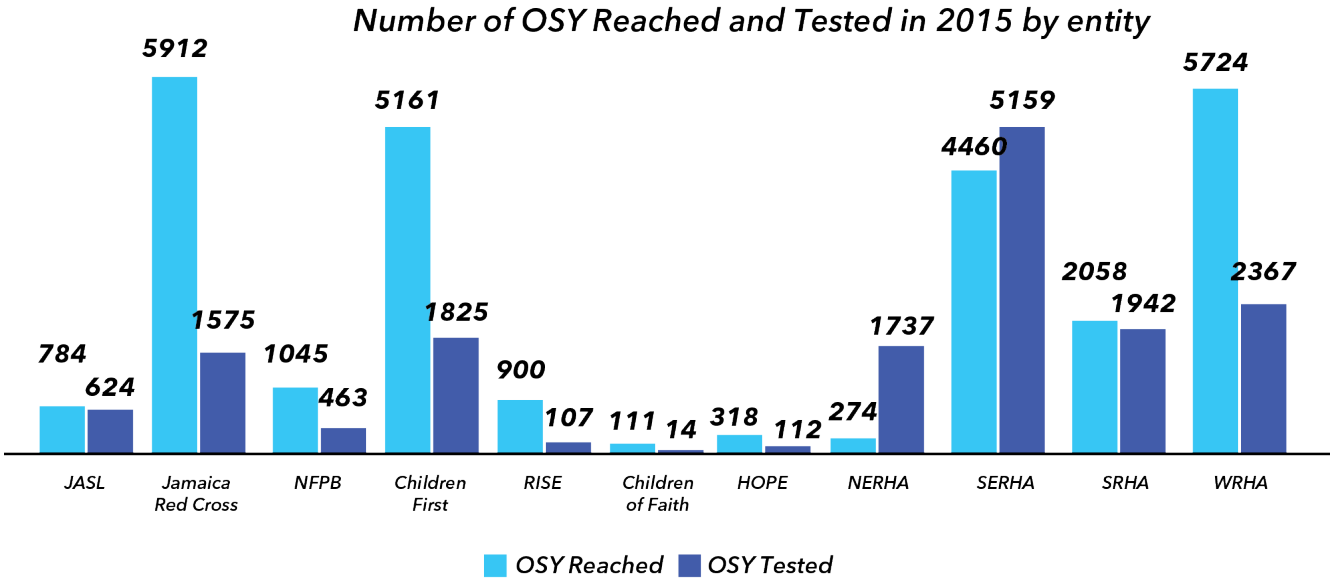
HOMELESS DRUG USERS

The HIV prevalence among homeless drug users (HDU) stood at 4% in 2015. Gonorrhoea was also prevalent among HDUs, most of whom have been homeless for less than five years and were predominantly male.

The National Council on Drug Abuse (NCDA) in collaboration with the NHP continues to provide support to homeless persons and drug users. The strategy of linking HIV positive substance abusers to HIV treatment, prevention and care services, rehabilitation and detox services continues. Through the support from the National HIV Programme, NCDA reached 1,277 persons for testing, feeding and substance abuse services.

OUT OF SCHOOL YOUTH

The cumulative number of OSY reached and tested in Jamaica in 2015 was 26,747 and 15,925 respectively. Similar to the number of MSM and SW reached and tested, the Western Regional Health Authority (WRHA) is the government regional entity that is most successful in this area. The WRHA reached a total of 5,724 OSY and tested 2,367 as shown below. On the other hand, the Jamaica Red Cross (JRC) was the civil society partner reaching and testing OSY accounting for 5,912 and 1,575 respectively.



OTHER HIV PREVENTION INTERVENTIONS

HIV OUTREACH TEAM (H.O.T)

The HIV Outreach Team of the Prevention Unit maintained its reach through two mobile units in the South East Region of the island. In 2015, the team provided HIV and Syphilis testing to 11,891 persons (4399 males and 7492 females), 86 (52 females and 34 males tested positive for HIV while 320 (206 females and 114 males) were reactive for Syphilis. This included 132 sex workers and 94 MSM.

Outreach VCT also continued across the regions in high risk communities with members of key populations. A total of 19,240 (6,810 males and 12,430 females) persons were tested.

TARGETED COMMUNITY INTERVENTION (TCI)

Targeted community interventions were implemented in high risk communities island-wide. The objectives of these interventions included:

- The promotion of mutual monogamy
- Promotion of appropriate STI health-seeking behaviour
- Promotion of consistent and correct condom use
- Promoting condom negotiation skills
- Promoting appropriate risk assessment skills
- Promotion of SRH services
- Conducting HIV and Syphilis screening

The NFPB reached 1,630 persons in four communities in Kingston. In the WRHA, 10 communities[1] were targeted: A total of 10,248 persons were reached; 5,182 persons (1677 males and 3505 females) were tested and received their results. More than 16,000 condoms (16,100) and 13,933 lubricants were distributed. Condom outlets were also established within all 10 communities in order to maintain a steady supply to community members. Persons received additional training in condom building skills and were able to pass on this information while distributing.

In the North East Region, 18 communities[2] were targeted reaching a total of 5,197 persons; 1134 were counselled and received their HIV and Syphilis results. A total of 49,919 condoms were distributed to both key population members and the general population.

In the Southern Region, 8 communities[3] were targeted: Rocky Point, Hannah Heights, Caanan Heights, Lacovia (lower and upper), Brinkley, Cedar Grove, Heartease, Brockery.

[1] *Communities include Catherine Hall, Train Line, Granville, Mobay North Gully, Lilliput. Cambridge, Catadupa, Cambridge, Maroon Town, Springfield*

[2] *The following communities were reached in NERHA: Beecher Town, Chalky Hill, Blackstonedge, Golden Grove, Pineapple, Murray Mount, Moneague, Linton Park, Pimento Walk, Watt Town, Barclay Town, Three Hills, Enfield, Esher, Lucky Hill, Oracabessa, Robin's Bay and Camberwell.*

[3] *Southern Region communities: Rocky Point, Hannah Heights, Caanan Heights, Lacovia (lower and upper), Brinkley, Cedar Grove, Heartease, Brockery.*

In the South-East Region, 19 communities[4] were targeted reaching a total of 6,546 persons (2,824 males and 3,722 females). Some 5,182 persons (1,677 males and 3,505 females) were tested and received their results. A total of 65,000 condoms and 13,933 lubes were distributed.

SPECIAL EVENTS

The National HIV/STI Programme commemorates three annual special events. These special events are Safer Sex Week during Valentines Week, Regional Testing Day (last Friday in June) and World AIDS Day on December 1 each year. These events are essential to normalizing testing and creating awareness around HIV transmission, condom use and other sexually transmitted infections (STI).

SAFER SEX WEEK 2015

The National Safer Sex Week event was held on Friday, February 14, 2015 (Valentines' Day) under the theme: Condom and Contraceptives – keep you protected. Activities were carried out in four communities – Rowlands field - St. Thomas, Gregory Park and Tawes Pen – St. Catherine, Rema and Greenwich Town in KSA

WORLD AIDS DAY

World AIDS Day 2015 was held under the theme 'Taking care of the real you …ask for your HIV test too"..

The aim of this was to increase the number of persons (including key populations) tested for HIV in health facilities.

[4] *South East Region communities: Allman Town, Jones town, Wilton Gardens, Kintyre, Highlite View, August town, Newlands, Gregory Park, Old Braeton, Demphire Pen, March Pen, Clifton, Homestead, Succaba, Old Harbour Bay, Bamboo Ridge, Commodore, Riversdale, West prospect.*

CHAPTER 3: TREATMENT, CARE AND SUPPORT

INTRODUCTION

The HIV treatment, care and support component is the technical arm of the national Programme. The Treatment, Care and Support Unit directs the activities of the Treatment, Care and Support (TCS) component of the Programme. The Unit is mandated to:

- Manage procurement and monitoring of testing and ART supplies
- Coordinate the care and psychosocial support services that are available at the various treatment sites across the country
- Build the capacity of staff deliver treatment care and support to PLHIV.

Since the introduction of ARVS in 2004, the AIDS-related mortality rate decreased by 76% and the vertical transmission of HIV has virtually been eliminated. These changes are due, in large part to the work of the national Programme.

Despite the successes to date, there are still some major challenges to be addressed for the scaling up of the response; these include: too few PLHIV being aware of their status; linkage and retention in care are suboptimal; ARV coverage for those who are eligible is lagging and viral suppression levels are low; STIs are the third most common cause of healthy life years

lost by women of reproductive age and Jamaica's case detection rates for TB over the 25-year period 1990-2014, fluctuated from a high of 79% in 1990 to a low of 48% in 20

In order to address these challenges, the unit set out to achieve the following objectives:

- Updating and improving treatment guidelines and capacity building
- Improving accessibility to diagnosis and monitoring of HIV at the point of care
- Improving supply chain management
- Provision of appropriate and accessible services

CONTINUUM OF CARE

With the advances and effectiveness of care and treatment, HIV has transitioned to a chronic condition that can be managed successfully for persons living with HIV to maintain healthy outcomes and live long. The Continuum of Care is an approach of diagnosing persons with HIV, linking them into care and treatment, retaining them in continuous care and achieving viral load suppression, which is the marker of a person's and community's health.

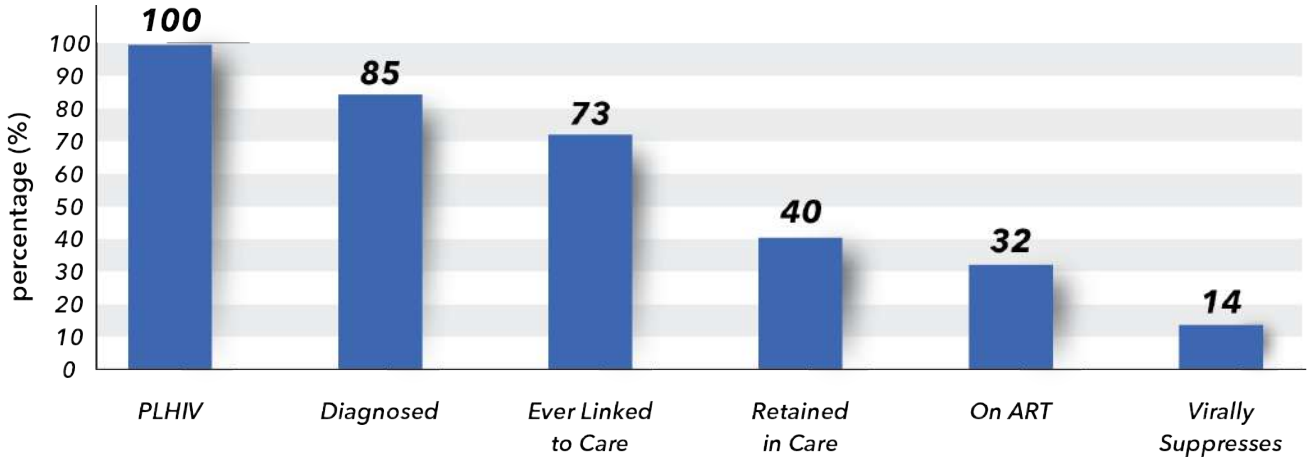
Early identification of PLHIV, timely initiation of ART and lifelong care are key elements of the strategy towards achieving universal access to HIV treatment and care and are recognized as the means to ending the AIDS epidemic by 2020. Entry into, and retention in care are therefore critical to the success of HIV treatment. Retention on ART is essential for individual patient outcomes and getting PLHIV virally suppressed also has positive public health consequences.

Jamaica has invested significantly in monitoring and surveillance and since 2014 has developed various treatment cascades which give a picture of what is happening not only among general population PLHIV but also among key population and other marginalised and vulnerable groups.

Efforts to make antiretroviral (ARV) available to all PLHIV who need it over the last decade have succeeded in increasing the number of PLHIV who are receiving life-saving drugs in Jamaica. This however has not translated into any significant increase in retention in care and viral suppression.

Whilst Jamaica has done very well at testing with 85% of persons estimated to be living with HIV knowing their status, the other areas in the cascade have lagged behind.

Figure 9: PLHIV Treatment Cascade 2015 by percentages



As indicated in the Figure 9 above, 85% of the estimated 29,000 persons living with HIV have been diagnosed. Of the latter, 73% have ever been linked to care and only 40% have been retained in care. Some 32% are on ART and only 14% are virally suppressed.

HIV TESTING, SUPPORT AND PITC UPTAKE

HIV TESTING

In 2015, approximately 171,245 HIV test were conducted across facilities in the public health system; the results of 4024 (or 2.35%) were HIV positive.

Table 6: Summary[5] of HIV Testing done at through the Public Health System, 2015

Month	HIV Tests Done	HIV Positive Test Results	% Positive
January	14,915	418	2.80
February	15,653	387	2.47
March	12,064	281	2.33
April	12,895	232	1.80
May	17,103	447	2.61
June	13,858	342	2.47
July	17,952	445	2.48
August	12,589	265	2.11
September	13,280	347	2.61
October	13,546	251	1.85
November	13,557	301	2.22
December	13,833	308	2.23
Total	171,245	4,024	2.35

[5] *6 of 14 labs consistently reported for all months*

Data from six of the island's fourteen private laboratories for 2015 show that little over 90,000 tests were conducted; of that number 613 (or 0.68%) returned HIV positive results.

Table 7: Summary[6] of HIV Testing done at through Private Laboratories, 2015

Month	HIV Tests Done	HIV Positive Test Results	% Positive
January	9,370	59	0.63
February	7,406	40	0.54
March	8,066	62	0.77
April	9,778	50	0.51
May	7,948	38	0.48
June	9,088	68	0.75
July	8,529	55	0.64
August	7,008	66	0.94
September	8,246	58	0.70
October	7,220	32	0.44
November	2,942	45	1.53
December	5,138	40	0.78
Total	90,739	613	0.68

The unit conducted a training of trainers workshops for the Rapid Test Quality Improvement Initiatives with support from the CDC. This programme aims to expand and improve the quality of HIV testing by using best practices at testing sites. This activity in turn supports the expansion of ART. A review of the programme was done at the annual retreat to inform the next steps in this programme.

The unit will, with assistance from the CDC, initiate the development a national HIV Testing Policy in 2016.

COUNSELLING

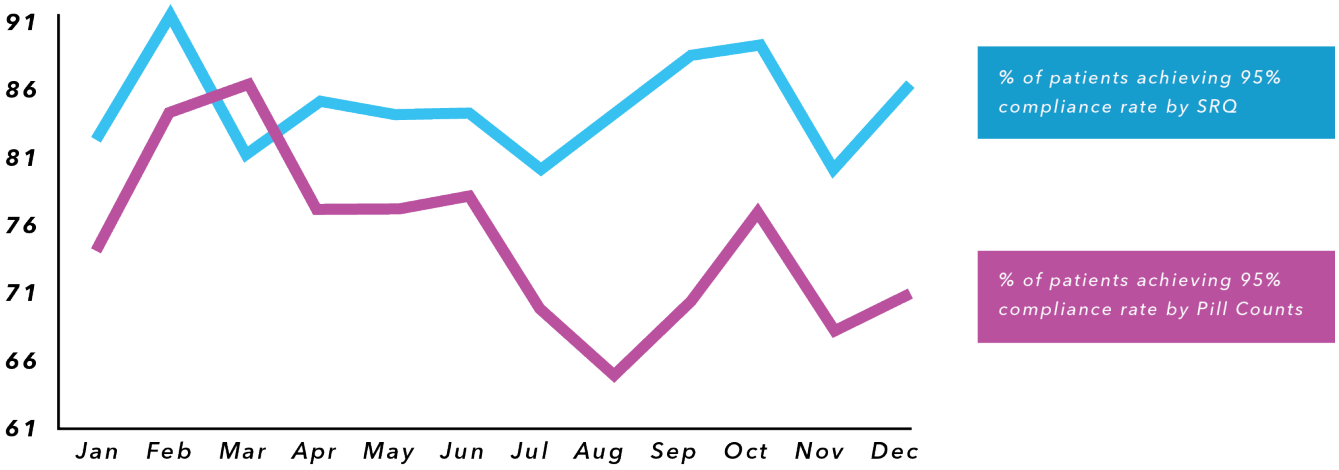
The National Programme provides support for PLHIV through a team of adherence counsellors, social workers and psychologists. The team conducts counselling, psychosocial analysis and mental health assessments. Liaison officers are assigned to each region to help support these and the contact investigators' activities.

