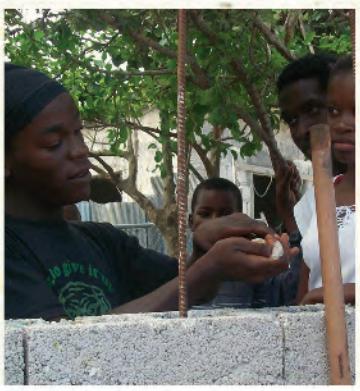
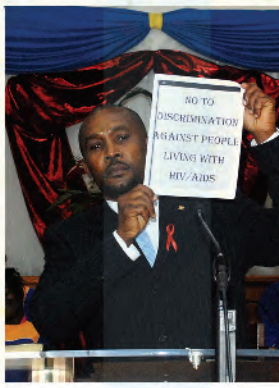
Ministry of Health, Jamaica
National HIV/ STI Programme

Annual Report 2010





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National HIV/STI Programme

MINISTRY OF HEALTH

Ministry of Health, Jamaica
National HIV/ STI
Programme Annual Report

2010 Editor: Debbie Carrington
Produced by: 360 Cre8tions Ltd

Message- Minister of Health

Honourable Rudyard Spencer

The work of the National HIV/STI Programme (NHP) for the past 24 years has been far reaching, cutting across ministries, agencies, private sector businesses, non-governmental organizations and civil society. Tackling the HIV/AIDS epidemic calls for a comprehensive, coordinated, and targeted intervention among all stakeholders and the NHP has made steady progress in this area by harmonizing its activities with relevant stakeholders.

The year, 2010, was successful, particularly in the areas of treatment and prevention that has taken us one step closer to fulfilling our commitment to the Millennium Development Goal of halting and reversing the spread of HIV/AIDS by 2015.

Since 2004, the number of deaths reported each year has decreased which is largely due to increased access and availability of antiretroviral treatment. The incidence of HIV has been lowered this year and mother-to-child transmission maintained at below 5%. Prevention is a critical component in the fight against HIV and funds allocated to this area was fully exploited through targeting most-at-risk populations such as sex workers (SW), men who have sex with men (MSM), persons living with HIV (PLHIV) and inmates.

The major financial supporters of the programme, namely the World Bank, Global Fund, United States Agency for International Development's (USAID), President Emergency Plan for AIDS Relief (PEPFAR) and United Nations Agency for International Development (UNAIDS) allocated considerable amounts of funds to drive the response to the HIV/AIDS epidemic in our country. The Government of Jamaica is extremely grateful for the continuous support of these organizations. Increased funding was a significant factor that accelerated the programme's agenda especially for capacity building, policy, monitoring and evaluation.

I want to acknowledge every member on the National HIV/STI Programme that has demonstrated great enthusiasm for the work they do, coupled with expertise, commitment and innovative thinking. Increased funding has been an essential catalyst for the growth and expansion of the programme, but it is the invaluable work of every team member that secures the longevity and success of the programme.

As we embark on achieving targets, getting closer to achieving the Millennium Development Goals, we reflect on the successes and challenges we encountered this year. Homophobia, stigma and discrimination and the early initiation of sexual activity among our teenagers are problems we continue to grapple with. Nevertheless, the Ministry of Health is committed to allocating necessary funding and partnering with various stakeholders to sustain this public health programme.

Hon. Rudyard Spencer, OD, MP
Minister of Health

Foreword Director, National HIV/ STI Programme

Dr. Kevin Harvey

In response to the current trends in the national HIV epidemic, the National HIV/ STI Programme (NHP) was deliberate in systematically strengthening and expanding programmes aimed at universal access throughout 2010.

Special emphasis was placed on HIV prevention efforts. The HIV prevention working group was established and is comprised of stakeholders from the public and private sectors as well as civil society. Their mandate was to provide a forum to review, evaluate and assess prevention efforts for Jamaica's most-at-risk populations (MARPS). Simultaneously, behaviour change communication (BCC) capacity building workshops were held for the entire prevention team, inclusive of managers, field coordinators and officers from the national, regional and parish levels.

The main objective of these training sessions was to ensure that all teams were cognizant of BCC principles, as well as the intervention strategies designed to increase coverage, reach and increase the effectiveness of monitoring MARPS. The acquisition of two mobile clinics equipped the outreach team to fulfill the mandate to scale up the offerings of voluntary counselling and testing (VCT). Both buses became fully operational in April, 2010 resulting in scaled up VCT in the South East Regional Health Authority (SERHA). The positive prevention strategy continued to be applied in 2010 and was focused on increasing coverage and support to HIV positive persons through two of the main components; individually focused health education and peer support groups.

In 2010, there were five major media campaign placements. The placement of the Stick to ONE Partner media campaign was highly relevant as Jamaica has a relatively high rate of multiple partnerships. The Get Tested media campaign was designed as a part of strategic efforts to increase HIV testing island wide. It has long been documented that HIV is a developmental issue, which means that sectors outside of health must be involved in the response if we hope to make a positive impact on the epidemic. The key ministries involved in the response, in Jamaica, during 2010 were the Ministry of Labour and Social Security (MLSS), Ministry of National Security (MNS) and the Ministry of Tourism (MoT).

HIV related stigma and discrimination remained an enormous barrier to the national HIV response. Therefore, discrimination reduction was prioritised as a key method of achieving an enabling environment. Discrimination reduction initiatives in collaboration with the Ministry of Education were under taken in 2010 and an anti stigma & discrimination training manual was developed for youth leaders. Additional strategies utilized in 2010 aimed at reducing stigma and discrimination included further development of the National HIV Related Discrimination Reporting and Redress System (NHDRRS) and the HIV Workplace Policy Programme, as well as increased advocacy among high level leadership and focusing policy and legislative approaches. Another major activity aimed to address HIV related stigma and discrimination during 2010 involved qualitative research among faith-based organization (FBO) leaders and stakeholders regarding

Foreword Director, National HIV/ STI Programme cont'd

their knowledge, attitude, practice and behaviour (KAPB) to most-at-risk population groups (MARPS). The data will be used to guide our work with FBOs.

As in previous years, during 2010, more persons living with HIV (PLHIV) accessed antiretroviral (ARV) treatment. There were 8,016 persons (7,560 adults and 456 children) on antiretroviral treatment as at December 31, 2010. The less than 5% chance of HIV transmission from mother-to-child was sustained and the elimination of congenital syphilis was achieved in 2010. In spite of these successes, adherence remains a major challenge to the success of the treatment and care programme.

Other Sexually Transmitted Infections (STIs) provide a vehicle for HIV transmission and as such the incidence of STIs must be constantly monitored. While new clients with STIs declined in 2010, the number of "revisits/old clients" increased particularly in the south east and north east health regions. This highlights the need for continued interventions among STI clinic attendees.

Monitoring and evaluation continues to play a fundamental role in the national HIV response; the outputs for 2010 have been used to chart the way forward for 2011 and beyond. During 2011, areas of foci include MARPS, maintaining the gains amongst the PLHIV and the intensification of HIV prevention efforts.

Table of Contents

Page Number

List of Tables

Page Number

List of Figures

Page Number

List of Figures

Page Number

1. The Epidemiology of HIV in Jamaica

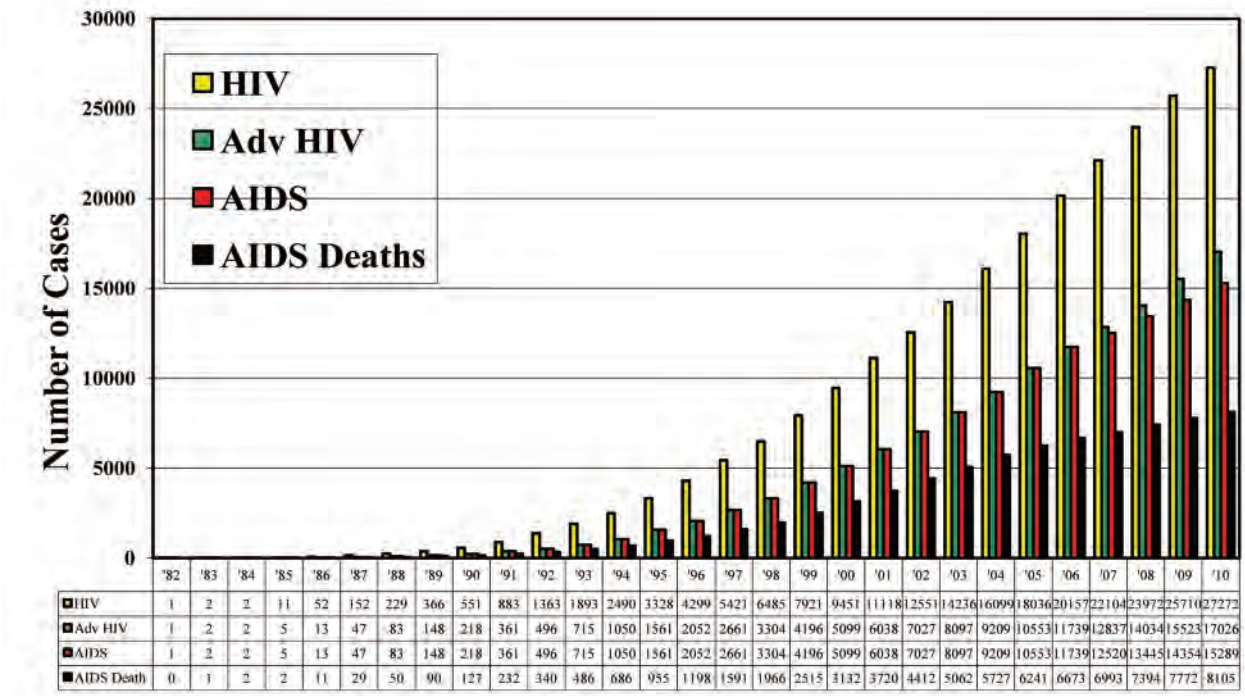
Jamaica had an estimated HIV prevalence of 1.7% in the general population. However the prevalence values recorded in vulnerable populations were higher: men who have sex with men (MSM), 31.8%; crack/cocaine users, 5%; sex workers (SW), 4.9%; prison inmates, 3.3% and persons attending sexually transmitted infection (STI) clinics, 2.4% (Table 1).

INDICATORS	JAMAICA
HIV prevalence rate, aged 15-49	1.5% (2005, sentinel surveillance of antenatal sites) 1.3% (2007, sentinel surveillance of antenatal sites) 1.2% (2009, sentinel surveillance of antenatal sites)
HIV prevalence rate among SW	9.0% (2005, second generation surveillance of SW) 4.9% (2008, second generation surveillance of SW)
HIV prevalence rate among MSM	31.8% (2008, MSM second generation surveillance)
HIV prevalence rate among STI clinic attendees	4.6% (2005, sentinel surveillance of STI clinic attendees) 3.6% (2007, sentinel surveillance of STI clinic attendees) 2.4% (2007, sentinel surveillance of STI clinic attendees)
HIV prevalence rate among inmates	3.3% (2006, surveillance of inmates)
Reported AIDS deaths	378 (2009), 330 (2010)

Table 1: Epidemiological profile, HIV/ AIDS indicators

It was estimated that 32,000 persons are living with HIV in the island and at least half of them are unaware of their status (UNAIDS, 2010). Between January 1982 and December 2010, the Ministry of Health received reports of 27,169 persons with HIV which included 15,209 persons with AIDS. Of the persons reported in 2010, one thousand, five hundred and three persons were staged as advanced HIV compared to 1,489 persons in 2009 (Figure 1). Of these persons, 935 were diagnosed with AIDS compared to 909 in 2009 and 1,112 persons in 2004. The 2010 figure represents a 16% decline in AIDS cases since the introduction of public access to antiretroviral therapy in 2004. Of note, the number of reported AIDS cases has not changed significantly over the past three years.

1. The Epidemiology of HIV in Jamaica cont'd



	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10
HIV	1	2	2	11	52	152	229	366	551	883	1363	1893	2490	3328	4299	5421	6485	7921	9451	11118	12551	14236	16099	18036	20157	22104	23972	25710	27272
Adv HIV	1	2	2	5	13	47	83	148	218	361	496	715	1050	1561	2052	2661	3304	4196	5099	6038	7027	8097	9209	10553	11739	12837	14034	15523	17026
AIDS	1	2	2	5	13	47	83	148	218	361	496	715	1050	1561	2052	2661	3304	4196	5099	6038	7027	8097	9209	10553	11739	12520	13445	14354	15289
AIDS Death	0	1	2	2	11	29	50	90	127	232	340	486	686	955	1198	1591	1966	2515	3132	3720	4412	5062	5727	6241	6673	6993	7394	7772	8105

Figure 1: HIV, Advanced HIV, AIDS and AIDS deaths reported in Jamaica by year, 1982-2010

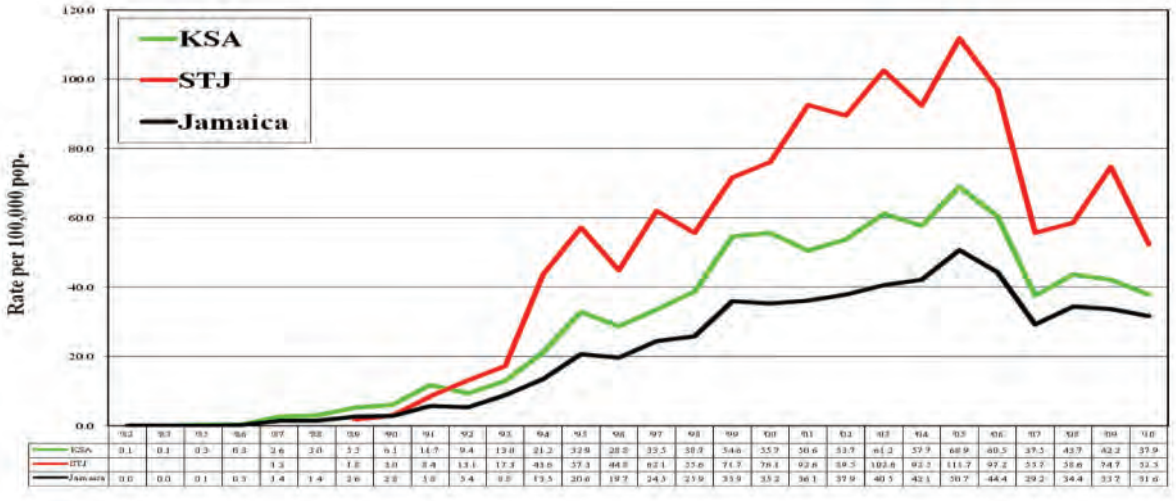


Figure 2: Annual AIDS case rates in Jamaica, St. James and Kingston & St. Andrew, 1982– 2010

1. The Epidemiology of HIV in Jamaica cont'd

The most urbanized areas continued to be more affected with the annual AIDS case rates in the two parishes with cities exceeding the case rate for the island (Figure 2).

Approximately 74% of all AIDS cases reported in 2010 are in the 20-49 year old age group, representing a slight increase from 69% of cases in 2008. Eighty six percent of all AIDS cases reported in 2010 were between 20 and 60 years old. The distribution of cases in 2010 reflects the distribution for all AIDS cases reported since 1982 (Figure 3).

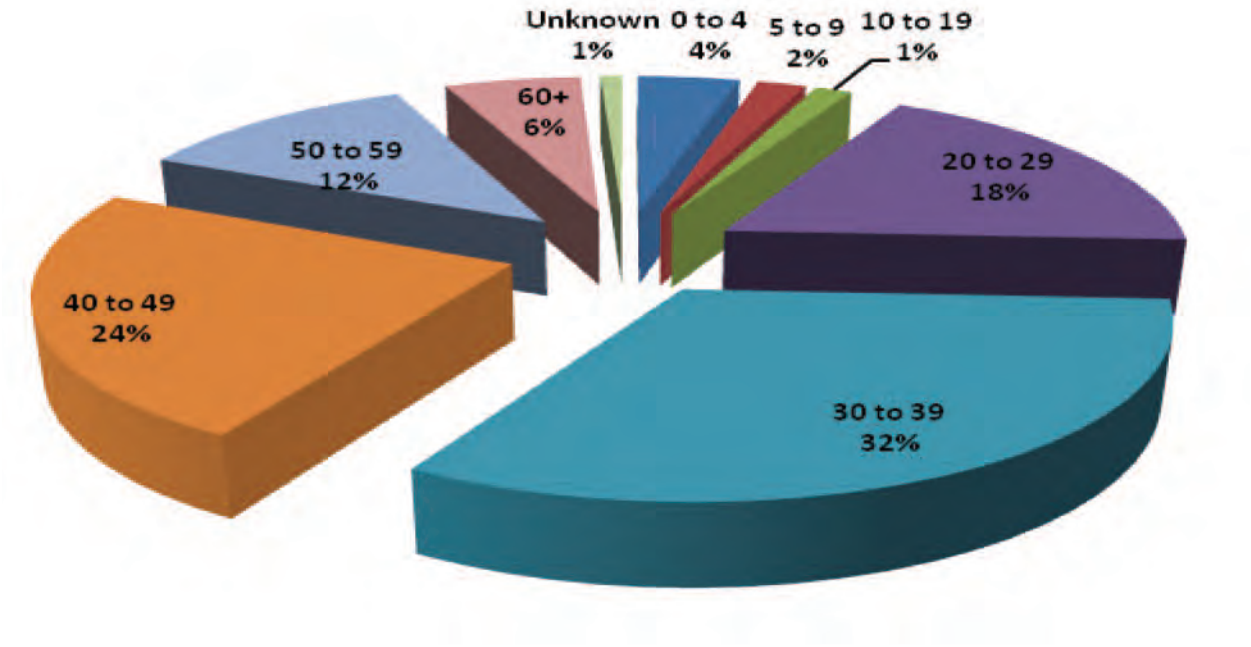


Figure 3: AIDS cases reported by age group, 1982 – 2010

In Jamaica, the primary route by which HIV was transmitted continued to be sexual intercourse. Among all reported adult HIV cases on whom data about sexual practices were available (77% of cases), heterosexual practice was reported by more than 95% of persons. In 2010, the sexual practice of 43% of men reported with HIV (and 41% of men reported with AIDS) was unknown. This was due to inadequate investigation and reporting of cases as well as unwillingness of cases to reveal their sexual orientation. Of the total number of men reported with HIV, 4% (571) self-identified as bisexual and 3.5% (464) self-identified as homosexual.

Among reported HIV cases on whom risk data were available, the main risk factors fuelling the epidemic were multiple sex partners, history of STIs, crack/cocaine use, and sex with sex workers. There was also a significant proportion of reported HIV cases for whom no high risk behaviour was reported; this may represent persons who report having only one sex partner who was HIV infected by another partner (Table 2). There has been no significant change in the distribution of the reported risk factors and sexual practices among persons diagnosed with HIV/AIDS in the last decade.

1. The Epidemiology of HIV in Jamaica cont'd

RISK	NUMBER OF PERSONS (%)
Sex with sex workers	3,773(20.1)
Crack/ cocaine use	1,188 (6.5)
STI history	8,653 (47.4)
Intravenous drug use	149 (0.8)
Multiple sexual partners/contacts	Estimated >80%
No high risk behaviour	5,215 (28.6)

Table 2: Reported risk behaviours among adults with HIV (January 1982 – December 2010 cumulative)

**N= 18,260

Poverty and socio-cultural practices combined with high risk behaviours continue to fuel the epidemic. The most recent national knowledge, attitude, behaviour and practices (KABP) survey conducted in 2008 revealed that high risk behaviours such as multiple partners, inconsistent condom use and early sexual debut persist. Specifically, 39% of sexually active persons admitted to having more than one partner within the last 12 months and of these, 47% did not use condom at last sex. More than 60% of persons with multiple partners who did not use condoms at last sex felt that they had little or no chance of being infected with HIV.

The KABP data also revealed that condom use with non-regular partners increased among men (84% in 2008, compared to 74% in 2004 and 78% in 2000) but decreased among women (66% in 2008 and 2004, compared to 71% in 2000). Failure to use condoms in high risk situations and failure to recognize risky behaviour were also observed in vulnerable populations such as SW and MSM. As a driving factor, the growth of sex tourism and the local sex work industry is considered to have contributed significantly to the spread of HIV. Reaching vulnerable groups continued to be challenging as the current legislative framework hinders disclosure and drives some persons at risk underground. The interventions with these populations and HIV testing were scaled up during 2010 as evidenced by the key output indicators tracked under the Global Fund Project (Annex 2).

2. Prevention: Most At-Risk Populations

In response to the current trends existing in the national HIV epidemic, the Prevention Component of the National HIV/ STI Programme was deliberate in systematically strengthening and expanding interventions to reach the most-at-risk populations (MARPS) throughout the island during 2010. In the context of the HIV epidemic in Jamaica, the following populations were considered to be MARPS: men who have sex with men (MSM), sex workers (SW), out-of-school youth (OSY), in-school adolescents, homeless drug users and prison inmates. Additionally, targeted interventions were also conducted with STI clinic attendees, adults 19 -49 years old, males 19 -39 years old and persons living with HIV (PLHIV). The core prevention messages were: consistent condom use, lubricant use, HIV testing, partner reduction and delay of sexual debut. These messages were audience specific, for example lubricant use has been designed to reach SW and MSM.

To further provide guidance to the prevention efforts, the HIV Prevention Working Group was established in April 2010. This group was comprised of stakeholders from the public and private sectors as well as civil society. Their mandate was to provide a forum to review, evaluate and assess prevention efforts for Jamaica's MARPS in order to identify gaps, build consensus regarding the prevention response and document best practices. During the period under review, there were two working groups, one which focused on SW and MSM, facilitated by the United Nations Population Fund (UNFPA) and the other, which focused on youth.

Behaviour change communication (BCC) capacity building training workshops were held for the entire prevention team inclusive of managers, supervisors and field interventionists from the national, regional and parish levels. The main objective of these training sessions was to ensure that all team players were fully cognisant of BCC principles as well as the intervention strategies designed to increase coverage, reach and increase the effectiveness of monitoring MARPS.

A needs assessment conducted with team members and stakeholders guided the design of these capacity building workshops. Increased training in the basic concepts of behaviour change communication, specifically the 'Stages of Change' and the 'Precede- Proceed' models, the two main models underpinning the interventions for MARPS, was identified as a major need along with: determinants of risky behaviours, the intervention strategies to reach MARPS and implementation skills for MARPS interventions.

The training was completed in the last quarter of 2010. Following the workshop, participants were required to implement an intervention designed in the workshop using the, Precede-Proceed, model. These interventions will be monitored and evaluated over a six month period.

The targeted interventions for MARPS were standardized to reflect basic inputs of: risk reduction conversations, building correct condom use skills, condom negotiation skills, improving self efficacy, voluntary counselling and testing and referrals and reduction of social vulnerability and social inclusion. These strategies were piloted and are being implemented island wide.

Men Who Have Sex With Men (MSM)

There was significant improvement in the coverage of the MSM population by the regional health authorities (RHAs) during the period under review. There are four RHAs in Jamaica: South East (SERHA), North East (NERHA), Western (WRHA) and Southern (SRHA). The observed improvement in coverage was achieved through focussed efforts on the implementation of the MSM HIV Prevention Strategy. Initiatives which helped to build in-roads with the population included the Men's Health Workshops and the recruitment of community peer educators to work directly with the MSM community. The highest number of contacts with the population was achieved by NERHA which reached 617 MSM during the year (Table 3).

REGIONAL HEALTH AUTHORITY	NUMBER OF MSM REACHED	NUMBER OF CONDOMS DISTRIBUTED	UNITS OF LUBRICANT DISTRIBUTED	NUMBER OF MSM TESTED FOR HIV
NERHA	617	952	276	66
SERHA	509	10,156	2,530	161
SRHA	149	2,557	651	40
WRHA	590	25,000	1,055	55
Total	1,865	38,665	4,512	322

Table 3: Number of MSM reached by Regional Health Authority, 2010

EMPOWERMENT WORKSHOPS:

In 2010, the Men's Health Workshops conducted by the RHAs and the sub-recipient, Children First were standardized. In view of the high HIV prevalence among MSM of 31.8% (2008), voluntary counselling and testing for HIV (VCT) remained integral to the intervention as a means of ensuring that persons are aware of their status and to encourage personal responsibility. Based on the data, this initiative was fairly successful with approximately 68% of participants undergoing testing (Table 4). Reportedly, persons who opted out of VCT were recently tested for HIV and thus aware of their status.

	NUMBER OF MSM REACHED	NUMBER OF MSM TESTED FOR HIV
NERHA	51	11
SERHA	133	119
SRHA	56	40
WRHA	102	55
CHILDREN FIRST	18	18
Total	360	243

Table 4: MSM reached and tested for HIV during Men's Health Workshops held in 2010

2. Prevention: Most At-Risk Populations cont'd

Participants were exposed to programmes offered by HEART Trust NTA, Jamaican Foundation for Lifelong Learning (JFLL) and the National Council on Drug Abuse (NCDA) to assist in addressing the issues of employability, literacy and drug use. There were 20 beneficiaries from the programmes with HEART/NTA and JFLL.

Post-workshop "lymes" were held as a way of maintaining contact with the participants. These activities were used as an opportunity to reinforce safer sexual behaviours as well as facilitate the identification of new participants.

PARTNERS:

The major partners in reaching the MSM population were the Jamaica Red Cross and Jamaica AIDS Support for Life (JASL). During 2010, Jamaica Red Cross continued to focus on their MSM Peer Education Programme. Thirty-nine MSM were trained in the use of a risk reduction questionnaire designed to facilitate in-depth discussion with peers regarding sexual risk behaviours and prevention planning. Three hundred and fourteen MSM were reached via this mechanism.

