MINISTRY OF HEALTH
JAMAICA
NATIONAL HIV/STI PROGRAMME
REPORT 2011

MESSAGE

The work of the National HIV/STI Programme (NHP) has spun some 25 years. This quarter-century milestone is significant because the impact of work done has reaped real rewards. The multi-sectoral approach through targeted interventions has led to tremendous successes in the areas of prevention and treatment.

In 2011, less than 1% of antenatal women are HIV+ and less than 2% transmission of HIV from an infected mother to the exposed infant. The NHP has also recorded a reduced HIV prevalence among sex workers by half, from 9% in 2005 to 4.1 in 2011%.

Based on the above-mentioned achievements, one can say that the year, 2011, was successful. This will propel us to join the global community in Getting to Zero: Zero new HIV infections. Zero discrimination. Zero AIDS related deaths. Overall, the number of reported AIDS deaths has decreased since the introduction of ARVs in the public sector. While significant strides in Treatment and Prevention have accounted for 2011 successes, the drive to create an enabling environment for most at risk populations (MARP) have also contributed to the reduction in prevalence. These MARP include as sex workers (SW), men who have sex with men (MSM) and persons living with HIV (PLHIV).

I must acknowledge the financial contributions of our international development Partners who have consistently allocated significant funding to drive the response, 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).

The Government of Jamaica is extremely grateful for the continuous support of these organizations. Increased funding was a significant factor that accelerated the National HIV/STI Programme's (NHP) mandate to increase reach to most at risk populations (MARP), strengthen capacity of staff, create an enabling environment and to advance monitoring and evaluation techniques.

I also want to recognize every staff member of the National HIV/STI Programme (NHP) for their contribution to meeting targets regardless of obstacles faced with reaching most at risk populations (MARP). Their wit, expertise and commitment to help those

who are in need of Treatment and Prevention services are admirable.

While 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 increased targets, getting closer to zero, we pause to reflect some persisting challenges. The prevalence of HIV among men who have sex with men (MSM) remains at 31.9% while nearly 80% of all reported AIDS cases are among young adults in the 20-49 year old age. These are issues that must be addressed as the Ministry of Health remains committed to the fight against HIV/AIDS.

Hon. Fenton Ferguson, CD, MP
Minister of Health

FOREWORD

The National HIV/STI Programme (NHP) was targeted in its approach to strengthening and expanding programmes aimed at getting to zero in 2011. Each technical component; Treatment, Prevention, Enabling Environment and Monitoring and Evaluation, had a mandate of increasing their reach or expanding their services.

Amidst the scale up of the quantity of interventions, there was similar scale up in terms of the quality. The Prevention component added two new activities to the strategic roll-out of programmes to reach most at risk populations (MARP), namely, the establishment of the Sex Worker Drop-in Centre and the Youth Mentorship Programme.

The Sex Worker Drop-in Centre was established, owing to a strong partnership with the Jamaica Red Cross. The Drop-in Centre serves as a mechanism for improving access to essential prevention and treatment services.

The Youth Mentorship Programme targeted youth in the 15-24 age group in the communities of Waterhouse, Tower Hill and August Town. Designed as a peer to peer programme, the selected mentors were required to be students attending tertiary institutions in the same age group willing to mentor youth from low income communities.

The achievements of the mentorship programme included several OSY becoming enrolled in an educational institution or gaining employment within the first four months of the mentorship programme, with 18 enrolling in various institutions for skills training, remedial literacy as well as formal secondary level examinations, such as CAPE and CXC. Ten persons also secured jobs as a result of the intervention.

In, 2011, three (3) media campaigns were designed and placed. Real Man Nuh Ride Widout Condom, featuring popular dancehall artiste Konshens encouraged adolescent males to use a condom through a catch theme song while Take your Meds, Doc's way focused on adherence by Diabetic, Hypertensive and HIV patients. The Ministry of Labour and Social Security produced a media campaign focusing on sexual risk behaviours and HIV transmission, stigma and discrimination, and workplace policy development in the tourism sector.

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

2011 were the Ministry of Education (MoE), 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. Discrimination reduction was prioritized as a key method of achieving an enabling environment. Significant steps included the continuation of the National HIV-Related Discrimination Reporting and Redress System (NHDRRS) and the HIV Workplace Policy Programme.

In the area of Treatment, more people living with HIV (PLHIV) accessed antiretroviral (ARV) treatment. Based on programme monitoring, there were 9,162 persons (8,676 adults and 486 children) with advanced HIV (59% of persons with HIV) started on antiretroviral treatment as at December 31, 2011.

Vertical transmission of HIV continued its decline in 2011 and it is anticipated that Jamaica will achieve the elimination targets come 2015. Psychosocial issues continue to be a major determinant of adherence and a multi-sectoral approach is required to bring these services to scale.

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 2011, the number of "revisits/old clients" increased particularly in SERHA and NERHA.

This highlights the need for continued interventions among STI Clinic attendees. The monitoring and evaluation continues to play a fundamental role in the national HIV response; the outputs for 2011have been used to chart the way forward for 2012 and beyond. During 2011, areas of foci include MARPs, maintaining the gains amongst the PLHIV and the intensification of HIV prevention efforts.

Dr. Nicola Skyers
Acting Director, National HIV/STI Programme

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ACRONYMS

AIDS . . . . . Acquired Immune Deficiency Syndrome
ANC . . . . . Antenatal Clinic(s)
ART . . . . . Antiretroviral Therapy
ARV . . . . . Antiretroviral
CDC . . . . . Center for Disease Control and Prevention
CHART . . . . . Caribbean HIV/AIDS Regional Training Network
GFATM . . . . . Global Fund to fight AIDS, Tuberculosis and Malaria
GIPA . . . . . Greater Involvement of People Living with HIV
HAART . . . . . Highly Active Antiretroviral Therapy
HFLE . . . . . Health and Family Life Education
HIV . . . . . Human Immunodeficiency Virus
IDP . . . . . International Development Partners
JaBCHA . . . . . Jamaica Business Council on HIV/AIDS
JN+ (JN Plus) . . . . . Jamaican Network of Seropositives
KABP . . . . . Knowledge, Attitudes, Behaviour, and Practices
M&E . . . . . Monitoring & Evaluation
MEASURE . . . . . Monitoring and Evaluation to Assess and Use Results
MERG . . . . . Monitoring and Evaluation Reference Group
MSM . . . . . Men who have Sex with Men
NHP . . . . . National HIV/STI Programme
NAC . . . . . National AIDS Committee
NERHA . . . . . North East Regional Health Authority
NGO(s) . . . . . Non-Government Organization(s)
OSY . . . . . Out of School Youth
OVC . . . . . Orphans and Vulnerable Children
PAHO . . . . . Pan American Health Organization
PLACE . . . . . Priority for Local AIDS Control Efforts
PLHIV . . . . . Persons Living with HIV
PMTCT . . . . . Prevention of Mother to Child Transmission
SERHA . . . . . South East Regional Health Authority
SRHA . . . . . Southern Regional Health Authority
STI . . . . . Sexually Transmitted Infections
SW . . . . . Sex Workers
UNAIDS . . . . . Joint United Nations Programme on HIV/AIDS
USAID . . . . . United States Agency for International Development
VCT . . . . . Voluntary Counselling and Testing
WRHA . . . . . Western Regional Health Authority

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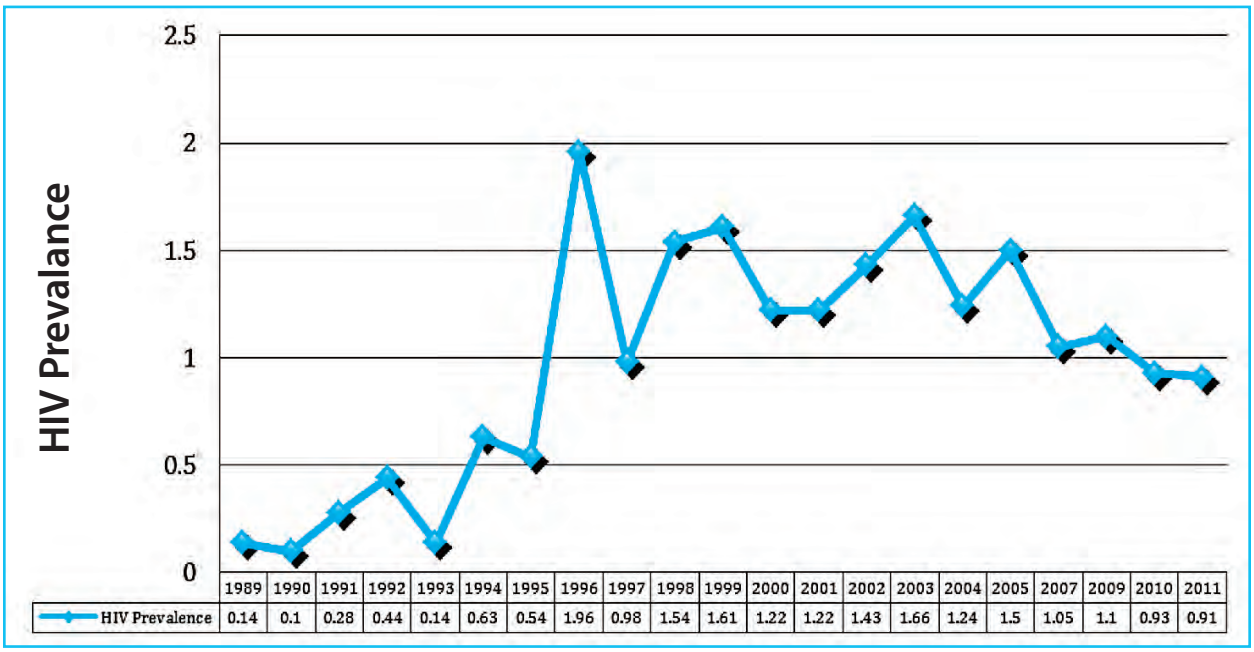
1.0 EPIDEMIOLOGY OF HIV IN JAMAICA

Jamaica has an estimated 32,000 persons living with HIV or 1.7% of the adult population. Approximately one half of these persons are unaware that they are infected with HIV. While new HIV infections in Jamaica have declined by 25% in the past decade, it is estimated that as many as 2,500 Jamaicans will become newly HIV infected in 2012. HIV remains a leading cause of death among adults 15-49 years, with over 333 reported deaths due to AIDS in 2010.

Between 1982 and 2011, 29,069 persons were reported with HIV in Jamaica and the cumulative number of reported AIDS deaths was 8,498. Overall, the number of reported AIDS deaths has decreased since the introduction of public access to antiretroviral medications (ARVs). Three hundred and ninety-three (393) AIDS deaths (234 males and 159 females) were reported in 2011 compared to 665 in 2004. This represents a 41% decline in AIDS deaths since the inception of Universal Access to ARVs in 2004, and a 33% decrease when compared to 2001 (588 AIDS deaths).

Young adults form the main group affected by HIV with approximately 79% of all reported AIDS cases in Jamaica occurring in the 20-49 year old age group, and 90% of all reported AIDS cases aged between 20 and 60 years. The AIDS case rate among men continues to exceed the AIDS case rate among women, though this gap has narrowed over the years.

Sentinel surveillance at antenatal clinic (ANC) sites was initiated in 1989 to estimate the impact of the epidemic in the general population. During the 1990s HIV prevalence increased rapidly among public ANC attendees, peaking at 1.96% in 1996 (Figure 1). Between 1997 and 2005 HIV prevalence among ANC attendees was relatively stable at around 1.5% with a decline to 1% starting in 2007. In 2010 and 2011, sentinel surveillance of ANC clients yielded HIV prevalence below 1% in both years.



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2007	2009	2010	2011
HIV Prevalence	0.14	0.1	0.28	0.44	0.14	0.63	0.54	1.96	0.98	1.54	1.61	1.22	1.22	1.43	1.66	1.24	1.5	1.05	1.1	0.93	0.91

Figure 1: HIV prevalence among public antenatal clinic attendees (15 -24) in Jamaica, 1989-2011

HIV Prevalence	2008 / 2009	2010 / 2011
Adults 15-49 years	1.6%	1.7%
ANC attendees	1.3% (2007) / 1.1% (2009)	0.93% (2 /010) / 0.90%(2011)
Female sex workers	9.0% (2005) / 4.9% (2008)	4.2% (2011)
STI clinic attendees	2.4% (2009)	2.8% (2010)
Men who have sex with men	32% (2007)	32% (2011)
Inmates	3.3% (2003)	2.2% (2010) / 2.5% (2011)
Homeless persons/Drug users	8.8% (2009)	12 (2010) / 8.2% (2011)

The emerging epidemiological data show a decline in HIV prevalence among ANC attendees, and STI clinic attendees. However the HIV prevalence among Men who have Sex with Men (MSM), Sex Workers (SW), Inmates and the Homeless/Drug Users, remain high (Table 1).

Survey data suggest that HIV prevalence is declining among female sex workers (Figure 2). Jamaican sex workers can be described as a highly mobile, heterogeneous group. They operate on streets, in exotic clubs, escort services, massage parlours and permeate the tourism industry.

The decline in HIV prevalence among Jamaican sex workers (SW) is credited to decades of sustained interventions with this population. However, other key populations such as MSM have not experienced similar declines in HIV prevalence prompting a review of strategies and scale up of effective interventions.

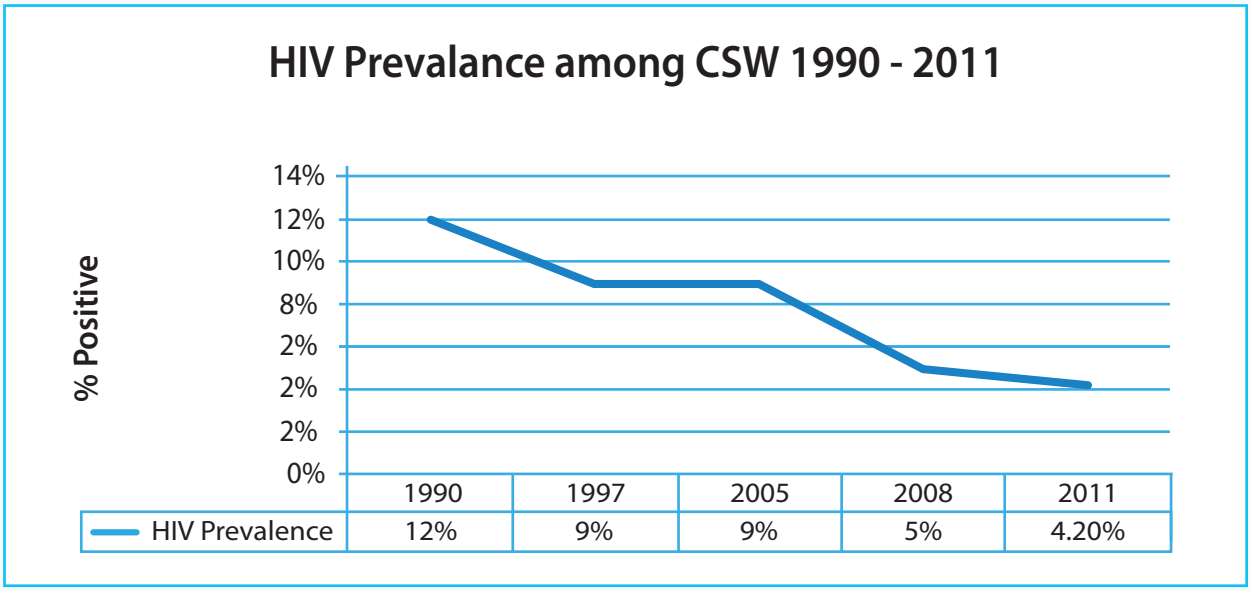


Figure 2: HIV Prevalence among SW, 1990 -2011

1.2 MODES OF TRANSMISSION

Surveillance data indicates that over 90% of HIV infection among Jamaican men and women are attributed to heterosexual transmission. However the sexual practice of 40% of men with AIDS is unknown and may reflect under-reporting by MSM who are unwilling to reveal their sexual practices or reluctance on the part of the health care workers to probe sexual practices in interviews. This gap represents a significant weakness in the national HIV surveillance system.

In 2011, the UNAIDS Modes of Transmission (MOT) model was applied to the HIV epidemic in Jamaica. This model allows policy makers to gain an understanding of the short-term risk of HIV infection in various risk groups and guide the national HIV response. The MOT analysis utilizes data for key risk groups, including the proportion of adults in each group, the current HIV prevalence, patterns of risk and levels of protection against HIV infection in each risk group.

The model suggests that approximately 2,500 new HIV infections will occur in Jamaica in 2012. Approximately 30% of persons with new infections will occur in the MSM group, making MSM the group at highest risk of HIV infection (Figure 4). Female partners of MSM are also at significant risk with an estimated 7% of new infections occurring in this group.

Female sex workers, their clients and the partners of sex worker clients will also contribute significantly with approximately 10% of incident infections occurring in these groups. Twenty-three percent of new infections will be among persons engaging in casual heterosexual sex. This includes unattached youth, STI clinic attendees, homeless drug users, and heterosexual men and women with high risk behaviours.

The distribution of incident cases supports the characterization of a concentrated HIV epidemic. However, the modeling process reinforces that, in Jamaica's context, HIV risk is not isolated to high risk groups as bridging populations may lead to the epidemic becoming generalized again over time.

Injection drug use, blood transfusion and occupational exposure risk groups were not included in the model as these modes of transmission do not contribute significantly to the Jamaica HIV epidemic based on surveillance data.

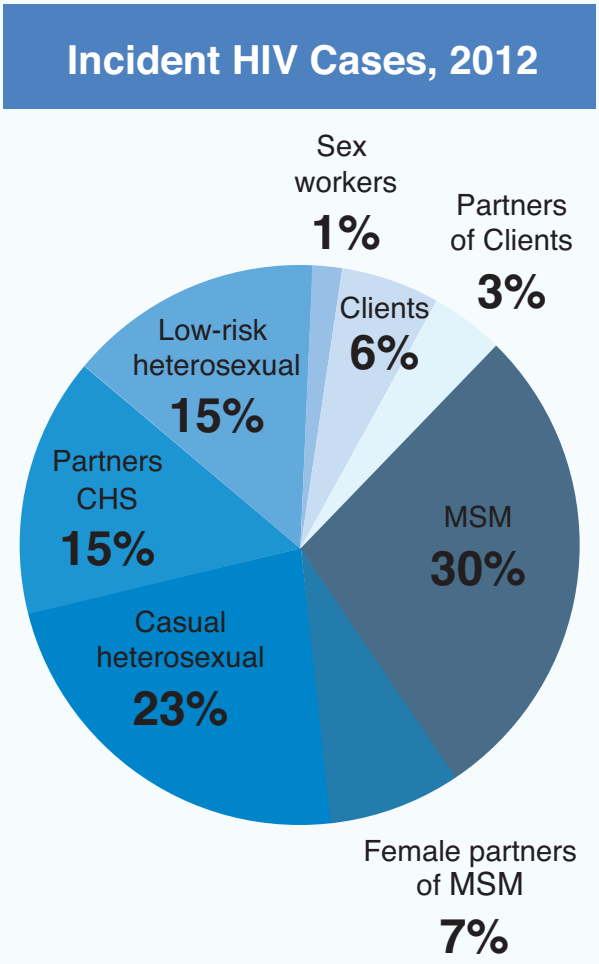


Figure 3: Distribution of incident HIV cases in Jamaica, 2012

2.0 OVERVIEW OF THE HIV RESPONSE

The Government of Jamaica began its national response to HIV/AIDS in 1986 with the start-up of a comprehensive National HIV/STI Programme (NHP). The HIV response in 2011 reflects the goals, vision, strategies, and priority areas of Jamaica's National Strategic Plan (NSP).

The NSP provides the foundation for Jamaica's multi-sectoral response and is outlined under 4 priority areas: prevention; treatment, care and support; enabling environment and human rights; and monitoring and evaluation.

Vision

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

This vision statement guides the national response, the National HIV/AIDS Policy and the National Strategic Plan.

Goal Statement

To reduce the transmission of new HIV infections while mitigating the impact of HIV/AIDS on the people of Jamaica within a sustained, effective multisectoral infrastructure and soliciting the necessary commitment to support the national response to HIV and AIDS.

Strategic Direction

Separate and apart from the priority strategies outlined in the introduction, the overarching strategies of the National Strategic Plan are:

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

3.0 PREVENTION: KEY POPULATIONS

Behavioural surveys and HIV surveillance confirm that the main factors driving the epidemic since 1982 have been multiple partnerships, early sexual debut, high levels of transactional sex and inadequate condom use (Ministry of Health, 2010; Figueroa et al, 2008). Prevention strategies of the National HIV/STI Programme (NHP) aim to influence underlying factors that contribute to these behaviours.

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

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

3.1 MEN WHO HAVE SEX WITH MEN (MSM)

MSM are estimated to represent 4.4% of the adult male population and account for approximately 30% of new HIV infections. HIV prevalence among MSM is 32.9%. These statistics emphasize the urgency for effective, scaled-up prevention interventions in this group. HIV prevention activities among MSM consist of empowerment workshops, voluntary counseling and testing (VCT) and peer education (including community and site based interventions peer educators).

Access to the MSM community continued to increase in 2011 through efforts of non-governmental organizations (NGOs) and the Regional Health Authorities (RHA). Prevention messages and VCT were offered discreetly at college campuses, parties, parks, clubs, private residences, and through PLACE (Prioritized Local AIDS Control Efforts) sites. VCT has been established as a core component of interventions in this population.

In 2011, 2198 MSM were reached by Regional Health Authorities compared to 1,865 in 2010 with Western Regional Health Authority (WRHA) experiencing more than 100% increase in MSM reached (Table 2). Most MSM attending empowerment workshops had HIV testing done except in the North-East Region (NERHA) where uptake of HIV testing was low.

INDICATORS	SERHA	SRHA	NERHA	WRHA	Total
No. of SW reach	72	28	80	115	
No. tested at empowerment workshops	246	58	17	44	
No. of MSM reached	590	211	338	1059	
No. of male condoms distributed	9126	3,647	891	23538	
No. of lubricants distributed	2810	551	n/a	1913	

Table 2: Prevention activities among MSM by regional Health Authorities, 2011

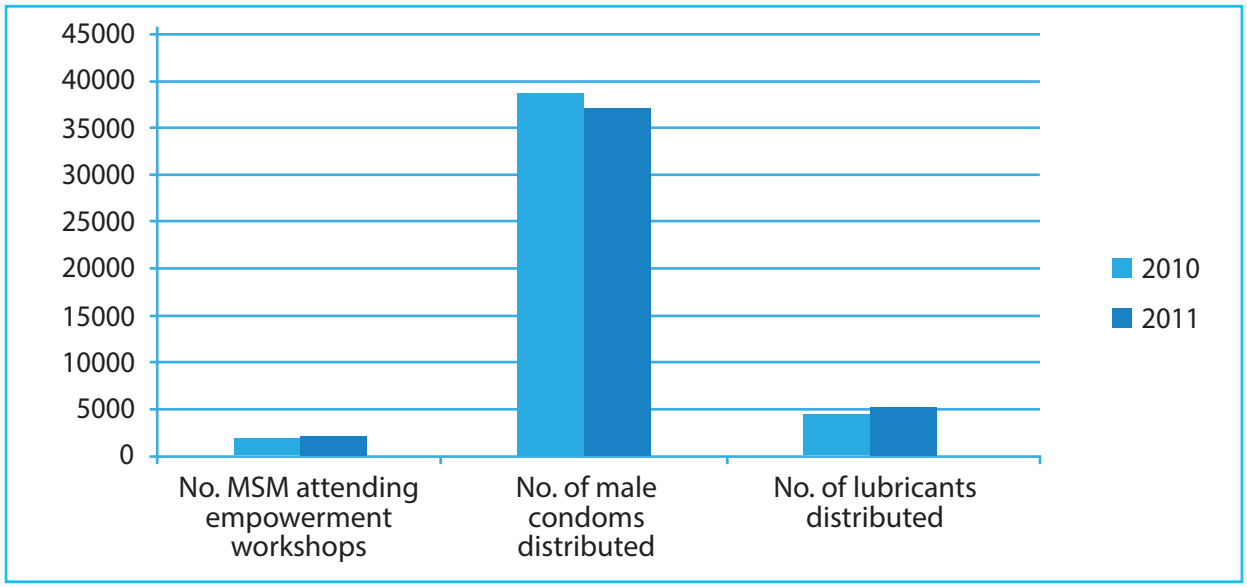


Figure 4: Summary of prevention activities for MSM, 2010 and 2011

Partners

The major partners working with the MSM community are the Jamaica Red Cross, Jamaica AIDS Support for Life (JASL), and Children First. In 2011, ASHE Performing Arts Ensemble signed an implementation agreement to provide a Safe Space for MSM and Out of School (OSY) resulting in 16 MSM receiving VCT.

