Jamaica National HIV/STI Programme Monitoring and Evaluation System 2007-2012

**Document A:
Monitoring & Evaluation Plan**

National HIV/STI Programme

**Ministry of Health
Jamaica**

Monitoring & Evaluation Plan
The Jamaica National HIV/STI Programme

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
BCC	Behaviour Change Communication
CAR	The Caribbean Community and Common Market (CARICOM)
CAREC	Caribbean Epidemiology Center
CD4	Cluster of Differentiation 4
CHRC	Caribbean Health Research Council
CI	Contact Investigator
CIMT	Caribbean Indicators and Measurement Tools (from CHRC)
CRIS	Country Response Information System
DBMS	Database Management System
ED	Enumeration Districts
GFATM	Global Fund for AIDS, TB, and Malaria
GOJ	Government of Jamaica
HATS	HIV/AIDS Tracking System
HFA	Health Facility Assessment
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMSR	Hospital Monthly Statistical Report
IEC	Information, Education and Communication
KABP	Knowledge, Attitude, Behaviour and Practices (Survey)
LIS	Laboratory Information System
M&E	Monitoring and Evaluation
MCSR	Monthly Clinical Summary Report
MERG	Monitoring and Evaluation Reference Group
MEWG	Monitoring and Evaluation Working Group
MICS	Multiple Indicators Cluster Survey
MOH	Ministry of Health
MRCA	Monthly Records Case Abstract
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission (of HIV)
NAC	National AIDS Council
NBTS	National Blood Transfusion Service
NGO	Non-Governmental Organization
NHP	National HIV/STI Programme
NPHL	National Public Health Laboratory
NSP	National Strategic Plan
OI	Opportunistic Infections
ON	Ophthalmia Neonatorium
OVC	Orphaned and Vulnerable Children
PAA	Parish AIDS Authority
PAC	Parish AIDS Council
PAHO	Pan-American Health Organization
PAS	Patient Administration System
PCR	Polymerase Chain Reaction

PEP	Post-Exposure Prophylaxis
PEPFAR	The (United States) President's Emergency Plan for AIDS Relief
PIOJ	Planning Institute of Jamaica
PLACE	Priorities for Local AIDS Control Efforts
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
RHS	Reproductive Health Survey
STATIN	Statistical Institute of Jamaica
STD	Sexually Transmitted Disease(s)
STI	Sexually Transmitted Infection(s)
SW	Sex Worker
TB	Tuberculosis
TCI	Targeted Community Initiative
TOR	Terms of reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UNICEF	The United Nations Children's Fund (originally United Nations International Children's Emergency Fund)
USAID	The United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank

1. Introduction

Monitoring and Evaluation (M&E) is the backbone of public health systems for providing essential information and evidence regarding the best practices and lessons learned in health programmes. The Jamaica National HIV/STI Programme's M&E system collects high quality data, analyses that data to produce programme information and supporting evidence for decision-makers and stakeholders throughout the programme. The M&E system is described in two documents: the M&E Plan (Document A) and the M&E Operations Manual (Document B). Together, these documents guide the implementation of specific M&E activities in a standardized, uniform manner so that programme strategies can both gather information for day-to-day management, as well as provide information to parish, regional and national efforts. These documents also formalize procedures to ensure programme transparency and preserve institutional memory.

This document is the M&E Plan. It is a fundamental follow-on document to the National Strategic Plan (NSP). It is a companion document to the 2007-2012 National Strategic Plan (NSP); therefore, please refer to the NSP for detailed information on the programme's specific objectives and interventions. The M&E Plan builds on the NSP's description of the programme objectives and the interventions to further describe the M&E procedures implemented to determine whether or not those objectives are met. The objectives of the Jamaica National HIV/STI Programme M&E Plan are:

- To track the implementation of the National HIV/STI Programme activities and establish whether the programme objectives have been achieved;
- To increase the understanding of trends in HIV/AIDS prevalence and explain the changes over time to allow for appropriate response to the epidemic; and
- To strengthen the capacity of the National HIV/STI Programme, regions, parishes and NGOs and civil society organizations to collect and use HIV/AIDS data.

Furthermore, the National HIV/STI Programme M&E Plan includes key characteristics of a sound and comprehensive M&E system for a National AIDS Programme as outlined by UNAIDS. These characteristics are listed below:
- Ensure efficient use of data and resources by making sure that indicators and sampling methodologies are comparable over time;
- Avoid duplication through repeat of baseline surveys or evaluation studies by ensuring that generated data serve many constituents, including programme managers, researchers or donors;
- Nationally, make sure that donor-funded M&E efforts best contribute to national needs, rather than simply serving the reporting needs of agencies or legislatures overseas;
- Encourage communication between different groups involved in the national response to HIV. Shared planning, execution, analysis or dissemination of data collection can reduce overlap in programming and increase co-operation between different groups;
- Facilitate ultimate use of data and indicators for programme planning and evaluation.
- Streamline data collection to focus only on needed data.

The M&E Plan first describes the relationship between the programme's expected outputs, outcomes, objectives and goals. It then describes the data and information required to illustrate this relationship (i.e., the indicators). Next, the M&E Plan details the necessary data sources, data collection systems, and information flow maps. In this way, the M&E Plan explains how a

programme will measure its achievements and provide for accountability to the stakeholder and donor communities.

The M&E Operations Manual (Document B) complements the M&E Plan by clearly detailing how each piece of the M&E system functions. Whereas the M&E Plan describes the overall M&E system and components, the M&E Operations Manual provides specific national guidance on procedures, protocols, policies, roles, responsibilities, timelines and other implementation factors described in the M&E Plan. It also details the value of programme information for decision-making at the local, national and donor levels. The M&E Operations Manual is intended to be used by stakeholders at all levels that contribute to or participate in the national M&E system to ensure high quality data is reported and resulting information is received in a timely manner at all levels of programme implementation (i.e., facility, local, national and donor levels).

2.   The National HIV/STI Programme Overview

2.1 Overview

The goals and objectives for each strategy and interventions within the National HIV/STI Programme are detailed in the NSP. The overarching goal of the programme is to achieve universal access to prevention and treatment services by focusing on four priority areas:

1. Prevention;
2. Treatment, Care & Support;
3. Empowerment & Governance; and
4. Enabling Environment & Human Rights.

The program conceptual model is illustrated in Diagram 2.1.

Diagram 2.1: Conceptual model of the NSP
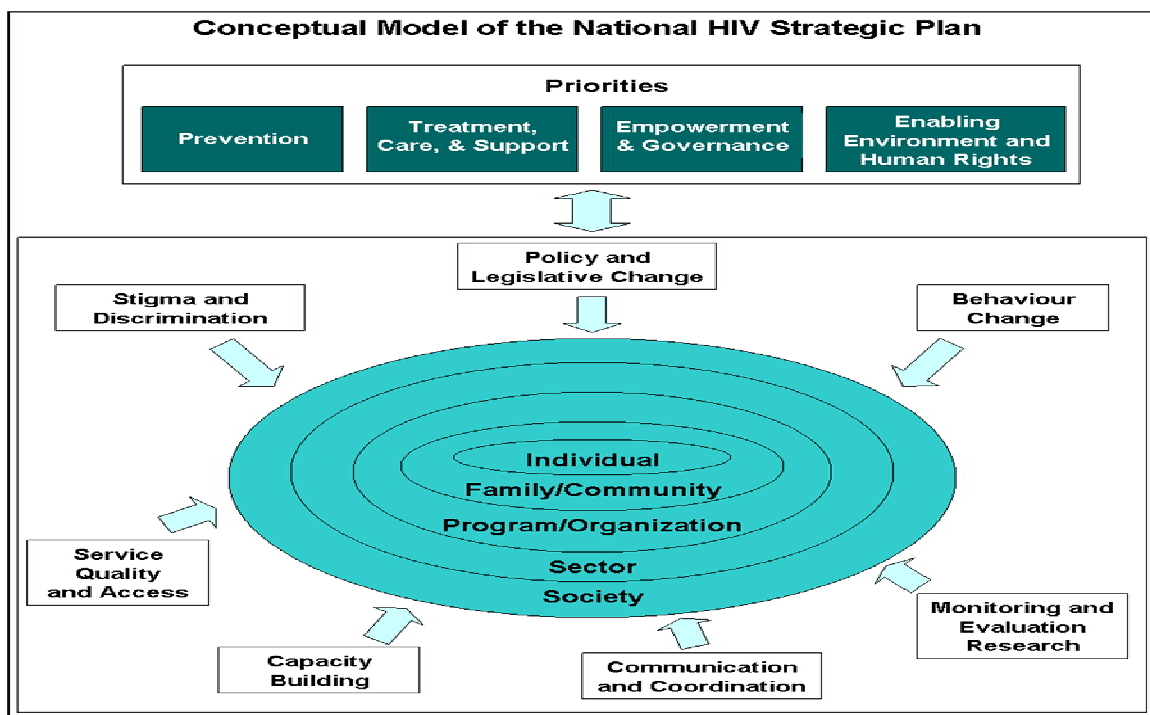
2.2 Summary Logical Framework

The table below provides a brief summary of the goal, purpose, objectives and indicators for each of the NHP priority areas. This logical framework provides the foundation for the programme M&E system. The indicators and systems to collect indicator data are based on this framework and described in this M&E Plan document. Not all objectives have indicators; however, this is a key area of focus for the 2008-2013 programme period. Please refer to the Appendix A or NSP to review the detailed framework.

Figure 1.1: Logical Framework for National HIV Strategic Plan 2007-12 with National Focus Indicators

	Prevention	Treatment Care & Support	Enabling Environment & Human Rights	Empowerment & Governance
GOAL	To reduce the transmission of new HIV infections Indicators • Percentage of men & women aged 15-24 who are HIV infected • Percentage of SW who are HIV infected • Percentage of MSM who are HIV infected	To mitigate the impact of HIV/AIDS on the people of Jamaica Indicators • % of adults or children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	To protect fundamental human rights and empower the Jamaican people to make healthy choices Indicators • Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS	To achieve a sustained, effective multi-sectoral infrastructure and commitment to support the National Response to HIV and AIDS Indicators • National Composite Policy Index • Domestic and international AIDS spending by categories and financing sources
PURPOSE	To achieve universal access to prevention services, focusing on most-at-risk populations Indicators • Number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.) • Number of people trained to provide prevention services by client and service area	To achieve universal access to high quality comprehensive treatment, care and support in an environment that is non-discriminatory and supports adherence Indicators • % of people by age, sex and at-risk group who received HIV testing in the last 12 months & know their results • % of women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy according to national guidelines	To decrease stigma and discrimination toward people with HIV/AIDS Indicators • Number and percent age of reported cases of HIV-related discrimination receiving redress by setting	Integration of HIV programs into existing human and social development programs Indicators • National Composite Policy Index
OBJECTIVES	**P1**. To increase quality of prevention services **P2**. To increase accurate information of ways to prevent HIV and dispel myths **P3**. To identify communities and populations most at-risk **P4**. To increase access to targeted, age-appropriate HIV prevention services for youth **P5**. To strengthen prevention efforts for SW and others engaging in transactional sex **P6**. To strengthen prevention efforts for MSM **P7**. To strengthen prevention efforts for tourism workers **P8**. To strengthen prevention efforts for inmates in correctional facilities	**T1**. To increase access to HIV testing among priority populations **T2**. To prevent Mother to Child Transmission of HIV **T3**. To improve access to and quality of ARV treatment **T4**. To increase adherence to treatment and care **T5**. To Improve care and support for Orphans and Vulnerable Children (OVC) **T6**. To improve access and use of Home Based Care **T7**. To improve infection control and access to (PEP) for accidentally exposed Health Care Workers **T8**. To strengthen prevention efforts for PLWHA **T9**. To improve the management of TB, especially in the HIV infected	**E1**. To systematically identify and report acts of discrimination **E2**. To improve public awareness of HIV and AIDS **E3**. To strengthen community advocacy against stigma and discrimination **E4**. To reduce stigma in all sectors **E5**. To reduce stigma and discrimination in the health sector **E6**. To empower youth to address stigma and discrimination **E7**. To empower PLWHA in the context of reducing stigma and discrimination and seeking treatment and care **E8**. To advocate for legislation that protects human rights **E9**. To advocate for non-discrimination among management and employees of the insurance sub-sector	**G1**. To build capacity and commitment of health sector to recognize their role and provide high-quality services for all people **G2**. To build capacity and commitment of other sectors **G3**. To develop one monitoring and evaluation framework **G4**. To improve procurement and financial management systems **G5**. To implement a sustainability plan **G6**. To assure multi-sectoral commitment to National Strategic Plan **G7**. To assure strong governance and accountability

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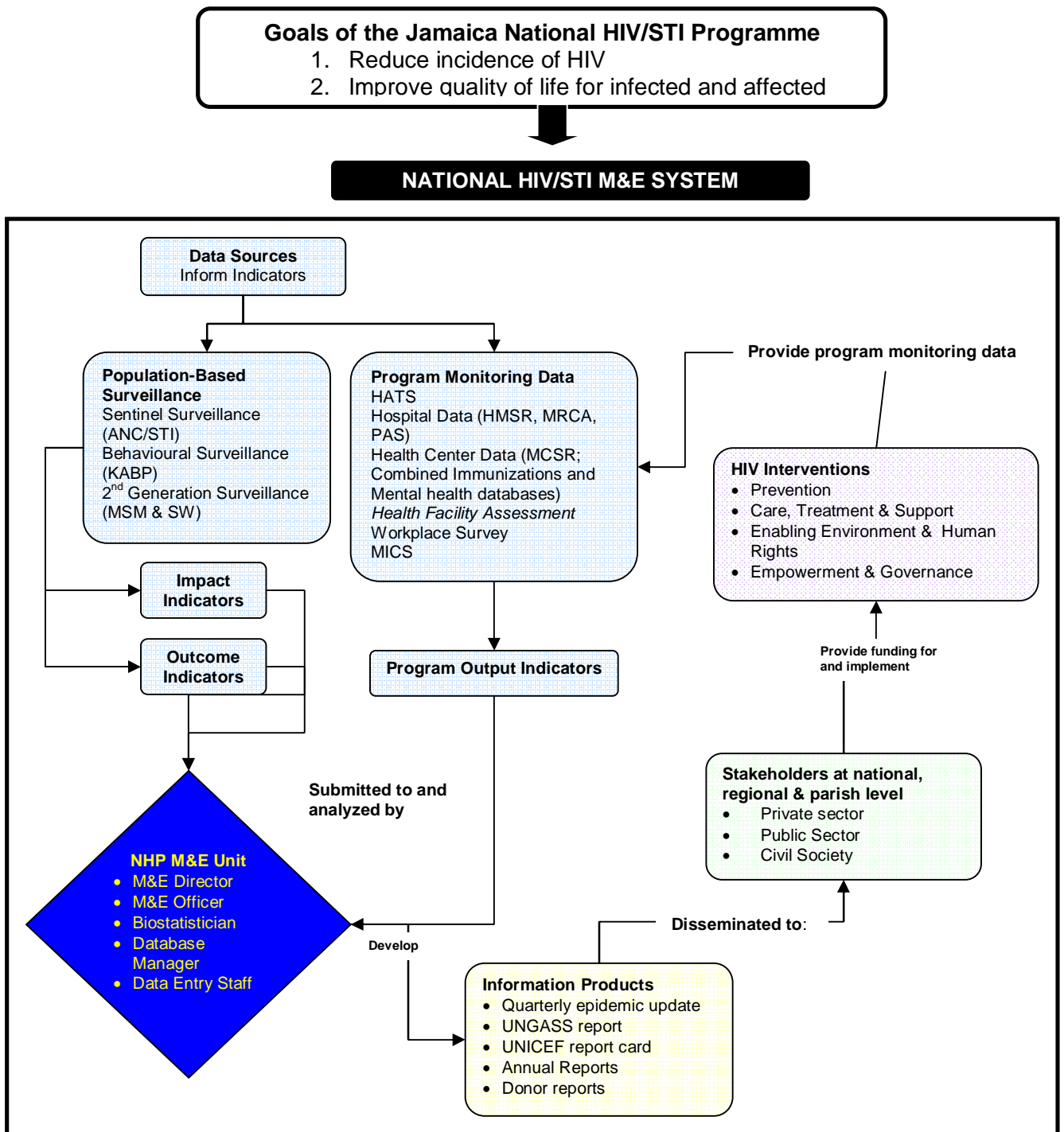**Figure 1.1: Logical Framework for National HIV Strategic Plan 2007-12 with National Focus Indicators**