The Peer Influencers Programme implemented by JASL, which operates from Kingston, Montego Bay and Ocho Rios, continued to add value to the work and services provided by the organization. Through individual and group interventions at the community level, the programme has improved in reach, coverage, condom distribution and referrals. Through the programme 102,742 male condoms, 15,882 female condoms and 14,648 units of lubricant were distributed and 8,889 MSM engaged with risk reduction messages. In addition to targeting MSM in general, this organization also specially caters to hearing impaired and homeless MSM, SW (both male and female) and persons living with and affected by HIV and AIDS.

PARTY INTERVENTION:

Parties and other social events are considered critical mechanisms by which to reach this largely underground priority population. However, due to violence, parties were significantly decreased in number during 2010 with only one such event being held in SERHA. Risk assessment and risk reduction conversations were conducted along with lubricant and condom distribution and demonstrations.

There was also one social event targeting the lesbian, gay, bisexual and transgender (LGBT) community. Approximately 75 males and females were reached. The event featured an MSM friendly movie. In addition to the condom distribution and demonstrations, the opportunity was used to display MSM specific risk reduction messages on screen during the showing.

CHALLENGES:

The BCC Unit has been working assiduously to strengthen the MSM interventions to ensure a holistic response to the community. There has been notable improvement in coverage and increased health seeking behaviour of the community. However, the homeless amongst this community are at even greater risk and before any behaviour change interventions will have an impact, social interventions to satisfy their basic needs for food and shelter must be addressed. MSM sex workers also require a unique intervention and the development and implementation of this activity will be a priority in the upcoming period.

2. Prevention: Most At-Risk Populations cont'd

Female Sex Workers (FSW)

The HIV prevalence among FSW has made a significant decline from 9% in 2005 to 5% in 2010. This success has been attributed to the comprehensive approach in interventions among this population. The strategies involved include: onsite risk reduction conversations, condom and lubricant distribution, onsite VCT and more recently, empowerment workshops and initiatives to reduce social vulnerability.

Despite this success, critical areas remain to be addressed. These include provision of psychosocial support for FSW, increased access to prevention services and opportunities for empowerment. The national programme's interventions with sex workers consider the whole person and have covered a wide range of activities from assistance in obtaining a birth certificate to building the confidence, efficacy and self worth to demand safe sex.

In 2010 there was a tremendous thrust towards skills building. Some of the successful outcomes were:

- Opportunities for remedial education training through the JFLL
- The women benefited from an eight week training course in housekeeping and janitorial services through the Institute of Workplace Education and Development (IWED)
- Empowerment workshops facilitated participants opening bank accounts for the first time and one individual accessed a small business loan to open a cook shop
- Start-up funds were disbursed to persons interested in itinerant vending
- One person started chicken rearing.

Between the RHAs and the HIV Outreach Team (HOT) operating out of the NHP, a total of 2,827 FSW were meaningfully engaged in 2010. This number does not include the many contacts made with FSW that consisted only of condom distribution and brief dialogue. Meaningful interaction is defined as: risk reduction conversations, condom skills building, VCT, HIV basic facts sessions and referral for STI screening (Figures 4 & 5).

Figure 4: Number of sex workers tested for HIV during 2010

2. Prevention: Most At-Risk Populations cont'd

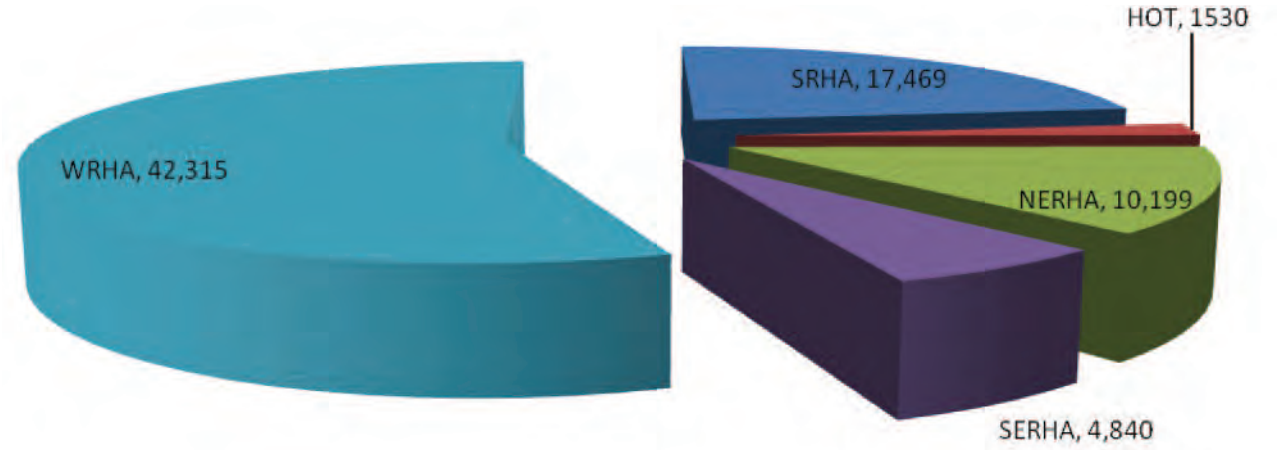


Figure 5: Number of condoms distributed to sex workers during 2010

Patrons at sex sites were engaged in prevention interventions in a similar fashion to sex workers. Risk reduction conversations were conducted, condoms and lubricants distributed and VCT was offered.

EMPOWERMENT WORKSHOPS:

A total of 490 FSW participated in empowerment workshops across the island (Figure 6). The aim of the empowerment approach is to reduce the social vulnerability of sex workers. Participants benefit not only from HIV/AIDS information and prevention tools but also from exposure to information and services offered by external agencies such as the NCDA, Registrar General's Department (RGD), JFLL, HEART Trust NTA and financial institutions. The workshops also cover issues such as parenting and conflict resolution.

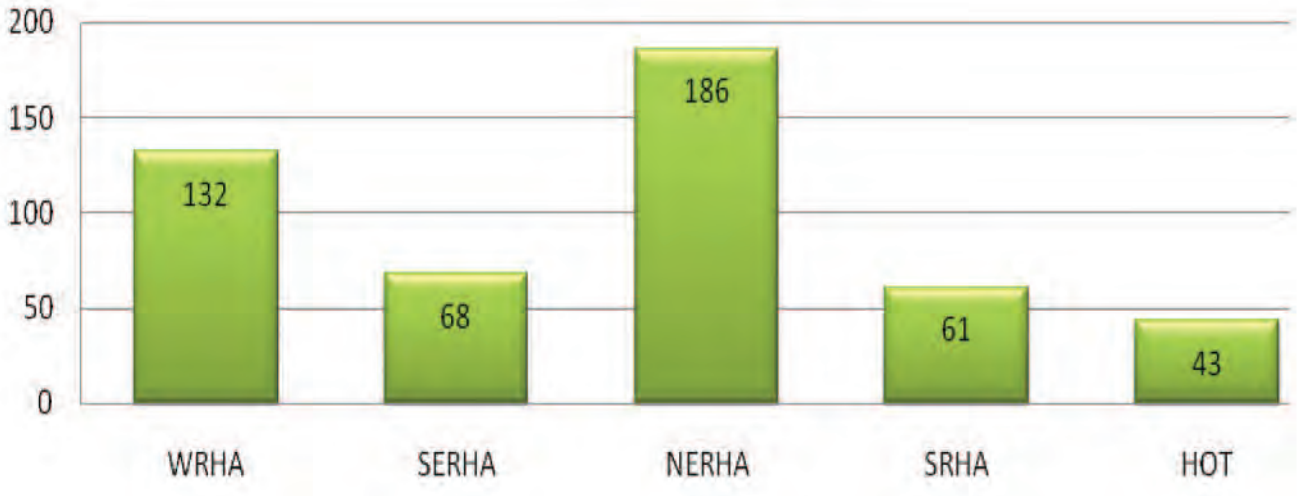


Figure 6: Number of sex workers reached via empowerment workshops

PARTNERS:

The two major partners reaching FSW are Children First and Jamaica Red Cross. The NHP and Children First entered into a memorandum of understanding aimed at reducing the vulnerability of young women engaging in transactional sex in a fishing village in St. Catherine. The services offered were: awareness raising sessions covering the topics of sexual exploitation, adult reproductive health and HIV/AIDS, parenting workshops/ HIV sensitization, community-based sensitization interventions and remedial education.

The Jamaica Red Cross agreed to house a drop-in centre to provide services to FSW. The centre was mandated to deliver the following: empowerment workshops, VCT, condom skills building, parenting workshops, Pap smears and STI screening by a medical doctor and home work sessions and interventions for the children of FSW accessing services.

Youth Interventions

ADOLESCENTS IN SCHOOL:

The "Hold On, Hold Off" school intervention complimented the Ministry of Education (MOE)'s revised Health and Family Life Education (HFLE) Curriculum and strategy to reach youth attending school with information on HIV, sexual and reproductive health (SRH) and life skills based information, amongst other critical areas. This intervention programme was designed mainly for students and schools situated in lower income communities.

The programme was geared towards working with young people in the lower classes in the Junior High and High School settings, the staff at the institutions as well as the parents. The summer camp which was one of the final activities of the intervention was included to achieve sustainability as students were trained as peer educators. Young people in three of the four health regions successfully conducted these sessions (Table 5). The programme was not implemented in the western region.

REGION	NUMBER OF SCHOOLS	NUMBER OF MALES	NUMBER OF FEMALES	NUMBER OF SUMMER CAMPS	NUMBER OF PEER EDUCATORS
NERHA	10	230	309	10	539
SERHA	8	1,206	1,123	3	75
SRHA	2	18	24	2	42
Total	20	1,454	1,456	15	656

Table 5: The "Hold On, Hold Off" school intervention

PARTNERS:

The primary partners in reaching youth in school during 2010 were the MOE and Ashe Ensemble. During 2007, the MOE adapted the Caribbean Community (CARICOM) HFLE Regional Curriculum Framework for ages 9-14 years and revised Jamaica's HFLE curricula for grades 1-6 and 7-9. This led to the incorporation of a life- skills based approach to teaching, as well as the use of interactive teaching methodology in the delivery of the HFLE Programme. There are four thematic areas:

- 1. Self and interpersonal relationships
- 2. Sexuality and sexual health including HIV
- 3. Appropriate eating and fitness
- 4. Managing the environment.

The life-skills approach promotes the development of healthy lifestyles and encourages students to make better decisions that will positively influence their values, attitudes and behaviours. The MOE is currently in the process of implementing this revised HFLE Programme in all government and independent schools in Jamaica, on a phased basis, to be completed in the year 2012. During 2010, 87% coverage of primary and secondary schools (i.e., 340,298 students) was achieved. Through support from the United Nations Children's Fund (UNICEF), the MOE will extend the programme to early childhood institutions in 2011.

The progress and the impact of the implementation of the HFLE curricula in primary and secondary schools in Jamaica were evaluated in 2010. The following were specifically assessed: (i) the impact of life-skill teaching on the knowledge, attitudes, behaviours and practices of adolescents exposed to the revised curriculum; (ii) the quality and effectiveness of teacher training and performance in the delivery of the life- skills methodology in teaching the program; (iii) the extent to which HFLE has been incorporated into the school's academic structure, especially as it relates to time-tabling and the assignment of classroom teachers to the subject; and (iv) acceptability of HFLE among students, teachers and parents.

Preliminary findings of the survey showed that students from HFLE schools reported more positive attitudes and norms, greater knowledge and fewer risk behaviours than students from their matched non-HFLE schools. In comparison with male students, female students were more knowledgeable about HIV/AIDS, were less involved in physical fights and drug use, exhibited less risky sexual behaviours, were more likely to practise healthy life style choices, were better informed about appropriate eating and fitness habits, were more likely to protect the environment, and had superior skills for everyday living.

There were however, instances in which non-HFLE schools performed better than HFLE schools on HFLE indicators. This was attributed to the sub-optimal implementation of the programme in some HFLE schools. To improve the delivery of HFLE, one of the recommendations from the study was to invest in teacher training to better equip teachers to deliver the curriculum.

ASHE Ensemble delivered the musical production "SAFE, STUPID or WHAT?"to three secondary schools in the corporate area. Through collaboration with the RE TV School Tour which showcased popular artistes;

students from St. Andrew College, Waterford High and Innswood High Schools in Kingston all benefited. In the upcoming year, the "SAFE, STUPID or WHAT?" drama piece will be presented in low-income vulnerable communities to further strengthen the interventions targeting OSY.

OUT-OF-SCHOOL YOUTH (OSY):

The regional health authorities and numerous non-governmental organizations combined their efforts to achieve the desired outcomes in the OSY population. This group of youth are defined as young people within the age group 15 – 24 years, who have stopped from school before completing their tenure or those who have finished school but are without skills. These individuals exhibit risky sexual behaviour and are apparently lacking the knowledge and skills to allow them to make informed choices. The interventions seek to address issues of economic and social vulnerabilities and risky sexual practices. They also offer HIV testing and seek to build life skills through risk reduction and self efficacy enhancing interactions.

The regional teams worked with OSY in their respective targeted community interventions (TCI). Over 9,000 youth were engaged by the combined teams during the review period. All participants were engaged in risk assessment, risk reduction conversations, as well as skills-building exercises for condom use and condom negotiation.

In addition to the above mentioned activities, empowering the youth to assist them in improving their quality of life was also important to these interventions. Some of the more successful outcomes included for example 19 OSY in SERHA were registered with HEART, five completed the stage 1 classes with JFLL and three individuals enrolled in the CAPE food preparation programme. Additionally, empowerment workshops were conducted in this region for the youth in one of the targeted communities. The WRHA also had empowerment workshops which benefited over 130 participants and exposed them to agencies such as NCDA, Jamaica Constabulary Force, National Insurance Scheme, Citizen Security and Justice Programme and the Inland Revenue Department which were partners in these training activities. This region has plans to have similar empowerment training sessions for this population during the January to March 2011 quarter.

JoAnne Williams, community peer educator interacts with young women attending an empowerment workshop

Corner risk-reduction conversations and condom skills.

PARTNERS:

There were many partners from the NGO sector involved in OSY interventions. The Children First Agency, with bases in Kingston, Spanish Town and Old Harbour had the largest outreach programme to adolescents and youth considered at-risk. Beneficiaries received adolescent reproductive health information and services including VCT, remedial education, and vocational skills training. The key objectives of interventions were to reduce vulnerability to HIV/STI and unplanned pregnancies and to increase abstinence and condom negotiation skills as tools of prevention.

	ADOLESCENTS/ YOUTH	ADULTS
NUMBER REACHED	33,217	10,514
NUMBER WHO RECEIVED VCT	2,286	2,359

Table 6: Persons reached by Children First during 2010

During the period under review, Children First implemented a two-week holistic interactive intervention in a corporate area school. The workshop entitled ***"Reality Check"*** included practical and innovative cultural pieces and interactive sessions by the CF Bashy Bus Kru to support and reinforce the topics. Cultural forms included drama, music and song. A total of 120 students aged 12-17 years were taken through a series of participatory sessions to address various sexual and reproductive health issues.

The Joy Town Community Development Foundation (JTCDF) is a faith-based organization which was incorporated to aid in community development in Trench Town and its environs. In August of 2010, JTCDF held two one-week Physical Health and Life Skills Summer Day Camps for boys and girls. Thirty boys and 30 girls aged 12- 19 years benefited from the camps. In addition to the camps, the JTCDF also established a remedial education programme in which 63 persons enrolled, as well as an ongoing healthy lifestyle programme for 134 adolescents and youth.

Hope Worldwide started a programme in August 2010. As at December 2010, there were about 27 consistent participants. Eighteen of these students were placed in programmes at the HEART /NTA. This NGO also participated in the World AIDS Day activities by way of community walks with HIV/AIDS one-on-one risk conversations. The team interacted with 110 persons and conducted 33 condom demonstrations and distributed 200 condoms.

During the period under review, the focus for Three D Projects was to create an enabling environment for persons with disabilities, their families and non-disabled peers to access factual information on STI/ HIV/ AIDS. This was achieved by conducting monthly ***"Abstinence Plus"*** meetings for persons with disabilities. These meetings were held at the organizations' offices in Morant Bay, St Thomas and in Linstead and Old Harbour in St Catherine. Training and community interventions by community rehabilitation

workers were also conducted in the same locations. Approximately 40 individuals with disabilities participated on a regular basis. Correct condom use, negotiating condom use, STIs, risk assessment, human growth and development and activities from the "Skills for Life" package were covered in the sessions.

Drug Users and Homeless Persons

In keeping with their mandate to educate the general public about the potential dangers of drug use and to prevent the indiscriminate use of drugs, the NCDA received support to target homeless persons and drug users with HIV treatment, prevention and care services.

During the year under review, 141 homeless persons (112 males and 29 females) were tested for HIV along with 47 persons from the general population (31 males and 16 females). One hundred and forty-three homeless persons (115 males and 28 females) were tested for substance abuse. Despite the challenges faced in ensuring adherence to chronic medication to persons who are homeless, two clients were placed on antiretroviral treatment in 2010.

The rehabilitation programme successfully reunited two homeless women with their families and three homeless men were enrolled in residential shelters. The mobile unit shuttled clients to Kingston Public Hospital, Food for the Poor Clinic and the Comprehensive Health Centre. Partnerships were also formed with other agencies that have feeding programmes specifically for this population, these included Webster's Memorial Church, Sonia's Homestyle Cooking and Nutrition Products Limited, Chelsea Jerk Centre, Ken Loshusan Supermarket, Maxfield Bakery, and Grace Kennedy Limited.

Inmates

Throughout 2010, the Department of Correctional Services (DCS) tested 1,048 inmates in the major receiving institutions and sensitized approximately 1,385 on HIV/AIDS Basic Facts. The DCS continued to implement the Inmate/Prison Intervention Strategy. Phase 1 included the expansion of the programme to have routine HIV testing at St. Catherine Adult Correction Centre, Fort Augusta Adult Correctional Centre and Tamarind Farm in addition to Tower Street Adult Correctional Centre (Table 7).

	NUMBER OFFERED VCT	NUMBER TESTED	NUMBER RECEIVED RESULTS	NUMBER POSITIVE
MALES	912	912	636	20
FEMALES	136	136	111	4
TOTAL	1,048	1,048	747	24

Table 7: Summary of HIV testing in the correctional institutions, 2010

2. Prevention: Most At-Risk Populations cont'd

Implementation of the second phase of the intervention also took place in 2010. Phase 2 was comprised of the parolee and new release prevention intervention. Individuals received risk reduction counselling, support packages and finals HIV tests and results. HIV positive inmates were also linked to support services within the communities to which they were returning, including notification of the relevant support staff at their nearest treatment site.

Targeted High Prevalence Geographic Communities (TCI)

The targeted community intervention (TCI) strategy is designed to reach the most-at- risk populations in the communities with high HIV prevalence. Within this context, the most-at-risk include males and females 19 -39 years old, OSY, as well as SW and MSM. The TCI is implemented in four phases from observation and establishing a baseline on the risk behaviours in the community, to working alongside community members to conduct several specific activities that are geared towards community involvement, ownership and empowerment to reduce HIV transmission.

The activities are risk-group specific and are conducted for a minimum one year period. Some of the activities carried out under these TCIs included, but were not confined to, dissemination of the findings of the baseline data to communities, community walks and stakeholders meetings, parenting workshops, workshops for community leaders and OSY, health fairs, awareness raising at community dances, parties and other functions, adolescent summer camps, outreach HIV testing and referrals for services. At the end of the intervention a memorandum of understanding is signed with community members who pledge responsibility to continue some of the important components of the intervention. These actions include maintenance of condom access points, peer education, environmental cues promoting safer sex and periodic awareness-raising activities. Each RHA has been conducting these interventions. There were 69 TCIs implemented by the RHAs combined; SERHA conducted 27, NERHA had 20 while WRHA and SRHA had 11 each. These interventions reached a total of 137,790 individuals (SERHA, 12,625; SRHA, 60,345; NERHA, 14,865 and WRHA 49,955).

In an effort to reach the parents of OSY and other adolescents, parenting workshops were conducted as part of the TCIs in two health regions. The aim was to improve their skills in communicating about sexuality and other reproductive issues with their children. Parents were introduced to the new Child Care and Protection Act as well as to some of the organizations that offers assistance in dealing with adolescents. Topics covered included HIV/AIDS basic facts, communication between parent and child, discipline versus punishment and how to talk to young persons about sex. In NERHA, 387 parents participated while in SERHA, there were 256 parents involved.

The SERHA also employed the strategy of identification and training of peer educators to continue HIV/ AIDS education and increase condom access in the communities. The peer educators were chosen based on skills displayed as well as being nominated by members of the communities. One hundred and twenty one persons completed this training between the parishes of St. Catherine, Kingston and St. Andrew and St. Thomas.

The prevailing negative social conditions of the communities targeted were significantly associated with low socioeconomic status of the community members. Empowerment fairs were found to be successful as a means of facilitating social inclusion. These empowerment fairs were held in partnership with various agencies which were able to provide individuals with the necessary documents to facilitate access to the social services, employment opportunities as well as numerous opportunities for acquiring marketable skills.

Some of the agencies which participated in many of the empowerment workshops held across Jamaica included:

1. HEART TRUST NTA which provided information about the various skills building programme offered by their organization and also allowed persons to be registered.
2. National Youth Services which registered persons for entry into their Job Placement programme.
3. Registrar General Department which registered persons for Birth Certificates and provided information on the process of acquiring Marriage and Death Certificates.
4. Ministry of Labour and Social Security which registered persons to receive their National Insurance Number and gave information about the National Health Fund
5. Jamaica Foundation for Lifelong Learning which has been an important partner in providing literacy training for the community members. Literacy has been identified as a major barrier to individuals in the community being able to access gainful employment.

Some of the other activities offered at some of these fairs included demonstrations by private sector companies (Grace and Lasco) on how to prepare low cost nutritious meals, blood pressure and blood sugar checks, mental health screening and referrals for health and other services. It is intended that TCIs in all parishes will come to a close by the end of the fiscal year 2010/2011, as a result exit surveys and assessments will be undertaken.

Males 20 - 49 Years

This sub-population has been specifically identified due to the high HIV prevalence rate within this group. The 2009 Jamaica HIV Epidemic Update indicated that 79% of all reported AIDS cases are in the 20 - 49 age group compared to 69% in the previous year. Additionally the 2008 KAPB reported that 51.7% of males had more than one sexual partner. Against this background, TCIs have included specifically designed activities to interact with males and to engage them in risk reduction conversations. Different strategies were used to reach this group during 2010; interventions were conducted amongst persons involved in sports, transport operators and fishermen.

Sporting events are particularly popular with young people throughout Jamaica. The potential for meaningful intervention through Jamaica's numerous football clubs, corner leagues, basketball tournaments, cricket cups and so on is tremendous. Tackling HIV/ AIDS through sport provides opportunities not only to promote knowledge of transmission and prevention of HIV, but also to build and maintain the attributes of leadership, self esteem and life skill.

2. Prevention: Most At-Risk Populations cont'd

There was ongoing training of coaches to disseminate HIV prevention information and the necessary prevention skills for transfer to players. In 2010 the programme was expanded through partnership with the Institute of Sports. The Institute of Sports convened an all-island football competition targeting out-of-school or unattached youth from low income communities. The NHP capitalized on this initiative as it presented an opportunity to reach this population in their own space and comfort zone. Outreach activities at sporting events included: risk reduction conversations, HIV basic facts, condom skills building, VCT and referral for STI screening and treatment.

The RHAs were also involved in these sporting activities. Two conducted residential training workshops for community coaches; SERHA trained 40 coaches while NERHA trained 25. These coaches interacted with both in and out-of-school youth.

The WRHA Prevention Team maintained high visibility at the actual football matches. In the parishes of Trelawny and Westmoreland, interventions were carried out at day and night matches and at corner leagues. In Hanover, the team attended football matches for Vidal's Beach Football Competition, the Western Confederation and the "Steve Shorty Malcolm" Competitions. In Westmoreland, the team partnered with the organizers to engage players and spectators at the "Captain's Bakery" Football Competition. The finalists of these competitions in both Hanover and Westmoreland were clad in football jerseys carrying the "Condom Everytime" and "Get Tested for HIV" messages. Interventions at football matches focused on risk assessment and building condom skills through demonstrations done by patrons as well as community peer educators. In a risk knowledge survey carried out in Hanover during one of these interventions, it was ascertained that 50% of spectators had comprehensive HIV risk knowledge.

Both SERHA and SRHA developed interventions to reach males in the transport sector, specifically taxi operators. This has come to be known as the Taxi Drivers' Intervention. This group is male dominated and has a fair representation from the 20 - 49 year old age group. Sensitization sessions were structured to be of less than 15 minutes duration to facilitate the operators who were continuously on the move. Operators would then use the information to engage their passengers in order to help them to assess their risk. Fifty six operators were trained in the two regions combined. The southern taxi drivers also distributed 11, 100 condoms. A series of seminars were also conducted targeting the Jamaica Urban Transit Association bus drivers stationed at the Norman Manley International Airport.

The SERHA also targeted fishermen in the 20 - 49 age group. The fishermen in Port Henderson Fishing Village in St. Catherine and in Port Morant, St. Thomas were engaged through regular sensitization sessions. HIV testing was also offered at these sessions. In Port Henderson, the intervention also included a parenting workshop held in the community. Thirty two fishermen were reached in total.

3. Prevention: Access to Voluntary Counselling and Testing & Condoms

The acquisition of two mobile clinics equipped the outreach team to fulfil the mandate to scale-up the offerings of voluntary counselling and testing (VCT). The new testing protocol in which one officer conducts pre-test counselling, administers the HIV test, gives the result and post-test counsels the client was implemented. This method considerably improved the processing time with each client taking approximately 20 to 30 minutes to be processed. The positive impact of this new thrust was evident in the number of persons tested; there was an increase of 400% over 2009. One thousand six hundred and nine rapid tests were offered in 2009 while 6,453 tests were done in 2010 and these numbers exclude those done at the Safer Sex Week and World AIDS Day national events (Table 8).