The role of adherence counsellors in monitoring treatment is critical element in the management of HIV and treatment outcomes. The counsellors pill counts and self-reporting questionnaires to determine adherence levels for PLHIV.

On average, in 2015, 75% of PLHIV achieved at least 95% compliance.

[6] *Data not received from all sites February- April, June, August-November*

Figure 10: Percentage of Persons Living with HIV achieving 95% compliance rate by SRQ and by Pill Counts, 2015



Discussions with clients who participate in support groups revealed that financial constraints are one of the major challenges to adherence.

In 2015, 25,104 received adherence support, orientation and prescription assistance. Clients were also able to benefit from the 108 support groups associated with treatment sites across the regions. Social workers had a combined total of 12, 870 contacts with PLHIV, an increase of 24% compared to the previous year. Of the 2,691 social investigations that were required, 87% (2,342) were conducted. There were 1445 home visits; this is a 6% increase when compared to the previous year.

The role of Psychologists is also critical for ensuring the clients' comprehensive care. The most prevalent diagnoses made by Psychologists for 2015 were major depression, substance/alcohol abuse, generalized anxiety, sleep disorders and post-traumatic stress disorder.

PROVIDER INITIATED TESTING AND COUNSELLING (PITC) PROGRAMME

The PITC was reintroduced in sixteen hospitals across the island in 2014. The initiative aims to provide persons who do not actively seek healthcare with an opportunity to know their HIV status as they access emergency care.

In 2015, the PITC programme in collaboration with CHAI, improved its capacity to deliver services. These include:

- Training of trainers workshop; core of trainers is available within each region
- Standard operating procedures (SOPs) developed for each hospital after consultation with the SMOs and the local infection control team. Best practices were developed and shared in the sensitization meetings.
- Signage posted at hospitals so that upon admission, the members of the public are aware of the opt-out HIV testing that is available; provision of PITC uptake graphs to track the progress in individual hospitals.
- Assessment of rollout of PITC conducted, starting in October 2015. Some of the

challenges identified included the lack of integration of PITC into the mandate of some of the infection control committees and lack of adherence to SOPs.

Of the 92040 admissions at the facilities across the six RHAs, 24.5% were tested, a slight decrease from the previous year in which 26.8%. The Southern Regional Health Authority recorded the highest share of tests conducted.

Table 8: PITC Uptake in Hospitals 2015

Regional Health Authority	Number of Admissions[7]	Number of Admissions Tested for HIV	Uptake (%)
Western	17256	2802	16.2
North Eastern	21507	3360	15.6
South Eastern	33005	8983	27.2
Southern	20272	7394	36.4
Total	92040	22539	24.5

TREATMENT SERVICES

ACCESS TO TREATMENT: TREATMENT SITES

PLHIV have access to 36 treatment sites across the island where they receive ART including antiretroviral (ARV) drugs free of cost. There were 9,370 patients on treatment in 2015. A total of 76% of PLHIV are on first line ARV drugs, 24% on second line and <1% on third line drugs.

Data presented indicates that in 2015, 80% of patients retained in care (9,370) were on ART and more than two thirds of these have had a viral load test in the past year. At least 65% of PLHIV on ARV have achieved viral suppression.

In the reporting year, the regional TCS staff conducted regular audits of treatment site pharmacies were conducted.

A select number of private pharmacies (8) also provide ARV drugs free or at reduced costs. The unit launched a survey in 2015, to assess the impact of the private pharmacies programme. The unit has considered that the following steps could strengthen the programme's impact:

- Pharmacies' increased compliance with reporting; including providing the requite training and guidance on how reporting should be done
- Increased enrolment numbers; particularly to pharmacies that are in underserved locations and or parishes.
- Adding private pharmacies to the NHF distribution list

ART PROVISION

For 2015, 75% (40,113) of patients were served with first line regimes, 25% (13,497) on second line and 0.2% (121) on third line (see figure 1). 41,921 first line regimes were dispensed, 13,993 second line and 127 third line.

[7] *excluding Obstetrics*

The unit's attempt to deliver ARV treatment was impacted by challenges such as the inconsistent supply from distributors.

Figure 11: Regimen dispensed and patient served by Line of Drug, 2015

	Type of Treatment		
	First line	Second Line	Third Line
Number of patients served	40113	13 497	121
Number of regimens dispensed	41921	13993	127

CARE SERVICES

CD4/VIRAL LOAD TESTING/DNA PCR TESTING

Services such as CD4/ Viral Load/DNA-PCR testing are critical components of ensuring that PLHIV, those who are exposed to HIV and their care providers are able to manage their health.

The CD4 and viral load tests in particular, are used as markers to monitor the stage of HIV disease of the PHLIV and the level of immune system impairment; the result are used therefore to determine the efficacy of ART on adult patients. All diagnosed persons should receive an initial test to determine their CD4 count upon linkage to the care team and twice annually thereafter as per national guidelines.

In 2015, 14,627 CD4 and 15097 viral load tests were processed; an increase of approximately 12% and 31% respectively when compared to the numbers from 2014.

Table 9: Summary of Types of Treatment Monitoring Testing Conducted 2013- 2015

	HIV positive adults						HIV-exposed Infants		
Description	CD4			Viral Load			DNA PCR		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
Received	10813	13038	14627	10407	11490	15097	765	1045	978
Rejected	423	440	574	433	506	322	21	76	66
Processed	10234	12598	14053	6969	10097	14775	719	891	912
HIV positive result	n/a	n/a	n/a	n/a	n/a	n/a	14	6	11
Testing rate	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

IMPROVING CD4/VIRAL LOAD DNA PCR TESTING CAPACITY

In 2015, the Unit began its efforts to decentralize CD4 testing. To that end, the Unit implemented PIMA training for 9 sites in an effort to further testing. By year-end, more than half of the sites trained had submitted their parallel studies for analysis.

In 2015 the CDC donated six FACS Presto machines to further expand point of care CD4 testing. The teams at the sites that received the machines received the requisite technical training sessions. At the time of this report, sites were conducting parallel testing for certification before routine usage.

The Unit has recorded a reduction in rejection rates of samples received for processing. This can be attributed to regional trainings that were held by the NPHL across the island.

For 2015, the Unit registered success with a no stock out of testing and monitoring reagents and supplies. This can be attributed to the strengthening of procurement processes and a closer working relationship between the Unit and the NPHL. Monthly and quarterly audits for example, have enabled the verification of stocks at the central warehouse and lab, which have significantly facilitated more accurate projections.

CHALLENGES

The Unit faced several challenges in 2015 that impacted its ability to deliver its services; these include:

- Malfunctioning of the air conditioning unit at the NPHL hindered the processing of samples resulting in a backlog of samples and the rejection of some CD4 samples.
- Malfunctioning of the COBAS Ampliprep machine used for VL testing delayed processing of samples. The NPHL secured a new machine by a lease agreement (at no cost to the NHP) with the manufacturer to be used while the malfunctioning machine underwent repairs; it will be used as a backup at the central lab.

PLANS FOR IMPROVING SERVICE DELIVERY

The Unit has outlined plans to improve the delivery of its services; this includes:

- Commissioning a feasibility study to examine the decentralizing viral load testing as a means of expanding viral load test access.
- Continue the development of job aids, as the needs of the treatment sites are identified by the treatment site audits. The specific actions include:
    a. HIV confirmatory testing algorithm
    b. HIV screening and monitoring test requirements, and
    c. Treatment guidelines

JAMAICA QUALITY IMPROVEMENT COLLABORATIVE (JAQIC!),

The Jamaica Quality Improvement Collaborative (JaQIC!) was created in 2013 in collaboration with UWI CHART, ERTU CHART Jamaica, the Ministry of Health and I-TECH. An improvement collaborative is a learning system that brings together a group of sites to focus on dramatic improvement in a focused topic area. Quality improvement teams (health care providers)

from each site learn to develop and test change strategies using Plan-Do-Study-Act (PDSA) cycles. PDSA is a rapid-cycle, continuous quality improvement (CQI) approach where teams test a change for improvement on a small scale, observe the results, and adjust the strategy or expand it, based upon their findings.

The collaborative is designed to provide support to clinical care teams to learn and apply improvement methods to achieve the following goals:

I. Improve reliable ordering and completion of CD4 and viral load tests (according to national guidelines).

II. Build knowledge, skills, and experience among frontline care delivery teams in quality improvement methods and the use of data for decision-making at the local level.

THE PROGRAMME'S KEY PERFORMANCE INDICATORS ARE:

- Viral suppression <1000 copies/ml
- On time pick up of prescriptions
- Prescription practices (no mono or dual therapy)
- VL turnaround time of 15 days
- CD turnaround time of 15 days

LINKAGE/RETENTION IN CARE

Once diagnosed, the PLHIV is expected to be linked to one of the 36 treatment sites that are approved for delivery of HIV treatment and care. Among the important interventions during this stage are:

- enrolment at a site for care
- Initial assessment of ART eligibility (after which patients in need of ART start promptly)
- Provision of comprehensive package of services and retention of patients in pre-ART care

The Treatment cascade shows that of the 24,650 people diagnosed with HIV, 14% were never linked to care. That is, they were never enrolled at a site for pre-ART care. Further along the cascade, of the 21,174 persons linked to care, only 11,713 or 48% received care in 2015. This indicates that some 9,461 (45%) PLHIV who were linked into care are being lost to follow up even before a decision is made on eligibility for ART.

Persons living with HIV who are eligible for ART based on CD4 cell count or other clinical criteria should be promptly started on treatment. Once initiated on ART, the ultimate goal is to ensure retention in lifelong successful treatment as evidenced by achieving and sustaining VL suppression.

Despite the issues impacting the treatment cascade, in 2015, at least 80% of patients in care were retained on treatment at six months and 12 months at most sites. Missed appointments have been reduced and there was also an increase in the number of patients retained in care compared to 2014. As it relates to loss to follow up (LTFU), there was a 20% reduction in LFTU compared to 2014 and 601 PLHIV returned to care between September 2015 and August 2016.

The above achievements have been partially attributed to the work of I-Tech which in 2015 initiated a number of strategies in collaboration with the Ministry of Health to plug the gap in LFTU. Some of these include

- Generating LFTU lists
- Telephone calls and text messages to LTFU clients
- Identifying, tracking and calling contacts of LTFU clients
- Field visits
- Utilization of data to drive initiatives
- Ongoing training of support staff
- Increased use of social and adherence support

ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV AND CONGENITAL SYPHILIS

In 2015 the unit continued its implementation of the the eMTCT initiative. Considerable efforts were made to bolster the ART coverage in HEI and improve access to antenatal care and ART coverage among pregnant PLHIV. The key activities included:

- HIV and syphilis rapid tests offered on presentation at the labour ward.
- Establishment of the eMTCT Initative oversight committee; this was accomplished in collaboration with various partners such as UNICEF and PAHO
- Integration of the eMTCT initiative into the maternal and child health programme
- Funding secured from NHF to sustain the programme.

The mother to child transmission rate of HIV decreased to 1% in 2015 from 2% in the previous year with 0.13 new paediatric HIV infections per 1000 live births compared to 0.23 infections in 2014 (see Table 1). The annual rate of congenital syphilis is 0.8 per 1000 live births, a slight increase over the previous year when the rate was 0.77. Antenatal care coverage increased to 78% up from 69% in 2014 while HIV testing among pregnant women was 89%. Syphilis testing was slightly lower at 87% despite the fact that the tests are offered simultaneously. ART coverage of HIV positive pregnant women stood at 90% in 2015, a decrease of 3% from the 2014 figure. Late presentation continues to be a factor affecting ART coverage. Treatment coverage for syphilis in 2015 was low at 26% and can be attributed to shortages in benzyl penicillin supply and gaps in data capture. ART coverage has remained at 98% over the period 2013-2015.

Table 10: eMTCT Validation Indiicators for Jamaica 2013 - 2015

Impact indicators	Target	2013			2014			2015		
HIV Mother to child transmission rate	<2%	4%	14	357	2%	8	374	1%	5	345
Annual rate of new paediatric HIV infections per 1000 infections by birth cohort	<0.3	.35	14	39,500[8]	.23	8	34,978[8]	.13	5	37,556[9]
Annual rate of congenital syphilis per 1000 live births	<0.5	.63	25	39,500[8]	.77	27	34,978[8]	.08	3	37,556[9]
Key Monitoring indicators										
Antenatal care coverage (at least one visit)	>95%	69%	27,394[11,12]	39,500[10]	68%	26,807[11,12]	34,978[10]	78%	29,406[12]	37,556[9,10]
HIV testing coverage of pregnant women	>95%	90%	35,479	39,500[10]	106%	37,040	34,978[10]	89%	33,552	37,556[9,10]
Syphillis testing coverage of pregnant women	>95%	62%	24,452[11]	39,500[10]	66%	23,020[11]	34,798[10]	87%	32,673	37,556[9,10]
ART coverage of HIV positive pregnant women	>95%	91%	407	449	93%	404	436	90%	414	460
Treatment coverage of syphillis positive pregnant women	>95%	65%	274[11]	425[11]	71%	290[11]	411[11]	23%	129	554

[8] *Source: Statistical Institute of Jamaica*
[9] *Source: Registrar General Department's preliminary data*
[10] *Number of live births is being used as a proxy to determine the number of pregnant women*
[11] *Source: Ministry of Health MCSR Table*
[12] *Number of first visits to ANC used as a proxy to determine women who have received ANC by a skilled healthcare worker*

CONGENITAL SYPHILIS

In the antenatal setting, although the prevention and control of syphilis and HIV are integrated with both rapid tests being provided simultaneously, reporting of syphilis data is behind HIV data. The table below shows data for congenital syphilis between 2010 and 2015. Indications are that the number of women tested for syphilis in 2015 was less than in 2014. In 2014, 35784 women were tested compared to 29,406 in 2015. Some 554 women tested positive for syphilis in 2015 at a rate of 1.65% and 31 babies were born with congenital syphilis. Incidence of congenital syphilis is 0.80 per 1000 live births. Incidence of congenital syphilis did not meet the target of <0.5 per 1000 live births for 2015.

Table 11: EMTCT Indicators & CS, 2010-2015

	2010	2011	2012	2013	2014	2015
Antenatal clinic attendees tested	20,259 73.8%	24,304 83.7%	24,207 85.6%	24,452 87.1%	35,784 >100%	29,406 78.3%
Pregnant women tested syphilis positive	317 1.6%	394 1.6%	516 2.1%	425 1.7%	553 1.5%	554 1.65%
Pregnant syphilis positive women treated	171 53.9%	235 59.6%	340 65.9%	274 64.55%	290 71%	
Live Births STATIN	39,804	39,673	39,348	39,500	34,441	37,556
# of infants with congenital syphilis*	10	3	16	25	27	31
Incidence of congenital syphilis per 1000 live births	0.25	0.080	0.410	0.73	0.81	0.80

IMPROVING CAPACITY FOR EMTCT

A team of PAHO consultants conducted an eMTCT pre-validation mission in December 2015. The main objective of the mission was to determine the readiness of the country to advance to eMTCT validation. An orientation exercise was conducted during which the oversight committee was apprised of the validation process; a review of the country data for 2013 and 2014 and site visits to Jubilee Hospital and the May Pen Health Centre was also conducted. Arising out of the recommendations from that prevalidation mission, a decision has been made to institutionalize the EMTCT initiative.

The way forward for the eMTCT programme in 2016 includes:

- introduction of dual testing kits for HIV and syphilis,
- thrust to encourage PLHIV to access antenatal care earlier in the pregnancies
- engagement of Family Health Unit to ensure 100% compliance with DNA PCR testing in HIV exposed babies
- Improved data capture and analysis to maintain the gains already made.

In order to account for obstetric patients that deliver privately, the unit now collects and collates monthly pMTCT reports from all private hospitals offering obstetrics services across the island; they are University Hospital of the West Indies, Nuttall Memorial Hospital, Andrews Memorial Hospital, Hargreaves Memorial Hospital, Royale Medical Centre and Montego Bay Hospital and Urology Centre. At the end of 2015, 2,671 women were tested for HIV during pregnancy with 11 (0.4%) being positive. The exposed infants of these positive mothers have all been linked to care and are being closely monitored. Over 34,000 HIV tests were conducted in the ANC in the public setting for 2015 with approximately 1% of test result being positive.