	Prevention	Treatment Care & Support	Enabling Environment & Human Rights	Empowerment & Governance
OBJECTIVES (continued)	**P9**. To increase prevention interventions in the labour sector directed at reducing stigma & discrimination **P10**. To strengthen prevention efforts for persons within the uniformed services **P11**. To strengthen HFLE program in the education sector (early childhood to tertiary) **P12**. To strengthen the capacity of the sectors in the national response to conduct prevention interventions **P13**. To reduce transmission from PLWHA to their partners and secondary infections **P14**. To improve prevention interventions for drug abusers **P15**. To increase the use of mass media in prevention efforts **P16**. To identify cultural influentials/gatekeepers who can positively shift existing risky cultural norms **P17**. To strengthen prevention efforts for vulnerable adolescents Indicators • % of young people (15-24) or at risk groups who both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions • % of young adults, 15 to 19 years old, who have never had sex • % of young men & women aged 15-24 reporting condom use the last time they had sex with a non-regular partner • % of SW reporting condom use with their most recent client • % of men reporting using a condom the last time they had anal sex with a male partner • Number of people trained to provide prevention services to persons most at risk	**T10**. To strengthen the management of STI, including syphilis **T11**. To improve the diagnostic capacity of the laboratory services **T12**. To strengthen and institutionalize the training programme Indicators • % of most-at-risk populations (youth, MSM, SW) who received HIV testing in the last 12 months & know the results • % of women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy according to national guidelines • % of infants born to HIV-infected mothers who are HIV-infected • % of PLWHA on ART reporting at least 90% adherence by pill count • Current school attendance among orphans and non-orphans, aged 10-14 • Number of persons trained to provide treatment services by client and service area • Proportion of confirmed TB cases tested for HIV • Incidence of congenital syphilis	Indicators • Number and percentage of reported cases of HIV-related discrimination receiving redress by setting • Number of persons trained by client and service area • Number of policy makers attending sensitization workshops on HIV/AIDS/STI • Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	Indicators • Number of persons trained by client and service area • Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS) • Number of NGOs providing HIV/AIDS prevention or treatment, care and support services according to national guidelines/ standards • Percentage of schools that provided life skills-based HIV/AIDS education in the last academic year • Number of policy makers attending sensitization workshops on HIV/AIDS/STI

2.3 Overview of the National HIV/STI Programme M&E System

Jamaica is in agreement with global leaders in the fight against HIV/AIDS to provide one national monitoring and evaluation plan. To that end, the National HIV/STI Programme (NHP) has developed a conceptual model, or system diagram, of the M&E system to illustrate the various components of the system and how they are interrelated to provide information for programmes. This diagram is shown in Diagram 2.3.

The system diagram illustrates how information is generated from special surveys and program monitoring data. These data inform specific indicators which provide information to local programme units, parishes, regional managers, and the NHP. The information is presented through various publications and reports on a regular basis. The M&E system benefits every contributor by providing information on various levels to improve programmes and policies around HIV/AIDS.

Diagram 2.3 NHP M&E System Conceptual Model

Goals of the Jamaica National HIV/STI Programme
1. Reduce incidence of HIV
2. Improve quality of life for infected and affected

NATIONAL HIV/STI M&E SYSTEM

Data Sources
Inform Indicators

Population-Based Surveillance
Sentinel Surveillance (ANC/STI)
Behavioural Surveillance (KABP)
2nd Generation Surveillance (MSM & SW)

Program Monitoring Data
HATS
Hospital Data (HMSR, MRCA, PAS)
Health Center Data (MCSR; Combined Immunizations and Mental health databases)
Health Facility Assessment
Workplace Survey
MICS

Provide program monitoring data

HIV Interventions
- Prevention
- Care, Treatment & Support
- Enabling Environment & Human Rights
- Empowerment & Governance

Impact Indicators

Outcome Indicators

Program Output Indicators

Provide funding for and implement

Submitted to and analyzed by

NHP M&E Unit
- M&E Director
- M&E Officer
- Biostatistician
- Database Manager
- Data Entry Staff

Stakeholders at national, regional & parish level
- Private sector
- Public Sector
- Civil Society

Disseminated to:

Develop

Information Products
- Quarterly epidemic update
- UNGASS report
- UNICEF report card
- Annual Reports
- Donor reports

2.3a Stakeholders and Human Capacity

HIV/AIDS M&E System: Stakeholder Map
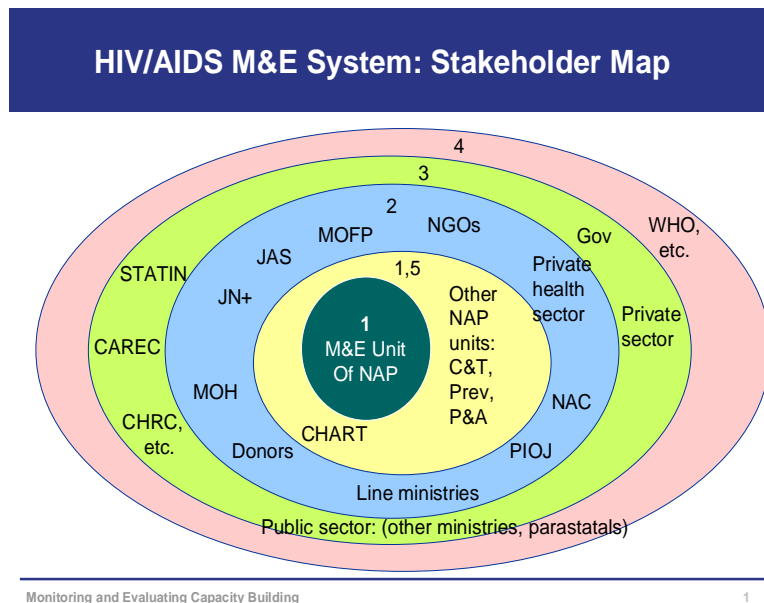
In addition to the above illustrated system components, human capacity is an overarching piece of the system that is essential and crucial for system success. The attached map depicts stakeholders based on the extent of their involvement in the system, as determined by the Capacity Assessment Workshop in August 2006. For example, the M&E Unit of the National HIV/STI Programme (NHP) is the primary stakeholder. Other units in NHP are strongly linked to the system. At levels two, three and four, the stake in or influence on the system becomes progressively less. This stakeholder map was adapted and endorsed in the national stakeholder meeting. More details on stakeholder involvement as discussed during the Capacity Building Assessment can be found in the M&E Operations Manual (Document B).

Beyond these listed organizations, everyone working in the National HIV/STI Programme has a role in M&E. Roles vary from completing forms upon service delivery, entering quality data, data analysis and interpretation, report writing, report review, and program review. Program managers, service providers, statisticians, assistants, and supervisors all play an important role in the system. These roles are specifically described in the M&E Operations Manual (Document B).

2.3b M&E Reference Group (MERG)

In 2006, the National HIV/STI Programme's M&E Unit organized a meeting of the M&E Reference Group, which consists of key stakeholders to guide and advise the M&E tasks for the program. The group meets semi-annually to review the M&E Plan and implementation, provide suggestions for assessments and modifications, and guide the overall system. The group consists of representatives from stakeholder organizations in the national response, such as Regional Health Authorities, NGOs, Line ministries, Donors, and other implementing Partners. The Terms of Reference for the group is provided in Appendix D.

2.3c Ongoing Capacity Building

The M&E Unit has explicitly included capacity building activities in its annual work plan as a way to maintain stakeholder engagement in M&E activities and further strengthen the coordination of the M&E system. Given this edition of the M&E Plan is the first of its kind, and accompanied by the Operations Manual (Document B), the M&E Unit has included in its work plan to conduct a series of workshops for the pair of documents to solicit stakeholder buy-in and increased understanding of the components of the M&E Plan, roles and responsibilities for data collection and reporting, and various uses for the information generated from the data.

2.3d Information Dissemination

The National HIV/STI Programme's M&E Unit provides two publications to stakeholders that provide information gathered from data collected during the year. The AIDS Epidemic Update (Epi Update) is published quarterly and provides trend data on key indicators for the epidemic in Jamaica. In addition, the M&E Unit will distribute newsletters every six months (in March and September) to report the context behind the information presented in the Epi Update (e.g., best practices that lead to positive trends, actions needed to manage negative trends). This newsletter is also an opportunity to provide stakeholders with updates on changes to any donor indicators, upcoming trainings, or other announcements related to M&E.

3. HIV/AIDS Indicators

Indicators are variables that measure one aspect of a programme or project related to the programme's objectives. Indicators provide M&E information crucial for decision-making at every level and stage of program implementation. The National HIV/STI Programme M&E system collects data on indicators at several levels: global, national, and local. Each level in the system has different data needs and will use the indicators differently.

Global indicators are required to sustain donor support and help provide a reflection of the current HIV/AIDS situation in the global context. In order for global indicators to be meaningful across countries, all must agree on what the indicator means, how to measure it, and must record it in the same way. Examples of global indicators for which Jamaica collects data are those reported to UNGASS, and donors such as the World Bank, the Global Fund and USAID (PEPFAR indicators).

National focus indicators help set the national health agenda and to monitor program effects. The National HIV/STI Programme, in collaboration with its stakeholders, has developed a list of national focus, or Core, indicators for this purpose. Many of these indicators overlap with global indicators.

Facility-level indicators provide more detailed, local-level information to help programme planners decide how best to address specific challenges (e.g., managing scarce resources to best meet the needs of its clients). They provide information on whether or not the target population is being reached, how well services are being provided, and whether or not sufficient resources exist to be able to provide adequate services. These are usually not required for programme management at the national level, but helpful for facility-level management.

The national focus indicators, which are included in the National Strategic Plan, are also presented as a separate table in Section 3.2. Section 3.3 provides a complete list of all of the indicators, both global and national, on which the programme must collect data and report. Please see Appendix B for a detailed matrix including data source, frequency, persons responsible, baselines, targets, and data tool development for each indicator.

3.1 Uses for the indicators

Indicators provide an evidence-based overview on programme strengths and weaknesses. They are used to monitor program effects and speak to how effectively a programme strategy and plan meet the national health agenda. **Information is only good when it is used.** The information garnered from the indicators can be used to make intervention-related decisions. Data that are not useful or that cannot be used should not be collected. Often, it is not that the data itself are useless, but that more training is needed on how to use it effectively. The M&E Operations Manual discusses in

detail the procedures and issues related to data collection and use. However, instances of information use at the global, national and local levels are provided below.

Global indicators are used by donors for decisions regarding:
• Realistic international 5-year targets
• Funding allocation
• International conferences and meetings

National indicators have been identified to inform decision and policy makers on:
• The level of donor commitment, and when high-level negotiations and changes are necessary
• How well the national system is functioning, and where additional support and training are needed

At the local level, indicators can provide information for managers and planners that will help to determine:
• Priority target groups
• How to most effectively allocate limited funding (programs, supplies, staff, etc.)
• Types of outreach activities that are needed
• Barriers to accessing prevention and treatment services

3.2 Summary of National Focus Indicators

The indicators listed below in Figure 3.2 are only those used to monitor and evaluate the National HIV/STI Program, as noted in the NSP Logical Framework (see Section 2.2). Some of these indicators overlap with the global indicators while others are specific to the Jamaican response to HIV. The indicators are listed with the corresponding NSP location (i.e., priority area and programmatic approach level) and donor association as a means to map the indicator to NSP and global donor frameworks.

Figure 3.2: National Focus Indicators

Priority Area 1: PREVENTION		
NSP	**Donor**	**Indicators**
GOAL	UNGASS/GFATM	Percentage of men and women aged 15 to 24 that are HIV infected
GOAL	UNGASS/USAID	Percentage of SW who are HIV infected
GOAL	UNGASS/USAID	Percentage of MSM who are HIV infected
PURPOSE	GFATM/USAID	Number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.)
PURPOSE, P7-P10, P12, P16	GoJ MOH	Number of persons trained to provide prevention services by client and service area
P2	UNGASS/GFATM/ CARICOM/CMIT	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
P4, P11, P15, P17	UNGASS/GFATM/ CMIT	Percentage of young adults, 15 to 19 years old, who have never had sex
P4, P15	UNGASS/GFATM/ CMIT	Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-regular partner
P5	UNGASS/GFATM/ CMIT/USAID	Percentage of SW reporting using a condom at last sex act with client
P6	UNGASS/GFATM	Percentage of men reporting using a condom the last time they had anal sex with a male partner
Priority Area 2: TREATMENT, CARE & SUPPORT		
GOAL	UNGASS/CARICOM	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART
PURPOSE, T1	UNGASS	Percentage of men and women aged 15-49 who received HIV testing in the last 12 months and who know their results
PURPOSE, T1	UNGASS	Percentage of most-at-risk populations (youth, MSM, SW) who received HIV testing in the last 12 months and who know their results
PURPOSE, T3	UNGASS/GFATM	Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines
T2	UNGASS/GFATM/ GOJ/USAID	Percentage of infants born to HIV-infected mothers who are HIV-infected
T4	GFATM	Percentage of PLWHA on ART reporting at least 90% adherence by pill count
T5	UNGASS	Current school attendance among orphans and non-orphans aged 10-14
T8, T12	GoJ MOH	Number of persons trained to provide treatment services by client and service area
T9	GoJ MOH	Proportion of confirmed TB cases tested for HIV
T10	GoJ MOH	Incidence of congenital syphilis

Priority Area 3: ENABLING ENVIRONMENT & HUMAN RIGHTS		
GOAL	GFATM/CMIT	Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS
PURPOSE	GoJ MOH	Number of persons trained to provide services by client and service area
PURPOSE, E5	GFATM	Number and percentage of reported cases of HIV-related discrimination receiving redress by setting
E8	GoJ MOH	Number of policy makers attending sensitization workshops on HIV/AIDS/STI
E9	PEPFAR	Number of local organizations provided with technical assistance for HIV-related policy development
Priority Area 4: EMPOWERMENT & GOVERNANCE		
GOAL, PURPOSE	UNGASS	National Composite Policy Index
GOAL, PURPOSE	UNGASS	AIDS spending, by categories and financing source
PURPOSE	GoJ MOH	Number of persons trained to provide services by client and service area
G2	PEPFAR	Number of local organizations provided with technical assistance for HIV-related policy development
G2	UNGASS	Percentage of schools that provided life skills-based HIV/AIDS education in the last academic year
G6	GoJ MOH	Number of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/standards
G7	GoJ MOH	Number of policy makers attending sensitization workshops on HIV/AIDS/STI

3.3 Summary of Complete List of Indicators (including national focus indicators **in bold**)

Below, in Figure 3.3, is a list of the National Focus Indicators and additional global indicators for which the NHP is responsible. This list of indicators provides a complete picture of the Jamaican response to HIV/AIDS, as measured by national and international indicators. Data collection for these indicators is described in following sections as well as in the M&E Operations Manual.