NUMBER OF MALES	NUMBER OF FEMALES	TOTAL TESTED	NUMBER OF FEMALES HIV POSITIVE	NUMBER OF MALES HIV POSITIVE	TOTAL HIV POSITIVE
2,667	3,833	6,453	32	31	63

Table 8: HIV outreach testing conducted by mobile units, February- December 2010

Both buses became fully operational in April 2010 resulting in scaled-up outreach testing in the south east region. The new HIV testing protocol has proven beneficial in that it facilitates more meaningful interaction with clients. In the last quarter of the year a number of new HIV cases were identified and the clients referred and fast tracked at Comprehensive Health Centre in Kingston for confirmatory testing. There has been a noticeable increase in the number of males accessing the VCT services and persons are now displaying more confidence in the HIV rapid tests.

Outreach testing has become a main feature of special event days namely Safer Sex Week and World AIDS Day. The total numbers, tested by the outreach team and SERHA at Safer Sex Week and World AIDS Day 2010 was 803 and 1,780 respectively. It is of interest to note, that while these larger outreach testing events yield greater numbers, the prevalence rate is usually consistent with the national prevalence rate of 1.7% or lower. This indicates that the most-at-risk population do not necessarily participate in these outreach events and therefore targeted interventions are warranted.

Based on reports received 114,569 HIV tests were done during outreach testing activities conducted by the RHAs (Figure 7). One of the most interesting observations was made in SERHA where several drop-in testing sites were based at health centres. While these testing sites were obviously gaining in acceptability, based on the increase in numbers, similar to other services offered at health centres, there were more women than men accessing the service.

3. Prevention: Access to Voluntary Counselling and Testing & Condoms cont'd

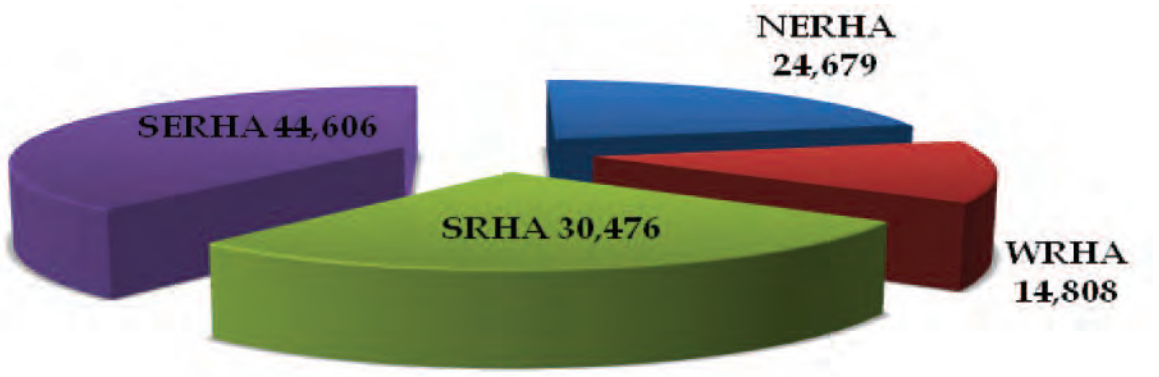


Figure 7: Numbers tested in outreach activities in the health regions, 2010

Condom use is one of the primary prevention practices promoted. The establishment of condom outlets is one strategy used to increase access to this commodity at the community level (Figure 8). Over 300,000 condoms were distributed free to clients during 2010 and this excludes the almost 100,000 condoms used in demonstrations and critical skills building exercises. Some non-traditional condom outlets were also established to sell condoms.

Figure 8: Number of condom outlets established by parish during 2010

Establishing and maintaining condom outlets can be challenging. While persons are usually eager to be involved in the establishment of condom outlets, once it realized that there are little financial benefits, interest tends to wane. Nevertheless, the introduction of the "Condom Everytime" in the final quarter of 2010 sparked renewed interest. This will require rigorous monitoring to sustain.

4. Positive Prevention

The implementation of the Positive Prevention Strategy continued in 2010 and was focused on increasing coverage and support to HIV positive persons through two of the main components: individually focused health education and peer support. Peer support groups included the provision of psychosocial support and strengthening referral systems to ensure access, scaling up and improved service delivery.

Support Groups

The number of support groups established was increased in 2010 with 36 active groups island wide and approximately 619 persons attending on a regular basis. Three of the Kingston and St. Andrew treatment sites had no associated support groups as there were no clinic-based social workers or adherence counsellors.

REGION	NUMBER OF SUPPORT GROUPS	TOTAL MEMBERS
NERHA	6	87
SERHA	15	450
WRHA	5	23
SRHA	10	59
TOTAL	36	619

Table 9: Support groups and number of members, 2010

Positive Prevention Workshops

Each RHA was mandated to reach at least 100 persons through Positive Prevention Workshops. In addition to discussing condom usage and negotiation, nutrition and adherence counselling, these workshops also incorporated empowerment opportunities and access to income generation projects for persons most in need. Additionally, all categories of treatment staff were trained in the delivery of prevention information and motivational interviewing. A total of 573 persons living with HIV were reached at the Positive Prevention Workshops held in 2010.

Social Support

The provision of social support was also a significant part of the Positive Prevention Strategy. This was

achieved through the assistance of partners such as Food for the Poor, Lasco, and Cari-Med Ltd. The Social Welfare Committee established in NERHA by health care workers assigned to the HIV programme also held fund raising activities to help PLHIV by providing a steady supply of food, clothes and pharmaceuticals to persons identified as most in need of this type of support.

Support was also provided in the form of materials to start a small business such dressmaking or farming; back to school assistance for children infected or affected by HIV; assistance for adult PLHIV who were interested in literacy classes, classes for Caribbean Examination Council (CXC) examinations, vocational learning among others. Persons were also identified to become beneficiaries through the income generating programme that was being funded by the National AIDS Committee during the period.

Ensuring Access, Scaling-up and Improving Service Delivery

The focus of this activity shifted to provide more support to the treatment staff to increase knowledge of Positive Prevention, addressing stigma and discrimination and subsequently increasing access, scaling up and improving service delivery. The agenda was based on topics identified in surveys with health care workers and clients. In 2010, two workshops were held in SERHA and NERHA reaching 77 and 23 health care workers respectively.

Sub-recipient, NGO Involvement in Positive Prevention

The Children of Faith programme provided support for persons living with or affected by HIV or AIDS through the provision of income generating projects in chicken rearing, retail clothing, farming and cosmetology. The organization which originated in St. James extended to the north east region during 2010 and its goal is to improve the lives of children infected with or affected by HIV or AIDS; consequently, households that benefit from the programme must include children.

Through partnerships with organizations such as the Rural Agricultural Development Agency (RADA), Child Development Agency (CDA), HEART Trust NTA, RGD, Kiwanis, Ocho Rios and the Inland Revenue Department, household heads are provided with the opportunity to improve the standard of living of their family through access to remedial education, skills training, social services and technical expertise in income generating areas. As part of the agreement, the families must commit to saving as well as reinvesting a portion of the income generated. Care for the emotional, physical and mental well being is also a component of this programme. The receipt of support is linked to accessing health care with mandatory visits to the psychologist for the children in the household.

During the year, 16 households comprising of 56 children from the north east and western regions of the island benefitted from varying income generating activities. Twelve families benefitted from chicken rearing, three households received consumer goods for resale, one household received equipment and beauty supplies and another household benefitted from support for farming.

Major Challenges and the Way Forward

Despite the tremendous strides made, maintaining consistent attendance at support groups was difficult, as was the attempt to increase the number of PLHIV being reached. Plans for 2011 include working closely with the social workers to unearth PLHIV who are not consistently attending the treatment sites and link them into support services where needed.

5. Line Ministries

Since HIV is a developmental issue, this means that sectors outside of health must be involved in the response if we hope to make a positive impact on the epidemic. The key ministries involved in the response in Jamaica during 2010 were the Ministry of Labour and Social Security (MLSS), Ministry of National Security (MNS) and the Ministry of Tourism (MoT).

Ministry of Labour and Social Security (MLSS)

The HIV/ AIDS Unit of the MLSS was primarily focused on the revival of the Voluntary Compliance Programme (VCP) and the promotion of the National Workplace Policy on HIV/ AIDS (NWP). The year 2010 commenced on a positive note; February 7, 2010 was the day on which the NWP was passed by the Lower House of Parliament. This was affirmed by the Upper House on July 30, 2010. The approved policy signals to companies that the MLSS is vigorously pursuing HIV/ AIDS legislation that will require compliance and will be supported by sanctions. The legislation will be the HIV/ AIDS Regulations that will be promulgated under the proposed Occupational Safety and Health (OSH) Act.

The MLSS HIV/ AIDS Unit received funding from the United States Agency for International Development (USAID) to assist in amending the policy to include parliament's recommendations and conduct consultations on the policy. Following the amendment process, the final version of the policy will be produced and printed for distribution.

In keeping to the tripartite approach, two capacity building workshops were conducted for union representatives to brief them on the NWP and the National HIV Discrimination Reporting and Redress System (NHDRRS). This information would subsequently assist the ministry in its efforts to encourage companies to implement a HIV/ AIDS policy and programme.

The VCP is intended to assist companies to recognize HIV/ AIDS as a workplace issue and to take the necessary measures to respond appropriately at the workplace level to mitigate the spread of the disease. The programme was launched in 2007 but lost momentum due to limited funding. In 2010 however, through funding from USAID, the programme was revived. On July 8, the first VCP awareness workshop was conducted. The objective of this workshop was to inform companies about the VCP, promote the NWP and to introduce the HIV VCP audit process. Companies were reminded that the purpose of the VCP was to assist them in their HIV policy formulation and implementation and also to urge them to take advantage of the assistance offered to them through the VCP.

Baseline audits are conducted on all companies enrolled in the VCP to assess the companies' workplace policies and programmes. To ensure a dynamic and sustainable audit component, the ministry trained 25 auditors. MLSS was able to conduct 15 audits in 2010. The audited companies included Federated Pharmaceuticals, Agricultural Chemicals, Lascelles Distribution, Kingston Container Terminal, INFO SERV, Appleton Estate, New Yarmouth, The Jamaica Observer, Breezes, and International Biscuits.

Other initiatives led by the MLSS in the fourth quarter of 2010 involved the initiative to hire consultants to increase public understanding, awareness and support for the HIV/AIDS Workplace Policy. Additionally, a

public education campaign regarding HIV regulations would be conducted for the small business and informal sector. Consultants will be responsible for designing and implementing a workplace public education programme to raise awareness of the NWP for MLSS internal staff, migrant workers and workplaces with 50-80 employees. Revision of the NWP was also on the MLSS agenda. The impetus of these activities will occur in 2011.

In addition to the previously mentioned activities, the MLSS was also quite involved in commemoration of special HIV awareness days. Safer Sex Week saw their 13 parish offices setting up a showcase with educational materials on safe sex and HIV/AIDS. The major event for the week was VCT which was conducted at the Spanish Town office on February 10, 2010.

The major event for World AIDS Day was the testing exercises at St. Ann's Bay parish office on November 24, 2010. HIV testing was also arranged for companies enrolled in the VCP (Table 10). Similar to Safer Sex Week the parish offices showcased educational materials and distributed condoms.

Company	Male	Female
Seprod (Head Office)	12	42
Red Stripe	127	121
Caribbean Products	17	16
St. Ann Parish Office	9	16
TOTAL	165	195

Table 10: Numbers of persons who received VCT in MLSS World AIDS Day activities 2010

During the period under review MLSS was a sub-recipient under the United Nations Population Fund (UNFPA)'s comprehensive condom programme. They received a total of 8,000 female and 50,976 male condoms of which they distributed 2,610 female and 30,910 male condoms. These condoms were distributed to clients at all local and parish offices and companies enrolled in the VCP.

Ministry of National Security (MNS)

The final draft of this ministry's HIV/AIDS Workplace Policy was reviewed. A sensitization session was scheduled to occur between the Ministry of Health's Legal Officer and the MNS Legal Officer, to facilitate future policy amendments. The date for this session has been proposed for early 2011.

MNS through a World AIDS Day Health and Information Fair also tested 82 staff members and sensitized

approximately 200 staff and patrons on HIV/ AIDS basic facts and condom use. Approximately 700 condoms were distributed.

The Medical Services Branch (MSB) of the Jamaica Constabulary Force (JCF) which falls under the MNS conducted six health fairs and nine HIV/ AIDS sensitization sessions. This resulted in 726 police officers and JCF civilians being sensitized and tested for HIV. There was also the distribution of approximately 1,470 condoms. Safer Sex Week activities were also conducted by the MSB, which resulted in 36 officers being tested and 44 sensitized on HIV/ AIDS basic facts.

Also during 2010, two workshops covering the areas of crisis counselling and adherence counselling were conducted for the Centre for Investigation of Sexual Offences and Child Abuse (CISOCA) staff/police officers. Seventy four persons were trained and about 380 condoms were distributed at these workshops.

Ministry of Tourism (MoT)

Over the period under review, the MoT HIV Unit focused on addressing prevention gaps identified within the tourism sector. These included expanding VCT outreach activities, increasing condom access and scaling-up dissemination and workplace policy development in the key zones of Montego Bay, Negril and Ocho Rios. The main objectives were to:

- Conduct a stigma and discrimination (S&D) workshops with human resource managers in entities with staff populations between 50 to 300 persons, to raise awareness on the negative impact of S&D on HIV positive workers
- Identify and establish five condom access points in high contact areas
- Conduct peer educator workshops with high quality content leading to ownership of HIV programmes by individual entities
- Increase VCT amongst targeted population tourism sector workers and specifically to encourage more males to get tested.
- Start a media campaign geared specifically towards tourism sector workers.
- Increase the number of one-on-one policy sessions and HIV sensitization sessions.

Achievements were coupled with challenges during 2010. Two condom-access points were identified; one in Montego Bay and the other in Negril. A third site within the Margaritaville chain will act as a temporary free condom distribution site. The two other locations will be identified in 2011. More male tourism sector workers were targeted with two VCT sessions scheduled specifically for contract carriage operators, 99% of whom are male. Also in testing conducted at hotels, there was a significant increase in the number of males reached in comparison to the same period last year.

5. Line Ministries

cont'd

The number of sensitization sessions were not as desired. Some entities were not eager to have the sessions conducted while others found it difficult to release workers from duties during hours of operation. Policy development was also slow as organizations did not deem HIV policy development to be an urgent matter. Until this is made mandatory, it will probably continue to be considered a low priority issue.

A consultant was contracted to develop a tourism sector specific media campaign for workers. This campaign will not only encourage VCT, correct condom use and partner reduction but it will aim to address stigma and discrimination in the workplace.

6. Media Campaigns, Support Material & Cultural Events

Two mass media campaigns were developed during 2010: Stick to ONE Partner and Get Tested: Ah Nuh Nutten. The Stick to ONE Partner media campaign was highly relevant as Jamaica has a relatively high rate of multiple partnerships, 38.9% according to the 2008 KAPB. The main message of fidelity is pertinent in the Jamaican society where multiple partnerships are promoted vociferously through dancehall music. The Get Tested media campaign was designed as a part of strategic efforts to increase HIV testing island wide. These media campaigns are critical to reinforcing messages being promoted by the prevention strategies.

Stick to ONE Partner: This campaign sought to persuade men in the 20 to 39 age group to reduce their number of partners and be faithful to one, uninfected partner. Inconsistent condom use, one of the risk behaviours fuelling the epidemic, was also captured in this media campaign.

Get Tested, Ah Nuh Nutten: The main focus of this campaign was to persuade men in the 20 to 39 year old age group to get tested for HIV. A major component of this media campaign was the positioning of HIV testing as easy and pain free.

6. Media Campaigns, Support Material & Cultural Events cont'd

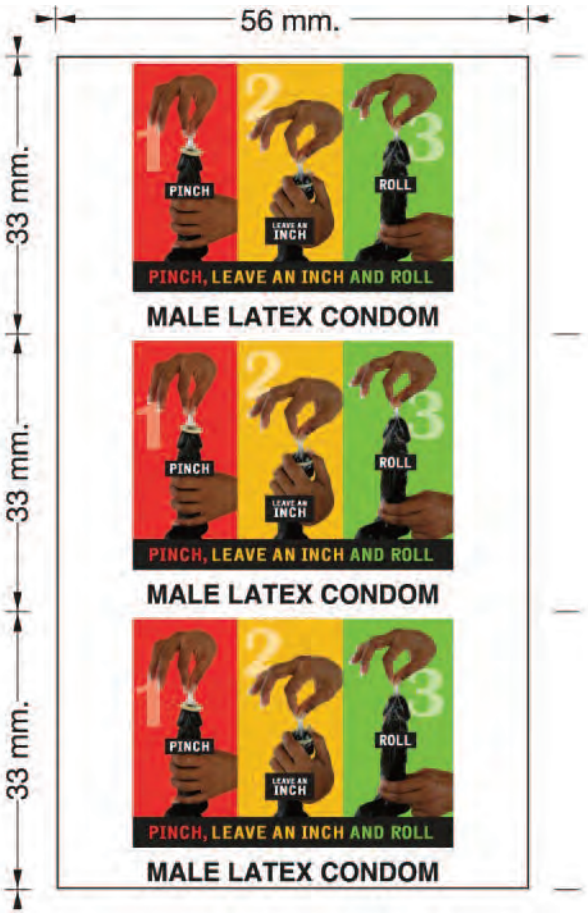
In 2010, there were five major media campaign placements. These were as follows:

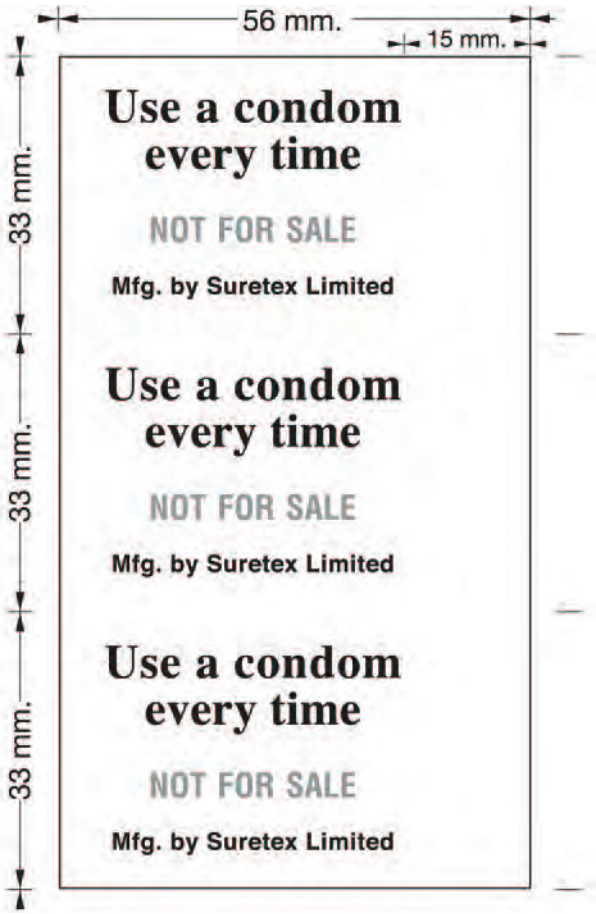
- **Stick to One Partner** – This campaign was placed on CVM Television during FIFA World Cup from June 11 – July 11, 2010. As part of this agreement, the NHP received bonus spots which were placed from July 12 – August 23, 2010. Additional spots were placed on Television Jamaica to complement the placement.

- **Smart Women Always Buy, Carry & Use Condoms** – This campaign ran on **major television and radio stations from August 3** – September 14, 2010.
  Ministry of Education's Health and Family Life Education (HFLE) Curriculum – This campaign was placed for six weeks from September 7 – October 19, 2010.

- **pMTCT, PLR and Get Tested** – These placements ran from September 13, 2010 to December 13, 2010.

- **Teen Seen Placement** – This was placed from October 2, 2010 to January 22, 2011.





The National HIV/STI Programme's website was redesigned and is now accessible at a new domain: http://www.nhpjamaica.org. The most important feature of this site is the **Information Centre**, which provides access to several NHP policies, annual reports, the United Nations General Assembly Special Session (UNGASS) reports, the current epidemic update, surveys, strategic plans, media campaigns, information, education and communication (IEC) materials and press releases. Additionally, an overview of the NHP and its components can be viewed in the About Us section which also provides short biographies on the members of the hard working Management Team at http://www.nhpjamaica.org/about/management_team.

Party Interventions

Parties remained important as one of the types of events at which meaningful interaction could be had with young persons. Over 3,000 adolescents and young adults were reached at various parties particularly those held in the NERHA for example Day Dream All Inclusive Party, Junction Explosion, Appleton's Party and Appleton Luau - Irresistible Heroes Weekend Series of Parties, Reggae Soca Carnival, Gold Label Special, March Madness, XXXPose Code Red Anniversary Party, Beach J'Ouvert, & Teen Splash.

7. Special HIV Awareness Events

Special events are commemorated each year to provide Jamaicans with opportunities to test for HIV at a central, convenient location outside of their communities. Two major special events are celebrated in Jamaica: Safer Sex Week during Valentine's Week in February and World AIDS Day on December 1. These events feature HIV/AIDS information, condom demonstrations, risk reduction conversations, empowerment opportunities, entertainment and most importantly, voluntary counselling and testing for HIV (VCT).

Radio personality Ms. Kitty poses with condom mascot.

A gleaner sales woman skilfully balances her newspapers while putting on a condom.

7. Special HIV Awareness Events cont'd

The National Safer Sex Week 2010 event took place at Orange Park, Downtown, Kingston on Thursday, February, 11 from 10:00 a.m. to 4:00 p.m. under the theme, ***"Smart Women Always Buy, Carry & Use Condoms"***. HIV testing and information was prominently featured. Eight hundred and three persons were tested for HIV and received their results. Across the island, events with testing were also conducted (Figure 9).

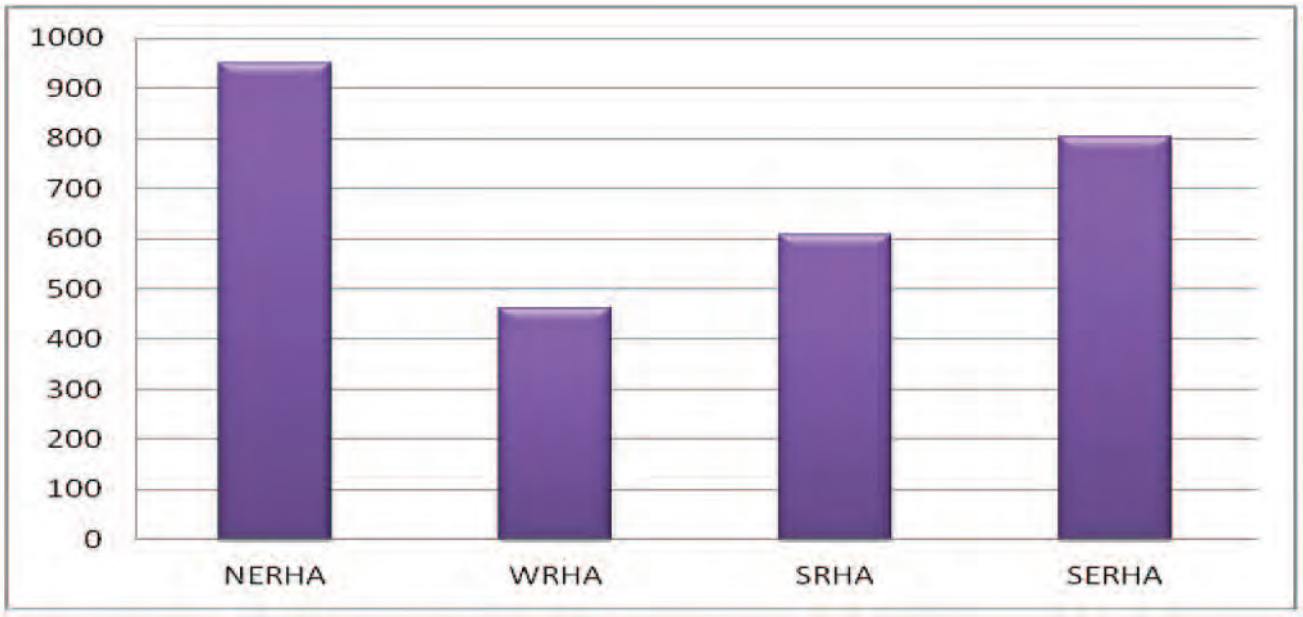


Figure 9: HIV testing conducted by the regional health authorities for Safer Sex Week 2010

The theme for World AIDS Day 201 was ***"It is your right...CLAIM IT!"*** Activities were organized by the NHP and several partners to observe this day. The following activities were held to commemorate the World AIDS Day:

Pastor Lorenzo King, J.P. greets Dr. Kevin Harvey, Director – National HIV /STI Programme. Immediately looking on are the Honorable Minister of Health Rudyard Spencer and Dr. Jean Dixon, Permanent Secretary in the Ministry of Health.

Pastor Lorenzo King, J.P. made a fervent call, with a placard, for an end to discrimination against people living with HIV/AIDS.

***1. The Proclamation & National Church* Service** was held on Saturday, November 27, 2010 at the Andrews Memorial Seventh-Day Adventist Church in Kingston. There was representation from the Ministry of Health; dignitaries in attendance included the Honourable Minister Rudyard Spencer, Permanent Secretary Dr. Jean Dixon and Director of the NHP, Dr. Kevin Harvey.

Claudette Pious facilitates a "Talk Up Di Tings" session at the World AIDS Day event at the National Heroes Park on Wednesday, December 1.