Children First continued empowerment workshops in 2011 reaching 94 young men and intervening in instances where participants' parents were finding it difficult to accept their sons' sexual orientation.

Jamaica Red Cross also commenced empowerment workshops for MSM in May 2011 and engaged 2 cohorts of MSM. VCT was offered with almost 100% uptake of HIV testing. Other activities undertaken by the Jamaica Red Cross include development of a blog to communicate prevention messages to the MSM community and peer education activities. Over 1,300 MSM contacts were made through the activities of 23 MSM peer educators from Kingston and St. James.

MSM prevention interventions conducted by **JASL** in 2011 included support group meetings, outreach VCT, peer education and positive prevention workshops. **JASL** in collaboration with the NHP, also commenced the development of 2 risk reduction videos focusing on multiple partnerships and condom use. The production of MSM friendly communication material is long overdue as the target population has stated that existing materials are "hetero-normative" and are not suitable for the MSM community.

3.1.1 MSM SEX WORKER

Very little data is available on the MSM sex worker population but this group has been identified as an important sub-group of MSM with specific intervention needs. These needs are not completely addressed by existing empowerment workshops. In 2011, steps were taken to address this important sub-population by facilitating 3 focus groups involving 9 MSM sex workers.

Participants revealed that HIV prevalence among MSM sex workers is high. They indicated that positive health, dignity and prevention as well as

linkages to treatment and care will need to be integral parts of HIV prevention interventions with the group. They stated that they are often victims of violence and abuse by other MSM, members of the public and the security forces. Participants also reported experiencing discrimination at public health centers.

CHALLENGES

While contact with the MSM population continued to improve in 2011, Behaviour Change Communication (BCC) teams were faced with several challenges. Firstly, many MSM lacked insight into their risky behaviours, sometimes denying their sexual orientation and sexuality. Secondly, the worsening economic climate posed a challenge for prevention efforts as some persons were unable to participate in workshops due to transportation costs and often requested funds from staff and facilitators. Many participants were homeless or lacked basic provisions including food.

Participants were also aggressive at times and often had physical fights with other participants. These and other factors indicated that there was an urgent need for psychological and mental health counseling.

3.2 FEMALE SEX WORKERS

HIV prevalence among female sex workers (SW) have declined from 9% in 2005 to 4.9% in 2008 and 4.2% in 2011 (Ministry of Health 2009, Ministry of Health, 2011). The declining trend is attributable to prevention interventions such as risk reduction conversations, condom and lubricant distribution, voluntary counseling and testing (VCT), empowerment workshops and initiatives to reduce social vulnerability.

The success of these interventions are confirmed in a 2011 survey of SW which revealed that 92.4% SW had HIV testing, and >90% reported condom use with paying clients at last sex. However, condom use with non-paying partners and regular partners were sub-optimal (Figure 5).

Figure 5: Condom use at last sex by client type, 2011 SW survey

Site based interventions are a critical component of the successful HIV prevention programme for SW. This refers to a package of prevention services which are presented to the sex worker in their usual environment and on their terms. This approach has increased the acceptability and accessibility of HIV prevention activities for SW.

Hence, in 2011, 79.7% of SW surveyed reported being exposed to HIV prevention programmes. Data from SW interventions and focus groups coupled with SW behavioural surveys have enhanced the quality of interventions. Consequently, the prevention strategy for female SW is constantly evolving to reflect their changing needs.

Empowerment workshops targeted building self-esteem, self-efficacy and life skills. In addition to HIV and STI information, participants were exposed to presentations, products and services offered by financial institutions, vocational training institutions (e.g. HEART TRUST NTA), National Housing Trust and National Council on Drug Abuse.

Such inter-agency collaborations improved social development and reduced vulnerability by providing opportunities for improving literacy and numeracy skills as well as facilitating education goals. Sex workers seeking to exit the trade also received grants in order to start small businesses such as shop-keeping, vending, chicken rearing and starting a restaurant.

In 2011, more than 4,000 contacts were made with SW by Regional Health Authorities with the WRHA reporting an 87% increase in the number of SW reached compared to the previous year. Over 100,000 male condoms were distributed and 1,231 HIV tests were done for SW (Table 3).

The introduction of onsite VCT has resulted in an increase in the number of SW, clients of SW, patrons and staff being tested for HIV. Some SW had recent HIV testing and opted not to be re-tested. Workshops included presentations on the reproductive system, money management, sexually transmitted infections, home ownership, and drug abuse.

Income generating grants used to start businesses chicken rearing, vending and vocational training.

Initiatives in 2011 also facilitated early diagnosis and treatment of STI and health maintenance visits for SW. They include:

PARISH	SERHA	SRHA	NERHA	WRHA
No. of empowerment workshops (no. of participants)	4 (44)	3 (61)	(114)	8 (74)
No. of contacts with SW	1637	602	1335	1638
No. of contacts with clients of SW	n/a	152	n/a	4761
No. of SW tested for HIV	225	558	120	328
No. of male condoms distributed	12,152	26,002	25,768	77,816
No. of female condoms distributed	380	n/a	n/a	2,629
No. of lubricants distributed	661	1,017	1792	1,910

Table 3: HIV prevention activities among SW in Jamaica by region, 2011

- The establishment of a drop in center by Jamaica Red Cross and the NHP: The center provides a safe space for prevention, treatment, care and support services for this population. Activities include empowerment workshops, a resource center, SW Peer Educators meeting/training, walk-in VCT, reproductive health screening, skills training and group counselling (psychosocial support).
- The Pap Smear Initiative: this resulted in 45 SW having pap smears done. The program also involved the treatment of STI and referrals for follow up at the health center.
- The fast-track program: SW were accompanied to the health center to facilitate access to health care in a timely manner. In 2011, 25 SW utilized the service and improvements have been observed in visits to the contact investigator.

CHALLENGES

Interventions with SW must continue to evolve as the risk profile changes. For example, some SW report increase requests for anal sex. In Kingston, St. Andrew and St. Catherine there is a noticeable increase in the number of women operating from street sites and some of these sites experience frequent outbreaks of violence, in particular, in St. Catherine (namely "Back Road").

Behaviour change requires repeated exposure to prevention interventions. However, delivery of prevention messages is challenged by the short time period available for conversations and interventions on-site. Continuity of interventions is also hindered by the high mobility of SW. Loss of contact occurs when SW move under-ground due to increase pressure from patrolling police. In parishes such as St. Thomas, some females engaging in SW do not self-identify as SW or recognize their behaviours as high risk. This prevents delivery of appropriate interventions.

3.3 ADOLESCENTS AND YOUTH

3.3.1 IN-SCHOOL ADOLESCENTS

In-school adolescents are reached primarily through the efforts of the regional health authorities and Ministry of Education, Youth & Culture

(MOEYC) as well as non-governmental organizations (NGOs) such as Children First. The main strategies are the "Hold On, Hold Off" school intervention and the Health and Family Life Education (HFLE) curriculum, which continued to be implemented in 2011.

During 2007, the MOEYC 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. At the end of the 2011 school term in July, 418,517 students were receiving HFLE and 87% of schools were delivering HFLE.

The "Hold On, Hold Off" school intervention targets students of schools in lower income communities and provides youth with information about HIV, sexual and reproductive health (SRH), life skills, amongst other critical areas. The interventions include:

- Peer Educator workshops
- Health fairs: HIV testing was amongst the services offered to parents, community members and students who received prior permission from their parents.
- Summer camps: The summer camps addressed issues affecting adolescents including sexuality, abstinence, peer pressure, self-esteem, relationships, life planning, substance abuse and risky behaviours.
- Presentations at Parent Teachers Association meetings with engagement of parents and teachers.
- Baseline data collection, analysis and dissemination to stakeholders.

In 2011, 26 schools were targeted for the "Hold on, Hold off" school intervention and over 100 summer camps were held (Table 4).

Region	No. of schools	No. of summer camps	No. peer educators trained	No. students reached
SERHA	8	4	99	3,293
NERHA	10	n/a	n/a	1481
WRHA	7	108	179	359
SRHA	2	2	42	302
TOTAL	26	114	278	5,435

Table 4: Hold on, Hold Off School intervention by region, 2011

Adolescents and Youth Participating in School Interventions

3.3.2 OUT-OF- SCHOOL YOUTH

Out-of-school youth (OSY) refers to young boys and girls aged 15 – 24 years who have dropped out of school before completing their tenure or those who have finished school but are without skills. This key population is targeted by Regional Health Authorities and NGOs such as Children First, JASL, and Jamaica Red Cross.

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

OSY were assisted in getting birth certificates and tax registration numbers, allowing them to access training at educational institutions and gain employment. OSY under 12 years of age were also referred to the Child Development Agency (CDA) and dialogue was held with parents, the police, and the schools which they last attended.

In 2011, 21,351 contacts were made with OSY with 710 youngsters participating in empowerment workshops. August Town was selected as a specific intervention site due to the challenges being faced by OSY as it relates to employment, education and crime and violence.

Parish	Number of contacts with OSY	Number OSY participating in empowerment workshops	Number of Male Condoms Distributed	Number of Female Condoms Distributed
SERHA	2,161	141	6,647	n/a
SRHA	2,721	236	10,759	234
NERHA	2261	125	n/a	n/a
WRHA	14,208	208	n/a	n/a
Total	**21,351**	**710**	**17,406**	**234**

Table 5: Interventions with Out of school by region, 2011

Interventions were carried out at street corners, football matches, community parties, taxi stands, bus parks, street corners, markets and at empowerment workshops. Youth mentorship programmes were also conducted in 3 communities: Waterhouse, Tower Hill and August Town. Designed as a peer to peer programme, the selected mentors were students attending tertiary institutions in similar age groups who were willing to mentor youth from low income communities.

Twenty university students from the University of the West Indies and the University of Technology participated in a 4-day Peer Mentors Training Session. This covered various topics including mentoring, HIV/STI information, conducting risk reduction and self-efficacy conversations, motivational interviewing, sex and sexuality. Each mentor was peered with 2 mentees and became familiar with their environment.

The monthly peer mentor's meeting was used as a forum to determine specific areas to be addressed by mentors. Some key areas addressed were development of a life plan, goal setting, assisting with job applications and interviews as well as school enrollment.

The achievements of the mentorship programme include enrollment of 18 OSY in various institutions for skills training, remedial literacy as well as formal secondary level examinations, such as CAPE and CXC. Ten persons also secured jobs as a result of the intervention.

Partners

Empowerment workshops involved several agencies island-wide. They facilitated distribution of birth certificates and Tax Registration Numbers (TRN) as well as enrollment in institutions. Agencies involved in training sessions included National Council on Drug Abuse, Jamaica Foundation for Lifelong Learning (JFLL), HEART TRUST NTA, Jamaica Constabulary Force, National Insurance Scheme (NIS), Child Development Agency (CDA), Citizen Security and Justice Programme and Revenue Department. In the South East Regional Health Authority (SERHA), 28 OSY registered with HEART NTA. Of these, 16 persons were successful with the entrance examinations and started classes. Eight OSY began classes with JFLL and 7 persons were accepted in the National Youth Service.

During the period under review, **Children First** conducted activities targeting OSY. Two youth rallies were conducted reaching 7,694 persons, including 4,038 youth. A 4-day residential training workshop resulted in the training of 44 youth peer educators from Waltham Park and Old Harbour Bay areas. In addition, 238 young men and 595 young women received VCT.

The **Jamaica Red Cross** trained 230 Peer Educators in 2011 reaching 1202 OSY peers and provided HIV testing to 1,992 persons. VCT has been incorporated into almost all Red Cross events.

Hope Worldwide also conducted activities targeting OSY, community outreach, mentoring and vocational skills training programmes. Over 115 youth were trained in life skills development to promote healthier lifestyle choices and self-analysis of behaviours.

Programmes engaged communities through HIV testing, community walk-and-talk, health fairs, and parenting sensitization and training sessions. The latter were conducted to build parenting capacity and create an environment in which persons are empowered and the relationship between parents and children improved. In addition, 57 persons (26 men and 31 women) accessed vocational training in a variety of areas.

CHALLENGES

Although the number of activities with OSY was increased in general, engagement of youth and parental support was often sub-optimal. As with other key populations, prevention interventions continued to be hampered by violence in some

communities. In some instances, interventions at street sites were also interrupted by police patrols.

3.4 INMATES

In 2011, the Department of Correctional Services (DCS) tested 1,188 inmates (964 male and 224 female inmates) in the major receiving institutions i.e. Tower Street, St Catherine and Fort August Adult Correctional Centers and Tamarind Farm.

HIV prevalence among new male admissions during the period was 2.8% while the prevalence among new female admissions mirrored that of the general population at 1.7% (Table 6). Having normalized VCT in correctional facilities, focus is now being placed on HIV testing and awareness at remand centers for both adults and juveniles.

HIV prevention activities also targeted visitors/partners of inmates, parolees and newly released inmates. An 8-week program was conducted at the Tower Street Adult Correctional Facility with the assistance of mental health officers, the public health nurse and the health educator.

A similar program was scheduled for St. Catherine District Prison but did not get underway. The intervention included risk reduction counseling, preparation of support packages, and VCT. HIV positive inmates were also referred to support services within their communities and the nearest treatment site.

Additional activities for this key population included partnering with the Youth Interventions team to conduct sessions on HIV risk reduction, sexual and reproductive health, condom use, building self-esteem and violence prevention.

The sessions targeted adolescent men and youth at the Metcalfe Street Juvenile Remand Centre. Two meetings were held in 2011 and the in-school lesson guide was revised to address issues affecting the young men at the center. Similar sessions were conducted with inmates and wards at Hilltop Correctional Facility, Pringles, Muirton Pen Boys' Home, and the Richmond Adult Correctional Facility (NERHA).

3.5 ORPHANS AND VULNERABLE CHILDREN (OVC)

Orphans and vulnerable children (OVC) refer to children 0 to 17 years who have lost one or more parents or is vulnerable due to HIV i.e. is HIV infected, lives in a household without adequate support due to HIV or is stigmatized or discriminated against. HIV-infected children have ready access to treatment and support services due to the successful prevention of mother to child transmission (PMTCT) programme.

However, support services and interventions for other children affected by HIV have been a gap in the HIV response. In 2011, the NHP and partners such as Children of Faith and Eve for Life implemented activities to address some of the needs of OVC.

	Men	Women
Number of inmates reached with VCT services	982	224
Number of inmates tested	964	224
Number of inmates receiving results	832	223
Number (percent) of inmates with HIV positive result	27 (2.8)	4 (1.7)

Table 6: HIV testing of inmates in Correctional Institutions, by sex.

More specifically, the Children of Faith provided income generating grants to parents and caregivers of households caring for children infected with and affected by HIV. Money management workshops were offered to grant recipients. Income generating projects funded include chicken rearing, farming, and retail clothing. The NGO also conducted:

- Parenting sessions – Fifty four (54) persons attended 3 one-day sessions in 2011.

- Psychological support sessions – One hundred and forty three (143) children benefited from counselling by a counselling psychologist.
- HIV anti-stigma and discrimination sensitization sessions – Two sessions were conducted in July and August with a total of 85 participants.

Eve for Life also piloted an intervention for OVC. Fifteen OVC and their parents or guardians participated in monthly support groups and one-on-one counselling by a psychologist. Parents and guardians were trained in a 3-day parenting workshop followed by regular parenting sessions.

At the end of the year, a proposal was submitted for scaling up the project with continued focus on OVC and other key populations affected by HIV-related stigma and discrimination.

4.0 PREVENTION: TARGETED COMMUNITY INTERVENTIONS

Targeted community interventions (TCI) are HIV prevention strategies designed for communities, usually lower income, with high HIV and STI prevalence. This prevention strategy aims to educate and empower community members to improve sexual and reproductive health and reduce vulnerability to HIV transmission.

Core elements of the TCI are HIV testing, health maintenance checks, parenting workshops, micro-financing, links to educational opportunities and other social support programmes. In addition, condom outlets are established and various influentials are trained as community peer counsellors. Interventions also occur at parties in the community with circulation of information on HIV/STI, condom demonstrations and hype sessions with disc jockeys promoting prevention messages throughout the night.

In 2011, TCI were conducted in approximately 34 communities in the Southern Regional Health Authority (SRHA), South-East Regional Health Authority (SERHA) and Western Regional Health Authority (WRHA). More than 20,000 contacts were made with men and women in the targeted communities (Table 7). In the southern region 571 persons (294 men and 277 women) were trained as peer counselors. This includes community leaders, taxi operators, MSM and community coaches. Five parties were attended by the team in SERHA and condom demonstrations were conducted with more than 1, 000 party-goers. In the North East Region over 300 party go-ers were reached with risk reduction conversations.

	Men	Women
Number of inmates reached with VCT services	982	224
Number of inmates tested	964	224
Number of inmates receiving results	832	223
Number (percent) of inmates with HIV positive result	27 (2.8)	4 (1.7)

Table 7: HIV testing of inmates in Correctional Institutions, by sex.

Condom building skills are a significant and essential part of all TCI. More than half a million condoms were distributed by the Regional Health Authorities with condom distributions being closely linked to condom demonstrations (Table 8). The overall ratio of condoms distributed to condom demonstrations conducted has varied between 8:1 and 13:1 across the regions.

Proprietors of non-traditional condom outlets, which are usually in commercial zones, were also equipped to ensure that condom demonstrations are done by consumers prior to purchasing condoms.

Region	No. of condom outlets established	No. of condoms distribute	Female condoms distributed	Male condoms distributed	No. of condom demonstrations
SERHA	94	134,643	n/a	n/a	15,830
SRHA	157	151,855	150,224	1,631	20,576
NERHA	71	93,757	91,223	2,534	6,304
WRHA	827	369,421	n/a	n/a	26,924

Table 8: Condom distribution and condom outlet establishment by region, 2011.

Eleven (11) empowerment fairs were held in collaboration with several agencies as part of TCI. Some agencies involved were:

- **HEART NTA** provided information about the various skills-building programs offered and facilitated registration of participants.
- **National Youth Services** provided opportunities to register for their job placement program.
- **Registrar General Department** assisted with acquisition of birth, marriage and death certificates. Five hundred and fifty (550) persons received birth certificates from the Registrars General Department.
- **Grace and Lasco** demonstrated how to prepare low-cost nutritious meals.
- **Ministry of Social Security** provided information on various social programs that persons could access including PATH, NIS and Social Security.
- **National Health Fund** registered persons and gave information on available health cards.
- **Bashy Bus Crew** pampered community members with facials, body massage, manicures, pedicures and hair care.

Partnerships were also established with community stakeholders such as, churches,

Community members being treated to nail care at an empowerment fair (2011).

schools, and the police to ensure sustainability as well as to address other problems affecting the community.

4.1 MALES 20-39 YEARS

Behavioural surveys, qualitative studies and local BCC (Behaviour Change Communication) specialists indicate that multiple partnerships, concurrency and inadequate condom use are prominent among young men 20-39 years old.

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

Prevention sessions conducted with men in the 20-39 age group consisted of sensitization around HIV-related issues and outreach VCT at sites frequented by this target group. This includes sporting events, parties and PLACE sites.

The young men and spectators were encouraged to know their status as well as the status of their partners. Interventions at football matches also focused on risk assessment and building condom skills through demonstrations done by patrons.

During the mid-season finals of the Hanover Major League, teams were outfitted with jerseys bearing HIV prevention slogans such as "Condom Everytime" and "Act responsibly…Prevent HIV". In the Southern Region, HIV sensitization workshops were also held over 5 days and 15 young men were tested for HIV and syphilis.

Prevention Interventions with young men

Coaches have also been trained in SRHA and WRHA as a strategy to reach adolescents and young men. The Southern Region Health Authority (SRHA) trained 40 coaches (36 men and 4 women) from the parishes of Manchester and Clarendon during the year.

PARISH	HANOVER	ST.JAMES	TRELAWNY	WEST/LAND	TOTAL
Party interventions (No. Participants)	14(259)	4(3043)	18(1554)	8(1600)	**44(6456)**
Sports interventions (No. Participants)	2(119)	0	2(71)	1(45)	**5(235)**
PLACE Sites	3	6	3	2	**14**

Table 9: Summary of Interventions with young men, WRHA

4.2 PRIORITIES FOR LOCAL AIDS CONTROL EFFORTS (PLACE) SITES

Interventions at sites where people meet new sex partners continue to be an important aspect of the prevention strategy. In 2011, 549 men and 475 women received prevention messages at 7 PLACE sites. In the Southern Region, 1,482 men and 1,329 women were engaged in risk reduction conversations with the BCC teams at 12 PLACE sites and 7,075 condoms were distributed. Environmental cues such as condom use posters and risk cards were also displayed.

CHALLENGES

Despite increased coverage of young men and persons in targeted communities, socio-cultural factors continue to have a strong influence on sexual behaviour. Multiple partnerships remain high and men continue to gauge their sexual health based on their partner's appearance and health.

Maintenance of newly established condom out lets also poses a challenge. While persons are eager to be involved in the establishment of condom outlets, they quickly lose interest due to the lack of financial benefit. Additionally, condom demonstrations have not been proportionate to the number of condoms distributed and needs to occur more frequently.

4.3 VOLUNTARY COUNSSELLING AND TESTING FOR HIV AND SYPHILIS

HIV and STI testing is an important aspect of prevention activities for several reasons. Early diagnosis of HIV infection translates to timely access to treatment, reduction of viral load and, hence, decrease in HIV transmission (Quinn et al, 2000; Donnel et. al, 2010). Awareness of one's HIV status may also result in reduced risky behaviour among persons who are known to be HIV positive. Recognition and treatment of other STI also

have an important role in the reduction of HIV transmission (CDC, 1998; Flemming, 1999). Several initiatives have resulted in a continued increase in HIV testing island-wide. This includes the establishment of an HIV Outreach Testing (HOT) team, acquisition of HIV testing mobile units and the operation of walk-in testing sites. Consequently, outreach HIV testing increased in comparison to the previous year and HIV testing has been normalized across the health regions.

In 2011, HIV testing occurred at socializing sites such as bus parks, plazas, major towns, night clubs, taxi stands and health fairs. Walk-in testing sites include the Windward Road Health Centre, St. Jago Park and Greater Portmore Health Centers. Plans were underway to establish a center at Linstead Health Center but this was delayed due to a lack of space and shortage of staff. Similarly, infrastructural challenges in St. Thomas led to the termination of the walk-in testing site in that parish. In 2011, 1,172 women and 382 men visited walk-in sites for HIV testing.

In total 7,076 men and 10,191 women were tested for HIV by the HOT team. In addition, 13,162 men and women were tested for syphilis.

Although, the number of men tested for HIV increased in 2011, the number of women continued to exceed the number of men tested at outreach events. Repeat testing by participants is also common.

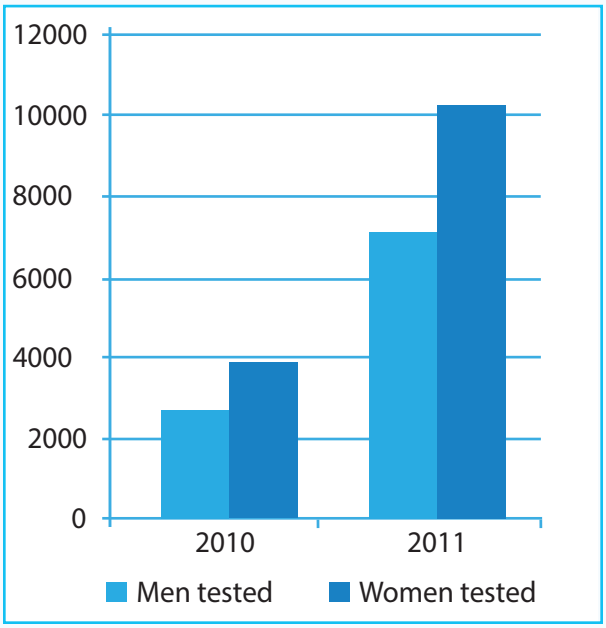


Figure 6: HIV testing conducted by HOT team in 2011 and 2010, by sex

Voluntary counseling and testing conducted by mobile testing unit during a community intervention.

Islandwide, 258,000 HIV tests were done in 2011 (see section 9.1).

5.0 PREVENTION: MEDIA CAMPAIGNS & SPECIAL EVENTS

Two mass media and outdoor advertising campaigns were designed during 2011: 'Real Man Nuh Ride Widout Condom' and 'Take your Medication'.