Figure 3.3: Complete List of Indicators (including national focus indicators in bold)

| Priority Area 1: PREVENTION	
IMPACT	
UNGASSGFATM/ CARICOM	**Percentage of men and women aged 15 to 24 that are HIV infected**
UNGASS/USAID	**Percentage of SW who are HIV infected**
UNGASS/USAID	**Percentage of MSM who are HIV infected**
CARICOM	Prevalence of HIV among STI clients
CARICOM	AIDS Case rate
OUTCOME	
UNGASS/GFATM/ CMIT	**Percentage of people by sex and age groups who reported condom use at last intercourse with non-regular partner**
UNGASS/GFATM/ CMIT/USAID	**Percentage of SW reporting using a condom with most recent client**
UNGASS/GFATM	**Percentage of men reporting using a condom the last time they had anal sex with a male partner**
UNGASS/GFATM/ CARICOM/CMIT	**Percentage of young women and men aged 15-24 or at risk groups who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**
GFATM	**Percentage of young adults, 15 to 19 years old, who have never had sex**
GFATM	Percentage of 15-19 year olds who reported no sexual actively in the last 12 months
UNGASS/CMIT	Percentage of donated blood units screened for HIV in a quality assured manner
UNGASS	Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15
UNGASS/GFATM/ CMIT	Percentage of young women and men aged 15-49 who have had sex with more than one partner in the last 12 months
UNGASS	Percentage of 15-49 year olds who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse
CIMT	Percentage of people 15-49 years old who can access a condom almost immediately (less than 5 minutes)
OUTPUT & PROCESS	
GFTAM/USAID	**Number of individuals reached through TCI including vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.)**
GoJ MOH	**Number of persons trained to provide prevention services by client and service area**
GFATM	Number of inmates, sex workers and MSM reached through prevention activities
GFATM	Number of service deliverers trained on HIV/AIDS prevention
GFATM	Percent of schools that provided life skills-based HIV education in the last academic year
GFATM	Number of students reached through life skills-based Health and Family Life Education interventions in schools
GFATM	Number of adolescents (10-14) and youth (15-24) reached through prevention interventions in out-of-school settings
PEPFAR	Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful
PEPFAR	Number of individuals trained to promote HIV/AIDS prevention *beyond* abstinence and/or being faithful
PEPFAR	Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment
PEPFAR	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful.
PEPFAR	Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behaviour change *beyond* abstinence and/or being faithful

Priority Area 2: TREATMENT, CARE & SUPPORT	
IMPACT	
UNGASS/CARICOM	**Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART**
UNGASS/GFATM/ GOJ/USAID	**Percentage of infants born to HIV-infected mothers who are HIV infected**
OUTCOME	
UNGASS	**Current school attendance among orphans and non-orphans aged 10-14**
UNGASS	**Percentage of men and women aged 15-49 who received an HIV test in the last 12 months and who know their results**
UNGASS	**Percentage of most-at-risk populations (youth, MSM, & SW) who received HIV testing in the last 12 months and know their results**
UNGASS/GFATM	**Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines**
GFATM	**Percentage of PLWHA on ART reporting at least 90% adherence by pill count**
GoJ MOH	**Proportion of confirmed TB cases tested for HIV**
GoJ MOH	**Incidence of congenital syphilis**
UNGASS/UNAIDS	Percentage of estimated HIV-positive incident TB patients that received treatment for TB and HIV
WB/GoJ	Percentage of ANC clients that are counselled and tested for HIV
UNGASS/GFATM/ CMIT	Percentage of HIV positive pregnant women who received a complete course of ARV prophylaxis to reduce the risk of MTCT
UNGASS/CMIT	Percentage of orphaned and vulnerable children (boys and girls, aged 0-17) whose households received free basic external support in caring for the child
GFATM/CMIT	Number of individuals counselled and tested for HIV according to guidelines in last 12 months & who know their results
GFATM	Number of infants born to HIV+ mothers receiving PCR testing according to national standards
GFATM	Number of individuals (children & adults) receiving CD4 tests in the public sector according to national guidelines
GFATM/CMIT	Number of individuals (children & adults) on ART receiving viral load testing in accordance with guidelines
OUTPUT & PROCESS	
GoJ MOH	**Number of persons trained to provide treatment services by client and service area**
GFATM	Number of public sector sites offering ART
GFATM	Number of PLWHA receiving adherence counselling
GFATM	Number of adherence support groups started by NGO/PAC partnerships using trained PLWHAs

Priority Area 3: ENABLING ENVIRONMENT & HUMAN RIGHTS	
OUTCOME	
GFATM	**Number of cases of HIV related discrimination reported by setting**
GFATM/CMIT	**Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS**
GFATM	**Number and percentage of reported cases of HIV-related discrimination receiving redress by setting**
GFATM	Number of cases of HIV related discrimination reported by setting
GFATM	Number of large (>100 employees) private organizations not requiring pre-employment HIV tests
OUTPUT & PROCESS	
GoJ MOH	**Number of policy makers attending sensitisation workshops on HIV/AIDS/STI**
PEPFAR	**Number of organizations provided with technical assistance for HIV-related policy development**
GoJ MOH	**Number of persons trained to provide services by client and service area**
PEPFAR	Number of local organizations provided with technical assistance for HIV-related institutional capacity building

PEPFAR	Number individuals trained in HIV-related policy development
PEPFAR	Number individuals trained in HIV-related institutional capacity building

Priority Area 4: EMPOWERMENT & GOVERNANCE	
OUTCOME	
UNGASS/UNAIDS	**National Composite Policy Index**
UNGASS/UNAIDS	**Domestic and international AIDS spending by categories and financing sources**
OUTPUT & PROCESS	
GoJ MOH	**Number of persons trained to provide services by client and service area**
PEPFAR	**Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)**
UNGASS/UNAIDS	**Percentage of schools that provided life skills-based HIV/AIDS education in the last academic year**
GoJ MOH	**Number of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/standards**
GoJ MOH	**Number of policy makers attending sensitisation workshops on HIV/AIDS/STI**
PEPFAR	Number of local organizations provided with technical assistance for strategic information activities (M&E and/or surveillance and/or HMIS)
CIMT	Number of individuals trained in HIV-related community mobilization and for prevention, care and/or treatment (male & female)
CIMT	Number of indigenous organizations provided with technical assistance for HIV-related institutional capacity building
WB	Number of implementing partners reporting on NSP indicators
WB	Number of implementing partners that have incorporated M&E components in their work plans
WB	Completion of computerization for: -NPHL -Nation Blood Transfusion services -surveillance system --drug inventory nationally and at regional treatment centers

4. Data Collection Plan

Because high quality data is essential to inform the national and donor indicators, as well as additional markers of the Jamaican response to HIV/AIDS, databases and other collection mechanisms are key components of the M&E system. The National HIV/STI Programme has multiple data sources and collection systems in place and under development that contribute to the M&E system. The M&E Plan and M&E Operations Manual document the harmonization of these data sources and collection systems to reduce duplicate reporting and improve data quality. The relationships between key data collection mechanisms of the M&E information system have been visualized in Diagram 4.

Diagram 4: NHP M&E Database Management System
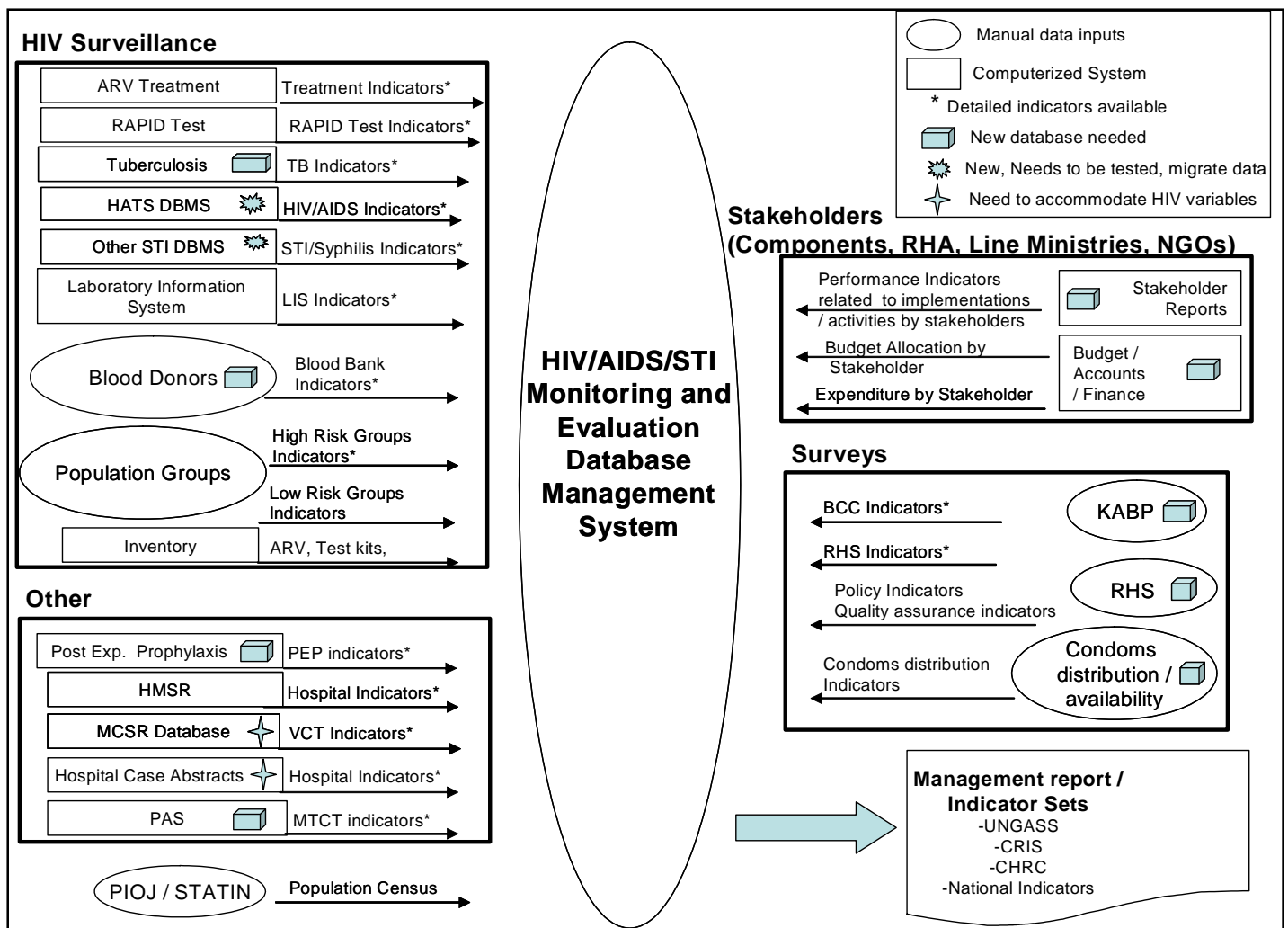
4.1 Routine Data Sources

Routine data sources provide data that are collected on a continuous basis, such as information that clinics collect on the patients utilizing their services. Although these data are collected

continuously, they are generally aggregated and reported periodically; for instance, data may be aggregated monthly and reported quarterly. Data collection from routine sources is useful because it can provide information on a timely basis. However, it can be difficult to obtain accurate estimates of catchment areas or target populations through this method, and the quality of the data may be poor because of inaccurate record keeping or incomplete reporting.

There are currently 8 key routine and 2 non-routine data sources within the National HIV/STI Programme. Additional data sources and means of harmonizing existing databases are planned for this 2007-2012 programme period. These data sources and indicators which they inform are discussed in the following sections.

4.1a Sentinel Surveillance of ANC and STI Clinic Attendees

The overall purpose of the HIV sentinel surveillance system is to monitor the trends in prevalence in some high risk groups in the country. Its main components are HIV sero-prevalence surveys among antenatal care and STI sentinel groups.

At the health centre level, a rapid test is applied or in some cases, the blood specimen is sent to a testing site within the parish. Positive rapid tests are then sent for testing by the ELISA method at a regional laboratory, or the National Public Health Laboratory if there is no referral laboratory in the region.

What does the National M&E System need from this data source?
- **Percentage of men & women aged 15 to 24 that are HIV infected**
- HIV prevalence among 15-49 year olds
- Prevalence of HIV among STI clients

Frequency of Data Collection and Reporting:
Sentinel surveillance involves testing 15-49 year old persons who attend ANC or STI clinics, typically between April and September of that year. This information is collected every 2 years.

4.1b HIV/AIDS Tracking System (HATS)

HATS is an ongoing HIV surveillance system based on confidential case reporting, which includes demographic information, mode of transmission, risk factors, and stage of infection. The M&E Unit receives case reports from health services, public and private, on newly diagnosed HIV/AIDS cases. In addition, the surveillance officer based at the National HIV/STI Programme *actively* visits hospitals, private practitioners, hospices, death registries, among others, to identify and complete HIV/AIDS case reports*.* These case reports are entered into the HATS database, which is routinely searched for double entries and revised periodically based on updates from the surveillance officer or contact investigators. The database is used to obtain national statistics.

What does the National M&E System need from this data source?
- AIDS Case rate
- Number of AIDS deaths
- Number of AIDS Cases
- **Number of HIV cases, disaggregated by age and at risk population**
- Number of advanced HIV cases

Frequency of Data Collection and Reporting:

Data are collected and entered in an on-going basis. Standard reports are generated by the NHP M&E Unit quarterly.

4.1c Health Information System

The Jamaican Health Information System in its present form consists of 6 stand-alone databases. The databases are directly managed by the Planning and Evaluation Department of the Ministry of Health and consist of data collected from the following two service delivery levels:

Hospitals:
- *Hospital Monthly Statistical Report (HMSR)* database – reports on workload information within the hospital system
- *Medical Records Case Abstract (MRCA)* database – stores patient demographics and information on diagnostic procedures, and discharge diagnoses
- *Patient Administration System (PAS)* – stores patient demographics and information on admission, diagnostic procedures, and discharge

Health Centres:
- *Monthly Clinical Summary Report (MCSR)* database – stores aggregate information on services including antenatal, postnatal, child health, Family Planning, etc.
- *Combined Immunization* database stores information on the number of vaccination doses given by parish.
- *Community Mental Health* database - stores information on Mental Health diagnostic categories submitted by parish Mental Health Officers.

Currently, there are 24 hospitals and 344 health centres across the 4 administrative regions of the island. Data from these two service delivery levels is aggregated on paper-based forms and sent directly to the Office of Planning and Evaluation. All of the above databases, with the exception of the MRCA, report monthly summaries on paper-based forms. The MRCA, however, tracks actual patient information based on the Taxation Registration Number (TRN), which, has its own limitations as a unique patient identifier.

Three of the above databases are on an older *FoxPro* based platform and have undergone minimal upgrading over the past five years. The only two databases implemented in more standard *MS Access* include the Immunization database and the MRCA database. There is a proposal to upgrade all systems under a unified MIS and with online connectivity. Successful implementation of the project is contingent upon timely availability of funding and buy-in from upper management.

At this time, the MCSR form has been revised to accommodate a few HIV related indicators. However, the form has not yet been implemented through the health system due to the obvious challenges involved in introducing a new form and the need to first have an upgraded MCSR database in place before starting to collect data using the new form. It is more than likely that as a fallback option the M&E unit will have to collect HIV data through other channels so that the NHP program is able to report on output indicators.

- Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT
- Percentage of ANC clients that are counselled and tested for HIV
- Number of individuals tested for HIV according to guidelines

Frequency of Data Collection and Reporting:
Data are collected by the facilities on an on-going basis. Quarterly, the data are collated and sent to the regional HIV coordinators who complete the Regional HIV/AIDS Summary Report, which is sent to the M&E Unit at the MOH.

4.1d Monitoring and Evaluation Database

This database captures all information from stakeholders of the National HIV/STI Programme. This information is primarily captured on standardized forms, which are described in the M&E Operations Manual. Some sources of data for this database are:

- Regional Quarterly Report and progress report
- CI Monthly Summary Statistics Form
- Laboratory Rapid Test database summary reports
- Line Ministries reports
- Stakeholder and sub-recipient reports, including PAA
- Internal program reports
- Special Investigation Form for Congenital Syphilis, ON and Paediatric HIV
- Monthly STI Summary Report

What does the National M&E System need from this data source?