SEXUALLY TRANSMITTED INFECTIONS

STI SURVEILLANCE FINDINGS

Data from the Jamaica STI Monthly Summary Report and the STI Epi Update 2013 - 2015 indicates that the STI burden remained high in 2015 with 41,703 cases reported in the public health system. This is an increase of 4% over the preceding year. STIs increases the risk of HIV infection as well as transmission as activated CD4 cells are more easily infected with the virus and viral load in vaginal and seminal fluids increase during an STI.

Table 12: STIs Epidemic Update 2013-2015

	2013	2014	2015
Genital discharge syndrome	41,281	39,962	41,703
Genital ulcer disease	886	915	745

Generally, there has been a steady increase in the total number of patients visiting STI clinics every year since 2007. This is primarily due to increases in the number of revisits as the number of new cases has decreased from 19992 in 2014 to 9722 in 2015(Figure 12.)

Men represented 30% of the total number of new clients attending STI clinics in 2015 and St Catherine reported the highest number of new cases with approximately a quarter (29%, 2777) of the new patients that visited STI clinics (Figure 13).

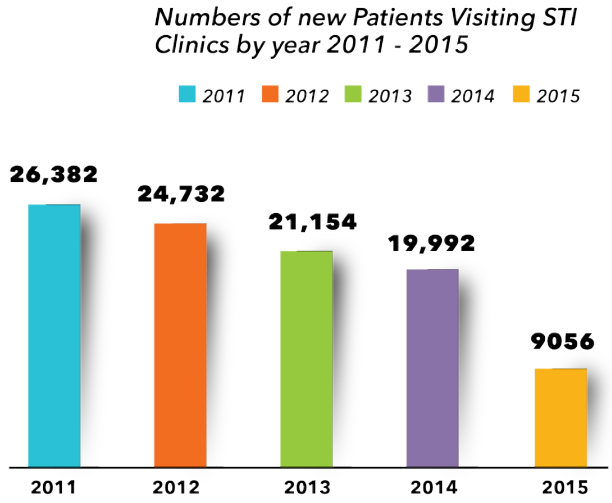


Figure 12: New Patients Visiting STI clinics 2011 – 2015

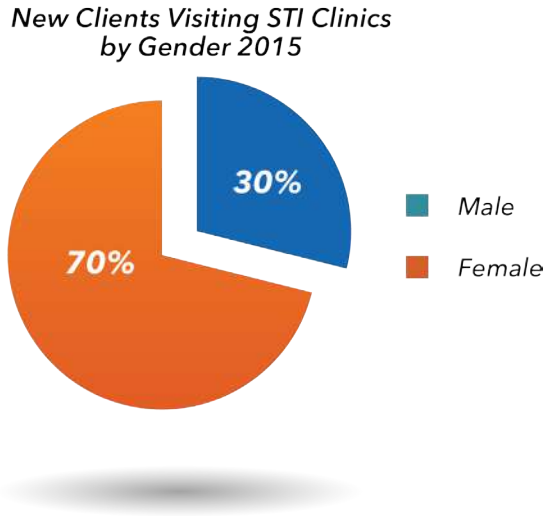
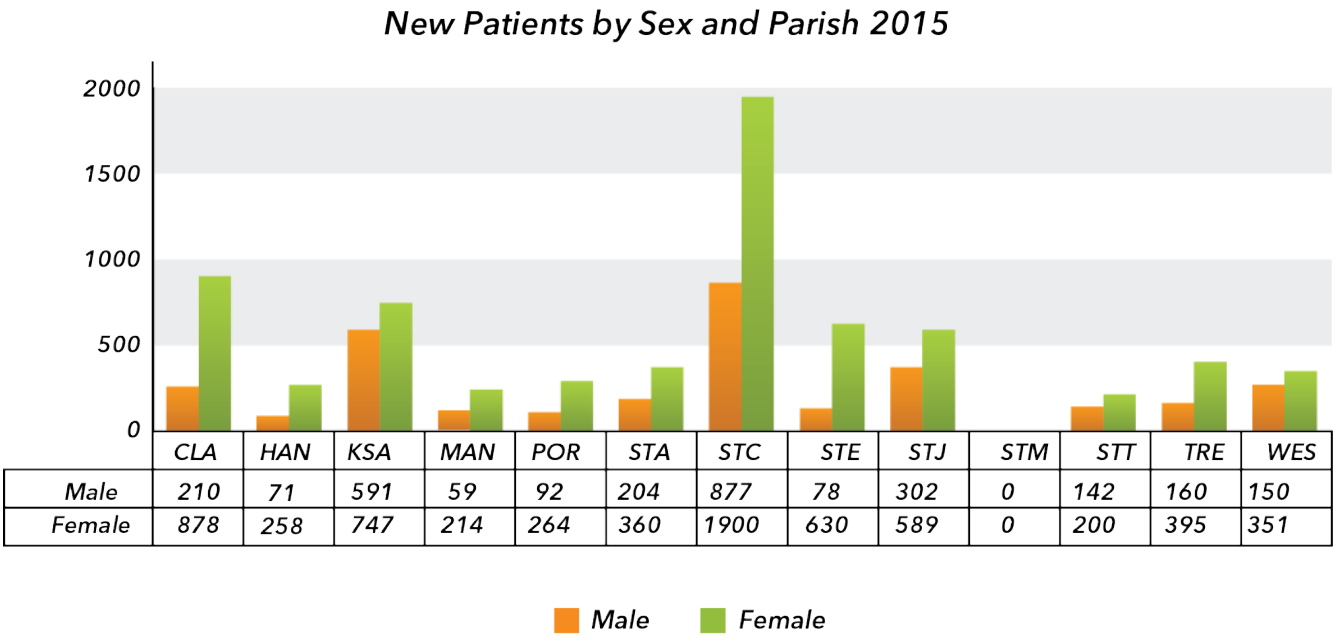


Figure 13: New Clients visiting clinics by gender 2011 – 2015

Figure 14 New Patients by Sex and Parish

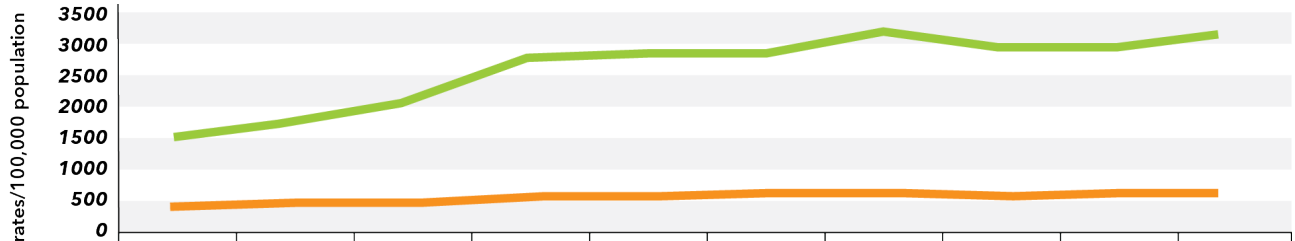


	CLA	HAN	KSA	MAN	POR	STA	STC	STE	STJ	STM	STT	TRE	WES
Male	210	71	591	59	92	204	877	78	302	0	142	160	150
Female	878	258	747	214	264	360	1900	630	589	0	200	395	351

GENITAL DISCHARGE SYNDROME (GDS)

Genital Discharge Syndrome was the most common syndrome diagnosed among STI clinic attendees. Overall, the rate of reported cases of GDS has trended upwards between 2006 - 2015. Women continue to record the greatest number of cases which account for 3 to 5 times as many cases of GDS when compared to men (Figure C). This disparity may be due to a combination of factors including greater susceptibility of women to STI, sex differences in health seeking behaviours and detection bias among women with regard to discharge syndromes. Women are more likely to present to a clinic for care and are more likely to accurately report genital discharge symptoms than men.

Figure 15: Genital Discharge Syndrome Rates/100,000 Population by Sex, 2006 - 2015



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Female	1216.6	1432.2	1678.7	2372.6	2429.2	2395	2702.3	2518.1	2378.9	2488.6
Male	379	392.5	465.8	528.2	540.2	561	588.7	551.5	591.4	611.2

Genital discharge syndromes were more frequently reported in the 20-24-year-old age group followed by the 15-19-year-old group, however the bulk of cases was spread across the 25 yrs. and older population.

GENITAL ULCER DISEASE SYNDROME (GUD)

A genital ulcer disease (GUD) is defined by the guidelines for practical case management of common STI syndromes published by the Ministry of Health (MOH) as "conditions of the genital region (with or without lymphadenopathy) which cause a break or dissolution of the epithelial lining of the skin or mucous membrane in this area". These include syphilis, chancroid, herpes simplex virus (HSV), granuloma inguinale (GL), and lymphogranuloma venereum (LGV).

Table 13: Genital Discharge syndrome rates/100000 Population by sex , 2012-2014

Parish	2014				2015			
	Female	Male	Total	Rate	Female	Male	Total	Rate
CLA	4436	1352	5788	2350	5301	1219	6520	2647
HAN	517	116	633	906	414	92	506	724
KSA	5314	1894	7208	1082	7435	2581	10016	1504
MAN	2524	327	2851	1494	1942	249	2191	1148
POR	2562	327	2889	3515	2723	338	3061	3725
STA	3198	1311	4509	2603	3312	1233	4545	2624
STC	3991	1093	5084	981	3834	1078	4912	948
STE	2558	266	2824	1870	2581	317	2898	1919
STJ	1186	149	1335	723	694	109	803	435
STM	2767	375	3142	2751	2458	381	2839	2485
STT	1936	663	2599	2753	1719	561	2280	2415
TRE	638	109	747	989	668	109	777	1028
WES	244	109	353	244	260	95	355	245
TOTAL	31871	8091	39962	1474	33341	8362	41703	1538

Table 14. Age-Specific GUD Rates/ 100,000 Population, 2007 - 2015

Age groups	2007		2008		2009		2010		2011		2012		2013		2014		2015	
	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
0-9 years	1	0	1	0	1	0	0	0	3	1	1	0	2	1	1	0	3	1
10-14 years	17	6	12	4	10	4	5	2	9	3	11	4	6	2	10	4	3	1
15-19 years	146	59	100	40	150	60	153	61	147	59	158	63	161	65	157	57	107	39
20-24 years	229	110	186	90	233	112	225	108	276	131	259	130	176	88	204	79	124	48
25 or older	542	37	596	40	924	62	799	54	799	53	747	50	580	39	555	16	508	33

St Thomas, Kingston & St Andrew (KSA), and St James recorded the top three highest rates of GUD cases for 2013 and 2014 while Manchester had the lowest rate (Table 3). Overall more women were diagnosed with syphilis than men over the 2007-2015 periods (figure 10). This is partly due to detection bias as women have increased access to tests for syphilis through antenatal clinics. In addition, the greater health seeking behaviour of women allows more timely diagnosis. However, it is important to note that the female to male ratio for infectious syphilis (primary and secondary syphilis) is 1.4:1 while the female to male ratio for STI clinic attendance is 4:1. This implies that infectious syphilis is more prevalent among male STI clinic attendees compared to female STI clinic attendees.

Table 15. Genital ulcer disease syndrome by parish and sex, 2014-2015

PARISH	2014				2015				Rate difference
	Female	Male	Total	Rate	Female	Male	Total	Rate	
KSA	167	164	331	50	181	172	353	53	-3
STC	36	37	73	14	78	29	107	43	-29
STT	96	39	135	143	28	9	37	39	104
POR	6	9	15	18	4	0	4	5	13
STM	23	5	28	25	5	5	10	9	16
STA	30	26	56	32	8	6	14	8	24
TRE	6	14	20	26	101	12	113	150	-124
STJ	95	57	152	82	29	43	72	39	43
HAN	11	11	22	31	1	1	2	3	28
WES	5	6	11	8	0	1	1	1	7
STE	10	10	20	13	8	5	13	9	4
MAN	4	5	9	5	1	2	3	2	3
CLA	20	23	43	17	8	8	16	6	11

Figure 17: Age Specific GUD'S Rates/ 100,000 Population, 2015

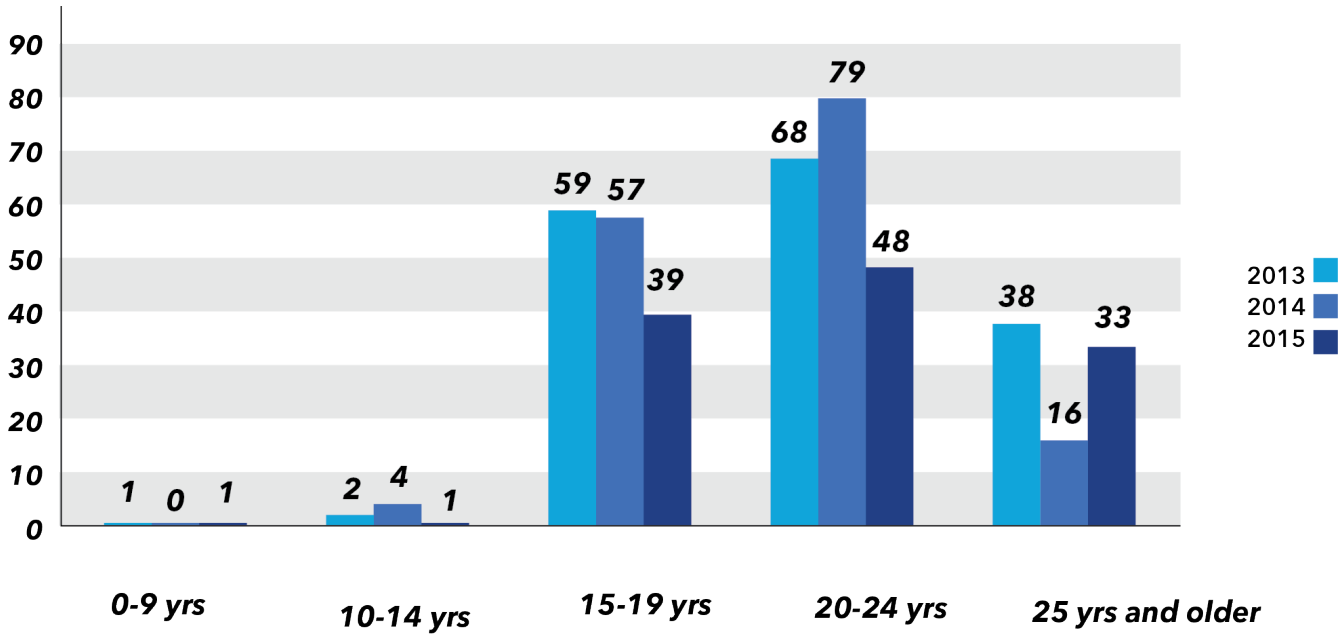
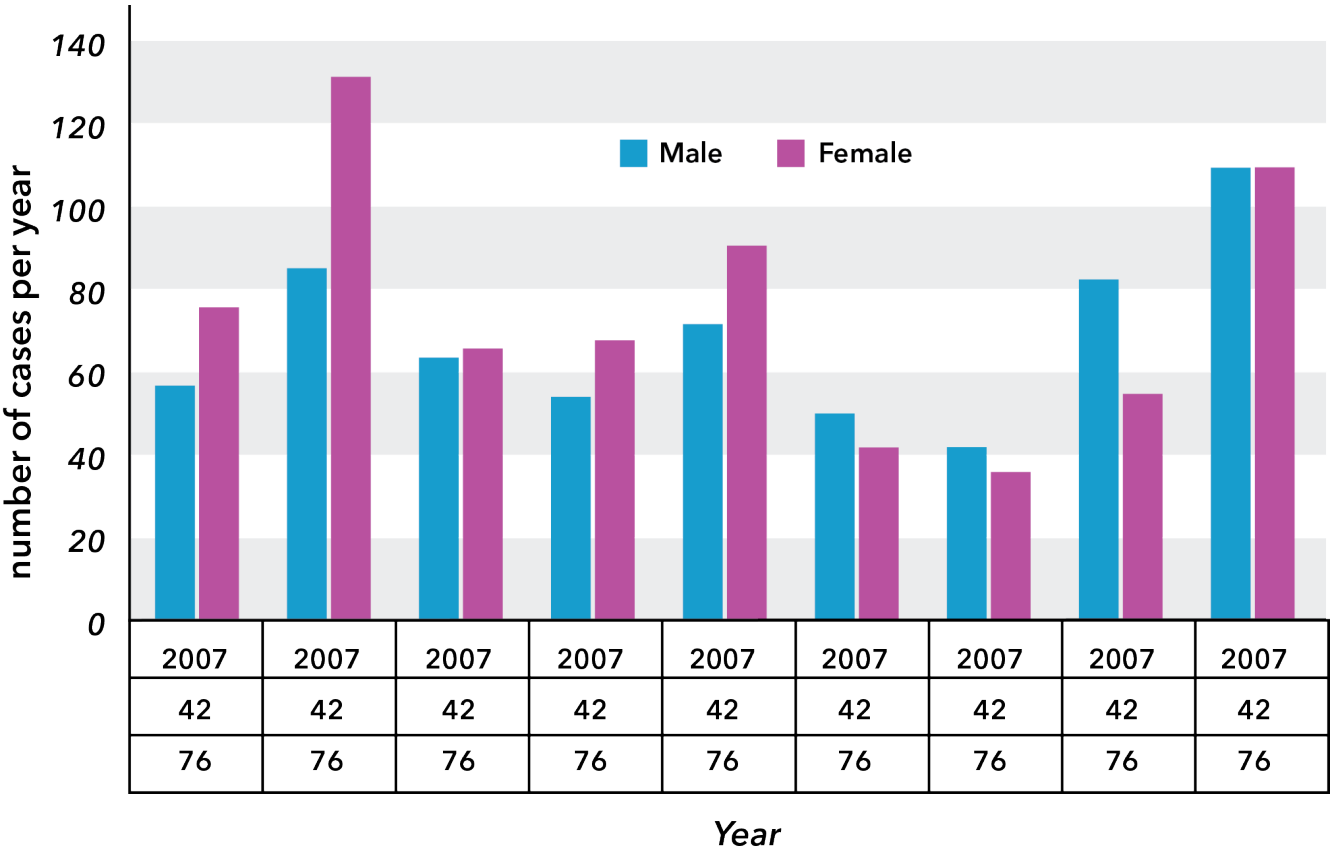