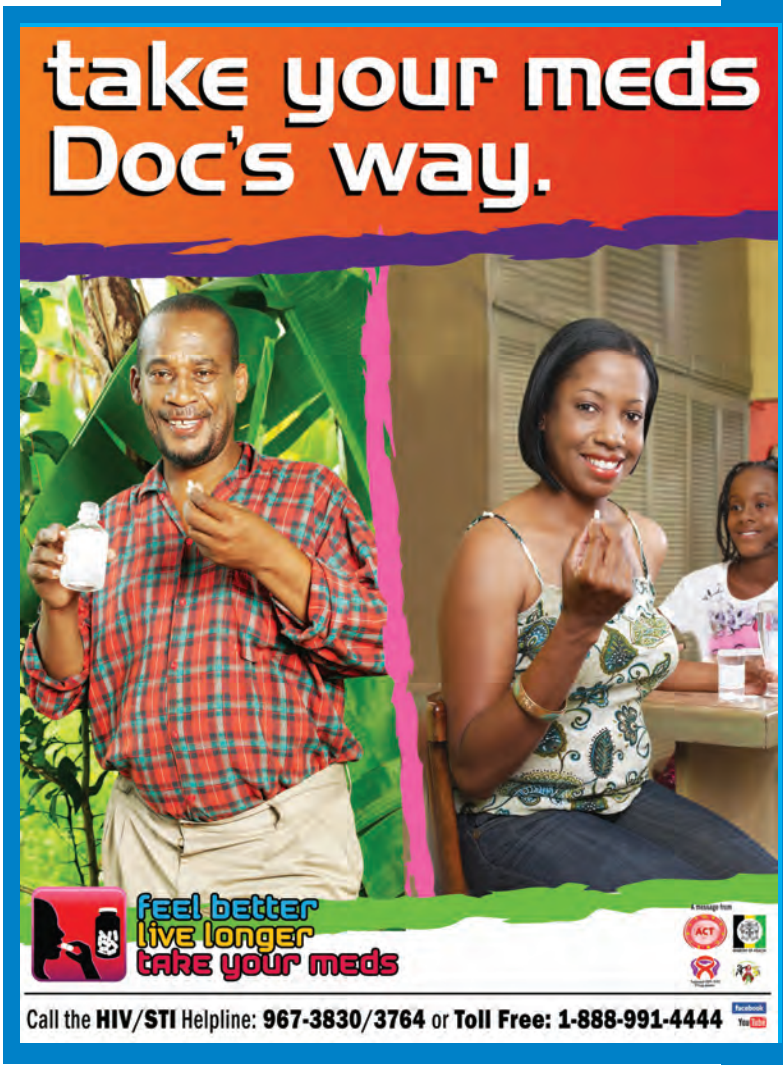
The 'Real Man Nuh Ride Widout Condom' media campaign was aimed at increasing condom use among young men age 15-24 years old who are sexually active. This media campaign reinforced key messages and contradicted cultural norms regarding multiple partnerships and condom use. The campaign consisted of a music video using a popular musical icon, Konshens, and 3 vignettes targeting issues surrounding condom use and multiple partnerships. It promoted the idea of men initiating open and honest sexual communication with their partner.

The materials were pilot tested among young men island-wide and received positive feedback. Participants indicated that the messages were pertinent and effectively conveyed. As part of the "Real Big Man Ting" campaign, a comic strip is also being developed to reinforce the messages with this target population. A consultant was identified and the script and illustrations were drafted.

In 2011, a general adherence media campaign was launched to deliver messages regarding adherence to medications for all chronic diseases. Previously campaigns on adherence targeted PLHIV who were on antiretroviral (ARV) medication. However, poor adherence to medication also causes morbidity and mortality due to other chronic illnesses such as diabetes mellitus and hypertension.

These chronic illnesses are major risk factors for cardiovascular diseases (e.g. myocardial infarction and stroke), which are the number one cause of death in Jamaica and accounts for a significant portion of the health budget.

Consequently, a general adherence media campaign was designed to improve adherence to medication among adults 29 – 39 and 49 – 59 years old. The campaign encourages PLHIV as well as persons with hypertension and diabetes to take their medication as instructed by their doctor. The benefits of taking medication consistently and, hence, living longer, healthier lives are emphasized. The final products of the campaign are a 30-second television advertisement, 30- second radio advertisement and a 17" x 11" poster.



5.1 MEDIA RECALL SURVEYS

Three media recall surveys were also conducted in 2011 with positive responses by the target audience. The surveys focused on "Yes I Can…Support Someone Living with HIV", "Pinch, Leave an Inch and Roll" and "Time to Talk" campaigns.

The media recall survey for **'Yes I Can…Support Someone Living with HIV'** campaign revealed that 83.8% of persons recalled having seen or heard the advertisement. Most persons felt that the advertisements reinforced the importance of family support and that PLHIV could lead a normal life. High levels of recall were also recorded for the **"Pinch, Leave an Inch and Roll"** campaign with over 85% of the respondents correctly completing the tag line. Fifty percent of respondents reported that they had discussed the campaign with others and 90% stated that many of their peers had seen the campaign.

On the other hand, recall of the **"Time to Talk"**campaign was low. However, the campaign was considered relevant and important because there is a major breakdown of communication between parents and children.

5.2 SPECIAL EVENTS

Three major special events are commemorated each year to promote HIV and syphilis testing as well as to deliver key HIV prevention message at a central, convenient location:

- **Safer Sex Week** was observed during the week of Valentine's Day
- **Regional Testing Day** was observed on June 27, 2011 in the Caribbean and
- **World AIDS Day** was observed on December 1, 2011 internationally.

In addition to HIV and syphilis testing, these events include distribution of HIV/AIDS information, condom demonstrations, risk reduction conversations, empowerment opportunities and entertainment.

5.2.1 SAFER SEX WEEK

The main event of National Safer Sex Week was held on Monday, February 14, 2011 (Valentines' Day) at the Portmore Community College (Old Harbour Campus) with the theme: 'Protect your Love, Use a Glove'. The event featured free HIV and syphilis testing, HIV/AIDS information and a live outside broadcast on RJR 94 FM during "Ruption", a popular radio talk show hosted by "Miss Kitty". Eight hundred and eighteen (818) persons were tested for HIV. The rapid tests for syphilis were piloted at this event with 165 persons volunteering to be tested. Island-wide, more than 2,000 persons were tested for HIV during safer sex week (Figure 7).

Mark Palmer (left), Targeted Intervention Officer, St. Catherine Health Department, demonstrates the use of a condom in thirty (30) seconds flat to host of the programme Khadine "Miss Kitty" Hylton (right).

This student of the Portmore Community College - Old Harbour Campus demonstrates the correct way of putting on a condom – Pinch, Leave an Inch and Roll- while her colleague attempts to do same.

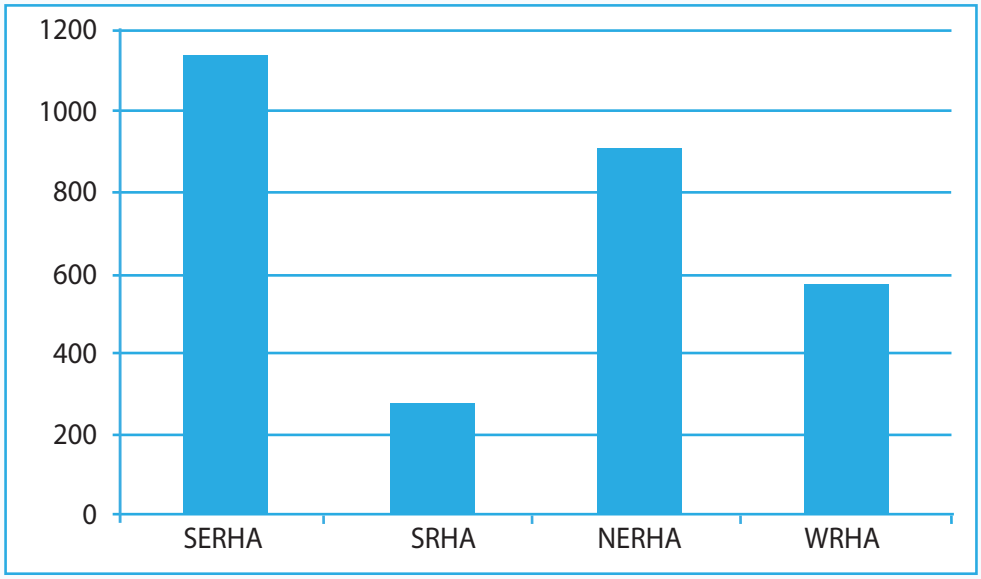


Figure 7: Number of persons tested for HIV during safer sex week, by region

5.2.2 REGIONAL TESTING DAY

The Caribbean Broadcasting Media Partnership on HIV and AIDS hosted a launch and testing event on Regional Testing Day in collaboration with the Scotia Bank and the National HIV/STI Programme. The launch was held on Friday, May 27, 2011 at 10:00 a.m. at the Scotia Center Branch, Downtown Kingston.

Several prominent persons were tested publicly for HIV, including the Honourable Rudyard Spencer Member of Parliament), the Honourable Portia Simpson-Miller, (Member of Parliament), Mr. Bruce Bowen (President and CEO of Scotiabank, Jamaica) Dr. Fenton Ferguson, MP and Mr. Robert Fuderich (UNICEF Country Representative). In total 1,167 persons were tested on Regional Testing Day.

Left to Right: Bruce Bowen, president and CEO of Scotia Group Jamaica, (left), Health Minister Rudyard Spencer, and Portia Simpson Miller, Leader of the Opposition, display their HIV test results at last week's launch of the regional HIV testing day initiative at Scotia Centre, downtown Kingston.

Kayan Lue, Field Coordinator (right) prepares to test Mr. Robert Fuderich, UNICEF Country Representative.

Dr. Fenton Ferguson, Opposition Spokesman on Health (left), waits calmly after being tested public for HIV while Outreach Officer, Dacota Nelson, documents the results.

5.2.3 WORLD AIDS DAY

Three activities were held in commemoration of World AIDS Day (WAD): a Proclamation, a church service and a HIV testing event under the theme: **"No New Infections, Know YOUR Status!"** The World AIDS Day activities emphasized "partnerships" as all activities were organized by various stakeholders of the national HIV response. The Proclamation was held on Friday, November 18, 2011 at Kings House and was attended by the Minister of Health, Honourable Rudyard Spencer, the Permanent Secretary, Ministry of Health – Dr. Jean Dixon and other stakeholders in the HIV response.

The national church service was held on Sunday, November 27, 2011 at the Universal Centre of Truth for Better Living. The National World AIDS Day Event was held on Thursday, December 1, 2011 at Devon House.

Hon. Rudyard Spencer, Minister of Health (right), receives the proclamation from the Governor General of Jamaica, Sir, Patrick Allen.

Sir Patrick Allen, Governor General of Jamaica is flanked by Health Minister Rudyard Spencer (left) and Permanent Secretary in the Ministry of Health, Dr. Jean Dixon (right). Also present were (left to right) Jermaine Spencer (Executive Director, Grata Foundation) Patricia Donald, (Gender Equality and HIV Technical Advisor), Mrs. Terry-Ann Frith (Coordinator, Projects Implementation and Administration) and Roshane Reid (Behaviour Change Communication Officer).

Ashé delivers a powerful rendition of “I speak life”.

A section of the World AIDS Day church service as congregants sang.

Roshane Reid, Behaviour Change Communication Officer is flanked by a few patrons and Emcee, Renee Garel (right) as she does a condom demonstration.

A female patron attempts to find the right side of the condom while doing a condom demonstration at the information booth.

The Tiling Try-A-Skills booth by the HEART Trust/NTA was brimming with men who wanted to learn.

World AIDS Day: Outreach Testing

The regional health authorities conducted almost 4,000 HIV tests on World AIDS Day (2011). (Figure 8). HIV testing was conducted at popular venues with HIV prevention messages and statistics resonating on the air-waves throughout the day.

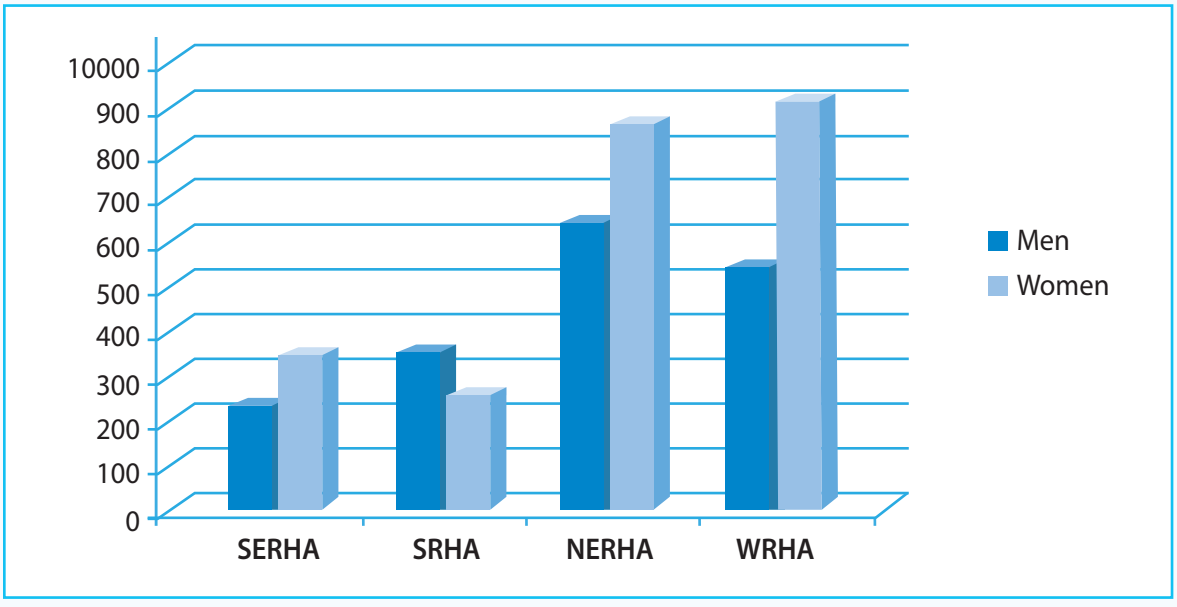


Figure 8: HIV tests done on World AIDS Day, by Region and sex

6.0 PREVENTION: POSITIVE HEALTH DIGNITY AND PREVENTION (PHDP) – TARGETING PERSONS LIVING WITH HIV

The three main components of this strategy are individually focused health education, peer support and provision of social support.

Positive Health Dignity and Prevention Workshops – Health Education

Support from the Center for Disease Control and Prevention (CDC) facilitated 2 training opportunities for health care workers on PHDP in 2011. Workshops at the regional level focused on training caregivers, provision of support to newly diagnosed PLHIV and training staff at treatment sites to improve service delivery in an atmosphere free of stigma and discrimination. Over 160 persons benefited from training in NERHA, SRHA and SERHA.

Social Support

Social support was provided to PLHIV through income generation grants, support groups, and services of partners such as Food for the Poor, LASCO, and CARIMED. In NERHA and SERHA, 170 persons benefitted from grants to establish micro-businesses and aid with back to school purchases.

Income generation grants were used to establish businesses such as chicken and pig rearing, shop keeping, gardening, farming, sale of phone cards, and drapery making. The beneficiaries (SW, MSM, OVC, PLHIV and OSY) were monitored monthly by the liaison officer, social workers and BCC officers. Three PHDP workshops were also held for 120 persons to build capacity of beneficiaries of income generating grants. Additional workshops were facilitated by a business consultant on budgeting, business management, and money management. Participants were also assisted with opening of bank accounts.

Peer Support

Support groups for PLHIV were also convened in 2011. SERHA continued to work with 16 support groups and 6 new support groups were established in SRHA. Fewer PLHIV were reached in workshops in the NERHA (24 persons) in comparison to 2010 due to financial constraints.

Generally, participants were selected from the treatment sites through referral from social workers and adherence counsellors. The first cohort of 7 support groups was completed in June 2011 and is now operating independent of the NHP. The second cohort of 9 support groups commenced in September 2011 and will end in March 2013. Topics covered include condom use and negotiation, nutrition and adherence counseling.

7.0 LINE (SECTOR) MINISTRIES

HIV is recognized as a developmental issue and requires a multi-sectoral response. Government ministries continued to play an important role in implementing the priorities of Jamaica's HIV response under the national strategic plan. In particular, the Ministry of Labour and Social Security, Ministry of National Security and Ministry of Tourism conducted activities in collaboration with the NHP.

7.1 MINISTRY OF LABOUR AND SOCIAL SECURITY

Activities conducted by the Ministry of Labour and Social Security (MLSS) during 2011 were primarily focused on the revival of the Voluntary Compliance Programme (VCP), promotion of the National Workplace Policy on HIV/AIDS and other HIV prevention activities.

The VCP was launched in 2007 and was developed to assist companies to recognize HIV/AIDS as a workplace issue and to take the necessary measures to respond appropriately at the workplace level in order to mitigate the spread of the disease.

During 2011, the MLSS conducted 4 workshops to re-acquaint companies enrolled in the programme with the objectives and future direction of the voluntary compliance programme. As a result, 82 new enterprises became enrolled in the programme. Twenty audits of enrolled companies were completed and 140 peer educators were trained to support the VCP initiative.

In 2011 the National Workplace Policy on HIV/AIDS was amended and public consultations were conducted as recommended by Parliament. A public education campaign was also launched to promote the development and implementation of HIV workplace policies in small businesses, (i.e. businesses employing less than 100 persons). Under this campaign a 30- second radio clip and a 60- second television clip were produced.

The Ministry of Labour and Social Security also supported the HIV response through other prevention activities. Under the United Nations Population Fund (UNFPA) comprehensive condom programme, 8,000 female and 50,976 male condoms were distributed by the ministry to clients at all offices and companies enrolled in the Voluntary Compliance Programme. In addition, MLSS coordinated a number of activities during Safer Sex Week and World AIDS including HIV testing and condom distribution.

7.2 MINISTRY OF NATIONAL SECURITY

The Ministry of National Security (MNS) completed the final draft of their HIV/AIDS Workplace Policy during 2011. The Medical Services Branch of the Jamaica Constabulary Force (JCF), with assistance from the NHP, conducted 850 HIV tests (487 men and 363 women) and distributed more than 9,000 condoms (8640 male condoms and 550 female condoms). The JCF also held 24 sessions on healthy lifestyles and 189 persons participated in 3 workshops on crisis and adherence counseling.

7.3 MINISTRY OF TOURISM

In 2011, the major focus for the Ministry of Tourism/ Tourism Product Development Company was the development and promotion of the Tourism Sector Media Campaign. This campaign focused on sexual risk behaviours, HIV transmission, stigma and discrimination, and workplace policy development in the tourism sector. Messages were delivered through a 15-minute docufeature, three 30-second radio advertisements and 3 posters. It is hoped that this campaign will act as a catalyst for HIV Workplace Policy development and HIV workplace programme maintenance within the sector.

In 2011, 304 hotel sector workers participated in sensitization sessions and 810 tourism sector workers were tested for HIV. Prevention interventions for contract carriage operators were paired with the Tourism Product Development Company's (TPDCo) inspection for licensing renewal and resulted in an increased uptake of HIV testing.

However, while some hoteliers have facilitated on-site testing for HIV, he overall response to HIV testing is sub-optimal and has not been recognized as a priority.

8.0 ENABLING

8.0 ENABLING ENVIRONMENT AND HUMAN RIGHTS

An enabling environment is a set of interrelated conditions which together reduce vuln ability to HIV and other diseases promote a healthy responsible lifestyle and facilitate access to services in a sustained and effective manner. These inter-related conditions are legal, organizational, fiscal, political, and cultural factors. Therefore, the primary objective of this priority area is to reduce stigma and discrimination in all sectors.

8.1 DISCRIMINATION REDUCTION

National HIV related Discrimination Reporting and Redress System

In 2011, 19 cases of discrimination were reported to the National HIV-related Discrimination Reporting and Redress System (NHDRRS). Of these, 17 cases were reviewed and had redress initiated (Figure 9). Steps were taken to improve the pace of addressing reported cases of discrimination. Specifically, the Interim Investigative Team of the NHDRRS, which was established to review and oversee the investigation of cases, reviewed and initiated action on all cases reported to the System in 2010 and 2011.

Additionally, 16 investigative officers were trained to improve the capacity of the system and various partners became engaged in the redress process. For example, the Public Defender, the Ministry of Education and the Nursing Council of Jamaica participated in resolution of reported cases of discrimination in 2011.

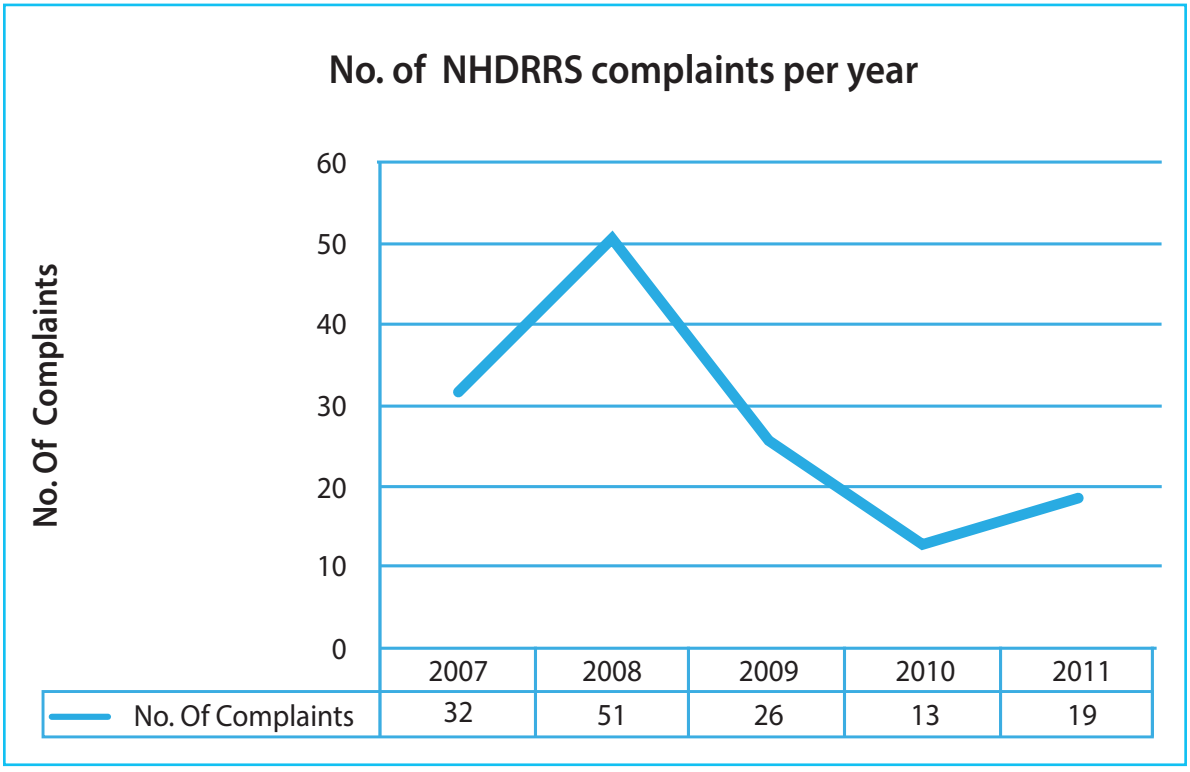


Figure 9: Number of complaints reported to the National HIV related Discrimination Reporting and Redress System (NHDRRS) 2007 – 2011.

8.2 LEGAL REFORM

a. Amendment to Public Health (Notifiable Diseases) Order

Significant progress was made in finalizing the Cabinet Submission to Amend the Public Health Order i.e. Notifiable Diseases. Consutations were held with the Ministry of Tourism, Ministry of Education, and the Ministry of Justice. The ministries supported the proposed amendment. The Attorney General's Department also provided feedback and recommendations, which were incorporated into the final cabinet submission.

b. Nurses and Midwives Act

The Nursing Council proposed to amend the Nurses and Midwives Act and began consultations with stakeholders. A position paper with recommendations was presented to the Council on behalf of the NHP. Key recommendations were:

- Inclusion of regulations for training programmes and continuous education to include care of PLHIV, confidentiality, stigma and discrimination, basic information on HIV including myths, HIV/TB co-infection, nutrition, prevention with care including prevention for positives, paediatric issues, ethics, moral and legal dilemmas;

    - Enforcement of the Code of Ethics including disciplinary action against breaches of standards of care and patient confidentiality.

c. Adolescent Working Group

In 2011, participation was ongoing in the Adolescent Policy Working Group. Enabling Environment and Human Rights in collaboration with the Adolescent Health desk at the Ministry of Health focused on providing support to the consultant commissioned to conduct a situational analysis for Voluntary Confidential Counselling and Testing (VCCT) for minors below 16 years.