- **Number of persons trained to provide services by client and service area**
- **Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)**
- Number of individuals tested for HIV according to guidelines in last 12 months & who know their results
- **Number of adults and children with HIV known to be on treatment 12 months after initiation of ART**
- Percentage of HIV positive pregnant women who received a complete course of ARV prophylaxis to reduce the risk of MTCT

4.1e HIV Rapid test Database:

The HIV Rapid Test Database contains information related to all HIV tests that are done using a 'rapid' test method. That is, test that are conducted and produce results within 30 minutes are considered 'rapid' tests. Most often in Jamaica, these tests are preformed by collecting a drop of blood from the client and providing the results to the client during the same visit. HIV rapid test results and is maintained at the regional laboratories. It is a resource for monitoring the implementation of the HIV rapid testing program and can generate aggregate reports on HIV tests done by client group (e.g. ANC attendees, STI clinic attendees, etc.).

<u>What does the National M&E System need from this data source?</u>
- **Percentage of men & women aged 15 to 24 that are HIV infected**
- Prevalence of HIV among STI clients

4.1f HIV Electronic Register with the HIV/AIDS Treatment Database and PMTCT Database:

The HIV Electronic Register contains a HIV/AIDS Treatment Database and PMTCT Database that collect treatment-related information on all HIV positive persons at the clinic level.   This database captures demographics and clinical data (e.g. CD4 counts, initiation of ART and OI prophylaxis). It also provides aggregate reports for the NHP M&E Unit.

<u>What does the National M&E System need from this data source?</u>
- **Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines**
- **Number of adults and children with HIV known to be on treatment 12 months after initiation of ART**
- Percentage of HIV positive pregnant women who received a complete course of ARV prophylaxis to reduce the risk of MTCT

4.1g Country Response Information System: CRIS

CRIS is a software application developed in 2002 in the UNAIDS Monitoring and Evaluation Department in close collaboration with the Monitoring, Operations Research, and Evaluation Unit and the Resource Tracking and Projections Unit. The application was developed in response to a need for an information system to assist with UNGASS reporting. Very quickly it became apparent that a system was needed to facilitate overall monitoring and Monitoring and Evaluation and reporting at country level. In response to these needs, CRIS was enhanced to support data on programmes and projects, routine monitoring at sub-national and facility levels, local system integration, customization, and data exchange.

<u>What does the National M&E System need from this data source?</u>

- The NHP M&E Unit uses this repository for UNGASS and national indicators.

4.1h NBTS & Public Health Lab Databases

The National Blood Transfusion Service and Public Health Labs collect information on blood safety and various investigations, including HIV testing. A laboratory information system is being implemented to facilitate storage of data and better monitoring. On a quarterly basis, the NBTS and NPHL provide the M&E Unit with the number of HIV tests conducted by risk category including: ANC, STI clients, outreach efforts, and hospitalizations. This information can be disaggregated by region, sex, and age.

<u>What does the National M&E System need from this data source?</u>
- HIV prevalence among 15-49 year olds
- Percentage of donated blood units screened for HIV in a quality assured manner
- Number of individuals receiving CD4 tests in the public sector according to national guidelines

4.1i Other Routine Data Sources

There are several other routine data sources that are at various stages of development. Many of these data sources are managed outside of the Ministry of Health and may even be outside of the health sector, but provide valuable information for the overall HIV/AIDS M&E system. During the 2007-2012 programme period, the NHP M&E Unit will assist the development and launch of these databases as appropriate. Examples of these initiatives include:

HIV-related Discrimination Reporting and Redress System database:

The HIV-related Discrimination Reporting and Redress System is being developed and will capture all reported cases of HIV-related Discrimination. It will include follow-up information on the redress process.

What does the National M&E System need from this data source?
- **Number of cases of HIV related discrimination reported by setting**
- **Number and percentage of reported cases of HIV-related discrimination receiving redress by setting**

National Health Fund (NHF) Database

One of the functions of the national health fund is to provide assistance to persons to purchase designated prescription drugs. Access to such services is tracked in a NHF database. It is the intention of the NHP that persons with advanced HIV are registered under the NHF and receive the NHF card. This will provide the means for tracking access to ARVs and adherence.

What does the National M&E System need from this data source?
- Percentage of PLWHA on ARV reporting at least 90% adherence by pill count
- **Percentage of adults and children with advance HIV infection who are receiving antiretroviral combination therapy according to national guidelines**
- **Number of adults and children with HIV known to be on treatment 12 months after initiation of ART**

VCT Records
The NHP has developed tools for tracking information on volunteer counselling and testing. This data will be reported to the NHP quarterly and stored in the M&E database. It will inform the following indicators:
- Percentage of ANC attendees counselled and tested for HIV.

4.2 Non-routine Data Sources

Non-routine data sources provide data that are collected on a periodic basis, usually annually or less frequently.

Using non-routine data avoids the problem of incorrectly estimating the target population when calculating coverage indicators. Another advantage is that both those using and those not using health facilities are included in the data.

Non-routine data have two main limitations: collecting them is often expensive, and this collection is done on an irregular basis. In order to make informed program decisions, program

managers usually need to receive data at more frequent intervals than non-routine data can accommodate.

4.2a National Knowledge, Attitudes, Behaviour and Practices (KABP) Surveys

The National HIV/STI Programme conducts National Knowledge, Attitudes, Behaviour and Practices (KABP) population-based surveys to obtain information on the knowledge and practices related to the prevention and transmission of HIV and other STIs.

These surveys have provided national level measures of outcome indicators and have focused on partner reduction, consistent use of condoms in regular and non-regular partnerships, delay of sexual activity among young persons, myths and appropriate practices regarding STI/HIV/AIDS, knowledge and awareness of STI, and condom accessibility.

The surveys have been implemented under a sub-contract agreement with a local contractor.

The sampling methodology is by clusters, using Enumeration Districts (EDs). The EDs are selected with probability proportionate to their size (measured in terms of the number of dwelling per ED). An equal number of dwellings are selected from each ED using a systematic sampling with a random start. For purpose of selection of the EDs, all EDs of the population census (after grouping them where necessary such that no ED contains less than 80 dwellings) are grouped into 234 strata (also called sampling regions) of equal size (again measured in terms of the number of dwellings. Every stratum contains approximately 25,000 dwellings and the EDs are selected from each sampling region with probability proportionate to its size.

The "paired selection" design has been adopted for the sample. It is a stratified multi-staged sample with quota control for gender. The target groups are male and female 15-24 years, and 25-49 years. Data is collected in confidential face to face interviews by trained interviewers. The rural/urban composition of this sample is generally representative of the country.

What does the National M&E System need from this data source?
- **Percentage of people by sex and age groups who reported using a condom at last sex with a non-regular partner**
- **Percentage of young adults, 15 to 19 years old, who have never had sex**
- **Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**
- Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15
- Percentage of people 15-49 years old who can access a condom almost immediately (less than 5 minutes)

Frequency of Data Collection and Reporting

The National HIV/STI Programme conducts a National Knowledge, Attitudes, Behaviour and Practices (KABP) population-based survey every 3-4 years. The last KABP was conducted in 2004 and subsequent surveys are scheduled to be implemented in 2008 and 2011.

4.2b Surveillance of Youth, MSM and SW

These surveys provide national level measures of outcome indicators and prevalence rates in high risk groups such as MSM and SW. They focus on use of condoms with regular and non-regular partners, myths and appropriate practices with regards to STI/HIV/AIDS, exposure to interventions, and other high risk behaviours such as substance abuse.

The MSM and SW surveys are modifications of the PLACE methodology and collects data using structured questionnaires. Biological samples are also collected for HIV testing.

The youth data is collected through the Healthy Lifestyles surveys that focus on school-based and population-based samples of 10-15 year olds and 15-19 year olds.

What does the National M&E System need from this data source?

MSM:
- **Percentage of MSM who received HIV testing in the last 12 months and who know the results**
- **Percentage of MSM who are HIV infected**
- **Percentage of MSM reporting using a condom the last time they had anal sex with a male partner**

SW:
- **Percentage of SW who received HIV testing in the last 12 months and who know the results**
- **Percentage of SW who are HIV infected**
- **Percentage of SW reporting using a condom with their most recent client**

Youth:
- **Percentage of people by sex and age groups who reported using a condom at last sex with a non-regular partner**
- **Percentage of young adults, 15 to 19 years old, who have never had sex**

Frequency of Data Collection and Reporting

Healthy Lifestyles data were collected in 2005 for the 10-15 year old survey and in 2006 for the 15-19 year old survey. The most recent SW study was done in 2005 and there is another one scheduled for 2008. There is also an MSM study in the field and final reports should be available by the end of 2008. These studies will be conducted every two to three years, depending on availability of funding.

4.3 New Data Sources

In addition to the specific instruments and methodologies listed above, the M&E Unit has gained access to additional data sources or will implement other data collection activities over the next few years to obtain data that are not covered by any of the above tools.
The following are some of the newly conducted or proposed studies/data activities:

NEW DATA SOURCE	FREQUENCY	IMPLEMENTATION	INSTITUTIONAL RESPONSIBILITY
Health facility survey	Every 5 years	No	M&E Unit
Workplace survey	Biennial	2005	Ministry of Labour
MICS (Multiple Indicator Cluster Survey)	Every 5 years	2005	UNICEF
Develop a National HIV/STI Programme M&E 10 Years Report of HIV/STI in Jamaica	Once	No	M&E Unit

4.3a Health Facility Assessment

The Objective of Health Facility Assessment (HFA) is to determine if the health centres and hospitals are capable of providing quality HIV/AIDS and STI services; and if not, what materials, equipment and training they need to full fill this goal.

The specific objectives of the HFA are:
- To establish whether the health facilities have the necessary infrastructure and equipment to deliver quality services; i.e., counselling materials and protocols, testing kits, IEC and job-aids, among others;
- To establish the clinical and management skills of health care personnel;
- To coordinate efforts with other health services and private practitioners by parish and region.

Frequency of Data Collection and Reporting
The Health Facility Assessment has not yet been implemented, but it is intended to be done at least once in the 2007-2012 programme period.

The frequency of HFA will be every two years, but will be contingent on the needs of the Jamaica National HIV/STI Programme. Ideally, it will be carried out together with population-based surveys, so that data can be triangulated to obtain information of both community interventions and service delivery.

The HFA will be conducted at health centres and hospitals, which will be randomly selected from the 4 regions. When possible, MOH qualified staff from local and regional level will be responsible for data collection and supervision. They will be trained as surveyors and supervisors.

The tools (observation check lists, exit interviews, health care worker interview and equipment and supplies checklist) will be designed and pre-tested according to the Jamaica HIV/STI Program needs. The data will flow from health facilities to parishes and from there to the regions, which will send the information to the HIV/STI Program M&E Unit. The information collected will be used at Parish, Regional and National levels to plan strategies and activities for improving the program.

4.3b Workplace Survey

A survey of workplaces will determine implementation of HIV policies and programs. This indicator will assess strengthening of the multi-sectoral response and the impact of activities undertaken to encourage an enabling environment. Data will be used to compare with findings of a 2005 survey of workplaces to determine progress made in this area.

4.3c Multiple Indicators Cluster survey (MICS)

UNICEF developed the Multiple Indicator Cluster Survey (MICS) methodology in the mid-1990s, in response to the need for filling data gaps for indicators used to track progress toward the World Summit for Children goals. The MICS surveys were designed to generate data in a timely and affordable manner. MICS surveys are a major source of data for MDG monitoring, as well as the assessment of progress toward other international goals such as those included in A World Fit for Children, and the UNGASS on HIV/AIDS, etc. The MICS is technically and financially supported by the UN in Jamaica (i.e. UNICEF, UNAIDS, UNESCO and UNDP), and technically supported by a Steering Committee comprising of the Cabinet Office, Early Childhood Commission, Planning Institute of Jamaica, Sir Arthur Lewis Institute for Social and Economic Science, Caribbean Child Development Centre of the University of the West Indies, UNAIDS, UNFPA, PAHO, Child Development Agency and the Ministry of Health. The MICS was last conducted in 2005 and published in 2007. The survey is planned to be conducted once during the 2007-2012 programmatic period.

4.3d National HIV/AIDS 10 Years Report of HIV/AIDS/STI in Jamaica

The current M&E system has several databases and data sources. Meaningful usage of the data requires an analytical and thoughtful review of the trends in various aspects of the national response to HIV. This will be the objective of a 10 year report of HIV/AIDS/STI in Jamaica thereby providing useful information for future strategic planning.

4.4 Special studies and operational research for 2007-2012

4.4a Studies of Vulnerable Populations
In addition to the MSM, SW and youth surveys, the NHP M&E Unit has planned to conduct surveillance studies to assess the status and needs of other vulnerable populations including inmates and crack/cocaine users. These surveys will methodologically estimate HIV prevalence in these populations and the behaviours that put them at risk. It will also provide a means for evaluating outreach activities conducted by the prevention team. In addition focus groups will be conducted with the aim to determine the barriers to changing high risk behaviours in vulnerable groups such as MSM.

4.4b School survey to evaluation HFLE

The NHP M&E Unit has planned to conduct an evaluation of the implemented revised lifeskills-based HFLE curriculum. This revised curriculum is a priority of the Ministry of Education and is intended to influence high-risk behaviour among adolescents. This evaluation will assess the effectiveness of the program as well as identify gaps for future planning initiatives.

4.4c Impact of adherence programmes

Adherence to ART is critical to patient health as well as protection from re-infection. An assessment of the effectiveness of current adherence programmes will provide information on the modifications required to achieve maximum impact. The study could also inform adherence indicators. Such

research will include patient surveys, observation, and analysis of programmatic data. An assessment of adherence of programmes will be conducted at least once during the strategic planning period.

4.4d Study to determine HIV drug resistance in Jamaica

Discussions with CDC, PAHO and other regional groups are in progress to determine the most cost -effective way to monitor HIV drug resistance in the Caribbean. The NHP will play an important role in such studies and specific research protocols will be developed to determine occurrence of drug resistance in our population.

4.5 Data Flow

Typically, national M&E systems focus primarily on data collection and reporting to national leaders and international donors. That is, local data support national and donor level analyses and reports, but are not used locally. This one-directional flow misses opportunities to provide valuable feedback to regional and local programmes. These missed opportunities may prevent local programmes from making simple mid-course corrections that could positively impact the health of their communities. Additionally, if information is not uniformly available so that it can be accessed and used by local programmes, there is little incentive to report quality data in a timely manner.

The MOH and other stakeholders in the National HIV/STI Programme recognize the importance of timely and accurate local level data and the use of that data by the data collectors as part of a fully functioning M&E system. Below, Diagram 4.4 illustrates the flow of data within the National M&E System between data collector and information user. This diagram was developed for the 2001-2006 National Strategic Plan. In the past year (2006-2007), the strengthening of the M&E Reference Group (MERG), the development of the M&E Working group, and additional technological advances (e.g., improved MOH website management) have improved the ability for national and regional level data users to provide information back to the local level; more work will be done in the future. The NHP has included revised procedures, information products, and information flow maps for each programme area in the M&E Operations Manual to further assist local facilities and programme managers in accessing the system's information.

Diagram 4.4

National M&E System Data Flow, Jamaica

Prime Minister

National HIV/STI Programme

CAREC

Donors

STATIN

Line Ministries Private Sector Civil Society Focal Points

NPHL

Regional Health Authority

NAC

Medical Officer of Health

Regional Labs

Health Centers, Hospitals

PAC

Key:

CAREC: Caribbean Epidemiology Center

NAC: National AIDS Council

NHAPCP: National HIV/STI Programme

NPHL: National Public Health Lab

PAC: Parish AIDS Council

STATIN: Statistical Institute of Jamaica

Symbols

Data Flow:

Processed Data:

Consolidated Data Reporting:

<u>4.6 Data Quality Issues</u>

Obviously, data are most useful when they are of the highest quality; however, data quality often requires a trade off with what is feasible to obtain. Data quality should be monitored and maintained throughout the data collection process. Potential biases should be considered, identified and adjusted for before data collection begins, and then monitored throughout the collection process. The highest quality of data is usually obtained through the triangulation of data from several sources (i.e., the use of different sources of data or information to increase reliability and validity).