This patron is deeply engrossed as she receives valuable information from PLACE outreach officer, Richard Pryce.

2. The National Event was held at the National Heroes Park on Wednesday, December 1, 2010. This event offered VCT, HIV/AIDS information, "Try a Skill" booths, "Talk Up Di Tings" sessions with Miss Claudette Pious and entertainment.

7. Special HIV Awareness Events cont'd

The regional health authorities tested over 7,500 persons island wide for World AIDS Day 2010 through numerous outreach testing activities (Figure 10). Testing was conducted at many locally popular venues and the media and popular community entertainers galvanized crowd support and reinforced HIV prevention messages. Some of the more unusual activities for this period included:

1. A march throughout the streets of Montego Bay, St. James with the support of students and non- governmental organizations.

2. A float parade was used to command attention in the communities of Rio Bueno, Clarks Town, Duncans and Falmouth in the parish of Trelawny.

3. In Hanover, patrons competed for the title of Mr and Miss Sexual Awareness.

Figure 10: HIV testing conducted by the regional health authorities for World AIDS Day 2010

8. Enabling Environment & Human Rights

The Enabling Environment & Human Rights (EEHR) Component is mandated to create an enabling environment in which the human rights of all Jamaicans are protected regardless of real or perceived HIV status. The component facilitates this process through advocating, creating and implementing policies, programmes and supportive legislation.

Guided by this mandate, the team members of the EEHR Component worked assiduously during 2010 to achieve targets through the development of new programmes and improvement of existing programmes to support the protection of human rights for all.

The priority strategies of 2010 included: reducing stigma and discrimination through further development of the National HIV Related Discrimination Reporting and Redress System (NHDRRS) and the HIV Workplace Policy Programme, as well as increased advocacy among high level leadership and focusing on policy and legislative approaches.

Discrimination Reduction

HIV related stigma and discrimination remained an enormous barrier to the national HIV response therefore the component prioritized discrimination reduction as a key method of achieving an enabling environment. Discrimination reduction initiatives continued in 2010 in collaboration with the Ministry of Education (MOE) and an anti stigma & discrimination training manual was developed for youth leaders. A situation analysis conducted in 2009 facilitated the development of the document. The manual addressed the need for the youth to be more sensitized on the basic facts of HIV, stigma & discrimination, disclosure and confidentiality. Content areas focused on stigma and discrimination, values clarification, behaviour change communication skills and ways of "rapping with different groups". The manual will be used to train 200 youth leaders in HIV anti stigma and discrimination methods. In the future, youth leaders will be directed to sensitize constituents under their purview and create opportunities for young people to participate in society without HIV related discrimination

The second major activity conducted during 2010 that was aimed to address HIV related stigma and discrimination, involved qualitative research among faith-based organization (FBO) leaders and stakeholders regarding their knowledge, attitude, practice and behaviour (KAPB) towards most-at-risk populations (MARPS). The MARPS in this instance were categorized as stated in previous chapters as inmates, men who have sex with men (MSM), sex workers (SW), youth between the ages of 15 to 24, homeless people, drug users, and persons living with HIV (PLHIV).

The study will evaluate the level of HIV- related stigma and discrimination to MARPS among FBO leaders (and persons within their organizations or communities) and their belief systems. It will also assess programmes including MARPS' access to HIV services and support, gaps in the current FBO response to the HIV epidemic as it relates to MARPS and the willingness of FBO leaders to work with the Ministry of Health (MOH) and other partners to improve the protection of the rights of selected vulnerable groups or MARPS. The findings will inform capacity building and discrimination reduction interventions in the FBO setting. In the last quarter of the year, two consultants were engaged to conduct research in the form of in-depth interviews and focus group discussions with high level FBO leaders and stakeholders.

HIV/ AIDS Workplace Policy Programme

HIV has been identified as a workplace issue within the National HIV Policy passed in 2005. Therefore the EEHR Component continued to strengthen and promote workplace programmes and initiatives. The passing of the National Workplace Policy on HIV/ AIDS in February 2010, symbolized a further step towards enacting legislation to support HIV policies and programmes within the workplace. T he Ministry of Labour and Social Security (M L S S) continued to vigorously pursue creation of HIV/ AIDS legislation, by formulating HIV/ AIDS regulations that will be promulgated under the proposed Occupational Safety and Health (OSH) Act. The EEHR Component actively supported these initiatives of the MLSS.

Throughout 2010 the Workplace Policy Programme through workplace programme officers deployed within the public and private sector experienced growth and continued success in reaching and increasing commitment of organizations, line ministries and non-line ministries.

In the public sector, the Ministry of Justice and the Office of the Services Commissions developed a new draft policy. Both the Ministry of Transport and Works and the MOH moved their policies from draft to final stage. The Ministry of Foreign Affairs and Foreign Trade updated and presented its policy to their Permanent Secretary for approval in April. During the year, 90 new public sector agencies were reached.

The workplace programme officers in the public sector were responsible for sensitization and training of approximately 3,094 employees at 138 events. Eight hundred and forty seven discrimination reduction conversations were conducted at 11 events. The private sector workplace programme officers spearheaded 44 sensitization and training events which captured an audience of 1,105 persons. During the year of activities almost 30,000 condoms were distributed (Figure 11)

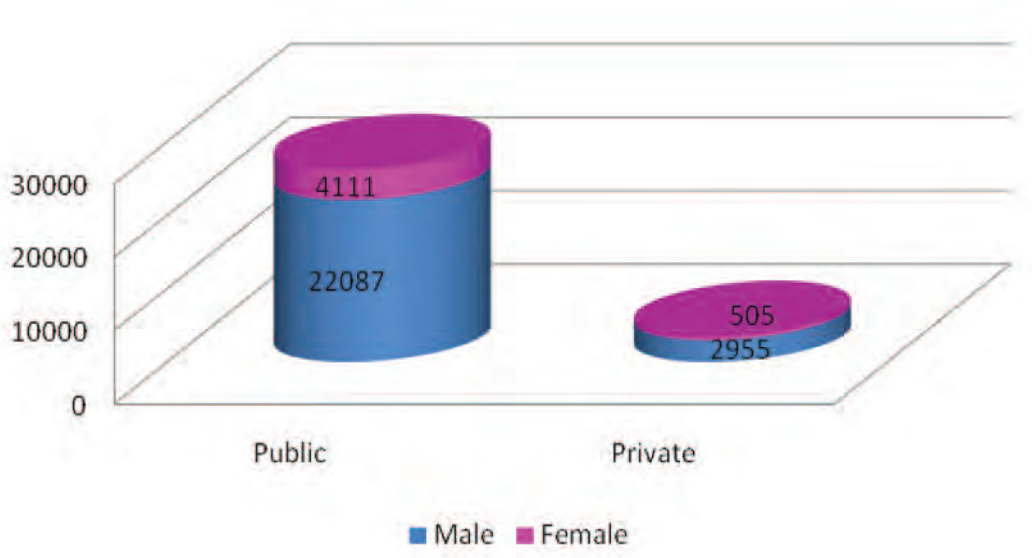


Figure 11: Number of condoms distributed by public and private sector during 2010

Within the private sector 29 new companies were reached, 27 new focal points were assigned and nine new steering committees were formed. New draft policies were developed by 17 entities and 17 polices were moved from draft to final. Cumulatively, 221 entities were on board at the end of 2010. These entities were divided between the Private Sector Organization of Jamaica (PSOJ), Jamaica Business Council on HIV/ AIDS (JaBCHA), Jamaica Manufacturers Association (JMA) and the Jamaica Employers' Federation (JEF). Additionally, there were 207 focal points and 94 steering committees (Table 11).

Entity	Number Reached	Policy/Action Plan	Focal Points	Signed Commitments	Number of Steering Committees
PSOJ	43	39	39	43	23
JaBCHA	56	41	58	41	34
JMA	59	48	60	49	24
JEF	63	37	50	21	13
Total	**221**	**165**	**207**	**154**	**94**

Table 11: Private sector entities adopting HIV Workplace Policies

Other initiatives during 2010 to improve the HIV Workplace Programme included the revision of the terms of reference of five workplace programme officers to incorporate investigations into HIV-related discrimination complaints as part of the NHDRRS.

Material development in the form of the HIV Workplace Programme Instructional Manual took place during the year. This manual was developed as a tool to assist organizations in developing and implementing comprehensive HIV workplace programmes/policies. The manual gives HIV facts as well as information on treating HIV as a workplace issue; it also provides an overview of the International Labour Organization (ILO) Principles on HIV/ AIDS and the world of work and governance frameworks. The manual contains implementation, monitoring and evaluation and reporting tools for organizations to utilize. Some 500 copies were produced for distribution among stakeholders, workplace programme officers and focal points within the public and private sectors.

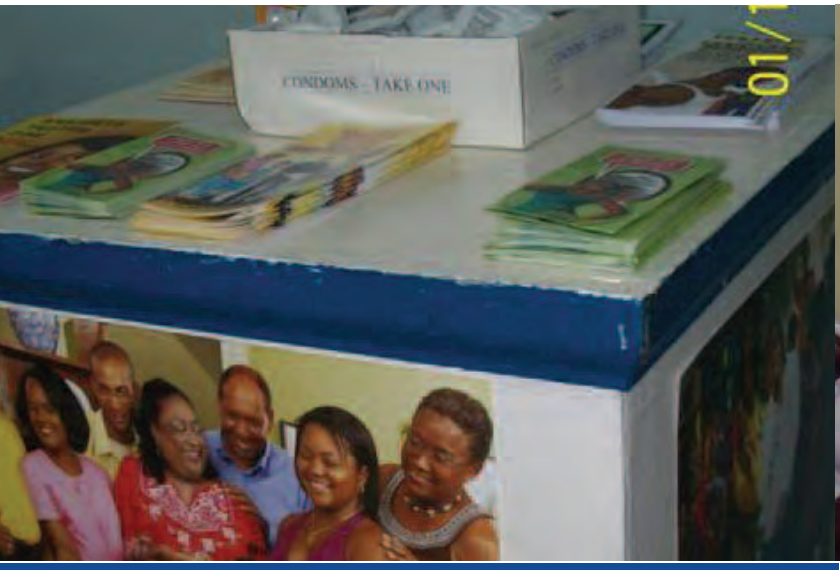
As part of the thrust to sustain the HIV Workplace Programme a team comprising the EEHR Component Director, Law and Human Rights Officer, and Greater Involvement of Persons with HIV/ AIDS (GIPA) Coordinator developed a manual for training trainers, facilitators and instructors in HIV/ AIDS Workplace Basics. The manual provided information and guidance for participants in conducting sessions on basic facts on HIV/ AIDS, sexuality and values clarification, the rights-based approach to HIV in the workplace, stigma and discrimination reduction and the NHDRRS, as well as PLHIV approaches to HIV transmission and prevention. Over the period, presentations were made to approximately 396 participants in existing workshops and meetings.

8. Enabling Environment & Human Rights cont'd

Commemorative Events: Safer Sex Week and World AIDS Day Activities

The EEHR Component continued to use commemorative events to address HIV related stigma and discrimination. As part of the Safer Sex Week interventions, discrimination reduction conversations were conducted with 499 individuals within the Ministry of Finance and the Public Service (297) and the Ministry of Agriculture and Fisheries (202). The facilitators used the discrimination reduction tool designed in 2009 to conduct the interventions.

For World AIDS Day, commemorative events complemented sensitization workshops, discrimination-reduction conversations and condom skills-building sessions within the public and private sectors. In the public sector 1,340 employees and clients participated in four events to mark this special day.



World AIDS Day 2010 Exhibition, Petrojam

World AIDS Day 2010 Audience, Ministry of Foreign Trade & Foreign Affairs

JaBCHA was another major player in the workplace during 2010. Membership increased from 39 to 43 companies during 2010 and a new Executive Director, Mr. Earl Moore was brought on board. The thrust during the last quarter of the year was towards increasing awareness among the private sector and high level leaders about JaBCHA's role in the national HIV/AIDS response and forging partnerships with major stakeholders in the private sector.

The establishment of a National Foundation for HIV/AIDS was another area that JaBCHA focused on, as the private sector is seen as an instrumental partner in the fight against HIV. It was proposed that a dedicated

fund be created to accommodate contributions from that sector through a specially created non-profit organization. It is expected that JaBCHA will operate this fund which will primarily be used to support initiatives of the NHP.

Policy & Legislation

The government of Jamaica was asked to consider three specific proposals: (1) amendment to the Public Health Act, (2) the integration of the redress aspect of the NHDRRS into the duties of existing entities and (3) placing the HIV Regulations within a proposed OSH Act. The Law and Human Rights Officer from the EEHR Component focused on these three areas during 2010 and aimed to facilitate reduction of stigma and discrimination in relation to HIV/AIDS by supporting and assisting in creating platforms for empowerment and accountability in regards to HIV. Other areas of input and participation included strengthening systems within the Jamaica Network of Seropositives (JN+) and addressing stigma and discrimination in the health sector.

1. National HIV-Related Discrimination Reporting and Redress System

The review of the NHDRRS Cabinet Submission and supporting documents continued throughout the period. Through the Multisectoral Advisory Group, discussions on the NHDRRS related documents were centred on integration of redress partners into the system and in particular:

i. Definition of redress and discrimination
ii. Amendment to governing legislation based on definition of redress and discrimination

The NHDRRS continued to be guided by the Multisectoral Advisory Group. The members comprised representatives from the NHP, JN+, MOH, MLSS, National AIDS Committee (NAC) and the Legal and Ethical Subcommittee of the NAC, Jamaica AIDS Support for Life, Jamaica Independent Council of Human Rights and UNAIDS. During the period five meetings were held. The key recommendations focused on refining the investigative aspect of the system. The following decisions were taken:

a. It was recognized that the complaint cases were not moving from intake to redress in a timely manner. The bottleneck was created at the investigation stage and it was agreed that the investigative capacity of NHDRRS needed to be increased. To achieve this end it was agreed that personnel in existing partner entities should be trained and engaged as investigators.

b. An Investigation Management Team (IMT) should be assembled to oversee the investigation process and make the final recommendations in relation to redress. The composition of the IMT would look very much like the Interim Investigative Team (IIT).

c. Informed consent from the complainants to conduct investigations and to effect redress was seen as critical to establishing the validity of and trust in the system. Two consent forms were designed by the Law and Human Rights Officer and these were reviewed and refined by the advisory group.

d. Rapid intervention mechanisms were to be put in place to address cases in which urgent redress action is required. This would not however circumvent the five-step process.

In order to action the recommendations of the Multisectoral Advisory Group, a consultant was engaged to design and conduct training sessions for persons selected to act as investigators. The terms of reference for the consultant as well as investigators in the NHDRRS were developed.

During the period the IIT reviewed and investigated the complaint cases. A total of 13 cases were reviewed and redress action initiated for 12 cases. The challenges posed in convening meetings of the IIT meant that more than half of scheduled meetings were postponed. This had direct implications for the efficiency of the entire NHDRRS and its ability to move cases from report to redress.

In an effort to sensitize several stakeholder groups including private and public sectors and PLHIV, several presentations were made informing them of the existence of the NHDRRS and sensitizing them to HIV-related discrimination and the rights-based approach.

2. Legislative/Policy Approaches to HIV-related Stigma & Discrimination

a. *Amendment to Public Health (Notifiable Diseases) Order*

A draft cabinet submission supported by a technical report on the proposed Amendment to the Public Health (Notifiable Diseases) Order were prepared. During the period consultations commenced on the proposed amendment. Meetings were held with the Legal Reform Unit of the Ministry of Justice and comments received on the proposal. These comments were incorporated into both the technical report and the cabinet submission. The draft submission was sent to the Permanent Secretaries of the Ministries of Tourism and Education as well as the legal unit of the MOE. No feedback or comments were received up to year end but further meetings will be arranged.

b. *National HIV Workplace Policy and HIV Regulations to Occupational Safety and Health Act*

In February 2010 the National HIV Workplace Policy was adopted by Parliament. This policy was spearheaded by the MLSS and supported by the NHP in the MOH. The Law and Human Rights Officer continued to give technical input into the draft regulations of the Occupational Safety and Health Act.

c. *Adolescent Working Group*

Throughout the period participation was ongoing in the Adolescent Policy Working Group (APWG). The particular focus for the period was on access of minors below the age of 16 to Voluntary Confidential Counselling and Testing (VCCT) without parental consent. The Law and Human Rights Officer developed the terms of reference and facilitated engagement of a consultant to conduct a situational analysis to make possible the development of a policy for the health care sector on minors' access to VCCT. This consultant was engaged on November 1, 2010. The consultant's final report should be received in the 2011 period.

Champions for Change

There continued to be a need to address issues surrounding the vulnerable populations from a policy and legislative perspective. Over the years several attempts were made to engage legislators/ parliamentarians to tackle these concerns. It was recognized that interventions to engage influentials around sensitive issues related to HIV should be evidence-based. Therefore a consultant was engaged to conduct qualitative research

in the form of in-depth interviews and focus group survey sessions with members of vulnerable populations, influential persons in business, entertainment, media, faith based organizations and parliament to understand their views on the following issues: (1) reduction of stigma and discrimination towards MSM and transgender (2) regulation and control of sex work (3) access to sexual and reproductive health services in schools (4) access to sexual and reproductive health services in prisons. Thereafter an advocacy programme would be designed and implemented (including monitoring and evaluation of outputs) to engage Champions for Change in helping to remove barriers to access of prevention services and treatment, care and support by vulnerable individuals and groups.

A consultant was engaged in November 30, 2009 and research was conducted over the period January – July 2010. The consultant's final report was submitted on November 29, 2010. Although the design of the advocacy programme was a part of the consultant's terms of reference, the technical team monitoring the consultancy felt that the consultant did not have the capacity to carry out this aspect of the work and therefore terminated the contract upon delivery of the final report on the research conducted. The design and implementation of an advocacy programme remains to be done.

Greater Involvement of Persons with HIV/ AIDS (GIPA)

The Greater Involvement of Persons with HIV/ AIDS continued to be facilitated through the GIPA Coordinator and GIPA Facilitator under the purview of the component. The key responsibilities of GIPA Coordinator and GIPA Facilitator were to coordinate, sensitize and train selected PLHIV. This process would enable trainees to effectively participate in the design and implementation of interventions to reduce the spread of HIV, to reduce discrimination and to facilitate positive prevention and access to treatment, care and support for PLHIV. Additionally the structure and competence of the JN+ self support groups would be enhanced.

A needs assessment among PLHIV was conducted with an objective of identifying basic needs (knowledge, skills and psychosocial needs) of proposed project participants so they may participate more effectively in worksites and specific interventions of the national HIV/ AIDS response. The findings, conclusions and recommendations informed a training programme and a cadre of PLHIV was selected to be part of the HIV workplace sensitization and training in the public and private sectors and to assist the self-support groups/ support groups. Annual cohorts of 20 select PLHIV will be recruited over a five year period and deployed to provide psycho-social help and mentoring.

Capacity building efforts included sensitization sessions for PLHIV. The objective of these sessions was to improve the knowledge and skills of PLHIV regarding JN+, basic facts on HIV & AIDS, workplace principles, anti stigma and discrimination issues, NHDRRS, and positive health, dignity, and HIV prevention so that they are equipped to function as presenters and workshop trainers. One-day sensitization training workshops were conducted on a quarterly basis with an average of 21 project participants (members and non-members of self support groups) in attendance. GIPA also made progress towards monitoring and evaluating (PLHIV) trainees as they conducted sessions in pre-selected workshops and self-support groups to increase the number of trained PLHIV participating in existing interventions. The GIPA Coordinator

organized the involvement of six PLHIV in conducting sessions in workshops planned by workplace programme officers and during self- support group meetings. The GIPA Coordinator also developed a system to identify, mobilize, and support trainees. Fifty-five sessions were conducted within government ministries (including departments and agencies), private sector companies, and civil society organizations such as FBOs and PLHIV network and groups in an effort to improve understanding of basic facts on HIV and AIDS and to promote GIPA and the NHDRRS.

The GIPA Coordinator continued to participate in the national response through participation in over 30 meetings to structure HIV/ AIDS programmes and interventions. This individual also continued to sit as part of the IIT of the NHDRRS which coordinates investigation of cases of HIV related discrimination.

Jamaica Network of Seropositives (JN+)

There were several shifts in the human resources composition of JN+. A Programme Coordinator and an Advocacy Officer assumed duties in January 2010. Three field officers were also employed. The Programme Coordinator was a timely and positive addition to the team to enhance the management and growth of JN+. One of the main responsibilities of the Advocacy Officer was to monitor and coordinate the activities of the NHDRRS. However on May 26th this officer resigned and those functions were undertaken jointly by the Programme Coordinator and the Reporting and Redress Field Officer.

The notable activities undertaken during the year included continued support of the NHDRSS through the receipt and documentation of complaints and assisting with investigation and redress management. Other activities included coordination of NHDRSS awareness sessions among self-support and affected groups and the coordination of monthly meetings of the advisory group. Nine persons were added to the Family and Friends Registry bringing the cumulative total to 45. A total of 114 names were added to the membership database in 2010 for a cumulative total of 675. One hundred and sixty self-support group meetings were conducted with a total of 1,162 participants in attendance. Increasing the visibility of JN+ through the maintenance and timely updating of the website was also a priority.

On March 4, JN+ held its annual general meeting (AGM) and conducted elections for board members. In preparation for the elections and as part of the effort to strengthen the governance capacity of JN+ an ad hoc committee was convened to oversee the electoral process. This Electoral Oversight Committee, as it was called, was chaired by the Law and Human Rights Officer. Three meetings were held from February to March 2010 to develop documents and procedures to guide the election process. These included a document entitled "A Guide to Election Process and Voting Regulations."

The Electoral Oversight Committee also provided the organization with advice on eligibility criteria of members to stand for positions on the board, to vote, as well as requirements (in accordance with the organization's constitution) for conducting an AGM. They also provided direct oversight to the nomination process and voting at the AGM.

8. Enabling Environment & Human Rights cont'd

Public Consultations for the National Strategic Plan (NSP)

The EEHR Component marshaled the mid-term review of the National HIV/AIDS Strategic Plan (2007-2012). The event was held at the Terra Nova Hotel in Kingston in February. The objectives were to conduct a review of the current strategic plan by stakeholders, present recommendations for the enhancing the current strategic plan and present ideas for the development of the next strategic plan.

From this consultative meeting, it was evident that some of the participants were unfamiliar with the NSP. Nevertheless, it was thought by the group that gender mainstreaming was not addressed adequately and that there should be a more structured approach in the next plan. It was also recommended that the NHP needed to make greater use of technology and social media opportunities.

Community system strengthening was identified as an area requiring improvement to ensure that NGOs and CBOs were sufficiently equipped to respond to the epidemic in Jamaica. The lack of decisiveness regarding the issue of minors and condoms was criticized and thought to be well overdue for finalization. The group also thought that there was need to conduct more training on human rights within communities to encourage more openness and acceptance of the right of every person to pursue their own sexual ideas.

Challenges

The slow pace of completing consultancies proved challenging throughout the year; several managed by this component had to be extended well beyond the contracted completion date. In the Workplace Policy Programme, although there was an increase in the number of companies reached and the number of commitments made, there was slow progress with regards to moving policies from draft to final. In addition, there was minimal advancement pertaining to legislative initiatives such as the HIV Regulations and the OSH Act.

Overall the component had its fair share of achievements and challenges. The priorities for 2011 will include further advocacy and interventions with high level leaders, legislative issues and the faith-based community, designing and disseminating the policy guidelines for access of minors to VCCT, supporting the initiatives of the MLSS which include the public education on National HIV Workplace Policy and approval for HIV regulations within the proposed OSH Act, supporting the private sector with the building of the national HIV response through the National Foundation and integrating discrimination reduction and GIPA into the national HIV response.

9. Treatment

As in previous years, during 2010, more persons living with HIV (PLHIV) accessed antiretroviral (ARV) treatment thereby improving their quality of life. Preliminary data indicates that the less than 5% chance of HIV transmission from mother-to-child was sustained in 2010 and by case definition, the elimination of Congenital Syphilis was achieved in 2010.

HIV Testing

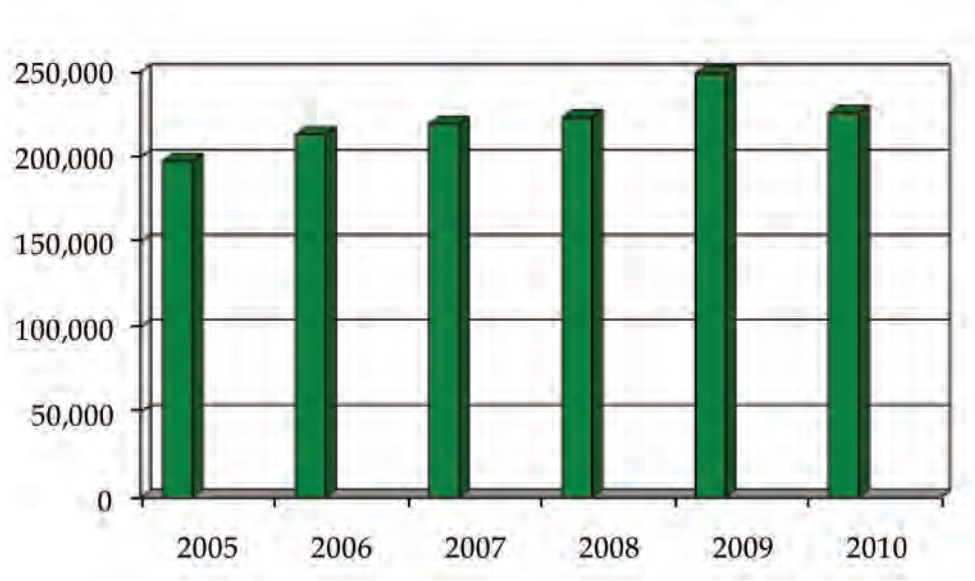


Figure 12: HIV testing conducted, 2005-2010

During the period January to December 2010 there was a marginal reduction in the number of HIV tests done. Within the year, 225,748 tests were conducted by the regional health authorities, private sector and other facilities. This reflected a 9% reduction when compared to the amount performed in 2009. An effort to increase the number of tests done is required in 2011 in order to provide early treatment, care and support to infected persons.