The report was finalized and disseminated to key stakeholders. One of the main recommendations was the need to have a comprehensive adolescent health programme that deals with the whole child including availability of specialized practitioners to manage adolescent related issues such as obesity, diabetes, HIV, teenage pregnancy, mental illness, violence, mental abuse and dental care.

8.3 ENGAGEMENT OF HIGH LEVEL LEADERS

Leadership Advocacy & Commitment

On April 29, 2011, a high level leadership consultation was held and a Declaration of Commitment to Eliminating Stigma and Discrimination and Gender Inequality affecting Jamaica's response to HIV/AIDS was signed by the then Prime Minister of Jamaica, Hon. Orette Bruce Golding and the then Leader of the Opposition, The Most Hon. Portia Simpson-Miller.

The Declaration was crafted by the Law and Human Rights Officer in the National HIV/STI Programme in consultation with representatives from government ministries including the Ministry of Foreign Affairs and Foreign Trade, non-governmental organizations, international development partners such as UNAIDS and PLHIV.

Persons in attendance included the Minister of Health, Hon. Rudyard Spencer, and United States Ambassador to Jamaica, Ambassador Pamela Bridgewater, state ministers, members of the opposition, civil society, the business community, technocrats and the media. The objective of the meeting was to examine and address the issues of stigma and discrimination and gender inequality that affect Jamaica's HIV response.

8.4 COMMEMORATIVE EVENTS: WORLD AIDS DAY AND SAFER SEX WEEK

On December 1, 2011, World AIDS Day, a high-level leadership breakfast was held. Over seventy (70) high level leaders in government, private sector and international donor communities met under the theme **"Courageous leadership - blazing the trail one success at a time"**. This event was a collaboration between UNAIDS and the NHP. The meeting provided a forum for the reaffirmation of the commitment of the Minister of Health to amend the Public Health Regulations. HIV workplace policies of the Ministry of Health and Ministry of Youth, Sport and Culture and the Office of the Services Commission were launched at this event.

The Ministry of Labour and Social Security also launched its Food Proclamation, which aims to address the high level of stigma and discrimination surrounding HIV in the food industry.

Several poster presentations were made including a Workplace Policy leader board, National HIV-Related Discrimination Reporting Redress System Statistics, Nurses Experiences of Stigma in HIV/AIDS care in Jamaica and the PLHIV Stigma Index preliminary findings.

Safer Sex Week was also well supported with a total of 10 private sector companies requesting activities/services ranging from booth displays to presentations within the workplace. HIV awareness and prevention activities were integrated into three health fairs where a total of two hundred (200) persons were in attendance.

Minister of Health, Hon. Rudyard Spencer addressing the audience at the World AIDS Day High Level Leadership Breakfast

Left to right: New NAC chair, Mr. Leopold Nesbeth, and Mr. & Mrs. Howard Hamilton enjoy the edutainment at the World AIDS Day High Level Leadership Breakfast

8.5 HIV/AIDS WORKPLACE POLICIES AND PROGRAMME

HIV has been identified as a workplace issue and HIV workplace policies, programmes and toolkits have been promulgated over previous and current strategic planning periods. However, with dwindling financial support for the programme, the focus shifted in 2010/2011 towards sustainability.

Hence, in 2011, the work of the private and public sector workplace technical officers was guided by a Sustainability and Exit Plan. The goal of the plan was to finalize all outstanding HIV workplace policies while establishing sustainable and functional HIV workplace programmes.

Objectives of the sustainability plan and corresponding actions in 2011 are summarized below.

1. **High level management engagement:** In the public sector presentations were made to the Permanent Secretaries' Board meeting highlighting the need to put mechanisms in place for a seamless transition of full ownership of programmes. Such ownership guarantees sustainability of HIV workplace programmes and garners support for finalization of workplace policies.

   Suggestions were made to include HIV-related issues in orientation packages and adjust the Terms of Reference for focal-points to include HIV-related duties.

2. **Increase commitment of Focal Points to the HIV workplace programme:** A self-assessment tool was developed for private sector companies to assist focal points and steering committee members to determine the company's progress towards development and implementation of a sustainable HIV workplace policy/programme.

   The tool includes possible approaches for becoming fully compliant with the current National HIV Workplace Policy and the proposed development of HIV Regulations that will be appended to the pending Occupational Safety and Health Act.

A recently trained Peer Educator (left) receives his Certificate of Completion from Mrs. Saani Fong, Director, Enabling Environment & Human Rights.

3. **Increase cadre of trained peer educators:** Staff within private and public sector entities were trained as peer educators (Table 10).

4. **Integration of targeted events and updates into organizational plans and systems:** The Ministry of Health and Regional Health Authorities achieved organizational integration in several ways. For example, HIV presentations and brochures were included in employee orientation sessions. The Ministry of Foreign Affairs and Foreign Trade invested in webcasting technology to facilitate participation of outpost staff in HIV-related events including the World AIDS Day observance function.

ENTITY	NO. OF PEER EDUCATORS TRAINED
Jamaica Business Council on HIV/AIDS	35
Jamaica Employees Federation	42
Jamaica Manufacturing Association	9
Ministry of Justice	10
Ministry of Foreign Affairs & Foreign Trade	2
Ministry of Energy & Mining	3
Investment Commerce	9
Ministry of Health	8
Ministry of Transport and Works	36
Ministry of Finance and the Public Service	78
Office of the Services Commissions	13

Table 10: Table 10: Number of Peer Educators trained under sustainability plan

5. **Increase Support of Ministry of Labour and Social Services (MLSS) Programmes:** Promotion and advocacy for the MLSS Voluntary Compliance Programme (VCP) and Occupational Safety Health (OSH) Act were deemed as key priorities. VCP audits were conducted at the request of the MLSS with the aim of increasing enrolment in the programme. By the end of 2011, 41 private sector companies were enrolled in the programme.

6. **Strengthen the Jamaica Business Council on HIV and AIDS (JaBCHA):** Efforts were made to increase the membership of JaBCHA. Private sector organizations disseminated JaBCHA brochures and membership forms while indicating the benefits of being a member of JaBCHA. Five companies became members of JaBCHA during the year.

7. **Increase engagement of Private Sector Organization of Jamaica (PSOJ) member companies with HIV Policies and Programmes:** Workshops and sensitization sessions were conducted to strengthen collaborations and communication with the PSOJ work-place technical officers. However, theseinitiatives proved to be futile.

Training and sensitization remained a core function of the HIV workplace programme. Workplace Technical Officers conducted sessions on a range of topics including HIV basics facts, workplace policy principles, HIV risk assessment and reduction, condom use skills, condom negotiation and sexuality. Condoms were also distributed to participants.

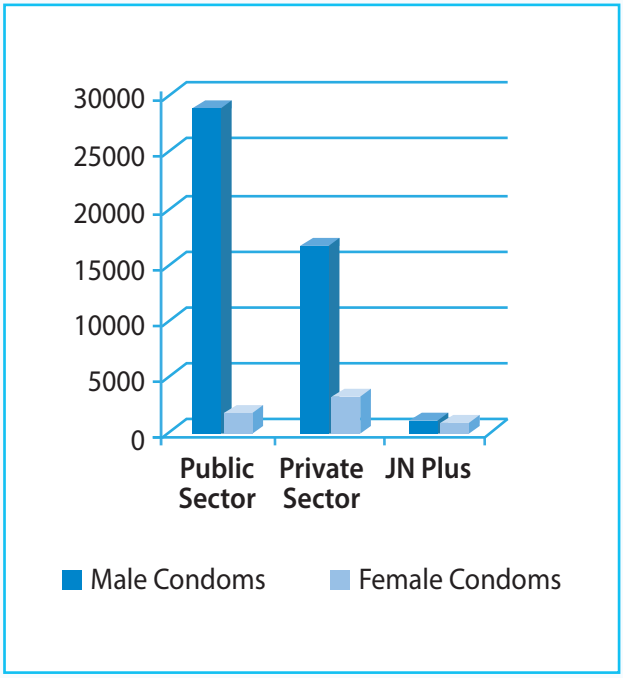


Figure 10: Number of condoms distributed under workplace programmes

Private Sector Entities Adopting HIV Workplace Policies (end of December 2011)					
Entity*	No. of persons Reached	Policy /Action Plan	Focal Point	Signed Commitment	Steering Committees
PSOJ	43	39	39	43	23
JaBCHA	56	44	59	44	35
JMA	62	49	62	53	26
JEF	64	37	52	23	15
Total	225	169	212	163	99

**PSOJ= Private sector organization of Jamaica, JaBCHA = Jamaica Business Council on HIV/AIDS, JMA = Jamaica Manufacturer's Association, JEF = Jamaica Employers Federation*

Table 11: Summary of Private Sector Entities Adopting HIV Workplace Policies

8.6 JAMAICA BUSINESS COUNCIL ON HIV/AIDS (JABCHA)

In March 2010, the Jamaica Business Council on HIV/AIDS (JaBCHA) was incorporated under the Companies Act as a Limited Liability Company and during 2011 JaBCHA continued to focus on achieving financial sustainability. Forty-five (45) members are currently enrolled.

On July 6, 2011 the JaBCHA National Foundation was launched under the patronage of His Excellency the Most Hon. Sir Patrick Linton Allen, ON, GCMG, CD, Governor-General of Jamaica. The Foundation is an incorporated, non-profit foundation with a mission to increase the funding available to Jamaica's National HIV response.

By the end of 2011, 6 million Jamaican dollars were committed to the foundation by private sector organizations. The Foundation is a credible and accountable conduit for private sector entities to channel resources in support of the national HIV programme and ensure its sustainability.

JaBCHA's visibility and influence also increased in 2011 by the show-casing of member companies who are actively implementing HIV workplace policies/prgrammes.

8.7 GREATER INVOLVEMENT OF PERSONS WITH HIV/AIDS (GIPA)

Based on data collection and analysis conducted in 2010, 30 PLHIV were selected to participate in the Greater Involvement of People Living with HIV/AIDS (GIPA) Capacity Building Programme. A GIPA Technical Working Group coordinated by the GIPA Coordinator was established to provide oversight of the design and implementation of the intervention. During 2011, sessions were conducted to increase the knowledge and improve the skills of the selected PLHIV. The sessions included:

a) Five (one-day) sensitization workshops. These were conducted on HIV Basic Facts, Positive Prevention, HIV/AIDS and the World of Work, GIPA and Disclosure Issues, Human Rights, Stigma and Discrimination

b) One two-day training workshop. This was conducted to help recruits hone their skills in presentation, facilitating discussion, and conducting interactive exercises for effective participation in training, educational interventions and activities as Community Facilitators in the workplace HIV/AIDS Programme.

Nineteen (19) participants completed all the sensitization and training workshops. Participants were also assessed by members of the technical working group. Areas of assessment included: delivery and mannerism, knowledge and use of visual aids, presentation skills in conducting PowerPoint presentations, interactive exercises and facilitating group discussions.

By the end of 2011, the GIPA unit in collaboration with the trained participants co-facilitated 88 sessions within the workplace and faith-based organizations.

8.8 JAMAICA NETWORK OF SERO-POSITIVES (JNPLUS)

The Jamaica Network of Seropositives (JNPlus) continued to meet its objectives in 2011, despite the absence of a Programme Coordinator for more than eight (8) months. At the end of the year the membership stood at 700 persons.

A major accomplishment in 2011 was the completion of the field work and data collection processes for the People Living with HIV Stigma Index Survey. This index was a collaboration with UNAIDS and other stakeholders. The steering committee was chaired by JN Plus, which also empowered and mobilized PLHIV to participate in the study. The study's aim was to collect information that would:

- Highlight the experience of PLHIV in different settings
- Provide evidence for policy change
- Establish a baseline and measure trends in HIV-related stigma and discrimination
- Compare specific situations related to stigma and discrimination across countries.

8.9 FAITH-BASED ORGANIZATIONS (FBO)

Two qualitative studies were completed in 2011 to determine the knowledge, attitudes and practices of faith-based and high-level leaders towards key populations as well as the level of HIV-related stigma and discrimination. Four (4) focus group discussions with 40 leaders of faith-based organizations (FBO) were conducted.

One-on-one in-depth interviews were held with 20 high-level leaders. A dissemination meeting was held in June 2011 to present the findings to study participants and internal stakeholders. One of the recommendations posited was to educate FBO leaders and their members on a broad range of topics related to the HIV epidemic, human rights, and stigma and discrimination.

Several presentations and email blasts also presented the information in a reader friendly format. A 5-year work plan was drafted based on the findings and recommendations made by the consultant.

Other activities targeting FBO in 2011 were:

- Training of FBO on HIV basics and stigma and discrimination.
- Formation of a FBO Technical Working Group to guide the development of HIV interventions involving FBO
- Development of an FBO Behaviour Change Communication (BCC) and Training Tool. Three (3) docu-dramas were developed as a BCC and training tool for FBO leaders and their congregation. Each docu-drama focused on a key population (MSM, SW, or PLHIV) and a combination of three of the following themes: accepting attitudes/unconditional love, human rights, stigma and discrimination and HIV basic facts.

CHALLENGES

The Enabling Environment and Human Rights Component experienced significant challenges which affected the implementation of activities. Firstly, the passing of the component director, Ms. Faith Hamer, on March 6, 2011 was a great loss to the NHP and resulted in shifts in roles and responsibilities. Secondly, some activities lost ground in 2011 for various reasons. The workplace programme in particular faced several challenges:

- **The reduction in the number of Workplace Technical Officers** affected the NHP's ability to contact and engage target companies and government agencies.

Filming of docudrama for Faith Based Organizations

- **The economic crisis** resulted in some of the targeted companies undertaking reclassification exercises, downsizing and a few went defunct. This made it difficult for private-sector Workplace Technical Officers to maintain HIV Steering Committees, or have staff released for participation in HIV-related sessions. Some companies declined requests for meetings and failed to keep appointments.

- **Failure to re-engage Private Sector Organization of Jamaica (PSOJ)** companies despite several initiatives at various levels due to more pressing issues in the workplace.

- **Absence of legislation and empirical evidence:** The HIV Workplace Policy Programme is voluntary and this lessens the incentive to develop and implement HIV workplace policies. In addition, evidence on the benefits of such policies and programmes is lacking. As a result, HIV is not always seen as a business issue with the ability to impact the company's success.

- **Support from top management** is inadequate and personnel changes in companies affect engagement of management on HIV issues.
- **Decreased funding** affected some aspects of this component of the HIV response. The indefinite suspension of capacity building interventions for PLHIV reduced activities of GIPA. Funding issues prevented development of a curriculum as a standard for sensitization and training.

In addition, uncertainties about funding limited the ability to plan and execute activities effectively and in a timely manner. These uncertainties also affected the ability to retain consultants.

9.0 TREATMENT, CARE AND SUPPORT

9.1 HIV TESTING

Expansion of HIV testing is a priority under this component because timely access to treatment reduces HIV-associated morbidity and mortality. For calendar year 2011, 258,000 HIV tests were done. This represents a 14% increase compared to 2010 (Figure 11).

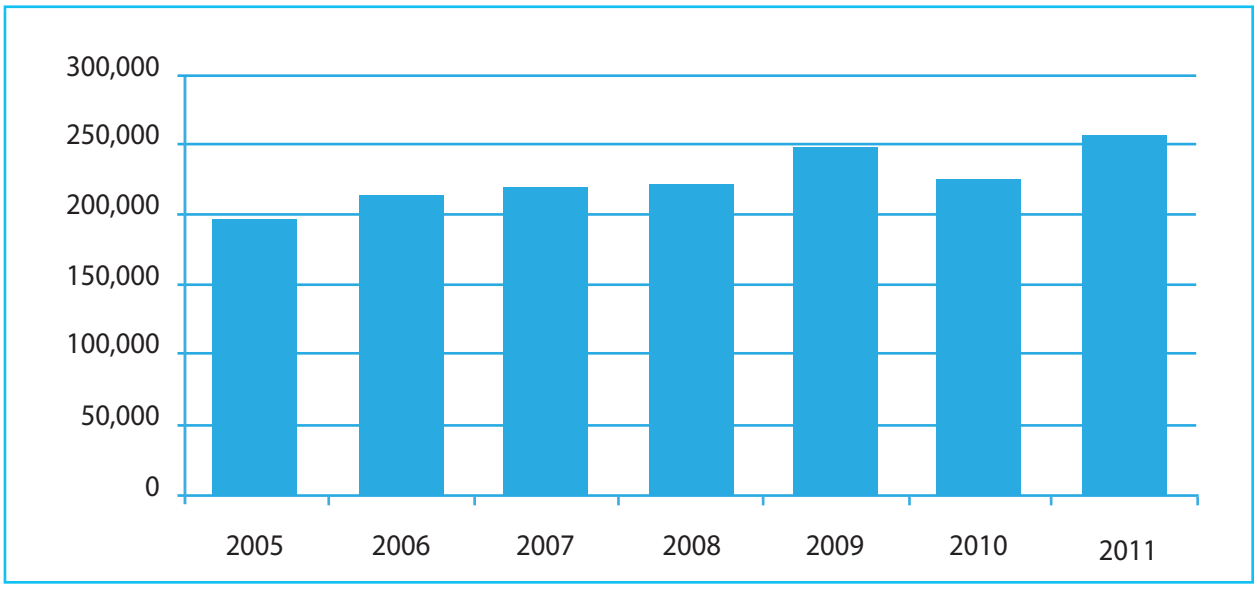


Figure 11: HIV Prevalence among SW, 1990 -2011

Of the 258,000 tests conducted, 25,593 HIV tests were done in antenatal clinics and 37,902 HIV tests were done in STI clinics. Over 100,000 tests were done on persons admitted to hospital with 2.7% of this population recording a positive HIV test.

9.2 MEDICAL MANAGEMENT

Access to Anti-retroviral Medication

In 2011, all treatment sites continued to provide multidisciplinary care in Jamaica. All treatment sites are located at facilities that provide other health services, making care for PLHIV available within an integrated service setting.

The comprehensive treatment programme includes antiretroviral medication (ARV) and remains free of cost in the public sector. Based on programme monitoring, there were 9,162 persons (8,676 adults and 486 children) started on ARV by December 31, 2011. This represents 59% of persons with advanced HIV.

Antiretroviral medications were dispensed by pharmacies at treatment sites with four private pharmacies providing private points of access for ARVs. Private practitioners who are certified by the NHP also continued to offer services to PLHIV who prefer to access care in the private sector.

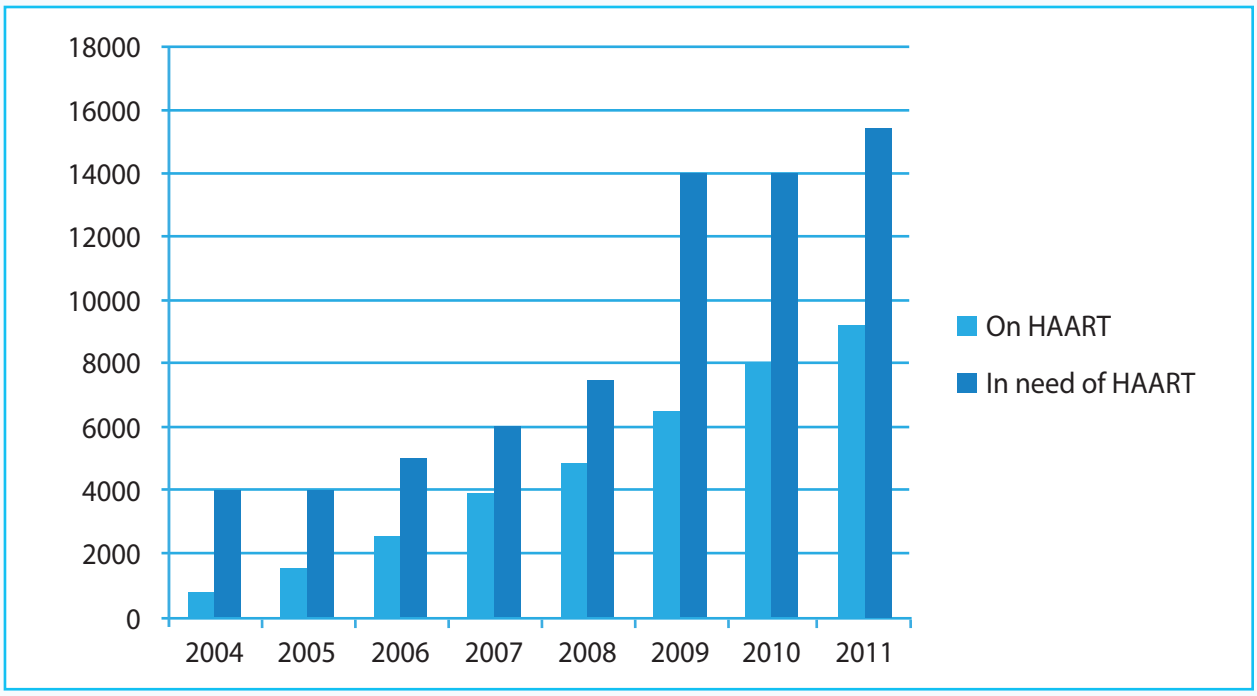


Figure 12: Number of persons on Anti-retroviral medication, 2004 - 2011

In 2011, the Annual HIV Clinical Management Workshop was integrated into the Caribbean Cytometry and Analytical Society's (CCAS) annual meeting, which was convened in August in Jamaica. The CCAS meeting focused mainly on the laboratory aspects of HIV care and the participants were mostly laboratory personnel.

However, representatives from the entire multi-disciplinary team also attended. Workshop participants received information on prevention of mother-to-child transmission (PMTCT) of HIV and syphilis, psychosocial issues affecting PLHIV and HIV management. The national treatment guidelines were also reinforced.

Laboratory Tests

In 2011, CD4, Viral load and DNA PCR testing all increased when compared to 2010 suggesting an increase access to treatment and care services. The CD4 count is an important test for the management of HIV positive individuals. Jamaica's National Guidelines on Management of HIV recommends that all HIV positive persons have a CD4 count done on diagnosis. Along with clinical findings, the CD4 count is used to determine when Highly Active Antiretroviral Therapy (HAART) should be initiated.

This test is routinely offered at both the National Public Health Laboratory (NPHL) and the Cornwall Regional Hospital (CRH). During 2011, CD4 testing using PIMA machines also continued at Port Antonio Hospital, Black River Hospital and Jamaica AIDS Support, Kingston Branch.

Plans were put in place to roll out this technology to other treatment sites in early 2012. This testing methodology is expected to improve access to CD4 testing.

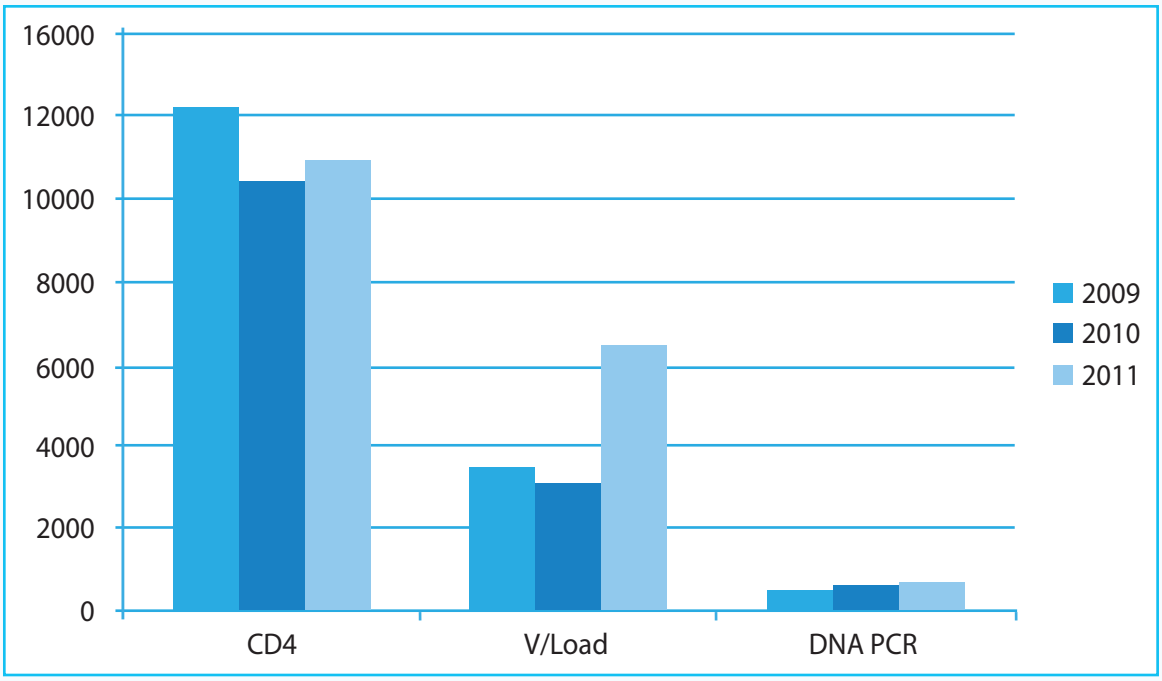


Figure 13: Number of Monitoring Tests (CD4, viral load and PCR) conducted, 2009 to 2011

9.3 ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION OF HIV AND SYPHILIS

The PMTCT programme resulted in provision of ARVs to 85% of HIV-infected pregnant women and all HIV exposed infants delivered in the public sector in 2011. The programme has maintained this level of performance since at least 2006.