It is also important to remember that behavioural and motivational factors of people collecting, collating, analyzing and reporting on the data can also affect the quality. Examples of common biases in data collection include:

Sampling bias: occurs when the sample taken to represent population values is not a representative sample

Non-sampling error: all other kinds of mis-measurement, including courtesy bias, incomplete records, and non-response rates

Subjective measurement: occurs when the data are influenced by the measurer

For each data set, the following data quality issues should be considered:

Coverage: Will the data cover all of the elements of interest? If not, what other data sets can be used to triangulate?

Completeness: Is there a complete set of data for each element of interest? If not, what is missing? Could missing data be obtained easily? What changes could be made to the system to solve this problem?

Accuracy: Have the instruments been tested to ensure validity and reliability of the data?

Duplication: Are the same people being counted more than once? What mechanism is in place to control for this?

Frequency: Are the data collected as frequently as needed, at each level? While the national program may only need the data annually, how often do regional or parish programs need the data?

Reporting Schedule: Do the available data reflect the time periods of interest? How do we reconcile different requests (i.e. GoJ Fiscal Year, Donor Year, Calendar Year, etc?)

Accessibility: Are the data needed collectible/retrievable? What are the barriers?

Power: Is the sample size big enough to provide a stable estimate or detect change?

5. Monitoring & Evaluation Plan

5.1 M&E Tasks
The table below lists the key tasks associated with the M&E System along with estimated year of completion dates. These dates are subject to change based on funding and MERG recommendations.

Tasks	2007	2008	2009	2010	2011	2012
Redefine targets for NSP						
Create targets for NSP indicators	**X**					
Distribute targets to MERG	**X**	**X**				
M&E Plan Development & Tools						
Distribute M&E Plan & Operations Manual to M&E Working Group for review	X	X				
Introduce Operations Manual and provide training on data collection, data quality and data use at the regional level		X	X			
Develop data quality monitoring plan		X				
Incorporate decision calendar and other DDIU tools into practice, as necessary		X				
Data Collection & Analysis						
Routine Data						
Finalize data collection forms with review committee	X	X				
Sentinel Surveillance – ANC	X		X		X	
Sentinel Surveillance – STI	X		X			
HATS	X	X	X	X	X	X
PEPFAR Reporting	X	X	X	X	X	X
Non-Routine Data						
KABP	X				X	
MSM Survey	X		X		X	
SW Survey		X		X		X
Health Facility Assessment		X		X		X
MICS			X			
Workplace Survey	X		X		X	
National Composite Index	X		X		X	
Information Products						
AIDS Report Epidemic Update	X	X	X	X	X	X
HIV Bulletin	X	X	X	X	X	X
UNGASS report	X	X	X	X	X	X
UNICEF report card	X	X	X	X	X	X
Reports to Donors	X	X	X	X	X	X

5.2 Mechanisms for Monitoring M&E System

In the true spirit of monitoring, evaluation, transparency and accountability, the M&E System described by this Plan and supporting documents (e.g., Operations Manual and National Strategic Plan) will be monitored based on a set of Performance Objectives. The objectives and related indicators listed below will be reviewed annually by the MERG. The information from this review will be implemented by updating the M&E Plan and supporting documents to improve system performance.

1. M&E System Performance Objective 1: Develop a National HIV/STI Programme M&E Plan
1.1 HIV/AIDS M&E plan linked to national strategic plan and addresses its objectives

2. M&E System Performance Objective 2: Implementation of an M&E Plan
2.1 Milestones in national HIV/STI Programme M&E plan reached

3. M&E System Performance Objective 3: Assessing and upgrading of M&E system capacity
3.1 Appropriate staffing levels maintained to effectively support M&E system

4. M&E System Performance Objective 4: Produce High Quality Data on a Timely Basis
4.1 Percentage of monthly reports arrive on time

5. M&E System Performance Objective 5: Communicate HIV/AIDS Information to Relevant Stakeholders and Facilitate the Use of Information among Stakeholders
5.1 Interagency and intra agency units share reports, review progress and communicate information to decision makers

5.3 Mechanism for updating plan

The M&E Plan will formally be reviewed on an annual basis by the Monitoring and Evaluation Reference Group (MERG). However, on-going assessments and suggestions for modifications may become evident during the course of a strategic planning year, requiring more immediate attention and adjustments of the framework.

APPENDIX A: NSP Logical Framework

Priority Area #1: PREVENTION

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
To reduce the transmission of new HIV infections	• Percentage of men & women aged 15-24 who are HIV infected	ANC/STI Surveillance	Collected every two years
	• Percentage of SW who are HIV infected	SW second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years.
	• Percentage of MSM who are HIV infected	MSM second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years. Success is dependent on trust with community.
PURPOSE			
To achieve universal access to prevention services, focusing on most-at-risk populations	• Number of individuals reached through TCI disaggregated by vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.)	Reported to M&E unit by MOH BCC unit on an annual basis	There are challenges associated with defining sub-populations and with double-counting
	• Number of people trained to provide prevention services to persons most at risk	Stakeholder reports	
OBJECTIVES			
P1. To increase quality of prevention services			
P2. To increase accurate information of ways to prevent HIV and dispel myths	• % of young people (15-24) or at risk groups who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/ generalizability at the general population level.
P3. To identify communities and populations most at-risk			

APPENDIX A: NSP Logical Framework

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
OBJECTIVES (continued)			
P4. To increase access to targeted, age-appropriate HIV prevention services for youth	• % of young adults, 15 to 19 years old, who have never had sex • Percentage of young people aged 15-49 who report condom use at last intercourse with non-regular partner	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/ generalizability at the general population level.
P5. To strengthen prevention efforts for SW and others engaging in transactional sex	• Percentage of SW reporting condom use the last time they had sex with a client	SW second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years.
P6. To strengthen prevention efforts for MSM	• % of men reporting using a condom the last time they had anal sex with a male partner	MSM second generation surveillance (PLACE-like methodology)	2006/2007 survey intended to be repeated every two years. Success is dependent on trust with community.
P7. To strengthen prevention efforts for tourism workers	• Number of persons trained by client and service area	Stakeholder reports	
P8. To strengthen prevention efforts for inmates in correctional facilities	• Number of persons trained by client and service area	Stakeholder reports	
P9. To increase prevention interventions in the labour sector directed at reducing stigma & discrimination	• Number of persons trained by client and service area	Stakeholder reports	
P10. To strengthen prevention efforts for persons within the uniformed services	• Number of persons trained by client and service area	Stakeholder reports	
P11. To strengthen HFLE program in the education sector (early childhood to tertiary)	• % of young adults, 15 to 19 years old, who have never had sex	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/ generalizability at the general population level.
P12. To strengthen the capacity of the sectors in the national response to conduct prevention interventions	• Number of persons trained by client and service area	Stakeholder reports	
P13. To reduce transmission from PLWHA to their partners and secondary infections			
P14. To improve prevention interventions for drug abusers			

APPENDIX A: NSP Logical Framework

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
OBJECTIVES (continued)			
P15. To increase the use of mass media in prevention efforts	• Percentage of young adults, 15 to 19 years old, who have never had sex • Percentage of young people aged 15-24 who had more than one sexual partner in the last 12 months	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/ generalizability at the general population level.
P16. To identify cultural influentials who can positively shift existing risky cultural norms	• Number of persons trained by client and service area	Stakeholder reports	
P17. To strengthen prevention efforts for vulnerable adolescents	• % of young adults, 15 to 19 years old, who have never had sex	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/ generalizability at the general population level.

PREVENTION ACTIVITIES

P1. To increase quality of prevention services

1.1   Develop guidelines, standards and a training curriculum in quality of care (respect, confidentiality, communication style, etc.) with specific focus on meeting the needs of youth, PLWHA, MSM, SW, people with disabilities, and recognizing gender differences
1.1a Build youth-friendly services using Youth. Now model
1.2   Train workers in quality of care across sectors including linkages to accreditation processes, e.g.:
- Health sector BCC specialists, outreach workers, etc.
- Guidance Counsellors
- Effective/popular school teachers & coaches
- Correctional facility resident nurses and pharmacists
- Pharmacists
1.3   Conduct quality control monitoring of prevention service delivery

P2. To increase public awareness of HIV prevention, sex and sexuality

2.1   Implement public campaigns involving the general population e.g. schools, clubs, churches, etc.
2.2   Recruit influential men (e.g. men on the corners) to lead, design and participate in interventions

APPENDIX A: NSP Logical Framework

PREVENTION ACTIVITIES (continued)

P3. To identify communities and populations most at risk

3.1   Map locations of target populations using PLACE data
3.2   Assess current coverage of prevention services related to targeted populations & set coverage targets
3.3   Develop workgroup to regularly review surveillance data for targeted community efforts.

P4. To increase access to targeted, age-appropriate HIV prevention services for youth

4.1 Facilitate stakeholder consultation (administration, youth, parents, service providers, legal community) on adolescents accessing SRH information & services towards developing evidenced-based programmes and/or policy position.
4.2 Update/develop policy and legislation to improve access to services and treatment (inclusive of VCT, contraception and disclosure etc.) without parental consent
4.3 Identify best-practice holistic peer education strategies through formative research and program evaluation.
4.4 Develop and implement a best-practice structured youth outreach, peer education and support programme. Consider partnering with existing non-HIV peer youth services.
4.5 Expand out-of-clinic youth services (and ensure governance by service provision policy)
4.6 Define and develop "Youth Safe Spaces" with age- , sexual orientation- and gender- specific activities
4.7 Tailor messages and outreach for youth with disabilities
4.8 Expand targeted interventions for youth in the Tourism Industry
4.9 Include HIV prevention as part of the Mandatory Community Placement Programme for tertiary students

P5. To strengthen prevention efforts for sex workers (SW) and others engaging in transactional sex

5.1   Conduct Formative Research to better understand:
      (1) Sexual behaviour of entertainment workers (e.g. masseurs, water sports operators)
      (2) Transactional sex practices
5.2   Develop and implement interventions that focus on the gender issues that inform sex work to empower sex workers – male and female to make healthy choices
5.3   Develop and implement interventions targeting entertainment workers through PLACE
5.4   Identify best practice for peer education and scale up
5.5   Improve skills to negotiate condom use with main partner

P6. To strengthen prevention efforts for Men who Have Sex with Men

6.1 Conduct participatory community-based research on social norms and access to social support within this population
6.2 Review international best practices related to prevention, treatment, and care among MSM and make recommendations for adaptations in Jamaica
6.3 Use/adapt existing interventions (e.g. PLACE) to reach MSM
6.4 Identify influentials that can provide access to other MSM networks
6.5 Increase access to prevention services

APPENDIX A: NSP Logical Framework

PREVENTION ACTIVITIES (continued)

P7. To strengthen prevention efforts for Tourism Workers

7.1 Conduct participatory community-based research on social norms and access to social support within this population
7.2 Replicate successful models (e.g. Sandals) in other hotels
7.3 Recruit "champions" in the hotel industry to address HIV/AIDS

P8. To strengthen prevention efforts for Inmates in Correctional Facilities

8.1 Review results and lessons learned of pilot project in Tower Street for implementation in other correctional facilities
8.2 Develop integration and sustainability plan for efforts in correctional facilities
8.3 Develop guidelines and reorientation training for persons employed in prisons
8.4 Strengthen the functions of the Department of Corrections resident nurse to reach staff through risk assessment and counselling

P9. To increase prevention interventions in the labour sector

9.1 Identify leaders and other influentials to mobilize the sector to own and address HIV/AIDS issues at the workplace
9.2 Equip sector with skills to establish sector wide prevention programmes for workers

P10. To strengthen prevention efforts for persons within the uniformed services

10.1 Establish condom outlets at sites where uniformed services are posted
10.2 Develop peer education program at sites for persons in uniformed services
10.3 Create supportive environment to reinforce practice of safer sex behaviours in this population

P11. To strengthen HFLE program in the education sector (early childhood to tertiary)

11.1 Complete revision of HFLE curriculum at all levels and implement comprehensive sector-wide programme
11.2 Revise and implement the national HFLE policy (and HIV/AIDS policy), inclusive of materials development, mandated time-tabling, etc.
11.3 Enforce the code of conduct of Guidance Counsellors (teaching professionals) especially regarding breach of confidentiality
11.4 Implementation of whole institution approach to teaching of HFLE

P12. To strengthen the capacity of the sectors in the national response to conduct prevention interventions

12.1 Introduction/expansion of courses at the tertiary level to equip a cadre of trained personnel to conduct prevention interventions in all sectors involved in the national response
12.2 Documentation of in-service training conducted within sectors to be used to inform curriculum for professional courses

APPENDIX A: NSP Logical Framework

PREVENTION ACTIVITIES (continued)

P13. To reduce transmission from PLWHA to their partners and secondary infections

13.1 Train health workers in age and gender-specific motivational interviewing techniques for positive prevention
13.2 Develop common messages for Positive Prevention including risks of secondary prevention
13.3 Create and implement support groups for PLWHA
13.4 Mobilize the community to provide leadership on this issue

P14. To improve prevention interventions for drug abusers

14.1 Develop and implement policy for most-at-risk drug abusers, involved in sex work
14.2 Improve access to prevention services rehab process

P15. To increases the use of the mass media in prevention efforts

15.1 Expand media alliance with media managers
15.2 Develop and air media campaign messages aimed at risk reduction and stigma reduction

P16. To identify cultural influentials who can positively shift existing risky cultural norms

16.1 Identify influentials in music, media, formal and informal community leaders and sports
16.2 Develop strategy to assist in shifting adult entertainment from mainstream media

P17. To strengthen prevention efforts for vulnerable adolescents

17.1 Assess size of population of vulnerable groups of adolescents (e.g. disabled, street children, adolescent sex workers, etc.)
17.2 Develop contextual and age appropriate interventions to reach this population
17.3 Improve access to prevention services for vulnerable adolescents

APPENDIX A: NSP Logical Framework

Priority Area #2: TREATMENT, CARE & SUPPORT

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
	• % of adults and children with HIV known to be on ART 12 months after initiation of antiretroviral therapy	Treatment database from electronic medical records	Treatment database only collects data on public health clients and misses those seen by private providers
PURPOSE			
To achieve universal access to high quality comprehensive treatment, care and support in an environment that is non-discriminatory and supports adherence	• % of most-at-risk populations (youth, MSM, SW) who received HIV testing in the last 12 months & know the results	• MSM & SW second generation surveillance (PLACE-like methodology) • Healthy Lifestyles Survey • KABP	2006/2007 surveys intended to be repeated every two to three years. Surveys are dependent on external funding.
	• % of women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy according to national guidelines	Monthly treatment site reports from program coordinators to parish medical officers and technical directors	Regions are clear on definitions and instructions on completion of monthly reporting forms. Timeliness is a problem. There are delays at each step in the data flow. Also, data only available for public health clients, not private.
OBJECTIVES			
T1. To increase access to HIV testing among priority populations	• % of most-at-risk populations (youth, MSM, SW) who received HIV testing in the last 12 months & know the results	• MSM & SW second generation surveillance (PLACE-like methodology) • Healthy Lifestyles Survey • KABP	2006/2007 surveys intended to be repeated every two to three years. Surveys are dependent on external funding.