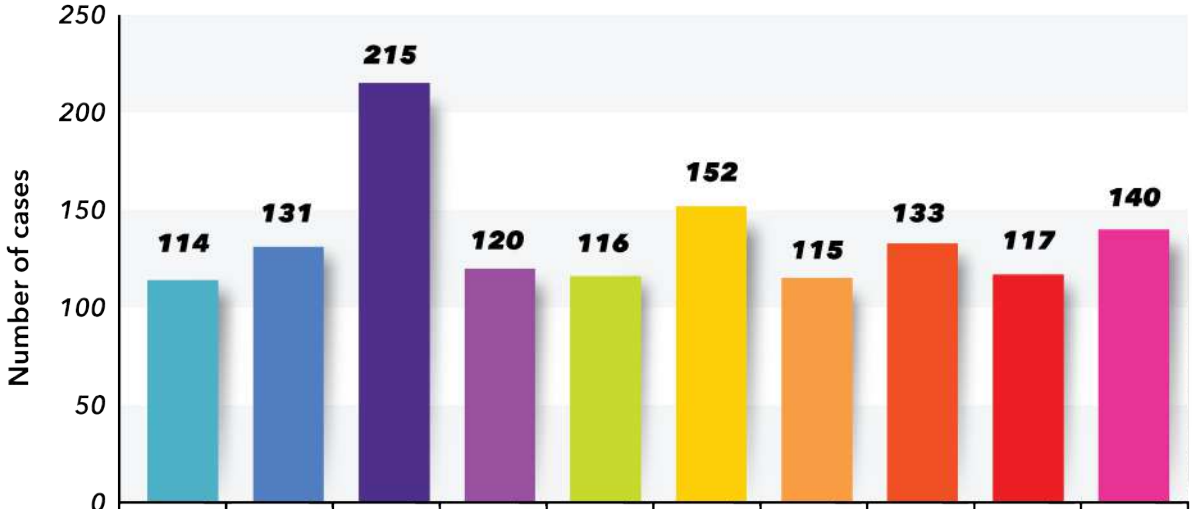
Figure 18: Syphilis Cases Reported by Sex, 2007 - 2015



The number of cases of infectious syphilis increased by 33% among men and by 96% among women between 2014-2015.

All age groups recorded decreases in reported infectious syphilis cases for 2014, namely categories 15-19 years through to 20-24 years. The highest rates of primary and secondary syphilis occurred in the 20-24 age group in 2012

Figure 19: Number of reported cases of Primary and Secondary Syphilis, 2006-2015.



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Cases per year	114	131	215	120	116	152	115	133	117	140

TUBERCULOSIS AND HIV/TUBERCULOSIS CO-INFECTION

The National Tuberculosis (Tb) Programme is subsumed by the HIV/STI/Tb Unit in order to maximize efficiency in the management of Tb and HIV/Tb coinfection. Patients diagnosed with the latter are managed at one of two main treatment sites across the island for a period of eight weeks (intensive phase) following which the maintenance phase of therapy is continued for another four months. Jamaica has a low burden of disease with an incidence of TB of less than 5 cases per 100,000 population between 2012 and 2014.

The initiation of ART in these patients is dependent on the patient's clinical status and CD4 counts. The programme was hampered by several challenges in 2015 including:

- Lack of availability of direct sputum testing and Genexpert tests which has hampered diagnosis and test of cure;
- Several stock-outs of isoniazid and rifampicin due to challenges of drug procurement

In spite of this, active case finding through contact tracing has led to an increase in identification of cases over the reporting period with 41% more suspected cases being identified over a similar period in 2014. The burden of HIV/Tb coinfection was approximately 18% of total suspected cases for 2015. There were 147 confirmed cases of TB in 2015. Of this 87 were also screened for HIV and 27 found to be HIV positive.

Table 16: Tuberculosis 2011-2015

Cases	2011	2012	2013	2014	2015
Number of TB cases Detected	118	95	104	86	147
Number Screened for HIV	90	72	95	79	87
Percentage (%) of TB Cases Screened for HIV	76	76	92	92	100
Of TB Cases Screened number Co-infected	17	16	16	19	27
Percentage of TB cases Co-infected (of those screened)	18.88	22	16.84	22	18.36

CAPACITY BUILDING

Treatment guidelines were updated in 2015. These guidelines now include the 2013 WHO recommendations of initiating treatment at CD4 500, treatment of the seropositive partner in a sero-discordant couple and treatment of all post-delivery mothers. These guidelines will become effective in January 2016 and it is estimated to increase the number of patients requiring medical treatment by 1000. Guidelines for the physical examination and care of key populations specifically MSM are also included. Pocket guides were developed for printing and dissemination.

Treatment site audits were carried out in SERHA and WRHA. The audits report for SERHA suggests that most of the challenges faced relate to the infrastructure being inadequate for the services offered; lack of privacy and storage space being two other major problems. Amendable issues have been addressed post audit, including improper use of testing algorithm, improper storage of medication, improper prescribing practices in the face of rapid staff turnover and unavailability of job aides.

A case management protocol was developed to provide appropriate guidelines for case managers to coordinate clients' optimal retention in care, compliance with medical and service specifications, and risk behaviour reduction. These guidelines were reviewed by the relevant stakeholders at the annual review in November.

Capacity building of the team members included training in STI management for Medical officers in every parish to provide information on current clinical management of STIs. Training of Contact Investigators in the use of the revised investigation forms and proper notification was done with the assistance of M and E, as well as ongoing treatment site database updates.

Several training sessions for support staff: social workers, psychologists, adherence counselors, has been done over the period to include stigma and discrimination, gender based violence, human rights and motivational interviewing. Treatment literacy and readiness was discussed among the support staff during the annual review in order to facilitate the introduction of the new treatment guidelines.

CHAPTER 4: ENABLING ENVIRONMENT & HUMAN RIGHTS

INTRODUCTION

The Enabling Environment and Human Rights (EEHR) Framework for the integrated national response to HIV is mandated to support the pursuit of a just, equitable society for PLHIV. The work of the EEHR Unit of the National Family Planning Board, along with the other components of the national response secure Jamaican's rights to sexual and reproductive health, to access treatment and care services and the right not suffer from stigma discrimination because of HIV status.

The national response to HIV emphasises partnership and multi-sectoral collaboration among governmental, non-governmental organisations (NGOs) and international development partners (IDPs). Key international development partners included the Global Fund to fight AIDS, Tuberculosis and Malaria (GF), the United States Agency for International Development President Emergency Plan for AIDS Relief (USAID/PEPFAR) and the Joint United Nations Team on HIV.

With respect to establishing an enabling environment and human rights framework, the Unit relies on its partnerships with the following national stakeholders:

1. Parliamentarians, responsible for approving the institutionalization of policy and legislative changes.
2. Organizations serving the needs of PLHIV by advocating on behalf of and monitoring the policy environment.
3. Government of Jamaica, ministries departments and agencies that are responsible for drafting and implementing policies & law reform/amendment

In 2015, the work of the national-level stakeholders was further advanced through the Enabling Environment and Human Rights Technical Working Group that was established in January 2014. The Technical Working Group is an independent advisory body of partners, policy experts and key thinkers in sexual reproductive health and human rights issues; the TWG provides guidance to the national sexual health response in the development of strategies and interventions focused on reducing human rights violations and stigma and discrimination.

With the support of IDPs in 2015, the Unit expanded its efforts to implement initiatives to strengthen the legislative and policy framework. The IDP support contributed to for example, assessments on HIV and the law as relevant first step in advancing legal reform and the submission of recommendations on the statutory review of the Sexual Offences Act.

Additionally the support of IDPs in 2015 focused on gender based violence and elimination of violence against women. The Unit and its partners set out do work in the following areas:

- Reform of the Governance Framework
- Stigma and Discrimination
- Greater Involvement of Persons Living with HIV and AIDS in National Response
- Workplace Programme Intervention
- Stakeholder Engagement and Outreach

REFORM OF THE GOVERNANCE FRAMEWORK

NATIONAL DATA PROTECTION ACT AND THE HEALTH INFORMATION PROTECTION REGULATIONS/CODES OF PRACTICE POLICY

During the reporting year the NFPB and the MOH commissioned an assessment of existing provisions related to the protection of personal health information within the health sector. One phase of the assessment included stakeholder consultations to develop the provisions Health Information Protection Regulations/Codes of Practice Policy. The stakeholders consulted included representatives from the following groups and organizations: PLHIV, the MOH, RHAs, administrative, legal and information technology arms of the GoJ, the University Hospital of the West Indies representatives, National Bio-Ethics Committee of Jamaica, professional associations and health insurance providers and academia.

The goal of this exercise was to have the provisions incorporated into the National Data Protection Act so as to ensure the protection and ethical use of personal health information and the rights of patients. The final steps in preparation of a submission to the Chief Parliamentary Counsel will be consultations under the joint leadership of legal and policy specialists.

CABINET APPROVAL OF THE REVISED NATIONAL HIV/AIDS POLICY

On June 1, 2015, Cabinet approved the revision of the National HIV/AIDS Policy. The approval was secured subsequent to the MOH's Minister and Permanent Secretary presentation of a concept paper outlining the rationale for the revision to the Human Resource Committee.

The Unit directed the policy revision process. The Unit established a steering Committee of stakeholder partners from various sectors to drive the process. The Committee's advice on the policy review process and the policy positions was that:

- The consultation process should to be used by the Ministry would involve, inter alia, discussions with different target groups island-wide, ministries and agencies, a gender review and a review by the Attorney General's Chambers. The Committee recommended that the MOH partner with the Social Development Commission (SDC) in the execution of public consultations, given the SDC's established connections with communities' island-wide.
- It was paramount that there be national discussions on issues such as the buggery law and discrimination on the basis of sexual orientation as they impacted policy implementation. In respect of the Offences Against the Person Act, it was noted that the provisions in the law led to restrictions in the prevention and treatment programmes targeting the MSM population. It was also stated that the practice of anal sex was not restricted to MSM, as an increasing number of heterosexuals were engaging in the practice.
- Considerations should be given to whether or not the revised Policy would be proposing amendments to the Sexual Offences Act (SOA) and the Charter of Fundamental Rights and Freedoms. It was noted that the SOA was currently being reviewed by Parliament with significant input from VERJ.

NATIONAL HUMAN RIGHT INSTITUTION (NHRI) INITIAL STAKEHOLDER CONSULTATION

Between September and November the Unit began its work on the national human rights framework by conducting 15 consultations, reaching 539 participants. The objective of the consultations was to gather feedback on the proposed establishment of a National Human Rights Institution (NHRI).

STIGMA AND DISCRIMINATION REDUCTION INTERVENTIONS

The key issues regarding stigma and discrimination for PLHIV include the lack of confidentiality when accessing treatment health facilities. The Unit's approach in 2015 included:

a. Engaging health workers and PLHIV to build their awareness of the human rights approach to the delivery of health services

b. Establishing mechanisms to strengthen the MOH Complaint Management System so as to engender confidence in the system's ability to deliver avenues for redress and,

c. Advocating for a systematic approach to monitoring the implementation of policies, protocols and guidelines at health care facilities.

BUILDING STAKEHOLDER CAPACITY

HEALTHCARE WORKERS, POLICY MONITORING

The Unit, in partnership with UN Women, the MOH, RHA and NFPB implemented an advocacy capacity building initiative for senior level healthcare workers. Through their participation in the exercise, the senior health care workers were expected to have:

a. Developed gender and policy monitoring skills

b. Improved their understanding of their roles in linking their clients to care, along the care continuum

c. Further developed their understanding of topics such as: human rights, confidentiality, the integration of HIV and SRH, family planning and HIV

d. Expanded their awareness of the MOH Complaint Management System and MOH guidelines on unauthorised disclosure of client's information (as stated in the Release of Client Information Policy Manual).

The initiative was intended to lay the foundation for the enhancing the policy and decision-making functions within the health care facilities so that, through their work health care workers can engender an environment in which the rights to confidentiality for persons in the key population and PLHIV is secured and stigma and discrimination is reduced.

ENGENDERING HUMAN-RIGHTS BASED APPROACH TO SERVICE DELIVERY

HEALTHCARE WORKERS

In 2015, 244 nurses (pre-service, registered nurses and midwives) and 14 social workers benefited from sensitization sessions that covered topics such as stigma and discrimination, human rights approach to service delivery, confidentiality and the Ministry of Health's Complaint Management System.

GOVERNMENT WORKERS

In late 2015, the Unit delivered two training workshops on human rights-based approaches to service delivery in public sector entities. The 38 participants were drawn from the public sector bodies in which they were severed as the Focal Points on HIV and or served in communications, policy and legal capacities at their respective institutions. The workshop objectives were to:

a. Develop participants' awareness of the effect of human rights violations on service uptake and,

b. Build the Policy, Legal and Communications Officers' capacity to integrate rights-based approaches into the legal and policy frameworks of government entities.

PUBLIC AND PRIVATE SECURITY

In 2015, 250 Jamaica Constabulary Force (JCF) recruits participated in sensitisation sessions that covered topics such as HIV Basic Facts, Stigma and Discrimination, and Human Rights and the JCF's Diversity Policy. The aim of the sessions was to engender a culture of using a human rights approach to service delivery.

The NFPB partnered with the Private Security Regulation Authority (PSRA) by providing financial support to host consultations that were aimed at developing a Code of Conduct for private security officers with respect to their role in providing services to the users of health facilities. The partnership was in response to concerns that were raised by PLHIV about the experiences interacting with security personnel who are assigned to the health facilities that they frequent for treatment.

THE JUDICIARY

From July 24 to 26, representatives from the judiciary branch including resident magistrates participated in a workshop titled "Issues in Human Rights relating to the Judiciary."

The two-day residential workshop was implemented in collaboration with the UNJT, the UNDP, CVCC, Court Management Services and the Justice Training Institute.

STRENGTHENING REDRESS SYSTEMS

ASSESSING REDRESS SYSTEMS

In 2015, the MOH and NFPB commissioned an assessment of the Western Regional Health Authority's service delivery mechanisms and its Complaint Management System. The findings of the assessment highlighted, for example the need to revise the WRHA's of the orientation programme in order to ensure that they are sensitized on importance of delivering their care services to key populations with confidentiality with respect the sensitising.

Following the completion of the assessment, four regional consultations were held with 74 health care workers to guide the development of their RHA's respective orientation curricula. The areas for discussion included: privacy and confidentiality, leadership and management and conflict resolution.