A review of PCR (Polymerase Chain Reaction) testing results for HIV exposed infants suggest that the chance of mother to child transmission in 2011 was 1.2%. This is consistent with the Elimination Initiative's target of 3 consecutive years of vertical transmission maintained below 2%.

Similarly, preliminary data suggests that the incidence of congenital syphilis in 2011 remained below the elimination initiative target of < 0.5 cases per 1,000 live births.

Adherence & Psychosocial Support Programme

Achieving adherence levels at a minimum of 95% is one of the primary challenges for PLHIV on HAART. The research has shown that it is possible but immense support is required for a sustainable effect. All multi-disciplinary care teams in the public sector have been sensitized to the adherence protocol and provide support to the social workers and adherence counsellors in this aspect of care.

However, as patient load increases and contact time with patients decreases, the challenge of adherence counseling becomes more evident. The present fiscal climate also affects adherence as PLHIV struggle to adhere to clinic visits due to transportation costs as well as the costs associated with purchasing food.

Based on reports from adherence counsellors, an average of 85% of persons self-reported adherence at the required level of 95% in 2011. Eighty-one percent were found to have achieved this level by pill count. This represents an increase of 6% and 8% respectively compared to 2010.

However, less than 20% of patients take their

	2005	2006	2007	2008	2009	2010	2011
Number of ANC[1] Attendees Tested	28,651 (96%)	28,446 (95%)	22,478 (95%)	29,119 (>95%)	30,076 (>95%)	26,697 (>95%)	27985 (>95%)
Number of HIV +ve women delivered	401	442	358	616	440	432	354
Percent of HIV +ve women attending ANC[1] receiving ARVs	74%	84%	84%	84%	84%	86.3	85%
Number of HIV – exposed infants	407	433	362	612	439	419	350
Number (%) of HIV – exposed infants getting ARVs for PMTCT	353 (87%)	403 (93%)	350 (97%)	605 (98%)	430 (98 %)	408 (97%)	354 (101%)
Transmission Rate	10%	<10%	<5%	<5%	4.3%	4.6%	1.19%

[1]ANC = Antenatal clinic

Table 12: The PMTCT Programme, Jamaica – 2005-2011 (Public Sector Data)

medication to clinic visits and this undermines efforts to accurately determine ARV adherence. PLHIV continued to access 17 support groups during 2011 but there is a need to scale up the number of support groups.

The impact of socioeconomic factors cannot be underemphasized as a major determinant of adherence. In an effort to address some of the socio-economic issues, the NHP continued to foster partnerships with various agencies to improve the social well-being of PLHIV. For example, empowerment programmes were organized to give PLHIV the opportunity to gain technical and vocational training 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. Some children who are infected with or affected by HIV received back-to- school assistance. Social workers and adherence counselors attached to health facilities identified needy families and referred them to the Parish AIDS Associations to receive support in the form of: i) payment of school fees, ii) purchase of school books, and iii) purchase of school uniforms.

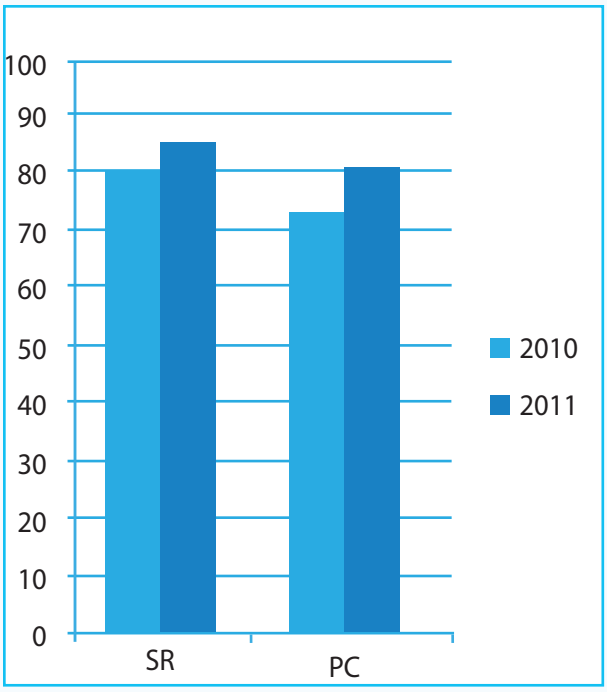


Figure 14: ARV adherence by Pill count (PC) and Self Reports (SR) (2010 – 2011)

In 2011, the partnership with the National AIDS Committee (NAC) continued as the NAC entered its third year of a US$100,000 per year grant from the Global Fund. The NAC provided opportunities for income generation by provision of small grants to PLHIV for setting up or expanding income generating projects, and to seek training or certification of skills.

However, strengthening of partnerships between other ministries of government (e.g. Ministry of Labour and Social Security), NGO, FBO, the private sector and other members of civil society is necessary in order to establish the required support network.

9.4 STIGMA AND DISCRIMINATION

Accepting attitudes to PLHIV have improved significantly over the past few years. However, HIV-related discrimination persists in some sectors and hinders access to services. The Ministry of Health and the NHP remianed committed to the creation of a supportive environment for PLHIV especially within the health sector.

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 were included in the design and implementation of such undertakings.

10.0 OTHER SEXUALLY TRANSMITTED INFECTIONS

In Jamaica, public sector clinics distributed across the island's four Regional Health Authorities manage clients with sexually transmitted infections (STI). STI surveillance in this setting is based on the syndromic surveillance model. Syphilis is one of two exceptions (the other being HIV) and is based on aetiologic reporting using testing data. HIV/AIDS surveillance also follows this model and is reported separately.

All STI surveillance reporting is completed monthly by contact investigators. Duplication of the data is minimal and it is important to note that the data only represent those clients who sought care at a public clinic, and for some health regions, only persons seen in STI clinics. Reports are completed by contact investigators. Hence reported cases vary by the level of coverage attained by the contact investigators. Therefore, all trends and summaries relate exclusively to the public sector. A single report is submitted for each parish and the data are compiled and stored centrally at the Ministry of Health. This report details utilization and disease rates as reported to the Ministry of Health's National HIV/STI Programme in Kingston.

10.1 STI SURVEILLANCE FINDINGS

Generally, there has been a steady increase in the total number of patients visiting STI clinics every year since 2007. This is primarily due to increases in the number of revisits as the number of new cases has not shown a similar trend. However, the number of new patients increased from 25,557 in 2010 to 26,382 in 2011.

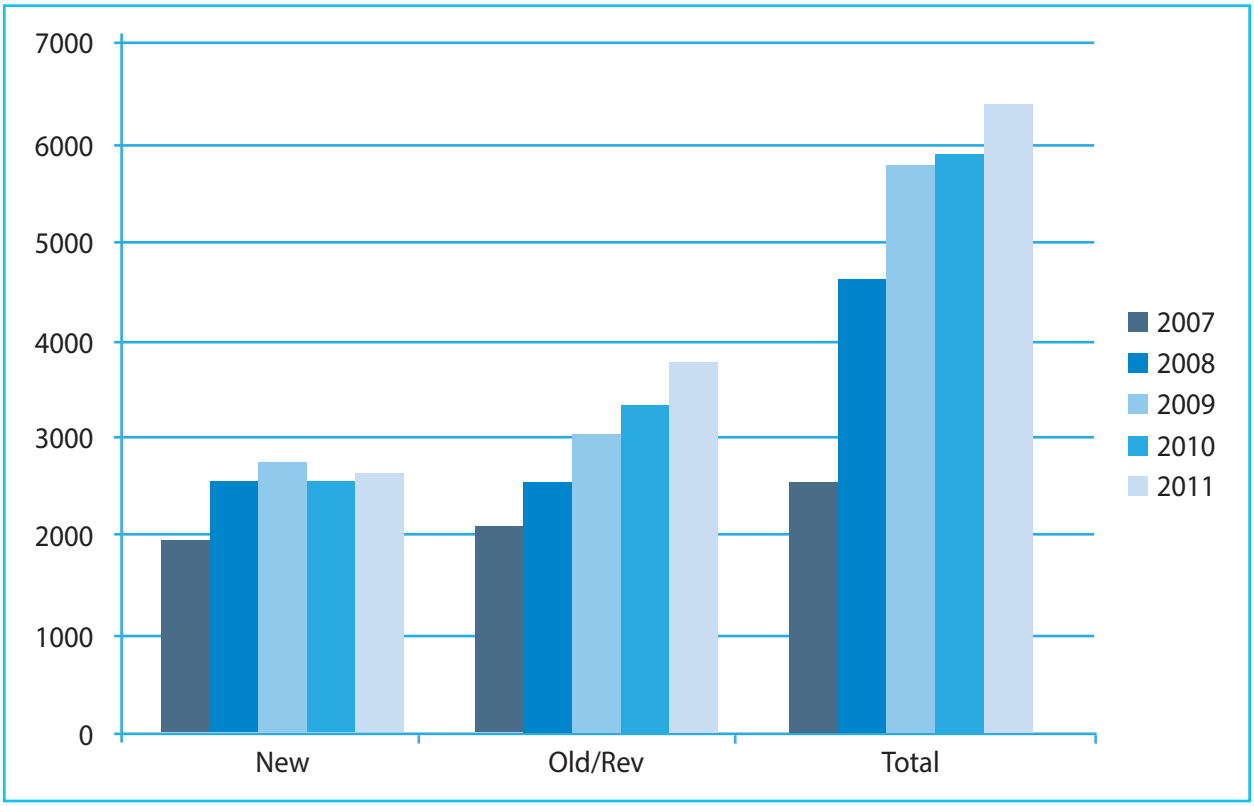


Figure 15: Number of patients visiting STI clinics by year, 2007 to 2011

Men represented approximately 27% of the total number of new clients attending STI clinics in 2011 with Clarendon reporting approximately a quarter of the new patients that visited STI clinics.

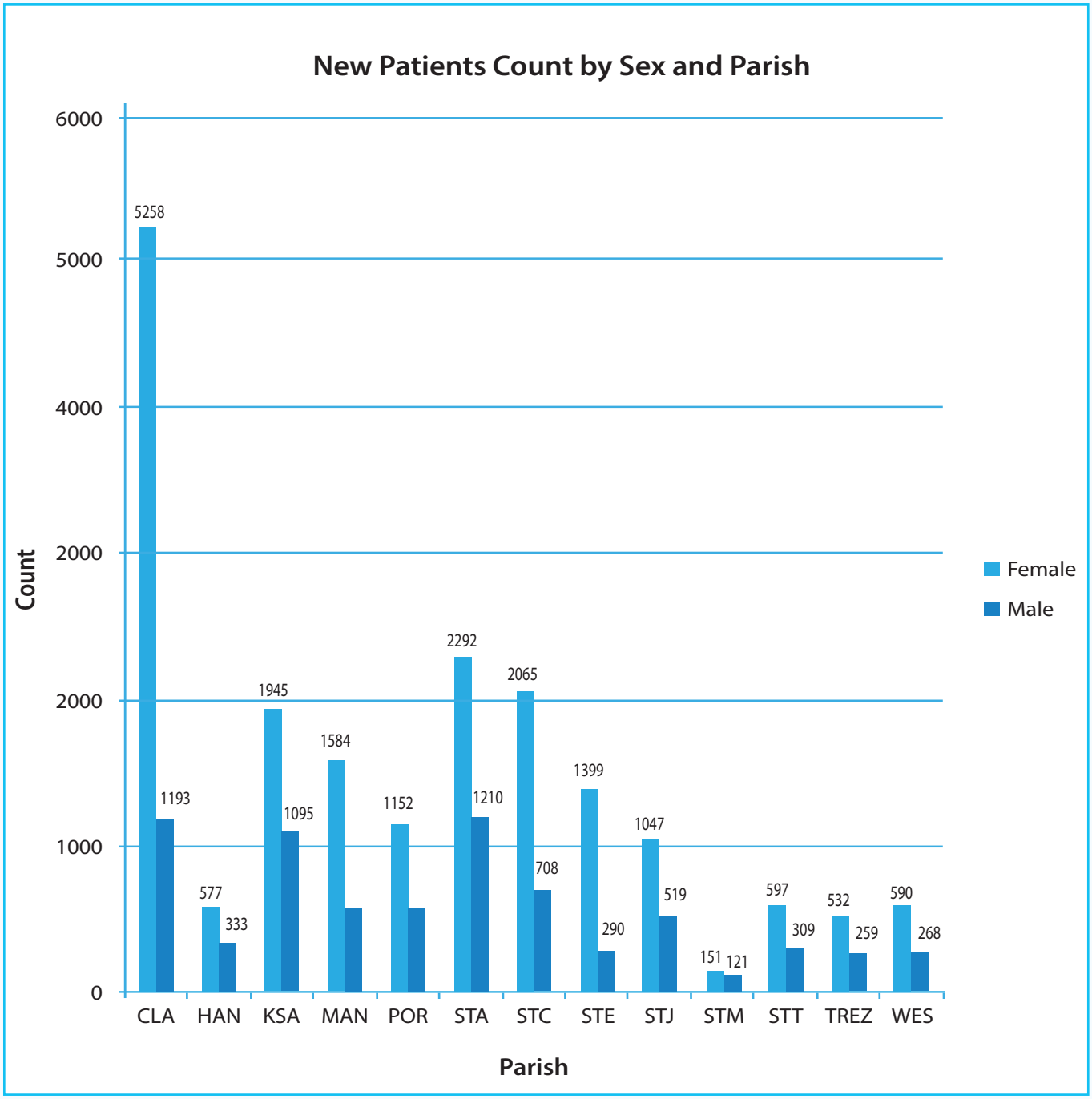


Figure 16: Number of New Patients visiting STI clinics in 2011, by sex and parish

10.2 GENITAL DISCHARGE SYNDROME (GDS)

Genital Discharge Syndrome (GDS):

According to the World Health Organization, Genital Discharge Syndrome (GDS) includes, "Urethral discharge in men with or without dysuria (most commonly caused by Neisseria gonorrhea and Chlamydia trachomatis) or abnormal vaginal discharge (amount, color, and odor) 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 2011 with 20,757 cases of GDS reported in 2010 compared to 33,969 in 2011. Overall, the rate and number of reported cases of GDS have trended upwards between 2006 and 2011. Women experienced the greatest increase and accounted for 3 to 4 times as many cases of GDS when compared to men (Figure 17). This disparity may be due to a combination of factors: greater susceptibility of women to STI, sex differences in health seeking behaviours and detection bias among women with regard to discharge syndromes. Women are more likely to present to a clinic for care and are more likely to accurately report genital discharge symptoms than men.

When disaggregated by age, the number of GDS cases reported at STI clinics between 2007 and 2011 increased in all age groups except among persons 0 to 9 years old. Genital discharge syndromes occurred more frequently in the 20-24 year old age group followed by the 15-19 year old group (Figure 18). In 2011, the GDS rate peaked at 4,076 per 100,000 populations in the 20-24 age groups.

Candidiasis continued to be the most frequently reported condition among GDS cases in 2011, accounting for 39% of all cases (Figure 19). Gonorrhea and Chlamydia (represented by Cervicitis/Erosion) accounted for approximately 11% of cases in 2011 while Trichomoniasis increased from 7,438 in 2010 to 8,075 in 2011.

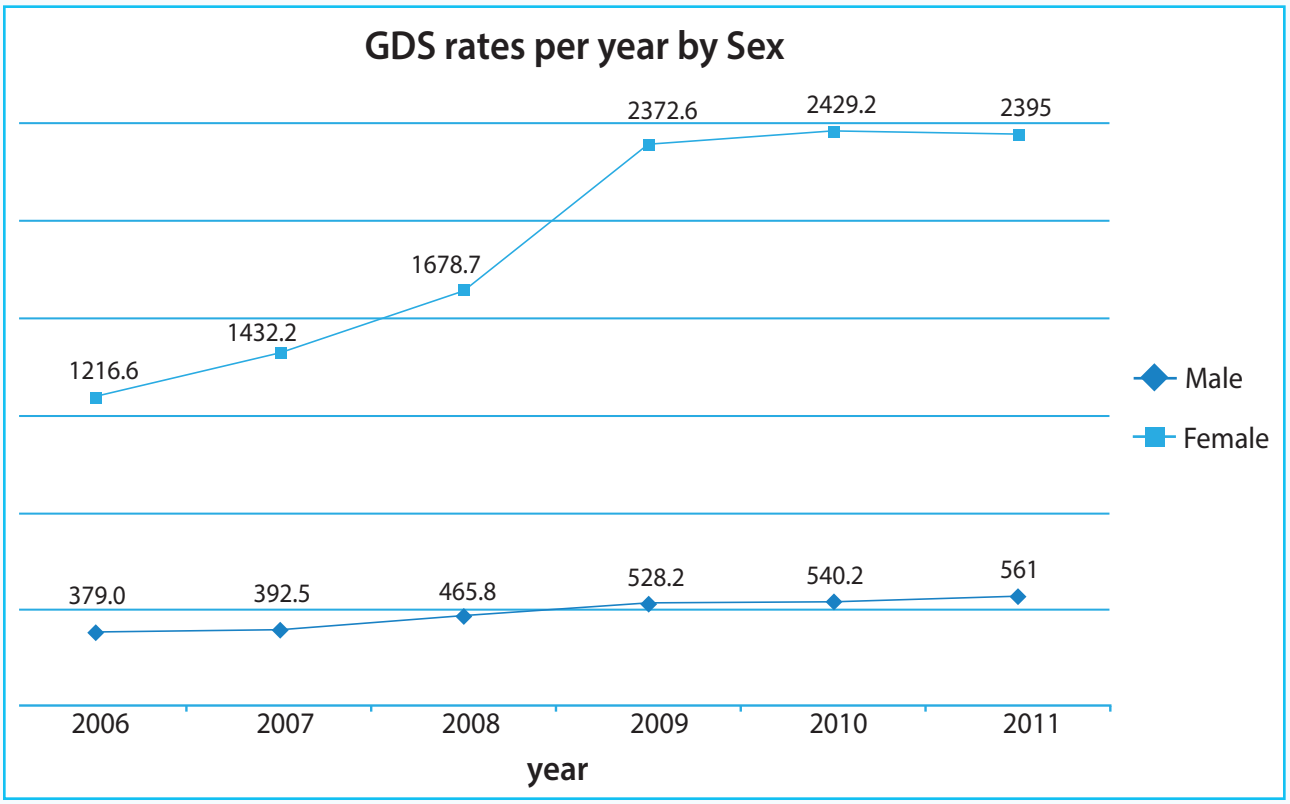
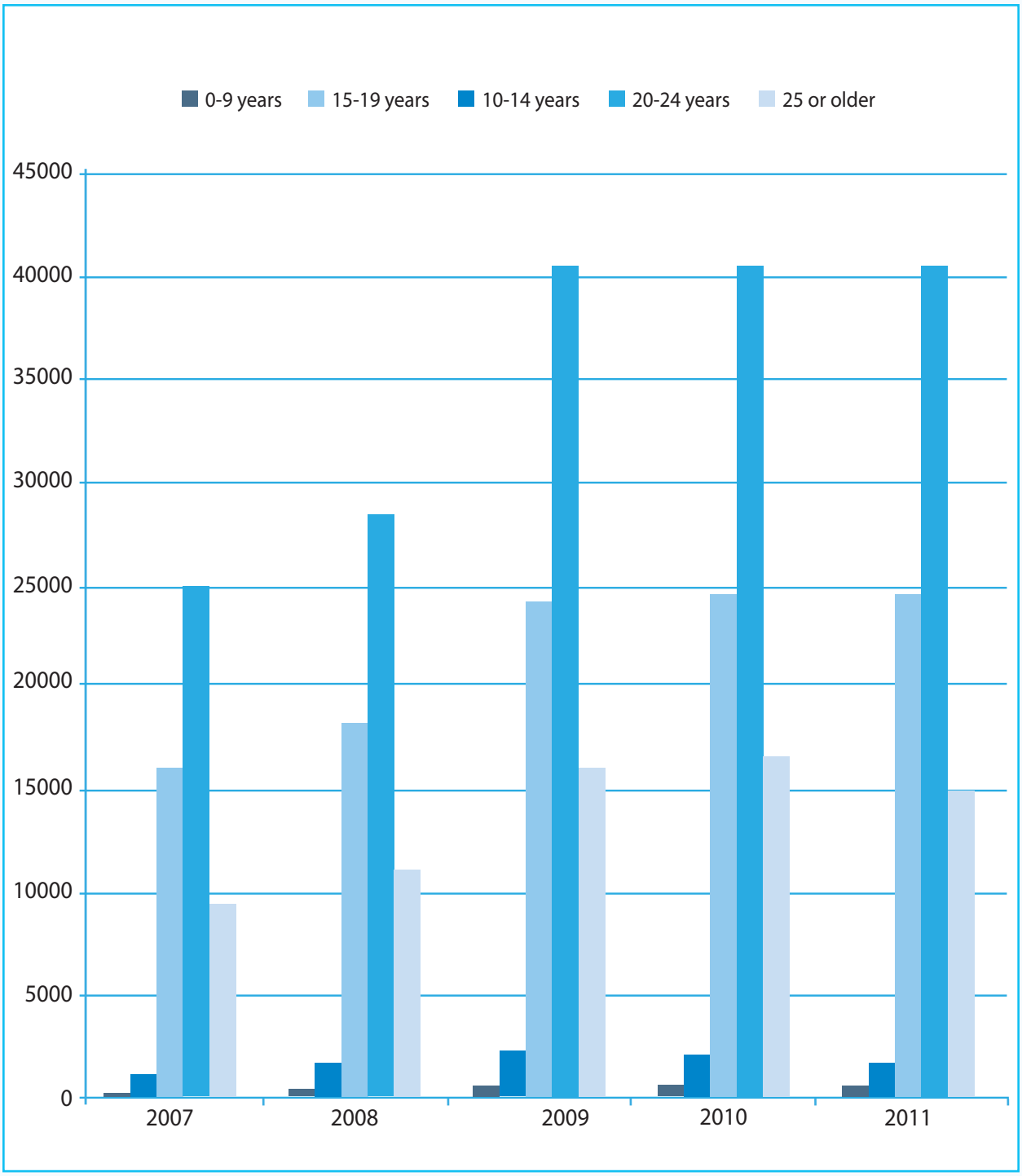


Figure 17: Genital Discharge Syndrome rates per year by sex, 2006 to 2011



Note: Total population from STATIN 2008 demographic report was used as denominator for rates for 2008 to 2010. The STATIN 2011 report was used for rates in 2011.