APPENDIX A: NSP Logical Framework

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
OBJECTIVES (continued)			
T2. To prevent Mother to Child Transmission of HIV	• % of infants born to HIV-infected mothers who are HIV infected	Regional HIV/AIDS Monthly Report Form (RHAMR)	Regions need clarified instructions and definitions
T3. To improve access to and quality of ARV treatment	• % of women, men & children with advanced HIV infection who are receiving antiretroviral combination therapy according to national guidelines	Monthly treatment site reports from program coordinators to parish medical officers and technical directors	Regions are clear on definitions and instructions on completion of monthly reporting forms. Timeliness is a problem. There are delays at each step in the data flow. Also, data only available for public health clients, not private.
T4. To increase adherence to treatment and care	• % of PLWHA on ARV reporting at least 90% adherence by pill count	National Health Fund Database Adherence counsellor/social worker reports	NHF Database has some issues Monthly reports
T5. To Improve care and support for Orphans and Vulnerable Children (OVC)	• Current school attendance among orphans and non-orphans, aged 10-14	MICS is done every 5 years by UNICEF.	First one was done in 2005-2006. STATIN does the analysis. MOH is a partner in the working group.
T6. To improve access and use of Home Based Care		Quarterly regional technical reports by the regional HIV coordinator from stakeholder reports and social workers.	Reporting process is new. There are difficulties defining home based care and difficulties with coordination among various players.
T7. To improve infection control and access to Post-Exposure Prophylaxis (PEP) for accidentally exposed Health Care Workers		Quarterly regional technical reports by the Regional HIV Coordinators Quarterly Regional Surveillance Officer reports	
T8. To strengthen prevention efforts for PLWHA	• Number of persons trained to provide treatment services by client and service area	Stakeholder reports	
T9. To improve the management of tuberculosis, especially in the HIV infected	• Proportion of confirmed TB cases tested for HIV	Quarterly Regional Surveillance Officer reports Quarterly NPHL Report	

APPENDIX A: NSP Logical Framework

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions

OBJECTIVES (continued)

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
T10. To strengthen the management of Sexually Transmitted Infections, including syphilis	• Incidence of congenital syphilis	Case reporting Health Facility Assessment	Monthly/Quarterly case reports; Health Facility Assessment not yet conducted
T11. To improve the diagnostic capacity of the laboratory services			
T12. To strengthen and institutionalize the training programme	• Number of persons trained to provide treatment services by client and service area	Stakeholder reports	

TREATMENT, CARE & SUPPORT ACTIVITIES

T1. To increase access to HIV testing among priority populations

1.1 Scale up PITC to all users of primary, secondary and tertiary services (especially for persons between the ages 10 to 60 years).
1.2 Test all persons who are being treated for STIs
1.3 Test all persons who are being treated for TB
1.4 Assure quality counselling and referrals and provide training in PITC
1.5 Conduct Formative Research to better understand the real and perceived barriers to testing and perception of risk
1.6 Conduct Media Campaign to increase awareness regarding the importance of testing and perception of risk
1.7 Build capacity in NGOs to capably address barriers to HIV testing
1.8 Reach vulnerable populations through peer approaches and their networks and events
1.9 Conduct targeted outreach of male youths by partnering with male-focused organizations, and going to heavily populated male events, use champions and role model men
1.10 Conduct VCT at sites where young spend time (e.g. Sports venues, Bashy Bus, Adolescents centre where young people do school work, etc.)
1.11 Increase number of confidential areas at testing sites to facilitate counselling and privacy

APPENDIX A: NSP Logical Framework

TREATMENT, CARE & SUPPORT ACTIVITIES (continued)

T2. To prevent Mother to Child Transmission of HIV

2.1 Retrain Public Health Nurses and Midwives in updated protocol PMTCT+ on an annual basis
2.2 Screen all HIV positive pregnant women with CD4 counts
2.3 Ensure all women testing positive receive appropriate antiretroviral therapy for prevention of mother to child transmission in accordance with revised PMTCT+ guidance
2.4 Identify mechanisms to reach at-home births (e.g. midwife training)
2.5 Ensure rapid testing for women arriving at maternity ward with unknown status
2.6 Conduct appropriate follow-up of mother-baby pairs
2.7 Ensure all points of service delivery must have starter packs of ARV.
2.8 Increase the number of sites offering the HIV testing service
2.9 Use Child Protection Act to assure testing and treatment of mother
2.10 Engage fathers in the delivery of the PMTCT programme by offering testing and providing HIV related information
2.11 Provide universal access to long term Family Planning Methods
2.12 Improve information sharing (M&E) between primary, secondary and national levels

T3. To improve access to and quality of ARV treatment

3.1 Increase the number of sites at which treatment is available by involving all Primary Care Staff in treatment and maintaining the current Treatment Centres as Specialist referral sites
3.2 Retrain clinic staff in updated HIV Management Protocol on an annual basis
3.3 Improve access to CD4 and viral load testing
3.4 Conduct resistance testing
3.5 Conduct appropriate follow-up of patients
3.6 Make existing and new sites 'Youth friendly' by hiring younger people, or involving them as volunteers, and providing holistic, non-judgmental support.
3.7 Identify best-practices for engaging men in treatment. (E.g. Examine the male health seeking behaviour and address the findings)
3.8 Review "User Fee Policies" to ensure that patients' fees are set appropriately and that treatment is not denied. Assess how User Fee Policies affect access to treatment.
3.9 Conduct quality assurance audits at all levels of service
3.10 Develop and implement an information tracking system that facilitates effective management of appointments and medication
3.11 Develop mechanism to integrate pharmacy outlets for ARV with treatment centers
3.12 Improve supply management structure for ARV

APPENDIX A: NSP Logical Framework

TREATMENT, CARE & SUPPORT ACTIVITIES (continued)

T4. To increase adherence to treatment and care

4.1 Enrolling persons on antiretrovirals with NHF, will allow them a further discounted access to medication
4.2 Review TOR of adherence counsellors to include counselling for HIV testing as well as adherence counselling on a wider scale, in the hospitals, etc.
4.3 Development of a structured adherence protocol for pre-ARV treatment
4.4 Strengthen adherence programme by involvement of all members of the treatment team
4.5 Ensure provision of nutritional advice and support by all members of the treatment team
4.6 Provide training in adherence to all members of the treatment team
4.7 Development of treatment support groups
4.8 Simplify regime by increased availability of fixed combination drugs
4.9 Collaborate with NGOs and other relevant agencies that can provide financial and social support (for meals, transportation, school fees) and income generating assistance to PLWHA
4.10 Develop linkages and referral mechanisms to community support
4.11 Utilize non-traditional health care workers to ensure follow-up with known PLWHA
4.12 Develop and distribute user-friendly material for PLWHA that describes treatment (medication, nutrition), and adherence

T5. To improve care and support for Orphans and Vulnerable Children (OVC)

5.1 Identify a specific agency (CDA?) to be charged with assuring that children are on medication and receive appropriate care
5.2 Employ a Children's Officer to work from the Ministry of Health to liaise with relevant agencies, develop and implement mechanisms to ensure the follow-up of OVC
5.3 Address issues of vulnerability taking into consideration the following specific groups:
  - Orphans in Homes
  - Street Children
  - Young girls who head households
  - Boys who have to hustle
  - Children with disabilities

T6. To improve access and use of Home Based Care

6.1 Develop a registry of home based caregivers and agencies to provide these services and disseminate this information
6.2 Provide training to care givers in Home Based Care
6.3 Involve family members and other support groups (e.g. Churches, etc.) in the training of home based care

T7. To improve infection control and access to Post Exposure Prophylaxis for accidentally exposed Health Care Workers

7.1 Implementation of an alternative technology for medical waste (including sharps) management
7.2 Update and reprint the infection control manual and distribute widely
7.3 Training of all levels of health care workers in the management of post-exposure prophylaxis

APPENDIX A: NSP Logical Framework

TREATMENT, CARE & SUPPORT ACTIVITIES (continued)

T8. To strengthen prevention efforts for PLWHA

8.1 Integrate expected roles and responsibilities of PLWHA into existing HIV/AIDS Policy
8.2 Develop standardized messages geared towards encouraging responsible sexual behaviour among PLWHA
8.3 Develop and strengthen support groups and provide intervention counselling for PLWHA attending treatment sites
8.4 Train available adherence counsellors in Positive Prevention Methodologies.
8.5 Conduct trainings in Positive prevention for PLWHA

T9. To improve the management of Tuberculosis especially in the HIV infected

9.1 Strengthen linkages between TB and HIV programmes.
9.2 Screen all HIV infected persons for TB as well as ensure the availability of facilities for early diagnosis.
9.3 Ensure the availability of anti-TB drugs
9.4 Conduct training for HCW in the management of TB and TB/HIV
9.5 Improve the follow-up of TB patients to ensure completion of course of medication
9.6 Improve the capacity of the laboratory to conduct diagnostic tests for TB and resistance testing.

T10. To strengthen the management of Sexually Transmitted Infections including Syphilis

10.1 Conduct trainings in the management of STIs including Syphilis
10.2 Improve the capacity of the laboratory to conduct testing to determine aetiological agents

T11. To improve the diagnostic capacity of the laboratory services

11.1 Expand the capacity of the laboratory services to deal with the increased numbers of persons being tested
11.2 Improve the management structure of the NPHL
11.3 Improve the capacity of the laboratories (in the regions also) to diagnose TB, STIs and opportunistic infections.
11.4 Expand the lab capacity to include resistance testing for Anti TB and HIV drugs.
11.5 Improve the capacity of the laboratory to carry out CD4, Viral Loads and other supportive investigation

T12. To strengthen and institutionalize the training programme

12.1 In collaboration with CHART to develop standard short courses for HIV case managements, PMTCT, Adherence, Infection Control and Counselling for HCW.
12.2 Conduct trainings for HCW
12.3 Regions to duplicate trainings to ensure dissemination of information to all relevant staff
12.4 Conduct audits to ensure standard and quality of care.

APPENDIX A: NSP Logical Framework

Priority Area #3: ENABLING ENVIRONMENT & HUMAN RIGHTS

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
To protect fundamental human rights and empower the Jamaican people to make healthy choices	• Percentage of people 15-49 years expressing accepting attitudes towards people with HIV/AIDS	KABP survey	2000, 2004 and every 3-4 years. Assumes representativeness/ generalizability at the general population level.
PURPOSE			
To decrease stigma and discrimination toward people with HIV/AIDS	• Number and percentage of reported cases of HIV-related discrimination receiving redress by setting	Reports from MOE, Red Cross, Ministry of Labour, and JAS to JN+ Additional sources might include UNHCR, UNAIDS, UNICEF, but are not HIV specific Stigma & discrimination working group	Would need to do a baseline court survey - affordability issues. Need to define redress (greater technical clarity) and incorporate definition into reporting system Need to establish coordinated mechanism and get buy in from partners.
OBJECTIVES			
E1. To systematically identify and report acts of discrimination	• Number of cases of HIV related discrimination reported by setting • Number and percentage of reported cases of HIV-related discrimination receiving redress by setting	JN+ stigma database collects this information and reports in quarterly to the NAC	Database is still under development
E2. To improve public awareness of HIV and AIDS	• Number of persons trained by client and service area	Stakeholder reports	
E3. To strengthen community advocacy against stigma and discrimination			

APPENDIX A: NSP Logical Framework

E4. To reduce stigma in all sectors		Stakeholder reports.	

E5. To reduce stigma and discrimination in the health sector			Need to do a baseline court survey - affordability issues. Need to define redress (greater technical clarity) and incorporate definition into reporting system Need to establish coordinated mechanism and get buy in from partners.
E6. To empower youth to address stigma and discrimination	• Number of policy makers attending sensitization workshops on HIV/AIDS/STI		

OBJECTIVES

E7. To empower PLWHA in the context of reducing stigma and discrimination and seeking treatment and care			
E8. To advocate for legislation that protects human rights	• Number of policy makers attending sensitization workshops on HIV/AIDS		
E9. To advocate for non-discrimination among management and employees of the insurance sub-sector			

APPENDIX A: NSP Logical Framework

ENABLING ENVIRONMENTS & HUMAN RIGHTS ACTIVITIES

E1. To systematically identify and report acts of discrimination

1.1 Assemble a multi-sector working group to define 'Discrimination' & identify specific examples including unequal access for people with disabilities.
1.2 Develop a common Discrimination Reporting tool for civil society and all sectors to report discrimination
1.3 Develop & maintain a system of data collection, data maintenance (database) and analysis of reports of stigma, discrimination and response
1.4 Establish a system with office of Public Defenders to act upon data on behalf of persons who have been discriminated against
1.5 Develop and implement a dissemination strategy/information campaign to civil society and all sectors so they utilize the Discrimination Reporting mechanism

ENABLING ENVIRONMENTS & HUMAN RIGHTS ACTIVITIES   (continued)

E.2 To improve public awareness of HIV and AIDS

2.1 Develop and implement anti stigma mass media campaign with supporting public relations campaign with gender-specific, geographic-specific and target-group-specific messages
2.2 Develop messages that reinforce that HIV is important to address because of the economic impact, potential to spread and for protection of human rights.
2.3 Use cell phones as avenues to reach young people in terms of HIV messages
2.4 Use drama and other cultural approaches to create awareness of gender specific issues

E3. To strengthen Community Advocacy against Stigma and Discrimination

3.1 Conduct community-specific research to identify the extent that PLWHA and families can challenge community level S&D
3.2 Facilitate community consultations in urban and rural parishes for development of support mechanisms for PLWHA and their families. Include a broad array of organizations including churches.

E4. To reduce stigma in all sectors

4.1 Expand development and implementation of workplace policies and programmes including action for breaches.
4.2 Implement disciplinary measures when Policy is violated
4.3 Promote existing Education Policy and Child Care Act in private schools and monitor activities which support or contravene principles enshrined in the Act.

E5. To reduce stigma and discrimination in the health sector

5.1 Develop and implement a health care policy to ensure adherence to a strict protocol for caregivers and other HCW when working with PLHIV, including privacy and confidentiality and a mechanism for recourse and sanctions for breaches of policy.

APPENDIX A: NSP Logical Framework

5.2 Develop a comprehensive S & D programme which incorporates training for quality of care for health workers.

E6. To empower Youth to address Stigma and Discrimination

6.1 Use Sphere of influence Model (reference to JASTYLE)
6.2 Infuse S&D messages into school curriculum such as the Safe Schools Programme
6.3 Utilize NYS Health Promotion Facilitators trained by MOH to undertake targeted interventions in the communities.
6.4 Develop programmes for young persons to interact with and show care and support for PLWHA e.g. Junior PAAs

E7. To empower PLWHA in the context of reducing stigma and discrimination and seeking treatment and care

7.1 Conduct research to understand social and economic needs of PLWHA and how best to engage them in services
7.2 Provide PLWHA with training and support in: (1) Life and communication skills (2) Positive prevention (3) anti stigma and discrimination interventions (4) work place implementation and treatment compliance and adherence (5) Skills to achieve economic independence (6) Psycho-social support to address perceived or internal stigma and to enhance self-esteem
7.3 Provide shelter and other facilities for persons who are negatively treated when they disclose their status e.g. Safe House
7.4 Adapt protocol and training for Contact Investigators to: (1) Address and support issues of disclosure to PLWHA partners (2) Refer PLWHA to the existing support and advisory boards and encourage their participation

E8. To advocate for Legislation that protects human rights

8.1 Submit recommendation to Cabinet for support of anti discrimination laws to reduce human rights violations
8.2 Provide legal assistance to PLWHA (*pro bono*)
8.3 Develop and Implement safeguards against sexual violence and exploitation of girls
8.4 Identify leaders/change champion for law reform including repeal of the buggery law (re human rights) and conduct education & dialogue on the issue
8.5 Assess/examine policy/legislative options regarding regulations of SW.
8.6 Amend education act to change HIV as a communicable disease and include private institutions
8.7 Enhance lobbying and advocacy for OVC in institutions: social integration etc.