The findings and recommendations will guide advocacy for the revision of WRHA orientation programme, support the development of a stigma and discrimination brochure, training manual and a specialized training curriculum for health care workers focusing on leadership and management development and conflict resolution. In addition, best practices identified will be shared and similar recommendations made for the revision of the orientation programmes of other RHAs.

REDRESS DIRECTORY OF SERVICES

The NFPB developed a Redress Directory of Services. It is a compilation organizations that offer service support to individuals and communities whose SRH rights are threatened or violated. The directory is a key output of a workshop that was implemented in 2015 to strengthen the redress framework; it was developed through the NFPB's collaborative efforts with redress partners.

LOCAL PARTNERSHIPS FOR ACTION

The national response remained focused on reducing stigma and discrimination through effective partnerships and collaborations. The major work carried out in 2015 includes:

- Development of a concept paper to Cabinet Human Resources Committee to seek approval for the revision and update of the National HIV/AIDS Policy. At the time of this report, the public consultations were underway; the Unit expects the revised and

updated Policy to be completed in 2016.

- Mayor of the City of Kingston- led community dialogue on human rights as a part of the HIV response. Over 50 students, parents and other community members benefited from discussions on HIV transmission, gender based violence and clarifications regarding what human rights are. The Mayor has also led community health fairs with a view to increase the reach of testing towards the first 90 of the 90-90-90 targets.
- Establishment of Civil Society's partnership with the RHAs was facilitated by the MOH and the NFPB. Through these partnerships, healthcare providers were trained or sensitized in how to effectively provide health care services to gay and bisexual men, how to improve their Client Complaint Systems and improve quality of care by monitoring the implementation of policies, guidelines and protocols. This partnership continues to bear fruit as improvements have been noted in the delivery of health care to the vulnerable groups.
- The NFPB received support to develop a gender responsive National Integrated HIV&AIDS Strategy (2012-2017).

GREATER INVOLVEMENT OF PERSONS LIVING WITH HIV AND AIDS (GIPA)

The GIPA Capacity Building Programme is an approach to empowering PLHIVs (especially key affected populations) by strengthening their abilities to play a role in the national response. Each year, the programme engages with a cohort of 30 participants for six months to a year to build key skills and alter deploy them to make representation on behalf of the key populations in various multi-sector efforts within the national response.

The Positive Health Dignity and Prevention (PHDP) Curriculum a tool developed for and by the participants, is the hallmark of the GIPA Programme. The GIPA Coordinator leads the programme implementation and coordinates the efforts of programme partners including the Jamaica Network of Seropositives (JN+) and other service providers to the community of PLHIV and key populations.

PHDP CURRICULUM AND COMMUNITY FACILITATORS

In 2015, Programme stakeholders such as key population groups, MSM and CSWs and adherence counsellors benefited from sensitization sessions that were delivered using the PHDP Curriculum. To date, over 77 PLHIV and some 200 other individuals from key populations groups have been sensitized using the PHDP Curriculum.

During the reporting year, five (5) community representatives who were participants in the GIPA Programme were deployed to the RHAs as Community Facilitators (CFs) to support the expanded work of the NFPB. The CFs were charged with providing of peer support to clients

and helping their peers attain viral suppression, by being retained in care.

The deployment of the CFs to health sector facilitators is a strategic approach designed to:

- Enhance community engagement in the national response
- Give PLHIV an avenue to gain greater legitimacy as community actors
- Lay the foundation for the Programmes work in Community System Strengthening (CSS) and,
- Support the achievement of health outcomes and targets such as the 90- 90- 90 targets.

WORKPLACE PROGRAMME

In 2015, the Ministry of Labour and Social Security (MLSS) established a steering committee to direct its efforts to increase its capacity to deliver the HIV Workplace response. The committee was comprised of senior staff of various departments and agencies of the ministry. One of the priorities of the Committee in 2015 was to manage and support the integration of an HIV response in the Ministry's operations and plans vis a vis the various departments and agencies.

Part of the MLSS's approach was to launch a media campaign on managing HIV in the workplace. In partnership with the Jamaica Information Service (JIS), the MLSS hosted a series of activities included a think tank session, one radio feature with placement and a documentary feature on HIV in the world of work.

In 2015, the MLSS developed an updated HIV curriculum for private sector entities/workplaces to be used to support HIV sensitization in the workplace and the preparation for the pending Occupational Safety and Health Act.

PARTNER-LED INITIATIVES

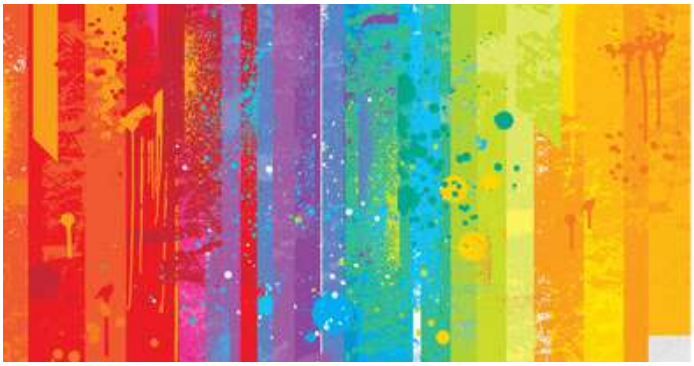
TRUST FUND TO END VIOLENCE AGAINST WOMEN - JAMAICA AIDS SUPPORT FOR LIFE

During the reporting period JASL completed year two of its UN Trust Fund to End Violence Against Women Project entitled "Expanding Gains to Decrease and Prevent Violence against Women in the Context of HIV and VAW". The project aims to increase the responsiveness in addressing violence against key populations of women including, women and girls living with HIV; female sex workers; lesbians, bisexual and transgender women; and women and girls with disabilities.

The project's six implementing partners are: the National HIV/STI Programme, Caribbean Vulnerable Communities Coalition; Jamaica Network of Seropositives; Jamaica Forum for Lesbian, All Sexual and Gays; and Eve for Life.

JASL expanded all its services to include GBV screening; general counselling and other services related to women who have been or are experiencing abuse. Additionally, women from the LGBT community, women who are living with HIV, women who are living with disabilities, women and girls who are living with HIV, and sex workers who are at greater risk of violence are being engaged in advocacy workshops. So far 898 women have accessed VAW related services at JASL clinics and 377 have participated in legal literacy workshops. Thirty six (36) Administrative Resident Magistrates Court Judges were sensitised to responding to the needs of women and girls affected by HIV and VAW.

MITIGATING RISKS AND ENABLING SAFE PUBLIC HEALTH SPACES FOR LGBT JAMAICANS - JFLAG



In 2015, J-FLAG implemented the "Mitigating Risks and Enabling Safe Public Health Spaces for LGBT Jamaicans" project. The objective of the project was to foster the development of an enabling environment where LGBT people's right to health are promoted and respected and LGBT people are able to seek essential HIV and AIDS services and support free from stigma and discrimination.

More specifically the project was designed to address the following areas:

- gaps in policies and laws which hinder LGBT from accessing HIV prevention, treatment, care and support services
- stigma and discrimination at public health services or by health care providers, and
- breaches in confidentiality in relation to sexual orientation and/or HIV status.

The programme activities include sensitisation sessions conducted with clients of health facilities, and a training programme to sensitize healthcare providers and enable them to provide better HIV-related service to this population.

A ten-module training manual covering a wide range of issues relating to the provision of services and specific issues affecting the LGBT community, was used to build the capacity of health care workers to deal with LGBT patients/clients. These included topics on Sexuality, Values and Attitudes, Sexual Health of MSM and Gay Men, Anal Sex, Social Context of MSM and Communication.

Following the training component, the programme team conducted site visits at the participations' respective health facilities to assess the trainings' usefulness and effectiveness.

The evaluation highlighted that there was:

- Lack of knowledge of and limited access to available services
- Lack of knowledge of SRH information
- Limited availability of LGBT friendly SRH services

The project has been impactful in terms of addressing concerns raised by LGBT clients. It has

improved the capacity of stakeholders to deal with and address stigma and discrimination at the community and national levels as well as successfully bringing together and mobilising critical state and civil society actors to work towards a common goal.

The project activities were implemented by JFLAG partnership with the HIV/STI/TB Unit, MOH and NFPB.

COMMEMORATING WORLD AIDS DAY - J-FLAG

At the end of the year, Civil Society led by JFLAG, hosted the National Breakfast Meeting to commemorate World AIDS Day. This initiative demonstrated the national response's commitment to creating an enabling environment through partnerships and collaborations.

THE JAMAICAN NETWORK OF SEROPOSITIVES (JN+)

In 2015, JN+ was able to increase its visibility and level of interaction with its membership. The organiziaton was able to do so by forging strategic partnerships. Along with its partners, JN+ advanced efforts to achieve redress for its members who had reported experiencing stigma and discrimination. One success from these efforts was the securing of an agreement between the MLSS, MOH and the Office of the Public Defender to formally investigate their complaints.

Also in 2015, JN+ began implementation of a three-year vocational skills training and HIV prevention intervention reaching 60 youth including YMSM. The participants were trained and certified in Barbering, Photography, Hair and Nails techniques. The project also had an HIV behaviour change communication component to it which featured HIV basic facts, Stigma and Discrimination and Human Rights. At the end of the project, participants were given start up kits that included tools and products needed to launch their own career. JN+ with technical support from the GIPA capacity building programme completed a preliminary assessment of its support group system and the leaders.

A NFPB/JN+ Redress Framework Workshop was conducted in which 42 multi-sectoral stakeholders (NGO, FBO, Government Ministries, departments and Agencies, civil societies organizations and 1 faith-based organization representative) were engaged in a three-day residential workshop, "Building Confidence in service delivery through effecting redress." The workshop highlighted the need for advocacy related to the development and implementation of a redress system that addresses human rights violations, stigma and discrimination and gender based violence. An expected output of the workshop is a directory listing of redress entities for dissemination among stakeholders.

RESPECT THEM; PROTECT THEM – OUR CHILDREN, OUR NOW - CHILDREN FIRST

Children First is an NGO whose intervention targets at risk populations, particularly youth. The organization's approach is to use edutainment as part of its interventions. For 2015, Children First hosted a Youth Jamboree in May under the theme "Respect them, Protect

them – Our Children, Our Now". The Jamboree was hosted in commemoration of Child's Month and reached over 145 adolescents aged 10 - 17 year old, 60% of whom were girls.

AT-RISK YOUTH - ASHE

Ashe utilises an edutainment approach to HIV prevention. In 2015, the entity partnered with CVCC to create a 'Facilitator's Manual for Reaching at Risk Youth'. The manual, which will be printed in 2016, is a guide on how to use edutainment to teach life skills and topics such as HIV and sexuality.

REVIEW OF THE SEXUAL OFFENCES ACT, VOICES FOR EQUAL RIGHTS AND JUSTICE

The Voices for Equal Rights and Justice (VERJ), is a coalition of civil society organisations that was established to promote greater protection from sexual abuse. The coalition was established in response to Parliaments' invitation for public submissions on the review of the Sexual Offences Act. The coalition benefited from technical support from the Unit and the UNDP in preparing the joint submission.

In its joint submission of recommended changes to the Sexual Offences Act, VERJ highlighted the peculiar vulnerabilities of different marginalized populations (children, women, boys, sex workers, the elderly, persons with disabilities etc.) and the state's duty to protect their rights while providing opportunities for their rights to be fulfilled.

GENDER-BASED VIOLENCE SILENT PROTEST 2015, NGO CONSORTIUM

On November 25, 2015, a consortium of NGOs including the AIDS Health Care Foundation (AHF), Eve for Life, Family Planning Association of Jamaica, Colour Pink Group, Women Inc and J-FLAG/We Change hosted a Silent Protest, "International for the Elimination of Violence Against Women".

Over 200 men and women took to the streets of Half Way Tree for a two-hour silent protest to take a stand against gender-based violence. The protesters represented 11 NGOs. The main objectives of the protest were to increase public awareness about the pervasiveness and effects of all forms of violence against women; stand in support of women who have experienced violence and denounce their guilt and shame, whether perceived or real; break the eerie silence about sexual violence in Jamaica and its negative effect on seeking healthcare and redress for physical and psychological injuries suffered; and call for action from the duty bearers to address the issue.

The protest, which was tracked on social media using the hashtag, #silencespeaks, was done in part to commemorate the International Day for the Elimination of all forms of Violence Against Women.

HIV POLICY - THE ANGLICAN CHURCH

Faith-based organizations (FBOs) are critical partners in the HIV response efforts. In 2015, the Diocese of Jamaica and the Cayman Islands developed a HIV Policy to enhance the contribution of the Anglican Church to the HIV response, guide the development of similar HIV policies for other denominations and expand the multi-sector response to HIV in Jamaica.

The Policy was informed by sensitization and consultation sessions across the island, as well as a national stakeholders' meeting with church leaders, members, and youth arms of the church, inclusive of members of key populations and the HIV-positive community. The

document was reviewed by the appropriate councils of the church and circulated to the wider diocese.

FAITH-BASED ORGANIZATIONS' CONTRIBUTION TO HIV RESPONSE, JAMAICA COUNCIL OF CHURCHES

In May 2015 the Jamaica Council of Churches (JCC) commissioned a mapping exercise on the HIV and AIDS response among faith-based organisations (FBOs), was conducted. The results of the mapping exercise revealed information that will be useful for coordinating the sector's support to the national response. The findings include for example that while FBOs across Jamaica are engaged in implementing a number of HIV prevention, counselling and care programmes; they are less engaged in delivering policy and advocacy initiatives and that training for the leadership is inadequate.

Recommended courses of action that could be used to close the gaps that the mapping highlighted include training in HIV awareness and stigma and discrimination for FBO leaders especially those in the less established FBOs; development of appropriate training modules for seminary students at tertiary institutions to prepare them to deal with HIV and AIDS issues in their FBOs; lobbying each denomination (or FBO) to develop its own HIV policy that will be driven and implemented from the national level and Funding for the sector over the next two to three years for projects aimed at de-stigmatisation within FBOs and broadening their response to PLHIV and key populations.

CHALLENGES AND LESSONS LEARNT

Whilst acknowledging the major progress made by Jamaica National HIV response to building an enabling environment in its response to HIV, challenges were identified as critical in moving forward post 2015. These included:

1. **Low Levels of awareness of human rights.** Mention of Human Rights elicited suspicion that rights discussions may be stigmatized as singularly focused to promote rights for sexual minorities and the socially marginalized. Legal literacy as it relates to rights, duties and responsibilities were low among all stakeholders, including government ministries, departments and agencies. Among most audiences, recollection of rights to life, employment, and family life is high; however, very low awareness of legislative framework or of reporting and redress for breach of rights. Rights in the context of gender were misunderstood or seen only as related to women.
2. **Literacy level.** Amongst key populations at consultations, low literacy levels remain a challenge for staging interventions. Organizing activities on week days during general business hours restricted contact to the key population representatives who were employed or from- higher socio-economic groups.
3. **Self-Stigma.** Added layers of stigma among key populations continued to be a barrier to recruitment and securing commitments for greater involvement from key populations,

e.g. fear of involuntary disclosure through peer groupings or by association.

4. **Staff Attrition.** High personnel turnover among CSO and HCP affected impact of interventions; assigned roles and change commitments are lost or delayed in the transitions
5. **Funding of Priorities.** Limited funding to support Community engagement to build scale and scope of GIPA and the core principles for greater involvement among key populations - to strengthen capacity of Civil Society to engage at the level of the RHAs and to document community engagement process in local communities. Limited multilateral funding support to conduct interventions targeting general populations including men, youths and adolescents, women and girls.
6. **Violence and threats among and towards key communities.** Reaching the key populations, in particular the MSM and TG, was affected by real and perceived acts or threats of violence to the safety of implementing partner staff and target populations.
7. **Low expectations for redress.** Confidence in the systems and expectation for redress between PLHIV and KP remains very low. This is evidenced by the minimal or suboptimal level of documented/reported complaints of HIV-related and other forms of discrimination, although partners report that PLHIV and KP share anecdotal evidence that violations of the rights of these populations occur regularly in all settings.