ARVs & Medical Management

In 2010, the 23 treatment sites continued the provision of multidisciplinary care in Jamaica. All sites are located at facilities that provide other health services, making care for PLHIV available within an integrated service setting. This comprehensive treatment (including antiretroviral medication) remained free of cost in the public sector. Based on programme monitoring, as at December 31, 2010, there were a total of 8,016 persons (7,560 adults and 456 children) with advanced HIV (57% of persons with advanced HIV) ever started on antiretroviral treatment (Figure 13).

9. Treatment

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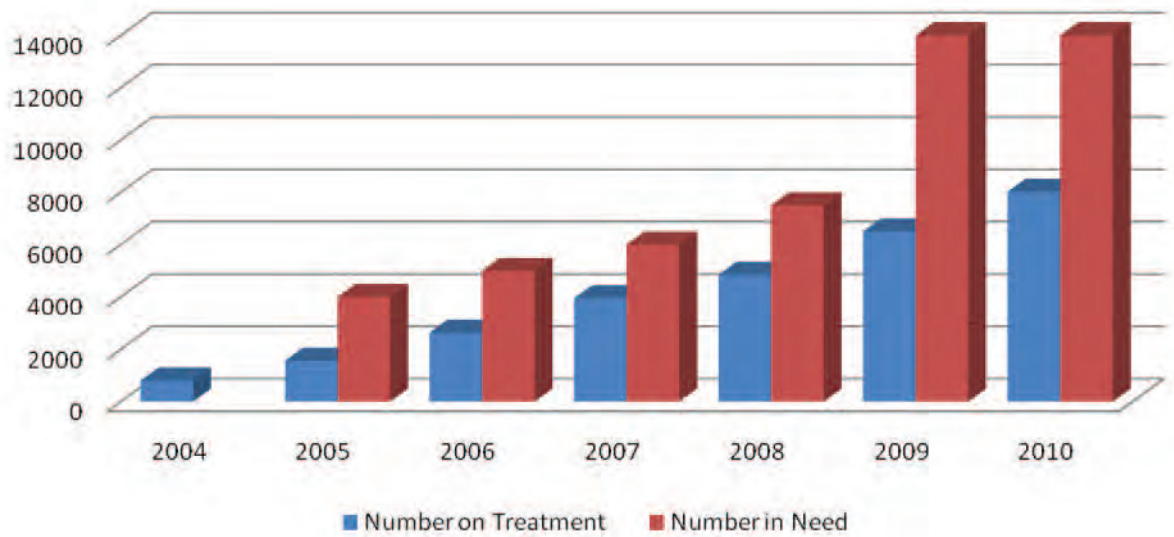


Figure 13: Number of persons on ARVs, 2004-2010

The 7th Annual HIV Clinical Management Workshop held in collaboration with ERTU- CHART was convened in June at the Sunset Jamaica Grande in Ocho Rios, St. Ann. These three workshops held over a one week period, facilitated the training of over 250 health care workers from the public and private sector along with volunteers. The entire multidisciplinary team was targeted including physicians, nurses, dentists, social workers, pharmacists, nutritionists, laboratory staff, adherence counsellors, contact investigators and PLHIV. Workshop participants received information on the Initiative for the Elimination of Vertical Transmission of HIV & Syphilis, Positive Prevention, tuberculosis, nutrition, gender issues and HIV care in resource limited settings among other topics along with the usual reinforcement of the treatment guidelines. The programme included booths which provided information on HIV rapid testing and the use of the ARV database.

The Annual Clinical Management Workshop 2010

9. Treatment

cont'd

The overall evaluation from these workshops showed that they were considered successful by the participants. Most respondents said that the objectives had been met, the topics were useful and the key concepts taught were realistic for them to implement in their current area of work. Of note, over 40% of the participants who attended the SERHA/ SRHA workshop were new to the annual workshop experience compared to 55% for the WRHA/ NERHA. The target for type/ category and numbers of participants was achieved.

The NHP/ Ministry of Health (MOH) continued to dispense ARVs from the treatment site pharmacies; the partnership with the Drug Serv pharmacies was maintained and three private pharmacies were added to the list of private sector points of access for ARVs. NHP/ MOH-certified practitioners continued to offer service to PLHIV who preferred to access care in the private sector. These private sector patients were also able to access ARVs free of cost through the Drug Serv and three private pharmacies involved in the programme.

Surveillance data, used to assess the impact of the treatment programme, showed a decrease (over 40%) in the number of AIDS deaths from 665 in 2004 to 333 in 2010. The year 2004 marked the commencement of public access to ARVs for PLHIV needing treatment.

Waste Management

The South East Medical Waste Treatment Facility (phase 1) was initially established to serve public and private healthcare facilities within the south east health region. However, with several public healthcare facilities in the other health regions experiencing significant waste treatment challenges due to frequent failure and extended downtime of their aged, unsuitable and poorly maintained on-site incinerators or 'burn boxes', the South East Medical Waste Treatment Facility quickly became the only environmentally sound alternative treatment option available to the public sector. It has served and continues to serve as a contingency treatment facility for most public healthcare facilities within the other three health regions (southern, north east and western).

At the outset, it was envisioned that phase 2 implementation of the regional medical waste treatment facility and collection system would have been sited in the western health region. Nevertheless, provision was made under Part 4 "Health Sector Development" of the Second World Bank Loan to upgrade of the South East Medical Waste Treatment Facility with additional treatment and collection capacity.

At year end, the goods and services to support the upgrade of the South East Medical Waste Management Treatment Facility were being procured; approval was obtained for the award of contract valued at US $899,668.02 to ECODAS to supply the items required to upgrade the capacity of the facility to 1,208 tonnes per year which is twice its current capability.

Laboratory Capacity to Identify Indicators of Progression of Infection / Immune Impairment (CD4 Count, Viral Load, PCR)

The CD4 count is one of the most important tests for the management of HIV positive individuals. It is recommended for all HIV positive persons on diagnosis. Along with the clinical presentation of the client, it is used to determine when ARV therapy should be initiated. This test is conducted at both the National Public Health Laboratory (NPHL) and the Cornwall Regional Hospital (CRH); during 2010, CD4 testing via the use of PIMA machines was introduced at Port Antonio and Black River Hospitals and Jamaica AIDS Support for Life, Kingston Branch. This testing methodology is expected to improve access to CD4 testing due to the fragility of this particular sample. There was a 14% decrease in the number of tests conducted as 10,487 samples were processed in 2010 compared to 12,204 in 2009 (Figure 14). This was due to a fall off in testing at CRH for the last 4 months of 2010 due to an air conditioning fault.

Viral Load testing was conducted solely at the NPHL which is still the only laboratory with this capability. Viral load determination should be carried out primarily to evaluate the benefit of ARV therapy. It is recommended six months after the initiation of therapy then annually thereafter. During 2010, 3,195 viral load samples were processed which represented a 10% decrease over the 3,559 samples processed in 2009 (Figure 14). The decrease was due to a supplies chain management issues. Incorrect sample collection also challenged the number of samples that were suitable for processing.

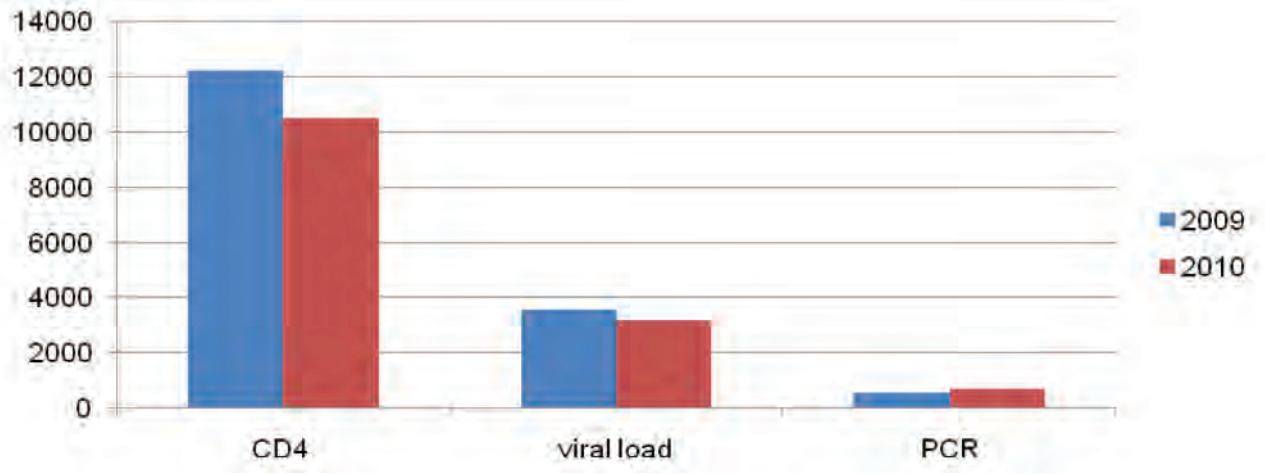


Figure 14: Monitoring tests conducted, 2009-2010

The number of samples that were submitted during 2010 for early infant diagnosis by Polymerase Chain Reaction (PCR) testing surpassed the number submitted in 2009. For 2010, all samples were Dried Blood Spot (DBS) samples as DNA PCR testing of HIV exposed infants, which was introduced in 2009, was fully implemented with all treatment sites using the methodology by the end 2010. At year end, all 2010 samples

had not been processed, however the positivity rate for the tests conducted was approximately 3.9%. The rate is expected to be lower as some of these are duplicate samples for the same infant as per protocol.

Initiative of Elimination of Mother-to-Child Transmission of HIV and Syphilis Adherence & Psychosocial Support Programme

With regards to Congenital Syphilis, based on the transmission rates for the period 2008 to 2010, Jamaica has achieved the elimination target (3 consecutive years of transmission rates less than 0.3 per 1000 live births). The transmission rates ranged from 0.15 to 0.21 cases per 1000 live births for the three year period.

Relating to HIV, the Prevention of Mother-to-Child Transmission (PMTCT) Programme has resulted in provision of ARVs for 87% of pregnant women and 98% of infants delivered in the public sector in 2010. The programme has maintained this level of performance since at least 2006. While data from the private sector are unavailable, national surveys and surveillance data such as paediatric AIDS and paediatric AIDS deaths suggest that similar coverage exists in the private sector.

A review of PCR testing results for HIV exposed infants confirmed that the chance of vertical transmission in 2010 was sustained a less than 5%. The outputs of the programme for the prevention of mother-to-child transmission of HIV are summarized in Table 12.

	2005	2006	2007	2008	2009	2010
Number of antenatal clinic attendees tested for HIV	28,651 (96%)	28,446 (95%)	22,478 (95%)	28,659 (>95%)	30,076	20,259
Number of HIV positive women delivered	401	442	358	616	440	404
% of women getting ARVs	**74%**	**84%**	**84%**	**84%**	**84%**	**87%**
Number of HIV-exposed infants	407	433	362	612	439	392
Number of infants getting PMTCT	353 (87%)	403 (93%)	**350 (97%)**	**605 (98%)**	**430 (98%)**	**383 (98%)**
Transmission Rate	**10%**	**<10%**	**<5%**	**<5%**	**<4.3%**	**<4.7%**

Table 12: The PMTCT Programme, Jamaica – 2005-2010, Public Sector Data

9. Treatment

cont'd

Adherence & Psychosocial Support Programme

Achieving adherence levels at a minimum of 95% is one of the primary challenges for PLHIV on ARVs. Research has shown that it is achievable but immense support is required for a sustainable effect. All regional health authority multi-disciplinary care teams have been sensitized to the adherence protocol and as such, provide support to the social workers and adherence counsellors in this aspect of care.

Based on reports from the adherence counsellors for 2010, an average of 9% of clients that received adherence counselling were new clients commencing ARV therapy. Seventy nine percent of persons, self-reported adherence at the required level of 95% and 73% were found to have achieved this level by pill count. This represents a marginal increase of three percent and two percent respectively over the latter half of 2009. The number of adherence support groups also increased by 113% from 16 at the end of 2009 to 34 at the end of 2010. The impact of socioeconomic factors cannot be overemphasized as the major determinant of adherence. Whist the efforts of the team are commendable, little fruit will be borne in our country's current economic climate.

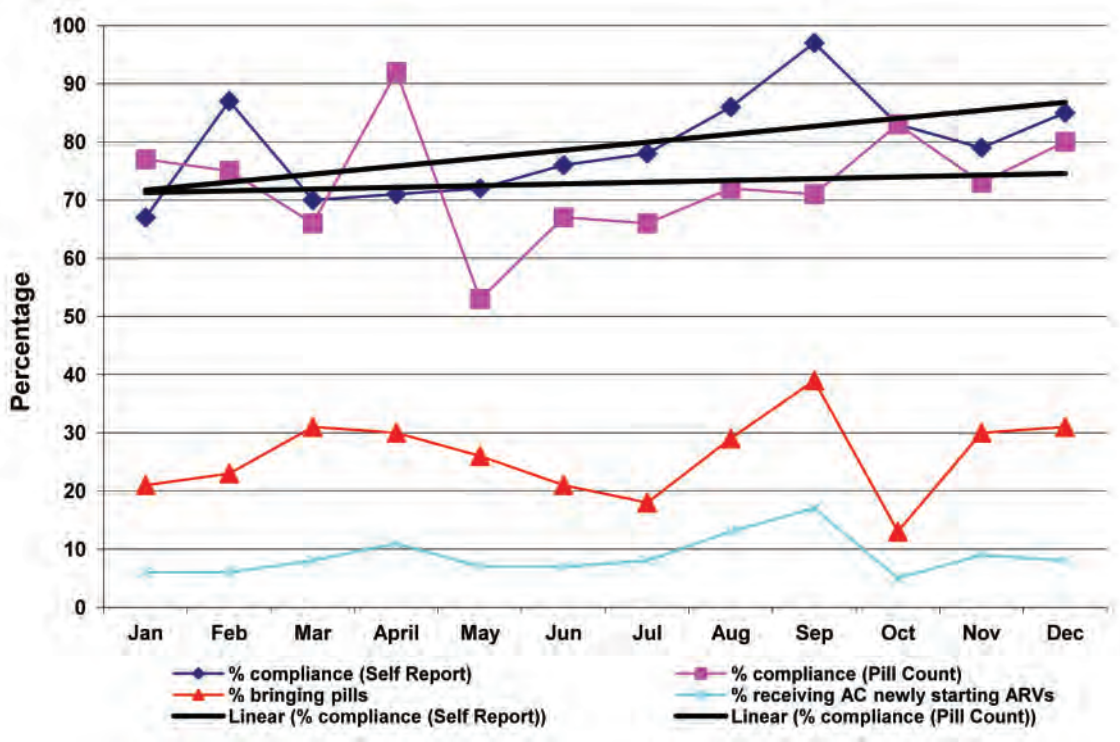


Figure 15: ARV adherence, selected indicators, 2010

In an effort to address some of the socioeconomic issues, the NHP with its limited resources to directly address these issues in a substantial manner, continued to foster partnerships and collaborative efforts. For example, empowerment programmes organized (through the Positive Prevention aspect of the Prevention Component) afforded a number of PLHIV the opportunity to gain technical and vocational training and certification as well as basic literacy and numeracy skills. The National AIDS Committee (NAC) and its associated Parish AIDS Associations (PAA) were also key partners in this effort and the referral system (from the treatment sites) facilitated assistance to clients. Significant contributions were made to the welfare of children who are infected with or affected by HIV by way of back to school assistance. Social workers and adherence counsellors attached to health facilities were able to identify families who were in need and referred them to the PAA to receive support in the form of the payment of school fees, purchase of school books and school uniforms.

In 2010, the partnership with the NAC continued as the NAC entered the second year of its three-year US$100,000/year grant from the Global Fund. The Global Fund grant through the NHP sponsored the Income Generating Grant Project. The NAC continued the provision of small grants to assist PLHIV in setting up or expanding income generating projects or to seek training or certification of skills. Despite these activities however, it is clear that only with further strengthening of partnerships between other related Ministries of the Government e.g. Ministry of Labour and Social Security, non- governmental organisations, faith-based organisations, the private sector and other members of civil society will the support network that is required be established.

Stigma and Discrimination

Accepting attitudes to PLHIV have improved significantly over the past few years however there are still negative effects, some caused by HIV related discrimination and others by environmental factors. The MOH and in particular the NHP remains committed to the task of creating a supportive environment for PLHIV. Many such initiatives were embarked on during 2009 and continued in 2010 within the three main components of Prevention, Treatment, Care and Support and Enabling Environment and Human Rights. Partnerships with organisations such as the Jamaican Network of Seropositives and with persons advocating the Greater Involvement of PLHIV were maintained in order to ensure that PLHIV are included in the design and implementation of such undertakings.

10. Other Sexually Transmitted Infections

In Jamaica, Sexually Transmitted Infection (STI) management is guided by a syndromic approach, which is detailed in a comprehensive STI manual. The clinical impression is noted along with the sydromic diagnosis and these data are used to estimate the prevalence of the different conditions. Syphilis and HIV, however, are based on aetiologic reporting using testing data. Contact tracing and investigation is central to halting the spread of all STIs including HIV. Contact investigator reports act as a central source of STI data and the data presented here represent trends in the public sector only.

Overview

The total number of clients attending STI clinics in Jamaica has increased since 2006 with the largest increase between 2007 and 2008. This was largely due to the removal of user fees while the 25% increase between 2008 and 2009, may be due to improved data capture as contact investigators implemented strategies to capture STI data in all health centres rather than capturing data only on STI clients that are referred to the contact investigator. While new clients with STIs declined in 2010, the number of "revisits/old clients" increased particularly in south east and north east health regions. It is unclear whether the latter was due to re-infections or inadequately treated infections that persisted. All health regions except the south east one recorded a decline in new STI clients (Annex 3).

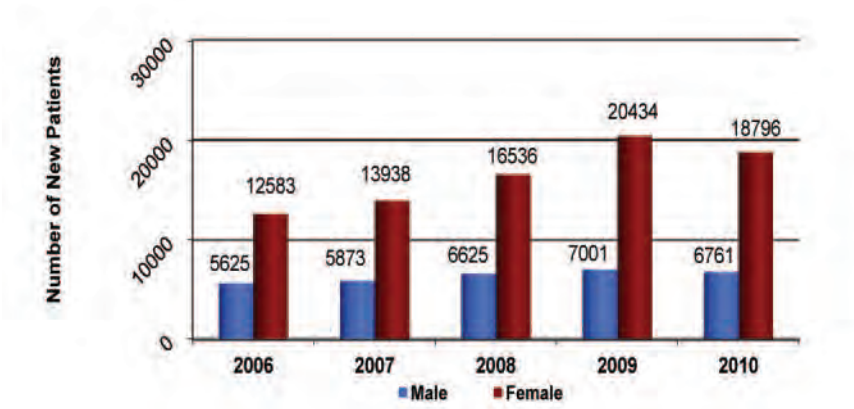


Figure 16: New STI clinic attendees in Jamaica by sex, 2006-2009

Female STI clients continued to outnumber male STI clients with women accounting for 75% of persons with STI in the public sector (Figure 16). The sex disparity was more noticeable in rural parishes (Table 13). For example, in Kingston and St. Andrew (KSA) 37% of STI clients were male compared to 17% and 24% male clients in St. Elizabeth and Portland respectively (p =0.000).

10. Other Sexually Transmitted Infections

cont'd

Gender	CLAREDON	HANOVER	KINGSTON & ST. ANDREW	MANCHESTER	PORTLAND	ST. ANN	ST. CATHERINE	ST. ELIZABETH	ST. JAMES	ST. MARY	ST. THOMAS	TRELAWNY	WESTMORELAND	Total
Female	5001	611	2092	1116	1283	2110	2307	1392	1090	162	701	257	674	18796
Male	1018	305	1242	384	401	984	778	291	549	101	353	125	230	6761
Total	6019	916	3334	1500	1684	3094	3085	1683	1639	263	1054	382	904	25557

Table 13: New STI patients by sex by parish, 2010

Genital Discharge Syndrome (GDS)

According to World Health Organization (2001) Genital Discharge Syndrome (GDS) includes, "Urethral discharge in men with or without dysuria (most commonly caused by Neisseria gonorrhoeae and Chlamydia trachomatis) or abnormal vaginal discharge (amount, colour, and odour) with or without lower abdominal pain or specific symptoms or specific risk factors."

GDS was the most common syndrome diagnosed among STI clinic attendees in 2010, with women accounting for three to four times as many cases of GDS compared to men (Figure 17). Candidiasis was the commonest cause (31% cases) of GDS followed by bacterial vaginosis (BV) and other causes (Figure 18). While GDS due to Trichomonas vaginalis (TV) increased, GDS attributed to cervicitis caused by Neisseria gonnorrhoea (GC) and Chlamydia trachomatis (CT) and unknown causes decreased (Figure 19).

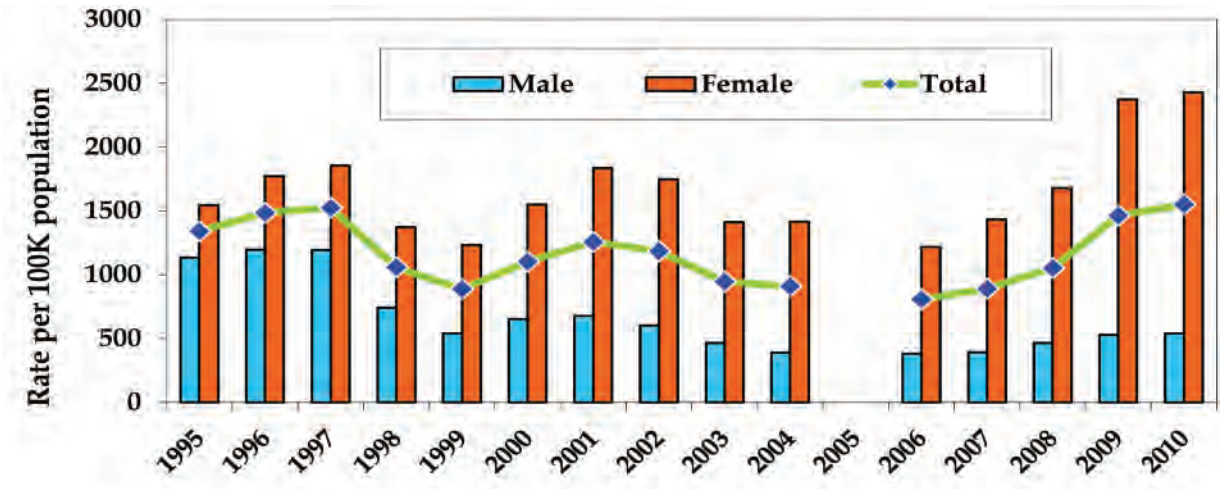


Figure 17: Rates of Genital Discharge Syndrome in Jamaica (1995-2010) by sex

***Aetiologic prevalence (1995): TV=25%; CT=25%; GC=16%**

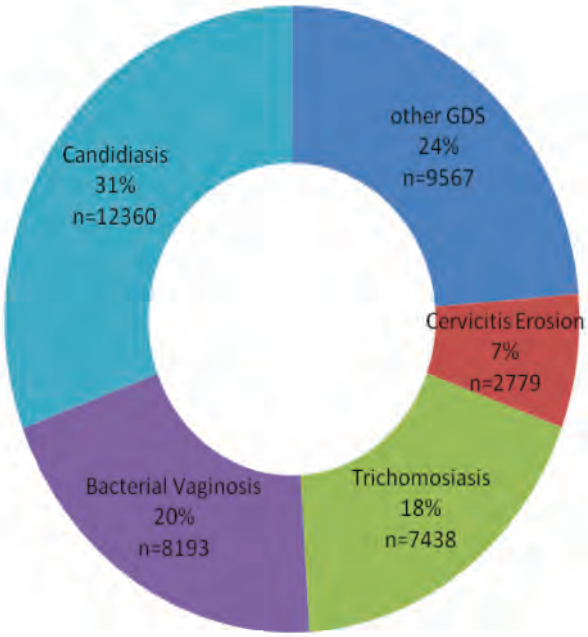


Figure 18: Distribution of causes of Genital Discharge Syndrome in Jamaica (2010)

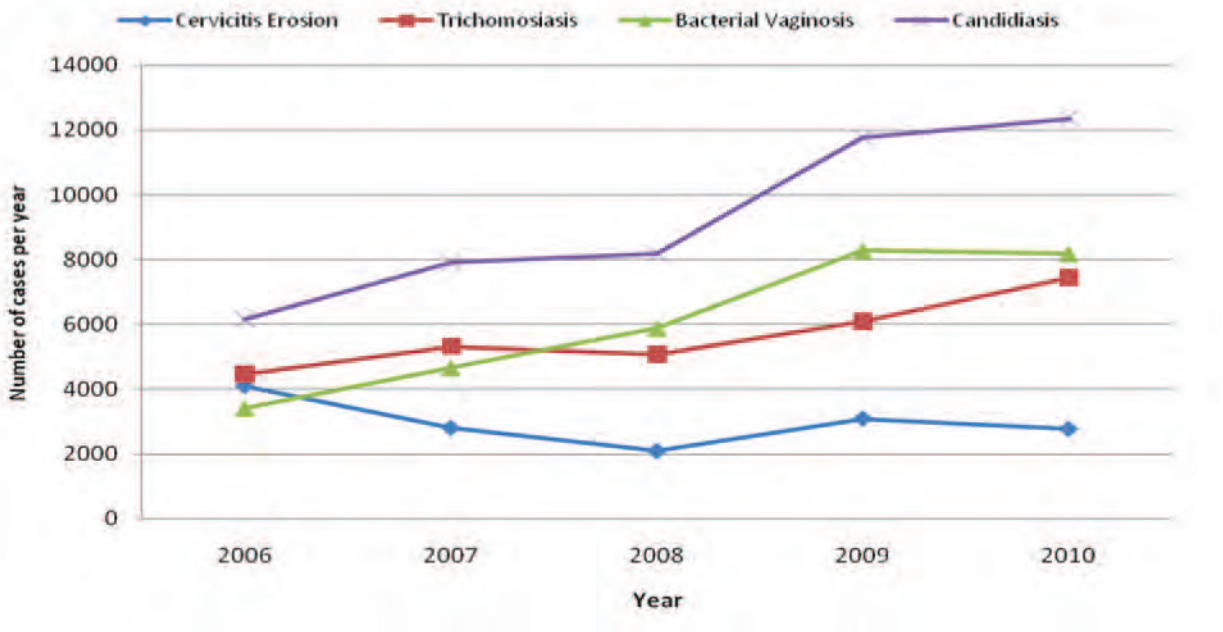


Figure 19: Causes of GDS, 2006 – 2010 (clinical diagnosis)

10. Other Sexually Transmitted Infections

cont'd

Based on reports received, between 2006 and 2010, most cases of GDS occurred in the 20-24 age group (4077 cases per 100,000 populations in 2010) and the highest rates were observed in Portland, St Mary and St. Thomas (Tables 14 and 15).