E.9 To advocate for non discrimination among management and employees of the Insurance sub sector

9.1 To establish and implement interventions targeted to management and employees in the Insurance sub sector focused on negotiations, advocacy, public education and training in regards to the 10 workplace principles

APPENDIX A: NSP Logical Framework

Priority Area #4: EMPOWERMENT & GOVERNANCE

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
GOAL			
To achieve a sustained, effective multi-sectoral infrastructure and commitment to support the National Response to HIV and AIDS	• National Composite Index • Domestic and international AIDS spending by categories and financing sources	Country Assessment done every 2 years by the M&E Unit	Adapted from UNGASS tool
PURPOSE			
Integration of HIV programs into existing human and social development programs	• National Composite Index	Country Assessment done every 2 years by the M&E Unit	Adapted from UNGASS tool
OBJECTIVES			
G.1 To build capacity and commitment of health sector to recognize their role and provide high-quality services for all people	• Number of persons trained by client and service area	Stakeholder reports	
G.2 To build capacity and commitment of other sectors			
G.3 To develop one monitoring and evaluation framework	• Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	Reported by stakeholders to M&E unit annually for PEPFAR reporting	Does not assess quality of training or TA
G.4 To improve procurement and financial management systems			
G.5 To implement a sustainability plan			

APPENDIX A: NSP Logical Framework

Narrative	Verifiable Indicators	Means of Verification	Risks & Assumptions
OBJECTIVES (continued)			
G.6 To assure multi-sectoral commitment to National Strategic Plan	• Number of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/ standards		
	• Percentage of schools that provided life-skills based HIV/AIDS education during the last academic year	Educational program review conducted by Ministry of Education every 2 years	
G.7 To assure strong governance and accountability	• Number of policy makers attending sensitization workshops on HIV/AIDS		

EMPOWERMENT & GOVERNANCE ACTIVITIES

G1. To build capacity and commitment of health sector to recognize their role and provide high-quality services for all people

1.1 Assess Human Resource needs as part of a sustainability plan and implement chosen recommendations
1.2 Strengthen staff knowledge and skills through Pre-service Training, CHART and other sensitisation and training
1.3 Develop a clinic-based information system
1.4 Implement a Laboratory Information System
1.5 Ensure participation of health care workers in the review of health data and decision-making processes

G2. To build capacity and commitment of other sectors to recognize their role in the response

2.1 Strengthen partner knowledge and skills through CHART and other sensitisation and training
2.2 Address barriers and improve implementation of a family life education in schools that adequately addresses sex, sexuality and health
2.3 Provide individualized technical assistance to selected NGOs (e.g., NAC, JN+, etc,) to build their capacity in accountability, quality control, M & E
2.4 Develop an NGO forum
2.5 Conduct outreach and training to civil society to understand policy processes, advocacy, and their role
2.6 Institutionalize mechanisms for participation of civil society (MSM, SW, PLWHA) in programme design, monitoring and evaluation
2.7 Develop a youth-board for input on planning, implementation and evaluation
2.8 Train young PLWHA as peer educators and outreach officers in schools, etc.
2.9 Provide capacity building training workshops for community youth and youth organizations in life & leadership skills

APPENDIX A: NSP Logical Framework

EMPOWERMENT & GOVERNANCE ACTIVITIES (continued)

G3. To develop one monitoring and evaluation framework

3.1 Identify priority indicators and sources for use by all sectors
3.2 Assist key partners in development and implementation of their M & E systems
3.3 Train stakeholders in data collection and surveillance methods for programme monitoring
3.4 Implement the HIV/AIDS Tracking System (HATS)
3.5 Monitor and Evaluate the National Strategic Plan

G4. To improve procurement and financial management systems

4.1 Align the GOJ procurement process to that of the International Donor Agencies
4.2 Allow for special provisions in the procurement process for the HIV/AIDS Programme

G5. To implement a sustainability plan

5.1 Institutionalize the positions of the National HIV/AIDS programme posts in the present government cadre
5.2 Include a separate budget line item for HIV/AIDS in the recurrent budget
5.3 Provide capacity building, training, and development of systems and guidelines across partners
5.4 Develop systems to strengthen integrity/transparency of resource allocation between intervention alternatives
5.5 Develop incentive scheme for ongoing service delivery after training
5.6 Include PLWHA and other vulnerable populations in the implementation of the plan

G6. To assure multi-sectoral commitment to National Strategic Plan

6.1 Establish mechanisms for communication, coordination, implementation and operation at the national and regional levels
6.2 Identify specific roles and responsibilities for each sector
6.3 Develop sector-specific work plans
6.4 Develop an NGO forum to share best-practices/lessons learned and to coordinate activities

G7. To assure strong governance and accountability

7.1 Establish a multi-sectoral working group to consider structure for One Authority (mechanism for coordination and accountability across all sectors)
7.2 Move forward on creation of One Authority once roadmap is agreed upon
7.3 Establish mechanisms for communication and coordination across sectors to minimize duplication of efforts
7.4 Implement the One Authority entity based on the selected structure/ format
7.5 Monitor and evaluate the performance of the One Authority entity

APPENDIX B: NSP Focus Indicators, Baselines and Targets

NSP	Reporting	Donor or Global Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
Goal	UNGASS, Global Fund, CARICOM	**UNGASS.** Percentage of men & women aged 15 to 24 that are HIV infected	ANC/STI Surveillance Report	Annually	National HIV Surveillance Officer	1.2% 1.5%	2002 2005	≤1.5%	2009 and 2011	Yes, but HATS needs full implementation
Goal	UNGASS, USAID, World Bank	**UNGASS.** Percentage of SW who are HIV infected	SW Second Generation Surveillance	2005 and every 2 years	NHP M&E Unit	9%	2005	7% <7%	2010 2012	Yes
Goal	UNGASS, USAID, World Bank	**UNGASS.** Percentage of MSM who are HIV infected	MSM Second Generation Surveillance	2006 and every 2 yrs	NHP M&E Unit	25 to 30%	2007 estimate	< 25%	2011	Data collection in progress
Purpose	Global Fund, USAID	**USAID.** Number of individuals reached through prevention activities disaggregated by vulnerable groups (e.g. youth, MSM, SW, prisoners, etc.)	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators	SW: 3480 MSM: 4800 STI clinic attendees: 40,000 Inmates: TBD		SW: 8500 MSM: 6,600 STI clinic attendees: 225,000 Inmates: 3000 (all cumulative)	2012	Yes - being implemented
Purpose P7-P10, P12, P16		Number of persons trained to provide prevention services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					
P2	UNGASS, Global Fund, CARICOM, CIMT, World Bank	**UNGASS.** Percentage of young women and men aged 15-24 or at-risk group who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	KABP	2000, 2004 and every 3-4 years	NHP M&E Unit	M: 29.6% F: 33.4% M:36.2% F: 40.0%	2000 2004	M: 60% F: 60%	2011	Yes
P4, P11, P15, P17	GFATM	Percentage of young adults, 15 to 19 years old, who have never had sex	KABP	2004 and every 3-4 years	MOH	M: 27.6% F: 50.5%	2004	M: 35% F: 55%	2011	Yes

APPENDIX B: NSP Focus Indicators, Baselines and Targets

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
P4, P15 (15-24 yrs)	UNGASS, Global Fund, World Bank, CIMT	% of people by sex, age, and at risk group reporting the use of a condom the last time they had sex with a non-regular partner	KABP	2004 and every 3-4 years	NHP M&E Unit	**Ages 15-49**				Yes
						M: 77.3% F: 71.7%	2000	M: 80% F: 75%	2011	
						M: 74% F: 66%	2004			
P5	UNGASS, Global Fund, USAID, World Bank, CIMT	**UNGASS.** Percentage of SW reporting using a condom at last sex act with client	SW survey	2005 & every 2-3 yr	NHP M&E Unit	75% 92%	2003 2005	>90%	2011	Yes
P6	UNGASS, Global Fund, World Bank	**UNGASS.** Percentage of men reporting using a condom the last time they had anal sex with a male partner	MSM survey	2006 & every 2-3 years	NHP M&E Unit	TBD	2003	10% increase	2010	Yes
								20% over baseline	2012	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
GOAL	UNGASS, CARICOM, World Bank	**UNGASS.** Percentage of adults & children with HIV known to be on treatment 12 months after initiation of ART	Treatment database from EMR	Monthly	Treatment coordinator	75%	2006	90%	2012	In development, 2004 estimate based on UNGASS calculations
PURPOSE, T1	UNGASS, World Bank	**UNGASS.** Percentage of people by sex, age, and at risk group) who received HIV testing in the last 12 months and who know the results	Surveys (MSM, SW, Healthy Lifestyles)	every 2 yr	NHP M&E Unit	SW: 43% MSM TBD	2005	SW 50%	2012	Yes
PURPOSE, T3	UNGASS, Global Fund, World Bank	**GFATM.** Percentage of men, women & children with advanced HIV receiving ART according to national guidelines	Treatment site reports	Monthly	Regional Surveillance Officers/ Treatment coordinator	3000	April 2007	Adult: 4,800 Children: 200 by 2008 then 500/ year	2012	Yes

APPENDIX B: NSP Focus Indicators, Baselines and Targets

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
T2	UNGASS, Global Fund, GOJ, USAID, World Bank	**UNGASS.** Percentage of infants born to HIV-infected mothers who are HIV-infected	Regional HIV/AIDS Monthly Report (RHAMR)	Monthly	Regional Surveillance Officers & HIV Coordinators	25% 12% 10%	2000 2005 2006	< 10% < 5%	2007 2012	Regional Report; PMTCT database needs full implementation
T4	GFATM	Percentage of PLWHA on ARV reporting at least 90% adherence by pill count	National Health Fund Database Adherence counsellor/ social worker reports	Monthly	Adherence counsellors, social workers, HIV Coordinators	75%	2006	80%	2012	Yes
T5	UNGASS, World Bank	**UNGASS.** Current school attendance among orphans and non-orphans, aged 10-14	MICS	every 5 yrs (Nov-Mar 2005-06)	UNICEF	0.99	2005	Maintain >0.9	2012	Yes
T8, T12		Number of persons trained to provide treatment services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					Yes
T9		Proportion of confirmed TB cases tested for HIV	Regional Surveillance Officer Reports NPHL Reports	Quarterly Quarterly	TB Surveillance Officer NPHL	85%	2005	>90%	2012	Yes

APPENDIX B: NSP Focus Indicators, Baselines and Targets

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
T10		Incidence of congenital syphilis	Case reporting	Annually	STI Officer	26.2 per 100,000 births	2004	15 per 100,000 births	2012	Yes
PRIORITY AREA #3: ENABLING ENVIRONMENT & HUMAN RIGHTS										
GOAL	Global Fund, CIMT	**GFATM.** Percentage of people 15-49 yrs expressing accepting attitudes towards people with HIV/AIDS	KABP	2004 and every 3-4 years	NHP M&E Unit	M: 8.7% F: 93%	2004	25%	2011	Yes
PURPOSE, E5	GFATM, World Bank	Number and percentage of reported cases of HIV-related discrimination receiving redress by setting	MOE, Red Cross, Ministry of Labour, JAS	Quarterly	Stigma & discrimination working group	25%	2006	75%	2012	Needs to be refined
E1	GFATM	Number of cases of HIV-related discrimination reported by setting	MOE, Red Cross, Ministry of Labour, JAS	Quarterly	Stigma & discrimination working group					
E2		Number of persons trained to provide services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					Yes
E8		Number of policy makers attending sensitisation workshops on HIV/AIDS/STI	Stakeholder & Regional Technical reports	Monthly	Policy Coordinator	TBD		100% increase over baseline	2012	
E9	PEPFAR	Number of local organizations provided with technical assistance for HIV-related policy development	Stakeholder & Regional Technical reports	Monthly	Policy working group	55	2006	110	2012	Yes

APPENDIX B: NSP Focus Indicators, Baselines and Targets

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
EMPOWERMENT & GOVERNANCE										
GOAL, PURPOSE	UNGASS	**UNGASS.** National Composite Policy Index	Country assessment	Every 2 years	NHP M&E Unit	TBD	2007			UNGASS tool adapted
GOAL, PURPOSE	UNGASS	**UNGASS.** AIDS spending, by category and financing source	Country Assessment	Every 2 years	NHP M&E Unit	TBD	2007			UNGASS tool adapted
G1		Number of persons trained to provide services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					Yes
G3	PEPFAR , World Bank	**PEPFAR.** Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)s ,	Stakeholder PEPFAR Reports: MOH M&E Unit, IISPEC, MEASURE	annually	NHP M&E Unit	80	2006	Approx. 100/year i.e. 450 by 2012	2012	Yes
G6		Number of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/standards	Stakeholder reports	Monthly	NHP M&E Unit/ Prevention Coordinator	TBD		TBD		Yes
G6	UNGASS	**UNGASS.** Percentage of schools that have provided life-skills based HIV/AIDS education in the last academic year	Educational program review	Every 2 years	Ministry of Education, focal point	24%	2007	TBD		Revised HFLE curriculum piloted in 24 schools in 2006.
G7		Number of policy makers attending sensitisation workshops on HIV/AIDS/STI	Stakeholder reports	Monthly	Policy Coordinator	TBD		TBD		Yes

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
IMPACT										
Goal	UNGASS, Global Fund, CARICOM	**UNGASS.** Percentage of men & women aged 15 to 24 that are HIV infected	ANC/STI Surveillance Report	Annually	National HIV Surveillance Officer	1.2% 1.5%	2002 2005	≤1.5%	FY 08	Yes, but HATS needs full implementation
Goal	UNGASS, USAID, World Bank	**UNGASS.** Percentage of SW who are HIV infected	SW Second Generation Surveillance	2005 and every 2 years	NHP M&E Unit	9%	2005	7%	2010	Yes
Goal	UNGASS, USAID, World Bank	**UNGASS.** Percentage of MSM who are HIV infected	MSM Second Generation Surveillance	2006 and every 2 yrs	NHP M&E Unit	25 to 30%	2007 estimate	< 25%	2011	Data collection in progress
	CARICOM	**CAR.** Prevalence of HIV among STI clients	STI Sentinel Surveillance Report[1]	Biennially	National HIV Surveillance Officer	4.6%	2005	< 4%	2006	Yes
	CARICOM	**CAR.** AIDS Case rate	HATS database updates	ongoing	National Surveillance Officer					Yes; need to fully implement HATS
OUTCOME										
P4, P15 (15-24 yrs)	UNGASS, Global Fund, World Bank, CIMT	**GFATM.** % of people by sex and age groups who reported condom use at last intercourse with non-regular partner	KABP	2004 and every 3-4 years	NHP M&E Unit	**Ages 15-49**				Yes
						M: 77.3% F: 71.7%	2000	M: 80% F: 75%	2011	
						M: 74 % F: 66%	2004			
P5	UNGASS, Global Fund, USAID, World Bank, CIMT	**UNGASS.** Percentage of SW reporting using a condom at last sex act with client	SW survey	2005 & every 2-3 yr	NHP M&E Unit	75% 84.3%	2003 2005	95%	2011	Yes
P6	UNGASS, Global Fund, World Bank	**UNGASS**. Percentage of men reporting using a condom the last time they had anal sex with a male partner	MSM survey	2006 & every 2-3 years	NHP M&E Unit	38%	2003	60% then increase by 10% over baseline	2012	Yes

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
OUTCOME										
P2	UNGASS, Global Fund, CARICOM, CIMT, World Bank	**UNGASS.** Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	KABP	2000, 2004 and every 3-4 years	NHP M&E Unit	M: 29.6% F: 33.4% M:36.2% F: 40.0%	2000 2004	M: 60% F: 60%	2011	Yes
P4, P11, P15, P17	GFATM	Percentage of young adults, 15 to 19 years old, who have never had sex	KABP	2004 and every 3-4 years	MOH	M: 27.6% F: 50.5%	2004	M: 35% F: 55%	2011	Yes
	UNGASS, CIMT	**UNGASS.** Percentage of donated blood units screened for HIV in a quality manner	Nat'l Blood Transfusion Service (NBTS) records	Annually	NBTS & Director-NPHL	100% 100%	2004 2005	100%		Yes
	UNGASS, World Bank, CIMT	**UNGASS.** Percentage of young men and women ages 15-24 who have had sexual intercourse before age 15	KABP	2004 and every 3-4 years	MOH/UWI	M: 47.7% F: 15.2%	2004	TBD		Yes