Figure 18: Age specific Genital Discharge Syndrome (GDS) per 100,000 populations 2007-2011

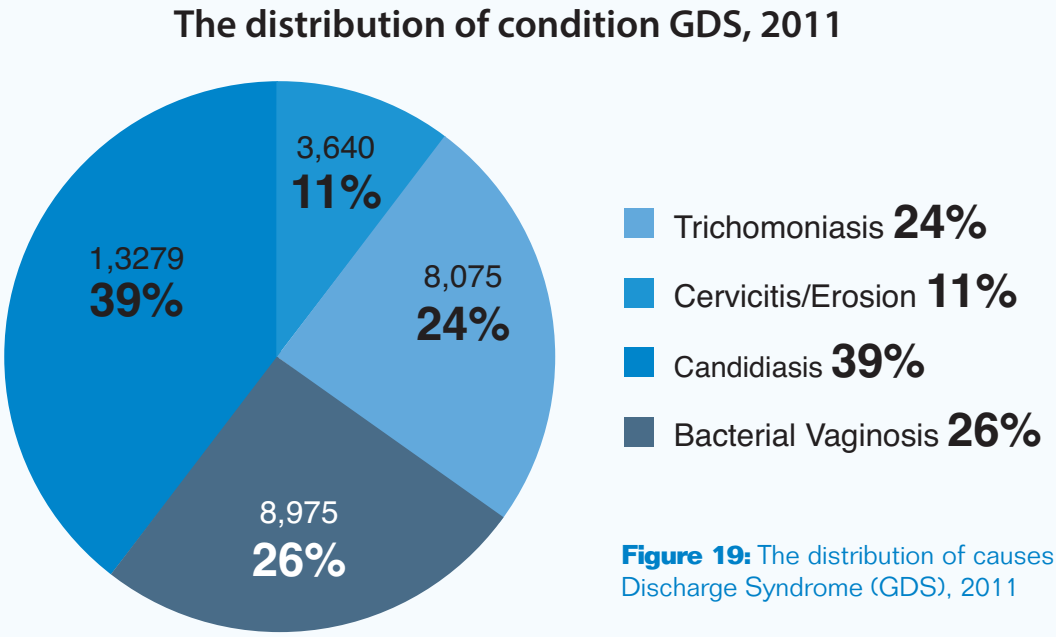


Figure 19: The distribution of causes of Genital Discharge Syndrome (GDS), 2011

St. Mary and Portland saw the largest reduction in GDS cases between 2010 and 2011 while Trelawny had the highest increase in GDS rate. The parishes of Hanover, Portland, St. Catherine and St. Thomas also experienced declines in the rates of GDS (Table 13).

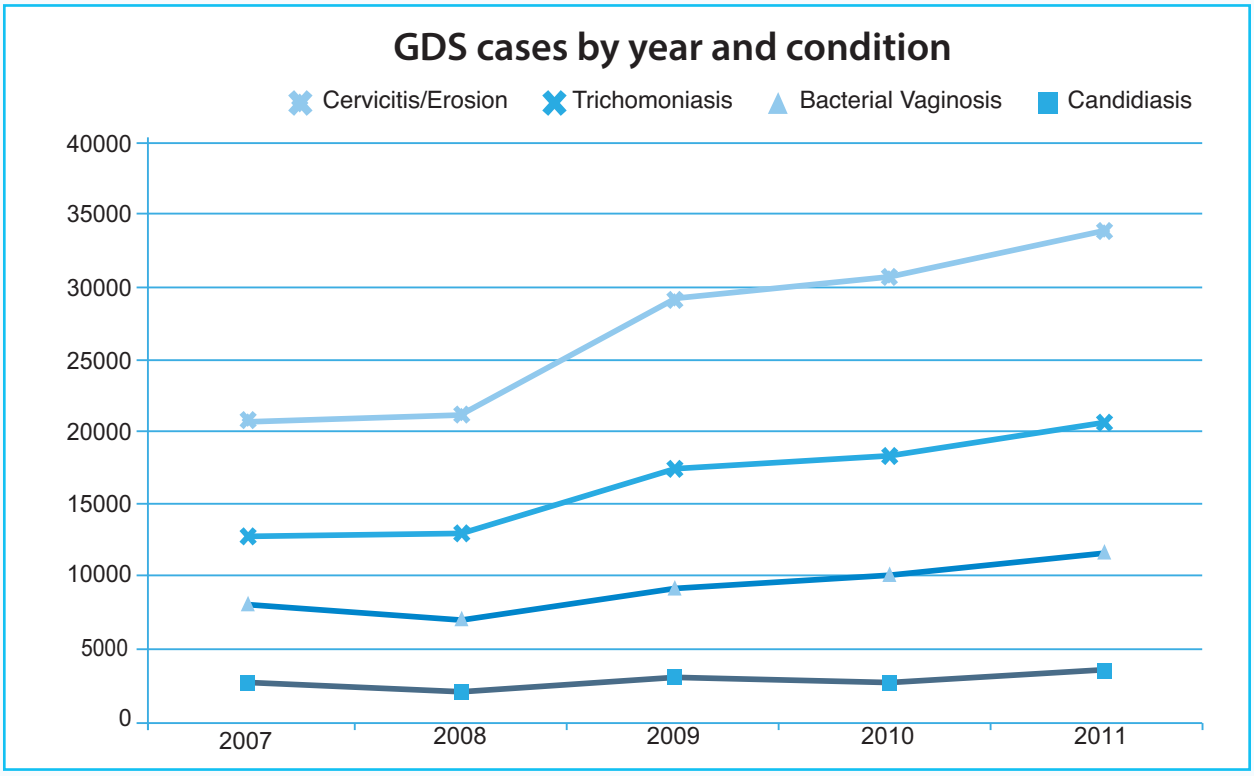


Figure 20: Number of Genital Discharge Syndrome cases by Year and Subgroup 2011

	2010				2011				
	female	male	Total	*Rate	female	male	total	*Rate	difference
CLA	5043	951	5994	2432	5174	1061	6235	2513	241
HAN	346	145	491	702	342	121	463	658	-28
KSA	6091	1785	7876	1182	6141	1977	8118	1212	242
MAN	1895	362	2257	1182	2169	409	2578	1342	321
POR	3352	295	3647	4434	2785	305	3090	3733	-557
STA	2725	1217	3942	2273	2945	1220	4165	2386	223
STC	4183	792	4975	998	3953	836	4789	955	-186
STE	1884	179	2063	1365	2014	188	2202	1448	139
STJ	1381	189	1570	851	1598	201	1799	969	229
STM	3307	507	3814	3336	2311	528	2839	2467	-975
STT	2090	611	2701	2866	1998	599	2597	2738	-104
TRE	300	61	361	477	960	165	1125	1478	764
WES	572	74	646	446	535	95	630	432	-16
Total	33169	7168	40337	1498	32925	7705	40630	1500	293

*Rate per 100,000 populations

Table 13: Genital Discharge Syndrome Rates by Sex and Parish 2010-2011

10.3 GENITAL ULCER DISEASE SYNDROME (GUD)

Genital ulcer disease (GUD) are, according to the Practical Case Management of Common STI Syndrome published by the MOH "conditions of the anogenital region (with or without lymphadenopathy) which cause a break or dissolution of the epithelial lining of the skin or mucous membrane in this area". These include: syphilis, chancroid, herpes simplex virus (HSV), granuloma inguinale (GI), Lymphogranuloma venereum (LGV).

There has been a fluctuation in the number of cases of GUD when disaggregated by sex between 2007 and 2011 (Table 14). Overall, there was an increase in GUD rates from 2010 to 2011 and the GUD rate for men surpassed the GUD rate among women for the first time (Table 14).

Year		female	male	total
2007	N	521	414	**935**
	rate	38.3	31.3	**34.9**
2008	N	496	399	**895**
	rate	36.3	30.1	**33.2**
2009	N	781	537	**1318**
	rate	57.2	40.5	**48.9**
2010	N	626	553	**1179**
	rate	45.8	41.7	**43.8**
2011	N	636	632	**1268**
	rate	46	47	**47**

Table 14: Genital Ulcer Disease rates per 100,000, by sex

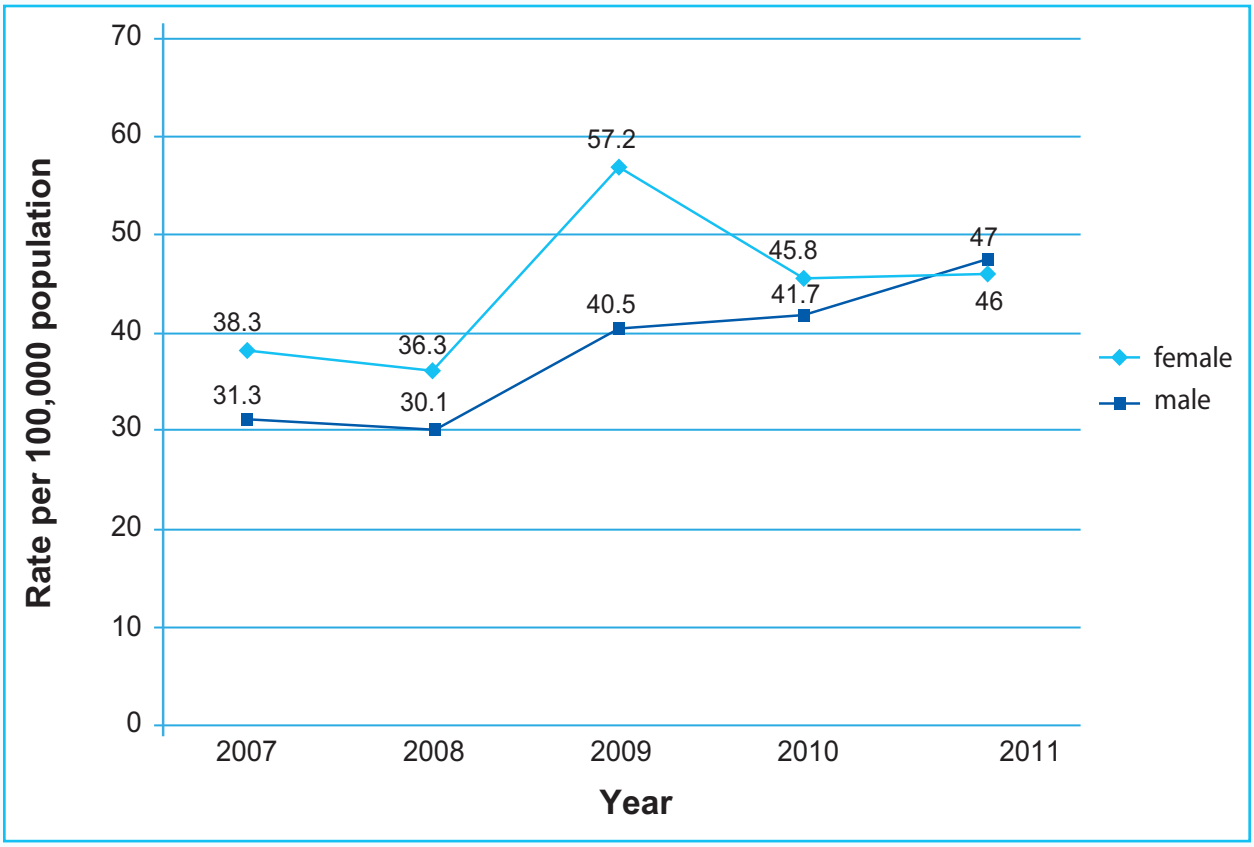


Figure 21: Genital Ulcer Disease rates per 100,000 population by sex, 2007-2011

The highest rates of infection were recorded in the 20-24 and 15-19 age cohorts (Table 15). As expected, low rates of GUD were recorded in the 0-9 age group for the 5 year period but the highest number of cases was recorded for this age group in 2011 (3 cases or 1per 100,000). Up to 2010, the number of cases of GUD in the 10-14 age group was trending downward but there was a slight increase in 2011 (5 cases in 2010 compared to 9 cases in 2011).

A 20% increase in GUD rates was recorded for the 20-24 age group between 2010 and 2011 (Table 15).

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

Table 15: Age adjusted Genital Ulcer Disease Rates (GUD), per 100,000 persons, 2007 to 2011

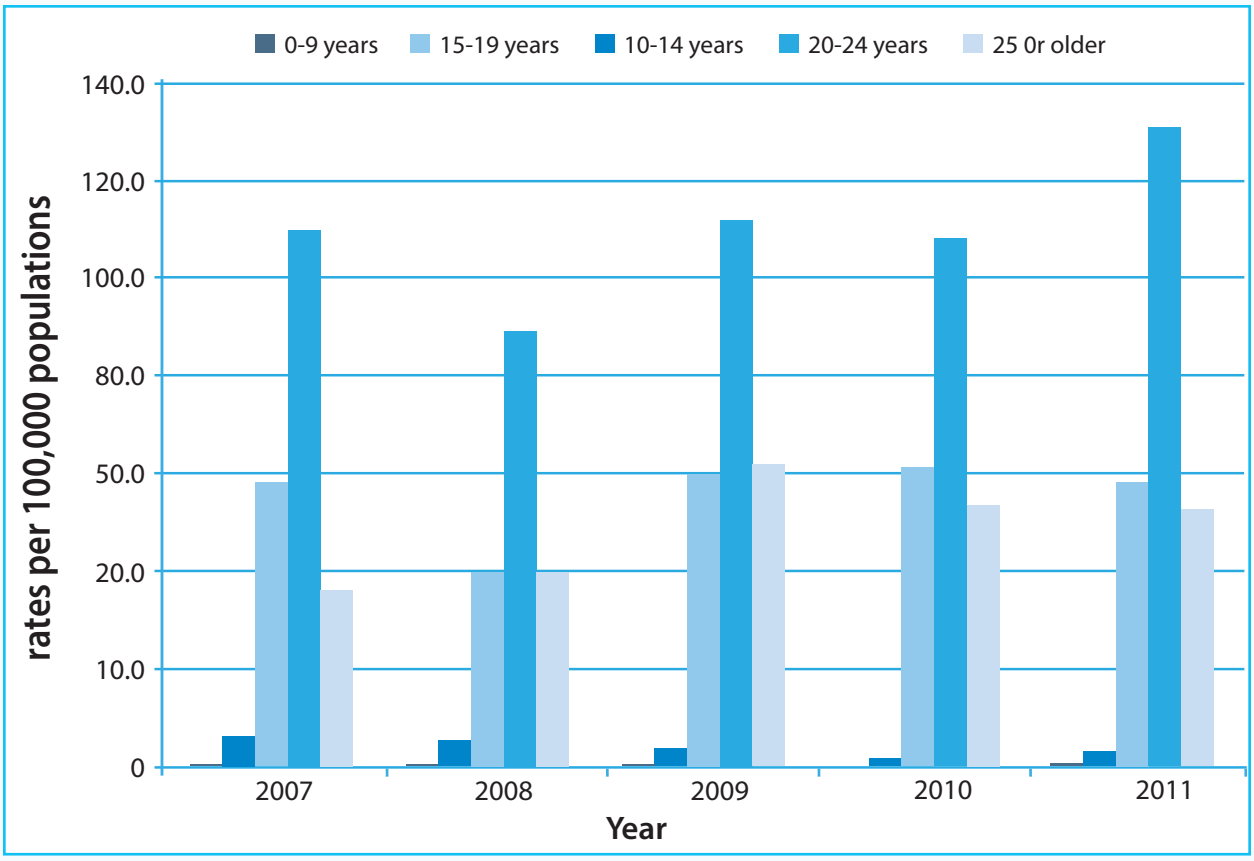


Figure 22: Age Specific GUD rates per 100,000 populations 2007-2011

Herpes, which represents the largest portion of reported GUD, decreased from 900 cases in 2010 to 775 in 2011 while chancroid increased from 35 cases in 2010 to 59 cases in 2011. Thirty cases of Granuloma Inguinale/Lymphogranuloma Venereum (GI/LV) were recorded in 2011 with no significant changes since 2007.

However, the number of cases of syphilis recorded trended upward between 2007 and 2011 with a 113% increase between 2010 and 2011 (Table 16 and Figure 23).

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

*Figures previously reported for 2010 have been revised upwards subsequent to the receipt of late reports for this period.

Table 16: GUD Cases by Year and Disease Category, 2007 – 2011

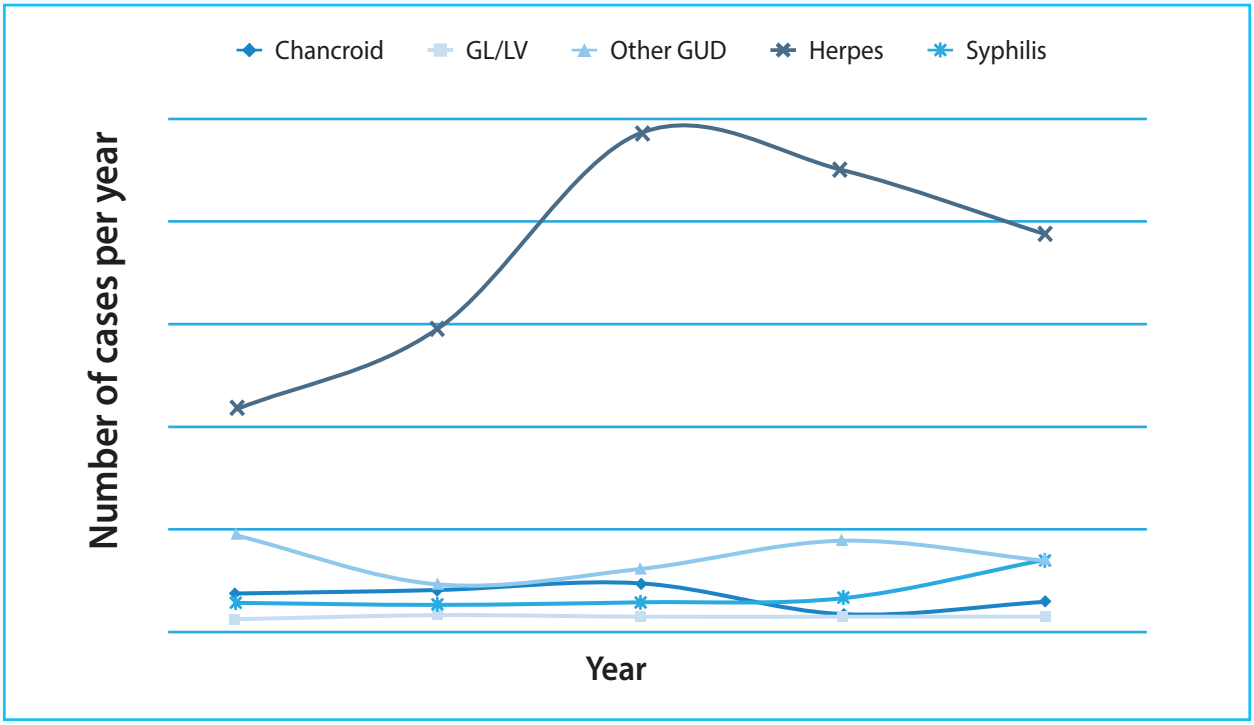


Figure 23: GUD cases by Year and subgroup 2007-2011

Herpes and Syphilis accounted for 80% of reported GUD in 2011 while unspecified ulcerative diseases made up 12% of all cases. Chancriod and GI/GLV represented 5% and 3% GUD respectively (Figure 24).

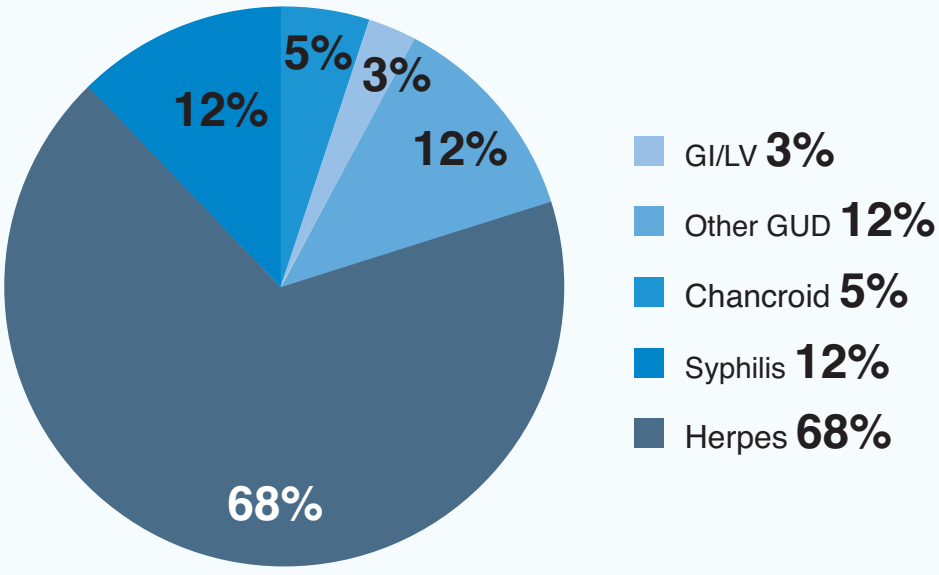


Figure 24: Distribution of causes of Genital Ulcer Disease 2011

Among the parishes, Kingston & St Andrew and St. Thomas, recorded the highest number of GUD cases for 2010 and 2011. However, St. Thomas and St Ann had the highest rate of GUD per 100,000 populations (153 and 142 respectively). St. Mary had the lowest rate with 11 GUD cases per 100,000 populations (Table 17).

Overall, more women were diagnosed with syphilis than men over the 2007-2011 period (Figure 25). This is partly due to detection bias as women have increased access to tests for syphilis through antenatal clinics. In addition, the greater health seeking behaviour of women allows more timely diagnosis.

However, it is important to note that the female to male ratio for infectious syphilis (primary and secondary syphilis) is 1.7:1 while the female: male ratio for STI clinic attendees is 4:1. This implies that infectious syphilis is more prevalent among male STI clinic attendees compared to female STI clinic attendees.

	2010				2011				
	female	male	Total	Rate	female	male	Total	Rate	Rate difference
CLA	18	14	**32**	13	63	36	**99**	40	27
HAN	14	18	**32**	46	16	15	**31**	44	-2
KSA	165	264	**492**	64	236	256	**492**	73	9
MAN	43	38	**81**	42	24	12	**36**	19	-23
POR	19	16	**35**	42	8	4	**12**	14	-28
STA	56	46	**102**	59	75	172	**247**	142	83
STC	68	48	**161**	23	33	35	**68**	14	-9
STE	15	15	**30**	20	34	17	**51**	34	14
STJ	98	28	**162**	68	24	15	**39**	21	-47
STM	6	7	**13**	11	7	6	**13**	11	0
STT	108	44	**125**	161	100	45	**145**	153	-8
TRE	5	6	**11**	15	9	8	**17**	22	7
WES	11	9	**20**	14	7	11	**18**	12	-2
Total	626	553	**1179**	44	636	632	**1268**	47	3

Table 17: GUD by Sex and Parish (Rate per 100,000 population)

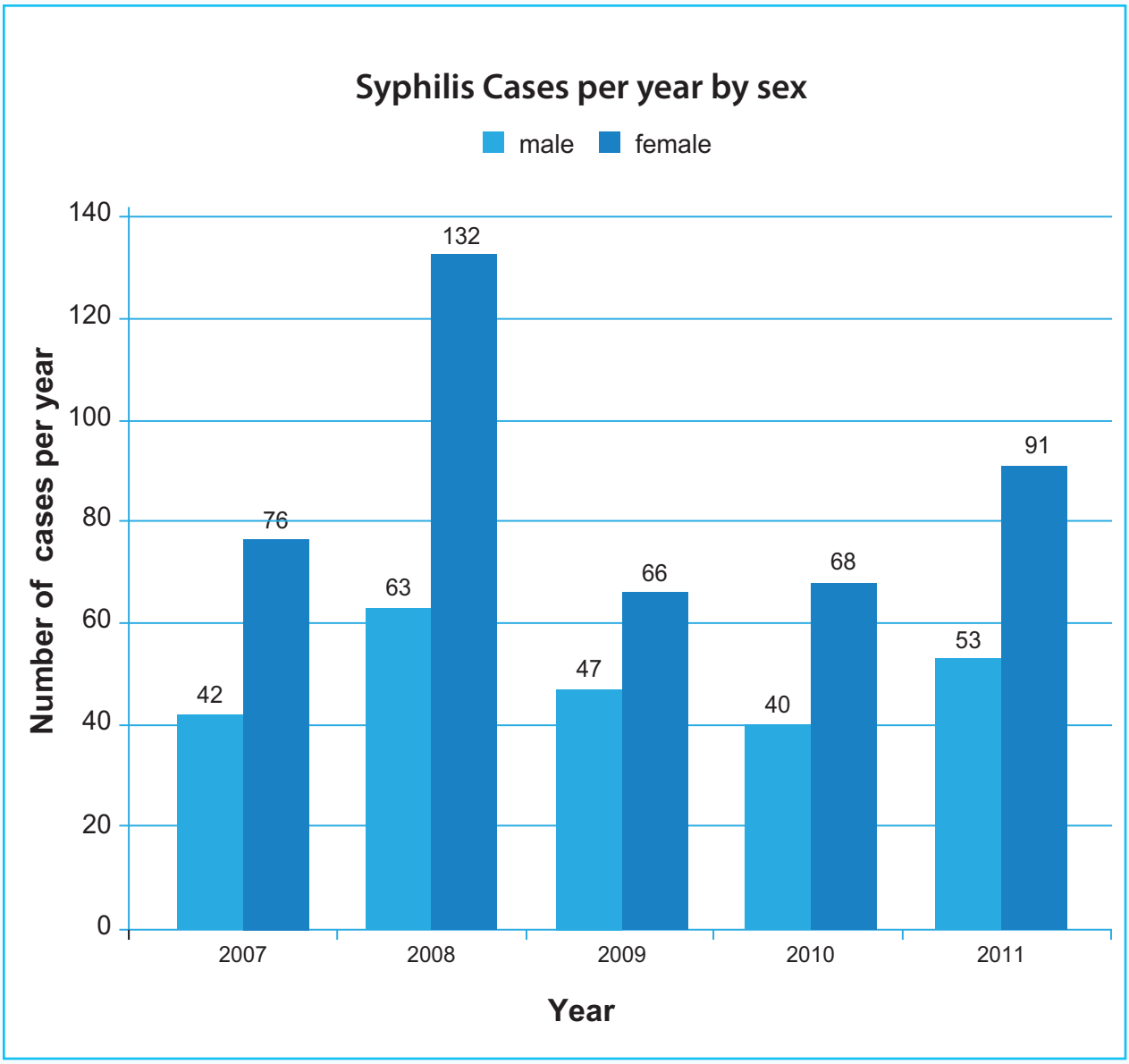


Figure 25: Number of Syphilis Cases by sex, 2007-2011

The number of cases of infectious syphilis increased by 32% among men and by 33% among women between 2010 and 2011. The 15-19 and 20-24 age groups were the only two age groups to record a reduction in the cases of infectious syphilis between 2010 and 2011 (Table 18). The highest rates of primary and secondary syphilis occurred in the 25 to 34 and 40 to 44 age groups in 2011.