SOLUTIONS

The national Programme committed to taking remedial actions to address some of the challenges that were faced by the EHHR component in 2015; these include:

1. **Foster and maintain partnerships** among donors, NGOs and government agencies in order to implement activities, programmes and interventions targeting HIV positive persons and key vulnerable populations. NGOs in particular play a critical and essential role in supporting the national HIV response and their contribution needs to be recognized, strengthened and supported.
2. **Basic human rights education** through public awareness, information and education campaigns and other relevant formats
3. **Greater coordination of the collaborative efforts** with civil society group as to respond adequately to the mutual and differentiated needs of the key population communities and priority populations
4. **Deliver support to strengthening the reporting and redress** by development of a protocol for complaints from adolescents, implementing targeted public education and outreach about the system and expanding the types of discrimination categories
5. **Securing funding and other resources for GIPA** to expand community engagement structures throughout Jamaica and to provide sustainable peer-to-peer support for key populations to achieve treatment targets and further reduce stigma and discrimination in health care and support settings.

CHAPTER 5: MONITORING & EVALUATION

ROUTINE PROGRAMME MONITORING AND SURVEILLANCE ACTIVITIES

HIV CASE-BASED SURVEILLANCE

HIV case-based surveillance took place throughout 2015. Data from investigation reports was collected, entered into a central HIV/AIDS Tracking System (i.e. HATS) database, cleaned and collated. This data was then analysed to produce routine data outputs, such as the GIS maps of HIV cases by STATIN community, and the HIV annual epidemiological update.

In addition to ongoing data cleaning efforts to identify duplicates and errors within this database, various attempts were made to actively validate and improve the quality of data received, primarily to minimize the impact of underreporting of the data.

A parish-specific comparative analysis of the average reported cases and deaths over the years 2011 to 2013 was made with the number of HIV cases and deaths reported in 2014. The data collected was sent back to the parishes, with highlighted areas which had a difference of more than 10 percentage point lower than their 3-year average.

Additionally, a triangulation of data between the central HATS Database and entries in the

over 30 treatment site databases was also done to identify whether diagnosed patients were accessing care at treatment sites that had not yet been reported through the surveillance system. Patients that were found (with sufficient demographic and clinical details noted to classify them) then had their case investigation form information printed from the treatment site databases, and forwarded through the routine internal channels for review, sign off and entry into the HATS database. Although this cross-referencing helped improve the data within HATS, parish-specific line listings of the additional cases identified through the mechanism was be sent out to the parishes to facilitate the additional follow-up needed to ensure cases are properly investigated. Overall, this process has re-emphasized the importance of data validation measures and going forward, this cross-referencing between data sources and feedback to the parishes will be done routinely. Finally, all of these data quality improvement initiatives around the case-based surveillance culminated in a surveillance system review with relevant field staff and technical managers in order to identify systematic breakdowns, bottlenecks and possible solutions to be implemented going forward.

In 2015, minor changes in how the surveillance data was captured and analysed were also made to improve the type of analyses that were done, and to improve the interpretation of the annual surveillance data. For example, persons reported as Advanced HIV, AIDS or even AIDS deaths in any given year may have also been included in previously reported cases that have only just been reported as having a later disease stage. This limited the ability to analyse trends among the newly diagnosed cases such as the proportion of newly reported cases that had a late stage diagnosis or even the age, sex or geographic location trends for persons being newly diagnosed. In 2015, this was addressed by separating out the patients that were being reported for the first time (and not just updates to earlier cases) so that they could be analysed separately as well as in the traditional manner.

RESEARCH AND EVALUATIONS

The main evaluation activity in 2015 was the assessment conducted by CARPHA of the M&E capacity to adequately monitor the treatment cascade indicators at a national and sub-national level. The findings generally recognized that a strong system was in place to capture and analyse data at the national level. However, notable gaps were found at the sub-national level, particularly for the utilization of site-specific data and the need for more structured guidance from the national level.

The findings from the evaluation resulted in additional support from the CARPHA M&E team in the revision of local standard operating procedures (SOPs) for data management, with special emphasis as it related to the database and also on-site coaching for the treatment site staff at two high volume sites in the WRHA.

The M&E research activities in 2015 included:

1. A Sexually Transmitted Infections (STIs) prevalence and drug resistance study

2. The annual HIV sentinel sero-survey
3. Participation in the Chikungunya and Ebola research

STI prevalence and drug resistance study: The STI prevalence and drug resistance study examined the prevalence of the four main Sexually Transmitted Infections (STIs) in patients attending the ANC and STI clinics at six sentinel sites across the island. The research methodology mirrored elements of the annual HIV sentinel serosurvey and was thus a cross-sectional study; testing consecutive STI and ANC clinic attendees, but testing urine samples (rather than blood) for the four specific sexual transmittants: Trichomonas vaginalis (Trichomonas), Chlamydia trachomatis (Chlamydia) Neisseria gonorrhoea (GC) and Mycoplasma genitalium.

This study represents the first STI prevalence study in Jamaica to include parishes outside of Kingston and St. Andrew (KSA), an asymptomatic population (i.e. ANC attendees) and also to assess the prevalence of Mycoplasma. Genetic material obtained from all positive Gonorrhoea samples will be further tested by the Microbiology department of the University Hospital of the West Indies to determine sensitivity to locally recommended treatments according to national guidelines. Memorandums of agreement were signed between both CARIGEN and the Microbiology department of the UHWI; and oversight for the overall implementation of the research provided by a research committee comprised of M&E officers, representatives from Treatment, Care & Support Unit within the HIV/STI/Tb Unit, a senior STI clinician and senior contact investigators. As at the end of 2015, 87% of sample collection had been completed with the rest to be submitted in January 2016.

Annual HIV sentinel sero-survey: The annual sentinel sero-survey was completed among antenatal and STI clinic attendees in six sentinel sites. HIV sero-surveys on STI and Antenatal sentinel groups have been conducted in Jamaica since 1990. Throughout the years testing expanded from the original parishes of KSA, St. Catherine and St. James to include other parishes and selected groups as deemed necessary, based on epidemiological evidence of STI/HIV risks. Since 2002, testing has been in six parishes- three urban parishes (KSA, St. Catherine and St James) and three rural parishes (Manchester, Westmoreland and St Ann).

Chikungunya and Ebola Research Committee: The M&E Unit participated in the Chikungunya and Ebola Research Committee. It contributed to the submission of proposals for ethical and grant approval, and also in the focus group discussions themselves. Work with this committee will continue in 2016 with the analysis of the qualitative data.

OTHER ACHIEVEMENTS UNDER NFPB

1. Population Service International (PSI) was engaged by the Ministry of Health to provide guidance on the national roll-out of a unique identification code (UIC). The following were achieved in 2015 through PSI support:
    - Island-wide sensitization and training of RHAs, CSO, NFPB, MOH personnel by PSI.
    - Validation for 374 UIC collected was completed. Of the total 374 UICs collected, 366 were actually representative of UIC and comprised 139 MSM, 24 TG and 203 FSW. Eight individuals (of the 374) were reached multiple times. The probability that two individuals shared the same UIC was estimated at 1.17%. Additionally, 6.8% of the UICs presented data collection errors.

- Finalization of outreach registers which is DHIS2-friendly.
- Finalization of the UIC information flow chart.

2. The Formative assessment of the men's health survey recruited key stakeholders from national organizations that provide advocacy, social and health services to Gay men, MSM, and Transgender persons. In-depth interviews (IDIs) were conducted among persons who were largely referred through key informants (KIs) or through the study lead and interviewers' personal and professional networks. A total of 27 individual interviews were completed during the assessment (12 key informants' interviews and 15 in-depth interviews). The findings revealed:
   - Differences such as gender equality, perceptions of masculinity/femininity, being 'out' versus 'closeted', and social class – based on education, income and family background – were identified as dividing factors between groups of people.
   - The class barriers that exist in Jamaica are heightened among MSM and transgender because of the need to be discreet and the perception of unequal risk if outed.
   - Class divisions seem to affect social interactions moreso than sexual interactions, as persons from the high economic group routinely engage partners from the lower socioeconomic group".

Subsequently the University of California San Francisco and the Government of Jamaica (including the NFPB) will be facilitating the implementation of integrated biological-behavioral surveillance (IBBS) among men who have sex with men and Transgender persons in Jamaica through a study called the 876 study over a two-year period.

CAPACITY BUILDING FOR M&E

A key initiative under capacity building for data management was the training of M&E officers (as well as sensitization of representatives from SITU, civil society and the regional MIS units) by certified experts in the manipulation of the DHIS2 software to develop a national web-based platform for HIV+ patients accessing care within the public sector. The introduction of the web-based database (that will be hosted by the Ministry of Health) will help minimize the level of duplication reported in national figures of treatment indicators and thus refine national coverage estimates. The database will also simplify the updating of entry fields and reports as well as perform other troubleshooting solutions to simplify data management at all levels.

Following the training with the DHIS2 experts that occurred in September 2015, development work has continued including consultations to review in detail the required fields and reports by end users in the field as well as internally to ensure that the new design meets the required needs.

Other data management and analysis trainings that members of M&E participated in throughout 2015 included Spectrum training for modelling of HIV estimates projections, training in advanced data management and analysis in excel and STATA and key performance indicator monitoring for laboratories, participation in the Jamaica statistical symposium that looked at statistics supporting policy and M&E in Project Management.

In addition to participation in trainings, M&E also led regional workshops on data management

and the treatment site database as well as one-on-one site-level training with various staff members that had responsibility for data entry and overall data management at the treatment sites. Routine Data Quality Assessments (i.e. database audits) were also conducted to assess the quality of inputs into the database and highlight the greatest areas of weakness at each site with suggestions to improve.

Capacity Building workshops for health care professionals in qualitative, quantitative data collection, reporting, analysis, hands-on Microsoft Excel and M&E were done by the NFPB. The main aim of the workshops was to strengthen monitoring, evaluation and research, as well as data collection, reporting and analysis for sexual and reproductive health programmes.

HIV INTERNATIONAL DONOR REPORTING

Compilation and submission of HIV programme progress reports to donors and international partners is a routine function for M&E. Quarterly reports to USAID and semi-annual programme reports to Global Fund, the two major donors of the HIV response in Jamaica, were completed. Additionally, the annual Global AIDS Response Progress Report (GARPR) to the UN General Assembly to show national progress towards reaching the '10 Political Declaration Targets' was also done. Data reported through these channels were first validated by national stakeholders through meetings of the Monitoring and Evaluation Reference Group (MERG), a multidisciplinary committee that monitors the implementation of the M&E operational plan, and also specific meetings convened for stakeholder validation of the GARPR report.

NATIONAL INTEGRATED STRATEGIC PLAN

The M&E unit was involved in the detailed review of programme and local survey data for the finalization of the 2014 - 2019 National Integrated Strategic Plan (NISP) for Sexual and Reproductive Health and HIV. Key changes for M&E that have been made in the NISP include M&E now being noted as a separate priority area within the NISP rather than just as a cross-cutting element of the other priority areas. There have also been considerable revisions to the national listing of impact, outcome and output indicators to be tracked and reported on for HIV. Additionally, changes were also been made to the reporting structures and targets going forward as the country updated its planned interventions to be responsive to the data. An implementation plan for the M&E priority area was also completed.

Similarly, the M&E plan was updated to reflect all the changes in the NISP that would impact monitoring and evaluation of the HIV programme, including detailed narrative around the structural changes that would affect reporting formats and the key actions to be implemented during the period of the NISP, an updated research agenda, a costed M&E work plan, updated indicator reference sheets, performance frameworks and also revised data collection forms to enable easy and systematic capture of the information for these new indicators.

M&E PARTNERSHIPS

The M&E unit's function is cross-cutting across the other components of the national HIV response and therefore, M&E often provides a supporting role in several other initiatives led by other components. In 2015, such collaborations included

- The Jamaica Quality Improvement Collaboration (JAQIC) with TCS, ERTU and ITECH

which was initiated in late 2013 continued briefly in 2014 and then was restarted in August 2015. JAQIC sought to increase quality of care to PLHIV attending treatment sites through several strategies including increased data review and utilization

- the Epidemiological Research and Data Analysis Unit with the preparation for the National Health Research Conference
- Analysis of CD4 parallel studies of tests conducted in the field with tests performed on the same samples at NPHL to guide the roll out of point of care CD4 tests

M&E also continues to work closely with other external partners such as the UN Joint Team (PAHO, UNAIDS, UNICEF, UNFPA) in the implementation of select work plan activities.

CHAPTER 6: FINANCE & ADMINISTRATION

INTRODUCTION

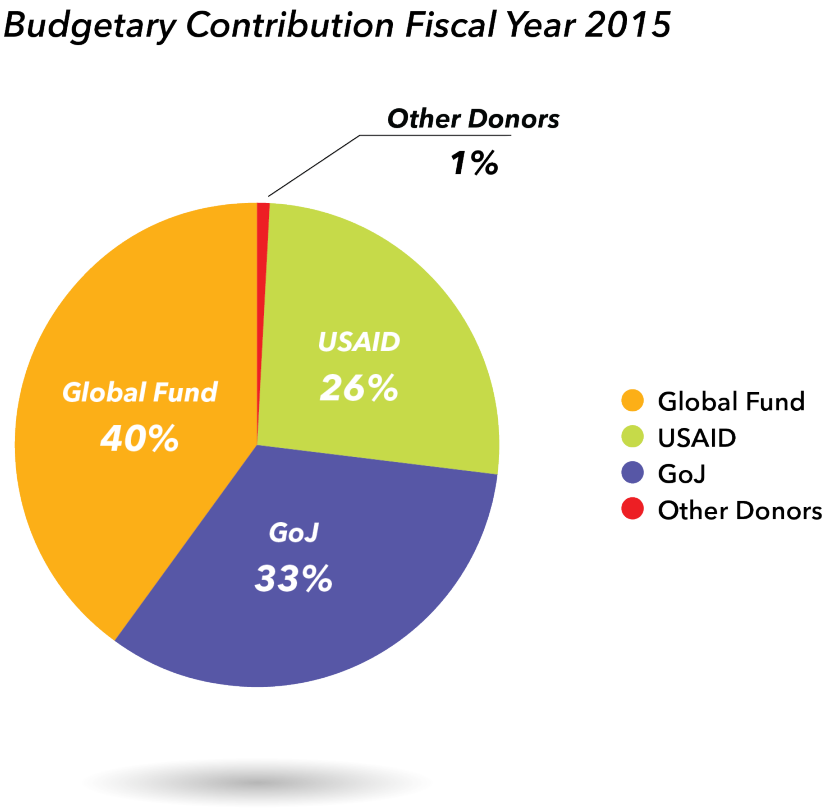
During 2015, the HIV and AIDS response was supported through external grant agreements between the GoJ and donor agencies such as Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and United States Agency for International Development (USAID). The Government of Jamaica (GoJ) also contributed significantly to the response through in-kind contributions and cash.

There was an increase in the amount of resources available to the Programme during the 2015 calendar year of approximately 29% or J$246.41M over that of 2014. The largest increase was through the Global Fund resources of 42%, while GoJ contribution in cash increased by 40%. The Transitional Funding Mechanism agreement under the Global Fund grant came to an end in December 2015 this is after the extension from the original end date of July 2015. The Transitional funding under the USAID Project had an original end date of September 2015, however approval was given to extend the project end date to June 2016.

Two new agreements were negotiated during the year, the Global Fund approved US$15.24M in funding for the National HIV/STI Programme for three years, commencing January 2016 through to December 2018. Under the USAID, a 5-year agreement was also signed in the amount of US$2.6M. The funds will be used to provide support geared at reaching the most

Two new agreements were negotiated during the year, the Global Fund approved US$15.24M in funding for the National HIV/STI Programme for three years, commencing January 2016 through to December 2018. Under the USAID, a 5-year agreement was also signed in the amount of US$2.6M. The funds will be used to provide support geared at reaching the most at risk populations (those most at risk of becoming HIV infected and those who are already infected) through the provision of treatment, care and support services.

The diagram below shows graphically the percentage contributed by each funding source.