	2006		2007		2008		2009		2010	
	No. of Cases	Rate	No. of Cases	Rate	No. of Cases	Rate	No. of Cases	Rate	No. of Cases	Rate*
0-9 years	136	28.8	189	40.0	236	48.59	304	64.4	296	62.66
10-14 years	291	104.8	375	135.1	495	178.3	644	232.0	603	217.23
15-19 years	3396	1364.9	4016	1614.1	4583	1842.0	6018	2418.7	6123	2460.91
20-24 years	4924	2373.1	5198	2505.1	5927	2856.5	8449	4071.9	8459	4076.76
25 or older	12760	858.6	14223	957.1	16965	1141.6	23994	1614.6	24856	1672.58

Table 14: Age adjusted GDS rates per 100,000 population, 2006 – 2010

*Used total population from STATIN 2008 demographic report as denominator for rates for 2008 to 2010.

Parish	2009				2010			
	Female	Male	Total	Rate	Female	Male	Total	Rate
CLARENDON	5535	875	6410	2600	5043	951	5994	2431
HANOVER	305	159	464	664	346	145	491	702
KINGSTON & ST. ANDREW	5765	1906	7671	1151	6091	1785	7876	1182
MANCHESTER	1748	442	2190	1147	1895	362	2257	1182
PORTLAND	2512	266	2778	3378	3352	295	3647	4434
ST. ANN	2634	1127	3761	2169	2725	1217	3942	2273
ST. CATHERINE	4552	752	5304	1064	4183	792	4975	998
ST. ELIZABETH	2541	186	2727	1805	1884	179	2063	1365
ST. JAMES	1059	83	1142	619	1381	189	1570	851
ST. MARY	2488	372	2860	2502	3307	507	3814	3336
ST. THOMAS	2380	710	3090	3279	2090	611	2701	2866
TRELAWNY	326	44	370	489	300	61	361	477
WESTMORELAND	552	87	639	441	572	74	646	446
Total	**32397**	**7009**	**39406**	1464	**33169**	**7168**	**40337**	1498

Table 15: GDS cases per 100,000 population by sex and parish, 2009-2010

10. Other Sexually Transmitted Infections

cont'd

Genital Ulcer Disease Syndrome (GUD)

Genital ulcer disease (GUD) refers to "conditions of the anogenital region (with or without lymphadenopathy) which cause a break or dissolution of the epithelial lining of the skin or mucous membrane in this area". GUD may be caused by: syphilis, chancroid, herpes simplex virus type 2 (HSV2), granuloma inguinale (GI), and lymphogranuloma venereum (LGV).

Women with GUD sometimes present with a genital discharge and lesions may not be as visible when compared to men. Nevertheless, GUD rates were higher in women compared to men but the gap was smaller compared to the sex disparity observed for GDS. While GUD rates have increased among men in 2010, fewer cases were reported among women in 2010 compared to 2009 (Figure 20).

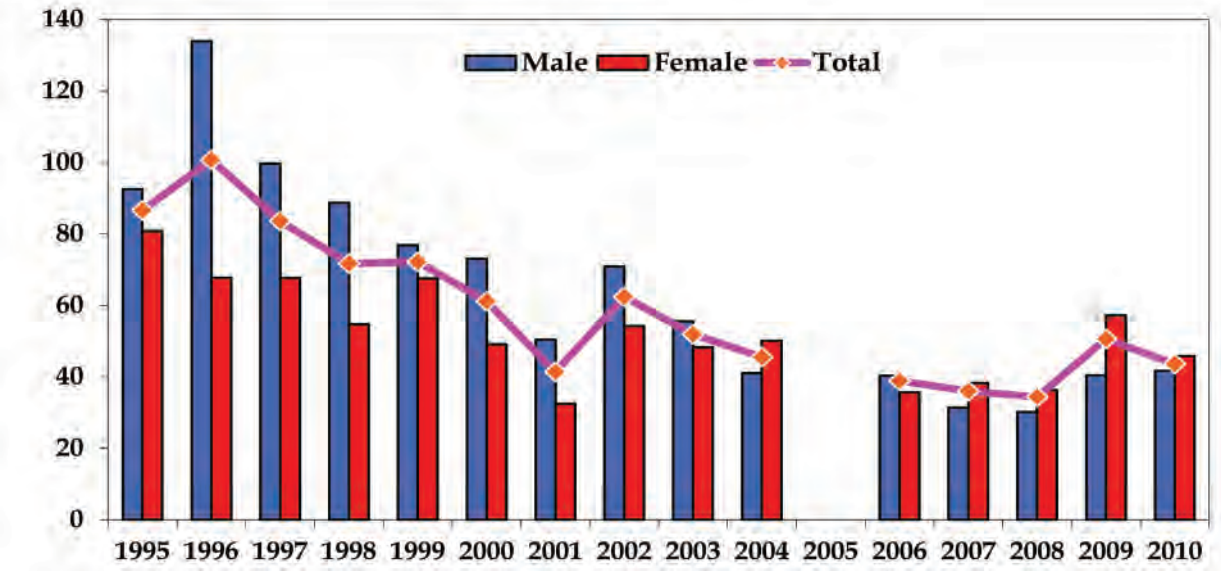


Figure 20: GUD rates per 100,000 in Jamaica, 1995 - 2010

The highest rates of GUD were recorded in the 20-24 year old age groups and non- significant declines were observed in all age categories except the 15-19 year old age group (Table 16).

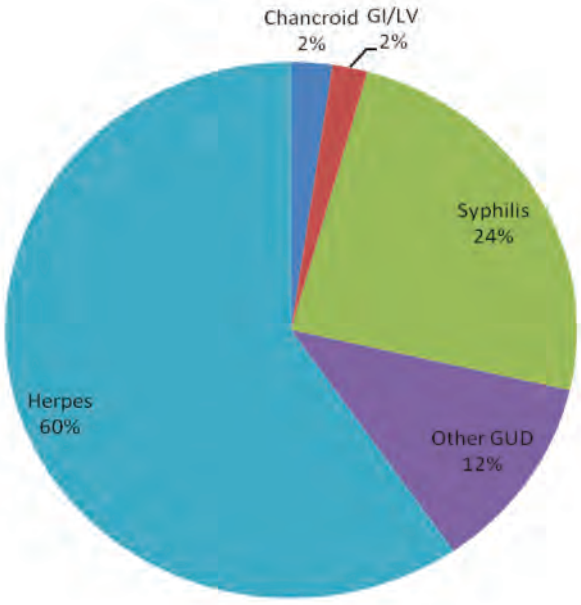
Herpes was identified as the most common cause of GUD among STI clients accounting for 60% of GUD (Figure 21). The increase in reported herpes cases may be attributable to increase use of diagnostic tests for HSV. However, these tests do not accurately differentiate between HSV 1 (which causes oral herpes or "cold sores" and is common in Jamaica), and HSV 2. This results in a significant number of false positives and misclassification of GUD due to herpes. Overall, GUD rates decreased by 10% but some parishes (St. Ann, St Elizabeth, St. James, St. Mary, and Trelawny) recorded a significant increase (Table 17).

10. Other Sexually Transmitted Infections

cont'd

Age Group	2006		2007		2008		2009		2010	
	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate
0-9 years	4	0.8	1	0.2	1	0.2	1	0.2	0	0.00
10-14 years	23	8.3	17	6.1	12	4.3	10	3.6	5	1.80
15-19 years	168	67.5	146	58.7	100	40.2	150	60.3	153	61.49
20-24 years	237	114.2	229	110.4	186	89.6	233	112.3	225	108.44
25 + years	580	39.0	542	36.5	596	40.1	924	62.2	796	53.56
										P=0.88

Table 16: Age adjusted GUD rates



GI = Granumloma Inguinale, LV = Lymphogranuloma Venerum

Figure 21: Distribution of diseases within the GUD category, 2010

10. Other Sexually Transmitted Infections

cont'd

Parish	2009				2010			
	Female	Male	Total	Rate	Female	Male	Total	Rate
Clarendon	29	27	**56**	23	18	14	**32**	13
Hanover	15	22	**37**	53	14	18	**32**	46
Kingston & St. Andrew	325	231	**556**	83	165	264	**429**	64
Manchester	49	31	**80**	42	43	38	**81**	42
Portland	26	26	**52**	63	19	16	**35**	43
St. Ann	34	34	**68**	39	56	46	**102**	59
St. Catherine	96	48	**144**	29	68	48	**116**	23
St. Elizabeth	17	9	**26**	17	15	15	**30**	20
St. James	18	25	**43**	23	98	28	**126**	68
St. Mary	6	4	**10**	9	6	7	**13**	11
St. Thomas	152	67	**219**	232	108	44	**152**	161
Trelawny	6	0	**6**	8	5	6	**11**	15
Westmoreland	8	13	**21**	14	11	9	**20**	14
Total	781	537	**1318**	49	626	553	**1179**	44

Table 17: GUD by sex and parish with rate per 100,000 population

Syphilis

Infectious syphilis and congenital syphilis have demonstrated significant declines for both men and women over the last decade (Figures 22 and 23 and Table 18). Clients 15- 19 and 40-44 year old were the only two age categories to record an increase in infectious syphilis between 2009 and 2010.

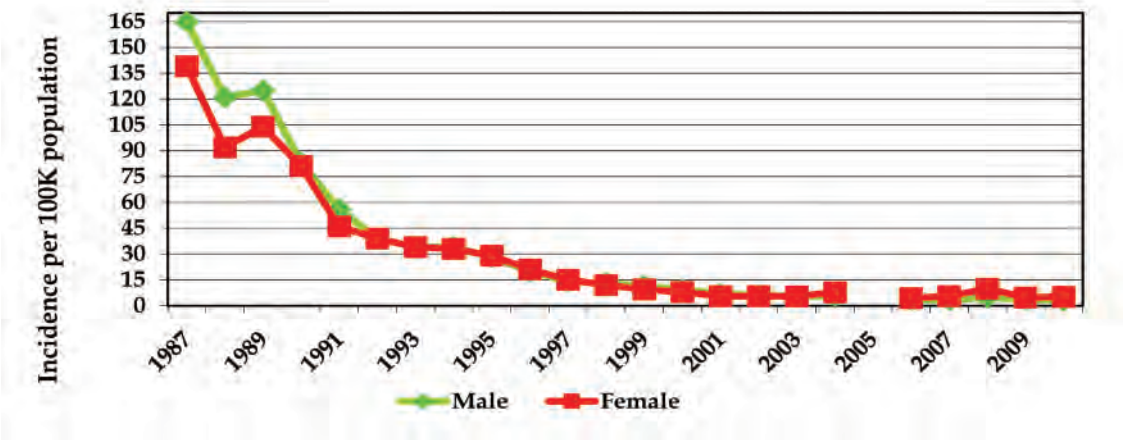


Figure 22: Incidence of primary and secondary syphilis in Jamaica, 1987 – 2010

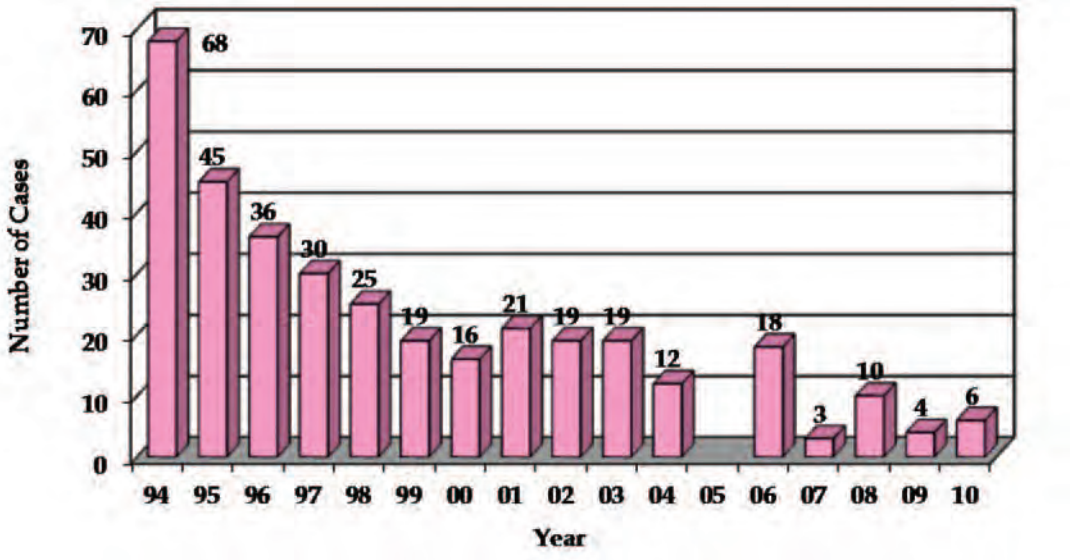


Figure 23: Cases of congenital syphilis in Jamaica, 1994 – 2010

Year	2009			2010		
Age Groups/ Years	Female	M ale	Total	Female	Male	Total
0-9	0	0	0	0	0	0
10-14	0	0	0	0	0	0
15-19	9	2	11	14	2	16
20-24	21	8	29	19	10	29
25-29	10	12	22	12	7	19
30-34	11	6	17	9	6	15
35-39	4	3	7	3	4	7
40-44	5	6	11	8	4	12
45 & over	6	10	16	3	7	10
Total	**66**	**47**	**113**	**68**	**40**	**108**

Table 18: Primary and secondary syphilis cases by sex and age group in Jamaica, 2009 and 2010

11. Monitoring and Evaluation of the National HIV/ STI Programme

The Monitoring and Evaluation (M&E) Component plays a fundamental role in the national HIV response as its primary responsibility is to track the progress of planned activities against targets and determine outcome and impact. In March 2010, a third report on progress on United Nations General Assembly Special Session (UNGASS) indicators was submitted to the Joint United Nations Program on HIV/AIDS (UNAIDS). This was the culmination of a series of meetings with stakeholders and various data gathering exercises including a survey, rapid assessments, and programme monitoring reports.

A summary of the UNGASS indicators is presented in Annex 1. The M&E framework for Phase 2 of Global Fund Round 7 Grant and the performance monitoring plan for United States Agency for International Development (USAID) project were also successfully negotiated in 2010. In addition, in 2010 the estimates process for Jamaica using Spectrum and estimation and projection packages was finalized for the UNAIDS 2010 publication. The findings were also detailed in a journal article which was accepted for publication in the British Medical Journal and published in Sexually Transmitted Infections.

Other achievements under the M&E priority areas identified for 2010 were as follows:

• Improved Data Capture

Although reporting by stakeholders continued to improve in 2010, timeliness and consistency of reporting continued to hamper decision making (Figure 24).

In an effort to improve reporting, a tracking system was implemented by the M&E Unit to determine the timeliness of all expected reports. Summary tables of performance were presented at monthly meetings. Limited dissemination occurred through various stakeholder meetings and distribution lists were established. Systems for wider distribution and hence update on status of reporting are being set up to have routine feedback to stakeholders in 2011.

In 2010, more than 100 copies of the M&E operations manual were printed and disseminated through six workshops in each health region to stakeholders. This activity was a critical step in standardization of data collection tools, reporting timelines and data flow. The manual was developed in collaboration with the team from Monitoring and Evaluation to Assess and Use Results (MEASURE) Evaluation Firm, University of North Carolina. As part of this activity several reporting forms were revised and distributed to improve data capture in keeping with reporting requirements.

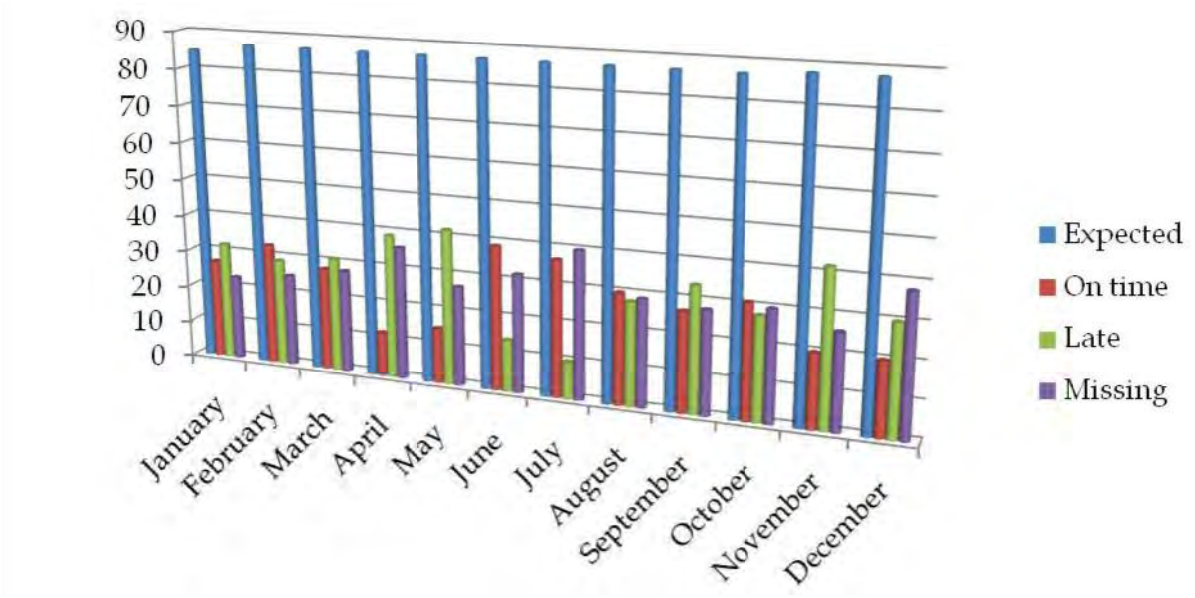


Figure 24: Reporting trend among stakeholders in Jamaica's HIV response, January to December 2010

The M&E Unit also capitalized on various stakeholder meetings to sensitize persons on their roles and responsibilities in the M&E system. Significant focus was placed on data quality in relation to prevention indicators and defining terms such as "reach" and "training" so that all persons responsible for collecting such data were aware of definitions and terminologies. Some meetings that the M&E Unit presented at or participated in, included behaviour change communication (BCC) retreats in all regional health authorities, the NHP's annual review, United Nations Development Assistance Framework (UNDAF) meetings, quarterly Treatment Component meetings, quarterly meetings of adherence counsellors, monthly BCC meetings and National AIDS Committee (NAC) stakeholder meetings including a capacity building exercise for civil society. These meetings provided opportunities for engaging stakeholders in the establishment of the M&E system and improving data capture.

In response to issues relating to data quality, a research officer was hired in November 2010. The officer's initial focus was hands-on training of staff on the treatment database at each treatment site. This was to facilitate the monthly generation of reports, tracking of all reports contributing to Global Fund indicators and reviewing reports for data quality issues. On review of reports, agencies were contacted regarding issues with data quality and followed-up for correction of reports. By December 31, 2010 most sites were printing reports from the treatment database and those sites without the database were provided with an excel sheet format with the appropriate age disaggregations for completion. (Annex 5). Data capture was also improved by strengthening the electronic information systems and capacity building activities which are detailed below.

• Increase Stakeholder Capacity to Conduct M&E

M&E capacity building is a priority for the next three years. This has been hampered by high turnover of staff in some sub-recipients. Previously, several workshops in basic M&E training, data analysis and data utilization were facilitated. However, while feedback on the workshops was positive, gaps persisted in reporting. In July, the unit conducted a rapid assessment of stakeholder training needs. The lessons learnt from the assessment were:

√ Despite their comfort with basic M&E concepts and some familiarity with basic data analysis, the interviewees all expressed the need for further training.

√ The subrecipients (SRs) all described inadequate capacity to perform data analysis.

√ The stakeholders who attended the data analysis workshop series expressed that they had few opportunities to practice the skills learnt in these workshops.

√ The SRs are involved in implementing various projects or interventions to address the needs of their target populations but there is no clear plan or indicators for monitoring the implementation of the intervention or a plan to evaluate its effectiveness.

√ Participants requested capacity building activities in the following areas:
- Data analysis and interpretation
- Data use
- Developing M&E plans for interventions
- Evaluating the impact of their interventions

In this regard, a training calendar was developed and series of training workshops were held. The major training events in 2010 are summarized in Table 19.

M& E Workshops	Number of Participants	Summary
Data Analysis Workshop for RHAs, NGO's govt ministries and NHP staff	74	Five data analysis workshops were held in the first week of January 2010 to build on data quality and utilization. The objectives of these workshops were; 1) Review difference between categorical and continuous data 2) Define and describe evaluation 3) Provide statistical theory for evaluation data analysis 4) Application of theory through an evaluation data exercise with real data.
Capacity Building Workshop for BCC personnel	82	Objectives: To describe basic M&E concepts, to identify characteristics of good indicators, to enhance data management and reporting among BCC personnel, to disseminate Class 1 notification booklets and standardize data capture from outreach testing activities.
Treatment Workshop	62	To familiarize field officers with the reporting requirements of the treatment programme and the importance of the ART database. All treatment sites were represented at the workshop.
Op Manual Workshop Rollout	154	Workshops were held across the regions to train stakeholders on use of the operations manual to improve reporting.
CHRC M&E workshop	15	In November, members of the M&E Unit along with several subrecipients participated in a M&E workshop. The workshop was held over three days and provided a very comprehensive introduction to M&E and setting up an M&E system for NGOs and projects.

Table 19: M&E workshops conducted in 2010.

In addition to training, the M&E staff offered technical assistance to stakeholders in development of data collection tools, data analysis, publication of articles and abstracts, and design of evaluation studies. This included:

~ Data entry and analysis of data from the "Tek it to dem" project which provided new data on the homeless, drug user population in Kingston.

~ Collaborations with BCC team resulted in the acceptance of five abstracts from Jamaica's NHP for the 2010 International AIDS Society Conference in Vienna.

~ Partnerships were also built with other agencies which strengthened the unit's capacity. This included continued collaboration with MEASURE Evaluation of University of North Carolina through USAID. Activities for technical support were identified including revision of the M&E plan and roll-out of the Operations Manual, third generation surveillance of men who have sex with men (MSM) and sex workers (SW), and data analysis of treatment databases.

~ Staff also benefited from regional training such as "population size estimates for most at risk populations (MARPS)" which was held by UNAIDS in June 2010. The NHP also continued to work with the M&E persons from UNAIDS (stigma index concept paper), Centre for Disease Control (CDC), USAID, and Panamerican Health Organization (PAHO).

By December 2010, a consultant was selected and a schedule and curriculum agreed on for a second series of data analysis workshops for stakeholders. The six workshops were scheduled for first quarter of 2011 (each regional health authority, non- governmental organizations, government ministries and NHP staff). A curriculum for evaluation workshops will also be held in collaboration with MEASURE in the first quarter of that year.

• Implement Databases

The information system has been strengthened by modification of the HIV/AIDS tracking system to reflect new variables. Other databases were modified in 2010 to reflect changes in algorithms and protocols e.g. rapid test and treatment databases. Meetings were held with key persons involved in the treatment programme to identify user requirements for the treatment database and to sensitize persons on the possible outputs of the treatment database if used consistently. In response to stakeholder requests, new modules and reports were added to the treatment database. In addition, NHP partnered with Clinton Health Access Initiative (CHAI) team to provide technical support to pharmacies and treatment sites with regard to strengthening forecasting and implementation of databases. As a result, two staff members from CHAI visited all the treatment sites to document extent of usage and barriers to implementation of pharmacy and treatment databases. A report is pending.

The M&E database was also revised to include a training module to capture all persons trained under the NHP. The forms were disseminated in the latter half of 2010.

The information technology officers of the M&E Unit also continued to offer technical support in maintaining the electronic information systems of the wider MOH. This included the development or modification of other

databases such as the obstetric summary database and surveillance databases. Geographic information systems (GIS) equipment was purchased and installed to map HIV cases thereby assisting targeted community interventions and supporting other general surveillance activities.

• Research

Operational research within the HIV response is recognized as critical for effective programme design and implementation. Several agencies have undertaken studies of key populations with limited dissemination of the findings. In 2010, the Monitoring and Evaluation Reference Group (MERG) provided an opportunity for partners to share areas of upcoming research and identify potential areas for partnerships. In 2010, some of the studies undertaken were:

√ STI PREVALENCE STUDY: This study determined the prevalence of five STIs (HIV, Gonorrhoea, Chlamydia, Trichomonas and Syphilis) in STI clinic attendees and also examined the associated behavioural factors. Previously, the most recent STI prevalence study was in 2005. This 2010 study was a cross sectional survey of 150 males and 150 female STI clinic attendees of Comprehensive Health Centre. STI prevalence in this population was: HIV 1.6%, syphilis 2.8%, GC 20.1%, CT 17.4%, TV 13.4%. Chart extractions are being conducted to determine the positive predictive value of syndromic management in this population.