Year	2010			2011			
Sex	Female	Male	Total	Female	Male	Total	Totals Difference
Age Groups							
0_9	0	0	0	0	0	0	0
10_14	0	0	0	1	1	2	2
15_19	14	2	16	4	5	9	-7
20_24	19	10	29	12	6	18	-11
25_29	12	7	19	20	9	29	10
30_34	9	6	15	18	7	25	10
35_39	3	4	7	18	6	24	17
40_44	8	4	12	8	8	16	4
45_and_over	3	7	10	10	11	21	11
Total	68	40	108	91	53	144	36

Table 18: Infectious Syphilis (Primary and Secondary), 2010 and 2011

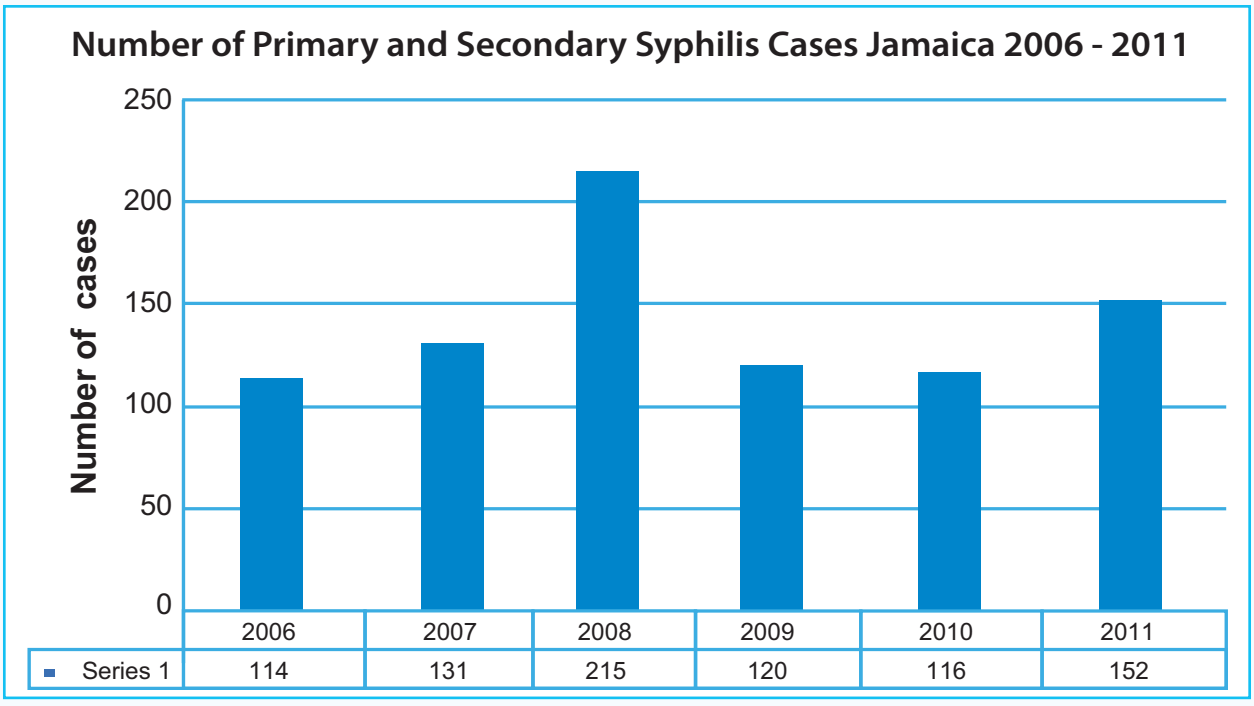


Figure 26: Number of cases of Primary and Secondary Syphilis, 2010 and 2011

11.0 MONITORING AND EVALUATION

Through research, training and improvement of databases, the Monitoring and Evaluation (M&E) Unit strengthened its capacity to track the implementation of activities, increased the understanding of trends in HIV prevalence and strengthened the capacity of stakeholders in Jamaica's HIV response to collect and use data.

11.1 RESEARCH STUDIES AND PROJECTS FOR 2011

During 2011, the M&E Unit moved the research agenda forward by completing a number of research studies and projects in collaboration with various stakeholders.

Third generation surveillance of MSM and CSW: These surveys provide important outcome and impact indicators including HIV prevalence in these key populations. The surveys focus on condom use with regular and non-regular partners, myths, knowledge about STI/HIV prevention, exposure to interventions, and high risk behaviours such as substance abuse.

The 2011 surveys also identified a cohort of MSM and SW for tracking purposes. MEASURE Evaluation provided financial, technical, and administrative support for protocol development, data collection, analysis and dissemination.

The MSM survey recruited a national sample of 453 MSM between December 2010 and August 2011. The HIV prevalence was 32.9%.

The SW survey protocol was extended to patrons and workers at PLACE sites i.e. locations where persons meet sex partners or participate in sexual activity. The aim was to collect bio-behavioural data for SW and patrons thereby determining HIV prevalence and improving interventions designed for this population.

Data collection began in September 2011 and was completed in December 2011. A total of 392 SW, 484 female workers (bartenders etc.), 278 female patrons, and 334 male patrons were recruited. HIV prevalence was 4.1% among SW, 0.8% among female patrons, 0.7% among male patrons, and 4.7% among female workers.

Key findings from these studies were presented at the 2011 Caribbean HIV Conference in the Bahamas and the NHP Annual Review.

National AIDS Spending Assessment (NASA): The NASA study was undertaken in 2011 with technical and financial support from UNAIDS. The NASA covered two financial years: April 2009 to March 2010 and April 2010 to March 2011. The NASA has 3 main objectives:

- To develop a strategy involving multisectoral and multi-level partners to track HIV-related spending
- To contribute to the implementation of a methodology for systematic monitoring of HIV/AIDS financial flows at national and regional level, and
- To build national and regional capacity to conduct such monitoring.

Findings from the NASA were presented at the annual review and the report was circulated for feedback.

People Living with HIV Stigma Index: The People Living with HIV Stigma Index is designed to measure the stigma experienced by PLHIV. The index was developed by the International Planned Parenthood Federation (IPPF), in partnership with UNAIDS, the Global Network of People Living with HIV (GNP+) and the International Community of Women living with HIV and AIDS. The Index has the potential to provide the basis for evidence based policy and programmatic interventions to combat stigma and discrimination.

This is important since stigma and discrimination

is considered a root cause of high HIV prevalence, low levels of HIV testing, late access to treatment, and poor health seeking behaviours. Preliminary finding were presented at the 2011 NHP Annual Review. The report is being reviewed by the Steering Committee and finalization for dissemination.

Psychiatric Prevalence Study: A protocol was developed to determine prevalence of psychiatric illnesses among PLHIV accessing care in the public sector. A total of 155 patients participated in the study from 5 treatment sites in SERHA and NERHA. The data was entered and analysis is underway.

Modes of Transmission: In 2011, the UNAIDS Modes of Transmission (MOT) model was applied to the HIV epidemic in Jamaica. This model allows policy makers to gain an understanding of the short-term risk of HIV infection in various risk groups and guide the national HIV response.

The MOT analysis utilizes data for key risk groups, including the proportion of adults in each group, the current HIV prevalence, patterns of risk behavior, and levels of protection against HIV infection in each risk group. The model indicates that approximately 2,500 new HIV infections will occur in Jamaica in 2012.

Approximately 30% of new HIV infections will occur among MSM, making MSM the group at highest risk of HIV infection. Approximately 50% of new infections will occur in heterosexuals, both high risk and low risk. UNAIDS will support dissemination of the MOT results through publication of the report, pamphlets, and consultation meetings with stakeholders.

Knowledge, Attitude, Behaviour, and Practices: The questionnaire used in this national study was revised during 2011 and Hope Enterprise was contracted to conduct the study in the first quarter of 2012. The survey was revised to increase the understanding of factors contributing to sub-optimal condom use, multiple partnerships, attitudes towards anal sex, attitudes towards homosexuality, and related policies. The new global indicator that tracks gender-based violence for the Global AIDS Response Progress Report (GARPR) was also included in this survey. With its inclusion, Jamaica will be one of the few countries that is able to report on this indicator in the 2012 GARPR.

PMTCT Adherence Study: To better undestand the factors that lead to continued mother to child transmission of HIV, a protocol was developed to conduct a study at the three major PMTCT hospitals in the South East region (Victoria Jubilee Hospital, Spanish Town Hospital, and University Hospital of the West Indies). This research uses monitoring data collected by the Ministry of Health's PMTCT programme.

Sentinel Surveillance: HIV Sentinel Surveillance of antenatal clinic (ANC) and sexually transmitted infection (STI) clinic attendees allow the NHP to monitor trends in HIV prevalence. Both were completed between April and September 2011 and a draft report was prepared.

11.2 CAPACITY BUILDING IN M&E

The area of capacity building remains an M&E priority for stakeholders. The M&E unit convened a number of capacity building interventions during the period January to December 2011. These capacity building initiatives are summarized in the following below.

The staff of the M&E unit also benefited from M&E training activities i.e.

- The M&E Director and M&E Officer participated in a 5-day advanced evaluation training, entitled "Impact Assessment Workshop on the Effectiveness of Social Programs for HIV-AIDS: Caribbean Region". The Caribbean Health Research Council (CHRC) and Instituto Nacional de Salud Publica, Mexico, facilitated the workshop.

- The Senior Director participated in a results-based M&E workshop that was facilitated by CHRC.

M&E Capacity Building Interventions	Number of Participants	Summary
Effectively using the HIV/ARV Data base – SERHA, WRHA	45 (SERHA) 20 (WRHA)	This workshop reviewed Monitoring & Evaluation of the ART Programme, Early Warning Indicators, understanding of data entry fields, roles and responsibilities, running reports.
Data analysis workshops	152	Six data analysis workshops were held throughout the 4 Regions and with Civil society. 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.
Onsite HIV/ARV Database training at of the 23 treatment sites	47 15	Onsite training was provided in: data entry, understanding data entry fields, searchingthe database and generating reports.
Annual STI conference for Contact Investigators Done by – Done by M&E and CHART	35	The conference focused on the presentation of STI data for 2010, updates on the HIV response, the elimination initiative, findings of the STI prevalence study, and TB/HIV co-infection.

Table 19: Monitoring & Evaluation Capacity Building Workshops held in 2011.

• The research officer attended the CHART /ITECH "Training Outcomes Workshop" in St. Lucia.

• The database manager participated in the National Health Information System (HIS) Assessment workshop. This workshop was sponsored by Pan American Health Organization (PAHO) and was designed to assess the existing HIS using a standardized assessment tool.

11.3 MANUALS AND PROGRAMME DOCUMENTS

The M&E unit is considered a clearing-house for all HIV-related data. Hence, the unit generated several reports and manuals in 2011. These reports were used at the national, regional and international level. This includes:

HIV Case-Based Surveillance Manual: The HIV case-based surveillance system was reviewed in collaboration with PAHO and Centers for

Disease Control and Prevention (CDC). An action plan was established for the completion of the updated HIV case-based Surveillance Operations Manual and the final version is awaiting approval by Ministry of Health officials. As part of the overall review, the HIV Confidential Reporting Form was updated and the corresponding changes will be made to the HATS database.

2012 – 2017 National HIV/STI Strategic Plan (NSP): The M&E Unit completed the epidemic profile and the M&E chapters for the NSP 2012-2017.

2012 -2017 M&E Plan: A major undertaking during 2011 was the development of a new M&E Plan. The M&E Plan complements the National Strategic Plan (NSP) and describes the M&E system and whether objectives of the National Strategic Plan are met.

The M&E Unit, with technical assistance from MEASURE, hosted a strategic planning retreat from July 25 – 27, 2011. Over 40 stakeholders participated in an in-depth assessment of the existing M&E system using the 12 Components organizing framework for a fully functioning M&E system as a guide. Stakeholders were asked to prioritize strategies that address gaps and improve strengths of the M&E system.

Other reports produced in 2011 include the 2010 AIDS Epi Update, the Global Fund Performance updates for periods 7 and 8, Country Response Information System (CRIS) progress report, 2010 ANC and STI Sentinel Surveillance Report, World Bank quarterly reports, annual report for Ministry of Health, and the HIV update for the Economic and Social Survey Jamaica.

11.4 DATA MANAGEMENT

The M&E Unit continued to work with regional staff and sub-recipients towards improving data quality. This involved detailed examination of all reports received for completeness and inconsistencies as well as giving feedback to all stakeholders involved.

Figure 27 summarizes reporting by stakeholders between January and December 2011. The graph represents monthly reports received against the number of reports that were expected from 84 Stakeholders. Only 61% of reports that were expected were received and 41% were received on time.

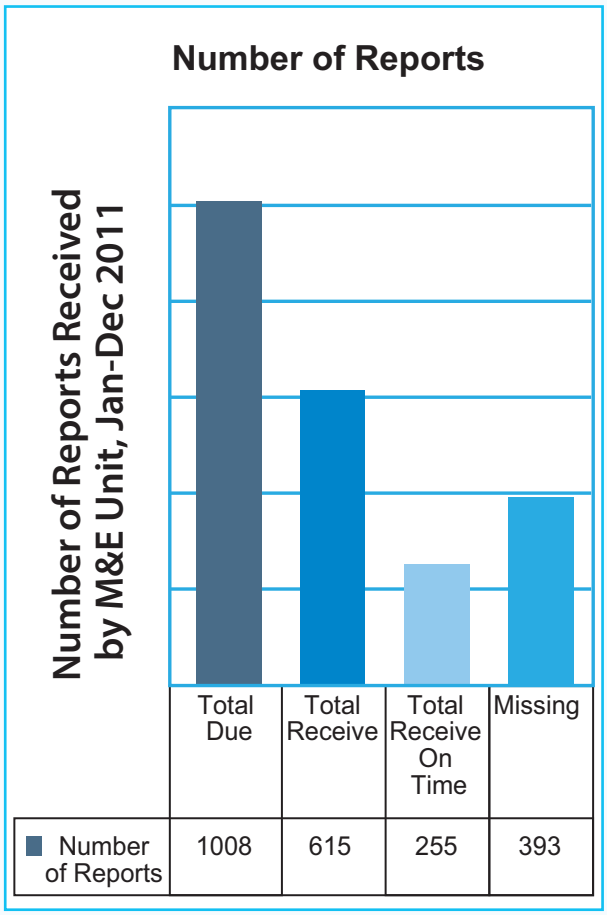


Figure 27: Reports received BY M&E unit during 2011

11.5 MONITORING AND EVALUATION DATABASES

Several databases are developed and maintained by the M&E unit to facilitate efficient data management. The databases are described below.

- The **M&E Database** captures all stakeholder reports and facilitates the generation of summary reports at the national level. Over the period, the

M&E database was updated to address gaps in the reports being captured by the system and eliminated the need for dual data entry.

- **Country Response Information System (CRIS3):** In January 2011, a consultant was hired to manage the roll out of the UNAIDS Country Response Information System (CRIS3) database to sub-recipients. However, due to the slow speed of uploading data, the CRIS3 system was tailored to include a standalone desktop version.

  Stakeholders will have full capabilities of the system and will be required to forward their reports to the M&E unit. To date, 28 beneficiaries have received the CRIS system, which amounts to 43 computers and monitors, 16 printers, 28 USB drives, 29 printer cartridges and 38 UPSs.

  The roll-out included on-site training and installation of hardware to build capacity, which ensured that organizations are equipped to efficiently utilize the CRIS3 package. The consultant also developed a local M&E user manual for the CRIS3 database and initial comments have been integrated. This manual will be further tested in workshops with stakeholders to produce a user-friendly tool.

- **ARV Database:** During 2011, 3 new treatment site databases were implemented: Duhaney Park Health Center, Tower Street Adult Correctional Center and Port Antonio Hospital. Each site received a new computer, a UPS and, in most cases, a printer.

  Following feedback from a regional training workshop, flash drives were procured to support data storage at each site. The M&E unit also provided training and technical support while addressing hardware and software issues.

  The ARV database was also strengthened through the effort of partners. For example, a draft database user manual was developed by a team from CHARES, led by the Medical Director. The manual is being updated based on feedback from stakeholders. This includes changes recommended by PAHO to capture HIV drug resistance early warning indicators.

  In addition, the M&E Unit continued to work with Clinton Health Access Initiative (CHAI) to strengthen the ARV database and pharmacy monitoring systems. Some key actions were identified by the team including procurement of computers for sites with "outdated" or insufficient hardware to support the treatment database.

- **HATS and ARV database merger:** In 2011, major strides were made in linking the ARV database. After consultation with key stakeholders from treatment sites, the consultant developed a process to merge the standalone HIV/ARV databases at Treatment Sites into one HIV/ARV database at the M&E Unit.

  The merger is aimed at integrating data from existing databases with the intention of moving towards an integrated Health Information System (HIS) system within the M&E Unit. This will achieve real-time updates from different treatment sites, which also allows for improved HIV case management.

  A pilot was done at the Comprehensive Health Centre examining 4 main elements of the merger: 1) loading of client treatment site records through the modified front-end application: 2) extraction of modified or new records from the treatment site database: 3) transmission of the extracted data to Ministry of Health and 4) loading the extracted data into a copy of the treatment site database at the Ministry of Health.

  Merger of the treatment site databases will be followed by linkage with the HIV/AIDS Tracking System (HATS). HATS continued to capture routine HIV case-based information to facilitate surveillance of HIV in Jamaica.

- **Rapid Test Database:** This database captures information on all HIV tests that are done using a rapid test method. The rapid testing

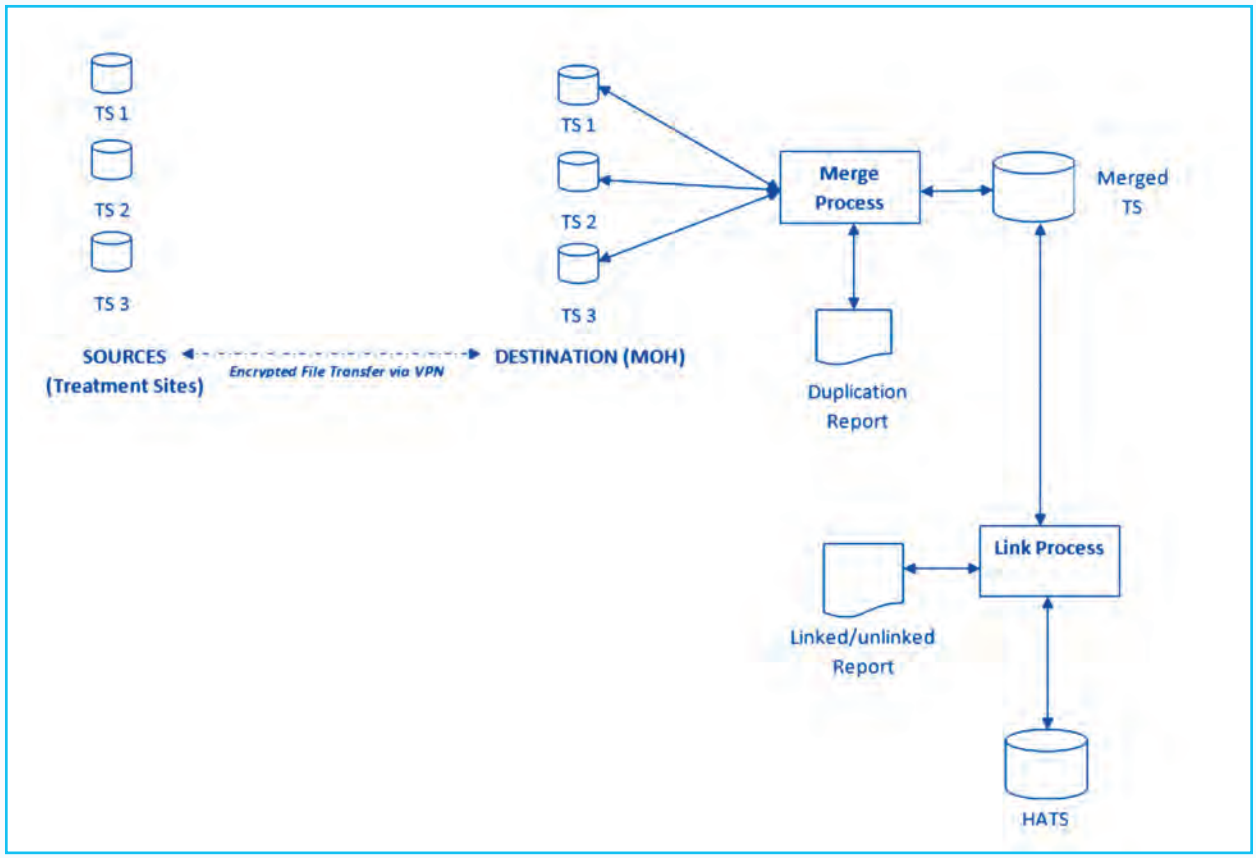


Figure 28: HATS and ARV database merger data process flow

algorithm was updated in 2011, and the M&E unit updated the syphilis and rapid test algorithms at 3 of the 4 Regional Laboratories.

11.6 MONITORING AND EVALUATION REFERENCE GROUP (MERG)

The national Monitoring and Evaluation Reference Group (MERG) was convened at several points in 2011 to provide technical support and validate data gathering processes. A meeting of the MERG was convened in June to review data in preparation for the 2011 regional HIV estimates workshop and in July for the strategic planning retreat to develop the new M&E Plan. Three additional meetings were convened to review the M&E plan and National Focus Indicators.

11.7 PRESENTATIONS AND WORKSHOPS

Data dissemination and M&E sensitization happened through two major routes: presentations and participation in workshops. During 2011, the M&E staff participated in several workshops as listed below.

- A conference facilitated by the University of the West Indies, Mona on "The Impact and Implications of Statistics and Statistical Data Analysis"
- Surveillance Unit workshop hosted by Ministry of Health
- HIV Programme Leadership Training hosted by the Caribbean Public Health Agency (CARPHA)

- 2011 Caribbean HIV Research Conference in the Bahamas
- Results-based M&E Skills Building Workshop hosted by Caribbean Health Research Council in Port of Spain, Trinidad
- HPV Surveillance workshop facilitated by Ministry of Health
- UNICEF funded workshop on young persons belonging to key populations
- Website training on Korean website portal for reports generated from the hospital system
- The UNAIDS led Caribbean region HIV estimates training

M&E Staff also made presentations as listed:

- Senior Director
  - Poster and oral presentation on "Turning HIV Policy into Action: The Jamaica Experience" at the 2011 Caribbean HIV Research Conference in the Bahamas
  - Panel discussion on the Guidelines for the M&E of most-at risk populations (MARPS) at the 2011 Caribbean HIV Research Conference in the Bahamas
  - "Adolescents and Youth: HIV Estimates and Service Statistics" at the UNICEF sponsored "Adolescents Living with HIV" Workshop
  - "Monitoring & evaluation of the National PMTCT programme" at the prevention of Mother to Child Transmission of HIV and Syphilis (PMTCT) Update Workshop
  - Presentation at the National Council on Drug Abuse's (NCDA) Tek it to Dem project at the JIS Think Tank
  - "Using ART successfully: Fostering Optimal Adherence" at CCAS/CDC/CHART/NHP Workshop
  - "Evolution of the National M&E System" at the World Band midterm review meeting
  - "Jamaica M&E System" MEASURE Study tour at University of North Carolina, Chapel Hill
- Director
  - "Designing Research-based Programmes – Practical Guidelines" at the 2011 Annual Review
  - "NASA Study – Preliminary Findings" at the 2011 Annual Review
  - "Overview of 2012-2017 M&E strategic plan" – NSP review committee

Presentations were also made by the Biostatistician, HIV Research Officer, Senior Director, and Database Manager at the WRHA and SERHA treatment workshops, Indicator Update Meeting, Monitoring and Evaluation Reference Group (MERG) and M&E Plan retreat.