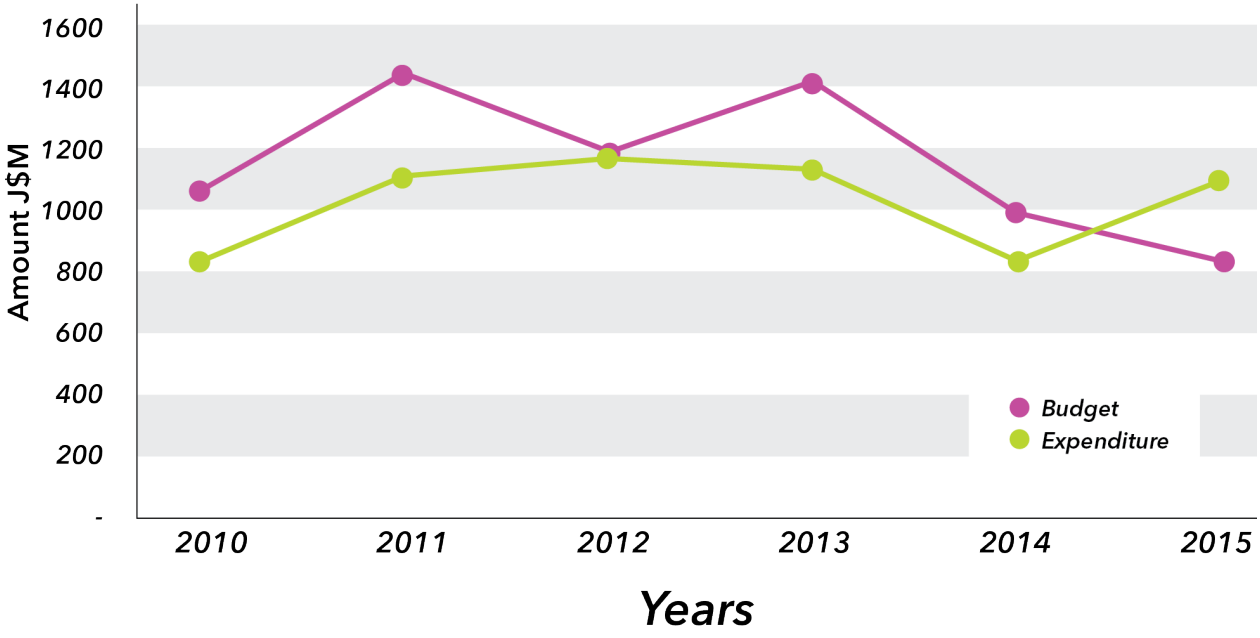
Source: National HIV/STI Program Financial Statements

During 2015, a sum of J$1.08b was budgeted to support the national response, of which J$1.10b was expended. The excess expenditure was supported from unspent resources available from the previous financial year. In addition to this, the aggregate budget for the year was converted at several exchange rates averaging JMD$108 for US$1, while the corresponding total expenditure were converted at exchange rates between JMD$116.5 and $120.15 for US$1.When the budget for the year is received from the donors it is pegged to one particular rate, however the expenses are converted based on the tranche rate of the disbursements that are received from the donors.

Principal Recipient expenditure for the year was J$506.88M, while J$593.46M was spent at the field level by the Sub-recipients (SRs).

The diagram below shows the pattern of budget and expenditure over the last six (6) years of the National Programme.

Figure 20: National HIV/STI Expenditure by Fiscal Years (J$M) 2010 -2015



Source: National HIV/STI Program Financial Statements

The foregoing analysis is done using calendar year figures in keeping with the requirements of the Annual Report, thus January 2015 - December 2015. The cash basis of accounting is also applied in the Programme.

The Programme has several components, these are detailed below:

Since the integration of the National HIV Programme in 2013, the National Family Planning Board (NFPB), became the technical lead on all Prevention programming. In keeping with the donors' thrust and focus, in 2015, the Prevention activities mainly targeted the key populations where the burden of the disease is concentrated. Efforts were scaled up to create a comprehensive programme of prevention services that addressed the needs of the key populations, through the procuring of condoms, workshops and support group sessions, campaigns and reproduction of IEC materials. The budget for the year was reduced by 12% when compared to 2014 for activities under this component. A budget of J$288.79MM was allocated to the component of which J$285.01 was expended. Low cost effective strategies were implemented through continued partnerships with civil society to increase coverage of key populations.

There was continued scaling up of programmes to address the gaps in Treatment, Care and Support component (TCS). The largest portion of the annual budget, 34% was allocated to the component. When compared to the previous year there were significant increases in the

budget and expenditure for the component as J$368.02M was budgeted and J$345.03M was expended during the year, while 2014 had a budget of J$175M and expended J$189.41M. In 2015, the National Programme adopted the UNAIDS 90, 90, 90 by 2030 initiative. In addition audits were conducted at HIV treatment sites across the island to define reported challenges and identify suitable solutions. There was an increase testing and counselling and representatives in private pharmacies underwent training and are dispensing ARVs across island in order to increase access to medication.

Enabling Environment & Human Rights (EE&HR) / Advocacy & Policy, the activities of this component for the Programme were also integrated into the National Family Planning Board (NFPB), thus the entity became the technical lead. Whilst much has been achieved to date, the Programme recognized that stigma and discrimination are major barriers to prevention services, treatment, as well as care and support of people living with HIV/AIDS. Focus was placed on sensitization programmes and there have been great efforts to strengthen health care systems to ensure access to quality services for all Jamaicans. The budget allotted for the calendar year was J$54.81M and J$62.14M was expended. The expenditure during the year represents an increase of 41% of that reported in 2014. The over expenditure exits because budgets and this report span two fiscal periods.

The **Capacity Building/Administration** component provides support to all the other components. A significant portion of the contribution received from GoJ support areas covering human resources and capacity building activities. As per calendar year 2015, the annual budget and expenditure showed an increase when compared to the previous year of 35% and 42% respectively. J$334.50M was budgeted while J$374.42M was expended. The over expenditure exits because this report span two fiscal period.

In 2015 J$38.47M was budgeted and J$33.75M was spent on activities for the **Monitoring and Evaluation component.** During the year, the M&E Unit facilitated internet connectivity through provision of hardware at some treatment sites to assist with the networking capability at sites and the secure wireless submission of data to the M&E Unit. In addition, new modules and reports were added to the treatment site database to further support the use of the electronic ARV registry and strengthen the tracking of indicators for the treatment cascade. Notwithstanding the significant strides that have been made by the component, disaggregated data on some key indicators are still unavailable. This limits the production of evidence based data impacting access to services by key populations, men and women, as well as boys and girls. In order to mitigate these challenges additional funds has been allocated towards developing a unique identifier system for key populations, and collecting bio-behavioral data for key populations, including adolescents and youth under the two new donor funded grants. In addition, a part of the futuristic plan is to use resources to explore ways to find strategies to address the policy barrier to testing youth.

The table 14 below shows a comparison of the budget and expenditure for the components over the years 2013 – 2015.

Table 17: Comparative Summary of component expenditures 2011 -2013

	Calendar Year 2012		Calendar Year 2013		Calendar Year 2013	
Components	Budget J$M	Actual J$M	Budget J$M	Actual J$M	Budget J$M	Actual J$M
Cash Basis						
Prevention	301.64	440.69	329.17	311.15	288.79	285.01
Treatment Care & Support	329.21	433.64	175.00	189.41	368.02	345.03
Monitoring & Evaluation	14.19	9.50	23.68	30.56	38.47	33.75
Capacity Building/ Administration	50.24	57.24	247.38	263.16	334.50	374.42
Enabling Environment/ Policy	268.72	187.72	62.95	44.03	54.81	62.14
Health Sector	42.66	8.14	-	-	-	-
Sub total	1006.66	1,136.94	838.19	838.32	1,084.60	1,100.34
In Kind Contribution		67.54	-	73.35	-	80.69
Grand Total	1,006.66	1,204.48	838.19	911.67	1,084.60	1,181.03

Source: National HIV/STI Program Financial Statements

2015 marked the end of the funding from the Transitional Funding Mechanism (TFM) under the Global Fund grant. Also within the year the Global Fund approved additional financing to the Programme of approximately US$15.42M for the New Funding Mechanism over the period Jan 2016 – Dec 2018. The Global Fund annual approved budget was J$438.45M, this is equivalent to 40% of the aggregate budget for the calendar year. Expenditure for the reporting period was J$475.96M, this expenditure span two fiscal periods, Jan – Mar 2014/15 and Apr – Dec 2015/16. The Project Coordinating Unit (PCU)/Principal Recipient (PR) expended $299.40M during the year while the amount of J$176.56M was expended at the Sub-recipients (SRs) level. The main areas of focus of the funds from the donor was on key population, treatment care and support. As a result of this, the major activities undertaken were the procurement of condoms, ARVs, test kits, reagents and staff cost mainly at the SRs level. Despite the gains achieved under the grant the year was not without challenges which includes:

- Late disbursement of resources from the donor
- Decommitting of expenditure from previous periods.
- Reduction of the amount to be disbursed to the Programme by US$0.94M

During 2015, two USAID PEPFAR projects were being implemented concurrently as the

Transitional grant period was extended to June 2016 and the Year 5 agreement valuing US$2.6M commenced in September 2015. The aggregate budget for the period was J$281.75M and the amount expended for the year was J$317.09M. The Year 5 agreement is being implemented by the PR and twelve (12) Sub-Recipients (SRs). The objectives include:

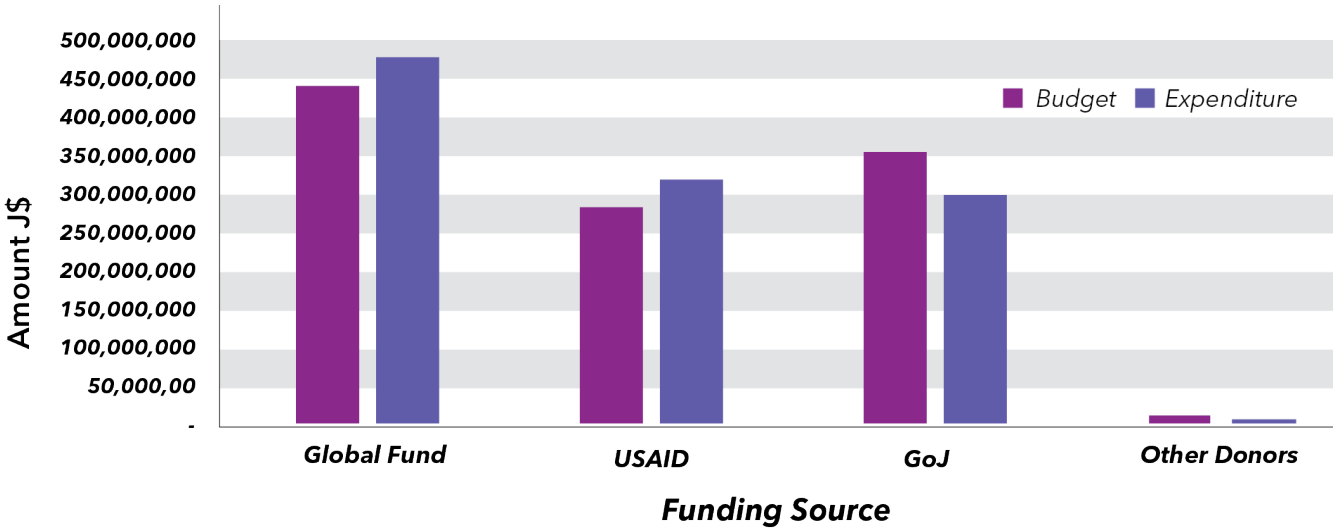
- To support key population groups (MSM and SW) and PLHIV in accessing the Continuum of Prevention, Care and Treatment (CoPCT) and improve retention in the clinical cascade.
- To reduce stigma and discrimination and improve the protection of the rights of selected vulnerable groups through building the capacity of stakeholders involved in HIV prevention, care, and treatment.
- To support the capacity of stakeholders (KP, PLHIV, CBO/NGO and government through use of strategic information to improve program and policy outcomes.

The Government of Jamaica (GoJ) continued to increase the amount of resources allocated to the Programme. In 2015 J$100.55M or approximately 40% more fiscal space was created. The budget for the Calendar year was J$353.59M of which J$296.49M was expended, this represents 25% or J$58.35M increase in expenses when compared to 2014. A significant portion of these resources were used to cover staff cost. However in order to achieve sustainability of the National response beyond the availability of donor resources, there was an increase in the amount allotted to health products such as reagents, infant formula and test kits of approximately 35% during the year.

In Kind contribution, by GoJ for the year was approximately J$80.69M, in the form of salaries, office rental, janitorial services and security cost. This contribution was J$7.34M more than the amount for 2014.

The diagram below shows an analysis of the budget vs expenditure for the respective project during calendar year 2015.

Figure 21: Budget vs Expenditure by Funding Source in 2015



CHALLENGES

During the year the Programme was faced with several challenges. These are listed below:

- Co-mingling of resources for the Global Fund projects
- Late disbursement of resources from the Global Fund donor
- Decommitting of expenditure from previous periods for the Global Fund project.
- Reduction of the amount to be disbursed to the Programme by US$0.94M under the Global Fund project
- Delay in the submission of the Global Fund audit to the donor.
- Slow and low burn rate by the implementation partners to liquidate the resources disbursed.

APPRAISALS

Audits were done for both USAID and the Global Fund Projects during the year as mandated by the project agreements. The audit for Global Fund reporting year was conducted by Mair Russell for the periods Apr 2014 – Mar 2015 and Apr – Dec 2015. USAID audit for the period Apr 2015 – Mar 2016 will be done by BDO and will be submitted by the due date to the donor for Dec 31, 2016.

OTHER ACHIEVEMENTS

During the Calendar year some operational efficiency exercise were undertaken, These were a part of preparedness work for the Global Fund New Funding model Grant to commence in January 2016 and the USIAD Year 5 workplan which commenced in Oct 2015. These changes where institutionalized in January 2016. Through Partnership with USAID Washington and the collaborative efforts of the Global Fund, Technical Assistance was received via a consultant to re-write the Programme Operations Manual to make it more relevant to the current operations. Prior to this the last update was in 2009, when a World Bank Loan existed. Concurrently several templates within the Programme were updated, to include the initiation form and monthly financial reporting templates. Further a series of grant readiness workshops were hosted covering Procurement processes and financial management.

Further to this the PCU embarked on a process to upgrade the electronic accounting software, ACCPAC. A consultant was identified to lend support in this regard. The sub-project and consultancy will cover new chart of accounts, updates from the current version to version 2014, set-up of the system, training in the use of the software and report writing. This consultancy will continue into the 2016 period when the new grants are operational, as this data will form the base of the system.

Within the year, the human resource capacity of the unit was strengthen with the filling of two (2) vacancies within the unit, and the creation of a Grant Manager position that strengthened the preparedness work for the upcoming grants. Challenges

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- Late disbursement of resources from the Global Fund donor
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ANNEXES

ANNEX 1: LIST OF EXPERTS, REVIEWERS AND CONTRIBUTORS

REVIEWERS

Ms. Marion Scott

Dr. Nicola Skyers

CONTRIBUTORS

Treatment Care & Support- Dr Jennifer Brown Tomlinson

Prevention- Ms Andrea Campbell

Enabling Environment and Human Rights- Mr Devon Gabourel/ Mrs Karlene Temple Anderson

Monitoring and Evaluation- Mrs Zarha Miller

Finance- Mrs Janice Walters

ANNEX 2: LIST OF BACKGROUND REPORTS

ENABLING ENVIRONMENT AND HUMAN RIGHTS COMPONENT

National Family Planning Board/Enabling Environment and Human Rights Unit. 2013. Annual Report 2012

National Family Planning Board/Enabling Environment and Human Rights Unit. 2014. Annual Report 2013

National Family Planning Board/Enabling Environment and Human Rights Unit. 2015. Annual Report 2014

National Family Planning Board/Enabling Environment and Human Rights Unit. 2016. Annual Report 2015

FINANCE AND ADMINISTRATION

National HIV/STI Programme. 2013. Finance Information Annual Report 2012

National HIV/STI Programme. 2013. Finance Information Annual Report 2013

National HIV/STI Programme. 2013. Finance Information Annual Report 2014

National HIV/STI Programme. 2013. Finance Information Annual Report 2015

MONITORING AND EVALUATION

National HIV/STI Programme. 2013. Monitoring & Evaluation Annual Report 2012

National HIV/STI Programme. 2014. Monitoring & Evaluation Annual Report 2013

National HIV/STI Programme. 2015. Monitoring & Evaluation Annual Report 2014

National HIV/STI Programme. 2016. Monitoring & Evaluation Annual Report 2015

TREATMENT CARE AND SUPPORT UNIT

National HIV/STI Programme. 2013. Treatment Care and Support Unit Annual Review 2012. Prepared by Dr T. Green Douglas, Mrs R. Khan-Francis and Ms. Paula Prince. Reviewed by Dr. J. Brown-Tomlinson.