√ MSM INTERVENTION STUDY: A consultant was hired in 2010 to conduct a literature review to identify elements of effective interventions in MSM populations and to conduct focus group discussions. The report highlighted elements of successful interventions based on literature review were engagement with socio-cultural context of the target population, matching of project staff with the target group, consultation with target groups from the earliest stages of the project, use of members of target group as peer educators, developing leadership and communication skills among members of the target population, group or community level of delivery, ethnographic research and long-term engagement. Many of these strategies are currently used by the NHP Prevention Team. Subsequently, five focus groups comprised of MSM who were transgendered, rural, HIV-positive, professionals, and homeless were held. The discussions highlighted elements of interventions that would be acceptable to the population, suitable media for delivery, subpopulations that exist and issues related to stigma and discrimination.

√ MSM BEHAVIOURAL AND SEROLOGICAL SURVEY: The 2007 protocol for third generation surveillance of MSM was revised and submitted for ethical approval. The study began in November 2010 and involved administration of a questionnaire, rapid testing for HIV and syphilis coupled with genprobe tests for gonorrhea and Chlamydia trachomatis. The study is a collaborative effort between the MOH and MEASURE Evaluation. By end of 2010, 60 participants were recruited.

√ WORKPLACE SURVEY: A survey was conducted to determine the extent of implementation of HIV policies and programmes in large enterprises. Between March and July 2010, interviewers administered questionnaires to human resource managers of 27 large companies (100 or more employees) and reviewed policies to determine consistency with international standards. All companies reported

having personnel policies with 15 (55.6%) having specific HIV/ AIDS policies. Policy contents were not always consistent with international standards but generally this showed an improved trend compared to a similar survey conducted in 2005.

√ NATIONAL COMPOSITE POLICY INDEX (NCPI): The NCPI is a UNAIDS core indicator that measures a country's commitment and action within their HIV programme. A five step methodology that consisted of a desk review, collaborative inquiry, stakeholder's interviews, data analysis and data validation was used. Twenty eight interviews were conducted to complete the NCPI survey. The findings revealed that in the areas of strategic planning, prevention, treatment, care and support, monitoring and evaluation, and civil society participation, the Jamaica HIV/ STI Programme has advanced. The human rights and political support areas however were noted to be lagging behind with the human rights area receiving the lowest ratings.

√ VOLUNTARY COUNSELING & TESTING (VCT) SURVEY: A survey of persons accessing VCT on World AIDS Day 2008 was conducted. In 2010, a 12 month follow-up of participants who participated in the initial survey was conducted to determine the impact of VCT on risk behaviours and the relationship between intentions and future behaviours. Of 1,610 persons receiving free VCT at 2008 World AIDS Day, 500 persons were randomly selected for follow-up and 372 persons (258 females, 114 males) responded. Key findings were: 62.5% women and 55.6% men, who said they would reduce their number of sex partners, did so, and of those that said they would abstain, 50% of women and 30% of men abstained from intercourse. Despite intentions of 100% condom use, many did not use a condom at last sex with an outside partner (25% men, 28% women) or main partner (43.5% men, 46.8% women). The data from this study were presented at the 2010 International AIDS Society Conference in Vienna.

√ EVALUATION OF THE NATIONAL STRATEGIC PLAN (NSP) IMPLEMENTATION: A mid- term evaluation of the NSP was scheduled to determine the impact and resource allocation under the NSP. This is in preparation for the next Global Fund Grant application. A suitable consultant was identified and a technical proposal was prepared and reviewed.

√ CO-OCCURRENCE OF PSYCHIATRIC DISORDERS IN HIV/ STI PATIENTS: A protocol was developed to determine prevalence of psychiatric illnesses among PLHIV assessing care in the public sector. In 2010, ethical approval was obtained from the Ministry of Health's Ethics Committee, research assistants were identified and all training materials were developed for the study.

√ STIGMA INDEX: A UNAIDS tool to determine perception of stigma and discrimination against PLHIV is being planned for 2011. The process is being led by Jamaica Network of Seropositives (JN+) and UNAIDS. A steering committee was formed and includes representatives from UNAIDS, MOH, JAS, JN+, University of the West Indies HIV/ AIDS Response Programme (UWIHARP), and Caribbean HIV/ AIDs Regional Training Network (CHART). In 2010, terms of reference were being drafted for the steering committee, interviewers and the research consultant. This project is funded by UNAIDS.

- **Other Activities**

Some routine reports generated in 2010 include World Bank reports, HIV/ AIDS Epidemic Updates for 2008 and 2009, quarterly global fund reports were generated, Caribbean Epidemiology Centre (CAREC) reports, report to UNGASS and the HIV section of Economic and Social Survey. For the most part, targets were met in 2010 for both the World Bank project and Global Fund Grant.

Jamaica's MERG convened three times in 2010. The first two meeting were focused on reviewing and endorsing the UNGASS report while the final meeting was a gathering of stakeholders conducting HIV research in Jamaica to avoid duplication of efforts and maximize use of resources for operational research. Presenters included C-CHANGE, Peace Corp, UNAIDS, NHP, UWIHARP, Red Cross, and PSI. Technical working groups were formed under the MERG during the year with foci as follows: compendium of HIV research in Jamaica, M&E of treatment programme, Research agenda, M&E of prevention programmes.

Additional M&E staff members were hired by the end of 2010 including a biostatistician and a research officer.

Challenges

Despite significant improvement of monitoring systems, little data exists on effectiveness of interventions and stakeholders have limited capacity to conduct impact evaluation. Consequently, many interventions continue to be implemented based on anecdotal evidence and outcome monitoring. While capacity to conduct or monitor impact studies have increased, staff turnover and limited resources continued to create barriers to rigorous evaluations.

Strengthening the electronic information systems is a priority for M&E. Numerous data bases have been designed with varying stages of implementation including a rapid test database in keeping with the scaled up testing programme, a treatment database, revised HIV/ AIDS Tracking System (HATS) and an M&E database. Full implementation of databases have been hampered by stakeholder commitment to use newer systems which require more time initially, lack of information technology support at the field level which results in inconsistency in electronic systems (crashed computers, lack of antiviral software etcetera) and inadequate human resources to perform required data entry functions. At the national level, inconsistency with inter- and intra-net also affected functioning of the unit in particular the maintenance of the HATS database. This contributed to the delay in the epidemic updates for 2009 as the server which houses the HATS database was sometimes inaccessible.

Other challenges faced by the NHP M&E Unit in 2010 included the disturbance in West Kingston in May which resulted in postponement of some M&E activities.

Limited human resource in the regional health authorities is often cited as the main reason for late and incomplete reporting by stakeholders. Increasing stakeholder buy- in through various meetings and

workshops as well as development of tools that will facilitate the reporting process were strategies employed to improve reporting.

HIV surveillance continued to be hampered by under-reporting in both the public and private sectors. Widespread sensitization of health care workers on HIV surveillance is necessary to improve reporting. Changes in the surveillance system have also been identified to improve data capture such as web-based systems and cross-matching cases in different databases such as CD4 testing, laboratory databases and HATS.

Stigma and discrimination, real or perceived, against persons living with and affected by HIV and other key populations resulted in challenges in recruitment for studies and general surveillance. Some sub-populations are still falling below the radar and limited data are available to understand these populations. However, improved partnerships with key populations and influentials have resulted in greater access to services including surveillance.

12. CHART

The vision of the Caribbean HIV/AIDS Regional Training (CHART) Network is to lead the way in training excellence with the aim of reducing the burden and impact of HIV/ AIDS and related conditions in every Caribbean country and territory. Its mission is to strengthen the capacity of national healthcare personnel and systems to provide access to quality HIV and AIDS prevention, care, treatment, and support services for all Caribbean people through the development of a robust and sustainable training network. While CHART's primary focus is training, other important tenets of this organization are research, provision of technical support and service. CHART Jamaica is located at the Epidemiology Research Training Unit (ERTU) building at the Comprehensive Health Centre (CHC) property at 55 Slipe Pen Road in Kingston and is sometimes referred to as ERTU-CHART.

Training

A total of 109 training sessions were conducted during 2010. This included 35 Level 1 training sessions comprised of lectures and presentations and 27 Level 2 or interactive skills building workshops utilizing methods such as case studies. The number of sessions held at the worksite of the participants increased during the period under review with continued implementation of the on-site mentorship programme. The Levels 3 and 4 type training facilitate practicums.

Figure 25: Number of training sessions by training level

Forty five percent of persons participated in Level 1 training sessions and 24% in Level 2. Ten percent of the persons were involved in Level 3 and 4 sessions. The remaining 21% of persons were participants in the Level 1 & 2 combined training.

More than 70% of CHART Jamaica's training sessions were held in the south east health region (Figure 26). Nine hundred (56%) of the 1,522 persons trained were from the south east (Figure 27). This was

attributed to the fact that the majority of treatment sites are located in that region. Participants included health care workers from hospitals, health centres, non-governmental organizations, line ministries, health departments, schools, universities and private organizations. Nurses and doctors accounted the highest cadres trained over the period with 350 and 250 in each group respectively.

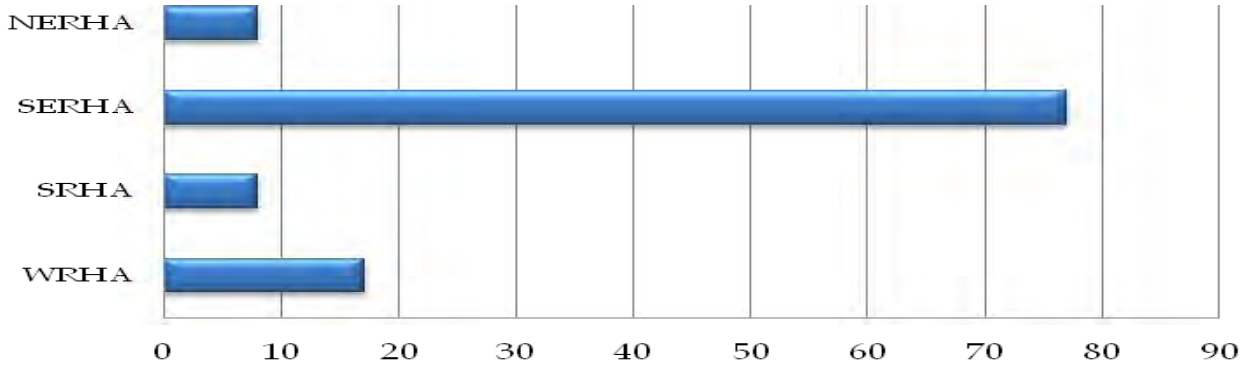


Figure 26: Number of training sessions conducted by health region, 2010

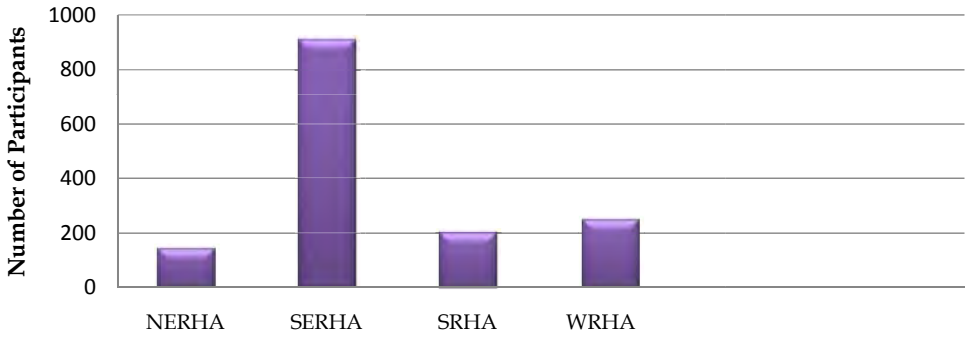


Figure 27: Number of participants trained by health region, 2010

NB. Ten Participants were from outside of Jamaica and 22 persons did not state their region.

The majority of training sessions which were conducted, covered the topics of antiretroviral therapy (ART) and palliative care. The next most commonly delivered topics included policy analysis, system strengthening and stigma and discrimination.

12. CHART

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Mentorship

The overall goal of the mentorship programme is to build the skills of mentees to effectively manage persons living with HIV/AIDS. The objectives are to:

- Maintain and progressively improve the quality of clinical care at all treatment sites by building the capacity of first- and second-level providers to manage unfamiliar or complicated cases (ART toxicity, immune reconstitution inflammatory syndrome, complicated HIV/tuberculosis (TB) cases, treatment of children or pregnant women) and to refer them when appropriate;

- Develop and motivate health care workers by providing effective technical support and communication;

- Identify and reduce the challenges to ART service delivery at the treatment sites.

The programme also includes an assessment of the mentee's treatment site's organizational issues and obstacles.

- Over the initial mentorship period 59 visits were made to treatment sites all around the island. There was an attempt to visit each treatment site every other month.

- Twenty-seven mentees started the mentorship programme over the period in review. Eight mentees left their treatment sites: six during the early stages of mentorship and two after having completed the mentorship. Eight clinicians completed the programme in 2010 and an additional six of the original number are slated to complete the mentorship in mid 2011.

- Even after having completed the formal programme the mentorship relationship continues and periodic visits are made along with frequent telephone or email consultations with the mentees.

Preceptorship

The preceptorship programme is designed to increase the knowledge and skills of physicians who provide treatment, care and support for persons living with HIV. Two physicians are usually paired together from two different regions in order to share experiences, foster networking and future collaboration. Participants are permitted to actively participate in client care or contact, examination, research or other work during his or her preceptorship.

Preceptorships were usually conducted on the fourth Thursday and Friday of each month for a minimum of five hours per day. Dr. Tina Hylton-Kong, Medical Director - CHART was the principal preceptor with assistance from Dr. Clive Anderson, Clinical Mentor CHART. Upon successful completion of the preceptorship a certificate of participation was issued to each individual.

12. CHART

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There were a total of 126 preceptees and mentees trained for the reporting period from treatment sites within Jamaica plus one individual from the Bahamas. The Bahamian participant had a two-week long preceptorship.

Centre of Excellence (COE)

The COE had a full calendar year with the commencement of a laboratory quality assurance consultancy on a part time basis and the establishment of a Pharmacovigilance Centre/ Centre for Post-Exposure Prophylaxis support. The telephone communication structure for this centre was organized.

During the period, the COE participated in two major STI related studies: STI Prevalence Survey and Assessing Counseling Message Effectiveness (ACME). The STI Prevalence Survey conducted in July-August of 2010 examined the prevalence of five sexually transmitted infections in 150 consecutive male and 150 female participants attending the CHC STI Clinic. This study included results from testing for HIV, Treponema pallidum (Syphilis), Trichomonas vaginalis, Chlamydia trachomatis (CT) and Neisseria gonorrhoeae (GC).

STI Clinic

For January to December 2010, there were 10, 956 patients registered for care at the COE STI Clinic. Of these, 4,008 were walk in patients. Six thousand, nine hundred and sixteen were tested for HIV yielding a prevalence rate of 2.7%. Three point five percent of persons tested were reactive for syphilis via the Toluidine Red Unheated Serum Test (TRUST). As of November 26, 2010, SD Bioline commenced use as the first-line screening test for syphilis. Samples determined positive using the SD Bioline were then tested again using the TRUST test which would be used to determine the reactivity titre. Sera from all reactive samples were sent to the National Public Health Laboratory for further testing (Annex 6).

Technical Assistance

Throughout the year the CHART Jamaica team provided technical assistance for a number of their partners. Technical assistance took many varied forms, such as: securing speakers for events both locally as well as regionally, editing of manuals for service delivery guidelines, review of new testing algorithms, conducting training based on need assessments, sharing presentations to assist technical staff in preparation for oral and other presentations and assisting other countries in the development of their Contact Investigation Programme just to list a few.

12. CHART

cont'd

Resources

A variety of resource materials totaling over 3,800 items were distributed to participants at various training workshops (Annex 7). These materials included pocket guides, books, DVDs and manuals. The majority of literature was distributed in the form of handouts such as Caribbean Guidelines for the Care & Treatment, Common Oral Lesions in HIV/AIDS, Healthy Eating for Better Living - Getting the Best from Your Food and Drugs, among others.

Resource material distributed by ERTU-CHART

Monitoring and Evaluation (M&E)

During 2010, several activities were undertaken to monitor and evaluate the CHART Programme against its work plan. The National Training Coordinator (NTC) and the Assistant Training Coordinator (ATC) collaborated to ensure that the work plan was integrated for all CHART activities despite funding streams.

Discussions were held on how to streamline and improve the monitoring and evaluation of the onsite mentoring programme. There was successful completion of the pilot phase of this programme; implementation is slated to begin early 2011.

To preserve the integrity of the voluntary counseling and testing training done by external organizations, the ATC made arrangements to observe these training sessions to ensure that the required standard was maintained.

In an effort to increase M&E capacity building, CHART worked closely with CHART RCU's M&E specialist on an ongoing basis. The ATC also participated in an "Introduction to Monitoring and Evaluation" training workshop held at the Wyndham Kingston Hotel, November 22-24 which included topics such as data quality and management, data collection techniques and tools, data flow and analysis among others.

Partnerships and Collaborations

The NHP was one of the primary partners of CHART Jamaica during 2010. Consequently, the team worked closely with NHP to ensure that the CHART programme was in line with the NHP National Strategic Plan. The organization and implementation of the 7th Annual HIV Management Workshops which were held in June 2010 at the Sunset Jamaica Grande Hotel in Ocho Rios, St. Ann was one such collaborative activity. As previously detailed in Chapter 9, more than 250 individuals participated in three workshops held over a one week period. Another major CHART/ Ministry of Health (MOH) activity was part of an intervention for MSM. The CHART Clinical Mentor, along with the MOH Men's Initiative Team partnered to deliver a series of lectures to a group of MSM. The lectures covered STIs and healthy lifestyle. The Clinical Mentor also returned HIV test results, provided counselling and information as well as referrals for follow-up to those needing care at treatment sites. Collaborations were also facilitated with other local, regional and international partners. Included were:

- The University of North Carolina facilitated a training session on the use of the Genprobe for STI testing. Participants were laboratory personnel from the NPHL and the CHC.

- The Office of AIDS Research (OAR)'s 2011 Caribbean HIV Conference Programme Development Meeting on August 6-8 in Puerto Rico. The Medical Director of CHART Jamaica was part of the Treatment and Care (Track D) technical planning group.

- A HIV-101 workshop was held with representatives from the following non- health organizations: Poor Relief Department, Combined Disabilities Association, Salvation Army, Youth at the Crossroads, West Help & VIP and Caribbean Conference of Churches.

- The ATC and the Behaviour Change Communication Coordinator from the SERHA mobilized eight VCT counsellors to facilitate testing and counselling sessions with the Jamaica Defence Force as a part of a Behavioural and Serological Surveillance Study conducted in November, 2010.

- The CHART team, working along with CHART-RCU completed and submitted the Organization of Eastern Caribbean States (OECS) Contact Investigation Assessment Report (Phase 1) to the OECS.

Challenges

CHART experienced a number of challenges and obstacles during 2010. The team had to be creative and resourceful in order to effectively carry out operations and meet the organizations objectives. There

were a number of unexpected obstacles where training was concerned which led to events either being postponed or cancelled. The civil unrest in West Kingston during the week May 24 – 28 was one such impediment which resulted in several sessions being rescheduled to the following month. Other barriers to the smooth implementation of training included scheduling conflicts, delays in receiving participants' lists from health departments, and competing duties making it difficult for health authorities to release staff to attend training sessions.

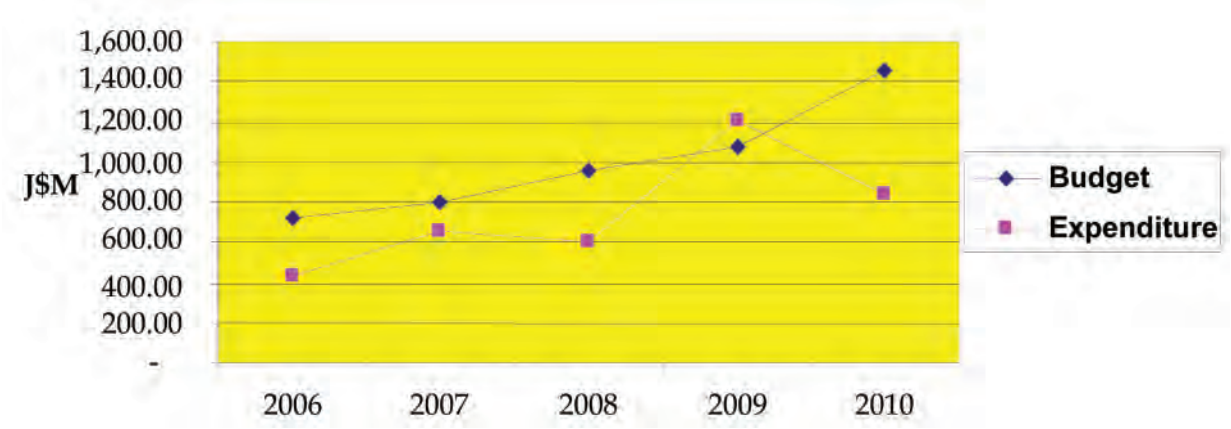
With respect to human resource, the Clinical Mentor position was threatened due to unexpected Global Fund budget cuts. There was overwhelming response to the advertisement of the position of administrative assistant for the COE. Over 400 applicants submitted resumes for the post. The selected candidate was appointed in August.

There were also a number of financial challenges experienced throughout the year. These were primarily due to delayed reimbursements or insufficient disbursements. Other obstacles that were related to the funding agencies were for example the mid- term introduction of changes in categorization of programme areas resulting in difficulties in document preparation to facilitate reimbursement and also the mid-term revision of the amounts of obligated funds with consequential mid-term budget revisions.

13. Finance

The national HIV/ STI response in Jamaica has been primarily financed through a loan agreement with the International Bank for Reconstruction and Development (IBRD/ World Bank), grants from the Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and the United States Agency for International Development President Emergency Plan for AIDS Relief (USAID PEPFAR) with support from the Government of Jamaica (GoJ).

During 2010, a sum of J$1,449.21 Billion was budgeted to support the national response representing an increase of 34% when compared to the J$1,077.80 Billion budgeted for 2009. However, only J$841.18M or 58% of the budget was actually utilized or paid out to suppliers for goods and services in 2010. This expenditure was however, 40% more than the amount spent in the previous calendar year. The shortfall in actual expenditure for 2010 resulted mainly from delays in the expansion of the waste management facility (SERHA) under the IBRD project and the procurement of ARV Drugs under the GF project, both of which accounted for 52% of the shortfall. These activities were scheduled to be conducted in the last three months of the 2010/2011 financial year and thus were not expected to have an impact on the expenditure for the 2010 calendar year.



Source: National HIV/STI Program Financial Statements

Figure 28: National HIV/STI expenditure by fiscal years

A comparative summary of the years 2008 – 2010 by component and implementing entity is demonstrated in Table 20. The resources support five major components: Treatment Care & Support, Prevention, Enabling Environment/Policy, Monitoring & Evaluation and Administration/ Project Management/ Empowerment & Governance.

13. Finance

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COMPONENTS	Calendar Year 2008 Budget J$M	Calendar Year 2008 Actual J$M	Calendar Year 2009 Budget J$M	Calendar Year 2009 Actual J$M	Calendar Year 2010 Budget J$M	Calendar Year 2010 Actual J$M
Treatment Care & Support	410.61	267.64	390.69	555.54	686.14	175.75
Prevention	221.25	164.73	314.07	325.15	330.77	380.55
Capacity Building	29.92	21.58	18.98	23.04	103.35	81.87
Policy & Advocacy	67.22	44.25	88.87	66.90	68.92	55.21
Monitoring & Evaluation	40.02	13.51	51.90	36.11	53.78	46.86
Administration	130.58	81.32	206.23	170.44	130.80	93.20
HADDS	-	-	-	-	55.56	-
RHAS	57.50	6.52	4.78	30.05	15.70	6.52
Line Ministries	-	1.50	2.28	1.95	4.19	1.20
Total	**957.10**	**601.05**	**1,077.80**	**1,209.18**	**1,449.21**	**841.18**

Table 20: Comparative summary of component expenditures, 2008 – 2010

Source: National HIV/STI Program Financial Statements

Over the three year period the Treatment Component received the largest portion of the allocated budgets. This was utilized primarily to procure ARV drugs, test kits, reagents and infant formula.

The funds allocated to the Prevention Component were fully utilized during 2010. This is directly attributed to the scaling up of activities in the targeted communities, for out-of-school youths and with the key populations of sex workers, drug users and men who have sex with men. Resources were spent mainly on mass media activities, purchasing condoms, staff costs and targeted community activities.

There has been a significant improvement in the amounts budgeted and liquidated for capacity building, policy and monitoring and evaluation as the indicators for the year under review were improved throughout the programme.

During 2010, the regional health authorities and line ministries demonstrated a greater level of ownership of their programme; hence more resources were disbursed to these entities. For the first time the regional health authorities received funding from the USAID PEPFAR Project and this was utilized mainly to support staff emoluments and other related costs.

The Global Fund was the largest funding source of the national programme recording expenditure of J$667.32 Million from the budget of $1,061.11 Billion for 2010. This under-expenditure was experienced because some of the project scheduled activities were not conducted until the last quarter of the financial year 2010/2011. The main areas of expenditure were for the procurement of ARV drugs, test kits, condoms, mass media activities, training and staff costs.