11.8 GEOGRAPHIC INFORMATION SYSTEM

The M&E Unit supports a Geographic Information System (GIS) Officer who is placed in the Epidemiological Research and Data Analysis Unit of the Ministry of Health. The GIS Officer provided technical assistance with respect to research, dataset development, data analysis, report generation and GIS to other units and divisions in the Ministry, the Regional Health Authorities and other agencies. Some key initiatives that benefited from GIS support are described below.

- **Technical assistance:** Weekly maps were presented at various meetings to support the investigation of the outbreak of ackee poisoning that occurred between November 2010 and April 2011. The Environmental Health Unit (EHU) was assisted with the capture and analysis of drinking water sites

based on readings of water quality officers. The GIS officer also assisted with compiling the backlog of HIV/AIDS datasets along with those files already mapped. The information was forwarded to Mona Geoinformatix Institute for mapping and analysis purposes. Unfortunately, the project was not completed as the dataset became corrupted on their system and was lost.

A proposal, including a draft budget and schedule was prepared and will utilize students from the University of Technology to map the backlog of data from the HIV/AIDS database.

- **Training:** The GIS Officer participated in training programmes that helped to develop research skills and applications of GIS within the health sector. Training sessions were conducted for 6 in-house members of staff and 6 public health inspectors in the Western Region on GIS and GPS.

  Officers were given all required software and resource materials after the training. The GIS Officer also received training over a 6-week period on accident reconstruction offered through the National Works Agency to look at motor vehicle accident reconstruction in Jamaica.

  The aim of the course was to educate participants about the dynamics of what happens in an accident and how to use physics and mathematical equations to re-enact what happened before and during a motor vehicle accident.

- **Mapping:** Numerous maps depicting health events and other health-related variables were produced for various units in the MOH and for external partners. Maps of health events depicted include:

- The number and rates of confirmed cases of ackee poisoning across Jamaica at the community level

- The number of suspected and confirmed cases of dengue by parish as well as rates per 100,000 population

- Cumulative HIV figure by parish from 1982 to 2010, January to December 2010 cases by parish and HIV rates per 100,000 Population (2010) by parish

- Number and rates per 100,000 population of cases of tuberculosis for 2010.

  Some of the maps that were also created to show spatial data for health related matters included:

- All health facilities by parish updated to 2010

- The location of selected hospitals and health centers island-wide where officers who will be receiving computers from the Mental Health Unit will be located. This information was required by the funding agency.

- A listing of health facilities by health district was done to facilitate the mapping of immunization cases in collaboration with an epidemiologist from the CDC. Health center catchment areas were also mapped during this exercise.

- Maps showing the location of ophthalmologists and optometrists in Jamaica.

- Health facilities coverage area maps were updated to facilitate mapping of immunization data across Jamaica.

- Blank parish maps showing communities and roads for distribution to surveillance officers to assist in capturing data on disease occurrences.

11.9 M&E STAFF

The M&E Unit experienced a number of staff changes during 2011 as Dr. Jacqueline Duncan, Director, M&E for 7 years, resigned. Dr. Sharlene

Jarrett was appointed as Senior Director in July 2011 and a new Director, Mrs. Suzanne Robinson-Davis, was appointed in September 2011.

The Research Officer, also vacated her post in September 2011 and a new research officer has since been appointed. Interviews were completed and a new HIV/STI information officer was selected and was scheduled to begin in January 2012.

11.10 CHALLENGES

The M&E Unit was faced with several challenges in 2011:

1. Despite significant improvement of monitoring systems, little data exists on effectiveness of interventions and stakeholders have limited capacity to conduct impact evaluation. Consequently, many interventions continue to be implemented based on anecdotal evidence and without outcome monitoring or evaluation.

   While capacity to conduct or monitor impact studies have increased, staff turnover and limited resources are barriers to rigorous evaluations.

2. An M&E priority is to strengthen the electronic information systems. Numerous databases have been designed with varying stages of implementation. Full implementation of databases has been hampered by stakeholder commitment to use newer systems, lack of technical support at the field level, which results in inconsistency in, electronic systems (crashed computers, lack of antiviral software etc.), and inadequate human resources to perform required data entry functions.

   At the national level, inconsistency with inter- and intra-net affected data bases, in particular the maintenance of the HATS database.

3. HIV surveillance continues to be hampered by under-reporting in public and private sectors. Widespread sensitization of health care workers on HIV surveillance is necessary to improve reporting.

4. A significant number of reports were late or missing. This impacted the M&E unit's ability to assess the HIV response accurately and to determine the progress towards our targets.

12.0 FINANCE

The National HIV/STI Programme is financed by loans, grants and in-kind contribution. No monetary value has been applied to the latter in this report. Financial resources are provided by the Government of Jamaica (GoJ) through the recurrent budget and counterpart contribution, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the International Bank for Reconstruction (IBRD) or World bank, the United States Agency for International Development (USAID), the United Nations Children's Fund (UNICEF) and the Joint United Nations Programme on HIV and AIDS (UNAIDS).

Over the past six calendar years (2006 – 2011), a total of J$6.20 Billion was budgeted to support the national response of which J$4.8 Billion or 78% was spent. The major area of expenditure was the provision of Treatment, Care and Support which accounted for 44%, followed by prevention at 23% and administration at 14%.

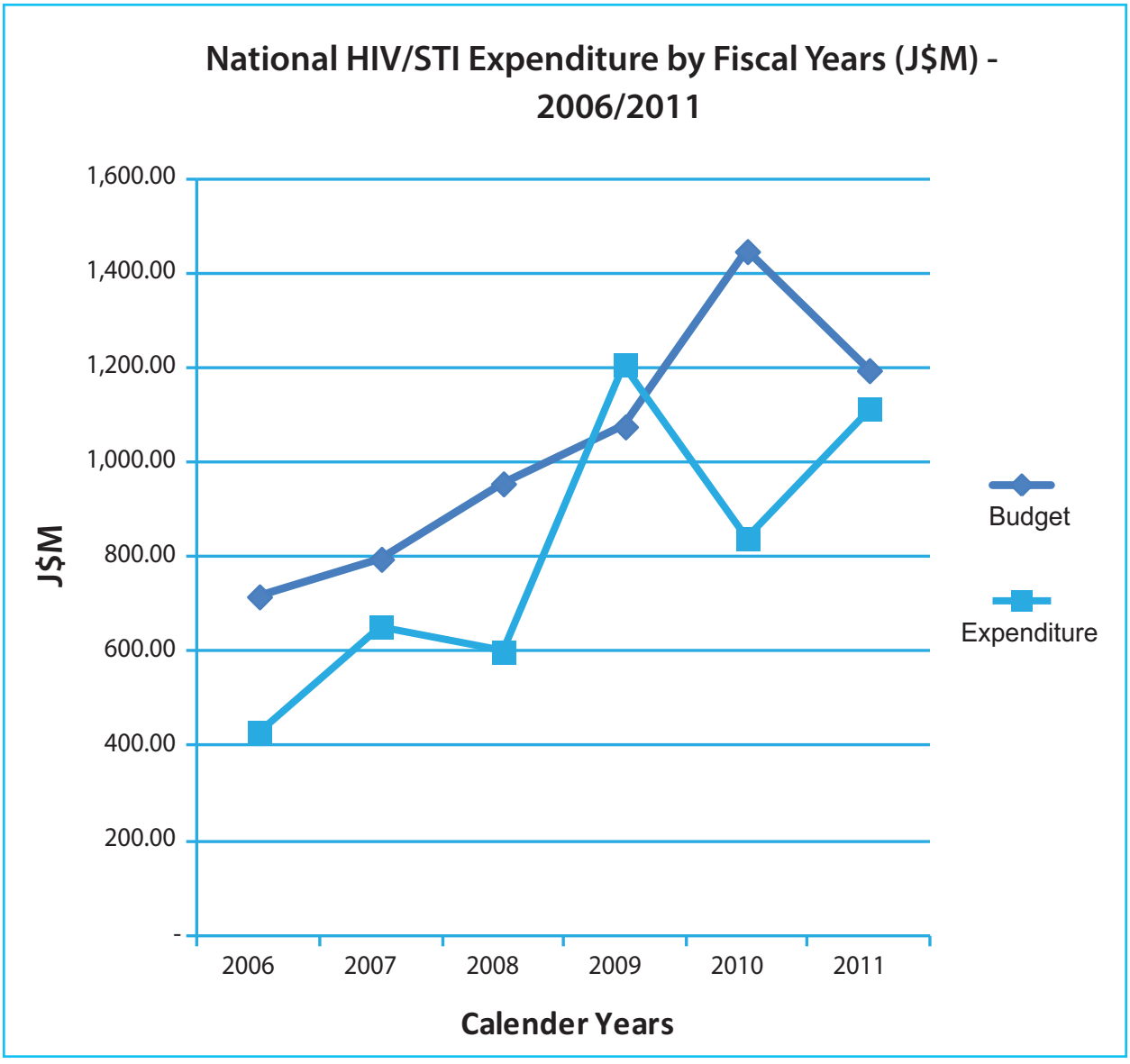


Figure 29: Trend in expenditure by National HIV/STI Program, 2006-2011

A comparative summary of the years 2009 – 2011 by component and implementing entity is shown in table 20. The resources support five major components - Treatment Care & Support, Prevention, Enabling Environment/Policy, Monitoring and Evaluation and Administration /Project Management / Empowerment and Governance.

There has been a significant improvement in the amounts budgeted and liquidated for capacity building, policy and M&E as the indicators for the year under review were increased throughout the program.

The Regional Health Authorities and Line Ministries

Comparative Summary of components expenditures 2009 - 2011

COMPONENTS	Calendar Year 2009		Calendar Year 2010		Calendar Year 2011	
	Budget J$M	Actual J$M	Budget J$M	Actual J$M	Budget J$M	Actual J$M
Treatment Care & Support	390.69	555.54	686.14	175.75	455.46	455.78
Prevention	314.07	325.15	330.77	380.55	273.82	283.33
Capacity Building	18.98	23.04	103.35	81.87	36.53	32.3
Policy & Advocacy	88.87	66.9	68.92	55.21	45.06	39.42
Monitoring & Evaluation	51.9	36.11	53.78	46.86	51.04	35.21
Administration	206.23	170.44	130.8	93.2	242.25	222.77
HADDS	-	-	55.56	-	57.62	0.05
RHAS	4.78	30.05	15.7	6.52	28.68	38.83
Line Ministries	2.28	1.95	4.19	1.2	6.99	7.26
Total	**1077.8**	**1209.18**	**1,449.21**	**841.16**	**1,197.45**	**1114.95**

Source: National HIV/STI Programme Financial Statements

Table 20: Comparative Summary of component expenditure 2009-2011

Expenditure for the calendar year 2011 was budgeted at J$1.197 Billion, 17% less than the previous year's budget of $1.449 Billion. However, actual expenditure for 2011 was $1.114 Billion, an increase of 32% over the previous year's expenditure. The burn rate for the year under review was 93%. The shortfall on actual expenditure for 2011 resulted mainly from delays in the expansion of the waste management facility (SERHA).

The funds allocated to the prevention component were fully utilized during the year. This is directly attributed to the increased activity in the targeted communities and with key populations (out of school youths, SW, drug users and MSM). Resources were spent mainly on mass media activities, purchasing condoms, staff cost and targeted community activities.

continued to experience increased funding, which is consistent with their increased involvement in project implementation island-wide. USAID PEPFAR project funding was provided during the year mainly to support staff emoluments and other related costs.

The Global Fund remained the largest funding source of the National Programme for Year 2011 recording an expenditure of J$723.49 million, an increase of $56.17 million or 8% above the previous year. The main areas of expenditures were procurement of ARV drugs, test kits, condoms, mass media activities, training and staff costs.

Prevention activities included Health and Family Life Education expenditure from the World Bank project (J$225.40 million from a budget of J$303.18 million for the reporting period). The

main areas funded under this project were the procurement of infant formulas, 8 portable dental suction units, staff related activities, and the promotion of HIV/AIDS safer sex messages through avenues such as 'The Magnum Kings and Queens' television programme.

The USAID PEPFAR project spent J$134.64 million representing an increase of $75.20 million or 126% of the previous year's expenditure. The funds were used to support 10 project objectives with the prevention component being the major beneficiary. The Government of Jamaica (GoJ) contributed J$21.51million of the expenditure for the year which was used to support capacity building.

Additional grant funding was received from the Joint United Nations Programme on HIV/AIDS (UNAIDS) during the year. J$3.46 million was spent against the approved budget of J$4.26 million. J$2.05 million was used for the preparation of the National Strategic Plan and the balance was used to support the World AIDS Day Leadership Breakfast, the HIV/STI National Family Planning Integration initiative and consultations on gender equality.

Figure 30 summarizes the contribution of the major funding sources.

CHALLENGES, ACHIEVEMENTS AND WAY FORWARD

Despite the improvements in expenditure, the NHP was faced with several challenges in 2011. These include:

- The lengthy timelines for the procurement process. This significantly delayed the implementation and corresponding expenditure on many activities such as the expansion of the Waste Management Facility in the South East Region.

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

- Delays in the receipt of funds for the USAID PEPFAR project. Cash advance requests are required to be made monthly and funds are received approximately one month after the request. In some instances funds had to be

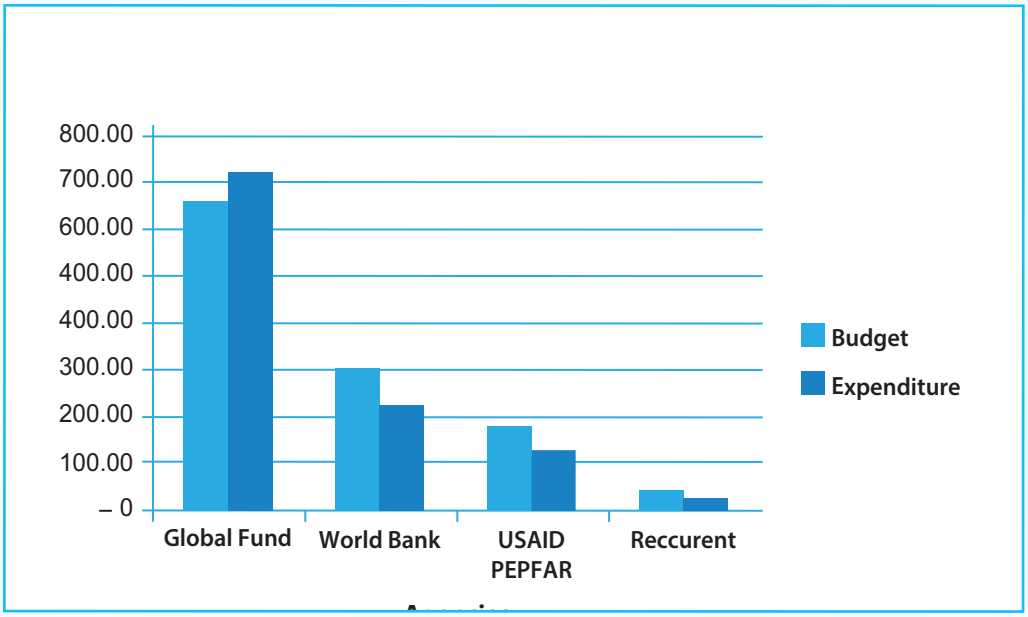


Figure 30: Programme expenditure by Funding Source for 2011

borrowed from other sources to fulfill project cash needs.

- Lengthy process involved in the procurement of ARV drugs. In addition, one major supplier was replaced during the year due to non-performance.

In spite of the challenges, the NHP managed to make significant progress during the year. There was an increase in the number of mass media activities, procurement of condoms, HIV test kits, infant formulas and ARV. Revenue was provided by the GoJ by way of the Recurrent Budget and counterpart funding under the USAID PEPFAR Grant and the IBRD (World Bank) Loan Project.

APPRAISALS

Audits for the financial year ending March 2011 were conducted for both the World Bank and Global Fund projects as mandated by the funding agencies. Audit services were provided by the audit firms KMPG and Mair Russell Grant Thornton respectively.

The audit for USAID PEPFAR was conducted during December 2011 as the project's financial year end was extended from July 31, 2011 to September 30, 2011. The audit report is required by USAID by June 2012.

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ANNEX 1: NATIONAL PERFORMANCE ON INDICATORS

Global Fund Period 8, April to September 2011				
No.	**Indicator Description**	**Intended Target to date**	**Actual Result to date**	**% achievement**
1.1	Number & Percentage of schools with at least one teacher trained in life-skills based HFLE and who taught it in the last year	760 (74%)	(933) 92%	123%
1.2	Number of students reached through life-skills based Health and Family life interventions in schools	490,000	443,790	91%
2.1	Number of sex workers currently reached through prevention activities	2,890	5,168	179%
2.2	Number of MSM currently reached through prevention activities	1,723	2,365	137%
2.3	Number of inmates currently reached through prevention activities	450	499	111%
2.4	Number of adolescents (10-14) currently reached through prevention interventions in out-of-school settings	5,500	6,098	111%
2.5	Number of youth (15-24) currently reached through prevention interventions in out-of-school settings	20,500	20,325	99%
2.6	Number of service deliverers trained on HIV prevention	2,269	3,027	133%
3.1	Percentage of sex workers that have received an HIV test in the last 12 months and who know their results	75%	75%	100%

3.2	Number of contacts who received testing and counselling services for HIV and received their test results	90,000	120,831	134%
4.1	Number of condom outlets established and monitored	1,227	1,412	115%
4.2	Number of condoms distributed for free	2,000,000	3,234,384	162%
6.1	Number of adults with advanced HIV currently receiving ARVs	7,708	7,978	104%
6.2	Number of children with advanced HIV currently receiving ARVs	474	492	104%
7.1	Number of CD4 tests done in accordance with guidelines	63,265	58,384	92%
7.2	Number of PCR tests done on infants born to HIV+ mothers according to national standards	2,747	3,179	116%

ANNEX 2: GLOBAL AIDS RESPONSE PROGRESS REPORT

2010- 2011 Global AIDS Response Progress Report		
1.1	Percentage of young women and men aged 15-24 who 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]	**Overall: 38.50%** **Men: 33.86% Women: 42.64% (2012, KABP survey)**
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 [National Target: TBD]	**Overall: 31.13%** **Men: 49.69%; Women: 13.51% (2012, KABP survey)**
1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months [National Target: Men: 47% Women: 15% by 2008]	**Overall: 28.11%;** **Men: 46.77% Women: 13.28% (2012, KABP survey)**
1.4	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse* [National Target: None]	**Overall: 56.93%;** **Men: 65.38% Women: 40.19% (2012, KABP survey)**
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results [National Target: TBD]	**Overall: 58.71%;** **Men: 47.24% Women: 67.74% (2012, KABP survey)**
1.6	Percentage of young people aged 15-24 who are living with HIV* [National Target: ≤1.5% by 2009]	**0.93% (2010) Sentinel surveillance of ANC clients)**

1.7	Percentage of sex workers reached with HIV prevention programmes	**79.7% SW (2011, Second generation surveillance)**
1.8	Percentage of sex workers reporting the use of a condom with their most recent client [National Target: 95% by 2011	85.2% of SW (2011, Second generation surveillance)
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results [National Target: 50% of SW by 2012]	**59.2% of SW (2011, Second generation surveillance)**
1.10	Percentage of sex workers who are living with HIV [National Target: ≤7% by 2011]	**4.1% of SW (2011, Second generation surveillance)**
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	**86.9% (2011, Second generation surveillance)** **14% (2011, Based on programme records, 4617 men were reached in 2011 from an estimate population of 33,000)**
1.12	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]	**75.52% of MSMs (2011, Second generation surveillance)**
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	**68.32% MSM (2011, Second generation surveillance)**
1.14	Percentage of men who have sex with men who are living with HIV [National Target: <25% by 2011]	**32.77% of MSMs (2011, Second generation surveillance)**

<table>
<tr><td>3.1</td><td>Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission

[National Target: 85% by 2009]</td><td>58.68% - 284/484; (2011, Spectrum and PMTCT Programme Monitoring)

84.3% (Dec 2011 – PMTCT Programme Monitoring)</td></tr>
<tr><td>3.2</td><td>Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth</td><td>87.1% (2011, PMTCT Programme Monitoring/ NPHL Lab Data)

58.5% (283/484: 2011, Spectrum/ NPHL Lab Data)</td></tr>
<tr><td>3.3</td><td>Mother-to-child transmission (modeled)</td><td>37 new infections (2011); 484 Women needing PMTCT (Spectrum Model)

20 cases or 0.35 (per 1000) (2010 – PMTCT programme monitoring)</td></tr>
<tr><td>4.1</td><td>Percentage of eligible adults and children currently receiving antiretroviral therapy*

[National Target: 8,008 Adults, 486 Children by 2012 or 75%)</td><td>58.06% (9162/15779 January 2012)</td></tr>
<tr><td>4.2</td><td>Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

[National Target: 85% by 2009]</td><td>75.6% (2012, ARV Database: Cohort initiating ART in 2010)</td></tr>
<tr><td>5.1</td><td>Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV</td><td>10/45; 22.2% (WHO Estimate)

There were 32 HIV-positive incident TB cases in 2010. 10 were placed on treatment based on National eligibility criteria (2011 National TB Programme)</td></tr>
<tr><td>6.1</td><td>Domestic and international AIDS spending by categories and financing sources</td><td>Completed (2011, NASA)

<table><tr><td>HIV & AIDS Expenditure by Financial Source</td><td>JMD 2009/10</td><td>JMD 2010/11</td></tr></table></td></tr>
</table>

		<table><tr><td>Total Spending</td><td>1,321,746,436</td><td>1,276,015,167</td></tr><tr><td>Public:</td><td>299,096,806</td><td>334,859,307</td></tr><tr><td>Percent</td><td>22.6%</td><td>26.2%</td></tr><tr><td>International:</td><td>1,018,649,631</td><td>937,155,860</td></tr><tr><td>Percent</td><td>77.1%</td><td>73.4%</td></tr><tr><td>Private:</td><td>4,000,000</td><td>4,000,000</td></tr><tr><td>Percent</td><td>0.3%</td><td>0.3%</td></tr></table>
7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Completed (2012, NCPI, See Appendix 2)
7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	**9.89% (2012, KABP survey)**
7.3	Current school attendance among orphans and non-orphans aged 10-14* [National Target: >0.9% by 2012]	Unavailable (2010/11)
7.4	Proportion of the poorest households who received external economic support in the last 3 months	Unavailable (2010/11)

ANNEX 3: LIST OF APPROVED TREATMENT SITES IN THE PUBLIC HEALTH CARE SYSTEM (2011)

South East Regional Health Authority (SERHA)

1. Comprehensive Health Centre
2. KPH
3. St. Jago Park
4. CHARES
5. Bustamante Children's' Hospital (Paeds)
6. UHWI Paediatric Clinic
7. National Chest Hospital 8.
8. Princess Margaret Hospital
9. Maxfield Park Health Centre
10. Victoria Jubilee Hospital (Maternity)
11. Windward Road Health Centre 12.
12. Spanish Town Hospital (Paeds)
13. Bellevue Hospital
14. Duhaney Park Health Centre
15. Tower Street Prison

Western Regional Health Authority (WRHA)

16. Cornwall Regional Hospital
17. Montego Bay Type V
18. Savanna-la-mar Hospital

North East Regional Health Authority (NERHA)

19. St Ann's Bay Type 4
20. St. Ann's Bay Hospital
21. Port Antonia Hospital
22. Port Maria Hospital

Southern Regional Health Authority (SRHA)

23. Mandeville Type V
24. Mandeville Hospital
25. May Pen Hospital
26. Black River Health Centre


USAID