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
OUTCOME										
	UNGASS, GFATM, CIMT, World Bank	**UNGASS.** Percentage of young women and men aged 15-49 who had sex with more than one partner in the last 12 months	KABP	2004 and every 3-4 years	NHP M&E Unit	For ages 15-24 M:89% F: 78%	2004	TBD		Yes
						For ages 15-49 M: 54% F: 15%	2000			
						For ages 15-49 M: 48% F: 11%	2004			
	Global Fund	**GFATM.** Percentage of youth 15-19 years who reported no sexual activity in the last 12 months	Healthy Lifestyles Survey/KABP	every 3 - 4 years	MOH/ UWI	48%	2000	M:> 30% F: > 50%	FY 08	Yes
						M:27.6 % F:50.5%	2004			
	Global Fund,	**GFATM.** Percentage of 15-49 year olds who reported having sex with multiple partners in the last 12 months	KABP	2004 and every 3-4 years	NHP M&E Unit	M: 54% F: 15%	2000	M: 47% F: 15%	FY 08	Yes
						M: 48% F: 11%	2004			
	CIMT	**CIMT.** % of people 15-49 years old who can access a condom almost immediately (less than 5 minutes)	KABP	2004 and every 3-4 years	NHP M&E Unit	M: 94% F: 87%	2004	TBD		Yes

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
OUTPUT & PROCESS										
Purpose	Global Fund, USAID	**USAID.** Number of individuals reached through TCI including vulnerable groups, (e.g. youth, MSM, SW, prisoners, etc.)	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators	200,000	2005	240,000 then increase by 100% annually	2012	Yes - being implemented
Purpose P7-P10, P12, P16		Number of persons trained to provide prevention services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					Yes
	GFATM	**GFATM.** Percentage of schools that provided life skills-based HIV education in the last academic year"	Stakeholder reports	Annual	Ministry of Education	5% 25%	2006 2007	50% 65% 80%	2010 2011 2012	Yes
	GFATM	**GFATM.** Number of students reached through life skills-based Healthy and Family Life Education interventions in schools	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators	45,000	2006	100,000 150,000 200,000 250,000	2009 2010 2011 2012	Yes
	GFATM	**GFATM.** Number of adolescents (10-14) and youth (15-24) reached through prevention interventions in out-of-school setting	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators	33,000	2007	80,000	2012	Yes
	Global Fund, World bank	**GFATM.** Number of inmates, sex workers and MSM reached through prevention activities	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators	300 SW 300 MSM	2005	Cumulative 840 SW 620 MSM 1320 SW 980 MSM	FY 08 FY 09	Yes

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
OUTPUT & PROCESS										
	Global Fund	**GFATM.** Number of service deliverers trained on HIV/AIDS prevention	Stakeholder & Regional Technical reports	Monthly	BCC /HIV Coordinators	125	2003	510	FY 08	
	PEPFAR	**PEPFAR.** Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	Stakeholder PEPFAR Reports: MOH BCC	Annually	NHP M&E Unit	48	2006	TBD		
	PEPFAR	**PEPFAR.** Number of individuals trained to promote HIV/AIDS prevention *beyond* abstinence and/or being faithful	Stakeholder PEPFAR Reports: MOH BCC	Annually	NHP M&E Unit	56	2006	TBD		
	PEPFAR	**PEPFAR.** Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	Stakeholder PEPFAR Reports: MOH BCC, IISPEC, SDC	Annually	NHP M&E Unit	542	2006	TBD		
	PEPFAR	**PEPFAR.** Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful.	Stakeholder PEPFAR Reports: MOH BCC, SDC	Annually	BCC/ HIV Coordinators & M&E Unit	3,271	2006	TBD		Yes - being implemented

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #1: PREVENTION										
OUTPUT & PROCESS										
	PEPFAR	**PEPFAR.** Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behaviour change *beyond* abstinence and/or being faithful	Stakeholder PEPFAR Reports: MOH BCC	Annually	BCC/ HIV Coordinators & M&E Unit	69,417	2006	TBD		Yes - being implemented.

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
IMPACT										
GOAL	UNGASS, CARICOM, World Bank	**UNGASS.** Percentage of adults & children with HIV known to be on treatment 12 months after initiation of ART	Treatment database from EMR	Monthly	Treatment coordinator	75%	2006	90%	2012	In development, 2004 estimate based on UNGASS calculations
T2	UNGASS, Global Fund, GOJ, USAID, World Bank	**UNGASS.** Percentage of infants born to HIV-infected mothers who are HIV-infected	Regional HIV/AIDS Monthly Report (RHAMR)	Monthly	Regional Surveillance Officers & HIV Coordinators	25% 12% 10%	2000 2005 5006	< 10% < 5%	2007 2012	Regional Report; PMTCT database needs full implementation
T5	UNGASS, World Bank	**UNGASS.** Current school attendance among orphans and non-orphans, aged 10-14	MICS	every 5 yrs (Nov-Mar 2005-06)	UNICEF	0.99	2005	Maintain >0.9	2012	Yes
PURPOSE, T1	UNGASS, World Bank	**UNGASS.** Percentage of people by sex, age and at-risk group who received HIV testing in the last 12 months and who know the results	Surveys (MSM, SW, Healthy Lifestyles)	every 2 yr	NHP M&E Unit	SW: 43%	2005	50%	2012	Yes

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
OUTCOME										
PURPOSE, T3	UNGASS, Global Fund, World Bank	**GFATM.** Percentage of men, women & children with advanced HIV receiving antiretroviral combination therapy according to national guidelines	Treatment site reports	Monthly	Regional Surveillance Officers/ Treatment coordinator	Adult: 50 Children: 0 2745	2003 2006	Adult: 4,800 Children: 200, then 500/year	2009	Yes
T4	GoJ, GFATM	Percentage of PLWHA on ARV reporting at least 90% adherence by pill count	National Health Fund Database Adherence counsellor/ social worker reports	Monthly	Adherence counsellors, social workers, HIV Coordinators	75%	2006	>80%	2012	Yes
T9		Percentage of HIV positive incident TB cases that received treatment for TB and HIV	Regional Surveillance Officer Reports	Quarterly	Regional Surveillance Officers	TBD				Yes
T10		Incidence of congenital syphilis	Case reporting	Annually	STI Officer	26.2 per 100,000 births	2004	15 per 100,000 births	2012	
	World Bank, GOJ	**World Bank.** Percentage of ANC clients that are counselled and tested for HIV	Regional HIV/AIDS Summary Report form	Monthly	Regional Surveillance Officer/ HIV coordinators	96.3%	2005	Maintain >90%	2012	Yes
	Global Fund, UNGASS, CIMT, World Bank	**UNGASS.** Percentage of HIV positive pregnant women who received a complete course of ARV prophylaxis to reduce the risk of MTCT	Regional HIV/AIDS Summary Report form	Monthly	Regional Surveillance Officer/ HIV coordinators	< 10% 47% 74%	2002 2004 2005	80% 85%	FY 08 FY 09	Yes

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
OUTCOME										
	UNGASS, CIMT	**UNGASS.** Percentage of orphans and vulnerable children (boys and girls ages 0-17) whose households received free basic external support in caring for the child	MICS	every 5 yrs (Nov-Mar 2005-06)	UNICEF	M:13.2% F: 15.5%	2005	TBD		Yes.
	Global Fund, CIMT, World Bank	**GFATM.** Number of individuals counselled and tested for HIV according to guidelines and who know their results	Regional HIV/AIDS Summary	Monthly	Regional HIV coordinator/ NPHL	25,000	2002	280,000 480,000	FY 08 FY 09	Yes
	Global Fund	**GFATM.** Number of infants born to HIV+ mothers receiving PCR testing according to national standards	Regional HIV/AIDS Summary Report form	Monthly	Treatment coordinator	0	2003	Cumulative 650 850	FY 08 FY 09	Yes
	Global Fund	**GFATM.** Number of individuals (children & adults) receiving CD4 tests in the public sector according to national guidelines	Lab reports	Monthly	Treatment Coordinator	0	2003	Cumulative 2500 3000	FY 08 FY 09	Yes - needs refinement
	Global Fund, CIMT	**GFATM.** Number of individuals (children & adults) on ART receiving viral load testing in accordance with guidelines	Lab reports	Monthly	Treatment Coordinator					Yes - needs refinement

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #2: TREATMENT, CARE & SUPPORT										
OUTPUT & PROCESS										
T8, T12		Number of persons trained to provide services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					Yes
	Global Fund	**GFATM.** Number of public sector sites offering ART	Treatment Coordinator records	Annually	Treatment Coordinator					N/A
	Global Fund	**GFATM.** Number of PLWHA receiving adherence counselling	Treatment Site reports	Monthly	Treatment Coordinator	0	2003	3,800 adults 4,800 adults	FY 08 FY 09	N/A
	Global Fund	**GFATM.** Number of adherence support groups started by NGO/PAC partnerships using trained PLWHA	Stakeholder reports	Monthly	Global Fund Coordinator	0	2003	Cumulative 10 12	FY 08 FY 09	Yes

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #3: ENABLING ENVIRONMENT & HUMAN RIGHTS										
OUTCOME										
GOAL	GFATM, CIMT	**GFATM.** Percentage of people 15-49 yrs expressing accepting attitudes towards people with HIV/AIDS	KABP	2004 and every 3-4 years	NHP M&E Unit	M:8.7% F: 93%	2004	25%	2011	Yes
PURPOSE, E5	GFATM, World Bank	Number and percentage of reported cases of HIV-related discrimination receiving redress by setting	MOE, Red Cross, Ministry of Labour, JAS	Quarterly	Stigma & discrimination working group	25%	2006	75%	2012	Needs to be refined
E1	GFATM	**GFATM.** Number of cases of HIV-related discrimination reported by setting	MOE, Red Cross, Ministry of Labour, JAS	Quarterly	Stigma & discrimination working group					
	GFATM	**GFATM.** Number of large (>100 employees) private organizations not requiring pre-employment HIV tests	Workplace Survey	Nov 2005 & every 2-3 years	Ministry of Labour/M&E Unit	40	2003	70	FY 07	Yes
OUTPUT & PROCESS										
E2		Number of persons trained to provide services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					Yes
E8		Number of policy makers attending sensitisation workshops on HIV/AIDS/STI	Stakeholder & Regional Technical reports	Monthly	Policy coordinator	TBD		100% increase over baseline	2012	

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
PRIORITY AREA #3: ENABLING ENVIRONMENT & HUMAN RIGHTS										
OUTPUT & PROCESS										
	PEPFAR/ GFATM	**PEPFAR.** Number of local organizations provided with technical assistance for HIV-related policy development	Stakeholder PEPFAR Reports: Constella Futures	Annually	NHP M&E Unit	55	2006	80 90 100 110	2010 2011 2012 2013	Yes
	PEPFAR	**PEPFAR.** Number of local organizations provided with technical assistance for HIV-related institutional capacity building	Stakeholder PEPFAR Reports: MOH BCC, Deloitte & Touche, IISPEC, Constella Futures, UWI-HARP, MEASURE Evaluation	Annually	NHP M&E Unit	TBD		TBD		
	PEPFAR	**PEPFAR.** Number individuals trained in HIV-related policy development	Stakeholder PEPFAR Reports: Deloitte & Touche, Constella Futures	Annually	NHP M&E Unit	TBD		TBD		
	PEPFAR	**PEPFAR.** Number individuals trained in HIV-related institutional capacity building	Stakeholder PEPFAR Reports: Deloitte & Touche, IISPEC, SDC, Constella Futures, MEASURE Evaluation	Annually	NHP M&E Unit	48	2006	TBD		

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
EMPOWERMENT & GOVERNANCE										
OUTCOME										
GOAL, PURPOSE	UNGASS	**UNGASS.** National Composite Policy Index	Country assessment	Every 2 years	NHP M&E Unit					UNGASS tool adapted
GOAL, PURPOSE	UNGASS	**UNGASS.** AIDS spending, by categories and financing source	Country assessment; UNFPA Survey of fin resource flow/ Financial database	Every 2 years	Finance unit & NHP M&E Unit	TBD	2007			UNGASS tool adapted
G1		Number of persons trained to provide services by client and service area	Stakeholder & Regional Technical reports	Monthly	BCC & HIV Coordinators					Yes
G3	PEPFAR, World Bank	**PEPFAR.** Number of individuals trained in strategic information (M&E and/or surveillance and/or HMIS)	Stakeholder PEPFAR Reports: MOH M&E Unit, IISPEC, MEASURE	annually	NHP M&E Unit	80	2006	100 per year i.e. 500 by 2012	2012	Yes
G6	UNGASS/ GFATM	**UNGASS.** Percentage of schools that have provided life-skills based HIV/AIDS education in the last academic year	Educational program review	Every 2 years	Ministry of Education, focal point	5% 24%	2006 2007	65% 80%	2011 2012/2013	Revised HFLE curriculum piloted in 24 schools in 2006. 2005 MOE programme estimate

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
EMPOWERMENT & GOVERNANCE										
OUTPUT & PROCESS										
G6		Number of NGOs providing HIV/AIDS prevention, treatment, care and support services according to national guidelines/standards	Stakeholder reports	Monthly	NHP M&E Unit/ Prevention Coordinator	TBD		TBD		Yes
G7		Number of policy makers attending sensitisation workshops on HIV/AIDS/STI	Stakeholder reports	Monthly	Policy Coordinator	TBD				Yes
	PEPFAR,	**PEPFAR.** Number of local organizations provided with technical assistance for strategic information activities (M&E and/or surveillance and/or HMIS)	Stakeholder PEPFAR Reports: IISPEC, MEASURE	Annually	NHP M&E Unit	1	2006	TBD		Yes
	CIMT	**CIMT**. Number of individuals trained in HIV-related community mobilization and for prevention, care and/or treatment (male & female)	Stakeholder & Regional Technical reports	monthly	Regional HIV & BCC Coordinators/F 135 NHP M&E Unit	TBD		TBD		Yes
	CIMT	**CIMT.** Number of indigenous organizations provided with technical assistance for HIV-related institutional capacity building	Stakeholder & Regional Technical reports	monthly	Regional HIV Coordinator/ NHP M&E Unit	TBD		TBD		Yes
	World Bank	Number of implementing partners reporting on NSP indicators	Stakeholder & Regional Technical reports	monthly	NHP M&E Unit	100%		100%	2012	

APPENDIX C: Complete Indicator Matrix

NSP	Reporting	Indicator	Data source	Frequency	Responsible Person/ Unit	Baseline		Target		Data tools developed?
						Value	Year	Value	Year	
EMPOWERMENT & GOVERNANCE										
OUTPUT & PROCESS										
	World Bank	Number of implementing partners that have incorporated M&E components in their work plans	Stakeholder & Regional Technical reports	monthly	NHP M&E Unit	80	2006	350	2012	
	World Bank	Completion of computerization for: -NPHL -Nation Blood Transfusion services -surveillance system --drug inventory nationally and at regional treatment centers	Desk review	annually	NHP	Ongoing		2012	Complete	

APPENDIX D: TOR for the MERG

Terms of Reference for the NHP M&E Reference Group

Goal: To monitor and evaluate the effectiveness of the National HIV/STI Programme in Jamaica by tracking program inputs, outputs and assessing their impacts.

1. Present and share the current knowledge on the status and trends of the HIV/AIDS epidemic in Jamaica.
2. To review the various epidemiological and behavioural pattern in the HIV/AIDS affected communities and to explore current issues.
3. To identify and design effective interventions to address the HIV/AIDS epidemic.
4. To review and analyse monthly, quarterly and annual statistical reports prior to dissemination.
5. To review monitoring and evaluation tools, mechanisms developed for surveillance and other research studies on HIV/AIDS/STI.
6. To generate information needed to guide the National HIV/STI Programme.
7. To evaluate and monitor the progress of projects linked to the National HIV/STI Programme.
8. To review and tailor Monitoring and Evaluation system for the Programme.
9. To review the resource needs to develop an effective and integrated Monitoring and Evaluation systems in the Health Regions.
10. To review program indicators on a regular basis
11. To meet program requirements in reporting.