13. Finance

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Expenditure from the World Bank project was J$114.34 Million from a budget of J$242.33 Million for the reporting period. The main areas funded under this project were the procurement of infant formula, support of staff related activities and the completion of civil works at the National Public Health Laboratory and Comprehensive Health Center at Slipe Pen Road in Kingston.

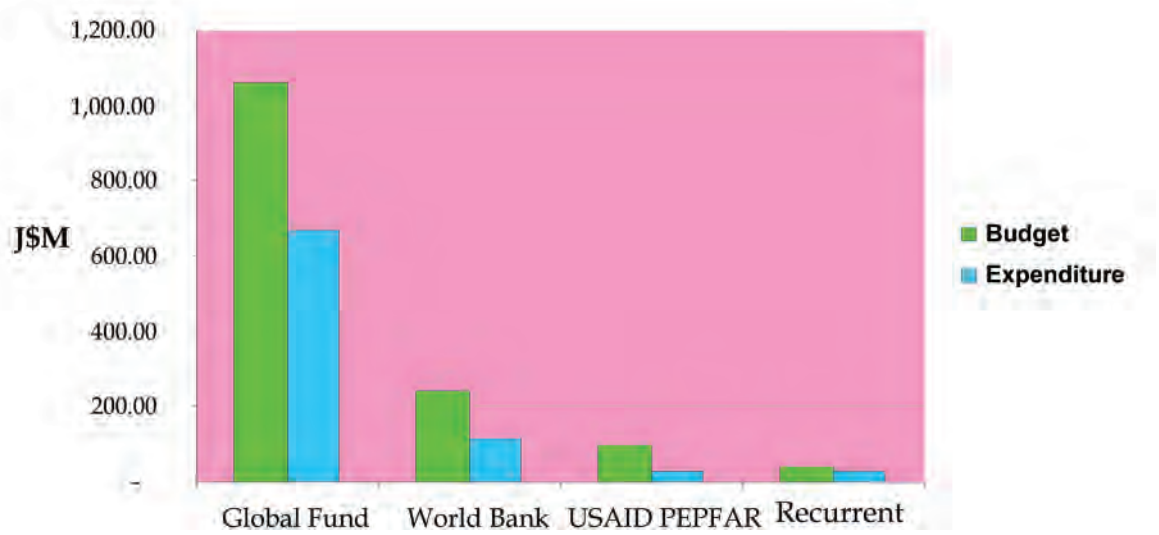

Figure 29: Programme expenditure by agency, 2010

The USAID PEPFAR project expended another J$27.81 Million or 28% of the J$100.78 Million budgeted for 2101. These amounts were used to support staff costs and training activities. The GoJ contributed to J$41.83 Million of the expenditure for the year from a budget of J$61.08 Million to support mainly staff cost.

Approval was received from the Joint United Nations Programme on HIV/ AIDS (UNAIDS) for a small grant of J$3.16 Million of which $J2.93 Million was spent to support the printing of the UNGASS report, the National Strategic Plan and posters for the Monitoring & Evaluation Unit. Figure 29 illustrates the contribution of the major funding sources.

Challenges, Achievements and Way Forward

Despite the improvements in expenditure, the NHP was faced with several challenges which included:

- The lengthy timelines for the procurement process. This significantly delayed the implementation and corresponding expenditure of many activities such as the expansion of the waste management facility in SERHA.

- The untimely release of warrants from both the Ministry of Finance and Planning and the Project Unit of the MOH.

- Delays in the receipt of the first disbursement of resources for the USAID PEPFAR. This amount was received in September 2010 even though the project started in June 2010.

- Delays in the approval of the Phase 2 work plan supported by the Global Fund.

Notwithstanding the challenges that were faced, significant milestones were reached during the year including the signing of memoranda of understanding for the regional health authorities under the USAID PEPFAR Grant. There was also a vast increase in the number of mass media activities, condoms, test kits, infant formula and drugs procured. The staff complement for the absorbed positions supported by the GoJ through the recurrent budget increased from five to 11. Revenue was also provided by the GoJ by way of counter-part funding under the USAID PEPFAR Grant.

Audits for the financial year ended March 2010 were conducted for both the World Bank and Global Fund projects as mandated by the funding agencies. The service was provided by audit firms KMPG and Mair Russell Grant Thornton respectively.

The audit for USAID PEPFAR will be conducted at the end of the project's financial year which was extended from July 31, 2011 to September 30, 2011.

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Ministry of Health Jamaica 2009. National HIV/ STI Programme Facts and Figures, HIV/ AIDS Epidemic Update, January to December 2009.

Ministry of Health Jamaica 2010. National HIV/ STI Programme Facts and Figures, HIV/ AIDS Epidemic Update, January to December 2010.

Annex 1: Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS, Jamaica: January 2008–December 2009

Indicators	
National Commitment & Action	
Expenditures	
Domestic and international AIDS spending by categories and financing sources	In progress
Policy Development and Implementation Status	
National Composite Policy Index **Areas covered**: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation	See Annex 2
National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education)	
Percentage of donated blood units screened for HIV in a quality assured manner [National Target: 100%]	100% (2009)
Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy [National Target: 4800 Adults 200 Children by 2009 or 75%]	50% (2005 – ARV Program monitoring) 53% (2006 – ARV Program monitoring) 61% (Nov 2007 – ARV program monitoring) 49% (Nov 2007 – ARV program monitoring) -It is estimated that there are 14,000 Jamaicans living with advanced HIV in 2009 (Spectrum/EPP software).
Percentage of HIV positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission [National Target: 85% by 2009]	47% (2004 – PMTCT Program monitoring) 65% (2005 – PMTCT Program monitoring) 85% (2006 - PMTCT Program monitoring) 85% (June 2007 – PMTCT Program monitoring) 83% (December 2009 – PMTCT Program monitoring)
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV [National Target: TBD]	64% received co-trimoxazole; 72% received ART (2006 National TB program records) -There were 25 HIV positive incident TB cases in 2006, and it appears that all who met criteria for ARV received such treatment.

National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education) cont'd	
Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results [National Target: TBD]	Men: 12.2% Women: 18.3% (2004, KABP survey) Men: 20.2% Women: 35.4% (2008, KABP survey)
Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results [National Target: 50% of SW by 2012]	43% of SW (2005 second generation surveillance of 450 female sex workers) 53% MSM (2007 MSM survey) 75% SW (2008 SW survey)
Percentage of most-at-risk populations reached with HIV prevention programmes [National Target: 8500 SW 6600 MSM by 2012]	60% of SW (2005 second generation surveillance) This indicator was not determined in second generation surveillance of MSM and SW Over 10,000 SW were reached in 2008 and 2009 (BCC Programme monitoring data) Over 4000 MSM were reached in 2008 and 2009 (BCC Programme monitoring data)
Percentage of schools that provided life skills-based HIV education in the last academic year [National Target: 60% by 2010]	24% of 1014 primary and secondary schools (2007, Ministry of Education HFLE Program monitoring) 44% (447) of 1014 primary and secondary schools (2009, Ministry of Education HFLE Program monitoring)
Knowledge and Behaviour	
Current school attendance among orphans and among non-orphans aged 10–14* [National Target: >0.9% by 2012]	0.97 Male; 1.01 Female 0.99 urban; 0.99 rural (2005- Multiple Indicator Cluster Survey)
** % 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 (MDG Target: 90% by 2005; 95% by 2010) [National Target: 60% by 2011]	38.1% of 15-24 y.o (2004 KABP); 40.2% of 15-24 y.o (2008 KABP) Females 46.7%, Males 22.8% (2004 KABP) Women: 59.8% (urban), 57.9% (rural) (2005 MICS) Men: 37.4% Women: 42.3% (2008 KABP)
Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission [National Target: TBD]	26.1% of SW (2005 second generation surveillance) (data not collected in most recent MSM and SW second generation surveillance studies)
Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 [National Target:TBD]	Men: 47.7% Women: 15.2% (2004 KABP) Men: 56.6% Women: 15.9% (2008 KABP)
Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months [National Target: M: 47% F: 15% by 2008]	Men: 48% Women: 11%(2004 KABP) Men: 61.5% Women: 16.8%(2008 KABP)

Knowledge and Behaviour cont'd	
Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse* [National Target: None]	Men: 66.9% Women: 53.8% (2004 KABP) Men: 64.5% Women: 52.1% (2008 KABP)
Percentage of female sex workers reporting the use of a condom with their most recent client [National Target: 95% by 2011]	84.2% (2005SW survey) 97% with new client 91% with regular client (2008 SW survey)
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner [National Target: 60% by 2012]	73% (2007 survey of MSM)
Female and male median age at first sex [National Target: None]	17.2 Females, 15.7 Males (2004 KABP) 16.9 Females, 16.0 Males (2008 KABP)
** % of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner [National Target: M:80% F:75% by 2011]	66% Females, 74% Males (2004 KABP)
Impact	
**% of young women and men aged 15-24 who are HIV infected (Target: 25% reduction in most affected countries by 2005; 25% reduction globally by 2010) [National Target: ≤ 1.5% by 2009]	1.1% (2004 sentinel surveillance of ANC clients) 1.5% (2005 sentinel surveillance of ANC clients) 1.3% (2007 sentinel surveillance of ANC clients) 1.0% (2009 sentinel surveillance of ANC clients)
Percentage of most-at-risk populations who are HIV infected [National Target: 7% SW; <25% MSM by 2011]	9% of SW (2005 second generation surveillance) 5% of SW (2008 second generation surveillance) 3.3% of inmates (2006, Surveillance of inmates) 32% (2007 MSM survey)
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy [National Target: 85% by 2009]	75% (2000, ARV program monitoring) 87.6% (2007, ARV database) 91% (2009, ARV database and chart review) 2009 data collected at 5 of 19 sites, which include sites representative of urban/rural and large/small populations.
**** Targets included for Millennium Development Goals**	

Annex 2: Global Fund Indicators (September 2010)

Global Fund Round 7 Period 6 – August & September 2010					
Indicator Description	Baseline Value	Year	Intended target to date	Actual Results to September 2010	Reasons for deviation
Number & Percentage of schools with at least one teacher trained in life-skills based HFLE and who taught it in the last year	51 of 1014 primary and secondary schools	2006	600 (60%)	647or 64% of schools had implemented HFLE program in the last school year (June 2009).	**Target met**
Number of students reached through life-skills based Health and Family life interv entions in schools	45,000	2006	329,626	340, 298 students were reached with the HFLE curriculum as of June 2010	**Target met**
Number of CSW, MSM, and inmates reached through prevention activities	7,790 CSW 7,832 MSM n/a Inmates	2008-03-01	550 CSW 450 MSM, 75 Inmates	1017 CSW, 508 MSM and 0 inmates were reached through prevention activities during P6. Bringing the cumulative total to 22069 CSW, 13836 MSM and 1866 Inmates	**Period target met** for the number of SW and MSM reached. **Target not met** for Inmates. There were no BCC officers in the Prison during this period due to staff turnover. A new team member has been hired and is currently working in the position.
Number of adolescents (10-14) and youth (15-24) reached through prevention interventions in out-of-school settings	33,000 (Total)	Jun-07	6,800 Youth, 1,833 adolescents	11063 Youth and 3077 Adolescents through prevention activities conducted by the Regional Health Authorities in out-of-school settings in P6. This brings the cumulative total to **87036** youth and **27318** adolescents	**Period target met**

Indicator Description	Baseline Value	Year	Intended target to date	Actual Results to September 2010	Reasons for deviation
Indicator Description	Baseline Value	Year	Intended target to date	Actual Results to September 2010	Reasons for deviation
Number of condoms distributed for free	150,000	2007	2,250,000	Approximately 64417 Male and Female condoms were distributed by the Regional Health Authorities, NGOs, Ministries and other SRs in P6. 106,678 were distributed through public health clinics and public health outreach services. An additional 738 were reported for P5. A total of 2282184 condoms have been distributed at the end of P6.	**Target met. Unidentified Gap in reporting system for condom distribution**
Number of service deliverers trained on HIV prevention	903	2008-03-01	1,949 service providers	218 teachers were trained to deliver the HFLE curriculum. This brings the total number of service providers trained to 2190	**Target met**
Number of persons receiving counselling and testing for HIV with provision of results	160,000	2006	45,000	28382 persons received counselling and testing during P6. An additional 1945 reported for P5 The total number of persons receiving VCT under R3 and R7 at the end of P6 is 727853	Period Target not met

Indicator Description	Baseline Value	Year	Intended target to date	Actual Results to September 2010	Reasons for deviation
Number of adults and children with advanced HIV receiving ARVs	3,697 adults 348 children	2008-03-01	7,108 adults 456 children	7460 adults and 455 Children, representing both new and existing patients, received ARVs through P6	**Based on cumulative results the target was exceeded for Adults.** According to National Guidelines, persons with CD4 count of 350 or clinical AIDS diagnosis are started on ARVs. **The target met** for Children. NO reports were received for September.
Number of CD4 tests done accordance with guidelines	17,671	2008-03-01	46,278	1425 CD4 tests were conducted during P6. This brings the cumulative number of tests conducted at the end of Period 6 to **42428**	**Target not met**
Number of PCR tests done on infants born to HIV+ mothers according to national standards	757	2008-03-01	2,247	172 tests were conducted during P6. Bringing the cumulative number of tests conducted at the end of Period to 2433	**Target met**

Annex 3: STI Clinic Attendance in Jamaica by Parish, 2006- 2010

	2006			2007			2008			2009			2010		
	New	Old/Rev	Total	New	Old/Rev	Total	New	Old/Rev	Total	New	Old/Rev	Total	New	Old/Rev	Total
SERHA	**5,320**	**8,599**	**13,919**	**7,679**	**10,971**	**18650**	**7,119**	**11,348**	**18,467**	**7,283**	**16,807**	**24,090**	**7,473**	**18,657**	**26130**
KSA	2,862	5,672	8,534	2,886	5,412	8,298	3,096	6,397	9,493	2,908	11,211	14,119	3,334	13,405	16739
STT	758	1,158	1,916	715	1,153	1,868	1,149	2,221	3,370	1,029	2,396	3,425	1,054	2,274	3328
STC	1,700	1,769	3,469	4,078	4,406	8,484	2,874	2,730	5,604	3,346	3,200	6,546	3,085	2,978	6063
SRHA	**5,794**	**2,328**	**8,122**	**5,493**	**2,518**	**8,011**	**8,532**	**3,175**	**11,707**	**10,260**	**4,056**	**14,316**	**9,202**	**3,284**	**12486**
CLA	3,369	721	4,090	3,310	865	4,175	5,207	564	5,771	6,411	670	7,081	6,019	401	6420
MAN	905	633	1,538	1,089	858	1,947	1,566	1,001	2,567	1,837	1,649	3,486	1,500	1,700	3,200
STE	1,520	974	2,494	1,094	795	1,889	1,759	1,610	3,369	2,012	1,737	3,749	1,683	1,183	2,866
WRHA	**3,855**	**5,683**	**9,538**	**4,167**	**5,733**	**9,900**	**3,945**	**5,876**	**9,821**	**4,104**	**5,380**	**9,484**	**3,841**	**5,439**	**9,280**
STJ	2,176	4,220	6,396	2,537	4,558	7,095	2,204	4,850	7,054	1,734	4,518	6,252	1,639	4,608	6,247
HAN	380	219	599	386	361	747	542	400	942	1,075	248	1,323	916	154	1,070
WES	637	256	893	818	337	1,155	926	509	1,435	955	310	1,265	904	317	1,221
TRE	662	988	1,650	426	477	903	273	117	390	340	304	644	382	360	742
NERHA	**3,239**	**2,570**	**5,809**	**2,472**	**1,824**	**4,296**	**3,560**	**2,808**	**6,368**	**5,788**	**4,401**	**10,189**	**5,041**	**6,257**	**11298**
STA	2,170	1,686	3,856	1,171	1,033	2,204	2,121	1,683	3,804	3,130	2,281	5,411	3,094	2,699	5,793
STM	264	42	306	353	115	468	462	67	529	594	45	639	263	45	308
POR	805	842	1,647	948	676	1,624	977	1,058	2,035	2,064	2,075	4,139	1,684	3,513	5,197
TOTAL	**18,208**	**19,180**	**37,388**	**19,811**	**21,046**	**40,857**	**23,156**	**23,207**	**46,363**	**27,435**	**30,644**	**58,079**	**25,557**	**33,637**	**59194**

Annex 4: Summary of STI Reported in the Public Sector, 2010

Year report	2009			2010			Difference
Gender	Female	Male	Total	Female	Male	Total	
All Syphilis	389	184	573	373	154	527	(46)
P&S Syphilis	66	47	113	68	40	108	(5)
TRUST/VDRL < 4dils	100	49	149	138	64	202	351
Genital Discharge Syndrome**	32,397	7,009	39,406	33,169	7,168	40,337	931
Cervicitis Erosion	3,053	48	3,101	2,764	15	2,779	(322)
Trichomoniasis	5,323	764	6,087	6,296	1,142	7,438	1351
Bacterial Vaginosis	8,274	2	8,276	8,193	0	8,193	(83)
Candidiasis	10,967	789	11,756	11,488	872	12,360	604
Genital Ulcer Disease**	781	537	1,318	496	399	895	(423)
Syphilis	31	27	58	210	157	367	309
Genital Herpes	549	423	972	529	371	900	(72)
Chancroid	50	45	95	14	21	35	(60)
Lymphogranuloma Venereum	2	11	13	9	7	16	3
Granuloma Inguinale	7	10	17	9	5	14	(3)
Other GUD	70	53	123	69	109	178	55
Other STD and Non STD Conditions			0			0	0
Epi Treatment for Syphillis	74	72	146	161	149	310	164
Epi Treatment for GC Chlamydia	1,305	1,277	2,582	1,584	1,393	2,977	395
Ophthalmia Neonatorum	73	68	141	70	67	137	(4)
Genital Warts	698	435	1,133	818	587	1,405	272
PID	4,091	66	4,157	3,512	0	3,512	(645)
Epididymo Orchitis	0	44	44	1	37	38	(6)
Congenital Syphilis < 1 yeay old	1	3	4	3	3	6	2
Lymphogranuloma Venereum - all forms	0	0	0	0	1	1	1
Bruising during sex	119	82	201	134	54	188	(13)
Pediculosis	20	15	35	8	27	35	0
Scabies	247	161	408	194	170	364	(44)
All other STD	1,726	984	2,710	1,300	843	2,143	(567)
Non STD Referals	4,976	2,842	7,818	4,278	2,419	6,697	(1,121)
New Patients	20,434	7,001	27,435	18,796	6,761	25,557	(1,878)
Old Patients*	14,758	3,989	18,747	14,283	4,045	18,328	(419)
*Does not include revisits							
** Categories are not mutually exclusive therefore the sum may exceed that of the general category							

Annex 5: Status of ARV Treatment Sites Databases

	ARV Treatment Site	Computer Assigned	Data to be Converted	Data Entry Started	Comments
	SOUTH EAST				
1	KPH	Yes	Completed	Yes	
2	St. Jago Park Health Center	Yes	Completed	Yes	
3	CHARES	Yes	Completed	Yes	
4	National Chest Hospital	Yes	Completed	Yes	
5	Comprehensive H/C	Yes	Completed	Yes	
6	Windward Road Health Center	Yes	Completed	No	Human resource issues
7	Maxfield Park Health Center	Yes	Completed	Yes	
8	Bellevue Hospital	Yes	Completed	Yes	
9	Duhaney Park Health Center	Yes	No	No	Site incomplete, Computer currently at Maxfield Park
10	Linstead Hospital	Yes	Completed	Yes	
	WESTERN				
11	Cornwall Regional - Peadiatrics	Yes	In process	No	Data managed by clinician using SPSS
12	Cornwall Regional - Adult	Yes	Completed	Yes	
13	Montego Bay Type 5	Yes	Completed	Yes	
14	Sav La Mar Hospital	Yes	Completed	Yes	
	NORTH EAST				
15	Port Antonio Hospital	Yes	Yes	Yes	Received computer in 2010
16	Port Maria Hospital	Yes	Completed	Yes	
17	St. Ann's Bay Type 4	Yes	Completed	Yes	
18	St. Ann's Bay Hospital	No	No	No	Patients referred to St. Ann's Bay Type 4
	SOUTHERN				
19	Mandeville Hospital	Yes	Completed	Yes	
20	May Pen Hospital	Yes	Yes	Yes	
21	Mandeville Type 5	Yes	Completed	Yes	
22	Black River Hospital	Yes	Completed	Yes	
	Other Sites				
23	Comprehensive Pediatrics			Yes	
24	Bustamante Hospital for Children			Yes	
25	Spanish Town Hospital			Yes	
26	UWHI Paediatrics			Yes	
27	JAS	Yes		Yes	Data entry not complete
28	Correctional services	NO		No	

Annex 6: Comprehensive Health Centre, Centre of Excellence (COE)

Annual STI Clinic Summary
January to December 2010

TOTAL REGISTERED PATIENTS SEEN:	10,956		Totals	Percent
Total Walk-In Clients	4008	HIV Determine test: Positive	285	7.1
		Syphilis TRUST Test: Reactive	159	4.0
		SD Bioline Positive	25	0.6
		TRUST Reactive ≥8	36	0.9
Total Tested STI Clinic Patients	6916	HIV Determine test: Positive	186	2.7
		Syphilis TRUST Test: Reactive	239	3.5
		SD Bioline Positive	35	0.5
		TRUST Reactive ≥8	63	0.9
For the Region: KSA ANC – Total Mothers tested	5476	HIV Determine test: Positive	56	0.8
		Syphilis TRUST Test: Reactive	71	1.3
		SD Bioline Positive	3	0.1
		TRUST Reactive ≥8	2	0.0
CD4 TESTING DONE:	**SUMMARY OF TOTAL ARV DATA**			
Total Number of patients who did CD4 test for 2010	1909	Total # of Patients on ARV database	2529	
Total Number of patients who did Viral Load test for 2010	1196	➢ Males ➢ Females	1149 1380	45.4 54.6
Total Number of patients who did CBC with CD4 for 2010	1778	Total # of Patients on ARV Therapy	1392	55.1
		➢ Males ➢ Females	653 739	46.9 53.1
		Total starting ARV therapy in 2010	206	17.1
		Total New Patients added to the ARV database in 2010	176	

Annex 7: Resources Distributed by ERTU-CHART

Resources	Total Distributed
ARV Pocket Guides	**55**
Caribbean Guidelines for the Care & Treatment of Persons	56
CHART Brochures	129
CHART Fact Sheet	30
CHART Flash Drive	2
CHART Folders	37
CHART Newsletter	19
Common Oral Lesions in with HIV/AIDS	40
Dental Resources - November 2005 (CDs)	10
Dietary Tips for Coping with problems that could affect your National Health	1
Food and Safety Hygiene	1
Get the Facts - Safe Sex is Best	262
Guidelines on Law, Ethics & Human Rights and HIV/AIDs	1
Handouts:	
~ Adverse Drug Reactions- Definition of Terms	243
~ Diagnostic Features of Vaginal Infection in Premenopausal Women	95
~ Drug Interactions with ARVs (2009) ppt.	1
~ Five HIV Prevention Steps for PLHIV	243
~ Four Main Principles of MI	226
~ Limitation of Pre-Marketing Clinical Trials	241
~ Major Clinical Features of Genital Ulcers- Checklist	125
~ MoH Drug Monitoring Form	245
~ Nutrition and its effect on HAART (2007) ppt.	1
~ Protocols for Desensitization to Cotrimoxazole	2
~ STI CODING	128
~ Universal Precautions	119
~ STI Surveillance - Annual Review 2005-2008 (M&Eunit/NHP)	1

Resources	Total Distributed
Healthy Eating for Better Living: - Getting the Best from Your Food and Drugs	1
Jamaica National HIV/AIDS Programme, Monitoring & Evaluation Plan	1
Lets talk about sex	520
Management of Sexually Transmitted Infections:Vade Mecum	276
National HIV/AIDS Policy	1
National HIV/AIDS Prevention & Control Programme: List of Approved Treatment Sites April 2009	1
National HIV/AIDS Programme: Annual Report 2007	1
National HIV/AIDS Programme: Annual Report 2008	1
National HIV/STI Programme: National Guidelines for the PMTCT	39
National HIV/STI Programme: Occupational Post Exposure Prophylaxis Summary Guidelines	35
National HIV/STI Programme: National Adult Antiretroviral Treatment/Post-Exposure	247
National HIV/STI Programme: National Adult/Paediatric Antiretroviral Treatment Guidelines June 2008	23
Pocket Guide	
~ Hot Girl Mackiesha	10
~ Are you at Risk	1
~ ARV - I'm in Control	3
~Prevention & Treatment of O.I for Adults and Children in the Caribbean 2005	1
~Adult HIV/AIDS Treatment 2007-Bartlett	43
~Caribbean HIV & AIDS Pocket Guide for Nurses	8
Posters	
~ Are you at Risk	1
~ ARV - I'm in Control	3
~ Condom/Prevention - Man a Girl's Man; Trust Me; One Time Fling	3
~ Genital Discharges	5
~ Genital Ulcer	4
~ PMTCT	16

Resources	Total Distributed
~ STI	2
~ Occupational Exposure to HIV, Hepatitis B&C	1
~ Path to Universal Access	1
~ Work Place Policy	1
Practical Case Management of Common STI Syndromes	88
Prevention and Treatment of O.I for Adults & Children in the Caribbean	4
Research Articles on HIV & Condoms:	
~ Comprehensive Response to HIV	1
~ Does a Choice of Condoms Impact	1
~Self reported condom use associated with the decrease in risk of STI	1
Sex Am I Ready?	20
Stigma & Discrimination Trigger Scenarios **(DVDs)**	21
Training Toolkit CD	1
Use a Condom Everytime-Are you at Risk? Checklist	96
WHO recommendations for ART initiation in infants and children	13

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