National HIV/STI Programme. 2014. Treatment Care and Support Unit Annual Review 2013. Prepared by Dr T. Green Douglas, Mrs R. Khan-Francis and Ms. Paula Prince. Reviewed by Dr. J. Brown-Tomlinson.

National HIV/STI Programme. 2015. Treatment Care and Support Unit Annual Review 2014

Ministry of Health/HIV/STI/Tb Unit/Health Promotion and Protection Branch. 2016. Treatment Care and Support Annual Report 2015

OTHER

Ministry of Health. 2015. Jamaica Country Progress Report: Global AIDS Response Progress Report 2014. Reporting Period: January 1 – December 31, 2014

Ministry of Health. 2016. Jamaica Country Progress Report: Global AIDS Response Progress Report 2015. Reporting Period: January 1 – December 31, 2015

Ministry of Health/National HIV/STI Programme. 2012. Jamaica HIV/AIDS Epidemic Update January to December 2012

Ministry of Health/National HIV/STI Programme. (2013) HIV Epidemiological Profile 2013, Facts & Figures

Ministry of Health/National HIV/STI Programme. (2014) HIV Epidemiological Profile 2014, Facts & Figures

Ministry of Health/National HIV/STI Programme. (2015) HIV Epidemiological Profile 2015, Facts & Figures

ANNEX 3: DATA TABLES

TABLE 1: SUMMARY OF HIV CASES REPORTED BY YEAR AND SEX, 1982 TO 2015

YEAR	MALE (%)	FEMALE (%)	UNKNOWN (%)	TOTAL
1982 to 1995	2123 (63.8)	1171 (35.2)	34 (0.01)	3328
Jan – Dec 1996	577 (59.4)	390 (40.2)	4 (0.4)	971
Jan - Dec 1997	690 (61.5)	430 (38.3)	2 (0.2)	1122
Jan – Dec 1998	633 (59.5)	430 (40.4)	1 (0.1)	1064
Jan – Dec 1999	805 (56.1)	629 (43.8)	2 (0.1)	1436
Jan - Dec. 2000	824 (53.9)	706 (46.1)	0 (0.0)	1530
Jan - Dec. 2001	835 (50.1)	827 (49.6)	5 (0.3)	1667
Jan - Dec. 2002	737 (51.4)	695 (48.5)	1 (0.1)	1433
Jan –Dec 2003	840 (49.9)	844 (50.1)	1 (0.0)	1685
Jan – Dec 2004	860 (46.2)	1003 (53.8)	0 (0.0)	1863
Jan – Dec 2005	884 (45.6)	1053 (54.4)	0 (0.0)	1937
Jan - Dec 2006	1006 (47.4)	1114 (52.5)	1 (0.1)	2121
Jan - Dec 2007	930 (47.8)	1015 (52.1)	2 (0.1)	1947
Jan - Dec 2008	875 (46.8)	993 (53.2)	0 (0.0)	1868
Jan - Dec 2009	835 (48.0)	903 (52.0)	0 (0.0)	1738
Jan - Dec. 2010	803 (51.4)	759 (48.5)	0 (0.0)	1562
Jan – Dec 2011	901 (50.1)	896 (49.9)	0 (0.0)	1797
Jan – Dec 2012	803 (51.8)	748 (48.2)	0 (0.0)	1551
Jan – Dec 2013	677 (53.0%)	601 (47%)	0 (0.0)	1,278
Jan – Dec 2014	657 (50.7%)	638 (49.3%)	0 (0.0)	1,295
Jan – Dec 2015	609 (49.8%	613 (50.2%)	0 (0.0)	1,222
Total	17,904 (52.0%)	16,458 (47.8%)	53 (0.2%)	34,415

TABLE 2: SUMMARY OF PERSONS WITH ADVANCED HIV* IN JAMAICA, 2005 to 2015

PERIOD	TOTAL	MALE	(%)	FEMALE	(%)
Cumulative 1982-2013	22,287	12,132	(54.5)	10,155	(45.5)
Jan – Dec 2005	1,333	692	(51.8)	641	(48.2)
Jan - Dec 2006	1,183	659	(55.6)	527	(44.4)
Jan - Dec 2007	1,090	590	(53.7)	508	(46.3)
Jan - Dec 2008	1,194	618	(51.6)	57.9	(48.4)
Jan - Dec 2009	1,477	704	(47.3)	785	(52.7)
Jan – Dec 2010	1,493	711	(47.3)	792	(52.7)
Jan – Dec 2011	1,245	661	(52.9)	589	(47.1)
Jan – Dec 2012	1,883	944	(50.0)	944	(50.0)
Jan – Dec 2013	778	423	(54.2)	357	(45.8)
Jan – Dec 2014	753	398	(52.9)	355	(47.1)
Jan – Dec 2015	686	349	(50.9)	337	(49.1)

**In July 2005, the national programme began monitoring cases of advanced HIV (i.e. persons with CD4 counts < 350). Figures reported for AIDS cases between July 2005 and December 2007 included persons with advanced HIV.*

TABLE 3: SUMMARY OF AIDS CASES IN JAMAICA, 1982 to 2015

PERIOD	TOTAL	MALE%		FEMALE%	
1982-1995	1,557	980	(62.9)	577	(37.1%)
Jan-Dec 1996	490	305	(62.5)	184	(47.50
Jan - Dec 1997	609	372	(61.1)	237	(38.9)
Jan – Dec 1998	643	410	(63.7)	233	(36.2)
Jan – Dec 1999	890	537	(60.4)	353	(39.5)
Jan - Dec. 2000	901	514	(57.0)	387	(43.0)
Jan - Dec. 2001	935	509	(54.4)	426	(45.6)
Jan – Dec 2004	1,110	602	(54.2)	508	(45.8)
Jan – Dec 2005	1,333	692	(51.8)	641	(48.2)
Jan - Dec 2006	1,183	658	(55.6)	525	(44.4)
Jan - Dec 2007	777	441	(56.6)	336	(43.4)
Jan - Dec 2008	923	524	(56.7)	399	(43.2)
Jan - Dec 2009	906	492	(54.4)	414	(45.6)
Jan - Dec. 2010	930	497	(53.2)	433	(46.8)
Jan - Dec. 2011	973	541	(55.6)	432	(44.4)
Jan - Dec. 2012	1,194	631	(52.9)	563	(47.1)
Jan – Dec 2013	682	383	(56.2)	299	(43.8)
Jan – Dec 2014	539	311	(57.7)	228	(42.3)
Jan – Dec 2015	441	244	(55.3)	197	(44.7)
Total	19,053	10,820	(56.8)	8,223	(43.2)

TABLE 4: SUMMARY OF HIV/AIDS CASES BY PARISH IN JAMAICA, 1982 – DEC 2015 (BY DATE OF REPORTING)

PARISH	Jan - Dec 2015	1982 – Dec 2015 Cumulative Total	RATE PER 100,000 POPULATION
Kingston & St. Andrew	290	11,983	1,787.6
St. Thomas	22	548	576.7
Portland	39	756	914.0
St. Mary	35	1,153	1,002.9
St. Ann	108	2,447	1,403.5
Trelawny	37	941	1,237.4
St. James	160	4,582	2,465.4
Hanover	54	889	1,264.2
Westmoreland	113	1,931	1,324.9
St. Elizabeth	43	919	604.7
Manchester	39	1,185	617.1
Clarendon	99	1,783	719.2
St. Catherine	167	4,679	896.9
Parish Not Known	15	296	n/a
Overseas Address	1	33	n/a
Total	1,222	34,125	1,250.5

TABLE 5. SUMMARY OF AIDS CASES BY PARISH IN JAMAICA, 1982 -2015 (BY DATE OF REPORTING)

PARISH	Jan - Dec 2015	1982 – Dec 2015 Cumulative Total	RATE PER 100,000 POPULATION
Kingston & St Andrew	137	6,927	1,033.4
St Thomas	5	302	317.8
Portland	19	393	475.1
St Mary	14	611	531.5
St Ann	15	1,192	683.7
Trelawny	10	529	695.6
St James	60	2,816	1,515.2
Hanover	23	478	679.7
Westmoreland	38	1,131	776.0
St Elizabeth	13	507	333.6
Manchester	16	653	340.0
Clarendon	4	882	355.8
St Catherine	83	2,600	498.4
Parish Unknown	4	19	n/a
Overseas Address	0	13	n/a
Total	441	19,053	698.2

TABLE 6: SUMMARY OF AIDS DEATHS IN JAMAICA, 1982 – DEC 2015

PERIOD	TOTAL	MALE (%)		FEMALE (%)	
1982 - Dec 2013	9,517	5,695	(59.8)	3,822	(40.2)
Jan – Dec 2000	617	358	(58.1)	259	(41.9)
Jan -Dec. 2001	587	329	(56.0)	258	(44.0)
Jan -Dec. 2002	690	405	(58.7)	285	(41.3)
Jan - Dec 2003	649	380	(58.6)	269	(41.4)
Jan - Dec 2004	663	376	(56.6)	287	(43.3)
Jan – Dec 2005	514	310	(60.3)	204	(39.7)
Jan – Dec 2006	432	262	(60.6)	170	(39.4)
Jan - Dec 2007	320	201	(62.8)	119	(37.2)
Jan - Dec 2008	400	236	(58.9)	164	(41.1)
Jan - Dec 2009	378	234	(61.9)	144	(38.1)
Jan – Dec 2010	332	197	(59.2)	135	(40.8)
Jan – Dec 2011	392	234	(59.5)	158	(40.5)
Jan – Dec 2012	259	155	(60.0)	104	(40.0)
Jan – Dec 2013	298	169	(56.7)	129	(43.3)
Jan – Dec 2014	219	122	(55.7)	99	(44.6)
Jan – Dec 2015	254	136	(53.5)	118	(56.7)

TABLE 7: SUMMARY OF AIDS DEATH BY PARISH IN JAMAICA, 1982 – DEC 2015 (BY DATE OF REPORTING)

Parish	January - Dec 2015	1982 – Dec 2015 Cumulative Total
Kingston & St. Andrew	62	3,531
St. Thomas	3	119
Portland	22	204
St. Mary	8	359
St. Ann	6	416
Trelawny	11	297
St. James	45	1,597
Hanover	17	291
Westmoreland	25	652
St. Elizabeth	7	268
Manchester	14	310
Clarendon	1	268
St. Catherine	32	1,185
Parish Not Known	1	12
Overseas Address	0	7
Total	254	9,517

TABLE 8: SUMMARY OF PAEDIATRIC AIDS CASES (AGE 0 - 9 YEARS), 1986 – 2015

PERIOD	TOTAL	MALE%		FEMALE%	
1986- Dec 2015	1,008	533	(53.3)	475	(46.7)
Jan- Dec 2000	83	49	(59.0)	34	(41.0)
Jan - Dec. 2001	65	39	(60.0)	26	(40.0)
Jan - Dec. 2002	81	37	(45.7)	44	(54.3)
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)
Jan - Dec 2007	27	14	(51.9)	13	(48.1)
Jan - Dec 2008	32	19	(59.4)	13	(40.6)
Jan - Dec 2009	26	17	(65.4)	9	(34.6)
Jan – Dec 2010	19	10	(52.6)	9	(47.4)
Jan – Dec 2011	21	15	(71.4)	6	(28.6)
Jan – Dec 2012	19	10	(52.6)	9	(47.4)
Jan – Dec 2013	10	3	(30.0)	7	(70.0)
Jan – Dec 2014	10	4	(40.0)	6	(60.0)
Jan – Dec 2015	6	3	(50.0)	3	(50.0)

TABLE 9: SUMMARY OF PAEDIATRIC AIDS CASES BY PARISH IN JAMAICA (BY DATE OF REPORTING), 1986 – 2015

PARISH	Cumulative Total	RATE PER 100,000 POPULATION 2006 Est. STATIN 0-9 age group
KINGSTON & ST. ANDREW	409	308.1
ST. THOMAS	28	133.2
PORTLAND	16	89.7
ST. MARY	29	115.9
ST. ANN	36	96.8
TRELAWNY	18	110.2
ST. JAMES	137	349.4
HANOVER	17	114.0
WESTMORELAND	39	124.3
ST. ELIZABETH	26	83.9
MANCHESTER	40	101.0
CLARENDON	57	101.5
ST. CATHERINE	153	145.3
PARISH NOT KNOWN	2	n/a
OVERSEAS ADDRESS	1	n/a
TOTAL	1,008	177.6

TABLE 10: SUMMARY OF PAEDIATRIC AIDS DEATHS, 1986 -2015

PERIOD	TOTAL	MALE%		FEMALE%	
1986 - Dec 2015	454	233	(51.4)	221	(48.6)
Jan – Dec 2000	34	20	(58.8)	14	(41.2)
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)
Jan - Dec 2007	9	4	(44.4)	5	(55.6)
Jan - Dec 2008	9	4	(44.4)	5	(55.6)
Jan - Dec 2009	5	3	(60.0)	2	(40.0)
Jan – Dec 2010	10	8	(80.0)	2	(20.0)
Jan – Dec 2011	3	2	(66.7)	1	(33.3)
Jan – Dec 2012	7	4	(57.1)	3	(42.9)
Jan – Dec 2013	3	1	(33.3)	2	(66.6)
Jan – Dec 2014	8	4	(50.0)	4	(50.0)
Jan – Dec 2015	3	1	(33.3)	2	(66.6)

TABLE 11: SUMMARY OF AIDS CASES BY 5-YEAR AGE GROUPS, 1986 – DEC. 2015, JAMAICA

AGE GROUP	MALE	FEMALE	TOTAL
00 to 4	367	311	678
05 to 9	127	131	258
10 to 14	18	23	41
15 to 19	67	194	261
20 to 24	443	711	1,154
25 to 29	1,132	1,232	2,364
30 to 34	1,572	1,388	2,960
35 to 39	1,787	1,261	3,048
40 to 44	1,605	988	2,593
45 to 49	1,256	686	1,942
50 to 54	979	449	1,428
55 to 59	638	334	972
60 to 64	361	213	574
65 to 69	193	117	310
70 to 74	89	67	156
75 to 79	44	29	73
80 to 84	9	16	25
85 to 89	3	3	6
90 to 94	0	2	2
Unknown	130	78	208
Total	10,820	8,233	19,053

TABLE 12: ADULT HIV CASES BY SEXUAL PRACTICES (1982 – DEC 2015 CUMULATIVE)

Sex Practice Category	Male	Female	Unknown**	Total
Heterosexual	8,582	15,504	0	24,086
Homosexual	683	0	0	683
Bisexual Males	713	0	0	713
Not Stated	6,951	1	29	6,981
Total	16,929	15,505	29	32,463
Child	851	788	23	1,662
Total	17,780	16,293	52	34,125

***29 reported as Unknown Gender*

TABLE 13: REPORTED RISK BEHAVIOURS AMONG ADULTS WITH HIV (1982 – DEC 2015 CUMULATIVE)

RISK	No. of Persons (%)
Sex with Sex workers	4,667 (14.4%)
Crack , Cocaine Use	1,357 (4.2%)
STI History	11,167 (34.4%)
IV Drug Use	196 (0.6%)
Multiple Sexual Partners/contacts	4,841 (13.1%)
No high risk behaviour	5,217 (16.8%)

TABLE 14: HIV STATUS OF PREGNANT WOMEN BY PARISH 2015*, JAMAICA

Parish	Total Tested	Total Positive	Percent Positive (95% C.I.)
Kingston & St Andrew	1,421	20	1.4 (0.86-2.17)
Manchester	588	3	0.5 (0.11-1.48)
St Ann	524	2	0.4 (0.05-1.37)
St Catherine	1,028	7	0.7 (0.53-3.02)
St James	418	12	2.9 (1.49-4.96)
Westmoreland	412	1	0.2 (0.01-1.34)
Total	4,391	45	1.00 (0.75-1.37)

**Survey conducted between April and September 2015*

TABLE 15: HIV STATUS OF STI CLINIC ATTENDEES BY PARISH 2015*, JAMAICA

Parish	Total Tested	Total Positive	Percent Positive (95% C.I.)
Kingston & St Andrew	1,241	49	3.95 (2.94-5.19)
Manchester	419	1	0.24 (0.01-1.32)
St Ann	626	8	1.28 (0.55-2.50)
St Catherine	974	32	3.29 (2.26-4.61)
St James	380	14	3.68 (2.03-6.10)
Westmoreland	381	10	2.62 (1.27-4.77)
Total	4,021	114	2.84 (2.34-3.40)

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